



## Respite Voucher Program Application

PLEASE PRINT CLEARLY AND COMPLETE EACH SECTION

### Caregiver Information:

*This is about YOU - the unpaid caregiver who is responsible for the care receiver.*

Name \_\_\_\_\_ DOB \_\_\_\_\_ Gender \_\_\_\_\_

Street address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

County \_\_\_\_\_ Mailing address  same or \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Primary Phone \_\_\_\_\_ Email \_\_\_\_\_

Preferred communication:  Phone  Email  Mail

Ethnicity:  White  Black/AA  Hispanic  Other

How are you related to the person for whom you provide care?  Parent  Spouse  Grandparent  
 Legal Guardian  Other: \_\_\_\_\_

Do you receive any financial compensation from any other source? \_\_\_\_\_

Do you or have you served in the military?  No  Retired Military  Veteran  Currently Active

Marital Status:  Married  Single  Widowed  Divorced  Domestic Partner / Civil Union

Number of people in your household: \_\_\_\_\_

#### Monthly House Income:

Under \$1,000  \$1,000-\$1,500  \$1,500-\$2,000  \$2,000-\$2,500  \$2,500-\$3,000  \$3,000 +

Is a language other than English primarily spoken in your home?  Yes  No Please specify: \_\_\_\_\_

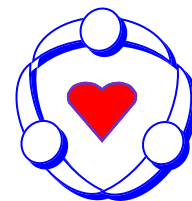
How many hours a day do you provide hands-on care? \_\_\_\_\_

How long have you provided care for the Care Receiver? (months / years) \_\_\_\_\_

Are you employed outside the home:  Full-time  Part-time  N/A

Have you applied or received a respite voucher from Care One Respite Services in the last 2 years?  Yes  No

How did you hear about Care One Respite Services of SC Respite Vouchers? \_\_\_\_\_



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**Care RECEIVER Information:**

*This is about the person for whom you provide care.*

Name \_\_\_\_\_ DOB \_\_\_\_\_ Gender \_\_\_\_\_

Care Receiver's Primary Diagnosis: \_\_\_\_\_

Do you live with this person?  Yes  No If no, how far to CR's home: \_\_\_\_\_ (miles) \_\_\_\_\_ (minutes)

Does this person live alone?  Yes  No

Care Receiver Address (if different from yours): Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Ethnicity:  White  Black/AA  Hispanic  Other

Does the Care Receiver receive any support services?  Medicaid  Medicare  DDSN  CLTC  Baby Net

Early Intervention  ABA Therapy  Other Services: \_\_\_\_\_

If under 21, does the CR attend school?  Yes  No If an adult, has the CR served in the military?  Yes  No

Besides you, does anyone else provide care to the care receiver?  Yes  No

Is there any other program that has provided respite services within the last 12 months?  Yes  No

**If you are awarded a voucher, who would you like to provide care while you take a break from caregiving?**

an In-Home Agency that bills Care One Respite Services directly. Preferred Agency: \_\_\_\_\_

an Adult Day Care that bills Care One Respite Services directly. Preferred Day Center: \_\_\_\_\_

at home with a private provider that I find, employ, and pay out of pocket to give me a break. Care One Respite Services will then reimburse me directly within 30-60 days after the care has occurred.

**What do you hope to get from having a voucher for respite? *Check all that apply***

just some time to myself  a vacation  a good night's sleep

some time with other family or friends without my loved one with special needs

catch up on medical and other appointments for me Other: \_\_\_\_\_



MAIL, EMAIL OR FAX ALL 3 PAGES FULLY COMPLETED TO:

P.O. BOX 50732 MYRTLE BEACH, SC 29579

EMAIL: careonerespitesc@yahoo.com

FAX: 855-756-3330

NOTE: We cannot determine eligibility with an incomplete application.

Respite Voucher Health Care Provider Medical/Special Needs Certification

Respite = regular, short-term breaks for the primary caregiver of someone of any age with special needs.

Care One Respite Services of SC is a non-profit organization working on respite for all family caregivers, no matter their age. With grant funds, we can provide respite vouchers. Your patient/client's family has requested funds for respite. The signatures below indicate their consent to have you release this information.

Name \_\_\_\_\_

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

Circle One: Parent Guardian Spouse Family Caregiver

Signature: \_\_\_\_\_

Name \_\_\_\_\_

Date of birth: \_\_\_\_\_

(Care receiver)

Signature (if able) \_\_\_\_\_

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

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

THIS SECTION TO BE COMPLETED BY A MEDICAL PROFESSIONAL ONLY

(Doctor, Nurse Practitioner, RN, or Physician Assistant.)

We cannot accept certification by CNAs, Social Workers. Case Managers or Early Interventionists.)

1) Please indicate the ability level (0 - 5) for each activity: 0 = independent -----> 5 = totally dependent Feeding \_\_\_ Ambulation \_\_\_ Transferring \_\_\_ bathing \_\_\_ Dressing \_\_\_ bedbound [ ] no [ ] yes

2) This care receiver/patient is [ ] incontinent [ ] bladder [ ] bowel [ ] self-toileting [ ] too young to train yet

4) Due to cognitive or other mental, emotional, or behavioral issues, the care receiver requires moderate to substantial supervision because their behavior poses a health or safety hazard to them self or others.

Yes [ ] No [ ] Cognitive Diagnosis: \_\_\_\_\_

5) In your professional opinion is this care receiver able to be left alone without supervision or assistance for any length of time (i.e., several hours)? Yes [ ] no [ ] overnight? Yes [ ] no [ ]

6) PRIMARY diagnosis \_\_\_\_\_

7) SECONDARY and/or CO-OCCURRING conditions \_\_\_\_\_

If this patient is an infant, child, or adolescent, does s/he require care beyond which a typical babysitter can provide? Yes [ ] No [ ] If yes, please briefly describe the skill set needed to safely care for this patient \_\_\_\_\_

Completed by Professional (printed name): \_\_\_\_\_

Title: \_\_\_\_\_ discipline: \_\_\_\_\_

Name of practice: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Email: \_\_\_\_\_

Professional Signature: \_\_\_\_\_ Date: \_\_\_\_\_