Questions about the program?

Email: Washcocares@outlook.com

PO Box 338 Funkstown, MD 21734

2025

Dear Caregiver,

Attached is an application for the Washington County CARES Respite Program. This grant provides financial reimbursement to assist with the cost of in-home care, or a short stay in a licensed assisted living or nursing facility. The program was created to support caregivers with financial support to help cover the cost of intermittent or temporary care so that caregivers can receive breaks and regain strength to fulfill daily care responsibilities. Community generosity made these grants available to Washington County families.

Reimbursement is contingent to the availability of funds. Grants are distributed at a maximum amount of $500.00 and available to eligible and approved applicants one time only.

Please note to be eligible for a grant, the maximum monthly income limit for an individual is $2,841 and $3,715 for a couple. Asset limits are $11,000 for one person and $14,000 for a couple.

To apply, please complete the attached application and consent form, email to washcocares@outlook.com or mail to the address below.

Washington County CARES

PO Box 338 Funkstown, MD 21734

Sincerely,

Amanda Crawford

Amanda Crawford

President

Washington County CARES

Washington County CARES Respite Fund Application

Person requiring caregiving services: _____

Address: _____

City: _____ State:_____ Zip: _____ Phone: _____

Health/Medical Concerns: _____

_____

Primary Caregiver Name: _____

Address: _____

City: _____**State**: _____ **Zip:** _____**Phone:** _____

Intent of how funds will be used: _____

If known, what person/agency will be providing care? _____

Are you receiving current services through the Dept of Social Services or public agency? _____

What is the monthly income (all sources) of the person requiring services? _____

What is the family income (all sources) of the person requiring services? _____

Is the applicant willing to send a letter of appreciation to Washington County CARES?

(Y/N)? _____

Answers to the following questions will help CARES maintain demographic info about caregivers in our community. This information will help us continue our efforts to seek grant funding that promotes the health and wellbeing of caregivers. Identifying information is completely confidential.

Person requiring caregiving services

(M/F)_____ Date of Birth _____ Race_____

Highest level of education (high school/college) _____

Primary Caregiver

(M/F) _____ Date of Birth_____ Race: _____

Employed (Yes/No) _____ Part time/Full time _____

We are thrilled to award grant monies to individuals in need of respite care. The CARES organization works tirelessly to raise funds for this important initiative. It is our duty to our donors to ensure that grant monies are utilized the way they were intended. The CARES organization requests documented proof of the funds awarded within 6 months of the award.

- I verify that the grant monies, if received, will be used only as described within this application. YES or NO _____
- I agree to submit documented proof of the utilization of awarded funds within 6 months of receiving funds. YES or NO _____

Washington County CARES

Hold Harmless and Consent to Release Information

In exchange for the right to participate in the Washington County CARES Respite Fund Program, I (we) hereby release and agree to hold harmless the Washington County CARES organization, its board of directors, representatives, members, volunteers, clients and /or providers, of and from all liability, loss, claims, and demands that may accrue from loss, damage, loss or damage of property, or injury to person(s) involved in any way resulting from, or arising in connection with my participation with the Respite Fund.

I/we _____, do hereby consent that Washington County CARES may share and release information to coordinate and arrange for payment with providers that offer safety supervision, companionship care, adult day care, etc. for Washington County CARES applicants and family.

Caregiver Name: _____

Signature: _____

Date: _____

Person requiring services: _____