



## Direct Care Service Criteria

AOS & Friends Care (AOS&FC) is a not-for-profit organization that provides funds to support the direct care needs of financially qualified individuals. Our mission is to provide direct care and community support with a focus in Moore County to older and disabled adults dealing with the challenges of aging, with a specific interest in those with some form of dementia. Applicants must submit an application and be approved by the AOS&FC board of directors.

### **Direct Care Services may include:**

- **Assessment of needs:** A written evaluation and assessment of needs identified between client and certified care manager\*.
- **Care Coordination:** The coordination of care services in the community to help meet identified needs, this may include equipment or devices to support safety and enable independence.
- **Placement Assistance:** Identify resources, level of care and placement options for those who are not able to remain safely in the home.
- **Caregiver support** through credentialed caregivers who provide private-duty caregiving services in the home.
- **Equipment, devices, and therapeutic aids** as deemed beneficial in the written assessment

### **Parameters for AOS & Friends Care direct service support include:**

- Recipient must be 50 years of age or older.
- Recipient may receive maximum funding support up to \$1000, depending on assessed need.
- Preference will be given to first time applicants, not currently utilizing care management services.
- Preference will be given to those not eligible for funding through other resources (such as social services).
- Preference will be given to those residing in Moore County.
- Financial qualification for services will be based on monthly income.

All interested applicants must submit an application and be available for interview. Additional paperwork and permissions may be required based upon the type of direct care support for which the applicant is applying.

***\*Please note all care managers must be certified to be considered as a provider. All direct caregivers must pass a multi-state background check and carry professional liability insurance or be covered through an employer workers compensation policy.***



## Direct Care Service Support Application

Direct Care Applicant Name: \_\_\_\_\_  
First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_

Name of Person Completing Application if different: \_\_\_\_\_

Relationship to Applicant: \_\_\_\_\_

Home Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County of Residence: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Mobile: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Marital Status:  Married  Widowed  Divorced  Single Gender:  Male  Female

Live Alone?  Yes  No If No, with whom: \_\_\_\_\_

Lives in:  Own Residence  Family Member's Residence  Other \_\_\_\_\_

Direct Care Services Requested (Check all that apply):  Care Coordination  Assessment

Placement Assistance  Caregiver Services  Other \_\_\_\_\_

**Primary Diagnosis or presenting problem:**  
\_\_\_\_\_  
\_\_\_\_\_

Please tell us how applicant will benefit from these direct care services (May attach additional sheets if more space is required):  
\_\_\_\_\_  
\_\_\_\_\_

### MONTHLY HOUSEHOLD INCOME

Source of Income	Recipient	Spouse	Other	Subtotal
Social Security	_____	_____	_____	_____
Pension	_____	_____	_____	_____
Wages	_____	_____	_____	_____
Other	_____	_____	_____	_____
				Total _____

I do hereby attest to the correctness and accurateness of the above information. I am prepared to provide documentation to support the above information.

Applicant/Family Member/Caregiver Signature (required): \_\_\_\_\_ Date: \_\_\_\_\_

Other (if application is completed on behalf of applicant): \_\_\_\_\_ Date: \_\_\_\_\_

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## Direct Care Service Application Review

Direct Care Applicant Name: \_\_\_\_\_  
First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_

Person Reviewing Application: \_\_\_\_\_ Date: \_\_\_\_\_

Service Requested: \_\_\_\_\_

Service Provider (if requested): \_\_\_\_\_

Stated monthly income: \_\_\_\_\_

Monthly Income Requirements:      Individual: **Below \$3,500 per month**  
    Couple: **Below \$4,000 per month**

Applicant meets AOS&FC Income Qualifications     Yes     No

Applicant has Special Circumstances listed below:

Direct Care Service Support is:     APPROVED in the amount of \$ \_\_\_\_\_  
     DENIED due to : \_\_\_\_\_

### Applicant Notification

Date: \_\_\_\_\_ Date Services to Begin (if approved): \_\_\_\_\_  
Provider: \_\_\_\_\_

Approved by the AOSF&C Board \_\_\_\_\_  
Date \_\_\_\_\_