Office Use Only

Date received: ___/___/___
Background check completed: ___/___/___
Date entered: ___/___/___

- Approved ___/___/___ to ___/___/___
- Denied

Please Return to: Nebraska Respite Network
PO Box 1235
McCook, NE 69001

INDIVIDUAL RESPITE PROVIDER APPLICATION

☐ Initial Application ☐ Annual Update

Applicant's Full Legal Name: ______________________________

Home Address: ______________________________ City, State, Zip: ______________________________

Mailing Address (if different): ______________________________City, State, Zip: ______________________________

Home or Cell Phone ____-____-______ Email: ______________________________

Can we contact you via email? Yes ☐ No ☐ Can we contact you via text? Yes ☐ No ☐

Please attach a copy of your Driver's License or Government Issued Photo ID for your Provider file.

Rates: $_______hourly $_____daily $_____overnight $ _____weekend ____volunteer

Number of years' experience caring for others: ______0-1 _____1-2 _____3-4 _____5-6 _____7-10 _____10+ years

Please list your experience relevant to providing respite care, personal and/or professional caregiving (include any training and <u>attach documentation</u> of current license, certifications and/or DHHS provider agreements):

____

____

____

____

If you have ever been Lifespan Respite Subsidy Provider, please list CONNECT Provider ID: ____________________

Please provide contact information for your past (2) employers (Include supervisor name, phone number, and name of company – if applicable):

____

____

Please list (2) personal or business references, no relatives. (Include phone number):

____

____

Check boxes for times available:	MON	TUES	WED	THURS	FRI	SAT	SUN
DAYTIME							
EVENINGS							
OVERNIGHTS							
EXTENDED PERIODS							
EMERGENCIES/CRISIS RESPITE							

Are you willing to travel to provide respite or transport care recipient to appointments, etc.? ☐ Yes ☐ No

If yes, maximum distance from your address: ☐ 10 miles ☐ 25 miles ☐ 50 miles ☐ over 50

Counties Served:

Please check types of care you are willing to provide:

☐ Non-skilled Companion ☐ Skilled Nursing

Please check where you are willing to provide respite:

☐ Care Recipient's Home ☐ Provider's Home ☐ Community Setting

Please check Activities of Daily Living (ADLs) you are you willing to work with:

☐ Toileting ☐ Bathing ☐ Dietary ☐ Grooming

☐ Mobility ☐ Dressing ☐ Transferring

Please check the Emotional and Behavioral Impairments you are willing to work with:

☐ ADD/ADHD ☐ Mental Disorders ☐ Reactive Attachment Disorder

☐ Anxiety ☐ Oppositional Defiant Disorder ☐ Self-Abusive

☐ Depression ☐ Physically Aggressive

☐ Fetal Syndrome Alcohol Syndrome ☐ Temper Tantrums

☐ Hyperactivity

Please check the Medical and Health Impairments and/or Specific Disabilities you are willing to work with:

☐ ALS/Lou Gehrig's Disease ☐ Hearing Impairment/ Hearing Aids ☐ Seizure Disorder

☐ Alzheimer's/Dementia ☐ Heart Problems ☐ Severe Allergies

☐ Autism / Autism Spectrum Disorder ☐ Speech and Language Delays

☐ Arthritis or other Joint Problems ☐ Spinal Cord

☐ Blood problems, such as Anemia or Sickle Cell Disease ☐ Stiff Person's Syndrome

☐ Breathing problems such as Asthma, COPD or Cystic Fibrosis ☐ Stroke

☐ Cancer ☐ Intellectual Disability/Developmental Delay ☐ Tracheotomy

☐ Catheter Care ☐ Multiple Sclerosis ☐ Traumatic Brain Injury

☐ Diabetes ☐ Muscular Dystrophy ☐ Visual Impairment

☐ Cerebral Palsy ☐ Paraplegia/Quadriplegia

☐ Feeding Tube ☐ Parkinson's Disease

Please check the ages you are willing to work with (check all that apply):

☐ 0-2 years ☐ 19-35 years ☐ 65-74 years ☐ all ages

☐ 3-5 years ☐ 36-50 years ☐ 75-84 years

☐ 6-18 years ☐ 51-64 years ☐ 85 and over

Please list languages you speak: ☐ English ☐ ________________________

How did you hear about the Nebraska Respite Network (check all that applies)?

