Desert Southwest Chapter

alz.org/dsw
800.272.3900

Chapter Office & Central Arizona Region
340 E Palm Ln, Suite 230
Phoenix, AZ 85004

602.528.0545 **p**
602.528.0546 **f**

Northern Arizona Region
3111 Clearwater Dr, Suite A
Prescott, AZ 86305

928.771.9257 **p**
928.771.9297 **f**

Southern Arizona Region
1159 N Craycroft Rd
Tucson, AZ 85712

520.322.6601 **p**
520.322.6739 **f**

Southern Nevada Region
5190 S Valley View Blvd #104
Las Vegas, NV 89118

702.248.2770 **p**
702.248.2771 **f**

alzheimer's association®

SNV Respite Voucher Program
Caregiver Application Packet

Dear Caregiver,

Thank You for your interest in applying for the Southern Nevada Respite Care Voucher Program. The Program is designed to provide short term relief from the physical and emotional daily demands of caring for an individual with Alzheimer's disease or a related disorder at home. Support is also provided through a Family Care Consultant who is available to assist you in evaluating needs, developing an individualized plan of care and accessing resources. The Respite Care Voucher, if awarded, would be used toward the cost of respite services through a licensed Provider Agency you select that offers:

- ***Facility Overnight Stay -*** Short term stay in a licensed care facility
- ***In Home Care -*** Services include personal care, companionship and homemaking duties
- ***Adult Day Care -*** Provides supervised activities and socialization in a group setting

Funding for this program is available primarily through a grant award to the Alzheimer's Association from the State of Nevada Aging and Disability Services Division. The amount available is limited. If awarded, the Respite Care Voucher can only be used during a sixty (60) day time period that cannot be extended.

Please fully complete/sign the following four (4) forms included in this packet and return with a copy of valid ID

1. **Respite Care Voucher Program Application Form -** two (2) pages to complete and sign
2. **Respite Participation Agreement -** review and sign
3. **Provider Agency Identification and Release of Information Form -** identify the Provider Agency you would like to use and sign the form to give us permission to contact them on your behalf.
4. **Diagnosis Verification Form -** complete and sign the top of this form and provide to the person with dementia's physician's office or other healthcare provider to complete and return to us.
5. **Valid State of Nevada photo ID or Proof of Residency for caregiver and care recipient -** *Must reside in same home*

We have also included a sixth *optional* form in this packet. The MedicAlert®+Safe Return® Program provides protection for the person with dementia who may wander and become lost. If you would also like to be considered for a full or partial enrollment scholarship for this program, we invite you to also complete and return the attached Scholarship Application Form.

We are unable to begin processing your application until all five (5) of the above Respite Care Voucher Program items above are completed and returned to our office. Please call us at 702-248-2770 if you have any questions or would like assistance completing these forms.

Please don't forget to take care of yourself as well, while you are caring for an individual with dementia.

Sincerely,

Nika Harris

Nika Harris
Office Manager

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Desert Southwest Chapter

RESPITE CARE VOUCHER PROGRAM APPLICATION

CARE RECIPIENT INFORMATION

MUST LIVE WITH CAREGIVER

name of person with dementia | date of birth | gender

address | city | state | zip

education
- some high school
- some college
- post / prof degree
- high school graduate
- bachelor degree
- prefer not to say

race / ethnicity
- white
- hawaiian / pacific island
- two or more races
- black / african american
- am indian / alaskan native
- other race
- hispanic / latino
- asian
- prefer not to say

monthly income: _____ **preferred language:** _____

type of insurance
- long-term care insurance
- medicaid
- hospice
- veteran

Primary Diagnosis: _____

Additional health problems that complicate caregiving: _____

CAREGIVER INFORMATION

name of caregiver | date of birth | gender

address | city | state | zip

home phone | work phone | cell phone | email

employment status | relationship to the person with dementia

education
- some high school
- some college
- post / prof degree
- high school graduate
- bachelor degree
- prefer not to say

race / ethnicity
- white
- hawaiian / pacific island
- two or more races
- black / african american
- am indian / alaskan native
- other race
- hispanic / latino
- asian
- prefer not to say

monthly income: _____

Is there another family member of friend who assists you in caregiving and/or in paying bills, who you want copied or contacted in communications about the Respite Care Voucher?

- yes
- no

name | relationship of this person to you

address | city | state | zip

home phone | work phone | cell phone | email

continues on back

RESPITE CARE VOUCHER PROGRAM

Does the care recipient have a medical diagnosis of Alzheimer's disease or a related disorder? ○ yes ○ no

If "no", please explain: _____

Does the caregiver live in the same household as the person with dementia? ○ yes ○ no

If "no", please explain: _____

Have you received a Respite Care Voucher from the Alzheimer's Association in the past year? ○ yes ○ no

PLEASE DESCRIBE THE CARE RECIPIENT'S LEVEL OF FUNCTIONING FOR THESE ACTIVITIES:

	INDEPENDENT *Able to perform the task without assistance*	**SOME ASSISTANCE** *Requires some assistance / supervision*	**DEPENDENT** *Requires constant assistance / supervision*
Bathing	○	○	○
Dressing	○	○	○
Eating	○	○	○
Mobility / Transfers	○	○	○
Toileting	○	○	○
Communication	○	○	○
Taking Medications	○	○	○
Food Preparation	○	○	○
Housekeeping	○	○	○
Managing Finances	○	○	○

