Directions for filling out the application are at the end of the application.

Return to:
DEAP
2200 Box Elder Suite 151
Miles City, MT 59301
attn: Vicki Clear

Application for Respite Voucher

Section 1

Care Recipient Information

These questions are about the person who is to be cared for.

Last Name:_____ **First Name:** _____

Address: _____ **Apt:** _____

City:_____ **State:** _____ **Zip:** _____

Telephone: _____ **Date of Birth:** _____

Gender: ☐ Male ☐ Female **Is the care recipient a veteran?** ☐ Yes ☐ No

Race: ☐ Native American or Alaska Native ☐ Asian or Asian American

☐ African American ☐ Native Hawaiian or Pacific Islander ☐ White/Caucasian

Ethnicity: ☐ Hispanic or Latino **# of people in household** _____

About the Care Recipient – answer all that apply:

Medical/Mental Health Diagnosis: _____

Disability: _____

Unable to be Left Unattended: _____

Other: _____

Living Arrangement: ☐ Alone ☐ With spouse only ☐ With spouse & other relatives

☐ With other relatives ☐ With Grandparent(s) ☐ With non-relative ☐ With parent(s)

☐ With son or daughter ☐ With grandchild ☐ With brother or sister

My caregiver is my: ☐ Wife ☐ Husband ☐ Daughter ☐ Son ☐ Brother ☐ Sister

☐ Daughter/Son (in-law) ☐ Mother ☐ Father ☐ Grandchild ☐ Other Relative

☐ Non-Relative (specify) _____

Section 2

Primary Caregiver Information

These questions are about the caregiver – the person who does the caregiving.

Last Name:_____ **First Name:** _____

Mailing Address: _____ **Apt:** _____
(If caregiver does not live with care recipient, please provide proof of address)

City: _____ **State:** _____ **Zip:** _____

Telephone: _____ **Cell phone:** _____

Email: _____ **Date of Birth:** _____

Gender: ☐ Male ☐ Female **Are you a veteran?** ☐ Yes ☐ No

Race: ☐ **Native American or Alaska Native** ☐ **Asian or Asian American**

☐ **African American** ☐ **Native Hawaiian or Pacific Islander** ☐ **White/Caucasian**

Ethnicity: ☐ **Hispanic or Latino**

Number of hours the caregiver is responsible for care recipient in an average week: _____

Type of services I'm interested in for the care recipient:

☐ In-home hourly care ☐ Temporary overnight care ☐ Adult Day Care

☐ Social Outing ☐ Crisis Care ☐ Other _____

☐ I need more information about choices: _____

Are you receiving any respite services now? (anything that could be considered a break from caregiving)

☐ Yes – If yes, what service(s)? _____ ☐ No

Agency or Program: _____ Funding Source: _____

Regular Care Provided by Primary Caregiver

As the caregiver for this individual, I regularly (daily/weekly assist him/her with the following: (check all that apply)

Basic Activities of Daily Living:

- ☐ Personal hygiene bathing/grooming ☐ Feeding
- ☐ Dressing and undressing ☐ Toileting
- ☐ Bowel and bladder management – including incontinence care
- ☐ Transferring/walking (moving from bed to wheelchair, getting on and off toilet)

Inability of Care Recipient to perform:

- ☐ Housework ☐ Meal preparation
- ☐ Medication management ☐ Shopping
- ☐ Money management ☐ Transportation
- ☐ Using the telephone and other communication devices

Special Health Care:

- ☐ Medical equipment (oxygen, feeding tube, respiratory equipment, etc.)
- ☐ Medication (prescribed, ongoing)
- ☐ Nursing assistance (visits regularly)
- ☐ Diabetes (insulin dependent/special diet)
- ☐ Use of wheelchair, cane, crutches, braces, or walker
- ☐ Incontinence – How often? _____
- ☐ Other specialized care needs _____

Care Recipient has difficulty:

☐ Seeing ☐ Hearing ☐ Communicating ☐ Comprehending

The Care Recipient has the following specific conditions:

- ☐ Aggressiveness ☐ Diabetes ☐ Acting out/impulsive
- ☐ Alzheimer's ☐ Dementia ☐ Autism
- ☐ Traumatic Brain Injury ☐ Mental Health Issues
- ☐ Seizures – Type _____

