Questions about the program?
Email Washcocares@outlook.com

*324 E. Antietam St., Suite 301*
*Hagerstown, MD 21740*

2023

Dear Caregiver,

Attached is an application for the Washington County CARES Respite Program. This grant provides financial reimbursement to assist with the cost of in-home care, adult day services, or a short stay in a licensed assisted living or nursing facility. The program was created to support caregivers with financial support to help cover the cost of intermittent or temporary care so caregivers can receive breaks and regain strength to fulfill daily care responsibilities. Community generosity made these grants available to Washington County families.

Reimbursement is contingent to the availability of funds. Grants are distributed at a maximum amount of $500.00 and available to eligible and approved applicants one time only.

Please note to be eligible for a grant, the maximum monthly income limit for an individual is $2,841and $3,715 for a couple. Asset limits are $11,000 for one person and $14,000 for a couple.

To apply, please complete the attached application and consent form, email to washcocares@outlook.com or mail to the address below.

Washington County CARES Respite Program
324 E. Antietam St., Suite 301
Hagerstown, MD 21740

If you have any questions or need assistance completing the application, please email washcocares@outlook.com

Sincerely,

*Amanda Crawford*

Amanda Crawford
President
Washington County CARES Respite Program

Washington County CARES

*324 E. Antietam St., Suite 301*
*Hagerstown, MD 21740*

# WASHINGTON COUNTY CARES RESPITE FUND APPLICATION

**(PLEASE PRINT LEGIBLY)**

**Person requiring caregiving services**: _____

Address_____

City_____ State_____Zip_____Phone_____

Health/Medical Problem(s) _____

**Primary Caregiver Name**_____

Address_____

City_____ State_____Zip_____Phone_____

**Intent of how funds will be used** _____

If known, what person/company/agency will be providing care and giving you a break?

_____

Estimated Cost (if available)_____

Amount Individual and/Family can contribute to caregiving services_____

Are you presently receiving services through the Department of Social Services or public agency? _____

What is the monthly income (all sources) of the person requiring caregiving services? _____

What is the family income (all sources) of the person requiring caregiving services? _____

Is applicant willing to send a letter of appreciation to Washington County CARES? ____Yes ___No

Answers to the following questions will help Washington County CARES maintain demographical information about caregivers in our community. This information will help us to continue our efforts to seek grant funding that promotes the health and wellbeing of caregivers. Identifying information is completely confidential.

**Person requiring caregiving services**

(M/F) _____Date of Birth _____Race _____

Highest level of education (High School, College) _____

**Primary Caregiver**

(M/F) _____ Date of Birth _____ Race _____

Employed (Yes/No) _____ Full time/Part time _____

# Washington County CARES
# Hold Harmless and Consent to Release Information

In exchange for the right to participate in the Washington County CARES Respite Fund Program, I (we) hereby release and agree to hold harmless the Washington County CARES organization, its board of directors, representatives, members, volunteers, clients and /or providers, of and from all liability, loss, claims, and demands that may accrue from loss, damage, loss or damage of property, or injury to person(s) involved in any way resulting from, or arising in connection with my participation with the Respite Fund.

I/we_____, do hereby consent that Washington County CARES may share and release information to coordinate and arrange for payment with respite providers that provide supervision, companionship care, adult day care, etc. for Washington County CARES applicants and family.

Caregiver Name: _____

Signature: _____

Date: _____

Relationship to the Person requiring caregiving services: _____