



Department of Health and Human Services
OPTIONAL CRISIS RESPITE APPLICATION\*
Nebraska Respite Network 1-866-737-7483

\*Care Recipient must be eligible to receive services from the Lifespan Respite Subsidy Program

Crisis Respite Funds may be used for crisis situations defined as an unforeseen circumstance or unplanned event that calls for immediate action or an urgent need for short-term assistance or relief to substitute for the Caregiver in the absence of any other funding source.

Referral Source Submitting Request (Name/Title) \*Date of Request

\*Organization/Agency

City \*Telephone Number (include area code)

Fax Email

\*Special circumstances justifying Crisis Respite assistance

Additional resources recommended for Caregiver's ongoing needs:

Does the Caregiver typically receive respite services from another program?
[ ] Yes [ ] No

If so, which program? \*First Request for Crisis respite
[ ] Yes [ ] No

\*Describe current memory and/or Behavior issues that are contributing to crisis needs/situation

Signature of Care Recipient or Authorized Representative Date

Send completed application to local Respite Network Coordinator:
(1-866-737-7483 for contact information)

---

**This Section to be completed by local Lifespan Respite Network Coordinator**

---

Does the Caregiver typically receive respite services from another program?

Yes     No

---

If so, which program?

Pending Lifespan Respite Subsidy application

---

\*First Request for Crisis Respite:

Yes     No

---

If no, date(s) of previous approval(s):

---

\*Describe current memory and/or behavior issues that are contributing to crisis needs/situation:

---

<p>Care Recipient meets Crisis Respite Eligibility Criteria:</p>	<p>Are there other funds or other financial resources for Crisis Respite services?</p>
--	--

Yes     No

Yes     No

---

If yes, describe Supplemental Support

---

Indicate if respite is being requested for one of the following reasons:

- Unplanned event that jeopardizes the health and safety of the Care Recipient
- Unplanned event that jeopardizes the health and safety of the Caregiver
- Immediate and unavoidable absence of the Caregiver in excess of 4 hours when a qualified caregiver is not available
- Circumstance of crisis need results in the immediate and unavoidable absence of the caregiver from the home in an excess of 4 hours at a time when a qualified caregiver is not available.

---

Discussion notes to assess need/eligibility/justifying use of crisis funds:

---

Program/Service Referrals made to support Care Recipient/Caregiver long-term:

---

Signature of local Lifespan Respite Network Coordinator	Date
---	------

---

**This Section to be completed by Central Office Statewide Respite Program Coordinator**

---

Action Taken: Approve

Yes     No

Provide Reason: \_\_\_\_\_

---

Amount Approved:	Date
------------------	------

## Instructions:

### Instructions for completing Form CFS-1400, "Lifespan Respite Subsidy Program Application"

**Use:** Form CFS-1400 is used as an application to determine eligibility for Lifespan Respite Subsidy Program benefits. Program Staff will use the form to collect data needed to determine eligibility for respite services. It also serves as a release of information when additional information is needed to determine eligibility. This program pays for respite services to give the primary caregiver a temporary break. Respite means the provision of short-term relief to primary caregivers from the demands of ongoing care for an individual with special needs. Ongoing care means continuous, full-time supervision/care for a person with special needs. DHHS Manual reference 464 NAC 1-007 and 1-008. It is NOT for people who are receiving respite services from another government program.

**Completion:** Program Staff will use the data to determine eligibility. Incomplete information may delay eligibility determination. The application must be signed and dated by the Care Recipient or his/her authorized representative.

**Section 1: CARE RECIPIENT INFORMATION (Person with special needs requiring full-time ongoing 24/7 care/supervision):** Enter the name, date of birth, gender, living arrangements, social security number, citizenship status, household type, city, state, zip code and county of the Care Recipient. Mark all the check boxes that apply.

**Immigration Status and Alien Number:** If the qualified alien box is checked provide immigration status and alien number.

**Self-Care Activities:** Mark all the check boxes that apply.

**Behavioral/Emotional Needs:** Mark all the check boxes that apply.

**Special Health Care Needs:** Mark all the check boxes that apply.

**Medical Diagnosis:** Mark all the check boxes that apply.

**Care Recipient's Special Needs:** This information is used to determine if the Care Recipient qualifies for the Lifespan Respite Subsidy Program. It may be used to establish priorities and waiting lists. It also tells about the caregiver's needs. Please explain how the individual's special need impacts his/her daily life.