Homebound (cannot leave home without considerable assistance):

☒ Yes ☐ No

Income Information

In order to determine our level of cost sharing please…
Complete Section A if you are caring for someone 18 or older
OR
Complete Section B if you are caring for someone under 18 years old

In the appropriate box list **all** Income – Taxable and non-taxable
(Married couples must report their combined income)

Please check one: Income below is from the past: ☐ **Year** ☐ **90 days**

Section A: ***Care Recipient (<u>and Spouse</u>) Income Information if the Care Recipient is <u>18 or older</u>:***

All Income Reported on Tax Return (As reported annually to the IRS)	$
Social Security/SSI/SSDI (If not reported on tax return)	$
Other Income (If not reported on tax return)	$

Section B: ***Caregiver Income Information if the care recipient is under 18 years old:***
*****Number of dependents living in household (including yourself/spouse): _____**

All Income Reported on Tax Return (As reported annually to the IRS)	$
Social Security/SSI/SSDI (If not reported on tax return)	$
Other Income (If not reported on tax return)	$

<u>Attach documentation for all income listed above.</u>

Medical Expenses

No matter which of the above Income Information sections you filled out, please include information about your medical expenses, if applicable. By submitting your Medical Expenses, we may be able to reduce your co-pay.

Medical Expenses – Please enter the amount of medical expenses paid over the past:

Year $_____ **OR** **90 Days** $ _____

Please refer to the *Medical Expenses* portion of the *Application Instructions* for details on eligible medical expenses.

You MUST send the following items with your application:

Proof of Primary Caregiver's Address (if living separate)
Proof of Care Recipient's Age
Income Verification
Medical Expense Verification (if any)
Modified Caregiver Strain Index

I certify, under penalty of perjury, that the information provided in this application is true and accurate.

Signature of Caregiver: _____

Date: _____

*******Where did you hear about this respite voucher program:***

_____

Application Instructions

To avoid any delay in processing application, please complete the **entire** application and include appropriate documentation. Application must be signed **by the primary caregiver**.

SECTION 1 – COMPLETE FOR *CARE RECIPIENT* INFORMATION:

Date of Birth: Acceptable proof includes a copy of the care recipient's birth certificate, driver's license, or State ID card.

Medical/Mental Health Diagnosis: Give a brief description of the medical or mental health diagnosis in the space provided on the application.

SECTION 2 – COMPLETE FOR *CAREGIVER* INFORMATION:

Proof of the primary caregiver's address must be included with this application. Acceptable proof includes a copy of the caregiver's current driver's license, State ID card or a utility bill.

Income Information: If care recipient is ***over the age of 18 years*** old the amount of cost share is based on the income of the care recipient and spouse, if applicable. If the care recipient is ***under the age of 18***, the cost share is determined by the household income.

Income Verification Requirements: All income must be reported and verified. Married couples living together must report and verify income of both spouses. Acceptable proof includes a copy of your most recent Income Tax Return, 1099 statements, Social Security award letter, pension checks, or bank statements. If applicable, include proof of interest, dividends, rental income, stocks and bonds.

If your tax return does not list your Social Security income (Form 1040A line 13a or Form 1040 line 20a) or if you do not file a tax return, you must send us a benefit award letter or bank statement providing how much Social Security and other income you received.

Other Income:
If you do not file an income tax return, the "Other Income" box is for pensions or other income that is not taxable but is considered income.

Medical Expenses: Ongoing paid medical expenses are deducted from your monthly income which reduces your countable income and may reduce your share of cost. Individuals applying on the basis of the last calendar year's income may report medical expenses paid during the previous 90 days.

Medical expenses include paid bills from physicians, dentists, vision and hearing specialists and other health care professionals, medical insurance including Medicare premiums and deductibles, ambulatory health care facilities, prescription medicines, institutional care, dental, vision and hearing devices, prosthetic and auxiliary apparatus. Proof of claimed medical expenses must be included with your application. Acceptable proof includes copies of paid receipts from your health insurance plan, receipts or print-outs of paid pharmacy bills or any other paid medical bills.