Respite Voucher Application

February 2013
Lifespan Respite Care funds through a grant from the NC Division of Aging & Adult Services.

These funds are from the Lifespan Respite Grant awarded to NC DAAS by the Administration on Aging in Washington.
Who’s Eligible?

• Respite services may be provided to a family caregiver or individual who is unpaid for their caregiving duties and who is age 18 or older.

• Funds awarded by the NCRCC respite committee generally are for those persons who are not eligible for respite services elsewhere. Priority will be given to those caregivers with the greatest social and economic needs.

• Exceptions may be made for emergency respite at the discretion of the respite voucher committee.
Important Points to Remember

- This is a voucher-based (reimbursement-based) program;
- These vouchers are available for family and informal caregivers through the lifespan.
- The maximum award available per family is $500.00.
- **These funds will only be available until August 31, 2013.**
- We will have approximately 75 vouchers to award.
- The completed application must be submitted to us through a referring agency. The referring agency must provide assurances that the applicant family is either:
  - on a waiting list for respite services,
  - is not eligible for any other respite funding source but is unable to pay privately, **OR**
  - has exhausted all other sources of respite funding.
IMPORTANT!!!

• The application must be fully complete, including the signed W-9 form.
• Incomplete applications will not be considered and will be returned.
• Traditional respite funding will be the first source for those needing respite and NCRCC respite assistance will not supplant other respite funding sources.
Referring Agency Responsibilities

• Provide community outreach to informal (unpaid) caregivers
• Screen applicant for need and support assuring that other funding sources are not available to pay for the needed respite
• Provide and assist unpaid family caregiver with Respite Voucher Application package of forms
• Submit completed, signed forms to NCRCC respite voucher committee
• Provide follow-up information, if requested, by respite voucher committee
The Application Form
FAMILY CAREGIVER and CARE RECIPIENT INFORMATION

Name (caregiver needing respite): ____________________________________________

Date of birth: ____________________ County of residence: ____________________

Relationship to person needing care or supervision____________________________

Street address or P.O. Box __________________________________________________

City: ____________________________ State: _ Zip code: _________________________

Daytime telephone: _______________ Other telephone: _________________________

Email address: ________________________________

Name of person needing care or supervision [Fill out separate application for each person needing care or supervision]: ________________________________

Date of birth: ________________ County of residence: _________________________

Amount of care the family caregiver provides: ___________________ hours per day
________________________________________ days per week

Does the family or care recipient have the ability to pay for care? ________________
REFERRING AGENCY/INDIVIDUAL SUBMITTING RESPITE REQUEST

Individual /professional referring caregiver __________________________________________

Agency name _________________________________________________________________

Street address or P.O. Box _______________________________________________________

City: ___________________________ State: _________ Zip code: ________________

Daytime telephone: _______________ Other telephone: _________________________

Email address: ________________________________

NC Respite Care Coalition Member: ☐ Yes ☐ No
TYPE OF RESPITE NEEDED

Emergency respite care: □ Yes □ No
Routine/ongoing respite care: □ Yes □ No
Explain: ____________________________________________
__________________________________________________
__________________________________________________

THE PERSON NEEDS SUPERVISION OR CARE DUE TO ... (check those that apply)

□ Developmental and/or physical disabilities: □ child or □ adult
□ Child with behavioral or emotional concerns
□ Is a minor grandchild being raised by a grandparent?
□ Adult with Alzheimer’s disease or similar memory impairment
□ Adult that needs assistance with multiple activities of daily living and/or chronic diseases
□ Other, please describe __________________________________________
__________________________________________________
__________________________________________________
__________________________________________________
OTHER SERVICES

Has the caregiver and/or care recipient applied for Medicaid? □ Yes □ No

Declared eligible/ineligible? ________________________________

Is the care recipient on a waiting list for services? □ Yes □ No
If so, provide service and where: __________________________________________

Is family receiving any other paid respite care or services for this person? □ Yes □ No

List services and how they are paid for? ______________________________________

________________________________________

________________________________________

________________________________________

________________________________________

Please describe reason respite cannot be obtained through another funding source/avenue

________________________________________

________________________________________

________________________________________

________________________________________
PLANNED RESpite CARE PROVISION

Name of paid caregiver / agency _____________________________

Planned site of care (please provide specific contact information):
   At care recipient’s home _______________________________
   Residential Facility _________________________________
   Day Center ___________________________
   Licensed foster home _______________________________
   Other ________________________________

Date(s) of care to be provided: from ___________________ to ___________________

And/or projected hours _______________

Estimated cost per day _______________ Number of days ___________________

TOTAL ESTIMATED COST (not to exceed $500) ___________________
If application is approved, the North Carolina Respite Care Coalition will reimburse the family caregiver for respite care provided up to but not exceeding $500.

____________________________________  ______________
Family Caregiver’s Signature                Date
Form W-9
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Name (as shown on your income tax return)

Business name/disregarded entity name, if different from above

Check appropriate box for federal tax classification:
- Individual/sole proprietor
- C Corporation
- S Corporation
- Partnership
- Trust/estate
- Limited liability company. Enter the tax classification (C= C corporation, S= S corporation, P= partnership)
- Exempt payee
- Other (see instructions)

Address (number, street, and apt. or suite no.)

City, state, and ZIP code

Requester's name and address (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the “Name” line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see How to get a TIN on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and

2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and

3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here

Signature of U.S. person

Date
Submit the completed NCRCC respite voucher application and IRS Form W-9 to:

Attention: Cindy Miles, NCRCC President
Southwestern Commission Council of Governments
125 Bonnie Lane
Sylva, NC 28779

Fax: (828) 586-1968
Email: NCRCCVouchers@gmail.com
IMPORTANT!!!

• The application must be fully complete, including the signed W-9 form.
• Incomplete applications will not be considered and will be returned.
Community Outreach by Providers / Partners

- Potential family caregiver screened by providers/partners
- Completed respite application and W-9 is submitted

NCRCC Respite Committee reviews applications and approves eligible grants;
Notification of respite award and forms sent to approved grantees; Forms sent to approved grantees

- Family caregivers hire respite provider and receive respite service;
- Caregiver submits the Record of Service form for reimbursement

Respite reimbursement request processed and mailed

NCDAAS conducts caregiver survey
Act Quickly!!

These funds will only be available until August 31, 2013.
QUESTIONS?
Contact Your Region’s NCRCC Board Member

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