☐ Presentation ☐ Brochure/Poster ☐ Friend/Relative

☐ Newspaper ☐ Newsletter ☐ Internet

☐ TV/Cable/Radio (please circle) ☐ Referral ☐ Other_________________________

If you are providing respite <u>in your home,</u> the following information must be completed and signed by any person age 19 or older living in the household, even if they are not applying to provide respite. If you are providing respite <u>outside of your home</u>, only the applicant needs to complete and sign. Attach additional sheets if needed.

By signing this Application the Applicant understands that as a condition of applying to be a Lifespan Respite Network-Approved Provider, compliance with Provider Standards is required:

1. Ensure individual provider, household member age 19 or older if providing respite in the applicant's home, or agency staff person having direct care recipient contact has been cleared with the DHHS Child Abuse/Neglect Central Registry, the DHHS Adult Protective Services Central Registry, State Patrol Sexual Offenders Registry and the State Patrol Criminal History Check. Agency applicant will maintain results of these checks in the employee personnel files and make available to the Department.
2. Agency provider is licensed and/or certified as required by state law.
3. Provide respite services as an independent contractor recognizing that the provider is not an employee of the Department or State.
4. Respect the care recipient's rights to confidentiality and safeguard confidential information.
5. Acknowledge responsibility for the care recipient's safety and property.
6. Have knowledge, experience, and / or skills to perform the task(s) agreed upon to safely provide respite care.
7. Assure that any suspected abuse or neglect will be immediately reported to law enforcement and / or the Abuse-Neglect hotline (1-800-652-1999).
8. Acknowledge Lifespan Respite Network application will be denied or approval immediately terminated when individual respite provider, household member age 19 or older if providing respite in the applicant's home, or agency staff is found to have a criminal history that includes conviction of any unlawful act endangering the health or safety of another individual. Such convictions include crimes against a child or vulnerable adult, crimes involving intentional bodily harm, crimes involving the sale, distribution or procurement of a controlled substance, or crimes involving moral turpitude on the part of the individual. These crimes include but are not limited to:
    a. Aggravated or armed robbery;
    b. Assault, first or second degree;
    c. Child abandonment;
    d. Child abuse;
    e. Child molestation or debauching a minor;
    f. Child neglect;
    g. Commercial sexual exploitation of a minor;
    h. Domestic violence;
    i. Exploitation of a minor involving drug offenses or conviction of drug offenses that involved a minor;
    j. Felony controlled substance offenses, other than possession;
    k. Felony violation of custody;
    l. Incest;
    m. Kidnapping;
    n. Murder, first or second degree;
    o. Sexual abuse of a minor;
    p. Sexual assault;
    q. Sexual exploitation of a minor, including child pornography; or
    r. Voluntary manslaughter.
9. Acknowledge Lifespan Respite Network application will be denied or approval immediately terminated when individual respite provider, household member age 19 or older if providing respite in the applicant's home, or agency staff is found to have a criminal history that includes conviction in the last 20 years of:
    a. Arson;
    b. Criminal non-support;
    c. Felony possession of controlled substance offenses;
    d. Felony theft; or
    e. Robbery

    The 20-year disqualification begins the date the conviction became final. Any time the individual is incarcerated, either in jail or a state or federal correctional facility, is not included in the calculation of the 20-year period of disqualification. If the individual has more than one conviction, the 20-year disqualification begins the date the most recent conviction became final.
10. Acknowledge Lifespan Respite Network application will be denied or approval immediately terminated when individual respite provider, household member age 19 or older if providing respite in the applicant's home, or agency staff is found to have a criminal history that includes conviction in the last five years of:

a. Burglary;
b. Driving under the influence: two or more convictions;
c. Felony bad check writing;
d. Misdemeanor controlled substance offenses;
e. Misdemeanor contributing to the delinquency of a child; or
f. Misdemeanor theft.

The five-year disqualification begins the date the conviction became final. Any time the individual is incarcerated, either in jail or a state or federal correctional facility, is not included in the calculation of the five-year period of disqualification. If the individual has more than one conviction, the five-year disqualification begins the date the most recent conviction became final.

