

# LIFESPAN RESPITE SUBSIDY PROGRAM

## Funding Request for Exceptional Circumstances, including Crisis Respite

### SECTION 1: Client Information (Person with special needs requiring ongoing care.)

Client Name:	Age:	Client ID:	Client Phone:
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Family Caregiver Name:	Family Caregiver Email:
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Client Mailing Address: <input type="checkbox"/> Check if the address has changed since last application.	City:	State:	Zip:
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Check all that apply:

- Unplanned event that jeopardizes the health and safety of the Client
- Unplanned event that jeopardizes the health and safety of the Family Caregiver
- Immediate and unavoidable absence of the Family Caregiver more than 4 hours when a qualified caregiver is not available

<input type="checkbox"/> Family Caregiver health crisis <input type="checkbox"/> Physical <input type="checkbox"/> Mental <input type="checkbox"/> Emotional	<input type="checkbox"/> Client has exceptionally high care needs requiring supervision <input type="checkbox"/> Medical / Physical Health <input type="checkbox"/> Behavioral and / or Emotional Needs <input type="checkbox"/> Personal Safety of <input type="checkbox"/> Self or <input type="checkbox"/> Others
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*Explain:*

In the next 30-45 days are you considering: <input type="checkbox"/> Assisted Living / Nursing Facility Placement <input type="checkbox"/> Foster Care / Group Home Placement <input type="checkbox"/> Extended Family Care <i>Explain:</i>	How "stressed" are you as a result of caring for the client: <input type="checkbox"/> Not at all stressed <input type="checkbox"/> Slightly stressed <input type="checkbox"/> Moderately stressed <input type="checkbox"/> Very stressed <input type="checkbox"/> Extremely stressed
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How would taking short breaks HELP you and the person you provide care to? *Explain:*

### SECTION 2: Respite Plan

1. What are your immediate respite needs?
  - a. Additional monthly respite supports necessary due to: \_\_\_\_\_
    - Special event
      - i. Caregiver needs: (break due to exceptional need, medical care, vacation, etc.)
      - ii. Camp (care recipient is attending a specifically scheduled camp, CBO event, Community Agency/provider activity/event, etc.)
      - iii. Increased needs of the care recipient (increased medical support needed, surgery/medical procedure, behavioral support increase, etc.)
    - Immediate short-term crisis
      - i. Illness in the family that requires the support of caregiver or the caregiver needs additional support due to illness
      - ii. Unplanned immediate or unavoidable absence of the Family Caregiver for an extended period when a qualified caregiver is not available.

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2. If approved, how do you plan to use the additional respite support? Please provide an outline below of how the funds you are requesting will be utilized.

Additional Funds monthly needed (if specified amount is provided for hours needed/camp/respite event):

Utilization of funds for a specific need (outline specific need that funds will be applied to):

Month(s) needed:

Do you need help finding a Provider:  Yes  No

Please visit [respite.ne.gov](http://respite.ne.gov) or call 1-866-RESPITE to contact a local Respite Network Coordinator to assist in finding a Respite Provider.

Name of Provider(s) who will give you a temporary break:

Name: \_\_\_\_\_ Email: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Email: \_\_\_\_\_ Phone: \_\_\_\_\_

If funds are not utilized as indicated above, the Respite Coordinator and Social Services Worker will need to be notified. Funds can be reviewed, on a case by case basis, to be banked to be utilized at another time during the eligibility period. This is only after review and approval by Department.

### SECTION 3: Employment

In the last six months, has one or more family caregivers needed to miss work due to unpaid family caregiving responsibilities?

Yes  No  Primary Caregiver not employed

If yes, how many days have you missed?

### SECTION 4: Agreement and Signature

I understand that my statements may be checked, and if I have given false statements or information, I may be found guilty of fraud.

I understand that whenever there are changes in the information I have given, I must immediately report them to the Nebraska Department of Health & Human Services, Respite Subsidy Program Coordinator.

I understand that if I do not think my request is handled correctly, I have the right to file an appeal.

I understand that the Nebraska Department of Health and Human Services may need to contact other agencies and individuals to determine my financial eligibility and to verify my need for the support for which I am applying, or to make referrals to assist me in obtaining services. I authorize the release of this confidential information.

I hereby attest that my response and the information provided on this form and any related application for public benefits are true, complete and accurate and I understand that this information may be used to verify my lawful presence in the United States.

<b>Signature of Authorized Representative:</b>	<b>Date:</b>
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### SECTION 5: Referral Source

Name / Title:		Organization / Agency or Relationship to Client:	
Address:		City:	State:
Phone:		Email:	

**Send completed application to:**

**Email:** [dhhs.respite@nebraska.gov](mailto:dhhs.respite@nebraska.gov)

**Mail:** Nebraska Department of Health and Human Services  
Division of Disability and Aging - Lifespan Respite  
Subsidy P.O. Box 98933  
Lincoln, NE 68509-8933

(402) 742-8356

**Fax:** (402) 471-9188

**Questions:**