The Association for Frontotemporal Degeneration
FIND HELP·SHARE HOPE

2700 Horizon Drive, Suite 120
King of Prussia, PA 19406
267.514.7221
info@theaftd.org
www.theaftd.org

Dear Family Care partner,

Thank you for your interest in AFTD's Comstock Respite Grant. We know how difficult it can be for care partners to meet their own needs while caring for a loved one at home. AFTD's respite grant may be used to cover the cost of respite care, where it can be arranged. Care partners may also use respite grants for healthcare services that help maintain their physical, emotional and psychological well-being.

The constant physical and emotional demands of caring for a loved-one with FTD can be overwhelming. It is important to take time for yourself, because reducing your stress can make being a care-partner more positive and may enable the person with FTD to remain at home longer.

Care partners may apply for one AFTD Comstock Respite Grant per fiscal year for as long as necessary. Individuals applying for their 5th or 10th grant will be asked to submit records showing that the person with FTD is receiving on-going medical care or services. Once approved, you arrange the services or purchase the goods you need and submit a request to AFTD for reimbursement up to the grant amount of $500. You can submit a reimbursement request by mail or email or use our online reimbursement form. AFTD reserves the right to ask for receipts or other documentation as needed from grantees who use the online reimbursement form.

The Comstock Grant program is just one way that AFTD can support you in the tremendous work you do as a family care-partner. Together we will continue to work for both care and a cure to change the future for people with frontotemporal degeneration and their families.

Sincerely,

Stephanie Quigley

Stephanie Quigley, MSW, LSW, CDP
HelpLine Manager
phone: 484-672-5686
email: ComstockGrants@theaftd.org

COMSTOCK RESPITE GRANT GUIDELINES

GOALS

- Help family care partners to meet their own needs while caring for a loved one at home.
- Provide time off (respite) for unpaid care partners
- Help fulltime unpaid care partners access healthcare services to maintain their own emotional, psychological and physical health.
- Maintain or improve care-partner well-being through use of respite and/or self-care which may enable the person with frontotemporal degeneration to remain home longer

EXAMPLES OF RESPITE CARE AND OTHER SERVICES COVERED

- In-home care (including family members and other community resources)
- Adult day services
- Short-term, overnight care at home or in assisted living or skilled nursing home
- Mental health counseling or therapy
- Yoga, mindfulness or other classes or resources to maintain well-being

ELIGIBILITY REQUIREMENTS

- Care partner and person with FTD must live together and be residents of the U.S.
- Persons with FTD that are currently receiving respite care through Hospice or any service covered by Medicare, Veterans Administration or other public healthcare benefits are not eligible
- A diagnostic report(s) showing why the FTD diagnosis was made. **A copy of a full evaluation by the diagnosing physician is preferred.** Other acceptable records include a neuropsychological testing report and/or brain imaging tests such as MRI or PET scans. If diagnostic records are not available, a letter from a current physician detailing the diagnostic records they have seen may be acceptable.
- **The confidentiality of all personal information is protected. Medical records are destroyed after initial grant is approved.**

STIPULATIONS

- AFTD will reimburse grantee for up to $500 for expenses incurred AFTER the date a grant is approved
- Applicant is responsible for contracting with the service vendor of his or her choice
- Applicant is responsible for providing AFTD receipts for services rendered upon request
- For every fifth respite grant, submission of additional/current medical records from current physician
- Please contact AFTD If you cannot use grant funds within six months of the approval date

For questions or assistance in completing this application, please contact:

Stephanie Quigley, MSW, LSW, CDP
HelpLine Manager
phone: 484-672-5686
email: ComstockGrants@theaftd.org

Keep this page for your records.

COMSTOCK RESPITE GRANT APPLICATION

Fill out and return this page **with documentation of FTD diagnosis**: (*If you have received a grant in a prior year, medical information is not necessary unless there has been a change in diagnosis.*)

via mail:
AFTD
2700 Horizon Drive, Suite 120
King of Prussia, PA 19406

via email:
comstockgrants@theaftd.org

PRIMARY FAMILY CARE PARTNER'S INFORMATION

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Relationship to Person with FTD: _____

Does the person live with you? ☐ Yes ☐ No

Have you ever received an AFTD care partner respite grant before? ☐ Yes (Year:_____) ☐ No

How do you anticipate using the grant? _____

Tell Us More About You and How We Can Help You

Please consider sharing this information, which can help AFTD to evaluate and expand the reach of our services.

Ethnicity – How do you publicly self-identify?

☐ Hispanic/Latino/Latina/Latinx ☐ Non-Hispanic/Latino/Latina/Latinx
☐ Multi Ethnic ☐ Unknown ☐ Decline to Say

Race – How do you publicly self-identify?

☐ Asian American/Pacific Islanders/Asian ☐ Black/African American/African
☐ Native American/American Indian/Indigenous ☐ White/Caucasian/European
☐ Multi Racial ☐ Unknown ☐ Decline to state

Gender Identity – How do you publicly self-identify?

☐ Female ☐ Male ☐ Non Binary ☐ Decline to state ☐ Other

PERSON DIAGNOSED

Name: _____ Date of Birth: _____

Does the person with FTD currently receive respite care? ☐ Yes ☐ No

Have they been diagnosed with frontotemporal degeneration? ☐ Yes ☐ No

Subtype (if known): ☐ bvFTD ☐ PPA ☐ CBD ☐ PSP ☐ FTD/ALS

Date of diagnosis: _____

Is the person living with FTD a U.S. veteran?

☐ Yes ☐ No ☐ I prefer not to disclose veteran status ☐ I don't know

Ethnicity – How does the person living with FTD publicly self-identify?

☐ Hispanic/Latino/Latina/Latinx ☐ Non-Hispanic/Latino/Latina/Latinx
☐ Multi Ethnic ☐ Unknown ☐ Decline to Say

Race – How does the person living with FTD publicly self-identify?

☐ Asian American/Pacific Islanders/Asian ☐ Black/African American/African
☐ Native American/American Indian/Indigenous ☐ White/Caucasian/European
☐ Multi Racial ☐ Unknown ☐ Decline to state

Gender Identity – How does the person living with FTD publicly self-identify?

☐ Female ☐ Male ☐ Non Binary ☐ Decline to state ☐ Other

HOW DID YOU LEARN ABOUT THE COMSTOCK GRANT PROGRAM? (Select all that apply)

☐ AFTD website ☐ FTD support group ☐ Friend or relative
☐ AFTD staff ☐ Other healthcare or community service provider

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REQUIRED SIGNATURE

I understand the above information to be correct as of _____.
[Today's Date]

Signature of Primary Family Care partner: _____

AFTD is a non-profit, 501(c)(3), charitable organization. A copy of AFTD's official registration and financial information may be obtained from the PA Department of State by calling toll free within Pennsylvania, 1-800-732-0999. Registration does not imply endorsement.