~ Virginia Lifespan Respite Voucher Program ~

Application Form

Name of Primary Family Caregiver (*the person applying for respite voucher funds*)		
Name of Respite Care Recipient (*the person receiving respite services*)		
Street Address (*of both Primary Family Caregiver and the Respite Care Recipient*)		
City	**State** Virginia	**Zip**
Primary Phone Number(s)	***E-mail** (*for Primary Family Caregiver)*	

***Communication about the status of your request for funding will be sent primarily via email unless no email is listed.**

The Primary Family Caregiver has the following relationship with the person receiving care:
☐parent; ☐court-appointed legal guardian; ☐foster parent; ☐grandparent; ☐grandchild; ☐son; ☐daughter; ☐sibling; ☐spouse; ☐other:_________________________________

Total number of family members in Primary Family Caregiver's household:

____Adults; ____Children (under 18 years)

How did you hear about the *Virginia Lifespan Respite Voucher Program?*
☐Area Agency on Aging;
☐Brain Injury Services Organization;
☐Center for Independent Living;
☐CSB (Case Management)
☐Hospice;
☐DARS Division on Aging;
☐DARS Brain Injury Services Coordination Unit;
☐Social Worker;
☐Another individual or organization (please list):
____

Required Questions:

1. **Do you live full time in the same residence as the Respite Care Recipient?** ☐Yes ☐ No
2. **Are you currently employed?** ☐Yes ☐ No
3. **Do you use non-family respite services?** ☐Yes, currently ☐No ☐Not currently but I have in the past
   If YES, please check: ☐Community Respite Organization: ______________________
   ☐Friends/Neighbor ☐ Church ☐Hospice
   Do you currently pay for these non-family respite services? ____
4. **Are you receiving respite services through a Medicaid Waiver?** ☐Yes ☐Waitlist ☐ No
   If YES, please select the type of waiver: ☐ID/DD ☐ EDCD ☐Other:
5. **Date(s) and hours (estimated) you plan to use respite services** (you have 90 days from date of approval to use respite services)**:** ____
6. **Amount of voucher funding requested: $**____________
7. **Will the Lifespan Respite Voucher be used for a service you are already receiving?** ☐Yes ☐ No

~ Virginia Lifespan Respite Voucher Program ~

Application Form

Description of Voucher Funding Request (required):

- **The type of respite I will use is:** ☐Skilled care ☐Unskilled care
  From: ☐Formal providers (hired and trained by an agency)
  ☐ Informal Providers (available through parent or caregiver cooperatives, churches, or family and friends)
- **The respite provider I will hire and pay is an:** ☐Individual ☐Agency ☐Other:
- **Respite services will be provided in:** ☐the family home ☐the home of a neighbor or friend ☐an adult day center ☐a respite center ☐a residential care facility ☐a group home ☐a recreational setting ☐a community based program ☐other:
- **The temporary break from caregiving duties this program provides will allow me to** (e.g. have a date night, go to a family reunion, take a nap, see a movie, go on vacation, get rest and relaxation, go to the store, etc.)**:** ________________
____
____

Respite Care Recipient Information		
Name of Respite Care Recipient (*the person receiving respite services*)		
Age	**Gender** ☐Male; ☐Female; ☐ Other	**Is the Respite Care Recipient a Veteran?** ☐Yes; ☐ No
Race and Ethnicity (Check the race the recipient identifies as and then write their ethnicity beside the race) ☐African American: _________ ☐Asian: _________ ☐Caucasian: _________ ☐Hispanic/Latino:_________ ☐Multiracial: _________ ☐Native American: _________ ☐Other: _________		
Using the list below, please write the disability or special need in the appropriate location (if other, please specify) **Primary** Disability or Special Need: ____________________ **Secondary** Disability or Special Need (optional): ____________________ **Intellectual/Developmental Disability**: Intellectual Disability; Autism; **Physical/Orthopedic/Mobility Impairment**: Multiple Sclerosis; Muscular Dystrophy; Cerebral Palsy; **Sensory/Communication Impairment**: Blind/vision impaired; Deaf/ hard of hearing; **Mental/Emotional/Psychosocial Impairment**: Mental Illness; Mood/Personality Disorders; **Degenerative Neurological Impairment**: Dementia/Alzheimer's; Parkinson's; ALS; **Neurological Impairment (nondegenerative)**: Stroke; Traumatic Brain Injury; Spinal Cord Injury; **Medically Fragile/ Frail Elderly**; **Other**		

***Documentation of the Respite Care Recipient's condition/disability must be included in this application form or it cannot be processed or approved. Documentation cannot be more than two years old (2016-2018)**

Examples of Acceptable Documentation of Condition / Disability: ***(Please limit documentation to one page)***

- Physician/Psychologist Written Diagnosis of Disability/Condition: 1 page
- Social Security Administration Letter of Determination for Disability Benefits: 1 page
- School District Special Education Eligibility/Individualized Educational Plan Cover Sheet/Sign off Sheet: 1 page
- Early Intervention Eligibility/Individualized Family Service Plan Cover Sheet/Sign-off Sheet: 1 page
- Vocational Rehabilitation Statement of Qualifying Disability: 1 page
- Long-term Disability Insurance Statement of Eligibility of Benefits: 1 page
- Medicaid Eligibility/Medical Assistance Eligibility Forms: 1 page

~ Virginia Lifespan Respite Voucher Program ~

Application Form

Acknowledgements

Primary Family Caregiver: Please read and initial *each* item below. Sign and date form before submitting the application to the Virginia Department for Aging and Rehabilitative Services (DARS).

