DARS
VIRGINIA DEPARTMENT FOR AGING AND REHABILITATIVE SERVICES

~ Virginia Lifespan Respite Voucher Program ~
Application Form

Applicant (Primary Family Caregiver) Information:

Primary Family Caregiver (***the person who applies for funding for respite services***)

Respite Care Recipient (***the person who receives respite services***)

City	**State**	**Zip**
	Virginia	

(***the location the Primary Family Caregiver and Respite Care Recipient reside***)

County of Residence **E-mail** ***(for Primary Family Caregiver)***

Home Phone **Cell Phone** **Work Phone**

Relationship of Primary Family Caregiver to the person receiving care: *(please circle one)*

parent; grandparent; foster parent; court-appointed legal guardian; other family member: _____; other: _____

Number of family members in Primary Caregiver's household:

____Adults ____Children (under 18 years)

1. **Do you currently use non-family respite services?** ___Yes or ___No.

   If YES, please describe (e.g., community respite organization, camp, Medicaid waiver etc.): _____

   _____

   How do you currently pay for these non-family respite services? _____

2. **Why are you requesting financial assistance for respite care services through the *Virginia Lifespan Respite Voucher Program*?**

   _____

   _____

Optional Question:

3. **Household Income Category:** under $25,000; $25-$50,000; $50,001-$75,000; $75,001-$100,000; $100,000+

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Description of Voucher Funding Request:

The total amount of voucher funding requested on this ***Application Form*** (not to exceed a maximum of $400 per family):
$ _____ (*estimated hourly rate for cost of respite services x number of hours*)

Date(s) and number of hours per date (estimated) you plan to use the voucher funding for respite care services:_____
_____
_____

Please describe how you plan to use your respite care voucher funds (e.g., hire an individual respite care provider or use a community respite organization):_____
_____
_____
_____

Respite Care Recipient Information:

Name of Respite Care Recipient (*person who receives respite services*): _____
Age: _____/ Gender: ___Male ___Female
Ethnicity: ___African American; ___Asian; ___Caucasian; ___Hispanic; ___Multiracial; ___Native American; ___Other:

Primary Disability or Special Need: (please circle the primary disability)

Intellectual Disability; Physical Disability; Mental Illness; Neurological Impairment; Brain Injury; Blind/Low Vision; Orthopedic Impairment; Deaf/Hearing Loss; Developmental Disability; Autism; Medically Fragile; Dementia; Alzheimer's; Frail Elderly; Cerebral Palsy; Multiple Sclerosis; ALS; Other: _____

How did you hear about the *Virginia Lifespan Respite Voucher Program*? If through an individual or agency/organization please list the name: _____

*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 (2010-2012).

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

- Physician's Record of 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

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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.

__I attest that I have read and understand the Department for the Aging and Rehabilitation Services (DARS) *Virginia Lifespan Respite Voucher Program* application procedures. I understand my signature below authorizes a release of information for program purposes only.

__I will use all funds paid to me through the *Lifespan Respite Voucher Program* to compensate an individual respite care provider or a respite provider organization for services provided to the Respite Care Recipient listed on this application. I understand that these funds cannot be used for any other purpose.

__I acknowledge that I am responsible for hiring an individual respite provider or respite provider organization of my choice and arranging for payment for any respite services received. Voucher funding is provided on a reimbursement basis only (you must pay for the respite services yourself and then submit a request for reimbursement using the *Virginia Lifespan Respite Voucher Program* ***Reimbursement Form***.) I understand that I will be reimbursed an amount not to exceed the amount approved by DARS on my ***Application Form***, a maximum of $400 per family. 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*** within thirty days (30 days) of the date of purchase and delivery of respite services or by July 31, 2013. Any unspent portion of my respite voucher may be forfeited if I have not made prior arrangements for planned use of my respite voucher funds by these deadlines.

__I agree to complete and return the required *Virginia Lifespan Respite Voucher Program* ***Satisfaction Survey***. Final voucher requests for reimbursement cannot not be processed or paid until the ***Satisfaction Survey*** and the ***Reimbursement Form*** are received by DARS.

__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 that the respite provider(s) of my choice may need to provide services to the respite care recipient.

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 either 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: Kristie Chamberlain,
Virginia Department for Aging and Rehabilitative Services (DARS), 8004 Franklin Farms Drive,
Henrico, Virginia 23229; or fax to 804/662-7663; or e-mail to Kristie.Chamberlain@dars.virginia.gov.