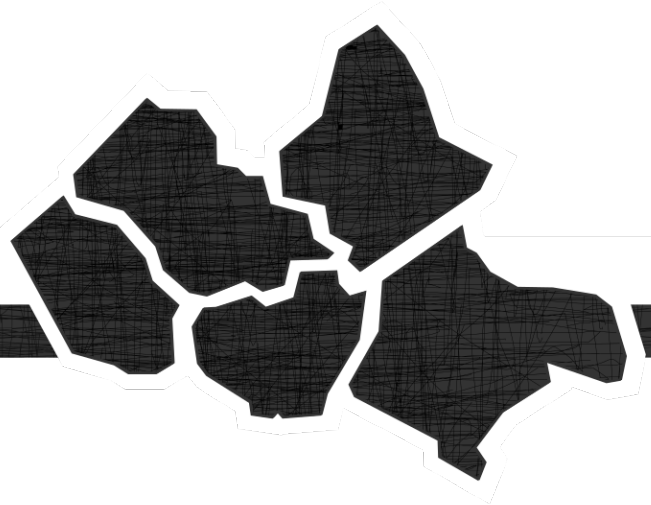
GATEWAY
AREA DEVELOPMENT DISTRICT
Bath | Menifee | Montgomery | Morgan | Rowan



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FY27

Dear Grandparent,

Thank you for your interest in the Gateway Area Development District (GADD) Area Agency on Aging's Kentucky Family Caregiver Program also known as the Grandparents Raising Grandchildren Program. Per state guidelines: Applications will be considered on a priority basis, with applicants that did not receive services through the program in the previous fiscal year receiving higher priority.

If funding is available and all applicants that did not receive services through the program in the previous fiscal year have been served, we will award funds based on the date your application was approved.

If you would like to be considered for funding this fiscal year (July 1, 2026 - June 30, 2027) you must have an approved application on file. And each year that you participate in the program, you will need to renew your application. The next step is completing the application process.

Please read this letter completely for detailed instructions on the application process for the GADD Grandparents Raising Grandchildren Program.

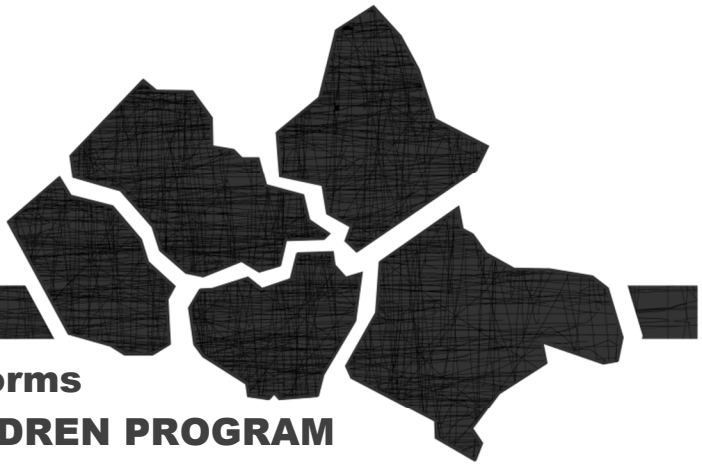
Enclosed you will find several forms that need to be completed and returned to determine your eligibility for the Kentucky Family Caregiver program. Please refer to the following chart for instructions on each form and commonly missed items or problems that may delay processing or eligibility.

When you are ready to submit your completed application including financial information, please contact me at the number below to schedule a time & date to meet in person at the local senior center in your county. You can also submit the application by sending it by mail to the main GADD office at the address at the bottom of the page or by scanning the application documents and sending them to me by email, however, the original notarized document must be submitted before the application can be approved.

It is my sincere pleasure to assist you!

