



VIRGINIA DEPARTMENT FOR AGING
AND REHABILITATIVE SERVICES

~ Virginia Lifespan Respite Voucher Program ~ Application Form

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Name of Primary Family Caregiver <i>(the person applying for respite voucher funds)</i>		
Name of Respite Care Recipient <i>(the person receiving respite services)</i>		
Street Address <i>(of both Primary Family Caregiver and the Respite Care Recipient)</i>		
City	State	Zip
	Virginia	
Primary Phone Number(s)	*E-mail <i>(for Primary Family Caregiver)</i>	

*Communication about the status of your request for funding will be sent primarily via email unless no email is listed.

The Primary Family Caregiver has the following relationship with the person receiving care:

- parent; court-appointed legal guardian; foster parent;
 grandparent; grandchild; son; daughter; sibling;
 spouse; other: _____

How did you hear about the Virginia Lifespan Respite Voucher Program?

- Area Agency on Aging;
 Brain Injury Services Organization;
 Center for Independent Living;
 CSB (Case Management)
 Hospice;
 DARS Division on Aging;
 DARS Brain Injury Services Coordination Unit;
 Social Worker;
 Another individual or organization (please list): _____

Total number of family members in Primary Family Caregiver's household:

____ Adults; ____ Children (under 18 years)

Required Questions:

- Do you live full time in the same residence as the Respite Care Recipient? Yes No
- Are you currently employed? Yes No
- Do you use non-family respite services? Yes, currently No Not currently but I have in the past
If YES, please check: Community Respite Organization: _____
 Friends/Neighbor Church Hospice
Do you currently pay for these non-family respite services? _____
- Are you receiving respite services through a Medicaid Waiver? Yes Waitlist No
If YES, please select the type of waiver: ID/DD EDCD Other:
- Date(s) and hours (estimated) you plan to use respite services (you have 90 days from date of approval to use respite services): _____
- Amount of voucher funding requested: \$ _____
- Will the Lifespan Respite Voucher be used for a service you are already receiving? Yes No



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Description of Voucher Funding Request (required):

- ❖ **The type of respite I will use is:** Skilled care Unskilled care
From: Formal providers (hired and trained by an agency)
 Informal Providers (available through parent or caregiver cooperatives, churches, or family and friends)
- ❖ **The respite provider I will hire and pay is an:** Individual Agency Other:
- ❖ **Respite services will be provided in:** the family home the home of a neighbor or friend an adult day center
 a respite center a residential care facility a group home a recreational setting a community based program
 other:
- ❖ **The temporary break from caregiving duties this program provides will allow me to** (e.g. have a date night, go to a family reunion, take a nap, see a movie, go on vacation, get rest and relaxation, go to the store, etc.): _____

Respite Care Recipient Information

Name of Respite Care Recipient (*the person receiving respite services*)

Age	Gender <input type="checkbox"/> Male; <input type="checkbox"/> Female; <input type="checkbox"/> Other	Is the Respite Care Recipient a Veteran? <input type="checkbox"/> Yes; <input type="checkbox"/> No
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Race and Ethnicity (Check the race the recipient identifies as and then write their ethnicity beside the race)
 African American: _____ Asian: _____ Caucasian: _____ Hispanic/Latino: _____
 Multiracial: _____ Native American: _____ Other: _____

Using the list below, please write the disability or special need in the appropriate location (if other, please specify)

Primary Disability or Special Need: _____

Secondary Disability or Special Need (optional): _____

Intellectual/Developmental Disability: Intellectual Disability; Autism; **Physical/Orthopedic/Mobility Impairment:** Multiple Sclerosis; Muscular Dystrophy; Cerebral Palsy; **Sensory/Communication Impairment:** Blind/vision impaired; Deaf/ hard of hearing; **Mental/Emotional/Psychosocial Impairment:** Mental Illness; Mood/Personality Disorders; **Degenerative Neurological Impairment:** Dementia/Alzheimer's; Parkinson's; ALS; **Neurological Impairment (nondegenerative):** Stroke; Traumatic Brain Injury; Spinal Cord Injury; **Medically Fragile/ Frail Elderly; Other**

