


LIFESPAN RESPITE SUBSIDY PROGRAM APPLICATION

(See instructions. If you need assistance completing this application: call 1-866-737-7483 for a local Respite Network Coordinator). Do you need an interpreter? Yes No If yes, what language do you speak: _____

Section 1: CARE RECIPIENT INFORMATION *(Person with special needs requiring ongoing care.)*

 Attach documentation to support request for respite (for example, letter from therapist or healthcare provider, current medical reports or IEP).

Care Recipient Name:	Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
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Living Arrangements: <input type="checkbox"/> With Caregiver in Home of Care Recipient <input type="checkbox"/> With Caregiver in Home of Caregiver <input type="checkbox"/> With Other Family or Friend <input type="checkbox"/> Lives Alone	Social Security Number:
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Care Recipient Citizenship Status:
 A citizen of the United States OR I am a qualified alien under the federal Immigration and Nationality Act.

Mailing Address:

City:	State:	Zip Code:	County:
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Does Care Recipient need help with any self-care activities:

Bathing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Toileting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Grooming	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dressing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Transfers	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mobility	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eating	<input type="checkbox"/> Yes <input type="checkbox"/> No	Walking	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Check all needs experienced by Care Recipient that requires supervision:

<input type="checkbox"/> Cognitive Impairment or Dementia	<input type="checkbox"/> Functional Limitations due to Aging	<input type="checkbox"/> Physical Disability
<input type="checkbox"/> Behavioral Challenges	<input type="checkbox"/> Learning Disability	<input type="checkbox"/> Other:
<input type="checkbox"/> Developmental and/or Intellectual Disability	<input type="checkbox"/> Mental Health Issues	

Describe Care Recipient's special needs such as day-to-day care routines that require extra support: *(Answer Required)*

High risk of out of home placement/facility care (such as a nursing home, foster care, mental health institution, group home):
 Yes No

Section 2: PRIMARY CAREGIVER INFORMATION *(Parent, Spouse, other Family or Friend providing on-going care.)*

Name of Authorized Representative: (Primary Family Caregiver)	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Age: <input type="checkbox"/> 18 and younger <input type="checkbox"/> 19-59 <input type="checkbox"/> 60-75 <input type="checkbox"/> 76+
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Caregiver is:

<input type="checkbox"/> Adoptive Parent	<input type="checkbox"/> Friend	<input type="checkbox"/> Legal Guardian	<input type="checkbox"/> Partner
<input type="checkbox"/> Biological Parent	<input type="checkbox"/> Foster Parent	<input type="checkbox"/> Sibling	<input type="checkbox"/> Power of Attorney
<input type="checkbox"/> Daughter/Son	<input type="checkbox"/> Grandparent	<input type="checkbox"/> Spouse	

Landline Phone Number:	Cell Phone Number:	Consent to text: <input type="checkbox"/> Yes <input type="checkbox"/> No Cell Carrier:
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Consent to contact via email: <input type="checkbox"/> Yes <input type="checkbox"/> No	Caregiver Email:
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Do you prefer communication via: Email Email & Text Mail Mail & Text

Time spent caregiving each week: <input type="checkbox"/> 5-10 Hours <input type="checkbox"/> 11-20 Hours <input type="checkbox"/> 21-35 Hours <input type="checkbox"/> Full-Time 24/7	How "stressed" are you as a result of caring for the care recipient:
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Health of Caregiver at time of request (check one): <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Disabled <input type="checkbox"/> Critical	<input type="checkbox"/> Not at all stressed <input type="checkbox"/> Slightly stressed
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Caregiver employed: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Not Employed or Retired	<input type="checkbox"/> Moderately stressed <input type="checkbox"/> Very stressed <input type="checkbox"/> Extremely stressed
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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:

Lifespan Respite will only provide respite supports for people not receiving respite services or eligible for other respite services from another government program.

Is the Care Recipient currently receiving respite services or eligible for other respite services from another government program? Yes No

Military Information:

Is anyone in the household currently active or reserve in any branch of the United States military? Yes No

Have you or any member of your household served in any branch of the military? Yes No

If yes, please provide information below for this person(s).

Name of Person in the Military or Spouse or Child of a Veteran:	He/She is a:
	<input type="checkbox"/> Veteran <input type="checkbox"/> Active <input type="checkbox"/> Spouse of Veteran <input type="checkbox"/> Reserve <input type="checkbox"/> Child of Veteran (18 or younger)
	<input type="checkbox"/> Veteran <input type="checkbox"/> Active <input type="checkbox"/> Spouse of Veteran <input type="checkbox"/> Reserve <input type="checkbox"/> Child of Veteran (18 or younger)
	<input type="checkbox"/> Veteran <input type="checkbox"/> Active <input type="checkbox"/> Spouse of Veteran <input type="checkbox"/> Reserve <input type="checkbox"/> Child of Veteran (18 or younger)

Section 3: LIVING ARRANGEMENTS *(List all who live in the household of Care Recipient):*

Name:	Date of Birth:	Relationship to Care Recipient:

(If care recipient receives benefits through the SNAP or MEDICAID NON-MAGI Programs skip to Section 7)

Does the care recipient age 18 and under have a parent living outside the home: Yes No

Section 4: RESOURCES/ASSETS

Do you or anyone in the home have any of the following: Yes No

If yes, check all that apply and list the resources/assets in the table below.