Gina Thompson
Kentucky Family Caregiver
Grandparents Raising Grandchildren Program
(606) 784-8466
gina.thompson@gwadd.org

GATEWAY
AREA DEVELOPMENT DISTRICT



# Directions for Filling Out Application Forms
# GRANDPARENTS RAISING GRANDCHILDREN PROGRAM

| Form | Be sure to double check: |
|---|---|
| DAIL-KFC-1 Application Page 1 | ▪ Provide all applicable information on grandparents and other family members **living** in the home.<br>▪ Check off **ALL** forms of income for **ALL** MEMBERS of the household, formal support, and informal support.<br>▪ Write in the actual amount of **ALL TOTAL MONTHLY HOUSEHOLD INCOME** before any taxes or any other deductions. |
| DAIL- KFC-1 Application Page 2 | ▪ **Complete a separate page 2 for each grandchild in the home.**<br>▪ Provide the full name, age, date of birth and social security number for each grandchild.<br>▪ List any resource requests you may have outside of clothing and supplies.<br>▪ Do not be concerned about the dollar amount to request, as that will be set through the Gateway budget allotment determination, which changes annually. |
| DAIL- KFC-1 Application Page 3 | This is the final page of the DAIL KFC Application<br>▪ **Make sure you read and understand this page completely before you SIGN and DATE for confirmation.**<br>▪ If you have any questions, please call the Gateway Aging & Disability Resource Center (ADRC) at (606) 780-0141 |
| DAIL Attestation of Relationship | ▪ This form is to be completed by a **FRIEND, FAMILY MEMBER OR PROFESSIONAL** willing to **confirm,** or **ATTEST,** on a **NOTARIZED** statement that you are a grandparent by blood, marriage, or adoption to the grandchild(ren). The **ATTESTANT'S** name should be shown in the very first blank on this document, which is on the first line.<br>▪ The **ATTESTANT** must also confirm **neither parent resides** in the **home** with the grandparent or grandchildren, entering their name **AGAIN** on the blank line in the second paragraph of this document. The **GRANDPARENT NAME** is entered in the second blank of the first sentence of this statement.<br>▪ List all grandchildren you are requesting to participate in this program on the appropriate 2nd line of the statement.<br>o This form must be **NOTARIZED with Commission Number and Expiration Date**<br>▪ Be sure each person signs on the appropriate line.<br>▪ Enter the date by each signature at the time of notarizing.<br><br>**Return this form with the application as required by the Kentucky Department of Aging and Independent Living (DAIL) as of October 2017.** |

| | |
|---|---|
| Additional Household Members (if applicable) | ▪ **Members of a household include:** Everyone who calls the residence their home, regardless of their relationship to the applicant and whether they received income and contribute to expenses or not.<br>▪ Do not list the grandparents and grandchildren who have already been listed on page 1 or page 2.<br>▪ If there are no other people living in your home besides you and the grandchildren you have listed on page 2, write **"NO ADDITIONAL"** at the top of the page and **INITIAL.** |
| Voter Registration Rights and Declination | ▪ Print your name at the top of the page.<br>▪ Check the appropriate box according to your status of voter registration.<br>▪ **Sign and Date**<br>▪ **If you prefer not to complete this form for any reason, please write**<br>▪ **"Declined to complete" at the top and initial.** |
| Grandparent Rights and Responsibilities | ▪ Read carefully, as this is a legal document.<br>▪ Initial where indicated.<br>▪ Sign the bottom line and fill in the date of your signature.<br>▪ **YOU MAY REQUEST A COPY FOR YOUR RECORDS**<br>▪ If you have any questions as to the meaning of this form regarding your responsibilities or the consequences of not presenting accurate information, please call us for a more complete explanation. |
| Program Consent Form | ▪ Please read carefully and call if you have questions regarding this form or other parts of the application process.<br>▪ Sign and date |
| Informed Consent and Release of Information and Records | ▪ Print your name and social security number at the top of the page.<br>▪ Initial by each of the information or records to be release (Kinship, K-TAP, etc.)<br>▪ Enter consent information each grandchild (name, SSN, relationship) in the table<br>▪ Enter the period of the authorization (12 months)<br>▪ Sign and date and have a witness sign and date |
| Shopping Preference & Referral Source | ▪ Check the box for the appropriate method and location for your preferred Walmart<br>▪ Identify how you heard about the Grandparents program<br>▪ Identify how you obtained the application materials |