______I attest that I am the Primary Family Caregiver of the Respite Care Recipient listed in this application form and that I reside full-time in the same residence with the Respite Care Recipient in the Commonwealth of Virginia.

______ I understand that the intention of the Virginia Lifespan Respite Voucher program is to allow the Primary Family Caregiver to get an opportunity of rest from providing care for their loved one (once they find out they are approved), by hiring a respite care provider to take care of that loved one. This program prohibits the use of these funds for rent, cleaning, transportation, medical supplies, food, and household expenditures or so the applicant can go to work.

______I attest that I have read and understand the DARS *Virginia Lifespan Respite Voucher Program* application procedures. I understand my signature below authorizes a release of information for program purposes only.

______I understand that the funds I receive from the *Lifespan Respite Voucher Program* are solely for services provided to the Respite Care Recipient listed on this application and that these funds cannot be used for any other purpose.

______I understand that if I have existing government debt, I may not receive my entire refund.

______I acknowledge that I am responsible for hiring the respite care provider and arranging the payment for services received. I understand that I will be reimbursed a sum not to exceed the amount approved by DARS on my ***Application Form***. I understand that I am responsible for any difference in the amount approved and the amount paid by me, if any.

______I will submit a ***Reimbursement Form*** and ***W-9 Form*** within 30 days of the date of purchase and delivery of respite services. I understand that any unspent portion of my respite voucher may be forfeited if I have not made prior arrangements for use of my respite voucher funds by this deadline. I understand that the ***W-9 Form*** is required by the Commonwealth in order to issue the reimbursement check; it is not sent to the IRS or any other entity for tax purposes. I agree to complete and return the required ***Satisfaction Survey***. *

______I understand that if I elect to hire my own individual respite care provider, I am responsible for negotiating the rate of pay with the identified respite services provider. I am also responsible for providing any training or instruction the respite care provider(s) of my choice may need to provide services to the respite care recipient.

* Final claims for reimbursement can't be processed until the ***Satisfaction Survey, W-9 Form,*** and the ***Reimbursement Form*** are received by DARS.

The Virginia Department for Aging & Rehabilitative Services (DARS) administers the *Virginia Lifespan Respite Voucher Program* to provide short-term funding for respite care services, but does not provide these services directly or indirectly. I attest that the information included in this ***Application Form*** is true and accurate to the best of my knowledge. I understand that falsification of information will result in termination of services.

Signature:____

Applicant (*Primary Family Caregiver*) **Date**

Print Name:____

Applicant (*Primary Family Caregiver*)

Please mail/fax or scan and email this form with the required documentation of disability or special need to:

Virginia Lifespan Respite Voucher Program, ATTN: Nick Slentz,
Virginia Department for Aging and Rehabilitative Services (DARS),
Virginia Division for the Aging
1610 Forest Avenue, Suite 100,
Henrico, VA 23229;
or Fax to 804.662.7035; or E-mail to Nick.Slentz@dars.virginia.gov.

This project was supported by a grant, number 90LRLI0020-01-00, from the Administration for Community Living, Administration on Aging, Department of Health and Human Services, Washington, DC 20201. Grantees undertaking projects under government sponsorship are encouraged to express freely their findings and conclusions. Points of view or opinions do not, therefore, necessarily represent official Administration on Aging Policy.

Caregiver Burden Inventory: Modified	Responses				
Items	Never	Rarely	Some-times	Quite Frequently	Nearly Always
Time Dependency Items					
1. He/she needs my help to perform many daily tasks.	0	1	2	3	4
2. He/she is dependent on me.	0	1	2	3	4
3. I have to watch him/her constantly.	0	1	2	3	4
4. I have to help him/her with many basic functions.	0	1	2	3	4
5. I don't have a minute's break from his/her chores.	0	1	2	3	4
Development Items					
6. I feel that I am missing out on life.	0	1	2	3	4
7. I wish I could escape from this situation.	0	1	2	3	4
8. My social life has suffered.	0	1	2	3	4
9. I feel emotionally drained due to caring for him/her.	0	1	2	3	4
10. I expected that things would be different at this point in my life.	0	1	2	3	4
Physical Health Items					
11. I'm not getting enough sleep.	0	1	2	3	4
12. My health has suffered.	0	1	2	3	4
13. Caregiving has made me physically sick.	0	1	2	3	4
14. I'm physically tired.	0	1	2	3	4
Social Relationships Items					
15. I don't get along with other family members as well as I used to.	0	1	2	3	4
16 My caregiving efforts aren't appreciated by others in my family.	0	1	2	3	4
17. I've had problems with my marriage (or other significant relationship).	0	1	2	3	4
18 I don't get along as well as I used to with others.	0	1	2	3	4
19. I feel resentful of other relatives who could but do not help.	0	1	2	3	4
Emotional Health Items					
20. I feel embarrassed over his/her behavior.	0	1	2	3	4
21. I feel ashamed of him/her.	0	1	2	3	4
22. I resent him/her.	0	1	2	3	4
23. I feel uncomfortable when I have friends over.	0	1	2	3	4
24. I feel angry about my interactions with him/her.	0	1	2	3	4

Total Score = ________ (0-96)