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|--|--|---|
| <input type="checkbox"/> Cash | <input type="checkbox"/> 401(K) | <input type="checkbox"/> Education Accounts |
| <input type="checkbox"/> Checking and Saving Accounts | <input type="checkbox"/> Other Resources | <input type="checkbox"/> Property (Land, Homes) |
| <input type="checkbox"/> Certificates of Deposits (CD) | <input type="checkbox"/> Retirement Accounts | <input type="checkbox"/> Burial Trusts |
| <input type="checkbox"/> Mutual Funds | <input type="checkbox"/> Stocks /Bonds | <input type="checkbox"/> Burial Arrangements |
| <input type="checkbox"/> Inheritance | <input type="checkbox"/> Annuities | <input type="checkbox"/> Trusts |

Name(s) on Account:	What do They Have:	Amount on Account:	Name(s) on Account:	What do They Have:	Amount on Account:

Section 5: INCOME (List all gross income (before deductions). For persons who have reached the age of 19, only the income of the applicant and the applicant's spouse will be listed. For persons under the age of 19, the income of the applicant and the taxable income of the custodial parent(s) will be listed. 464 NAC 1.011.02(A))

Income Type:	Amount:	How Often is it Received:	Who Receives it:
<input type="checkbox"/> Wages: <input type="checkbox"/> Self-Employment: (Self-employment must attach IRS verification of income)			
<input type="checkbox"/> Social Security Disability Insurance (SSDI)			
<input type="checkbox"/> Social Security Retirement			
Income Type:	Amount:	How Often is it Received:	Who Receives it:
<input type="checkbox"/> Pension under SS Retirement:			
<input type="checkbox"/> Child Support:			
<input type="checkbox"/> Alimony:			
Other:			

Section 6: DISABILITY-RELATED EXPENSES (Unreimbursed out-of-pocket costs only)

List disability-related expenses not covered by any other source, the Care Recipient has to pay in a year's time. Examples of expenses: doctor visits, prescriptions, adult incontinence products, medical transportation, wheelchairs, lifts, loans for architectural modification. Do not include expenses of other family members:

Expense:	Cost:	How Often:

Section 7: OPTIONAL DEMOGRAPHICS

Ethnicity:	Race:
<input type="checkbox"/> Not of Hispanic, Latino, or Spanish origin <input type="checkbox"/> Mexican <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Central American <input type="checkbox"/> Cuban <input type="checkbox"/> South American <input type="checkbox"/> Other Hispanic, Latino, or Spanish Origin <input type="checkbox"/> Other/Unknown	<input type="checkbox"/> Black/African American <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Asian <input type="checkbox"/> American Indian <input type="checkbox"/> Alaskan Native <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Other/Unknown

SECTION 8: 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 understand payments for benefits may be delayed if I did not provide the Social Security Number for Care Recipient.

I understand 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.

Signature of Adult Care Recipient or Authorized Representative:	Date:
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Signature of Person Helping Complete this Application, if applicable:

Relationship to Care Recipient:	Helper Telephone:	Helper Email:
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Section 9: REFERRAL SOURCE (Who told you about the program)

Name/Title:	Organization/Agency or Relationship to Care Recipient:	
Address:	City:	State:
Telephone:	Email:	



Send completed application and supporting documentation to:

Email: (recommended)	dhhs.respite@nebraska.gov	Mail:	DHHS
Fax:	(402) 742-8356		Lifespan Respite Subsidy Program
Social Services Worker:	(402) 471-9188		P.O. Box 98933
Local Respite Coordinator:	1-866-RESPITE (1-866-737-7483)		Lincoln, NE 68509-8933

INSTRUCTIONS:

Instructions for completing Form CFS-1400, "Lifespan Respite Subsidy Program Application"

Use: Form CFS-1400 is used as an application to determine eligibility for Lifespan Respite Subsidy Program benefits. Program Staff will use the form to collect data needed to determine eligibility for respite services. It also serves as a release of information when additional information is needed to determine eligibility. This program pays for respite services to give the primary caregiver a temporary break. **Respite means the provision of short-term relief to primary caregivers from the demands of ongoing care for an individual with special needs.** Ongoing care means continuous, full-time supervision/care for a person with special needs. DHHS Manual reference 464 NAC 1.001.01, 464 NAC 1.009, and 464 NAC 1.010. It is NOT for people who are receiving respite services from another government program.