# *DAIL-KFC-1 APPLICATION FOR KENTUCKY FAMILY CAREGIVER SERVICES*

***Complete all information on this application. (Some questions asked for statistical information)***

***Grandparent and Household Information:***

*Name (s) of Grandparent Caregiver(s)* *Gender* *Social Security #* *Birthdate*

*1.* _____ _____ _____-____- _____ ____/____/_____

*2.* _____ _____ _____-____- _____ ____/____/_____

*Address* _____

*City* _____, *KY Zip:*_____ *County*_____

*Phone:* _____ *Resident of KY? Yes ___ No ___ US Citizen? Yes ___ No ___*

*Alt Phone:* _____ *Marital Status* _____ *Race 1.* _____ *2.*_____

*Number of grandchildren being cared for:* _____ *(Give information for each grandchild on next page(s)*

*Total Number living in household:* _____ *Total Household Income(earned and unearned):*_____

*Emergency Contact Name and Phone #* _____

***Documentation of Gross (before deductions/taxes) Earned and Unearned Income for all members living in the household: (Please attach a copy of pay stubs, letters, etc to verify all income) Check all that apply***

_____ *Federal Tax Form (1040, 1040A, etc.) --*
_____ *W2(s)*
_____ *Employment*
_____ *K-Tap*
____ *Veterans*
_____ *Kinship Care*
_____ *Other: Please list:* _____
_____
_____

____ *Social Security*
____ *SSI*
____ *Social Security Disability Income (SSDI)*
____ *Pension/Retirement*
____ *Dividends, subsidies, etc.*
____ *Child Care Assistance*

***Formal Support (programs and agencies that are helping you other than those listed above) Check all that apply.***

*FRYSC/Family Resource Center ____ Comp Car/Mental Health Services ____ First Steps ____*
*IMPACT ____ IMPACT Plus ____ Food Stamps ____ Women, Infants & Children (WIC) ____*
*Commission for Children with Special Health Care Needs (CCSHCN) _____*
*Early Periodic Screening Diagnosis and Treatment (EPSDT) _____*
*Other:* _____
_____

***Informal support (that offer you help): Check all that apply***

*Family ___ Friends ___ Neighbors ___ Church ____ Volunteers/Helpers ____*
*Other:* _____

# *KENTUCKY FAMILY CAREGIVER PROGRAM APPLICATION*

***Grandchild Information (Complete one page per grandchild)***

*Name of grandchild:* _____ *Birthdate* _____
*SS#*_____ *Gender* _____ *Race* _____

*Is the grandparent(s) the full-time primary caregiver for this grandchild? Yes* ☐ *No* ☐
*How are you related to grandchild? Blood* ☐ *Marriage* ☐ *Adoption-*☐*-Date (final)* _____
*Does this grandchild reside with you? Yes* ☐ *No*☐
*Does the parent(s) of this grandchild reside in the home? Yes* ☐ *No* ☐
*Does this grandchild receive Kentucky Kinship Care funds? Yes*☐ *No* ☐
*Does this grandchild receive Kentucky Transitional Assistance Program (K-Tap)? Yes*☐ *No* ☐
*Does this grandchild receive Kentucky Children's Health Insurance Program (KCHIP)? Yes* ☐ *No* ☐

| ***Supplemental Services/Needs*** | ***Amount/Vendor (for agency use)*** |
|---|---|
| ***Clothing for grandchild****: Write in number needed next to each item*<br>*Pants/Shorts ___ Skirt/Dress ___ Shirts/Blouses ___*<br>*Sweaters ___ Underwear ___ Socks ___ Pajamas ___*<br>*Shoes/Boots ___ Coat/Jacket ___ hat/gloves ___* | *Amount:* _____<br>*Vendor:* _____<br>*Vendor:* _____<br>*Vendor:* _____ |
| ***Personal Care Needs*** *(write in items)* | *Amount:*<br>*Vendor:* _____<br>*Vendor:* _____<br>*Vendor:* _____ |
| ***Educational Needs*** *(attach documentation from child's school)*<br>*School Supplies/Equipment (one back pack with school supplies)*<br>_____<br>_____<br>_____<br>*Academic Assistance/Tutoring: Explain type and how often:*<br>_____<br>_____ | *Amount:* _____<br>*Vendor:* _____<br>*Vendor:* _____<br>*Vendor:* _____ |
| ***Legal Services Pursuant to 910 KAR 1:260 Section 7(4):*** *Please explain the need (attach document showing cost)* | *Amount:* _____<br>*Vendor:* _____<br>*Vendor:* _____ |
| ***Medical and/or Dental Services:*** *Please explain/attach verification* | *Amount:* _____<br>*Vendor:* _____<br>*Vendor:* _____ |
| ***Furniture for grandchild such as****: (check the item)*<br>*Bed* ☐ *Crib* ☐ *Toddler Bed* ☐ *Dresser* ☐ | *Amount:* _____<br>*Vendor:* _____<br>*Vendor:* _____<br>*Vendor:* _____ |
| ***Respite*** *(limited break from care giving): Please explain* | *Amount:* _____<br>*Vendor:* _____<br>*Vendor:* _____<br>*Vendor:* _____ |

