SENIORS IN SERVICE

1380 Greg Street, Suite 212 • Sparks, NV 89431 • www.seniorsinservicenevada.org

Seniors in Service engages vibrant and experienced volunteers to enrich Northern Nevada communities one life at a time.

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SAMS	
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Respite Voucher Referral Form

Fiscal Year beginning July 1, 2020

Barbara Lewison – Phone# 775-358-3914 – Fax# 775-358-3633
Email: barbara@seniorsinservicenevada.org

To be completed by Patient or Personal Representative

Patient Name: ______________________________________ DOB: ____________

Address: ______________________________ City: ___________ Zip: ________

Phone: ________________ Email: ______________________________________

Primary Language: ( ) English ( ) Spanish ( ) Other (specify) _______________

Live-in Caregiver Name: _______________________________ DOB: __________

Address: ______________________________ City: ___________ Zip: ________

Phone: ________________ Email: ______________________________________

Relationship to Patient: ( ) Spouse/Partner ( ) Child ( ) Parent
( ) Other (specify) ______________________

( ) Proof of Residency is attached for Patient and Caregiver.

Official documentation must be provided proving that caregiver and care receiver reside in the same home physical address. Photocopies of driver's licenses or official identification showing both reside at same address will suffice.

How did you hear about our Program? ______________________________________

Release of Information

Applicant: Please complete the information on the top half of this page and have the patient's physician or professional care provider complete the bottom portion and return it to Seniors in Service. Approval for the respite voucher cannot be completed until we receive the physician or professional provider's statement.

I agree to the release of medical information on:

Name of patient/care receiver: ___________________________________ DOB: _________

Signature: ____ Date: ________________
(Patient Signature or Caregiver Signature if Patient unable to sign; check box below accordingly)

Please check if the patient provided verbal consent instead of signature. ☐

Physician's Statement

Physician:
An application has been submitted for our Respite Voucher Program for the individual named above. In order to provide financial assistance, information regarding your patient's medical condition and the individual's level of care is needed. Please complete the following information and return to:

Seniors in Service - 1380 Greg Street, Suite 212, Sparks, NV 89431
Ph# 775-358-3914 Fax: 775-358-3633 Email: barbara@seniorsinservicenevada.org

Patient Name: _______________________________________ DOB: _________________

Primary Diagnosis: ____

Comments: ____

( ) Patient and Live-in Caregiver would benefit from Respite Care Services.
( ) Patient and Live-in Caregiver do not meet criteria for Respite Care Services at this time.

Physician/Professional Provider Name: ____

Agency Name (if professional provider): ____

Address: ____ Ph# ___________________

Physician/Professional Provider Signature: _______________________________________

Seniors in Service
Respite Voucher Program
Policy Statement

Summary of the program: To provide respite vouchers to qualifying live-in caregivers throughout Northern Nevada. "Respite is for the caregiver and "Care" is for the person requiring medical supervision/care. Respite is a form of temporary relief for the live-in caregiver. If you do not take time off while caring for your loved one, you can burn out. The use of respite services is a way to reduce your stress so you can be a better caregiver.

This program is funded by the
State of Nevada Aging and Disability Services Division.

Definitions

For the purposes of this program, the following terms are defined:

Respite: "Time off" for the primary caregiver of a person who is not safe when left alone or cannot be left alone due to a verifiable medical/chronic condition.

Primary Caregiver: A person who has assumed the responsibility for managing and providing day-to-day care of a person and **who lives in the same household** as the person requiring care.

Care Receiver: The person diagnosed with a medical/chronic condition and who requires supervision/care and assistance in multiple areas of daily living (i.e., bathing, feeding, walking, etc.). Please note that any diagnosis of Alzheimer's or dementia must be referred to the Alzheimer's Association of Northern Nevada, as we cannot duplicate services.

Respite Voucher: The respite voucher is a means to provide reimbursement to the live-in primary caregiver or professional agency for paid respite care.

Seniors in Service: We provide respite voucher services to qualifying live-in caregivers throughout Northern Nevada and south to Tonopah.

Eligibility Criteria

Care Receiver is at least 60 years of age.

Care Receiver lives in the community but not in an assisted living or residential care facility or a nursing home.

Care Receiver has a functional impairment that necessitates someone to provide for safety and well-being in order to remain living at home. (Dementia/Alzheimer's is managed through the Alzheimer's Association, (775) 786-8061.

Care Receiver needs supervision and/or hands on assistance with most ADL's.

Care Receiver has a family member, friend or other unpaid caregiver as primary caregiver to maintain safety and wellbeing.

Caregiver must reside in the same residence as the care receiver. Photo identification required.

Care Receiver lives in one of the following counties: Carson City, Churchill, Douglas, Elko, Humboldt, Lander, Lyon, Mineral, Pershing, Eureka, Nye, Storey, White Pine and Washoe.

We target and give priority to those Care Receiver's whose net income meets 300% of DHHS poverty guidelines, but services are available to those who exceed low-income guidelines.

Please contact Seniors in Service at (775) 358-3914

This is a grant funded program and is contingent upon fund availability and applicant's eligibility. Those who qualify for this grant and who are selected to receive assistance will be notified by phone and mail.

