Department of Health & Human Services
DHHS
NEBRASKA

Department of Health and Human Services

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).

Section 1 CARE RECIPIENT INFORMATION (Person with special needs requiring full-time ongoing 24/7 care/supervision)

Care Recipient Name:	Date of Birth:	Gender: ☐ Male ☐ Female

Living Arrangements:
☐ With Caregiver in Home of Care Recipient ☐ With Caregiver in Home of Caregiver
☐ With Other Family or Friend ☐ Lives Alone

Social Security Number

Care Recipient Citizenship Status:
☐ A citizen of the United States OR ☐ I am a qualified alien under the federal Immigration and Nationality Act.

Immigration Status and Alien Number:

Address:

City:	State: NE	Zip Code:	County:

Does the Care Recipient need help with any of the following self-care activities?

Bathing	☐ Yes	☐ No	Toileting	☐ Yes	☐ No	Grooming	☐ Yes	☐ No
Dressing	☐ Yes	☐ No	Transfers	☐ Yes	☐ No	Mobility	☐ Yes	☐ No
Eating	☐ Yes	☐ No	Walking	☐ Yes	☐ No			

Please check the Behavioral/Emotional needs experienced by Care Recipient that require supervision: (Check all that apply)

☐ ADD/ADHD ☐ Hyperactivity ☐ Reactive Attachment Disorder
☐ Anxiety ☐ Mental Illness ☐ Self-Abusive
☐ Bipolar ☐ Non-Verbal ☐ Temper Tantrums
☐ Depression ☐ Physically Aggressive ☐ Wandering
☐ Other:_____

Please check the special health care needs experienced by Care Recipient: (Check all that apply)

☐ Arthritis or other joint problems ☐ Feeding Tube ☐ Seizures
☐ Blood problems, such as anemia or sickle cell disease ☐ Heart Problems ☐ Severe Allergies
☐ Breathing problems such as Asthma or COPD ☐ Nebulizer ☐ Catheter
☐ Recovering from Surgery ☐ Tracheotomy ☐ Diabetes
☐ Other_____

Please check medical diagnosis of Care Recipient: (Check all that apply)

☐ AIDS ☐ Cystic Fibrosis ☐ Neurodegenerative Disease
☐ Alzheimer's / Dementia ☐ Depression ☐ Orthopedic Impairments
☐ Arthritis ☐ Developmental Delay ☐ Parkinson's Disease
☐ Autism/Autism Spectrum Disorder ☐ Renal Failure
☐ Brain Injury - Stroke / CVA ☐ Digestive System Disorder ☐ Seizure Disorder
☐ Brain Injury - TBI ☐ Fetal Alcohol Syndrome ☐ Speech and Language Delay
☐ Cancer ☐ Hearing Impairment/Hearing Aids ☐ Spinal Injury/Disorder
☐ Cerebral Palsy ☐ Heart Condition
☐ Chromosomal Abnormality ☐ Intellectual Disability/Developmental Delay
☐ Congestive Heart Failure ☐ Multiple Sclerosis
☐ Coronary Heart Disease ☐ Muscular Dystrophy
☐ Other:_____

Attach additional sheet or documentation, if needed, to support request for respite (for example, letter from therapist, current medical reports or IEP).

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).

Caregiver Name(s):	Gender: ☐ Male ☐ Female

Caregiver is:

☐ Adoptive Parent ☐ Friend ☐ Legal Guardian ☐ Partner
☐ Biological Parent ☐ Foster Parent ☐ Sibling ☐ Power of Attorney
☐ Daughter/Son ☐ Grandparent ☐ Spouse

☐ Other: _____

Telephone (Home) No:	Cell:	Work:

Can Program staff contact you via email? ☐ Yes No	Email:

Time Spent Caregiving each week:
☐ 5 - 10 Hours ☐ 11 - 20 Hours ☐ Full-Time 24/7

Health of Caregiver at time of request (check one):
☐ Good ☐ Fair ☐ Disabled ☐ Critical

Employed:
☐ Full Time ☐ Part Time ☐ Not Employed or Retired

Explain Caregiver's need for respite (break from caregiving responsibilities)

Section 3: LIVING ARRANGEMENTS

List the people who live in the household of Care Recipient:

Name	Date of Birth	Relationship to Care Recipient

Section 4: SUPPORT SERVICES

Are you now receiving any financial assistance for respite?
Yes ☐ No

If yes, who pays for the respite?

Care Recipient receiving services from (check all that apply)

- ☐ Aged & Disabled Medicaid Waiver
- ☐ Behavioral Health
- ☐ Developmental Disabilities System
- ☐ Health Insurance
- ☐ Medicaid - Master Case Number, if known_____
- ☐ SSI-DCP Program
- ☐ Subsidized Adoption
- ☐ Veterans Administration (VA) Benefits

Section 5: 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 incomple information may cause eligibility determination delay.

Do you or anyone in the home have any of the following:

Yes | No If yes, list everything below.

- ☐ Cash
- ☐ Checking and Saving Accounts
- ☐ Certificates of Deposits (CD)
- ☐ Proceeds from Sale of Home(s)
- ☐ Mutual Funds
- ☐ Inheritance
- ☐ 401(K)
- ☐ Other Resources
- ☐ Retirement Accounts
- ☐ Stocks /Bonds
- ☐ Annuities
- ☐ Education Accounts
- ☐ Property (Land, Homes)
- ☐ Trusts

Person Who Has It	What Do They Have?	Amount	Person Who Has It	What Do They Have?	Amount

Section 6: 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.