***TOTAL FUNDS REQUESTED FOR THIS GRANDCHILD: $_____***

# *KENTUCKY FAMILY CAREGIVER PROGRAM APPLICATION*

## ***Authorization and Signature Page***

***Grandparent: Please read information below then sign and date where it says Grandparent.***

*I am applying to receive services from the Kentucky Family Caregiver Program.*

*I understand that within thirty (30) days of verifying eligibility, I will be notified if eligible or not eligible for services. If declared not eligible, I have the right to request a local resolution with the district of residence. If I am dissatisfied with the results of the local resolution, I may request an administrative hearing in accordance with KRS Chapter 13B.*

*I give permission for the Area Agency on Aging and Independent Living or the Department for Aging and Independent Living or its designated contract agency to verify eligibility which includes contacting the Department of Community Services to confirm benefits being received.*

*I understand if I am found to be fraudulent in the information I share or in the use of the voucher or grant for this program that I could be prosecuted pursuant to KRS Chapter 514 and shall be permanently prohibited from participating in the Kentucky Family Caregiver Program.*

*I can expect all information concerning me to be kept confidential in accordance with Open Records Statutes; however, I do understand portions of this information may be shared with appropriate parties for purpose of an Exception Request and on a referral basis as identified above or as required by law.*

_____ _____

***Grandparent Signature*** ***Date Signed***

*I am requesting an Exception by completing Page 3 of this Application*

_____ _____

***Grandparent Signature*** ***Date Signed***

_____ _____

***KFCP Staff Signature*** ***Date Received***

***Date Client Notified of Eligibility Status:***

***Eligible: _____*** ***Not Eligible: _____ _____***

***By phone: _____*** ***by letter: _____***

Department of Aging and Independent Living

Attestation of Relationship for the Caregiver Program

I, _____, can attest that _____ is the grandparent to _____ by blood, marriage, or adoption. The above individual is also the primary caregiver for the grandchild (ren) listed above which also resides in their home.

I, _____, can also attest that the parents to the above grandchild (ren) do not reside in the house with the grandparents and grandchild (ren).

I am a (friend/family member) to the above grandparent.

*I hereby certify that the above information is true and accurate to the best of my knowledge and belief. I understand that if I intentionally provide inaccurate information, the applicant will be terminated from the Caregivers program and may be subject to legal penalties from the Department of Aging and Independent Living (DAIL). (This form must be notarized in order to be acceptable verification for the program.)*

Signature/ date of Applicant

_____ (MM/DD/YYYY)

Signature/ date of Attestant

_____ (MM/DD/YYYY)

Signature/ date of Notary

_____ (MM/DD/YYYY)

My Commission Number _____

My Commission Expiration Date _____

GATEWAY
AREA DEVELOPMENT DISTRICT

## Grandparents Raising Grandchildren Program

### ADDITIONAL HOUSEHOLD MEMBERS

*Do Not Include Grandparent or Grandchildren Already Listed on Page One or Two of the Application Forms.*

| # | NAME<br>First and Last | Social Security Number | Relationship | Income |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |

DAIL-VR-01
(R. 7/11)

COMMONWEALTH OF KENTUCKY
Cabinet for Health and Family Services
Department for Aging and Independent Living

# VOTER REGISTRATION RIGHTS AND DECLINATION

_____
(Applicant's Name)

REGISTERING TO VOTE

If you are not registered to vote where you live now, would you like to apply to register to vote? (please check the appropriate box).

