HELPING HANDS of VEGAS VALLEY
2320 Paseo Del Prado B-204, Las Vegas, NV 89102
(702) 633-7264 ext. 26 or Fax (702) 728-2963

RESPITE CARE VOUCHER PROGRAM

Dear Applicant:

Thank you for your interest in the Helping Hands of Vegas Valley Respite Care Voucher Program. The program is designed to serve those who are in need of a break from being a care giver and designed to reach as many people as possible.

Our respite program, funded by the State of Nevada Aging & Disability Services Division, provides short-term relief from the physical, emotional and daily demands of caring for an individual in the home. Respite funds must be used to obtain needed services to provide a break from caregiving. Services that can be paid for through the respite program include:

- **Facility Overnight Stay** – Short term stay in a facility to provide a break from caregiving
- **In Home Care** – Services may include personal care, companionship and homemaking duties
- **Adult Day Care** – Provides supervised activities and socialization

Please complete and return the entire application, making sure that all sections of the application are filled out before mailing it back to our office. **We are unable to process an incomplete application.** Please print clearly and include signatures where indicated. Further, you must select a respite provider from our approved list of licensed agencies (see provided list). Approval of respite is dependent upon available funding.

Once approved, both the agency provider and the caregiver will be sent a voucher for respite services in a designated amount. The agency provider will bill Helping Hands of Vegas Valley directly. The money must be used within **90 days** of being issued. Helping Hands of Vegas Valley will not be responsible for charges that exceed the voucher amount of those that fall outside of the authorized dates. **Once the voucher has expired, any remaining funds will automatically be returned to the respite program**. If for some reason, you are unable to utilize the awarded respite funds, please notify the undersigned as soon as possible, so that the funds can be redistributed to another family in need.

Please retain this page for your own records. If you have questions about filling out the application, please call us at **702.633.7264 ext. 26**. Or you can e-mail me at: cory.lutz@hhovv.org.

Sincerely,

Cory Lutz
Respite Care Coordinator

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Application Check List:

Please Complete and return the following with this page:

☐ **Proof of Address** (Either a NV ID or NV Driver's License must be submitted. The addresses for the Caregiver and Recipient/Patient must be the same, and match the address on the application.
(A utility bill with the persons' name or Social Security statement may be substituted in place of the NV ID.)

☐ **Completed Application Page**

☐ **Completed Certificate of Eligibility**

☐ **Completed Release of Liability**

If you do not submit a complete application, including proof of address, your application will be set aside and not processed.

To my knowledge I am submitting a complete application for the Helping Hands Respite Voucher Program. I understand that if approved, we will have 90 days to complete the voucher.

Signature of Caregiver: _____

Date: _____

HELPING HANDS of VEGAS VALLEY
2320 Paseo Del Prado B-112, Las Vegas, NV 89102
(702) 633-7264 ext. 26 or Fax (702) 649-6438

Respite Voucher Application

Patient/Recipient NAME (First/Last): _____ ☐ MALE ☐ FEMALE

DATE OF BIRTH: ____/____/____ PHONE NUMBER: (____) _____

PHYSICAL ADDRESS: _____ MAILING ADDRESS: (If Different) _____

☐ **Veteran** ☐ **Veteran Dependent** ☐ **U.S. Citizen**

CAREGIVERS CONTACT INFORMATION ***(Attach additional papers if more than one person):***

NAME (First/Last): _____ RELATIONSHIP: _____

HOME PHONE: (____) _____ WORK OR CELL PHONE: (____) _____

E-Mail: _____

Patient /Recipient's Information:

☐ **Married** ☐ **D** ☐ **W** ☐ **Single** ☐ **Separated**

ETHNICITY

☐ HISPANIC OR LATINO ☐ NON-HISPANIC OR LATINO

RACE

☐ WHITE, CAUCASIAN ☐ ASIAN
☐ BLACK / AFRICAN AMERICAN ☐ HISPANIC
☐ AMERICAN INDIAN / ALASKAN NATIVE
☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
☐ OTHER _____

If you do not speak English, what is your primary language?_____

According to the current Federal Poverty Guidelines, YOUR (Senior and spouse, if applicable only) INCOME IS:
(see back of page for current Poverty Guidelines)

A. POVERTY: ☐ BELOW **OR** ☐ ABOVE

B. 300% Supplemental Security Income: ☐ BELOW **OR** ☐ ABOVE

ARE YOU DISABLED? ☐ Yes ☐ No
If you are disabled, do you use:
☐ Wheelchair ☐ Able to transfer
☐ Walker ☐ Cane ☐ Power Chair
☐ Other_____

Frail? ☐ Yes ☐ No
Homebound? ☐ Yes ☐ No
Medicare Eligible? ☐ Yes ☐ No
Receiving Social Security? ☐ Yes ☐ No

WHICH OF THE FOLLOWING ARE YOU *UNABLE* TO PERFORM WITHOUT ASSISTANCE?

