Respite Rx Program
Intake/ Application Form

Providing care for someone can be incredibly challenging on many levels. Between managing prescriptions, budgeting, scheduling appointments and the countless responsibilities in-between, providing care can quickly become overwhelming and stressful. Don’t forget to take care of yourself so you can take care of others. Find time to relax, do something you enjoy, sleep or find other ways to reduce stress. This precious time is called RESPITE!

I first heard about the Respite Rx Project from:

<table>
<thead>
<tr>
<th>Caregiver Intake</th>
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</thead>
<tbody>
<tr>
<td>Name:</td>
</tr>
<tr>
<td>Date of Birth:</td>
</tr>
<tr>
<td>Physical Address:</td>
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<tr>
<td>Ok to Email</td>
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<table>
<thead>
<tr>
<th>Caregiver Demographics</th>
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</table>
| Ethnicity: Hispanic or Latino
| Non-Hispanic or Non-Latino |
| Race: White, Caucasian
| American Indian/Alaskan
| Native Hawaiian or Pacific
| Islander |
| Household Income: Below Poverty
| Above Poverty
| Below 300% SSI
| Above 300% SSI |
| Do you live alone? Yes
| No |
| Are you disabled? Yes |
| No |
| Are you frail? Yes |
| No |
| Are you homebound? Yes |
| No |
| Are you employed? Yes |
| No |
| # Hours Per Week |

<table>
<thead>
<tr>
<th>Activities of Daily Living (ADLS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Without assistance, I am unable to:</td>
</tr>
<tr>
<td>Bathe</td>
</tr>
<tr>
<td>Eat</td>
</tr>
<tr>
<td>Walk</td>
</tr>
<tr>
<td>N/A - I can perform all</td>
</tr>
<tr>
<td>Have you served in the U.S. military? Yes No</td>
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<table>
<thead>
<tr>
<th>Instrumental Activities of Daily Living (IADLS)</th>
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<tbody>
<tr>
<td>Without assistance, I am unable to:</td>
</tr>
<tr>
<td>Prepare Meals</td>
</tr>
<tr>
<td>Take Medication</td>
</tr>
<tr>
<td>Manage Money</td>
</tr>
<tr>
<td>Shop</td>
</tr>
<tr>
<td>N/A - I can perform all</td>
</tr>
</tbody>
</table>

Special Accommodations
To get services for Respite Rx, applicants will have contact with the Program Coordinator by phone or in person. Do you have a physical or mental condition that requires special accommodations during this program? Yes No
Do you speak English? Yes No If NO, what language do you speak? 
Do you need an interpreter? Yes No

Caregiving Information
Please select the choice that best reflects your role as a caregiver.
Yes, provides care regularly. (Refer to respite)
Yes, provides assistance occasionally, or as requested. (Refer to respite)
No, does not provide support at a distance, due to not being physically present to provide assistance.
No, does not personally provided any assistance, but knows he/she has a need for some support.
No, does not personally provided any assistance, but has an increasing concern about his/her ability to manage things without help.

Updated: 8.19.2019
No, currently does not provide any type of direct care, support, or assistance.  

None of the above. Statement (optional):

How long have you been giving extra care and assistance to the person in your care? Give an approximate length of time.

- Initial Request
- < 1 year
- 1-5 years
- 6-10 years
- > 10 years

How has giving care or assistance impacted your life? Please select all statements that apply.

- The care recipient is now living in my home, so I can provide care.
- I now live in the care recipient's home, so I can provide care.
- I often or regularly go to the care recipient's home to provide care, as I do not live with the care recipient.
- I live in rural or frontier areas of Nevada where resources are limited.
- I am providing support at a distance, so it’s difficult to arrange.
- I have taken leave from work or reduced hours at work to meet their needs or provide care.
- I have felt worried, anxious or depressed since I began to provide care or support.
- The demands of care giving are increasing, and I am struggling to meet them.
- The care recipient cannot be safely left alone for extended periods of time.
- Other (explain):

What tasks do you perform in giving care? Select all that apply.

- Transportation
- Personal Care
- Financial Management/Assistance
- Shopping
- Medical (medication administration, etc.)
- Overall Management
- Other, please specify: ____________________________

Are you providing care to more than one person? (i.e. children, grandchildren, and/or other adults?)  

- Yes
- No

If yes, give the ages of all the people you provide care to:

- 0-3 ___
- 4-17 ___
- 18-24 ___
- 25-39 ___
- 40-64 ___
- > 65 ___

Caregiver Burden Interview

<table>
<thead>
<tr>
<th>Do you feel…?</th>
<th>Never (0)</th>
<th>Rarely (1)</th>
<th>Sometimes (2)</th>
<th>Quite Frequently (3)</th>
<th>Nearly Always (4)</th>
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<tbody>
<tr>
<td>That because of your time you spend with your relative that you don’t have enough time for yourself?</td>
<td></td>
<td></td>
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<td>Stressed between caring for your relative and trying to meet other responsibilities (work/family)?</td>
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<td>Irritated when you are around your relative?</td>
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<td>That your relative currently affects your relationship with family members or friends in a negative way?</td>
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<tr>
<td>That your health has suffered because of your involvement with your relative?</td>
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<td>That you don’t have as much privacy as you would like because of your relative?</td>
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<td>That your social life has suffered because you are caring for your relative?</td>
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</table>
That you have lost control of your life since your relative’s illness?

Uncertain about what to do about your relative?

You should be doing more for your relative?

You could do a better job in caring for your relative?

**Caregiver Needs**

What specific concerns do you have about caregiving?

