North Carolina Lifespan Respite Program
Voucher Application

Before you begin, please explain to applicant:

1- Lifespan respite funds are only awarded when other funding sources are not available
2- If awarded, respite voucher will be valid for a maximum of 90 days
3- Priority recipients are caregivers who have not had publicly-funded respite within the last 6 months.

Referring Agency Information

Agency name _____

Individual/professional referring caregiver _____

Mailing address _____

City: _____ State: _____ Zip code: _____

Daytime telephone: _____ Other telephone: _____

Email address: _____

Family Caregiver Information

Name of caregiver: _____

Date of birth: _____ County of residence: _____

Relationship to person needing care or supervision_____

Mailing address _____

City: _____ State: _____ Zip code: _____

Daytime telephone: _____ Other telephone: _____

Email address: _____

Care Recipient Information

Name of care recipient [*One application per care recipient*]: _____

Recipient date of birth: _____ Recipient county of residence: _____

Amount of care the family caregiver provides: _____ hours per day _____ days per week

Background Information

When was the last time the caregiver had any type of break (respite) from a publicly-funded source?

_____ Month _____ Year **OR** _____ Never

When was the last time the caregiver had any type of break (respite) from a family member or friend?

_____ Month _____ Year **OR** _____ Never

Has the care recipient applied for Medicaid? ☐ Yes ☐ No

Declared: ☐ Eligible ☐ Ineligible

Is the care recipient on a waiting list for services? ☐ Yes ☐ No

If Yes, provide service and anticipated wait time: _____

Is family receiving any other paid respite care or services for this person? ☐ Yes ☐ No

If Yes, list services and how they are paid for: _____

_____

Is the family receiving any other in-home assistance (CAP, CAP-DA, Innovations, Project CARE, Family Caregiver Support Respite) ☐ Yes ☐ No

Please specify: _____

Describe why respite cannot be obtained through another funding source/avenue _____

_____

Does the family caregiver understand they may need to pay the respite bill prior to receipt of reimbursement? ☐ Yes ☐ No

**Reimbursement check will be mailed within five (5) business days of receipt of completed paperwork.*

Type of Respite Needed

Emergency respite care: ☐ Yes ☐ No

Short-term, temporary respite care: ☐ Yes ☐ No

Routine/ongoing respite care: ☐ Yes ☐ No

Explain: _____

Check all that apply to care recipient:

☐ Adult with Alzheimer's disease or related dementia

*If checked, please refer to Project CARE:

https://www.ncdhhs.gov/assistance/adult-services/project-care

☐ Developmental and/or physical disabilities: ☐ child or ☐ adult

☐ Child with behavioral or emotional concerns

☐ Minor grandchild being raised by a grandparent

☐ Adult that needs assistance with multiple activities of daily living and/or chronic diseases

☐ Other, please describe _____

Family Caregiver Certification

NOTE: Read each statement to the caregiver. By checking the box, you are certifying that the information was verified by the caregiver.

- ☐ I understand the questions and statements on this application.
- ☐ I attest to the truthfulness of the information provided in this application.
- ☐ I understand that this is a request for a reimbursement-based voucher for the sole purpose of receiving respite care.
- ☐ I understand that the respite voucher will be valid for a maximum of 90 days from the date of approval.
- ☐ I understand that if I do not use the full amount within the 90 days, I will lose the remaining balance.
- ☐ I understand that if my application is approved, I am eligible for up to $500 of respite care.
- ☐ I understand that the High Country Area Agency on Aging may contact other persons or organizations to obtain needed proof of my eligibility.
- ☐ I have agreed to submit this application by electronic means. By signing this application electronically, I certify that my answers are correct and complete to the best of my knowledge.
- ☐ I understand that an electronic signature has the same legal effect and can be enforced in the same way as a written signature and that I am electronically signing my application.

Referring Agency Signature

I, (your name) _____ have assisted this family caregiver with the completion of this application for a respite voucher from the North Carolina Lifespan Respite Program. By my electronic signature below, I warrant that I have performed due diligence to ensure that the family reasonably meets one or more of the following eligibility criteria:

Check all that apply:

- ☐ The family is ineligible for any other respite resource
- ☐ The family has exhausted all available respite resources and is unable to pay privately
- ☐ The family is on a wait list for respite resources

Electronic Signature (Type Name) _____

Additional notes:

_____

_____

_____

Lifespan Respite Vouchers are brought to you by the NC Lifespan Respite Project and administered by the High Country Area Agency on Aging