



## NEBRASKA LIFESPAN RESPITE NETWORK

### CRISIS RESPITE APPLICATION

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

\*Date of Request: \_\_\_\_\_

\*Name/Title: \_\_\_\_\_ \*Organization/Agency: \_\_\_\_\_

City: \_\_\_\_\_ \*Telephone Number: (\_\_\_\_) \_\_\_\_\_ Fax or Email: \_\_\_\_\_

\*Special Circumstances Justifying Crisis Respite Assistance versus Traditional Respite:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Additional resources recommended for Caregiver's ongoing needs:

\_\_\_\_\_  
\_\_\_\_\_

#### Primary Caregiver Information (Parent, Spouse, other Family or Friend providing on-going care)

\*Caregiver Name: \_\_\_\_\_ Gender:  Male  Female

\*Caregiver is:  Parent  Grandparent  Partner  Foster Parent  Sibling  Friend  
 Family  Son  Daughter  Other \_\_\_\_\_

\*Address: \_\_\_\_\_ \*City: \_\_\_\_\_ State: NE Zip Code: \_\_\_\_\_  
 Townhouse  Apartment  Single Family Home

\*Home or Cell Phone: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

Time Spent Caregiving each week:  5-10 Hours  11-20 Hours  Full-Time 24/7

Health of Caregiver at time of request (circle one):  Good  Fair  Disabled  Critical

\*Employed:  Full Time  Part Time  Not Employed or Retired  
Caregiver Income:  Less than \$25,999  \$26,000-\$40,999  above  Refuse to Answer

Does the Caregiver typically receive respite services from another program?  Yes  No  
If so, which program? \_\_\_\_\_ \*First Request for Crisis Respite:  Yes  No

Alternate Caregiver Name and Telephone: \_\_\_\_\_

\*Persons who live in the household of the Care Recipient:

Name	Date of Birth	Relationship to Care Recipient
_____	_____	_____
_____	_____	_____
_____	_____	_____

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**Care Recipient Information (Person with special needs requiring direct care)**

\*Care Recipient Name: \_\_\_\_\_ \*DOB: \_\_\_\_\_ \*Gender:  Male  Female  
\*Care Recipient Citizenship Status:  U.S. Citizen  Qualified Alien

\*Living Arrangements:  With Caregiver in Home of Care Recipient  With Caregiver in Caregiver's Home  
 With Other Family Member or Friend  Lives Alone

\*Address (if different from Caregiver): \_\_\_\_\_ \*City: \_\_\_\_\_ State: NE

Does the Care Recipient need help with any of the following?

Bathing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Toileting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dressing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Transfers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eating	<input type="checkbox"/> Yes <input type="checkbox"/> No	Walking	<input type="checkbox"/> Yes <input type="checkbox"/> No

\*Describe Memory and/or Behavior issues (if applicable):

\_\_\_\_\_  
\_\_\_\_\_

\*Please explain Care Recipient's Primary Diagnosis/Disease/Disability Needs: \_\_\_\_\_  
\_\_\_\_\_

**Care Recipient Income and Resources**

Estimated Income of Care Recipient: \_\_\_\_\_ SSI and/or SSDI  Yes  No  
Retirement Income  Yes  No Veteran  Yes  No  
Insurance:  Yes  No Medicaid/Medicare Supplemental Insurance:  Yes  No

**AGREEMENT AND SIGNATURE**

I understand that my statements may be checked, and if I have given false statements or information, I may be found guilty of fraud.

I understand that whenever there are any changes in the information I have given, I must immediately report them to the Nebraska Lifespan Respite Network - Respite Coordinator serving my community.

I understand that if I do not think my request is handled correctly, I have the right to file an appeal.

I understand that the Nebraska Lifespan Respite Network - Respite representative may need to contact other agencies and individuals to determine my financial eligibility and to verify my need for the support for which I am applying, or to make referrals to assist me in obtaining services.

I authorize the release of this confidential information.

I hereby attest that my response and the information provided on this form and any related application for public benefits are true, complete, and accurate and I understand that this information may be used to verify my lawful presence in the United States.

\*Applicant Signature: \_\_\_\_\_ \* Date: \_\_\_\_\_

\*Signature of Person Helping Complete Application, if applicable: \_\_\_\_\_

Address \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

\* Home or Cell Phone: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

Send completed application (or call/email questions) to:

**Lifespan Respite Program Use Only (Use additional pages if needed)**

Care Recipient meets Crisis Respite Eligibility Criteria:  Yes  No

Are there other funds or other financial resources for Crisis Respite services?  Yes  No

Lawful Presence Documentation:  DAS Attestation Form  Lawful Presence verification pending receipt of Attestation Form  Verified in "SAVE"

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:

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

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Action Taken:  Approved  Denied (provide reason): \_\_\_\_\_

Amount Approved: \_\_\_\_\_ Source: \_\_\_\_\_

Authorizing Signature, Title: \_\_\_\_\_ Date: \_\_\_\_\_