NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Department of Health and Human Services

LIFESPAN RESPITE SUBSIDY PROGRAM APPLICATION

(See instructions. If you need assistance completing this application: call 1-866-737-7483 for a local Respite Network Coordinator). Do you need an interpreter? ☐ Yes ☐ No If yes, what language do you speak: _____

Section 1: CARE RECIPIENT INFORMATION *(Person with special needs requiring full-time ongoing 24/7 care/supervision)*

Attach documentation to support request for respite (for example, letter from therapist or healthcare provider, current medical reports or IEP).

Care Recipient Name:	Date of Birth:	Gender: ☐ Male ☐ Female

Living Arrangements:
☐ With Caregiver in Home of Care Recipient ☐ With Caregiver in Home of Caregiver
☐ With Other Family or Friend ☐ Lives Alone

Social Security Number:

Care Recipient Citizenship Status:
☐ A citizen of the United States OR ☐ I am a qualified alien under the federal Immigration and Nationality Act.

Mailing Address:

City:	State:	Zip Code:	County:

Does Care Recipient need help with any self-care activities:

Bathing	☐ Yes	☐ No	Toileting	☐ Yes	☐ No	Grooming	☐ Yes	☐ No
Dressing	☐ Yes	☐ No	Transfers	☐ Yes	☐ No	Mobility	☐ Yes	☐ No
Eating	☐ Yes	☐ No	Walking	☐ Yes	☐ No			

Check all needs experienced by Care Recipient that requires supervision:
☐ Cognitive Impairment or Dementia ☐ Functional Limitations due to Aging ☐ Physical Disability
☐ Behavioral Challenges ☐ Learning Disability ☐ Other:
☐ Developmental and/or Intellectual Disability ☐ Mental Health Issues

Describe Care Recipient's special needs such as day-to-day care routines that require extra support: *(Answer Required)*

High risk of out of home placement/facility care (such as a nursing home, foster care, mental health institution, group home:
☐ Yes ☐ No

Section 2: PRIMARY CAREGIVER INFORMATION *(Parent, Spouse, other Family or Friend providing on-going care).*

Name of Authorized Representative: (Primary Family Caregiver)	Gender: ☐ Male ☐ Female	Age: ☐ 18 and younger ☐ 19-59 ☐ 60-75 ☐ 76+

Caregiver is:

☐ Adoptive Parent	☐ Friend	☐ Legal Guardian	☐ Partner
☐ Biological Parent	☐ Foster Parent	☐ Sibling	☐ Power of Attorney
☐ Daughter/Son	☐ Grandparent	☐ Spouse	

Landline Phone Number:	Cell Phone Number:	Consent to text: ☐ Yes ☐ No Cell Carrier:

Consent to contact via email: ☐ Yes ☐ No	Caregiver Email:

Do you prefer communication via: ☐ Email ☐ Email & Text ☐ Mail ☐ Mail & Text

Time spent caregiving each week:
☐ 5 - 10 Hours ☐ 11 - 20 Hours ☐ Full-Time 24/7

Health of Caregiver at time of request (check one):
☐ Good ☐ Fair ☐ Disabled ☐ Critical

Caregiver employed:
☐ Full Time ☐ Part Time ☐ Not Employed or Retired

How "stressed" are you as a result of caring for the care recipient:
☐ Not at all stressed ☐ Slightly stressed
☐ Moderately stressed ☐ Very stressed
☐ Extremely stressed

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In the last six months, has one or more family caregivers needed to miss work due to unpaid family caregiving responsibilities: ☐ Yes ☐ No ☐ Primary Caregiver not employed

If Yes, how many days have you missed:

Section 3: LIVING ARRANGEMENTS *(List all who live in the household of Care Recipient):*

Does the care recipient age 18 and under have a parent living outside the home: ☐ Yes ☐ No

Name:	Date of Birth:	Relationship to Care Recipient:

(If care recipient receives Medicaid, SNAP, ADC, State Disability, or AABD skip to Section 7)

Section 4: RESOURCES/ASSETS

Do you or anyone in the home have any of the following: ☐ Yes ☐ No If yes, check all that apply:

