

# Delaware Lifespan Respite Care Network 2011

## Application For Financial Assistance



Thank you for applying to the Delaware Lifespan Respite Network for financial assistance. In order to process your application, please take the time to answer all questions and provide all information asked for. Thank You.

### 1. Personal Information:

Personal Information: Today's date:	
Parent/Caregiver name:	
Parent/caregiver preferred email address:	
Name of person receiving care:	

### 2. Please indicate your relationship to the person receiving care.:

Parent  Grandparent  Other Family Member (specify below)

Foster parent  Court-appointed Legal Guardian  Other (specify below)

Other Family Member/Other: \_\_\_\_\_

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### 3. Care Recipient's sex

- Male  
 Female

### 4. How old is the person who is receiving care?

- 0-12 years old  
 13-20 years old  
 21-60 years old  
 60-75 years old  
 older than 75 years

Please indicate current age of the person who is receiving care:

### 5. Please indicate the primary disability of the person receiving care (check one only)

- Autism       Cerebral Palsy       Other Developmental Disability       ADHD/Behavior Disorder   
Bipolar/Mood Disorder       Dementia/Alzheimer's       Other (specify below)

Other : \_\_\_\_\_

### 6. Did you receive funds from the Delaware Lifespan Respite Care Network last Year (2010)?

- YES  
 NO

### 7. Please indicate which county you live in:

- New Castle       Kent       Sussex

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### 8. Care recipient requires help with: (please check all that apply)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> assistance with behavior problems | <input type="checkbox"/> sibling rivalry           | <input type="checkbox"/> requires a wheelchair        |
| <input type="checkbox"/> physical transferring and lifting | <input type="checkbox"/> medication administration | <input type="checkbox"/> repeated hospitalizations    |
| <input type="checkbox"/> transporting                      | <input type="checkbox"/> ventilator equipment      | <input type="checkbox"/> requires 24 hour supervision |
| <input type="checkbox"/> social interaction                | <input type="checkbox"/> has a feeding tube        | <input type="checkbox"/> Other, Please specify below  |
| <input type="checkbox"/> educational needs                 | <input type="checkbox"/> bathing assistance        |   |
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### 9. Parent/Caregiver information: (please check all that apply)

- Provides support alone
- cares for more than one recipient
- has financial problems
- has no time for day-to-day tasks
- cannot find support
- is unable to work due to caregiving
- other, please specify: \_\_\_\_\_

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10. Have you applied for any of the following services? If YES, please indicate result (eligible, not eligible, pending):

	YES	NO	Eligible	NOT Eligible	Pending
DDDS respite services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DSAAPD respite/personal care/Grand Time Off	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medicaid/Medicaid Waiver	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DE Autism Program respite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (indicate below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
None	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other: \_\_\_\_\_

11. If you indicated that you are eligible for any of the services above, please indicate amount of hours, days, or funds you are eligible for on a monthly and/or annual basis

Program	Amount of funds, hours, days eligible for on a monthly and/or annual basis

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**12. In order to provide the best possible assistance to you, please provide a brief explanation of how you currently access respite services and how you pay for them.**

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**13. Explain why you need financial assistance from the Delaware Lifespan Respite Network if you are eligible for respite services from other funding sources.**

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**14. Eligible persons may receive up to \$500.00 per care recipient per year in financial assistance as funds are available. Please indicate below the total amount of funds you are requesting. \$ \_\_\_\_\_**

**15. Do you need assistance with locating a respite provider?**

Yes  No

**16. How do you currently locate and hire respite care providers:**

- Family Members
- Neighbors
- Friends
- Private Pay
- Home Health Agency
- Through School
- Other - Please specify \_\_\_\_\_

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### 17. Parent/Caregiver Verification Information **NOTE: Questions with an "\*" requires an answer**

\*Name: \_\_\_\_\_

\*Address 1: \_\_\_\_\_

Address 2: \_\_\_\_\_

\*City: \_\_\_\_\_

\*State: \_\_\_\_\_

\*Zip Code: \_\_\_\_\_

\*Primary Phone: \_\_\_\_\_

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

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

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

18. I agree to follow the respite care provider requirements listed below.

The care provider:

- a. is 19 years of age or older
- b. has provided either a Social Security number or a tax ID (EIN) number
- c. is NOT the caregiver's spouse/partner or care recipient's parent
- d. is NOT the care recipient's regular care provider, unless being used for additional hours of respite care beyond normal care schedule

I have read and agree to follow these guidelines

**YES, I agree to follow these guidelines**

**NO, I do not agree**

**Please Return this application to:**  
**Delaware Lifespan Respite Care Network**  
**61 Corporate Circle**  
**New Castle DE 19720**

If you have any questions about this application please call 302.221.2087

Thank You