The Arc
Northern Chesapeake Region

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To: Whom it May Concern
Subject: Respite Application

Enclosed please find an application for Respite Services. Please be sure to complete the following forms:

- The Arc Northern Chesapeake Region application for Services
- Documentation of Developmental Disability
  Please send a copy of ***one*** of the following:

  1. Physical Exam
  2. Psychological Documentation
  3. IEP (Only if it includes a diagnosis)
  4. Professional Report that lists the diagnosis

- Income Eligibility Form
  For individuals *18 and over*, please send copies of the following:

  1. Copy of Award Letter from Social Security (or other benefits) stating amount
  2. Copy of Pay Stubs for 1 month if the individual is employed

  For individuals *under 18*, please send copies of the following for all persons living in the home:

  1. Copy of Award Letters stating amount of benefits (SSI, SSA, TCA)
  2. Copies of Pay Stubs for all employed household members

- Authorization to Release/Obtain Information

Once we receive the application, we will send you a letter notifying you of the status of your application and the process for accessing Respite Care.

Your contact for Harford County is:

- Family Support Services at 410-836-7177 ext. 383 or Fax: 410-893-3909

COMMON RESPITE QUESTIONS

What is the purpose?

The purpose of Respite Care is to provide a period of rest and renewal so that caregivers can take a break from their routine responsibilities. It provides an opportunity for families to have time to themselves, time to spend with other children, and/or time to take care of their own needs. It may also be used for emergency situations, such as hospitalization.

Who is eligible for Respite Care?

An adult or the family of a child must meet the income criteria. Families are eligible if they reside in Harford County and support an individual with a developmental disability. Persons who reside in supervised situations such as a group home or community living arrangement are not eligible.

Who provides these services?

Families are encouraged to find their own caregiver. Families and the individual are generally more comfortable with people they know. If families have no one, The Arc NCR can provide names of persons, who have been screened, that the family can interview and select. This is a private arrangement between the family and the caregiver. The caregiver can be a friend or relative. The caregiver may not live in the same house as the person for whom the respite is provided. Payment is made to the family.

Where is the respite provided?

Typically the respite would be provided in the home. This causes the least disruption to the routine of the individual. There are occasions when this is not desirable. In those cases the respite can be in the provider's home. It is the family's responsibility to determine the appropriate place for respite to occur. **This is considered an independent private arrangement. The Arc Northern Chesapeake Region is not liable.**

What is the amount of subsidy families can be given to pay the worker?

The amount is income based. It is based on a sliding scale. The maximum amount is $75.00 per day for Level I. Individuals considered at Level II, meaning requires the care of a nurse, will be reimbursed based on the rate charged by the nurse or nursing agency, up to $25.00 per hour or $250.00 per day. In order to be reimbursed at this rate, we must have a statement from the doctor stating that the individual receiving care does need licensed nursing care requiring G-tube feedings, tracheostomy care, ostomy care or injections, etc. We will maintain this on file and ask this be updated yearly. Upon receipt of the timesheet, we will verify, through the Board of Nursing, that the person providing care is licensed by The State of Maryland. Should you decide to use a non-licensed family member or friend whom you trained, we will reimburse you the regular rate, up to $7.50 per hour or $75.00 per day.

If two or more individuals live in the same home, the first is paid the full determined amount and the others are paid at 50% of that amount.

How many days of respite are available per person?

This program is first come, first served. Funds are limited. Currently 7 days or 70 hours a year is the maximum a family can receive. The year begins July 1 and ends June 30.

When will the subsidy be given to the family?

You will be reimbursed the 4th Friday of the following month after the service is provided. For example, if services are provided on January 15th, payment will be made the 4th Friday of February. When you request respite please remember to request a timesheet. This must be signed by the family member **and** the respite provider.

How often will the family need to apply?

There is a one time application. However, once an applicant is determined to be eligible for services, a redetermination form is required every 12 months. This is sent to the family and if it is not returned an applicant is determined ineligible.

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Application for Respite Services

(Please Print or Type)

Date of Application: _____

Please print clearly when completing the application. Please include ***ALL*** documentation requested.

APPLICANT'S GENERAL INFORMATION

Name: _____
Last First Middle

Date of Birth:____/____/_____

Address: _____
Street City State Zip Code

Phone Number: _____ Social Security Number: _____/_____/_____

Medical Assistance #:_____ Medicare #:_____

Does Applicant have a Service Coordinator? _____
Name Phone #

PARENT/GUARDIAN/CAREGIVER INFORMATION

Name: _____ Relationship to Applicant: _____

Address: _____

City/State/Zip: _____

Phone Number: _____ Cell Phone Number:_____

E-Mail Address:_____

May we send you information via e-mail? _____

Occupation _____ Age _____

Legal Guardianship □ Yes □ No

Date Guardianship was attained: _____

Type of Guardianship (Check whichever applies):

❑ Full ❑ Property ❑ Limited ❑ Medical ❑ Person

Number of occupants living in the home: _____

ALL PERSONS LIVING IN THE HOME (Use additional paper if necessary):

NAME	BIRTH DATE	RELATION TO APPLICANT	PHONE #	OCCUPATION

EMERGENCY CONTACT: (Other than Parent/Guardian/Caregiver) .

