# Mississippi Lifespan Respite Initial 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; child; guardian; other): _____

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?**

**Respite Service:** Does the CR currently receive respite service? Yes or No

***If yes, please do NOT continue to fill out the application.**

**Insurance Information:**

Does the Care Recipient have health insurance? Yes or No

If yes, type of coverage Medicare Medicaid Private_____

**Disability/Special Needs Services:**

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

**Household Information:**

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

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**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): _____

MDHS will reimburse funds to Caregiver within 30 business days upon receipt of invoice.

**Consent to Release Information:**

I, _____ parent/guardian give MAC Center/MDHS 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(provider):_____

Address: _____ Telephone: _____

**Initial:** [ ] If granted a respite 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 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.

**CAREGIVER SELF-ASSESSMENT**

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| | | | | | |
|---|---|---|---|---|---|
| 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 (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

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**Relative-Respite-Provider Release and Indemnity Agreement**

The undersigned releases and agrees to indemnify The Mississippi Family Caregiver Coalition (MFCC), 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, 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.***

_____

Print Care Recipient Name

_____

Print Caregiver Name Date

_____

Caregiver Signature

_____

Address City State Zip

_____

Telephone Number E-mail