



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
_____	_____	_____
_____	_____	_____
_____	_____	_____

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:

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

Action Taken: Approved Denied (provide reason): _____

Amount Approved: _____ Source: _____

Authorizing Signature, Title: _____ Date: _____