Idaho Lifespan Respite Application

CARE RECIPIENT INFORMATION (person receiving care)

Last Name:	**First Name:**	**Middle Initial**:
Physical Address:	**City:**	**State:** **Zip:**
Mailing Address: ☐ **same as physical**	**County:**	**Home Phone:**

Cell/Other Number:	**Date of Birth:**	**Gender:** ☐ Male ☐ Female	**Veteran:** ☐Yes ☐No	**Marital Status:** ☐ Single ☐ Legally Separated ☐ Married ☐ Widowed ☐ Declined to State

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

Ethnicity:
- ☐ Not Hispanic or Latino
- ☐ Hispanic or Latino
- ☐ Declined to State
- ☐ Other/Unknown

Race:
- ☐ American Indian/Native Alaskan
- ☐ Asian
- ☐ Black/African American
- ☐ Native Hawaiian/ Other Pacific Islander
- ☐ Non-Minority (white, Non-Hispanic)
- ☐ Other/Unknown
- ☐ White-Hispanic
- ☐ Declined to State

Check any activities the care recipient requires assistance:

☐ Bathing	☐ Transfers	☐ Meal Prep	☐ Transportation
☐ Dressing	☐ Walking	☐ Shopping	☐ Money Management
☐ Eating	☐ Grooming	☐ Medication	
☐ Toileting	☐ Mobility	☐ Telephone	

Check primary need of care recipient that requires respite services:

☐ Dementia or Alzheimer's	☐ Cancer
☐ Functional limitations due to aging	☐ Behavioral Challenges
☐ Physical Disability	☐ Developmental and/or Intellectual Disability
☐ Mental Health Issues	☐ Other

Any additional services in place?

Any additional referrals needed?

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CARE GIVER INFORMATION (person providing care)

Last Name:		**First Name:**		**Middle Initial:**
Physical Address:		**City:**	**State:**	**Zip:**
Mailing Address:		**County:**	**Home Phone:**	
Cell/Other Number:	**Email:**	**Gender:** ☐ Male ☐ Female	**Veteran:** ☐Yes ☐No	**Date of Birth:**
Does Caregiver live full time with Care Recipient? ☐Yes ☐No	**Caregiver Employed:** ☐Full Time ☐Part Time ☐Not employed	**Weekly caregiving hours**: ☐5-10 hours ☐11-20 hours ☐Full Time 24/7	**Marital Status:** ☐ Married ☐ Single ☐ Divorced	☐ Legally Separated ☐ Widowed ☐ Declined to state

Ethnicity:	**Race:**
☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Declined to State ☐ Other/Unknown	☐ American Indian/Native Alaskan ☐ Asian ☐ Black/African American ☐ Native Hawaiian/ Other Pacific Islander ☐ Non-Minority (white, Non-Hispanic) ☐ Other/Unknown ☐ White-Hispanic ☐ Declined to State

The Caregiver is:

☐ Husband ☐ Wife ☐ Daughter ☐ Son	☐ Parent ☐ Grandparent ☐ Foster parent ☐ Grandchild	☐ Legal Guardian ☐ Power of Attorney ☐ Partner ☐ Sibling	☐ Friend ☐ Other family member ☐ Other

Type of respite provider caregiver would like to use:

☐ Informal providers (family, friends, neighbor, etc.) ☐ Formal/Agency Care	☐ Care Center (adult day care, camps for children, etc.) ☐ Employee (someone I hire but is not affiliated with an agency)

How did you learn about the Idaho Lifespan Respite Program?

☐ Friend/Family Member ☐ Presentation ☐ Doctor ☐ Health Fair	☐ Flyer/Brochure ☐ Home Health/Hospice Agency ☐ Discharge Planner ☐ Other

Would the caregiver like to list an emergency contact? ☐Yes ☐No

Name	Phone Number	Relationship to Caregiver

Any additional services in place?

Any additional referrals needed?

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LIVING ARRANGEMENTS

Is Household Income: □ Below Poverty Line □ Above Poverty Line
Does the care recipient age 18 and under have a parent living outside the home: □ Yes □ No

AGREEMENT AND SIGNATURES

Initial	Agreement
	I attest that I am the primary caregiver of the respite care Recipient listed in this application form.
	I attest that the information included in this application form is true and accurate to the best of my knowledge. I understand that falsification of information will result in termination of services.
	I attest that I have read and understand the Idaho Lifespan Respite Program procedures and guidelines.
	I understand my signature below authorizes a release of information for program purposes only. I authorize this release of information for other agencies and individuals to make referrals to assist in obtaining services.
	I understand that the funds I receive from the Idaho Lifespan Respite Program are solely for respite services and that these funds cannot be used for any other purpose.
	I understand that I will be reimbursed a sum not to exceed the amount approved by Idaho Lifespan Respite Program.
	I understand that any unspent portion of my respite voucher will be forfeited and not rolled over.
	I understand that I am responsible for hiring, training and negotiating the rate of pay with the identified respite services provider.
	Complaints or grievances may be filed to XXXXX, Executive Director, Area XX Senior Services Agency. All complaints will be reviewed and investigated. AAA will respond to complaints by phone within three business days of receipt and will provide a written resolution within 5 business days of the call.

Signature of Caregiver:	Date:
Signature of AAA Representative:	Date:

Lifespan Respite Coordinator		**Mail:**	Area Agency on Aging
Fax:			
Email:			
Phone:			