



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.



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Office of Community
Access & Independence
Divisions of Aging & Adult Services



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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.

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.coloradospitecoalition.org. If you do not have access to the Internet please contact Meghan Baskett at 303.233.1666 x 257 for information.

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.



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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

Mailing Address: _____

City/Town: _____

Zip Code: _____

Home County: _____

Phone Number: _____ Preferred

Alternate Phone: _____ Preferred

Email: _____ Preferred

Age: _____ Gender: Male / Female

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):

- | | |
|--|--|
| <input type="checkbox"/> A physical disability (<i>hip surgery, stroke, TBI, etc.</i>) | <input type="checkbox"/> An intellectual / developmental disability |
| <input type="checkbox"/> A behavioral concern | <input type="checkbox"/> A memory condition (Alzheimer's, dementia, etc.) |
| <input type="checkbox"/> Mental health condition | <input type="checkbox"/> Another diagnosis (please list below) |
| <input type="checkbox"/> Medical support needs (medication reminders, etc.) | <input type="checkbox"/> 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

- | | |
|---|----------------------------------|
| <input type="checkbox"/> Married / committed partner in household | <input type="checkbox"/> Single |
| <input type="checkbox"/> Divorced / Separated | <input type="checkbox"/> 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***

<u>CAREGIVER</u>	<u>CARE RECIPIENT</u>
<p><u>Home Location:</u> City: _____ County: _____</p> <p><u>Ethnicity:</u> (Check all that apply.)</p> <p><input type="checkbox"/> Hispanic <input type="checkbox"/> African American / Black <input type="checkbox"/> American Indian / Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian / Pacific Islander <input type="checkbox"/> White / Caucasian <input type="checkbox"/> Mixed Race</p> <p><u>Military Service:</u> <input type="checkbox"/> Active duty with _____ <input type="checkbox"/> Veteran</p>	<p><u>Home Location:</u> City: _____ County: _____</p> <p><u>Ethnicity:</u> (Check all that apply.)</p> <p><input type="checkbox"/> Hispanic <input type="checkbox"/> African American / Black <input type="checkbox"/> American Indian / Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian / Pacific Islander <input type="checkbox"/> White / Caucasian <input type="checkbox"/> Mixed Race</p> <p><u>Military Service:</u> <input type="checkbox"/> Active duty with _____ <input type="checkbox"/> Veteran</p>