Thinking of your own needs, what would help the most? (select all that apply)

- Good information about resources and services available.
- Advice from other caregivers, gathered from their experiences.
- Regular or temporary breaks from caregiving role.
- Extra assistance or help so you can provide the care needed.
- Training so you can provide better care.
- Strategies to make your caregiving easier.
- Other (please specify):

How likely would YOU be to use Respite?

- Extremely likely
- Very likely
- Moderately likely
- Slightly likely
- Not at all likely

*If not likely, why not?*

**Respite Usage**

*Are you currently receiving any respite services?* □ Yes □ No

If yes, please provide more information (how frequent, who is paying for it, who provides the respite, etc.):

*Why are you interested in the Respite Rx?* (select all that apply)

□ Choice/Flexibility □ In-Home Care □ After Hours Care □ Emergency □ Other

*How many hours per week of respite would be ideal to have?*

*Will you be using the voucher for a planned, larger respite purchase? (i.e. summer camp)* □ Yes □ No

If yes, when is the respite? ______ How much will it cost? ______
Care Recipient
Person in your Care

Enrolled w/ ADRC: [ ] Yes [ ] No

Name:
Age:
Gender: [ ] Female [ ] Male
Relationship to person in your care:

Veteran Status:
[ ] None [ ] Veteran [ ] Disabled Veteran
[ ] Veteran Dependent

Ethnicity:
[ ] Hispanic/Latino [ ] Not Hispanic/Latino

Primary Diagnosis of Care Recipient:

Does he/she have a diagnosed dementia (i.e. Alzheimer’s, dementia, Vascular dementia, etc.)? [ ] Yes [ ] No

Specify diagnosis:

If yes, what stage of dementia? [ ] Early [ ] Mild/Middle [ ] Severe [ ] Unknown

If no, are you concerned about dementia or a memory impairment? [ ] Yes [ ] No

Assistance/Supervision Needed (Check all that apply):

- [ ] Bathing & Hygiene
- [ ] Eating or feeding
- [ ] Standing or Walking
- [ ] Medication reminders
- [ ] Communication/Coordination
- [ ] Manage Finances/Pay Bills
- [ ] Dressing & Grooming
- [ ] Meal Preparation
- [ ] Social/Recreation
- [ ] Medical care (medication administration)
- [ ] Behavioral Support
- [ ] Shopping
- [ ] Toileting/Bladder Care
- [ ] Transfers In/Out
- [ ] Give/Arrange Transportation
- [ ] Decisions/Advocacy
- [ ] Light Housekeeping/Chores
- [ ] General supervision

Intake Notes & Referrals Made

[ ] Care Consultation (ongoing caregiver support)
[ ] Emergency Respite Voucher
[ ] CarePro (Alz caregiver skills building)
[ ] Respite (provider: )
[ ] EPIC (early stage Alz education and training)
[ ] Caregiver Training (REST, Online, etc)
[ ] CDSME (provider: )
[ ] Other, specify:

Notes: Resource Center Contact (Name & Number):

Intake Application can be submitted via email or regular mail. Send completed application to:

Nevada Aging and Disability Services Division
Attn: Wendy Thornley
3416 Goni Road, D-132
Carson City, NV 89706
Email: wthornley@adsd.nv.gov

Please NOTE: In subject line of email- Respite Rx- (Last Name of Caregiver) and please provide a brief summary of anything you think may be pertinent or important for Program coordinator to be aware of.
Please Read and Initial Each Statement Below:

_____ I attest that the information included in this application is true and complete. I understand that any falsification of information will result in the termination of services.

_____ I attest that I have read and understand the Respite Rx Project policies and procedures. I agree to abide by the guidelines and provisions set forth. I understand my signature below authorizes a release of information, for program purposes only.

_____ I understand the use of all funds available to me through the Respite Rx Project is to compensate respite workers or respite programs for respite services that have been provided to me during the grant period. I understand that these funds cannot be used for any other purpose. I am also responsible for any respite service charge over the voucher limit I am awarded.

_____ I acknowledge that I am responsible for hiring the respite worker(s) of my choice and am responsible for negotiating the rate of pay for respite services I acquire. I understand that I am also responsible to provide any training or instruction that the respite worker(s) of my choice may need to provide care.

_____ I will sign and submit respite timesheets promptly, and budget authority will end on July 31, 2020. Any unspent portion of my respite voucher budget can be forfeited if I have not made prior arrangements for my planned use of voucher funds.

_____ I agree to regular program monitoring and will complete and return the required surveys and assessments. I also understand that the Respite Rx Project is a pilot program only, and no continuation of respite services under this program will extend beyond the grant period.

Nevada Aging & Disability Services Division and the Respite Rx Project will operate the grant program that provides funding to pay for respite services but will not be providing those services directly or indirectly. The applicant recognizes and agrees that these entities are not liable for any damages that may result from the services received and holds them harmless from the same.

Applicant (Caregiver) Signature __________________________  Date ________________

☐ ADRC Verbal consent done by: ___________________________ Date: ________________

OFFICE USE ONLY - Please do not write in this box

Received: ________________  Priority Rating: ________________  FMS Date Processed: ________________  PALCO ID#: ________________

☐ Pre-Respite Survey completed on: __________  ☐ Approval/ Letter Sent on: __________

☐ Respite Design scheduled on: __________

☐ Recruitment Plan

☐ Job Description needed/ completed on: __________  ☐ Job Description approved by caregiver on: __________

☐ PALCO Paperwork review and paperwork Sent on: __________  ☐ Spending Plan finalized on: __________

☐ Paperwork sent to ADSD for approval on __________  ☐ Paperwork submitted to PALCO on: __________

Background requested: Y or N