Activities of Daily Living (ADLs)
Without assistance, I am unable to:

☐ Bathe ☐ Get Dressed
☐ Eat ☐ Use the Bathroom
☐ Walk ☐ Transfer In or Out of a Bed or Chair
☐ **None – I can perform these activities**

Instrumental Activities of Daily Living (IADLs)
Without assistance, I am unable to:

☐ Prepare Meals ☐ Do Light Housework
☐ Take Medication ☐ Do Heavy Housework
☐ Manage Money ☐ Use the Telephone
☐ Shop ☐ Use Transportation Services
☐ **None – I can perform these activities**

☐ I was provided with the *Notice of Privacy Practices*

☐ **Yes** ☐ **No Caregiver resides in the same household as the recipient.**

By signing below, the caregiver agrees that the information provided is accurate and agrees to provide Helping Hands of Vegas Valley with information for verification purposes to determine need. **Any information subsequently found to be false may void the grant.**

▶ **Signature of Caregiver:** _____ **Date:**

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
2015 FEDERAL POVERTY GUIDELINES

A.	Poverty Guidelines *48 Contiguous States and D.C.*	
	Annual Income	**Monthly Income*** (Senior and Spouse only)
1	**$11,770**	**$980.83**
2	**$15,930**	**$1,327.50**
3	**$20,090**	**$1,674.17**
4	**$24,250**	**$2,020.83**
5	**$28,410**	**$2,367.50**
6	**$32,570**	**$2,714.17**
7	**$36,730**	**$3,060.83**
8	**$40,890**	**$3,407.50**
For family units with more than 8 members, add the following amount for each additional family member: $4,160 per year		
SOURCE: *Federal Register* / Vol. 80, No. 14 / January 22, 2015 / pp. 3236 – 3237 *Monthly income was calculated by dividing the Poverty Guideline, which is an annual figure, by 12 (months).		

B.

Social Security Administration
Supplemental Security Income (SSI)

Senior/Client *only*

Per Month

If the ***Senior*** makes less than $2199.00/ month, please mark that they are ***below*** 300% SSI.

If the ***Senior*** makes more than $2199.00/month, then please mark that they are ***above*** 300% SSI.

Thank you.

CERTIFICATE OF ELIGIBILITY

FOR RESPITE CARE VOUCHER PROGRAM

_____(Caregiver) has requested financial aid for respite care for their loved one.

This statement is to certify that_____(Recipient) is in my care and is in need of continuous supervision.

This statement must be signed by a licensed healthcare practitioner, who is responsible for recipient's diagnosis and ongoing care such as a physician, nurse or social worker. This information will be verified.

_____ _____

Signature (Dr., Nurse or SW) **Printed Name**

_____ _____

Date **State License # (Required)**

_____ _____

Company / Organization name **Phone #**

_____

Street Address

_____

City, State, ZIP

Recipient's Primary Diagnosis :

_____

_____

_____

VOUCHER INFORMATION

(This must be signed in order to process the application)

Select the type of respite you would like to receive (If known at this time):

☐ In home care ☐ Adult Day Care ☐ Facility Overnight Stay

Provider Requested: _____

An agency/provider must be selected. If you do not know which agency you will use, we will provide you a list upon approval of the voucher. The provider must be chosen from our approved provider list.

Caregiver's Signature:_____ Date:_____

RELEASE OF LIABILITY

(This must be signed in order to process the application)

I_____(Caregiver) hereby agree to accept a voucher through Helping Hands of Vegas Valley respite care program to provide services for _____ _____(Care Recipient). I understand it is my responsibility not to exceed the amount of the voucher.

Helping Hands of Vegas Valley assumes no liability or responsibility for injury, accident, or negligence by your chosen provider that may occur to (Care Recipient) _____ _____while services are received under this grant.

Caregiver's Signature:_____ Date:_____

VERIFICATION OF INFORMATION

(This must be signed in order to process the application)

By signing below, the caregiver agrees that information provided is accurate and agrees to provide Helping Hands of Vegas Valley with information for verification purposes to determine need. **Any information subsequently found to be false may void grant.**

Caregiver's Signature:_____ Date:_____