☐ Cash
☐ Checking and Saving Accounts
☐ Certificates of Deposits (CD)
☐ Mutual Funds
☐ Inheritance
☐ 401(K)
☐ Other Resources
☐ Retirement Accounts
☐ Stocks /Bonds
☐ Annuities
☐ Education Accounts
☐ Property (Land, Homes)
☐ Burial Trusts
☐ Burial Arrangements
☐ Trusts

Name(s) on Account:	What do They Have:	Amount on Account:	Name(s) on Account:	What do They Have:	Amount on Account:

Section 5: INCOME *(List all gross income (before deductions). Include Care Recipient, their spouse and children under age 19. If Care Recipient is under age 19, include parents and siblings under age 19)*

Income Type:	Amount:	How Often is it Received:	Who Receives it:
☐ Wages: ☐ Self-Employment: *(Self-employment must attach IRS verification of income)*			
☐ Social Security Disability Insurance (SSDI)			
☐ Social Security Retirement			
Income Type:	**Amount:**	**How Often is it Received:**	**Who Receives it:**
☐ Pension under SS Retirement: ☐ Child Support: ☐ Alimony:			
Other:			

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Section 6: DISABILITY-RELATED EXPENSES *(Unreimbursed out-of-pocket costs only)*

List disability-related expenses not covered by any other source, the Care Recipient has to pay in a year's time. Examples of expenses: doctor visits, prescriptions, adult incontinence products, medical transportation, wheelchairs, lifts, loans for architectural modification. Do not include expenses of other family members:

Expense:	Cost:	How Often:

Section 7: OPTIONAL DEMOGRAPHICS

Ethnicity:	Race:
☐ Not of Hispanic, Latino, or Spanish origin	☐ Black/African American
☐ Mexican	☐ White/Caucasian
☐ Puerto Rican	☐ Asian
☐ Central American	☐ American Indian
☐ Cuban	☐ Alaskan Native
☐ South American	☐ Native Hawaiian
☐ Other Hispanic, Latino, or Spanish Origin	☐ Other Pacific Islander
☐ Other/Unknown	☐ Other/Unknown

SECTION 8: 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 changes in the information I have given, I must immediately report them to the Nebraska Department of Health & Human Services, Respite Subsidy Program Coordinator.

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 Department of Health and Human Services 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 understand payments for benefits may be delayed if I did not provide the Social Security Number for Care Recipient.

I understand 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.

Signature of Adult Care Recipient or Authorized Representative:	Date:
Signature of Person Helping Complete this Application, if applicable:	

Relationship to Care Recipient:	Helper Telephone:	Helper Email:

Section 9: REFERRAL SOURCE *(Who told you about the program)*

Name/Title:	Organization/Agency or Relationship to Care Recipient:

Address:	City:	State:

Telephone:	Email:

Send completed application and supporting documentation to:

Email: *(recommended)*	**dhhs.respite@nebraska.gov**	**Mail:**	**DHHS** Lifespan Respite Subsidy Program P.O. Box 98933 Lincoln, NE 68509-9994
Fax:	(402) 742-8356		
Social Services Worker:	(402) 471-9188		
Local Respite Coordinator:	**1-866-RESPITE** (1-866-737-7483)		

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INSTRUCTIONS:

Instructions for completing Form CFS-1400, "Lifespan Respite Subsidy Program Application"

Use: Form CFS-1400 is used as an application to determine eligibility for Lifespan Respite Subsidy Program benefits. Program Staff will use the form to collect data needed to determine eligibility for respite services. It also serves as a release of information when additional information is needed to determine eligibility. This program pays for respite services to give the primary caregiver a temporary break. ***Respite means the provision of short-term relief to primary caregivers from the demands of ongoing care for an individual with special needs.*** Ongoing care means continuous, full-time supervision/care for a person with special needs. DHHS Manual reference 464 NAC 1-007 and 1-008. It is NOT for people who are receiving respite services from another government program.

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 Adult Care Recipient or his/her authorized representative.

Section 1: CARE RECIPIENT INFORMATION (Person with special needs requiring full-time ongoing 24/7 care/supervision): Enter the name, date of birth, gender, living arrangements, social security number, citizenship status, address, city, state, zip code and county of the Care Recipient. Mark all the check boxes that apply.