☐ YES ☐ NO ☐ ALREADY REGISTERED

IF YOU DO NOT CHECK ONE OF THE BOXES ABOVE, IT WILL BE CONSIDERED THAT YOU HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

_____ _____
(Applicant's Signature) (Date)

If you register to vote or decline to register to vote, this decision and any information regarding the office to which the application was submitted remains confidential and is used only for voter registration purposes.

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

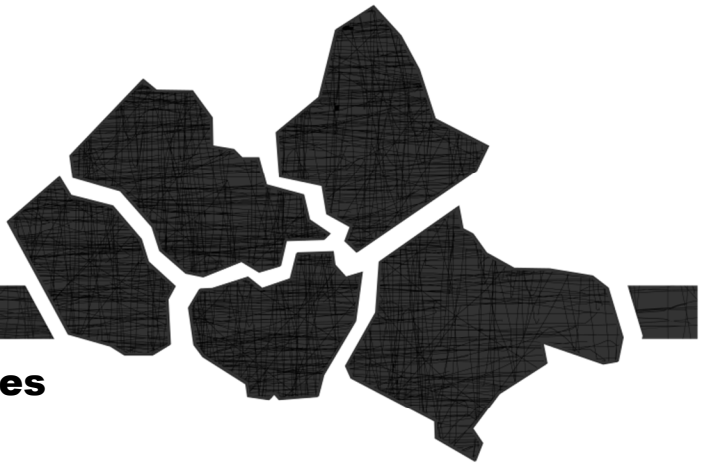
If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may complete the application form in private, if you desire.

If you complete a voter registration application form, it will be forwarded to your local county clerk who will assign you a voting precinct. A confirmation notice with your precinct and voting location will be mailed to you by the county clerk. IF YOU DO NOT RECEIVE SUCH NOTICE WITHIN THREE (3) WEEKS, PLEASE CALL YOUR COUNTY CLERK.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register, or in applying to register to vote, or your right to choose your own political party or other preference, you may file a complaint by writing or calling the State Board of Elections, 140 Walnut Street, Frankfort KY 40601, phone 1-800-246-1399.

Please note that KRS 116.045(2) requires the clerk to close all registration 28 days prior to any election. If your application is received during this period, you will not be eligible to vote until the next election.

GATEWAY
AREA DEVELOPMENT DISTRICT



# Grandparent Rights and Responsibilities

The State Regulations governing the Gateway Area Development District's (GADD) Kentucky Family Caregiver Program A.k.a. Grandparent Raising Grandchildren Program are as follows:

910 KAR 1:260 Kentucky Caregiver Program relates to KRS 199.011 (4), 205.455 (4), 42 U.S. C. 601,651, 1381, 3030s, 3030s-1. Statutory Authority: 2006 KY. Acts ch. 252, KRS 194A.050 (1) Necessity, function, and conformity: 2006 KY. Acts ch. 252 requires the Cabinet to implement the Kentucky Family Caregiver Program providing assistance, including grants or vouchers, to grandparents who are primary caregivers of their grandchildren.

To be eligible for the GADD Grandparents Raising Grandchildren program the following must apply:

| Section 2. 910 KAR 1:260 | Initial |
|---|---|
| 1. Be a Kentucky Resident | _____ |
| 2. Be the primary caregiver for a grandchild | _____ |
| 3. Be related to the grandchild by blood, marriage or adoption | _____ |
| 4. Shall not reside in the same household as the parents of the grandchild | _____ |
| 5. 922 KAR 1:030: Shall not receive a monthly payment of Kinship Care | _____ |
| 6. Income shall not exceed 150 percent of Federal Poverty Level | _____ |

