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

LIFESPAN RESPITE SUBSIDY PROGRAM

Funding Request for Exceptional Circumstances, including Crisis Respite

SECTION 1: Client Information (Person with special needs requiring ongoing care.)

Client Name:	Age:	Client ID:	Client Phone:
Family Caregiver Name:	Family Caregiver Email:		
Client Mailing Address: ☐ Check if the address has changed since last application.	City:	State:	Zip:

Check all that apply:
☐ Unplanned event that jeopardizes the health and safety of the Client
☐ Unplanned event that jeopardizes the health and safety of the Family Caregiver
☐ Immediate and unavoidable absence of the Family Caregiver more than 4 hours when a qualified caregiver is not available

☐ Family Caregiver health crisis ☐ Physical ☐ Mental ☐ Emotional	☐ Client has exceptionally high care needs requiring supervision ☐ Medical / Physical Health ☐ Behavioral and / or Emotional Needs ☐ Personal Safety of ☐ Self or ☐ Others

Explain:

In the next 30-45 days are you considering: ☐ Assisted Living / Nursing Facility Placement ☐ Foster Care / Group Home Placement ☐ Extended Family Care *Explain:*	How "stressed" are you as a result of caring for the client: ☐ Not at all stressed ☐ Slightly stressed ☐ Moderately stressed ☐ Very stressed ☐ Extremely stressed

How would taking short breaks HELP you and the person you provide care to? Explain:

SECTION 2: Respite Plan

1. What are your immediate respite needs?
   a. Additional monthly respite supports necessary due to: _____
      - Special event
        i. Caregiver needs: (break due to exceptional need, medical care, vacation, etc.)
        ii. Camp (care recipient is attending a specifically scheduled camp, CBO event, Community Agency/ provider activity/event, etc.)
        iii. Increased needs of the care recipient (increased medical support needed, surgery/medical procedure, behavioral support increase, etc.)
      - Immediate short-term crisis
        i. Illness in the family that requires the support of caregiver or the caregiver needs additional support due to illness
        ii. Unplanned immediate or unavoidable absence of the Family Caregiver for an extended period when a qualified caregiver is not available.

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2. If approved, how do you plan to use the additional respite support? Please provide an outline below of how the funds you are requesting will be utilized.

   Additional Funds monthly needed (if specified amount is provided for hours needed/camp/respite event):

   _____

   Utilization of funds for a specific need (outline specific need that funds will be applied to):

   _____

   Month(s) needed:

   _____

Do you need help finding a Provider: ☐ Yes ☐ No
Please visit respite.ne.gov or call 1-866-RESPITE to contact a local Respite Network Coordinator to assist in finding a Respite Provider.

Name of Provider(s) who will give you a temporary break:

Name: _____ Email: _____ Phone: _____

Name: _____ Email: _____ Phone: _____

If funds are not utilized as indicated above, the Respite Coordinator and Social Services Worker will need to be notified. Funds can be reviewed, on a case by case basis, to be banked to be utilized at another time during the eligibility period. This is only after review and approval by Department.

SECTION 3: Employment

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 4: 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 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.

Signature of Authorized Representative: Date:

SECTION 5: Referral Source

Name / Title:	Organization / Agency or Relationship to Client:

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Address:	City:	State:
Phone:	Email:	

Send completed application to:

Email: dhhs.respite@nebraska.gov

Mail: Nebraska Department of Health and Human Services
Nebraska Department of Health and Human
CFS, Economic Assistance - Lifespan Respite Subsidy
P.O. Box 98933
Lincoln, NE 68509-8933

Fax: (402) 742-8356

Questions: (402) 471-9188