



### What is respite (res-pit)?

Respite is short, temporary breaks from providing hands on care for a loved one with a significant disability, special need or chronic illness.

### How does the SCRC Voucher Program work?

The SCRC awards vouchers in the amount of \$500 to eligible family caregivers. These vouchers may be used, for example, to pay an in-home agency, an Adult Day Center, or a private individual to provide respite. SCRC staff works with each approved family to find the best respite option for their situation.

Vouchers are only used to pay for breaks from hands on caregiving. They may not be used to:

- Pay the family caregiver directly for the care he/she is providing
- Pay for care of a loved while the caregiver goes to work
- Pay for care that occurred before the voucher was issued
- Pay medical bills or purchase medical supplies
- Offset the cost of paid care already in place

Vouchers are valid up to 6 months. Eligible family caregivers may receive 2 vouchers yearly, as program funds are available.

### Who is eligible?

Family caregivers providing unpaid care for a loved one with a significant disability, special need or chronic illness, requiring 24/7 care. The SCRC serves all ages of caregiver and care receiver, but does focus on parents of children (young or adult) with special needs and family caregivers of disabled or terminally ill adults under the age of 60. Caregivers of elders over the age of 60 may be referred to their county's Area Agency on Aging (AAA)\*.

### How to apply?

Please call the SCRC office at 803.935.5027 and ask to speak to the Voucher Program Coordinator with any questions or to request an application.

#### *\*Coordination with Area Agencies on Aging*

*The SCRC works closely with the 10 Area Agencies on Aging (AAAs) across South Carolina. AAAs, which operate under the SC Lt Governor's Office on Aging, are generally the best source of support for caregivers of an elder. If you are caring for an elder and have not applied for respite with the AAA serving your county, the SCRC can provide you with the correct contact information.*



South Carolina Respite for the Lifespan
Respite Voucher Program
Application Form – page 1 of 5 revised 10-2015



PLEASE PRINT CLEARLY AND FILL OUT EVERYTHING!

Family Caregiver Information: This is about YOU - the person who is responsible and is the primary caregiver. We cannot accept applications filled out by Social Workers on behalf of a client/client's family.

Full Name: \_\_\_\_\_ County: \_\_\_\_\_
Street address \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_
Zip Code: \_\_\_\_\_ mailing address: [ ] same or \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_
Email: \_\_\_\_\_ work phone (if you work) : \_\_\_\_\_

Care Receiver Information: This is about the person for whom you give care.

Full Name: \_\_\_\_\_ Do you live with this person? Yes No
Address (if different from above): \_\_\_\_\_ City: \_\_\_\_\_
State: \_\_\_\_\_ Zip code: \_\_\_\_\_ phone: \_\_\_\_\_ e-mail: \_\_\_\_\_

Is the Care Receiver (CR) being served by any of the following? Please circle an answer for each question.

Community Long Term Care (CLTC) Services:

- 1. Is the CR eligible for CLTC Services? Yes No Has the CR applied for CLTC Services? Yes No
2. Does the CR receive CLTC Services? Yes No
If yes - \_\_\_\_\_ hrs/day \_\_\_\_\_ days per week. If yes - \_\_\_\_\_ days a week at Adult Day Programs.
Has CLTC ever provided nursing home/facility respite for the CR? Yes No

Disabilities and Special Needs (DDSN) Services:

- 1. Does the CR have a Service Manager at DDSN Yes No DDSN Board: \_\_\_\_\_
If Yes: Name: \_\_\_\_\_ Phone: \_\_\_\_\_
e-mail: \_\_\_\_\_ fax: \_\_\_\_\_
2. Does the CR have services from DDSN? Yes No If Yes: \_\_\_\_\_ hrs/day \_\_\_\_\_ days per week
Type of services: \_\_\_\_\_

Veteran Affairs for Disabled Veterans (VA) Services:

- 1. Is the CR a disabled Veteran? Yes No Does the CR get medical care from the VA? Yes No
2. Does the CR get financial assistance from the VA? Yes No If so how much? \_\_\_\_\_ .00 monthly
3. Does the CR get home services from the VA? Yes No If yes \_\_\_\_\_ hrs/day \_\_\_\_\_ days per week
What type of services are they? \_\_\_\_\_
4. Has the VA ever provided facility (nursing home) based respite to the family? Yes No

Insurance Information: Does the Care Receiver have health insurance? Yes No

If yes type(s) of coverage: Medicare Medicaid Private

Household Information:

Number in the home: \_\_\_\_\_ Monthly Household Income (do not include care receiver income) \_\_\_\_\_ (gross)



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**Are you, the Family Caregiver (CG), served by any of the following?** Circle yes or no and answer as appropriate.