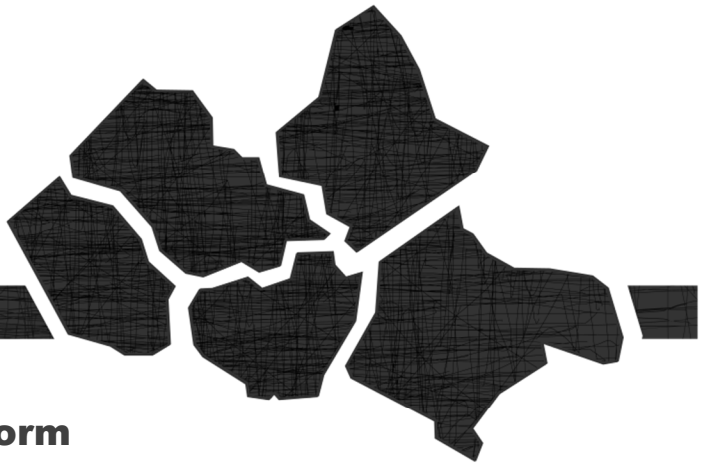
(1) A Grandparent shall apply and/or reapply for the Kentucky Family Caregiver Program each fiscal year. Failure to complete a new application will restrict the use of supplemental assistance for the fiscal year until an updated application is completed and approved. (2) A Grandparent shall provide the District with accurate and verifiable information. (3) A grandparent must immediately notify the district of status changes that are noncompliant with the eligibility requirements. (4) Under no circumstance should the grandparent contact the vendor about the voucher system process. The grandparent's relationship is with GADD and GADD is responsible for communication with the vendor. (5) If the grandparent seeks an appeal, he/she must adhere to the District appeals process. Every grandparent denied service has the right to appeal. (6) A grandparent must comply with the policies and procedures set forth by the Area Agency on Aging and Independent Living and the District.

KRS 194A.505 states, "No person shall, with intent to defraud, knowingly make a false statement or misrepresentation or by other means fail to disclose a material fact used in determining the person's qualification to receive benefits under any assistance program. (2) No person shall, with intent to defraud, fail to report a change in the factors affecting a person's eligibility for benefits." By not disclosing pertinent information as it pertains to the GADD Grandparents Raising Grandchildren program you are knowingly committing a fraudulent act. You must provide accurate information about your situation in order to maintain services with the GADD Grandparents Raising Grandchildren Program.

Signature of Caregiver _____ Date _____

Witness _____ Date _____

GATEWAY
AREA DEVELOPMENT DISTRICT



## Family Caregivers Program Consent Form

I am applying for Family Caregivers Program services which might include information, assistance, counseling, support services, education/training, respite, and supplemental services. I understand my caregiver needs will be assessed and that some of the services may have certain requirements I must meet in order to be eligible to receive them.

I can expect all information concerning myself to be kept confidential in accordance with Open Records Statutes; however, I do understand portions of this information may be shared with appropriate parties on a referral basis as approved by myself or required by law.

I realize my participation may be counted and documented as part of the Family Caregivers Program, but any personal information would not be reported, it would only appear as group totals.

If I am declared ineligible to receive services, I have the right to request an Administrative Hearing in writing. I also understand that the determination of eligibility for these services does not affect any other services or benefits that I may be receiving.

| | |
|---|---|
| Applicant/Proxy Signature | Date |
| Witness (if applicable) | Date |

(R. 01/07)

COMMONWEALTH OF KENTUCKY
Cabinet for Health and Family Services
Department for Aging and Independent Living

## INFORMED CONSENT AND RELEASE OF INFORMATION AND RECORDS

**Name**_____ **SSN**_____

I understand to help my family and I get the services we need, the Area Agency on Aging (AAA), Division of Aging (DAS) and the Department for Community Based Services (DCBS) may need to share information and records in order to provide or verify eligibility for these services. By signing this form, I give AAA and DCBS staff permission to share information needed to see if I am eligible for any assistance program. I also give permission for AAA and DCBS to share information and records with one another about services or benefits provided to me and my family.

