

Betty Bazemore Memorial Respite Grant Application

Date Received _____
 FOR OFFICIAL USE ONLY

Recipient Information (Person Receiving Care)

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 _____ Email Address _____

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:

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Additional Information

Partners in Aging Grant Providers		
Care Advantage 10653 Spotsylvania Ave. Fredericksburg, VA 22408 540-324-4543	Comfort Keepers 304 Westwood Office Park Fredericksburg, VA 22401 (540) 205-8743	Home Instead 111 Olde Greenwich Drive, Suite 107 Fredericksburg, VA 22408 (540) 899-1422
Right At Home 2124 Jefferson Davis Hwy., Suite 101 Stafford, VA 22554 (540) 720-0734	Magnolia Home Care, LLC 2217 Princess Anne St., Suite 219-1B Fredericksburg, VA 22401 (540) 287-1705	Virginia Home Care Partners 10718 Ballantraye Dr., Suite 410 Fredericksburg, VA 22407 (540) 419-1615
Visiting Angels 1952 William St. Fredericksburg, VA 22401 (540) 373-6906		
One of the above listed Partners in Aging Companies must be used for your approved 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	\$37,650.00
2	\$51,100.00
3	\$64,550.00
4	\$78,000.00

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

Please mail completed application to:
Partners in Aging PO Box 8237, Fredericksburg, VA 22404

Please allow 2 weeks for processing

Date Processed _____
Reviewed By _____
Approved/Denied _____
Letter Sent _____
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