1. Have you received an Alzheimer's Voucher? Yes No If yes- how much money was it? \_\_\_\_\_  
If yes – About when did you get it? month \_\_\_\_\_ year 20 \_\_\_\_ Past years? Yes no
2. Have you received funds from Family Caregiver Support Program? Yes No If yes – how much? \_\_\_\_\_  
If yes – About what dates did you get it? month \_\_\_\_\_ year \_\_\_\_\_ past years? Yes no
3. Have you received respite funds from any other program or agency over the past year? Yes No  
If yes, what program or agency: \_\_\_\_\_ SC DDSN? Yes No
4. Is the CR under the care of a Hospice? Yes No If yes: Hospice Agency: \_\_\_\_\_  
Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ e-mail: \_\_\_\_\_  
Has the Hospice ever offered and/or provided facility (nursing home based respite to your family? Yes No
5. Have you used Adult Day Care Facility? Yes No If you use it now, what days: \_\_\_\_\_  
If yes: Facility Name: \_\_\_\_\_  
How did/do you pay for this care? \_\_\_ Out of pocket Other payer (be specific) \_\_\_\_\_
6. Have you used an In Home Agency for care? Yes No If yes -Name: \_\_\_\_\_  
How did you pay for this care? \_\_\_ Out of pocket Other payer (please be specific) \_\_\_\_\_

**Family Caregiver Information:** Your date of birth: \_\_\_\_\_ year \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_  
Race: \_\_\_\_\_ Relationship to CR: \_\_\_\_\_

Please Circle one:

1. Do you work? Yes No How many hours per week? Full Time Part Time As Needed
2. If you work, where is your loved one during that time? School Home Adult Day Center Other
3. If your loved one is at home, who is there with them? No one Family Paid Assistant
4. Do you get breaks from: Church? Neighbors? Family? private providers I pay? If you pay, what rate? \_\_\_\_\_

Please Circle one:

How is your health? Excellent Good Okay Poor Is Care giving 24/7 for you? Yes No

How many hours a day do you provide personal Care? \_\_\_\_\_ hrs

Please describe the types of care/assistance you provide on a daily basis (continue over, if you need to) \_\_\_\_\_

How did you hear about SC Respite Coalition Life Span Voucher? \_\_\_\_\_

**Care Receiver (CR) Information:**

Date of Birth: \_\_\_\_\_ year \_\_\_\_\_ Age: \_\_\_\_\_ Race: \_\_\_\_\_ Gender: \_\_\_\_\_

Monthly Income, if any: \_\_\_\_\_ (gross) Where from? \_\_\_\_\_

If under the age of 21, does the CR currently attend school? Yes No

If under the age of 3, does the child have baby net services? Yes no If yes, Case Manager phone: \_\_\_\_\_

C.M. Name \_\_\_\_\_ e-mail: \_\_\_\_\_

## Preferred TYPE of Respite

If you get a voucher to take a break from care giving, which do you want:

- an In Home Agency that bills SCRC directly for services. Which one, if you know \_\_\_\_\_
- an Adult Day Care that bills SCRC directly for services. Which one, if you know \_\_\_\_\_
- at home with a private provider that I find, employ and out of pocket to give me a break. The SCRC will then reimburse me directly within 30-60 days after the care has occurred.
- other (be specific) \_\_\_\_\_

## Consent to Release Information

I, the caregiver or their representative, give permission for the South Carolina Respite Coalition to contact the following organizations so that those involved with my care can communicate and work together on planning for me to go there for respite care. This is valid through June 30, 2018.

The enclosed medical and personal information may be sent to:

Respite Provider (agency you choose): \_\_\_\_\_  
Address: \_\_\_\_\_  
Other: \_\_\_\_\_  
Address: \_\_\_\_\_

Initial [  ] If we receive a SCRC voucher, I understand that my regional Family Caregiver Support Program must be informed in order to help coordinate an SC respite system that service the most families possible. This would be our names and address only.

Initial [  ] We do not yet know the agency, adult day care or program we will use, but agree to allow the SC Respite Coalition to provide our information to the one on which we agree after we negotiate the best place for our respite services, with the understanding that only those who need to know will receive the information and will keep it confidential.

