Family Respite Voucher Program

Welcome to the **Colorado Respite Care Program Respite Voucher Program**, beginning December 1, 2015! This application offers a resource for unserved and underserved family caregivers who have limited access to respite care and/or other supports through current systems. This program is intended to act as a Payer of Last Resorts. Please check out the eligibility requirements below, then submit your application accordingly. Applications will be accepted from December 14, 2015 - April 15, 2016.

Instructions:

Please fill out the application and return it as soon as possible. If you provide care to more than one care recipient, on the application, print out page two for each care recipient/family member; however, as a general rule there will be only one award granted per household. You may **email or postal mail** your application, as noted:

Email/scan: mbaskett@eastersealscolorado.org

Postal mail: Colorado Respite Care Program
ATTN: Meghan Baskett
5755 W Alameda Avenue
Lakewood, CO 80226

Questions: 303.233.1666 x 257

Do I qualify?

☐ I am a family caregiver and provide 40 hours or more of care weekly.

☐ I understand that this statewide program is not income-based and is available for any age or disability.

☐ I understand this program is designed as a Payer of Last Resort for families in need of respite care services.

☐ I am not scheduled to receive respite care services within 30 days of this application.

Family Caregiver Qualifications to Receive a Respite Voucher:

Caregivers of individuals who need support with personal care, supervision, and monitoring, may find themselves in need of respite (or short breaks) from time to time. The purpose of this voucher program is to meet planned respite needs for unserved and underserved family caregivers. Applicants must meet the following criteria to qualify for a respite voucher:

1. The family caregiver provides care for a family member, friend, or neighbor (broadening the definition of "family"); both individuals live in Colorado.

2. The care recipient has a **"special need"** (please see box below to right).

3. The caregiver may not sign up for respite with a pre-approved provider agency without **first being notified in writing** by the Colorado Respite Care Program.

4. The caregiver is able to utilize the respite voucher within 90 days of receipt of award. *Please note unused funds must be returned.*

5. The family is not currently receiving any funding that can be used for respite care (i.e. Medicaid waiver, Area Agency on Aging voucher). This voucher is designed as a Payer of Last Resort.

*The family caregiver can receive a respite voucher if the caregiver is on a wait list and **not scheduled to receive services** from a formal respite care program within 30 days of application.*

Caregivers are **not guaranteed** the maximum amount of funds available; some may receive smaller vouchers based on the type of respite requested.

Caregivers must agree to work with authorized Respite Provider Agencies (RPA), pre-approved by the Colorado Respite Care Program. Individual (independent) providers — including other family members, friends, or registered providers — may not be used for this respite voucher system. However, some areas in the state may not have a contracted provider. Efforts may be made to contract with this agency if they meet eligibility requirements and time constraints.

SPECIAL NEED: As described by the Lifespan Respite Act of 2006, "special need" means:

Adult: An individual 18 years of age or older who requires care or supervision to:

1. Meet the person's basic needs;
2. Prevent physical self-injury or injury to others; or
3. Avoid placement in an out-of-home, long-term care setting.

Child: An individual less than 18 years of age who requires care or supervision beyond that required of children generally to:

1. Meet the child's basic needs; or
2. Prevent physical injury, self-injury, or injury to others.

Vouchers will be awarded on a first-come, first-served basis for those who are eligible. Criteria for awards and use of the vouchers are subject to change to best meet the needs of a varied group of caregivers. Funding is limited and no awards will be guaranteed.

For additional and/or updated information about this respite voucher system (definitions, selected/contracted respite provider agencies, other helpful links and information), please check out the website, www.coloradorespitecoalition.org. If you do not have access to the Internet please contact Meghan Baskett at 303.233.1666 x 257 for information.

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Family Application for Colorado Respite Care Program Respite Voucher

Please print	**Family Caregiver** *(family, friend, or neighbor)*	**Individual in Need of Care**
Name:		
Prefers to be called:		
Age:	Gender: Male / Female	Age: Gender: Male / Female
Mailing Address:		
City/Town:		
Zip Code:		
Home County:		
Phone Number:	*Preferred*	
Alternate Phone:	*Preferred*	
Email:	*Preferred*	

Caregiver's relationship to person needing care**:** _____

I provide care, supervision, and/or monitoring **40 or more hours** per week. ___ Yes ___ No

Where did you learn about this program? *(website, organization, etc.)* _____

Name of individual who **referred** you: _____

Referral contact information**:** _____

May we contact the above individual for additional information? ___Yes ___ No

Name(s) of others I authorize to facilitate a respite voucher for me (case managers, referral source, family members who may speak on my behalf):_____

Please tell us why you need this respite voucher: _____

_____

_____

_____

_____

This application is true and accurate. I have had the opportunity to review the instruction page accompanying it. Respite services will not be paid for without prior authorization by the Colorado Respite Care Program through a Family Caregiver Agreement.

Signature: _____ _____
Date

Printed Name: _____

Please tell us a little more about yourself and your loved one. Information will not affect decisions made about eligibility, but may help the program with reporting requirements for funding sources.

The individual I provide care/supervision for has *(check all that apply)*:

- ☐ A physical disability *(hip surgery, stroke, TBI, etc.)*
- ☐ A behavioral concern
- ☐ Mental health condition
- ☐ Medical support needs (medication reminders, etc.)
- ☐ An intellectual / developmental disability
- ☐ A memory condition (Alzheimer's, dementia, etc.)
- ☐ Another diagnosis (please list below)
- ☐ Assistance needs with one or more activities of daily living (feeding, dressing, bathing, etc.)

What, if any, diagnoses exist? _____

The person cared for is currently receiving in-home or out-of-home respite (within past 60 days) ☐ Yes ☐ No

If yes, name of program: _____

The person cared for is currently receiving funding for respite care (i.e. Medicaid waiver, Area Agency on Aging, etc.) (within past 60 days) ☐ Yes ☐ No

If yes, name of program: _____

CAREGIVER Marital Status

___ Married / committed partner in household
___ Divorced / Separated
___ Single
___ Widowed

CAREGIVER Income – *circle the appropriate income range for the one who provides the care**

$0 – 30,000 $30,001 – 59,999 $60,000 +

income is not a factor for eligibility

CAREGIVER

Home Location:
City:
County:

Ethnicity: *(Check all that apply.)*

- ☐ Hispanic
- ☐ African American / Black
- ☐ American Indian / Alaska Native
- ☐ Asian
- ☐ Native Hawaiian / Pacific Islander
- ☐ White / Caucasian
- ☐ Mixed Race

Military Service:

- ☐ Active duty with _____
- ☐ Veteran

CARE RECIPIENT

Home Location:
City:
County:

Ethnicity: *(Check all that apply.)*

- ☐ Hispanic
- ☐ African American / Black
- ☐ American Indian / Alaska Native
- ☐ Asian
- ☐ Native Hawaiian / Pacific Islander
- ☐ White / Caucasian
- ☐ Mixed Race

Military Service:

- ☐ Active duty with _____
- ☐ Veteran