Name: _____ Relationship to applicant:_____

Address: _____ Phone Number:_____

MEDICAL INFORMATION

A. Diagnosis:_____
Age of Onset:_____

B. Applicant's primary health care provider/physician:_____

Hospital familiar with applicant (if any):_____

C. List any medication(s) taken by applicant

MEDICATION	DOSAGE	TIME GIVEN	REASON

D. Seizures

1. Does the applicant have seizures? ❑ YES ❑ NO
2. Frequency: ❑ Daily ❑ Weekly ❑ At least once a month ❑ Every few months
3. Type of seizures:_____
4. Are seizures controlled by medication? ❑ YES ❑ NO

E. Applicant's Mobility

❑ Walks independently ❑ Uses cane ❑ Uses crutches ❑ Uses walker
❑ Uses wheelchair ❑ YES ❑ NO ❑ Manual ❑ Electric ❑ Self propelled

F. Vision

1. Any vision impairment: ❑ YES ❑ NO

2. Legally Blind: ❑ YES ❑ NO

G. Hearing

1. Does applicant have a hearing problem? ❑ YES ❑ NO
2. Does applicant wear a hearing aid: ❑ YES ❑ NO
3. Deaf: ❑ YES ❑ NO

H. Equipment Needed

❑ Hoyer Lift ❑ Bed Rails ❑ Need for oxygen? ❑ Other adaptive / special equipment_____

_____

I. Allergies (bee stings, drugs, dust, mold, food, etc.)

_____

_____

J. Diet (chopped food, tube fed, finger foods)_____

_____

Does applicant have any other medical problems not listed?

_____

_____

SPEECH AND LANGUAGE INFORMATION

1. Does applicant have a speech / language impairment: ❑ YES ❑NO
2. Is applicant verbal? ❑ YES ❑ NO
3. Means of communication:
   ❑ Speech ❑ Sign Language ❑ Gestures ❑ Communication Board

MENTAL HEALTH

1. Does applicant have a history of mental health treatment, alcohol or substance abuse? ❑ YES ❑ NO
2. Is the applicant currently in treatment? ❑ YES ❑ NO
3. Diagnosis: _____

BACKGROUND INFORMATION

Please indicate the school, day program, or employment the individual currently attends.

Name of program	**Address**

Does applicant have a history of behavioral problems? ❑ YES ❑ NO
(If so, describe the problem using the chart below).

BEHAVIOR	FREQUENCY	SEVERITY	INTERVENTION

SKILLS CHECKLIST

A. Is applicant independent in personal self-care skills? ❑ YES ❑ NO
(i.e. bathing, dressing, feeding, toileting)

Type of assistance needed with toileting: _____

B. Can applicant self medicate? ❑ YES ❑ NO

C. Does applicant sleep through the night? ❑ YES ❑ NO

Does the applicant receive any services or financial assistance from an agency funded by the Developmental Disability Administration (DDA) or the Department of Human Resources (DHR) such as LISS, Respite Services, In-Home Supports, Foster Care, Community Living, Day Services or any other type of service? ___Yes ___No

If yes, please list agency / agencies and explain in detail

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

The Department of Human Resources Respite Grant is an income based program. If the individual is under 18 years of age the income of all household members is considered.
If they are over eighteen the subsidy is based upon only their income. Medical expenses not covered by insurance may be considered.

Parent/Caregiver Gross Income:
If the individual to be cared for is **under age 18**, please list income of all household members, including the individual. List by sources and gross income, w(weekly), m(monthly) or a(annually). Attach proof of income.

	Individual	Care Provider	Other persons in home	Other persons in home	Other persons in home
Wages from employment					
SSI, SSA, SSDI					
Temporary Cash Assistance					
Pension					
Unemployment					
Child Support					

Applicant's Gross Income:
If the individual to be cared for is **age 18 or above**, please list the income of the individual and the person's spouse, if married and attach proof of income.

	Individual	Spouse
Wages from employment (indicate weekly, monthly or annual)		
SSA		
SSI		
TCA (Temporary Cash Assistance)		
Child support		
Other: pension, workman comp, etc.		

Medical expenses not covered by insurance: (verification must be attached)

MEDICAL EXPENSES	AMOUNT

Number of individuals living in the home:_____

Please attach a copy of the 2 most recent pay stubs, the letter from Social Security stating amount of benefit, Temporary Cash Assistance letter or other documentation indicating source and amount of income*
I certify that the above information is accurate.

Signature of applicant (if applicant is at least 18 years old) Date

Signature of parent/guardian (if applicable) Date

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AUTHORIZATION TO
OBTAIN INFORMATION

Date authorization becomes effective: _____ and expires on _____.

I, _____ hereby authorize

Clinician/Doctor/Evaluator name and address:

_____

_____

Phone number:_____

to release the following : _____ Social History _____ Psychological Reports _____Vocational Evaluations

_____Medical Information _____Counseling Reports _____Other (specify below)

_____ to The Arc Northern Chesapeake Region, Inc. 4513 Philadelphia Rd Aberdeen, MD 21001

I understand that the information being requested will be used by The Arc Northern Chesapeake Region, Inc to assist in determining the agency's capacity to support me now and/or assist in planning with me for the future.

I understand that all information shared with The Arc Northern Chesapeake Region, Inc will be treated in a strictly confidential manner, and any further sharing of my information will require my additional authorization. I understand that authorization is extended for this request only and at this time only.

I understand that I have the right to revoke this authorization in writing at any time except to the extent that action on this authorization has already occurred (i.e. the information was already distributed).

_____ _____
Individual's Signature Date

_____ _____
Parent/Guardian (must sign if person is under 18) Date

_____ _____
Witness (must sign if "X" is used) Date

_____ _____
Relationship of Witness to Individual Date

_____ _____
Agency Representative Date

_____
Title of Agency Representative

Revised 8/2012