South Carolina Respite Coalition

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 _____ **DOB** _____ **Gender**_____

Street address _____ **City** _____ **State** _____ **Zip Code** _____

County _____Mailing address □same or _____State _____Zip Code _____

Primary Phone_____ **Email** _____

Preferred communication: ☐Phone ☐Email ☐Mail

Race: ☐White ☐Black/AA ☐Asian ☐Indian Asian ☐Pacific Islander ☐Amer. Indian/Alaskan ☐Other

Ethnicity: ☐Hispanic / LatinX ☐Not Hispanic / LatinX ☐Neither

How are you related to the person for whom you provide care? ☐Parent ☐Spouse ☐Grandparent ☐Legal Guardian ☐Other: _____

Do you receive any financial compensation from any of the following for the care you provide?

☐ CLTC Provider ☐ DDSN Personal Care Aide ☐ DSS Adoption / Foster Care Subsidy
☐ Kinship Care ☐ Other _____

Do you or have you served in the military?: ☐ No ☐Retired Military ☐Veteran ☐ Currently Active

Marital Status: ☐Married ☐Single ☐Widowed ☐Divorced ☐Domestic Partner / Civil Union

Number of people in your household: _____

Monthly House Income:
☐Under $1,074 ☐$1,074-$1,452 ☐$1,453-$1,830 ☐$1,831-$2,208 ☐$2,209-$2,589 ☐$2,590+

Is a language other than English primarily spoken in your home? ☐Yes ☐No Please specify:_____

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

How long have you provided care for the Care Receiver? (months / years) _____

Are you employed outside the home: ☐Full-time ☐Part-time ☐N/A

Have you applied or received a respite voucher from the SC Respite Coalition in the last 2 years? ☐Yes ☐No

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 _____ **DOB** _____ **Gender** _____

Care Receiver's Primary Diagnosis: _____

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: _____

Race: White Black/AA Asian Indian Asian Pacific Islander Amer. Indian/Alaskan Other

Ethnicity: ☐ Hispanic / LatinX ☐ Not Hispanic / LatinX ☐ Neither

Does the CR receive any support services? ☐ 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 care receiver? ☐ Yes ☐ No

Is there any other program that has provided respite services within the last 12 months? ☐ Yes ☐ No

If you are awarded a voucher, who would you like to provide care while you take a break from caregiving?

☐ an In-Home Agency that bills SCRC directly for services. Preferred Agency _____

☐ an Adult Day Care that bills SCRC directly for services. Preferred Day Center _____

☐ 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.

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: _____

How did you hear about the SC Respite Coalition voucher program:

☐ Facebook ☐ Area Agency on Aging ☐ DDSN Board ☐ Friend

☐ Other: _____

CAREGIVER ASSESSMENT

Bakas Caregiver Outcome Scale							
As a result of Providing Care for the Patient:	Changed for the worst			No change	Changed for the best		
1. My self esteem	-3	-2	-1	0	1	2	3
2. My physical health	-3	-2	-1	0	1	2	3
3. My time for family activities	-3	-2	-1	0	1	2	3
4. My ability to cope with stress	-3	-2	-1	0	1	2	3
5. My relationship with friends	-3	-2	-1	0	1	2	3
6. My future outlook	-3	-2	-1	0	1	2	3
7. My ability to pay the bills	-3	-2	-1	0	1	2	3
8. My emotional well-being	-3	-2	-1	0	1	2	3
9. My time for social activities with friends	-3	-2	-1	0	1	2	3
10. My relationship with my family	-3	-2	-1	0	1	2	3
11. My ability to buy necessities	-3	-2	-1	0	1	2	3
12. My relationship with the patient	-3	-2	-1	0	1	2	3
13. In general, how has your life changed as a result of taking care of the patient?	-3	-2	-1	0	1	2	3

UCLA Three-Item Scale			
	Hardly Ever	Some of the Time	Often
How often do you feel that you lack companionship?			
How often do you feel left out?			
How often do you feel isolated from others?			

* How many other dependent adults do you care for? # _____
  Do any of these adults have a diagnosed disability or special need? # _____

* How many other dependent children (under 18) do you care for? # _____
  Do any of these children have a diagnosed disability or special need? # _____

* How many hours in a week…
  do you get a break from caregiving? _____ hours a week
  would provide you with adequate time to yourself while being a caregiver? _____ hours a week

MAIL, EMAIL OR FAX ALL 4 FULLY COMPLETED* PAGES TO: P.O. Box 493, Columbia, SC 29202
respite@screspite.org FAX 803.935.5229
* NOTE: We cannot determine eligibility with an incomplete application

South Carolina Respite Coalition

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 _____ Date: _____

Circle One: Parent Guardian Spouse Family Caregiver

Signature: _____

Name _____ Date of birth: _____

(care receiver)

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 _____ Dressing _____ 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: _____