# Respite Rx Program

Voucher Application Form

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|---|---|
| **Today's Date:** | **Date Received** *(ADSD use only)*: |
| **Caregiver Name:** | |
| **Phone Number:** | **Email:** |
| **Person in my care name:** | |

## 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? _____

**Assistance/Supervision Needed for (Person in my care name):** _ _____

**(Check all that apply):**

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

| | |
|---|---|
| **Primary Diagnosis of Care Recipient:** | **Relationship to Care Recipient:** |

## Third Party Verification & Authorization of Release of Information Section

*(Someone Who Can Verify You Are Caregiver of the Above-Named Person)*

| | |
|---|---|
| **Contact Name:** | **Agency:** |
| **Phone Number:** | **Email:** |

| | |
|---|---|
| ☐ Social Worker/Case Manager | ☐ Minister/Clergy |
| ☐ Medical Provider (inc. hospital) | ☐ School/Teacher |
| ☐ Government Agency | ☐ Non-Profit Agency (describe) |

I, (Care Recipient _____) authorize the person named above to verify my relationship with (Caregiver _____) and disclose this information to representatives of Respite Rx to determine eligibility for caregiver to receive respite services.

Signature_____ Date_____

**PLEASE TURN OVER TO COMPLETE APPLICATION**

I first heard about the Respite Rx Project from: (Referral Source)

## 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

**Application and Pre-Survey 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

**OFFICE USE ONLY - Please do not write in this box** ☐ **Complete** ☐ **Missing** _____

**Received:** _____ **Verification :** _____ **Processed By:** _____ Date PC Received: _____

☐ Approved: _____ Priority Rating: _____ Award Letter Sent: _____ Data Entered: _____

AA Award Approved: _____ Award Amount: _____ FMS Date Entered: _____ Data Entered: _____