Live-In Caregiver Information

Live-in Caregiver Name: ___________________________________ DOB: ____________

Address: _________________________________ City: _____________ Zip: _________

County: ______________________ Cell#: ________________ Work# _______________

How Many people reside in the home? _________

Gender: ( ) Male ( ) Female

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) Partner

Ethnicity: ( ) Caucasian ( ) Hispanic ( ) Asian
( ) African-American ( ) American Indian/Native Alaskan

Race: ( ) White – Not Hispanic ( ) Hispanic-Latino ( ) Other _________________

Income of Caregiver Only: *This is used for data purposes only and will not affect eligibility.*

( ) Under $8000 ( ) $8001 - $11,999 ( ) $12,000 - $14,999
( ) $15,000 - $19,999 ( ) $20,000 - $29,999 ( ) $30,000 - $39,999
( ) Other ___________________

Employment Status: ( )Full-time ( )Part-time ( )Retired ( )Homemaker ( )Unemployed

Respite Care Desired:
( ) In Home Care ( ) Adult Day Care ( ) Overnight care outside of home

When do you anticipate using respite care? _______________________________

YES	NO	
( )	( )	Do you live in same household as Patient?
( )	( )	Have you received a Respite Voucher from Seniors in Service in prior years?
( )	( )	Have you received a Respite Voucher from the Alzheimer's Assoc. in prior years?

Patient Information

Patient Name: ______________________________________ DOB: ____________________

Gender: ( ) Male ( ) Female

Ethnicity: ( ) Caucasian ( ) Hispanic ( ) Asian
( ) African-American ( ) American Indian/Native Alaskan

Race: ( ) White – Not Hispanic ( ) Hispanic-Latino ( ) Other __________________

Are you: Unable to leave your home without assistance? ( ) Yes ( ) No
A veteran/served in Armed Forces? ( ) Yes ( ) No
On State of Nevada Medicaid? ( ) Yes ( ) No

Which services are you or the patient currently using?

( ) Companion ( ) Friendly Visitor ( ) Homemaker Services ( ) Personal Care
( ) Adult Day Care ( ) Transportation Services ( ) Support Groups ( ) Counseling
( ) Caregiver Training Program ( ) Home Delivered Meals ( ) Hospice
( ) Other (please explain): ____

( ) Yes ( ) No Patient has a condition that requires assistance for their safety and wellbeing.

Chronic Illnesses Affecting Patient:

( ) Cancer Type? ____ _____
( ) Stroke/CVA Date of Last Stroke/CVA: ______________________________
( ) Multiple Sclerosis When was it diagnosed? ______________________________
( ) ALS When was it diagnosed? ______________________________
( ) Parkinson's disease When was it diagnosed? ______________________________
( ) Brain Injury When was it diagnosed? ______________________________
( ) Para/Quadriplegic When was it diagnosed? ______________________________
( ) Respiratory/COPD When was it diagnosed? ________________________________
( ) Other impairment
Please explain if this is a primary diagnosis: ______________________________________

Ambulation: ( ) Walker ( ) Wheelchair ( ) Cane ( ) Other _________________________

Patient Information *(continued)*

How much assistance is provided to the Patient?

Eating:	( ) None	( ) Setting up food	( ) Feeding	
Getting in and out of Bed:	( ) None	( ) Occasional	( ) Always	( ) Bed-Bound
Getting around house:	( ) None	( ) Verbal Direction	( ) Hands on Assist	
Getting around outside:	( ) None	( ) Supervised	( ) Hands on Assist	
Dressing/Bathing:	( ) None	( ) Supervised	( ) Hands on Assist	
Toileting:	( ) None	( ) Supervised	( ) Hands on Assist	
Taking Medication:	( ) None	( ) Reminders	( ) Hands on Assist	
Managing Money:	( ) None	( ) Supervised	( ) Managed	

Is there anything you would like us to know when considering your request? _______________

____

How long have you been caring for this person: _________ Years __________ Months

Care Receiver Monthly Expenses

Rent/Mortgage: __________ Utilities: __________ Taxes: _____________

Prescriptions: __________ Therapy: __________

Transportation (including auto insurance, fuel, taxi, public transportation) _______________

Medical Expenses (including Doctor visits, insurance premiums and co-pays) _____________

Paid Out-of-Pocket Respite Care (Other than Seniors in Service Voucher) ______________

Total Monthly Expenses: _____________ **Total Monthly Income:** _______________

Staff Use Only:

Patient Annual Income:__________ Less:__________ Net Income:__________

By signing below, the caregiver agrees that this information is accurate and true. Caregiver agrees to provide Seniors in Service with any changes as soon as they become aware of such changes.

____ Date: _____________

(Signature of Live-In Caregiver)

Residency Statement:

The Patient, ________________________, has lived in Nevada for ____ years and ____ months.

____ Date: _____________

(Signature of Live-In Caregiver)

Release of Information

I, ____, give my permission for any representative of
(Print Patient's Name)
The Seniors in Service Respite Voucher Program to communicate with various service agencies, physicians and/or organizations to which I have been referred or from which I am currently receiving services. **This release allows the Seniors in Service Respite Program to both give and receive verbal and/or written information about myself.**

____ Date: _____________
(Patient OR Power of Attorney signature)

RESPITE PROGRAM APPLICANT SURVEY

To Be Completed by Caregiver

Current Level of Stress	( ) High	( ) Medium	( ) Low
Your Ability to Take Time for Yourself	( ) Poor	( ) Fair	( ) Good
Current Emotional Health	( ) Poor	( ) Fair	( ) Good
Access to Caregiver Support	( ) Poor	( ) Fair	( ) Good

Comments regarding your needs as a caregiver:

____
____
____
____

Seniors in Service does welcome donations to support this program. Services will not be denied to those who choose not to make a donation.