

# Mississippi Lifespan Respite Voucher Program Application



**Family Caregiver Information: The person who is responsible and is the primary caregiver.**

Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ County: \_\_\_\_\_

Mailing address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_ E-mail: \_\_\_\_\_

**Care Recipient (CR) Information: The individual who receives care.**

Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ County: \_\_\_\_\_

What is your relationship to care recipient? (parent; child; guardian; other): \_\_\_\_\_

Address (if different from above): \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

**Please complete each question.**

**Is the CR being served by any of the following?**

**Respite Service:** Does the CR currently receive respite service? Yes or No

**\*If yes, please do NOT continue to fill out the application.**

**Insurance Information:**

Does the Care Recipient have health insurance? Yes or No

If yes, type of coverage Medicare Medicaid Private \_\_\_\_\_

**Disability/Special Needs Services:**

Does the CR have a disability or chronic illness? Yes or No Please provide information: \_\_\_\_\_

**Household Information:**

Number of family members living in the home \_\_\_\_\_ Combined annual household income \_\_\_\_\_

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## Preferred type of Respite to take a break from caregiving:

An In-Home Care Agency

Agency Name: \_\_\_\_\_

An out-of-home Care Agency/Facility

Agency Name: \_\_\_\_\_

An at-home private provider that I find, employ and pay out-of-pocket

Private Provider Name: \_\_\_\_\_

Other Care Provider (please be specific): \_\_\_\_\_

Families As Allies will reimburse funds to Caregiver within 30 business days upon receipt of invoice.

## Consent to Release Information:

I, \_\_\_\_\_ parent/guardian give MAC Center/MDHS staff permission to contact the following organization and to communicate on our behalf to assist with obtaining respite care services.

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

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

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

Other(provider): \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

**Initial:** [  ] If granted a respite voucher, I understand that the Family Caregiver Support Program will be informed in order to help coordinate a MS Respite System that serves families throughout the state.

**Initial:** [  ] A respite provider, agency, or adult day care program has not been chosen. We agree to allow the MAC Center staff to communicate on our behalf and provide our information to respite service providers to assist with options for care providers. All information will be provided to respite providers with the understanding that records/information will be kept confidential.

**Initial:** [  ] We are willing [  ] not willing to share our caregiving and respite story with other Mississippians around the state and [  ] give [  ] do not give FAA/MDHS/MFCC permission to use photos of us on flyers and/or on the website. Please contact me for follow-up information if permission is granted.

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## CAREGIVER SELF-ASSESSMENT

1. I feel my health is worse and I am getting sick more.	Never	Rarely	Sometime	Often
2. My sleep is affected by stress and responsibility.	Never	Rarely	Sometime	Often
3. My social life has suffered due to caregiving.	Never	Rarely	Sometime	Often
4. I get everything done I need to in a typical day.	Never	Rarely	Sometime	Often
5. I have trouble keeping my mind focused.	Never	Rarely	Sometime	Often
6. I am irritable or angry more than I used to be.	Never	Rarely	Sometime	Often
7. I cry often.	Never	Rarely	Sometime	Often
8. I resent that my loved one needs so much.	Never	Rarely	Sometime	Often
9. I feel lonely.	Never	Rarely	Sometime	Often
10. I feel like I have nowhere to turn for help.	Never	Rarely	Sometime	Often

Printed Name (Caregiver): \_\_\_\_\_

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

**NOTE: Please provide all requested information. We reserve the right to reject incomplete applications.**

Mail or email completed applications to:

MS Department of Human Services  
James Davis, Home & Community-Based Coordinator  
Division of Aging and Adult Services, 5<sup>th</sup> Floor  
200 South Lamar Street  
Jackson, MS 39201 or  
Email to [james.davis@mdhs.ms.gov](mailto:james.davis@mdhs.ms.gov)

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## Relative-Respite-Provider Release and Indemnity Agreement

The undersigned releases and agrees to indemnify The Mississippi Family Caregiver Coalition (MFCC), Families As Allies (FAA), The Mississippi Department of Human Services (MDHS), their officers, directors, employees, agents and representatives, of and from any and all rights, claims, demands and causes of action whatsoever kind and nature. The undersigned has read the above and agrees that in no event will MFCC, FAA, nor MDHS be held liable for any damages, injuries, accidents, or losses suffered by care recipients, caregivers, and/or property while participating in respite service provision and they are hereby released there from.

If a family member (*who does not reside with the care recipient or caregiver*) is chosen to serve in providing compensated Respite, the caregiver and care recipient may choose not to require a background check.

***This agreement may not be modified orally or in writing by any individual.***

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Print Care Recipient Name

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Print Caregiver Name

Date

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Caregiver Signature

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Address

City

State

Zip

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Telephone Number

E-mail