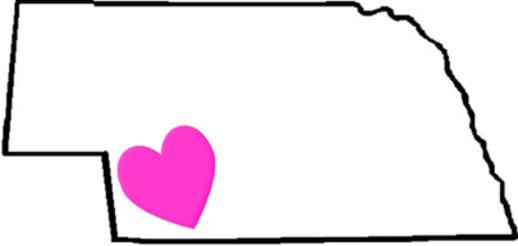


APPLICATION FOR RESPITE PROVIDER



Nebraska Respite Network

1 866 RESPITE

308.345.4990

Office Use only

Date Received: ___/___/___

Background Check Completed: ___/___/___

Date Entered: ___/___/___

Please return to:

Nebraska Respite Network

Southwest Service Area

404 West 10th St / PO Box 1235

McCook NE 69001

respite@swhealth.ne.gov

Date: ___/___/___ County: _____

Applicant: _____ Former names: _____

Address: _____ City: _____ ST: _____ Zip code: _____

Phone # (Home) ___-___-___ (Work) ___-___-___ Cellular: ___-___-___

Can you be contacted at work? Yes No

Email Address (if applicable): _____

Can we contact you via e-mail? Yes No

I would like to be part of the 2-1-1 system and internet. Yes No

This section is optional for you to complete.

- High school/GED
- College: Degree (major/minor) or what studies:

Present occupation, if applicable:

Current position: _____

Employed by: _____

Address: _____

How long: _____

Attended Respite Training: Yes No

Where: _____

Year: _____

Would you be interested in future training?

Yes No

What topics would interest you?

Do you have Accreditation for:

Medication Aide: CPR/First Aid: RN: LPN:

How did you learn about this Respite Program?

- Presentation Brochure/Poster Friend/Relative
- Newspaper Newsletter Radio
- TV/Cable Referral Internet
- Other _____

Do you speak a language other than English? Yes No which language(s)

Years of experience in providing respite services: _____

REFERENCES: List (3) personal or business references, no more than one relative:

Name _____

Address _____

City : _____ ST: _____ Zip code: _____

Name _____

Address _____

City : _____ ST: _____ Zip code: _____

Name _____

Address _____

City : _____ ST: _____ Zip code: _____

RELEASES:

I _____ (**PRINT NAME**), hereby apply to be an approved respite provider with Nebraska Respite Network. In making application for approval it is understood that:

I/We give the Agency permission to contact law enforcement personnel and references about my/our character and background as it affects the provision of care for children/youth/adults.

I/We understand and give permission to have my/our names checked with the State Central Registry of child/adult abuse and neglect.

I (the applicant) give the Agency permission to enter information, as needed, into the IRis information and referral system.

I further state that any information that I give in the investigation of my application will be true and correct to the best of my/our knowledge.

If you are providing respite in your home, the following information must be completed and signed by any person 19 or older living in the household, even if they are not applying to provide respite.

	____/____/____ Date of Birth	____/____/____ Date Signed
Applicant's Signature		
	____/____/____ Date of Birth	____/____/____ Date Signed
Household member's signature		
	____/____/____ Date of Birth	____/____/____ Date Signed
Household member		

Have you had any experience with the following? (Experience not necessary for approval)

Please check Yes or No.

	No	YES	IF YES, PLEASE DESCRIBE
Wheel chair users			
Toileting			
Transferring/lifting/ positioning			
Catheter			
Feeding tubes			
Physical disabilities			
Seizures			
Communication devices			
Sign language			
Person who is non-verbal			
Speech delayed			
Visual impairment			
Hearing impairment			
Self-abusive behavior			
Behaviors			
Physically aggressive behavior			
ADHD			
Mental retardation			
Autism			
Alzheimer's or other forms of dementia			

EXPERIENCE:

Have you cared for a family member/friend with special needs? Yes No

Briefly describe any **other** volunteer, personal or job experience and/or training you may have in working with children, adults or elderly with special needs:

Check boxes for times you may have available	MON	TUES	WED	THURS	FRI	SAT	SUN
DAYTIME							
EVENINGS							
OVERNIGHTS							
EXTENDED PERIODS							
EMERGENCIES							

I am interested in providing respite as follows: (Check the following categories of interest)

Ages: 0-18 19-59 60 or older

Disabilities/special needs you would work with

- Families in crisis
- Alzheimer's/dementia
- Behavioral
- Chronic Illness
- Developmental Disabilities
- Frail Elderly
- Medical Needs
- Mental Illness

Locations you would provide respite services:

- In Client's Home
- Out of Client

(Is your home barrier free?)

- Yes No

Counties/Towns willing to serve:

Funding sources you would be willing to accept for payment:

- Government/State Funded
- Private Pay
- Volunteer, if needed

Fee rate: \$____.____ hourly \$____.____ daily \$____.____ overnight \$____.____ weekend ____ negotiable

Paid Providers: Any fees charged are negotiated between the provider and family caregiver requesting respite. If you are unsure of the rates you would require, please think about a range that you feel comfortable with and negotiate with the family. Your rates may change due to the varying needs of families.)

Transportation, you do not have to drive to provide respite:

- Would you provide transportation? Yes No
- Are you willing to travel to provide respite? Yes No
- Less than 10 miles 26-50 miles 11-25 miles over 50 miles

United States Citizenship Attestation Form

For the purpose of complying with Neb. Rev. Stat. §§ 4-108 through 4-114, I attest as follows:

I am a citizen of the United States.

— OR —

I am a qualified alien under the federal Immigration and Nationality Act, my immigration status and alien number are as follows: _____, and I agree to provide a copy of my USCIS documentation upon request.

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.

PRINT NAME	<hr/> <u>(first, middle, last)</u>
SIGNATURE	<hr/> <hr/>
DATE	<hr/> <hr/>



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: Respite Network – Southwest Service Area / FAX: 308-345-4289

Address and Phone Number: 404 W 10th ST., P O Box 1235 McCook, NE. 69001/Phone: 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.

Print Full Legal Name: (applicant) _____

Signature (applicant)

Date

Current Address: _____
(Street/City/State/Zip)

Applicant Date of Birth

Applicant Social Security Number

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

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

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