Attach documentation to support request for respite (for example, letter from therapist or healthcare provider, current medical reports or IEP).

High Risk of Out of Home Placement/Facility Care: Mark the check box that applies.

Section 2: PRIMARY CAREGIVER INFORMATION (Parent, Spouse, other Family or Friend providing on-going care): Enter the caregiver's name. Mark all the boxes that apply for gender, age and role(s). Enter telephone number(s) for home, cell and work.

Consent to Text: Mark the check box that applies. If yes, list your cell phone carrier.

Email Contact: Check the box if Program Staff may contact us by email. Enter an email address.

Time Spent Caregiving Each Week: Mark the check box that applies.

Stress Level: Mark the check box that applies.

Communication Preference: Mark the check box that applies.

Health of Caregiver: Mark the check box that applies.

Employment Status: Mark the check box that applies.

Missed Work: Mark the check box that applies. List number of missed days.

Section 3: LIVING ARRANGEMENTS: List all who live in the household. Be sure to include everyone's date of birth and relationship to Care Recipient.

If care recipient receives Medicaid, SNAP, ADC, state disability, or AABD skip to Section 7 (Optional Demographics).

Section 4: RESOURCES/ASSETS: *You may be asked by Program Staff to verify Resources/Assets to comply with state statute, defined administrative and audit requirements to demonstrate client financial need eligibility for use of program funds. Failure to respond or providing incomplete information may cause eligibility determination delay.

Mark all the check boxes that apply. List person(s) who has the funds checked and the amount of each. List any liquid resources including cash on hand, checking and savings accounts, certificates of deposit, stocks, bonds, life insurance cash values, IRA and Keogh Funds, etc. This data will be used as another factor of eligibility.

Section 5: INCOME: *You may be asked by Program Staff to verify Resources/Assets to comply with state statute, defined administrative and audit requirements to demonstrate client financial need eligibility for use of program funds. Failure to respond or providing incomplete information may cause eligibility determination delay.

Use more paper if there is not enough room for your answers on this application.

Wages and/or Self-Employment: List current household gross wages (before taxes and deductions) or self-employment by amount, frequency and who receives it.

Child Support, Alimony: List amount, frequency and who receives it.

Section 6: DISABILITY-RELATED EXPENSES: List all disability-related expenses paid on behalf of the Care Recipient in a year's time. Do not include amounts covered by insurance or other benefit program(s). Information listed here will be considered to see if the expense may be disregarded from the income. It should include things such as out-of-pocket expenses for prescriptions, home modifications, diapers for individuals above age 3, etc.

Optional Race and Ethnicity: Mark all the check boxes that apply.

Section 7: OPTIONAL DEMOGRAPHICS: Indicate the race and ethnic category of care recipient. Title VI of the Civil Rights Act of 1964 allows the Department to ask for this information. This information will not be used in determining eligibility for program funding. If you do not provide this information, it will not affect your application. The Department asks for the information to assure that benefits are distributed without regard to race, color, ethnicity, or national origin.

Section 8: AGREEMENT AND SIGNATURE: The Adult Care Recipient or authorized representative must sign the application before Program Staff can authorize benefits. Person assisting with completing application must sign and list relationship, date, telephone, and email..

Section 9: REFERRAL SOURCE (Who told you about this program?): List name, organization/agency /or relationship to care recipient and contact information of how you learned about the Lifespan Respite Subsidy Program.

Send completed application and supporting documentation to:

<table>
<tr><td>Email: (recommended)</td><td>dhhs.respite@nebraska.gov</td><td>Mail:</td><td rowspan="4">DHHS
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</table>

WHO PROVIDES RESPITE

There is some flexibility in finding providers. Your local Respite Coordinator can assist you with finding a provider in your area. You may be able to use family members, friends or neighbors as paid providers. Other possibilities include: organizations, camps, a trusted agency, a local volunteer-led organization or group, volunteer-led school-based program, equine program, faith-based or other approved activities. While your loved one is attending an activity, you are getting a break—and that's what respite is all about!

You can locate screened respite providers at: **nrrs.ne.gov/respite.** Click on "**Find a Provider**"