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 *

First Name Last Name

Date of Birth *

Month Day Year

Gender *

- ☐ Male
- ☐ Female

Phone Number *

Area Code Phone Number

Email *

example@example.com

Marital Status

- ☐ Married
- ☐ Single
- ☐ N/A

Spouse's Name

First Name Last Name

Do you actively serve in the military? *

- ○ YES
- ○ NO

Race *

Ethnicity *

Are you a veteran? *

- ○ YES
- ○ NO

Address *

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Highest level of education *

- ☐ GED / High School
- ☐ Some College
- ☐ Assoc / Bach
- ☐ Graduate
- ☐ Other

Are you employed outside of the home? *

- ○ YES
- ○ NO

Primary Language in Household *

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

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

Number in your household *

Annual Household Income *

Are you related to the person you care for? *

- ○ YES
- ○ NO

Tell us about your Care Receiver:

Name *

First Name Last Name

Date of Birth *

Month Day Year

Gender *

- ☐ Male
- ☐ Female

Race *

Ethnicity *

Care Receiver's Primary Diagnosis *

Address: (if different than yours)

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Care Receiver's Secondary or Cognitive Diagnosis

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?

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? *

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

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

- ○ YES
- ○ NO

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

City State / Province

Postal / Zip Code

Phone Number

Area Code Phone Number

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

First Name Last Name

Name: Care Receiver

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...

- ☐ time to myself
- ☐ vacation
- ☐ a good night sleep
- ☐ time with other family or friends
- ☐ medical appointment for myself
- ☐ other

if you chose "other", please explain:

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

**** 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.***

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?	

2) This care receiver/patient is:

- ☐ Incontinent
- ☐ Bladder
- ☐ Bowel
- ☐ Self-toileting
- ☐ Too young to train

Primary Diagnosis:

Secondary and/or Co-Occurring Diag.

4b) Cognitive Diagnosis:

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

- ○ YES
- ○ NO

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

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:_____