Eastern Carolina Council Area Agency on Aging

Family Caregiver Support Program Client Waiver Form

Applicant Agency _____ **County:**_____

Waiver Request Budget: Please complete the budget table below indicating client waiver request above the ECC-AAA $1,500, **not to exceed the NC State FCSP cap of $2,500.**

Client Name:	FCSP Client DOB:	Client FCSP Service Code	Client To Date FCSP spending:	Funding Increase Amount Requesting	Total Caregiver FY 17-18 Allocations- Not to exceed the State Cap of $2,500
1.			$	$	$
2.			$	$	$

**Please note:* The ECC-AAA FCSP will need to be notified of any client allocation funding amounts during grant time period and prior written approval from ECC-AAA will be required clients ECC-AAA cap will be exceeded.

Does the care recipient have a diagnosis of Dementia or Alzheimer's? **YES** **NO**

Has this Caregiver been serviced and/or referred through Project CARE funding for FY 2017-2018? **YES** **NO**

If YES, how much has the client received funding from Project CARE for FY 2017-2018? $ _____

_____ _____
Provider Signature *Date*

ECC-AAA Office Use Only

Date Request Received _____

- ☐ **ECC-AAA Waiver approved**
- ☐ **Request for Further Information (Date::_____)**

_____ _____ _____ _____
ECCAAA-Director Approval Signature *Date* *ECCAAA-FCSP Signature* *Date*

Eastern Carolina Council Area Agency on Aging

Family Caregiver Support Program Grant Budget Revision

Client Initials: _____

Waiver Request Amount: $_____

Date of Requested Increase of ECCAAA FCSP allocations: _____

Explanation of client funding waiver request:

(Example: Services pursing for client, long term goal, on waiting list, Emergency Caregiver Services, short term hardship, etc…)