NEBRASKA RESPITE NETWORK
1-866-RESPITE

Department of Health & Human Services
DHHS
NEBRASKA

Office Use only

Date Received: ___/___/_____
Background Check Completed: ___/___/_____
Date Entered: ___/___/_____
- *Approved* ___/___/_____ *to* ___/___/_____
- *Denied*

Please return to:

Local Network Information

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 attach documentation 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:

_____

_____

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 miles
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 substances 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 has 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 substances 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 "Agency Request for Information from the Nebraska Adult and Child Abuse and Neglect Register/Registry" Form CSE-72 **MUST** BE ATTACHED.

Department of Health & Human Services
DHHS
NEBRASKA

Division of Children and Family Services

Agency Request for Information from the Nebraska Adult and Child Abuse and Neglect Register/Registry

I hereby request information from the Nebraska Adult and Child Abuse and Neglect Registry. I agree to use the requested information to determine whether to hire or retain the individual to provide care, custody, treatment, transportation or supervision of children or vulnerable adults.

Agency Name	Fax Number
Nebraska Respite Network Southwest Service Area	308-345-4289
Address	**Phone Number**
404 West 10th ST/PO Box 1235 McCook. NE 69001	308-345-4990

I hereby authorize the Division of Children and Family Services to disclose whether I have an Adult and/or Child Abuse and Neglect Register/Registry record to the above-named agency.

Full Legal Name (applicant)		
Address	**City/State**	**Zip**
Date of Birth	**Social Security Number**	

Other names previously used such as former married names, maiden name and nick names.

Names and birth dates of your children and children who have lived with you.

Any Address at which you have resided during the past 20 years.

Signatures and Dates

Print full legal name

Signature

Date

SOY INK