Mississippi Lifespan Respite Voucher Program Application

Family Caregiver Information: The person who is responsible and is the primary caregiver.

Name: _____ D.O.B. _____County: _____

Mailing address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work: _____ Cell: _____ E-mail: _____

Care Recipient (CR) Information: The individual who receives care.

Name: _____ D.O.B. _____County: _____

What is your relationship to care recipient? (parent; grandparent; guardian): _____

Address (if different from above):_____ City: _____

State: _____ Zip Code: _____ Phone: _____ E-mail: _____

Please complete each question. **Is the CR being served by any of the following?**

Community Long Term Care (CLTC) Services: (Medicaid Waiver or Respite Services)

Is the CR eligible for CLTC Services? Yes or No Has the CR applied for CLTC Services? Yes or No

Disability/Special Needs Services:

Does the CR have a disability or chronic illness? Yes or No Please provide information: _____

Veteran Affairs for Disabled Veterans (VA) Services:

Is the CR a disabled Veteran? Yes or No Does the CR get medical care from VA? Yes or No

Does the CR get home services from the VA? Yes or No If yes, what type of services? _____

Insurance Information:

Does the Care Recipient have health insurance? Yes or No

If yes, type of coverage Medicare Medicaid Private _____

Household Information:

Number of family members living in the home _____ Combined annual household income _____

Mississippi Lifespan Respite Voucher Program Application

Preferred type of Respite to take a break from caregiving:

___An In-Home Care Agency

Agency Name: _____

___An out-of-home Care Agency/Facility

Agency Name: _____

___ An at-home private provider that I find, employ and pay out- of-pocket

Private Provider Name: _____

___Other Care Provider (please be specific): _____

Families As Allies will reimburse funds to Caregiver within 30 business days upon receipt of invoice.

Consent to Release Information:

I, _____ parent/guardian give MAC Center staff permission to contact the following organization and to communicate on our behalf to assist with obtaining respite care services.

Signature: _____ Date: _____

Respite Provider (agency you choose):_____

Address: _____ Telephone: _____

Other: _____

Address: _____ Telephone: _____

Initial: [ ] If granted a care voucher, I understand that the Family Caregiver Support Program will be informed in order to help coordinate a MS Respite System that serves families throughout the state.

Initial: [ ] A respite provider, agency, or adult day care program has not been chosen. We agree to allow the MAC Center staff to communicate on our behalf and provide our information to respite service providers to assist with options for care providers. All information will be provided to respite providers with the understanding that records/information will be kept confidential.

Initial: [ ] We are willing [ ] not willing to share our caregiving and respite story with other Mississippians around the state and [ ] give [ ] do not give FAA/MDHS/MFCC permission to use photos of us on flyers and/or on the website. Please contact me for follow-up information if permission is granted.

Mississippi Lifespan Respite Voucher Program Application

CAREGIVER SELF-ASSESSMENT

1. I feel my health is worse and I am getting sick more.	Never	Rarely	Sometime	Often
2. My sleep is affected by stress and responsibility.	Never	Rarely	Sometime	Often
3. My social life has suffered due to caregiving.	Never	Rarely	Sometime	Often
4. I get everything done I need to in a typical day.	Never	Rarely	Sometime	Often
5. I have trouble keeping my mind focused.	Never	Rarely	Sometime	Often
6. I am irritable or angry more than I used to be.	Never	Rarely	Sometime	Often
7. I cry often.	Never	Rarely	Sometime	Often
8. I resent that my loved one needs so much.	Never	Rarely	Sometime	Often
9. I feel lonely.	Never	Rarely	Sometime	Often
10. I feel like I have nowhere to turn for help.	Never	Rarely	Sometime	Often

Printed Name (Parent/Guardian/Caregiver):_____

Signature: _____Date: _____

NOTE: ***Please provide all requested information. We reserve the right to reject incomplete applications.***

Mail or email completed applications to:

MS Department of Human Services
James Davis, Home & Community-Based Coordinator
Division of Aging and Adult Services, 5th Floor
200 South Lamar Street
Jackson, MS 39201 or
Email to james.davis@mdhs.ms.gov

Mississippi Lifespan Respite Voucher Program Application

Relative-Respite-Provider Release and Indemnity Agreement

The undersigned releases and agrees to indemnify The Mississippi Family Caregiver Coalition (MFCC), Families As Allies (FAA), The Mississippi Department of Human Services (MDHS), their officers, directors, employees, agents and representatives, of and from any and all rights, claims, demands and causes of action whatsoever kind and nature. The undersigned has read the above and agrees that in no event will MFCC, FAA, nor MDHS be held liable for any damages, injuries, accidents, or losses suffered by care recipients, caregivers, and/or property while participating in respite service provision and they are hereby released there from.

If a family member (*who does not reside with the care recipient or caregiver*) is chosen to serve in providing compensated Respite, the caregiver and care recipient may choose not to require a background check.

This agreement may not be modified orally or in writing by any individual.

_____

Care Recipient/Guardian Signature Date

_____

Print Care Recipient Name

_____

Caregiver Signature Date

_____

Print Caregiver Name

_____

Address City State Zip

_____

Telephone Number E-mail

_____

Witness Signature Date

_____

Print Witness Name