Completion: Program Staff will use the data to determine eligibility. Incomplete information may delay eligibility determination. The application must be signed and dated by the Adult Care Recipient or his/her authorized representative.

Section 1: CARE RECIPIENT INFORMATION (Person with special needs requiring full-time ongoing care:

Enter the name, date of birth, gender, living arrangements, social security number, citizenship status, address, city, state, zip code and county of the Care Recipient. Mark all the check boxes that apply.



Attach documentation to support request for respite (for example, letter from therapist or healthcare provider, current medical reports or IEP).

High Risk of Out of Home Placement/Facility Care: Mark the check box that applies.

Section 2: PRIMARY CAREGIVER INFORMATION (Parent, Spouse, other Family or Friend providing

ongoing care): Enter the caregiver's name. Mark all the boxes that apply for gender, age and role(s). Enter telephone number(s) for home, cell and work.

Consent to Text: Mark the check box that applies. If yes, list your cell phone carrier.

Email Contact: Check the box if Program Staff may contact you by email. Enter an email address.

Time Spent Caregiving Each Week: Mark the check box that applies.

Stress Level: Mark the check box that applies.

Communication Preference: Mark the check box that applies.

Health of Caregiver: Mark the check box that applies.

Employment Status: Mark the check box that applies.

Missed Work: Mark the check box that applies. List number of missed days.

Section 3: LIVING ARRANGEMENTS: List all who live in the household. Be sure to include everyone’s date of birth and relationship to Care Recipient.

If care recipient receives Medicaid, SNAP, ADC, state disability, or AABD skip to Section 7 (Optional Demographics).

Section 4: RESOURCES/ASSETS: *You may be asked by Program Staff to verify Resources/Assets to comply with state statute, defined administrative and audit requirements to demonstrate client financial need eligibility for use of program funds. Failure to respond or providing incomplete information may cause eligibility determination delay.

Mark all the check boxes that apply. List person(s) who has the funds checked and the amount of each. List any liquid resources including cash on hand, checking and savings accounts, certificates of deposit, stocks, bonds, life insurance cash values, IRA and Keogh Funds, etc. This data will be used as another factor of eligibility.

Section 5: INCOME: *You may be asked by Program Staff to verify Resources/Assets to comply with state statute, defined administrative and audit requirements to demonstrate client financial need eligibility for use of program funds. Failure to respond or providing incomplete information may cause eligibility determination delay.

Use more paper if there is not enough room for your answers on this application.

Wages and/or Self-Employment: List current household gross wages (before taxes and deductions) or self-employment by amount, frequency and who receives it.

Child Support, Alimony: List amount, frequency and who receives it.

Section 6: DISABILITY-RELATED EXPENSES: List all disability-related expenses paid on behalf of the Care Recipient in a year’s time. Do not include amounts covered by insurance or other benefit program(s). Information listed here will be considered to see if the expense may be disregarded from the income. It should include things such as out-of-pocket expenses for prescriptions, home modifications, diapers for individuals above age 3, etc.

Optional Race and Ethnicity: Mark all the check boxes that apply.

Section 7: OPTIONAL DEMOGRAPHICS: Indicate the race and ethnic category of care recipient. Title VI of the Civil Rights Act of 1964 allows the Department to ask for this information. This information will not be used in determining eligibility for program funding. If you do not provide this information, it will not affect your application. The Department asks for the information to assure that benefits are distributed without regard to race, color, ethnicity, or national origin.

Section 8: AGREEMENT AND SIGNATURE: The Adult Care Recipient or authorized representative must sign the application before Program Staff can authorize benefits. Person assisting with completing application must sign and list relationship, date, telephone, and email.

Section 9: REFERRAL SOURCE (Who told you about this program?): List name, organization/agency /or relationship to care recipient and contact information of how you learned about the Lifespan Respite Subsidy Program.

Send completed application and supporting documentation to:

Email: (recommended)	dhhs.respite@nebraska.gov	Mail:	DHHS Lifespan Respite Subsidy Program P.O. Box 98933 Lincoln, NE 68509-8933
Fax:	(402) 742-8356		
Social Services Worker:	(402) 471-9188		
Local Respite Coordinator:	1-866-RESPITE (1-866-737-7483)		

WHO PROVIDES RESPITE

There is some flexibility in finding providers. Your local Respite Coordinator can assist you with finding a Network screened provider in your area. You may be able to use family members, friends or neighbors as paid providers. Other possibilities include: organizations, camps, a trusted agency, a local volunteer-led organization or group, volunteer-led school-based program, equine program, faith-based or other approved activities. While your loved one is attending an activity, you are getting a break—and that’s what respite is all about!

You can locate Network screened respite providers at: respite.ne.gov. Click on “Read more” to navigate to the Respite Provider Match or NRRS Respite Search to assist in locating a provider in your area.