My consent includes the following information and records (please put your initials beside each checked item that you consent to):

____ Residential Records
____ Kinship
____ Food Stamp Record
____ K-TAP Records
____ Child Support Records
____ Other_____

This consent applies to the following members of my family:

| Member Name | SSN | Relationship | Member Name | SSN | Relationship |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

I understand that:

- This authorization will be in effect for a period of _____ (not to exceed 12 months) from the signature date.
- I may revoke this consent at any time in writing unless action has already been taken based on my consent.
- Signing this form is voluntary, but failing to sign it, or revoking it before the necessary information is obtained, could prevent an accurate or timely response and could result in denial or loss of benefits.
- Information disclosed to DCBS may no longer be protected by the health information privacy provisions of 45 CFR Parts 160 and 164 pursuant to the Health Insurance Portability and Accountability Act (HIPAA).
- Information may be redisclosed by AAA without my consent if authorized by State Law or Federal Laws such as the Privacy Act or 42 CFR Part 2 or to comply with laws regarding mandatory reporting of suspected abuse, neglect or exploitation, or assessment that there is a danger of serious harm to self or others.
- I have received a copy of this form. I may also request a copy of the information retained with it.

**Signature** _____ Date _____
Grandparent

**Signature** _____ Date _____
Grandparent

**Witness Signature** _____ Date _____

GATEWAY
AREA DEVELOPMENT DISTRICT

## SHOPPING PREFERENCE

❑ I prefer to shop **in person** at Walmart at the following location:

- ❑ **Morehead** – Walmart Supercenter, 200 Walmart Way, Morehead, KY 40351
- ❑ **Mount Sterling** – Walmart Supercenter, 499 Indian Mound Dr., Mt. Sterling, KY 40353

## REFERRAL & APPLICATION SOURCES

How were you referred to the GADD and the Grandparents Raising Grandchildren Program?

Where / How did you get the application materials for the Grandparents Program?

Don't forget to include your income documentation. Not including copies of these documents will delay processing of your application.

If you have any questions, please contact the program coordinator, Gina Thompson, at (606) 784-8466 or gina.thompson@gwadd.org

Grandparent Eligible and Ineligible Items List with Quantity Limits

| Items Allowed | Quantity Allowed | Price Per Item |
|---|---|---|
| Pants/Shorts | Multiple | No more than $50 per one item |
| Shirts/Blouses | Multiple | No more than $50 per one item |
| Skirts/Dresses | Multiple | No more than $50 per one item |
| Sweaters/Hoodies | Multiple | No more than $50 per one item |
| Underwear/Bras/Pajamas | Multiple Pkgs or Pairs | Varied |
| Socks | Multiple Pkgs or Pairs | Varied |
| Shoes | 2 Pair | $50.00 max per pair |
| Coats/Jackets | Multiple | Varied |
| Hats & Gloves | Limit 1 of each | Varied |
| Backpack | Limit 1 | $25.00 |
| Hairbrush/Comb | Limit 1 | Varied |
| Soap/Body Wash | Limit 2 | Varied |
| Shampoo/Conditioner | Limit 2 | Varied |
| Deodorant | Limit 2 | Varied |
| Sheets/Pillowcases/Comforter | 1 Set | Varied |
| Diapers (appropriate to age) | Multiple | Varied |
| Diaper Wipes (appropriate to age) | 10 individual packs or 2 cases | Varied |
| | | |
| **Total Order not to exceed $500** | **Items are reviewed and accepted or deleted from order based on discretion of Coordinator** | **If order totals over $500, the least expense item(s) will be removed to allow for shipping.** |
| | | |
| **Items NOT Allowed** | Please be sure to allow for shipping to be added to your order. | |
| NO Perfume/Cologne/Body Spray/After Shave | | |
| NO Lotions, Butter, Creams, etc. | | |
| NO Exfoliating Products (gloves, mitts, scrubs, etc.) | | |
| NO Jewelry | | |
| NO Cosmetics/Makeup | | |
| NO Hair Accessories (NO Headbands/NO Barrettes) | | |
| NO Purse/Wallet | | |
| NO Games/Toys/Electronics | | |
| NO purchases for grandparent or anyone else other than the grandchild specified on the order | | |
| NO Swimsuits/Swim Trunks unless needed for physician ordered aquatic therapy. | | |
| Infants/ Toddlers are allowed car seat, high chair, basic swing, or crib | Limit one of any item | Varied |