List all gross income (before deductions). Include Care Recipient, their spouse and children under 19. If Care Recipient is under 19, include parents and siblings under 19.

Income Type	Amount	How Often Is It Received	Who Receives It
Wages, Self-Employment (Self-employment must attach IRS verification of income)			
Assistance Programs ☐ Social Security ☐ SSI ☐ ADC ☐ Veterans			
Interest, Dividends			
Child Support, Alimony			
Other			

Section 7: DISABILITY-RELATED EXPENSES

List all disability-related expenses the Care Recipient has to pay in a year's time. Do not include amounts covered by insurance or other benefit program(s). Examples of expenses: doctor visits, prescriptions, diapers, medical transportation, wheelchairs, lifts, loans for architectural modification. Do not include expenses of other family members.

Expense	Cost	How Often

Optional Race and Ethnicity

Indicate the race and ethnic category of the head of household. Title VI of the Civil Rights Act of 1964 allows us to ask for this information. This information will not be used in determining eligibility for assistance. If you do not provide this information, it will not affect your application. We ask for the information to assure benefits are distributed without regard to race, color, national origin, age, disability, sex, gender identity, religion, reprisal and where applicable, political beliefs, marital status, familial or parental status, sexual orientation or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the department. If you do not enter any information, the worker will enter an answer.

Race: Select all that apply

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other:_____

Ethnic Category – Are you Hispanic or Latino? | Yes | No

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.

Payments for benefits may be delayed if you did not provide the Social Security Number for Care Recipient.

I hereby attest 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 Care Recipient or Authorized Representative	Date

Signature of Person Helping Complete this Application, identified below.

Relationship to Care Recipient		Date
Helper Address:	City:	State:
Telephone:		Email:

Send completed application to:

1. Email — dhhs.respite@nebraska.gov
2. Mail — Nebraska Department of Health and Human Services
CFS, Economic Assistance - Lifespan Respite Subsidy
PO Box 95026
Lincoln, NE 68509-5026
3. Fax OR — (402) 742-8356 (fax)

Questions: (402) 471-9188 / OR
1-866-Respite (1-866-737-7483) for a local Respite Network Coordinator

Section 9: REFERRAL SOURCE

Name/Title:		Organization/Agency:
Address:	City:	State:
Telephone:		Email:

Crisis Respite Request Attached: (Optional)

| Yes | No |

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 1-007 and 1-008. 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 Care Recipient or his/her authorized representative.

Section 1: CARE RECIPIENT INFORMATION (Person with special needs requiring full-time ongoing 24/7 care/ supervision): 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.

Immigration Status and Alien Number: If the qualified alien box is checked provide immigration status and alien number.

Self-Care Activities: Mark all the check boxes that apply.

Behavioral/Emotional Needs: Mark all the check boxes that apply.

Special Health Care Needs: Mark all the check boxes that apply.

Medical Diagnosis: Mark all the check boxes that apply.

Care Recipient's Special Needs: This information is used to determine if the Care Recipient qualifies for the Lifespan Respite Subsidy Program. It may be used to establish priorities and waiting lists. It also tells about the caregiver's needs. Please explain how the individual's special need impacts his/her daily life.

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

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

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

Health of Caregiver: Mark the check box that applies.

Employment Status: Mark the check box that applies.

Caregiver's Need for Respite: This information is used to determine if request meets Program guidelines.

Section 3: LIVING ARRANGEMENTS: List the names of all persons living in Care Recipient's household. Be sure to include everyone's date of birth and relationship to Care Recipient.

Section 4: SUPPORT SERVICES: This information helps to identify other programs that may be more appropriate than the Lifespan Respite Subsidy Program based on funding requirements. It is a factor in program eligibility. Mark the check box that applies and list payment source if you mark yes.

Care Recipient Services: Mark all the check boxes that apply.

Section 5: 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 6: 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 income by amount, frequency and who receives it.

Assistance Programs: Mark all the check boxes that apply. List unearned income by amount, frequency and who receives it.

Interest, Dividends: List amount, frequency and who receives it.

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

Section 7: 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 8: AGREEMENT AND SIGNATURE: The 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, address, telephone, and email.

Section 9: REFERRAL SOURCE: List name, organization/agency and contact information of how you learned about the Lifespan Respite Subsidy Program.

Crisis Respite Request (Optional): Crisis Respite funds may be used for crisis situations defined as an unforeseen circumstance or unplanned event that calls for immediate action or an urgent need for short-term assistance or relief to substitute for the Caregiver in the absence of any other funding source. Requests must be submitted to the local Respite Coordinator on the DHHS "Crisis Respite Application" Form CFS-1410.

Send completed application (and supportive documentation, if needed) to:

1. Email	dhhs.respite@nebraska.gov
2. Mail	Nebraska Department of Health and Human Services CFS, Economic Assistance - Lifespan Respite Subsidy PO Box 95026 Lincoln, NE 68509-5026
3. Fax	(402) 742-8356 (fax)

Questions: (402) 471-9188 / OR 1-866-Respite (1-866-737-7483) for a local Respite Network Coordinator. You may also visit the DHHS supported website "Nebraska Resource and Referral System" at https://nrrs.ne.gov/respitesearch/ . This free service will assist you 24/7 in finding Network-approved respite providers that best fit your needs and location. You can easily search for respite resources and supportive services throughout Nebraska on the site.