The Dementia Expense And Nursing Assistance Foundation

Background

The DEANA Caregiving Grant is an award named to honor the founder's mother Deana Alves who was diagnosed with Early Onset Semantic Dementia. Her family was fortunate enough to have the support around to help with full-time home care for Deana. The DEANA Foundation knows that families in the middle class struggle with home care for their loved ones.

Eligibility

The Eligibility requirements are listed below:

- Doctor's diagnosis of Dementia
- Combine Household Income in the range of $35,000 and $150,000 annually
- Patient is a resident of Riverside County or within our geographical region. Email for specifications.
- Board Members may not self apply

Submitting the Application

- To fill out this packet, save on your computer first
- Then fill out and email to Cassandra@thedeanafoundation.org as an attachment, or you can print it out and mail it to:

  The DEANA Foundation
  7535 Jurupa Ave Unit F
  Riverside, CA 92504
- Make sure you attach all the required documents in your email (See Checklist requirements)

Questions

Any Questions email Cassandra at Cassandra@thedeanafoundation.org or call her at (951) 796- 8859.

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Checklist

- Completed application
- 2 personal references with letters of recommendation
- Personal hardship statement (short paragraph)– How has dementia affected your family and finances?
- Completed Proof of diagnosis Form by physician
- Most current taxes
- Completed financial form
- Proof of Residency in Riverside County

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Application

Applicant's Name:

Address

City **State** **Zip code**

Patient's Name:

Address

City **State** **Zip code**

Phone

Email

Relationship to Applicant:

Are you currently, or have in the past, received any type of financial aid for this patient?
☐ **Yes** ☐ **No**

If yes, Please fill out the information below

Source **Amount ($)** **Date Recieved**

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What types of care are you interested in receiving?

Respite Care ☐
Full-time Home Care ☐
Full-time Care in facility ☐
Part-time Home Care ☐
Part-time Care in facility ☐
Any of the above ☐

Is the patient currently receiving any type of care?

If yes, and you would like to continue using them, please describe the type of care and the name of the facility or company you are currently using.

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Diagnosis

Please provide official documentation of the patient's diagnosis of Alzheimer's or another form of dementia in one of the following forms:

- **A doctor's note (on letterhead)**
- **A copy of a social security or disability letter with diagnosis stated**

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Financial Forms

With this form, include your tax form 1040 and any accompanying schedules from the most recent completed year.

The next three forms are for the last three months. Please fill out as accurately as possible for the patient (including spouse).

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Month 1

Income:	Amount:
Salary	
Retirement	
Social Security	
Alimony	
Child Support	
Disability	
Long – Term Health Care	
Investment Income	
Total Monthly Income:	

Expenses:	Amount:
Rent/Mortgage	
Utilities	
Car Payment 1	
Car Payment 2	
Credit Card 1	
Credit Card 2	
Credit Card 3	
Groceries	
Health Insurance	
Life Insurance	
Other	
Other	
Other	
Total Monthly Expenses:	

Total Monthly Net Income (Loss) – Subtract total monthly expenses from total	

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monthly income	

Month 2

Income:	Amount:
Salary	
Retirement	
Social Security	
Alimony	
Child Support	
Disability	
Long – Term Health Care	
Investment Income	
Total Monthly Income:	

Expenses:	Amount:
Rent/Mortgage	
Utilities	
Car Payment 1	
Car Payment 2	
Credit Card 1	
Credit Card 2	
Credit Card 3	
Groceries	
Health Insurance	
Life Insurance	
Other	
Other	
Other	
Total Monthly Expenses:	

Total Monthly Net Income (Loss) –	

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Subtract total monthly expenses from total monthly income	

Month 3

Income:	Amount:
Salary	
Retirement	
Social Security	
Alimony	
Child Support	
Disability	
Long – Term Health Care	
Investment Income	
Total Monthly Income:	

Expenses:	Amount:
Rent/Mortgage	
Utilities	
Car Payment 1	
Car Payment 2	
Credit Card 1	
Credit Card 2	
Credit Card 3	
Groceries	
Health Insurance	
Life Insurance	
Other	
Other	
Other	
Total Monthly Expenses:	

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Total Monthly Net Income (Loss) – Subtract total monthly expenses from total monthly income	

Residency Verification

Please provide us with proof of residency by attaching a copy of a utility bill.