Date Received _____

FOR OFFICIAL USE ONLY

Betty Bazemore Memorial Respite Grant Application

Recipient Information

_____ _____ __ _____ _____

Mr/Ms/Mrs/Miss First Name M.I. Last Name Suffix (Jr, Sr, Etc.)

DOB _____ / _____ / _____ Sex: ☐ M ☐ F Marital Status: S M W D

Address _____ Address 2 _____

City _____, VA Zip _____

County _____

(_____)_____-_____ _____

Home Phone Email Address

Caregiver's Name _____

Recipient's Gross Monthly Household Income: Include income from ALL sources (Your household includes you, your spouse/partner and all dependents)

Name of Person in Household	Source and Amount of Income	Source and Amount of Income	Source and Amount of Income	Source and Amount of Income
			Total MONTHLY Household Income	

Name of the Partners in Aging Company that will be providing care: _____

(See listing of companies on back)

Please tell us how this grant will be used:

The grant must be used within 90 days of approval unless prior arrangements have been made.

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Additional Information

Partners in Aging In-Home Care Companies		
BrightStar 10401 Courthouse Road, Suite D Spotsylvania, VA 22553 (540) 376-3131	Comfort Keepers 419 Chatham Square Office Park Fredericksburg, VA 22405 (540) 370-0008	Home Instead Senior Care 111 Olde Greenwich Drive, Suite107 Fredericksburg, VA 22408 (540) 899-1422
One on One Care 300 Garrisonville Road, Suite 101 Stafford, VA 22554 (540) 288-1300	Right At Home 2124 Jefferson Davis Hwy., Suite 101 Stafford, VA 22554 (540) 720-0734	Sweet Home Serenity Care 13279 Kings Hwy., Suite #1 King George, VA 22485 (540) 384-2273
Virginia Home Care Partners 1135 Heatherstone Drive Fredericksburg, VA 22407 (540) 419-1615		
One of the above listed Partners in Aging Companies must be used for your 8 hours of care. If you currently use a different company, they may become partners by following the application process at www.partnersinaging.org.		

Example of how to fill in income information

Name of Person in Household	Source and Amount of Income	Source and Amount of Income	Source and Amount of Income	Source and Amount of Income
John Jones	$980 Social Security	$320 Pension		
Alberta Jones	$892 Social Security Disability			
			Total MONTHLY Household Income	$2192

Income Limits	
Persons in Family Unit	250% Poverty Level Annual
1	$29,700.00
2	$40,050.00
3	$50,400.00
4	$60,750.00

I certify that the information provided on this application is accurate. I understand that withholding of information or giving false information will result in denial of funds. I also understand the grant must be used within 90 days of approval unless prior arrangements have been made.

_____ _____

Signature of Caregiver/Person Making Application Date

Date Processed _____

Reviewed By _____

Approved/Denied _____

Letter Sent _____

FOR OFFICIAL USE ONLY

Please mail completed application to:
Partner's in Aging PO Box 8237, Fredericksburg, VA 22404

Please allow 2 weeks for processing