



SENIORS IN SERVICE

1380 Greg Street, Suite #230, Sparks, NV 89431 • www.seniorsinservicevada.org
Seniors in Service engages vibrant and experienced volunteers
to enrich Northern Nevada communities one life at a time.

Respite Voucher Application

Fiscal Year beginning July 1, 2021

Barbara Lewison – Phone# 775-358-2768 – Fax# 775-358-3633
Email: barbara@sisnv.org

<i>Office Use Only</i>	
Approved	
Packet	
SAMS	
QB	

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? _____



Foster Grandparent Program • Senior Companion Program • Caregiver Voucher Program
Phone: 775-358-2768 Fax: 775-358-3633 or 775-358-2783



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:

Patient Name: _____ 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 required level of care is needed. Please complete the following information and return to:

Seniors in Service - 1380 Greg Street, Suite 230, Sparks, NV 89431
Ph# 775-358-2768 Fax: 775-358-3633 Email: barbara@sisnv.org

Physician/Professional Provider Name: _____

Agency Name: _____

Address: _____ Ph# _____

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 Signature: _____

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.

Respite Voucher Program 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# _____

Gender: Male Female

Marital Status: Single Married / Partner Divorced Widowed

Ethnicity: Caucasian Hispanic Asian African-American
 American Indian/Native Alaskan Other _____

How Many people reside in the home? _____

Emergency Contact Name & Phone#: _____

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

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

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

Patient's 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:** _____

Office Use Only:

Annual Income: _____ Expenses: _____ Net Income: _____ < 300% PGL () Yes () No

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

(Signature of Live-In Caregiver) Date: _____

Residency Statement:

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

(Signature of Live-In Caregiver) Date: _____

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	<input type="checkbox"/> High	<input type="checkbox"/> Medium	<input type="checkbox"/> Low
Your Ability to Take Time for Yourself	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Good
Current Emotional Health	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Good
Access to Caregiver Support	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> 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.***