



## Adult Day Scholarship Application

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### Caregiver Applicant Information

- **Caregiver Applicant Name:** \_\_\_\_\_
  - **Relationship to Participant:** \_\_\_\_\_
  - **Phone Number:** \_\_\_\_\_
  - **Email Address:** \_\_\_\_\_
  - **Home Address:** \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_
  - **Primary Language Spoken at Home:** \_\_\_\_\_
  - **Caregiver Applicant Employment Status:**  Full-time  Part-time  Retired  Unemployed
  - **Other Caregiving Responsibilities (check all that apply):**  
 Caring for a child  Caring for another adult  Sole caregiver  Other: \_\_\_\_\_
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### Participant's Information

- **Name of Participant:** \_\_\_\_\_
  - **Age:** \_\_\_\_\_
  - **Diagnosis:**  
 Alzheimer's Disease  
 Other Dementia (please specify): \_\_\_\_\_
  - **Diagnosing Physician:** \_\_\_\_\_
  - **Date of Diagnosis:** \_\_\_\_\_
  - **Stage of Dementia (if known):** \_\_\_\_\_
  - **Other Health Conditions (mobility, diabetes, vision/hearing issues, etc.):**  
\_\_\_\_\_
  - **Behavioral Considerations (wandering, sundowning, fall risk, etc.):**  
\_\_\_\_\_
  - **Currently residing at home with Caregiver?**  Yes  No
  - **Is the Participant a veteran?**  Yes  No
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## Caregiving Journey

Please provide a detailed description of your caregiving experience and current circumstances. (Minimum 2–3 paragraphs recommended.)

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- **Average hours per week spent caregiving:** \_\_\_\_\_
- **Current support system (family help, paid aides, none, etc.):**

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- **Top 2–3 challenges you face as a caregiver:**

## Financial & Emotional Hardship

Please describe any financial or emotional challenges you are currently experiencing due to caregiving:

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- **Do you or the Participant have Long-Term Care Insurance?**  Yes  No

## Scholarship Request

- **Have you applied for a scholarship before?**  Yes  No
  - If yes, date of last application: \_\_\_\_\_
- **Have you received a scholarship award from The Memory Connection in the past 12 months?**  
 Yes  No
  - If yes, how many? \_\_\_\_\_ (maximum of 2 per year)

**Proposed Adult Day Program:** \_\_\_\_\_

**City & State of Program:** \_\_\_\_\_

**Is the Program licensed according to state requirements?**  Yes  No

**ADP License Number:** \_\_\_\_\_

**Number of days per week requested:** \_\_\_\_\_

**Approximate hours of respite needed per week/month:** \_\_\_\_\_

**Do you need transportation to/from the program?**  Yes  No

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## Verification & Consent

- **Release of Information Consent:**  
I give permission for The Memory Connection to contact the Adult Day Program

provider listed above to verify licensing, enrollment, and availability.

Yes  No

• **Optional Photo/Story Release:**

I consent to The Memory Connection sharing my caregiver story, photo, or testimonial for program awareness and donor reporting (check one):

Yes, I consent

No, I do not consent

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## Acknowledgment

By signing below, I affirm that the information provided is true and accurate. I understand that scholarship awards have no cash value and cover Adult Day Program services only. I also acknowledge that the Adult Day Program provider must be appropriately licensed, in accordance with The Memory Connection's [Scholarship Program and Policy Terms](#).

**Signature of Caregiver Applicant:** \_\_\_\_\_

Date: \_\_\_\_\_

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 **Submit completed applications to:** [info@thememoryconnection.org](mailto:info@thememoryconnection.org)

 **Learn more:** [Scholarship Program and Policy Terms](#)