I certify that I have read and understand the standards as stated and referenced above and agree to comply with all Provider Standards.

___________________________	_________________________	____/____/______
Applicant Signature	Printed Name	Date (Month, Day, Year)
___________________________	_________________________	____/____/______
Household Member Signature	Printed Name	Date (Month, Day, Year)
___________________________	_________________________	____/____/______
Household Member Signature	Printed Name	Date (Month, Day, Year)

I give permission to include my information on the Official Nebraska Government Website, Nebraska Resource and Referral System (NRRS) Provider Listing for Respite Resources. If you mark "NO" your information will remain private through the Nebraska Lifespan Respite Network secure online system. ☐ **YES** ☐ **NO**

A completed DHHS "Authorization for Release of Information" from the Nebraska Adult and Child Abuse and Neglect Registry (Form CFS 5) **MUST** BE ATTACHED.

Department of Health & Human Services
DHHS
NEBRASKA

Division of Children and Family Services (CFS)

Nebraska Child Abuse and Neglect Central Registry (CAN Registry)/ Nebraska Adult Protective Services Central Registry (APS Registry) Authorization for Release of Information for Registered Organizations

All designated fields must be completed or the request will be returned and not processed. Please type or print legibly. **This form is for use only by organizations who have registered with CFS to obtain CAN Registry and/or APS Registry information**. For information on how to register your organization go to: http://dhhs.ne.gov/children_family_services/Pages/nea_cr.aspx .

ORGANIZATION INFORMATION

Registered Organization ID Number	Registered Organization Name

APPLICANT INFORMATION

First	Middle	Last Name

Date of Birth	Age	Social Security Number

Current Address

City	State	Zip Code

Applicant's E-Mail Address (Please leave the E-Mail field blank if you prefer to receive correspondence by U.S. Mail).

Other names, such as a maiden name, former married name, or nickname, used in the past 20 years:

Names and birthdates of your children and children who lived with you:

All previous addresses at which you have resided in the past 20 years (minimum City & State):

Please release the following information to the Organization listed above: (Check all that apply):

☐ Nebraska Child Abuse and Neglect Central Registry (CAN Registry)

1. Whether or not I am listed on the CAN Registry, and the following information regarding any listing(s) which relate or pertain to me:
   a. Date of the alleged child abuse or neglect; and
   b. The classification of the case pursuant to Neb. Rev. Stat. 28-720. (i.e., Agency Substantiated or Court Substantiated).

☐ Nebraska Adult Protective Services Registry (APS Registry)

1. Whether or not I am listed on the APS Registry, and the following information regarding any listing(s) which relate or pertain to me:
   a. Date of the alleged adult abuse or neglect; and
   b. The classification of the case pursuant to Neb. Rev. Stat. 28-376. (i.e., Agency Substantiated or Court Substantiated).

This authorization is valid for a period of 6 months from the date of signature.

____ ____________________

Signature of Applicant Date

(NOTE: If Applicant is less than 19 years of age the signature of Applicant's Legal Guardian is also required below)

Section A - Verification of Identity of Applicant: Section A or B must be completed.

STATE OF______________________________)
) ss.
COUNTY OF_____________________________)

The foregoing instrument was acknowledged before me this__________day of ____________________, 20________ by:

____

(Printed Name of Applicant) .

Affix Official Notary seal here

____

Notary Public

Section B - Verification of Identity of Applicant: Section A or B must be completed.

The undersigned Organization employee hereby certifies that he or she has verified the identify of the Applicant by examining the Applicant's identification documents.

____ ____________________

Signature of Organization Employee Date

____

Printed Name of Organization Employee

____ ____________________

Signature of Applicant's Legal Guardian Date

(NOTE: This signature is necessary only if Applicant is less than 19 years of age).

Verification of Identity of Applicant's Legal Guardian (If applicable)

STATE OF______________________________)
) ss.
COUNTY OF_____________________________)

The foregoing instrument was acknowledged before me this__________day of ____________________, 20________ by:

____

(Printed name of Applicant's Legal Guardian) .

Affix Official Notary seal here

____

Notary Public