**High Risk of Out of Home Placement/Facility Care:** Mark the check box that applies.

**Section 2: PRIMARY CAREGIVER INFORMATION (Parent, Spouse, other Family or Friend providing on-going care):** Enter the caregiver's name. Mark all the boxes that apply for gender and role(s). Enter telephone number(s) for home, cell and work.

**Email Contact:** Check the box if Program Staff may contact caregiver by email. Enter an email address.

**Time Spent Caregiving Each Week:** Mark the check box that applies.

**Health of Caregiver:** Mark the check box that applies.

**Employment Status:** Mark the check box that applies.

**Caregiver's Need for Respite:** This information is used to determine if request meets Program guidelines.

**Section 3: LIVING ARRANGEMENTS:** List the names of all persons living in Care Recipient's household. Be sure to include everyone's date of birth and relationship to Care Recipient.

**Section 4: SUPPORT SERVICES:** This information helps to identify other programs that may be more appropriate than the Lifespan Respite Subsidy Program based on funding requirements. It is a factor in program eligibility. Mark the check box that applies and list payment source if you mark yes.

**Care Recipient Services:** Mark all the check boxes that apply.

**Medicaid/Medicare Supplemental Insurance:** List name of policy (ies).

**Section 5: RESOURCES/ASSETS:** Mark all the check boxes that apply. List person(s) who has the funds checked and the amount of each. List any liquid resources including cash on hand, checking and savings accounts, certificates of deposit, stocks, bonds, life insurance cash values, IRA and Keogh Funds, etc., This data will be used as another factor of eligibility.

**Section 6: INCOME:** Use more paper if there is not enough room for your answers on this application.

**Wages and/or Self-Employment:** List current household gross wages (before taxes and deductions) or self-employment income by amount, frequency and who receives it.

**Assistance Programs:** Mark all the check boxes that apply. List unearned income by amount, frequency and who receives it.

**Interest, Dividends:** List amount, frequency and who receives it.

**Child Support, Alimony:** List amount, frequency and who receives it.

**Section 7: DISABILITY-RELATED EXPENSES:** List all disability-related expenses paid on behalf of the Care Recipient in a year's time. Do not include amounts covered by insurance or other benefit program(s). Information listed here will be considered to see if the expense may be disregarded from the income. It should include things such as out-of-pocket expenses for prescriptions, home modifications, diapers for individuals above age 3, etc.

**Optional Race and Ethnicity:** Mark all the check boxes that apply.

**Section 8: AGREEMENT AND SIGNATURE:** The Care Recipient or authorized representative must sign the application before Program Staff can authorize benefits. Person assisting with completing application must sign and list relationship, date, address, telephone, and email.

**Section 9: REFERRAL SOURCE:** List name, organization/agency and contact information of how you learned about the Lifespan Respite Subsidy Program.

**Crisis Respite Request (Optional):** Crisis Respite funds may be used for crisis situations defined as an unforeseen circumstance or unplanned event that calls for immediate action or an urgent need for short-term assistance or relief to substitute for the Caregiver in the absence of any other funding source. Requests must be submitted to the local Respite Coordinator on the DHHS "Crisis Respite Application" Form CFS-1410.

**Send completed application (and supportive documentation, if needed) to:**

1. Email [dhhs.respite@nebraska.gov](mailto:dhhs.respite@nebraska.gov)
2. Mail  
Nebraska Department of Health and Human Services  
CFS, Economic Assistance - Lifespan Respite Subsidy  
PO Box 95026  
Lincoln, NE 68509-5026
3. Fax  
(402) 471-9226 (fax)

Questions: (402) 471-3531 / OR 1-866-Respite (1-866-737-7483) for a local Respite Network Coordinator. You may also visit the DHHS supported website "Nebraska Resource and Referral System" at <https://nrrs.ne.gov/respitesearch/>. This free service will assist you 24/7 in finding Network-approved respite providers that best fit your needs and location. You can easily search for respite resources and supportive services throughout Nebraska on the site.