Initial [  ] We are willing to share our care giving and respite story for the SCRC "Faces of Respite" flyers and/or on the website. Please contact me for follow-up information.

Printed Name (Parent/Guardian/Caregiver): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Person Receiving Care (if applicable and can sign):

Printed Name : \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**South Carolina Respite for the Lifespan  
Voucher program application**

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**South Carolina Respite Coalition  
CAREGIVER SELF-ASSESSMENT**

**MAIL, EMAIL OR FAX ALL 5 FULLY COMPLETED\* PAGES TO:** P.O. Box 493, Columbia, S.C. 29202  
 respite@screspitcoalition.org FAX 803.935.5229

\* NOTE: We need all the information and reserve the right to reject incomplete applications

How are YOU doing?	Never	rarely	Some times	often
1. I feel my health is worse and I am getting sick more.				
2. My sleep is affected by stress and responsibility.				
3 My social life has suffered due to care giving.				
4. I get everything done I need to in a typical day.				
5. I have trouble keeping my mind focused.				
6. I am irritable or angry more than I used to be.				
7. I cry often.				
8. I resent that my loved one needs so much.				
9. I feel lonely.				
10. I feel like I have nowhere to turn for help.				
11. It is very difficult to get away to do something I want to do.				
12. I feel guilt if I leave my loved one with someone else.				
13. My relationships with other family members are suffering because I spend so much time providing care.				
14. I feel no one can take care of my loved one as well as me.				

What do you hope to get from having this voucher for respite?

- just some time to myself                       a vacation                       a good night's sleep  
 some time with other family or friends without my loved one with special needs  
 catch up some medical and other appointments for me    personal care/a bath for my loved one  
 other \_\_\_\_\_

I am a parent of a child under 10. My need for a break is different from that of a "typical" parent because:

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South Carolina Respite for the Lifespan
Respite Voucher Health Care Provider
Medical/Special Needs Certification revised 10-2015



Respite = regular, short term breaks for the main Caregiver of someone of any age with special needs.

The South Carolina Respite Coalition is the only statewide, non-profit organization working on respite for all family caregivers no matter their age. With grant funds we can provide limited respite vouchers. Your patient/client's family has requested funds for respite. The signatures below indicate their consent to have you release this information.

Name \_\_\_\_\_ Parent/Guardian/Spouse/Family Caregiver)

Signature: \_\_\_\_\_ date: \_\_\_\_\_

Name \_\_\_\_\_ (Care receiver) date of birth: \_\_\_\_\_

Signature (if able) \_\_\_\_\_ date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

THIS SECTION TO BE COMPLETED BY A MEDICAL PROFESSIONAL ONLY (Doctor, Nurse Practitioner, Physician Assistant, Licensed Social Worker, trained DDSN Case Managers. We cannot accept certification by CNAs.)

1) Please indicate the ability level (0 – 5) for each activity: 0 = independent -----> 5 = totally dependent
Feeding \_\_\_\_ Ambulation \_\_\_\_ Transferring \_\_\_\_ bathing \_\_\_\_ This person is bedbound [ ] no [ ]yes

2) This care receiver/patient is [ ] incontinent [ ] bladder [ ] bowel [ ] self toileting [ ] too young to train yet

4) Due to cognitive or other mental, emotional, or behavioral issues, the care receiver requires moderate to substantial supervision because their behavior poses a health or safety hazard to them self or others.
Yes [ ] No [ ] Cognitive Diagnosis: \_\_\_\_\_

5) In your professional opinion is this care receiver able to be left alone without supervision or assistance for any length of time (i.e. several hours)? Yes [ ] no [ ] overnight? Yes [ ] no [ ]

6) PRIMARY diagnosis \_\_\_\_\_

7) SECONDARY and/or CO-OCCURRING conditions \_\_\_\_\_

If this patient is an infant, child or adolescent, does s/he require care beyond which a typical babysitter can provide?
Yes [ ] No [ ] If yes, please briefly describe the skill set needed to safely care for this patient \_\_\_\_\_

Completed by Professional (printed name): \_\_\_\_\_

Title: \_\_\_\_\_ discipline: \_\_\_\_\_

Name of practice: \_\_\_\_\_

Address: \_\_\_\_\_ phone: \_\_\_\_\_

City: \_\_\_\_\_ zip code: \_\_\_\_\_ e-mail: \_\_\_\_\_ fax: \_\_\_\_\_

Professional Signature: \_\_\_\_\_ date: \_\_\_\_\_