***Documentation of the Respite Care Recipient's condition/disability must be included in this application form or it cannot be processed or approved. Documentation cannot be more than two years old (2013-2015)**

Examples of Acceptable Documentation of Condition / Disability: *(Please limit documentation to one page)*

- Physician/Psychologist Written Diagnosis of Disability/Condition: 1 page
- Social Security Administration Letter of Determination for Disability Benefits: 1 page
- School District Special Education Eligibility/Individualized Educational Plan Cover Sheet/Sign off Sheet: 1 page
- Early Intervention Eligibility/Individualized Family Service Plan Cover Sheet/Sign-off Sheet: 1 page
- Vocational Rehabilitation Statement of Qualifying Disability: 1 page
- Long-term Disability Insurance Statement of Eligibility of Benefits: 1 page
- Medicaid Eligibility/Medical Assistance Eligibility Forms: 1 page



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Acknowledgements

Primary Family Caregiver: Please read and initial each item below. Sign and date form before submitting the application to the Virginia Department for Aging and Rehabilitative Services (DARS).

_____ I attest that I am the Primary Family Caregiver of the Respite Care Recipient listed in this application form and that I reside full-time in the same residence with the Respite Care Recipient in the Commonwealth of Virginia.

_____ I understand that the intention of the Virginia Lifespan Respite Voucher program is to allow the Primary Family Caregiver to get an opportunity of rest from providing care for their loved one (once they find out they are approved), by hiring a respite care provider to take care of that loved one. This program prohibits the use of these funds for rent, cleaning, transportation, medical supplies, food, and household expenditures or so the applicant can go to work.

_____ I attest that I have read and understand the DARS *Virginia Lifespan Respite Voucher Program* application procedures. I understand my signature below authorizes a release of information for program purposes only.

_____ I understand that the funds I receive from the *Lifespan Respite Voucher Program* are solely for services provided to the Respite Care Recipient listed on this application and that these funds cannot be used for any other purpose.

_____ I understand that if I have existing government debt, I may not receive my entire refund.

_____ I acknowledge that I am responsible for hiring the respite care provider and arranging the payment for services received. I understand that I will be reimbursed a sum not to exceed the amount approved by DARS on my **Application Form**. I understand that I am responsible for any difference in the amount approved and the amount paid by me, if any.

_____ I will submit a **Reimbursement Form** and **W-9 Form** within 30 days of the date of purchase and delivery of respite services. I understand that any unspent portion of my respite voucher may be forfeited if I have not made prior arrangements for use of my respite voucher funds by this deadline. I understand that the **W-9 Form** is required by the Commonwealth in order to issue the reimbursement check; it is not sent to the IRS or any other entity for tax purposes. I agree to complete and return the required **Satisfaction Survey**. *

_____ I understand that if I elect to hire my own individual respite care provider, I am responsible for negotiating the rate of pay with the identified respite services provider. I am also responsible for providing any training or instruction the respite care provider(s) of my choice may need to provide services to the respite care recipient.

* Final claims for reimbursement can't be processed until the **Satisfaction Survey**, **W-9 Form**, and the **Reimbursement Form** are received by DARS.

The Virginia Department for Aging & Rehabilitative Services (DARS) administers the *Virginia Lifespan Respite Voucher Program* to provide short-term funding for respite care services, but does not provide these services directly or indirectly.

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.

Signature: _____

Applicant (Primary Family Caregiver)

Date

Print Name: _____

Applicant (Primary Family Caregiver)

Please mail/fax or scan and email this form with the required documentation of disability or special need to:

Virginia Lifespan Respite Voucher Program, ATTN: Andi Platea,
Virginia Department for Aging and Rehabilitative Services (DARS),
Virginia Division for the Aging
1610 Forest Avenue, Suite 100,
Henrico, VA 23229;

or Fax to 804/662-7035; or E-mail to Andi.platea@dars.virginia.gov.

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