

# 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- Respite voucher will be valid for a maximum of 90 days

## Referring Agency Information

Agency name \_\_\_\_\_

Individual/professional referring caregiver \_\_\_\_\_

Mailing address \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Daytime telephone: \_\_\_\_\_ Other telephone: \_\_\_\_\_

Email address: \_\_\_\_\_

NC Respite Care Coalition Member (NCRCC):  Yes  No

- Agencies must join NCRCC as a requirement of submitting this application. Membership is free. Visit <http://northcarolinarespitecarecoalition.org> click "join now" at the bottom on the home page.

## 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, etc.) \_\_\_\_\_

\_\_\_\_\_

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:

Developmental and/or physical disabilities:  child or  adult

Child with behavioral or emotional concerns

Minor grandchild being raised by a grandparent

Adult with Alzheimer's disease or similar memory impairment

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

**Additional notes:**

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

