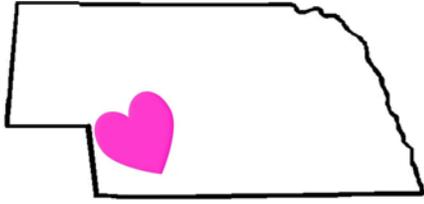


RESPIRE PROVIDER RENEWAL FORM



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
P O Box 1235
McCook NE 69001
respite@swhealth.ne.gov

Date _____ County: _____
Applicant _____ Former names _____
Address _____ City/State/Zip _____
Phone # (H) _____ (W) _____
Cellular: _____ Can you be contacted at work? Yes No
Email Address (if applicable): _____
Can we contact your 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 Yes No CPR/First Aid Yes No
RN Yes No LPN Yes No

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.*

<i>Applicant's Signature</i>	Date of Birth	Date Signed
Household member's signature	Date of Birth	Date Signed
Household member's signature	Date of Birth	Date Signed

In an effort to make the best referrals possible, please answer the following 3 questions:

Are you a respite provider because you "need" respite hours as part of your livelihood?

Are you currently wanting more respite hours? If yes, how many would you prefer to have per week?

Are you content just helping families out as needed?

(Please complete *only* if your information has changed over the past year)

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			

Any additional information about you or your experience that might help us with the referral process:

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:

- | | | |
|---|---|--|
| <input type="checkbox"/> Families in crisis | <input type="checkbox"/> Chronic Illness | <input type="checkbox"/> Medical Needs |
| <input type="checkbox"/> Alzheimer's/dementia | <input type="checkbox"/> Developmental Disabilities | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Behavioral | <input type="checkbox"/> Frail Elderly | <input type="checkbox"/> Physical Disabilities |

Locations you would provide respite services:

- In Client's Home Out of Client's Home (*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/> (first, middle, last)
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.

