Delaware Lifespan Respite Care Network 2011

Application For Financial Assistance

Thank you for applying to the Delaware Lifespan Respite Network for financial assistance. In order to process your application, please take the time to answer all questions and provide all information asked for. Thank You.

1. Personal Information:

Personal Information: Today's date:	
Parent/Caregiver name:	
Parent/caregiver preferred email address:	
Name of person receiving care:	

2. Please indicate your relationship to the person receiving care.:

Parent ☐ **Grandparent** ☐ **Other Family Member (specify below)** ☐

Foster parent ☐ **Court-appointed Legal Guardian** ☐ **Other (specify below)** ☐

Other Family Member/Other:_____

3. Care Recipient's sex

- Male
- Female

4. How old is the person who is receiving care?

- 0-12 years old
- 13-20 years old
- 21-60 years old
- 60-75 years old
- older than 75 years

Please indicate current age of the person who is receiving care:

5. Please indicate the primary disability of the person receiving care (check one only)

Autism ☐ **Cerebral Palsy** ☐ **Other Developmental Disability** ☐ **ADHD/Behavior Disorder** ☐

Bipolar/Mood Disorder ☐ **Dementia/Alzheimer's** ☐ **Other (specify below)** ☐

Other :_____

6. Did you receive funds from the Delaware Lifespan Respite Care Network last Year (2010)?

- YES
- NO

7. Please indicate which county you live in:

New Castle ☐ **Kent** ☐ **Sussex** ☐

8. Care recipient requires help with: (please check all that apply)

- ☐ assistance with behavior problems
- ☐ physical transferring and lifting
- ☐ transporting
- ☐ social interaction
- ☐ educational needs
- ☐ sibling rivalry
- ☐ medication administration
- ☐ ventilator equipment
- ☐ has a feeding tube
- ☐ bathing assistance
- ☐ requires a wheelchair
- ☐ repeated hospitalizations
- ☐ requires 24 hour supervision
- ☐ Other, Please specify below

_____

9. Parent/Caregiver information: (please check all that apply)

- ☐ Provides support alone
- ☐ cares for more than one recipient
- ☐ has financial problems
- ☐ has no time for day-to-day tasks
- ☐ cannot find support
- ☐ is unable to work due to caregiving
- ☐ other, please specify:_____

10. Have you applied for any of the following services? If YES, please indicate result (eligible, not eligible, pending):

	YES	NO	Eligible	NOT Eligible	Pending
DDDS respite services	☐	☐	☐	☐	☐
DSAAPD respite/personal care/Grand Time Off	☐	☐	☐	☐	☐
Medicaid/Medicaid Waiver	☐	☐	☐	☐	☐
DE Autism Program respite	☐	☐	☐	☐	☐
Other (indicate below)	☐	☐	☐	☐	☐
None	☐	☐	☐	☐	☐

Other:_____

11. If you indicated that you are eligible for any of the services above, please indicate amount of hours, days, or funds you are eligible for on a monthly and/or annual basis

Program	Amount of funds, hours, days eligible for on a monthly and/or annual basis

12. In order to provide the best possible assistance to you, please provide a brief explanation of how you currently access respite services and how you pay for them.

13. Explain why you need financial assistance from the Delaware Lifespan Respite Network if you are eligible for respite services from other funding sources.

14. Eligible persons may receive up to $500.00 per care recipient per year in financial assistance as funds are available. Please indicate below the total amount of funds you are requesting. $_____

15. Do you need assistance with locating a respite provider?

○ Yes ○ No

16. How do you currently locate and hire respite care providers:

- ☐ Family Members
- ☐ Neighbors
- ☐ Friends
- ☐ Private Pay
- ☐ Home Health Agency
- ☐ Through School
- ☐ Other - Please specify_____

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17. Parent/Caregiver Verification Information **NOTE: Questions with an "*" requires an answer**

*Name: _____

*Address 1: _____

Address 2: _____

*City: _____

*State: _____

*Zip Code: _____

*Primary Phone: _____

Cell Phone: _____

Work Phone: _____

Email Address: _____

18. I agree to follow the respite care provider requirements listed below.
The care provider:
a. is 19 years of age or older
b. has provided either a Social Security number or a tax ID (EIN) number
c. is NOT the caregiver's spouse/partner or care recipient's parent
d. is NOT the care recipient's regular care provider, unless being used for additional hours of respite care beyond normal care schedule

I have read and agree to follow these guidelines

YES, I agree to follow these guidelines ☐ **NO, I do not agree** ☐

Please Return this application to:
Delaware Lifespan Respite Care Network
61 Corporate Circle
New Castle DE 19720

If you have any questions about this application please call 302.221.2087 Thank You