



LifeSpan Respite Voucher Application



Application is to be filled out by the unpaid primary caregiver seeking respite services.

* NOTE: All information and pages included in this application must be submitted at the same time. This includes the Healthcare Provider Medical/Special Needs Certification form. SCRC reserves the right to reject an incomplete applications.

Name *

Date of Birth *

Gender *

First Name Last Name

Month Day Year



Male
Female

Phone Number *

Email *

Area Code Phone Number

example@example.com

Marital Status

Spouse's Name

Do you actively serve in the military? *

Race *

Married
Single
N/A

First Name Last Name

YES
NO

Ethnicity *

Address *

Are you a veteran? *

YES
NO

Street Address

Are you employed outside of the home? *

Street Address Line 2

Highest level of education *

YES
NO

City

State / Province

GED / High School
Some College
Assoc / Bach
Graduate
Other

Primary Language in Household *

Postal / Zip Code

Do you receive any compensation to care for your Care Receiver? *

Number in your household *

Annual Household Income *

None
Community Long Term Care
DSS Adoption/Foster Care Subsidy
Kinship Care
Other:

Are you related to the person you care for? *

YES
NO

Tell us about your Care Receiver:

Name *

Date of Birth *

Gender *



First Name

Last Name

Month Day Year

Male

Female

Race *

Ethnicity *

Care Receiver's Primary Diagnosis *

Address: (if different than yours)

Care Receiver's Secondary or Cognitive Diagnosis

Street Address

Street Address Line 2

City

State / Province

If Care Receiver does not reside with you, do they reside alone?

YES

NO

If Care Receiver does not reside with you, how many miles away are they from you?

Postal / Zip Code

Is the Care Receiver receiving any support services?

Medicaid

Medicare

DDSN

CLTC Baby Net

Early Intervention

ABA Therapy

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

Besides you, does anyone else provide care to the Care Receiver? *

YES

NO

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

If so, who or what type of provider?

How many hours a day does someone else provide care?

If under 21, does the Care Receiver attend school?

YES

NO

If an adult, has the Care Receiver served in the military?

YES

NO

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.

** you may leave blank if a provider has not yet been chosen.*

Respite Provider: agency you choose or name of "at home" private provider: Address

Street Address

Street Address Line 2

Phone Number

City

State / Province

Area Code

Phone Number

Postal / Zip Code

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.

Name: Parent/Guardian/Caregiver

Name: Care Receiver

First Name Last Name

First Name Last Name

Signature of Parent/Guardian/Caregiver:

Signature of Care Receiver (if able):

Date



Month Day Year

Date



Month Day Year

Self-Assessment

1. 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?

2. Thinking about how often you are in touch with friends, neighbors, and relatives, is this...

3. 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?

4. Regarding your present social activities, do you feel that you are doing

5. In general, how would you describe your emotional well-being?

6. During the past 30 days, how often have you had difficult or painful feelings such as stress, grief, worry, anger, or loneliness?

7. 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?

8. How do you rate your health?

9. Have your caregiver responsibilities ever affected your job?

YES

NO

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

11. If you get a voucher to take a break from care giving, which do you intend to use?

If you chose "other", please explain:

12. What do you hope to get from having a voucher for respite? check all that apply...

if you chose "other", please explain:

time to myself

vacation

a good night sleep

time with other family or friends

medical appointment for myself

other

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

Questions or Comments:

**MAIL, EMAIL OR FAX ALL FULLY COMPLETED* PAGES TO:
P.O. Box 493, Columbia, SC 29202
respite@screspitecoalition.org
FAX 803.935.5229**

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LifeSpan Voucher Application Healthcare Provider Medical/Special Needs Certification



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/Caregiver

Name: Care Receiver

Signature:

Signature:

THIS SECTION TO BE COMPLETED AND SIGNED BY AN AUTHORIZED PROFESSIONAL ONLY

(authorized: Doctor, Nurse Practitioner, Reg. Nurse, Physician Asst., Lic. Social Worker, DDSN Case Manager.)

1) Please indicate the ability level for each activity:

Scale of 0-5

Feeding

Ambulation

Transferring

Bathing

Bedbound?

3a) If this patient is an infant, child or adolescent, does s/he require care beyond which a typical babysitter can provide?

YES

NO

2) This care receiver/patient is:

Incontinent

Bladder

Bowel

Self-toileting

Too young to train

4a) 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

Primary Diagnosis:

Secondary and/or Co-Occurring Diag.

4b) Cognitive Diagnosis:

5a) In your professional opinion is this care receiver able to be left alone without supervision?

YES

NO

5b) Overnight?

YES

NO

3b) If yes, please briefly describe the skill set needed to safely care for this patient

Name: _____ Title: _____ Discipline: _____

Name of Practice: _____ Address: _____

Email: _____ Phone: _____ Fax: _____

Signature of Professional: _____ Date: _____