South Carolina Respite Coalition

South Carolina Respite for the Lifespan Respite Voucher Program Application

PLEASE PRINT CLEARLY AND COMPLETE EACH SECTION

Caregiver (CG) Information: This is about YOU - the unpaid caregiver who is responsible for the care receiver.

Name _____ Date of Birth _____ Gender_____

Street address _____City _____ State _____ Zip Code _____

County: _____Mailing address ☐same or _____State: _____Zip Code _____

Primary Phone_____ Email_____

Race (Please Circle): White - Black/AA - Asian - Indian Asian - Pacific Islander - American Indian/Alaskan - Other

Ethnicity (Please Circle): Hispanic - MENA(Middle Eastern/Northern African) - Neither

How are you related to the person you care for? _____

Are you in the military currently? Yes No Are you a veteran? Yes No

Marital Status_____ Spouse's Name_____

What is your highest level of formal education GED High School Some college College Graduate Degree

Number of people in your household _____ Annual Household Income _____

Primary language spoken in your home _____

How many hours a day do you provide hands-on care? _____

How long have you provided care for the Care Receiver?_____

Are you employed outside the home (circle one) Full-time Part-time

How did you hear about SC Respite Coalition Lifespan Voucher? _____

Care Receiver (CR) Information: This is about the person for whom you provide care.

Name_____ Date of Birth_____ Gender_____

Ethnicity_____ CRs Primary Diagnosis(es) _____

Do you live with this person? Yes No If no, how far to CR's home:_____ (miles) _____ (minutes)

Does this person live alone? Yes No

CR Address (if different from yours): _____City: _____

Does the CR receive any support services? Please circle: Medicaid Medicare DDSN CLTC Baby Net Early Intervention ABA Therapy Other Services _____

If under 21, does the CR attend school? Yes No

If an adult, has the CR served in the military? Yes No

Besides you, does anyone else provide care to the CR? Family Church Private Sitter In-home Agency DDSN Provider CLTC Provider

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If you get a voucher to take a break from care giving, which do you want: (check one below)

☐ an In-Home Agency that bills SCRC directly for services. Which one, if you know _____

☐ an Adult Day Care that bills SCRC directly for services. Which one, if you know _____

☐ at home with a private provider that I find, employ and pay out of pocket to give me a break. The SCRC will then reimburse me directly within 30-60 days after the care has occurred.

☐ other (be specific) _____

What do you hope to get from having a voucher for respite? *Check all that apply*

☐ just some time to myself ☐ a vacation ☐ a good night's sleep

☐ some time with other family or friends without my loved one with special needs

☐ catch up on medical and other appointments for me Other: _____

Consent to Release Information

I, the caregiver or their representative, give permission for the South Carolina Respite Coalition to contact the following organization(s) or private provider(s) so that those involved with my respite care can communicate and work together on planning for my respite care. This is valid until otherwise revoked in writing.

Respite Provider (agency you choose or name of private "at home provider"): _____

Address: _____

Other: _____

Address: _____

If I receive a SCRC voucher, I understand that my regional Family Caregiver Support Program must be informed to help coordinate a SC respite system that serves the most families possible. If I do not yet know the agency, adult day care or program we will use, I agree to allow the SC Respite Coalition to provide our information to the one which I eventually choose for our respite services, with the understanding that only those who need the information and will receive it and keep it confidential.

Printed Name (Parent/Guardian/Caregiver): _____

Signature: _____ Date: _____

Printed Name (Care Receiver) _____Signature (if able) _____

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CAREGIVER SELF-ASSESSMENT

How are YOU doing?

During an average week, how many days are you in touch by phone, Internet (email), or in person with a friend, neighbor, or relative who does not live with you? *(circle one below)*

0 Days 1 Day 2 Days 3 Days 4 Days 5 Days 6 Days 7 Days

Thinking about how often you are in touch with friends, neighbors, and relatives, is this *(circle one below)*

Not enough (would like to do more) About enough Too much

During an average week, how many days do you leave home to go to a movie, sports event, club meeting, class, or place of worship? *(circle one below)*

0 Days 1 Day 2 Days 3 Days 4 Days 5 Days 6 Days 7 Days

Regarding your present social activities, do you feel that you are doing *(circle one below)*

Not enough (would like to do more) About enough Too much

In general, how would you describe your emotional well-being? *(circle one below)*

Excellent Very Good Good Fair Poor

During the past 30 days, how often have you had difficult or painful feelings such as stress, grief, worry, anger, or loneliness? *(circle one below)*

Always Usually Sometimes Rarely Never

During the past 30 days, to what extent have feelings such as stress, grief, worry, anger, or loneliness interfered with your normal social activities with family, friends, neighbors, or groups? *(circle one below)*

Always Usually Sometimes Rarely Never

How do you rate your health? *(circle one below)*

Excellent Above Average Average Below Average Poor

Have your caregiver responsibilities ever affected your job? Yes No

Do you ever feel that caregiving is stressful? Yes No

If yes, what do you do to cope with the stress related to the challenges of caregiving?

I am a parent of a child under 12. My need for a break is different from that of a "typical" parent because:

MAIL, EMAIL OR FAX ALL 4 FULLY COMPLETED* PAGES TO: P.O. Box 493, Columbia, SC 29202
respite@screspitecoalition.org FAX 803.935.5229
* NOTE: We need all the information and reserve the right to reject incomplete applications

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Respite Voucher Health Care Provider
Medical/Special Needs Certification

Respite = regular, short term breaks for the primary caregiver of someone of any age with special needs.

The South Carolina Respite Coalition is the only statewide, non-profit organization working on respite for all family caregivers no matter their age. With grant funds we can provide limited respite vouchers. Your patient/client's family has requested funds for respite. The signatures below indicate their consent to have you release this information.

Name _____Parent/Guardian/Spouse/Family Caregiver
Signature: _____ date: _____
Name _____ (Care Receiver) date of birth: _____
Signature (if able) _____ date: _____
Address: _____ Phone: _____

THIS SECTION TO BE COMPLETED BY A MEDICAL PROFESSIONAL ONLY (Doctor, Nurse Practitioner, RN, Physician Assistant, Licensed Social Worker, trained DDSN Case Managers. We cannot accept certification by CNAs.)

1) Please indicate the ability level (0 – 5) for each activity: 0 = independent --------→ 5 = totally dependent
Feeding ____ Ambulation _____ Transferring _____ bathing _____ This person is bedbound [ ] no [ ]yes

2) This care receiver/patient is [ ] incontinent [ ] bladder [ ] bowel [ ] self-toileting [ ] too young to train yet

4) Due to cognitive or other mental, emotional, or behavioral issues, the care receiver requires moderate to substantial supervision because their behavior poses a health or safety hazard to them self or others.
Yes [ ] No [ ] Cognitive Diagnosis: _____

5) In your professional opinion is this care receiver able to be left alone without supervision or assistance for any length of time (i.e. several hours)? Yes [ ] no [ ] overnight? Yes [ ] no [ ]

6) PRIMARY diagnosis _____

7) SECONDARY and/or CO-OCCURING conditions _____

If this patient is an infant, child or adolescent, does s/he require care beyond which a typical babysitter can provide?
Yes [ ] No [ ] If yes, please briefly describe the skill set needed to safely care for this patient _____
_____

Completed by Professional (printed name): _____
Title: _____ discipline: _____
Name of practice: _____
Address: _____ phone: _____
City: _____zip code: _____ e-mail: _____fax: _____

Professional Signature: _____ date: _____