



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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If so, which program?	*First Request for Crisis respite <input type="checkbox"/> Yes <input type="checkbox"/> No

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

Signature of Care Recipient or Authorized Representative	Date
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Send completed application to local Respite Network Coordinator:  
 (1-866-737-7483 for contact information)

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

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Does the Caregiver typically receive respite services from another program?

Yes     No

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If so, which program?

Pending Lifespan Respite Subsidy application

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\*First Request for Crisis Respite:

Yes     No

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

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

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Care Recipient meets Crisis Respite Eligibility Criteria:	Are there other funds or other financial resources for Crisis Respite services?
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If yes, describe Supplemental Support

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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.

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

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

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Signature of local Lifespan Respite Network Coordinator	Date
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**This Section to be completed by Central Office Statewide Respite Program Coordinator**

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Action Taken: Approve

Yes     No

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

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Amount Approved:	Date
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## Instructions:

### Instructions:

**Instructions for completing Form CFS-1410, "Optional Crisis Respite Application" \*Care Recipient must be eligible to receive services from the Lifespan Respite Subsidy Program.**

**Use:** Form CFS-1410 is used as an application to determine eligibility for the Lifespan Respite Subsidy Program supplemental crisis respite funds. Applicant must be eligible for the Lifespan Respite Subsidy Program to be considered for crisis respite funds. Crisis Respite Eligibility Criteria must be met to be considered for funding. A crisis situation is 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.

**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\* and submitted for first-level approval to the local Respite Coordinator. The Statewide Respite Program Coordinator makes the final eligibility decision and determines financial assistance to be awarded.

**Referral Source Submitting Request (Name/Title):** Enter the name and title of the person submitting the crisis respite request.

**Date of Request:** Enter date application submitted.

**Organization/Agency:** Name of organization or agency submitting request.

**City:** Enter city where referring organization or agency is located.

**Telephone Number (include area code):** Enter organization or agency business or cellular telephone number where referrer may be reached.

**Fax:** Enter organization or agency fax number.

**Email:** Enter referrer's email address for expedited communications.

**Special circumstances justifying Crisis Respite assistance:** Describe need for crisis respite ensuring eligibility criteria is met. This information is used to determine if request meets eligibility criteria. The actual amount funded is determined on a case by case basis so detailed information is important.

**Additional resources recommended for Caregiver's ongoing needs:** Describe options explored, including DHHS programs or other paid/unpaid community referrals made to address long-term need for caregiver support beyond respite.

**Does the Caregiver typically receive services from another program?** List other DHHS or local services Caregiver is authorized to receive.

**If so, which program?** Identify program(s) providing services listed in earlier question.

**First Request for Crisis Respite?** Mark check box that applies.

**Describe current memory and/or Behavior issues that are contributing to crisis needs/situation:** Provide detail of care recipient need to justify crisis respite funding.

**\*Signature of Care Recipient or Authorized Representative:** Actual signature may be substituted by referrer's acknowledgement of accepting signature by telephone or care recipient/authorized representative's absence due to crisis circumstance. A note with referrer's initial is required.

**Date:** Include date application is submitted.

**Section to be completed by local Lifespan Respite Network Coordinator:** First level review of applicant referral information verified for accuracy prior to submitting to Statewide Program Coordinator for final eligibility review and funding decision, if applicable. Additional detail may be provided to assist with eligibility decision. Information must be supported by new or existing Lifespan Respite Subsidy program application.

Section to be completed by Central office Statewide Respite Program Coordinator: Documentation of application request decision.

**Send completed application (and supportive documentation, if needed) to local Respite Network Coordinator. Use numbers below or website referenced to find name and contact information:**

**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.