

Office Use Only:

- Federal Grant Other
 DOH



Application for Lifespan Respite Voucher

<i>Please print</i>	Unpaid Family Caregiver <i>(family, friend, or neighbor)</i>	Individual in Need of Care
Caregiver Name:		
Prefers to be called:	<i>(e.g. first name, or "Mrs. __")</i>	
Relationship:		
Age <i>(to offer resources.)</i> :		Age: _____ Birth Date: <u> </u> <u> </u> / <u> </u> / <u> </u> <i>month/year</i>
Street Address:		<input type="checkbox"/> Same as caregiver If different, note below:
Mailing Address:		
City/Town:		
Zip Code:		
Home County:		
Phone Number:		<input type="checkbox"/> Preferred method of contact
Alternate Phone:		<input type="checkbox"/> Preferred method of contact
Email:		<input type="checkbox"/> Preferred method of contact

Where did you learn about this program (website, organization, etc.)?

Name of individual who referred you: _____ Phone: _____

Agency: _____ Email: _____

May we contact the above individual for additional information? No Yes

Name(s) of others I authorize to facilitate a respite voucher for me (case managers, referents, family members who may speak on my behalf):

Additional information about my caregiving situation:

I provide care, supervision, and/or monitoring **40 or more hours** per week. No Yes

The person receiving my care **is receiving an in-home or out-of-home service** through a formal program (MPC, COPEs, VA, etc.) No Yes

If yes, name of program: _____

I receive respite care through a formal or public system (DDA, VA, FCSP, etc.) No Yes

If so, which agency? _____

If on a wait list, how long has it been? _____

I am a foster parent. I am a kinship caregiver; e.g., grandparent with guardianship/custody.



The individual I provide care/supervision for has (check all that apply):

- A physical disability (*hip surgery, stroke, TBI, etc.*)
- An emotional or behavioral concern
- Mental health condition
- Medical support needs (medication reminders, etc.)
- An intellectual / developmental disability
- A memory condition (Alzheimer's, dementia, etc.)
- Another diagnosis (ASD, Down Syndrome, etc.)
- Assistance with one or more daily living activities (feeding, dressing, bathing, etc.)

What, if any, diagnoses exist? _____

What is the reason you feel you could use a short break from caregiving? _____

Please tell us a little more about yourself and your loved one. The information provided in this application may be entered into a statewide database to show caregiver needs and trends, and, hopefully to assist in gaining additional funding for future programming.

CAREGIVER Information:		
<p><u>MARITAL STATUS</u></p> <input type="checkbox"/> Married / Committed partner <input type="checkbox"/> Divorced / Separated <input type="checkbox"/> Single <input type="checkbox"/> Widowed	<p><u>INCOME</u></p> <input type="checkbox"/> \$0 – 9,999 <input type="checkbox"/> \$10,000 – 19,999 <input type="checkbox"/> \$20,000 – 29,999 <input type="checkbox"/> \$30,000 – 39,999 <input type="checkbox"/> \$40,000 – 49,999 <input type="checkbox"/> \$50,000 – 59,999 <input type="checkbox"/> \$60,000 – 69,999 <input type="checkbox"/> \$70,000 and up	<p><u>ETHNICITY</u></p> <input type="checkbox"/> Hispanic / Latino
<p><u>HOME LOCATION</u></p> <input type="checkbox"/> Rural <input type="checkbox"/> Suburb Small City <input type="checkbox"/> Urban		<p><u>RACE</u></p> <input type="checkbox"/> African American / Black <input type="checkbox"/> American Indian / Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian / Pacific Islander <input type="checkbox"/> White / Caucasian <input type="checkbox"/> Mixed Race
<p>MILITARY SERVICE: <input type="checkbox"/> Active duty <input type="checkbox"/> Veteran <input type="checkbox"/> Wounded Warrior</p>		

Care RECIPIENT Information:		
<p><u>HOME LOCATION</u></p> <input type="checkbox"/> Rural <input type="checkbox"/> Suburb / Small City <input type="checkbox"/> Urban	<p><u>RACE</u></p> <input type="checkbox"/> African American / Black <input type="checkbox"/> American Indian / Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian / Pacific Islander <input type="checkbox"/> White / Caucasian <input type="checkbox"/> Mixed Race	<p><u>MILITARY SERVICE</u></p> <input type="checkbox"/> Active duty <input type="checkbox"/> Veteran <input type="checkbox"/> Wounded Warrior
<p><u>ETHNICITY</u></p> <input type="checkbox"/> Hispanic / Latino		

I have had the opportunity to review the eligibility requirements and to ask questions to better understand how this voucher works. I attest this application is true and accurate. I give permission for SENIOR SERVICES OF SNOHOMISH COUNTY (SSSC) to report information from this application to the program funder(s), as well as to selected vendor agency (or agencies). I authorize the exchange of information via common methods (phone, in person, postal mail, fax, email) among all parties to coordinate/deliver services on our behalf. I understand respite services will not be paid without prior authorization by SSSC through a Family Caregiver Agreement signed by SSSC, the Respite Provider Agency or Agencies, and myself.

Printed Name: _____ Signature: _____ Date: _____



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