THE CARE RECIPIENT DISPLAYS THE FOLLOWING BEHAVIORS:

○ Sleep Disturbances	○ Anger	○ Depression
○ Incontinence	○ Paranoia	○ Agitation
○ Wandering	○ Hallucinations	○ Aggression *(hitting, kicking, throwing objects, physical violence, etc)*
○ Repetitive Actions	○ Delusions	

Please describe the type of assistance you would like through the Respite Care Voucher Program and any of other comments to describe your circumstances that you feel would be helpful to this Application:

_____

_____

Respite Care Vouchers, when awarded, must be used within a sixty (60) day time frame. Extensions of the approved time frame are not possible. Please, state the sixty (60) day time frame that you would prefer, if awarded.

START DATE: _____ **END DATE:** _____

COMPLETED BY _____ **DATE** _____

RETURN COMPLETED FORM TO:

Southern Nevada Region
5190 S Valley View Blvd, Suite 104 - Las Vegas, NV 89118
702.248.2770 p 702.248.2771 f
[redacted]

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Desert Southwest Chapter

Respite Care Voucher Program

RESPITE CARE VOUCHER PROGRAM PARTICIPATION AGREEMENT

I understand that the Alzheimer's Association Desert Southwest Chapter Southern Nevada Respite Care Voucher Program provides limited financial support for families in need of respite and care consultation. Specifically, the program provides the following free of charge:

- **Respite Care Voucher** to pay for respite care provided by qualified community provider agencies. The voucher will identify a care provider that will be paid for respite services provided, up to a maximum dollar amount and within specified dates.
- **Care Consultation** by professional social services staff to help families evaluate needs, develop an individualized plan of care, and access resources available to them within the Chapter and in the community. This service is provided in families' homes, our office or via telephone.
- **Optional** –MedicAlert®+Safe Return® Enrollment Scholarship, depending upon availability of funding.

If I am awarded a Respite Care Voucher, I understand and agree to the following:

- Payment for respite care services will be made by the Alzheimer's Association directly to the respite service providing agency ("Provider Agency") that I select, not to me or to any other family member.
- The Respite Care Voucher may only be used during the 60 day period that will be noted on the voucher. The Alzheimer's Association is unable to provide extensions of these dates. I would be responsible for any payments to the Provider Agency for services before or after the stated dates.
- A maximum amount will be noted on the Respite Care Voucher. I would be responsible for any payments to the Provider Agency for any amounts incurred above the maximum amount.
- I will schedule time to meet with the Family Care Consultant, either in person or by telephone, as part of my receipt of the Respite Care Voucher.

In addition, I will not hold the Alzheimer's Association Desert Southwest Chapter, the Association's employees, Board Members, or volunteers liable for any injury or harm related to or resulting from services provided or arranged through the Southern Nevada Respite Care Program.

By signing below I further agree that:

- The information provided in my application is accurate.
- I will provide the Alzheimer's Association with verification information on request.
- I will provide the Alzheimer's Association with any changes to my current Application.
- I authorize the release of information to the Provider Agency that I select related to the Respite Care Voucher.

Printed Name of Caregiver: _____

Signed: _____ Date: _____

Relationship to the Person With Dementia: _____

FOR OFFICE USE:
Date of Review: _____ Approved: [ ] Yes [ ] No Staff: _____

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Respite Care Voucher Program

PROVIDER AGENCY IDENTIFICATION & RELEASE OF INFORMATION FORM

Select the type of respite care you would like to receive:

- ☐ **Facility Overnight Stay** - Short term stay in a licensed care facility
- ☐ **In Home Care** - Services include personal care, companionship and homemaking duties
- ☐ **Adult Day Care** - Provides supervised activities and socialization in a group setting

A licensed Provider Agency needs to be selected before the Respite Care Voucher may be issued. Please select a Provider Agency from our Resource List.

Name of Provider Agency you would like to use: _____

Address: _____

Phone Number: _____

Authorization to Release Information

Care Recipient's Name: _____

Caregiver Name: _____ Relationship: _____

Address: _____

Phone: _____

I authorize the Alzheimer's Association Desert Southwest Chapter to release information to and obtain information from the Provider Agency I have named above for the purpose of the Southern Nevada Respite Care Program.

Information to be shared may include the Respite Care Voucher with the name and contact information of both the care recipient and caregiver, the type of respite service needed, and communication related to the Alzheimer's Association verification of service provision and receipt of invoices to enable the Provider Agency to be paid on my behalf.

Expiration of Authorization: This authorization to release information to the named Provider Agency will be in effect until the Respite Care Voucher Program services have been fully completed and paid.

Signature: _____ Date: _____

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Respite Care Voucher Program

DIAGNOSIS VERIFICATION FORM

To be completed by Caregiver: Please complete and sign the top of this form. Provide this to the physician's office or other care provider that serves the person with dementia, asking them to complete the bottom section and return to the Alzheimer's Association.

Caregiver's Name: *(please print)* _____

I have applied for assistance through the Southern Nevada Respite Care Voucher Program. I authorize the physician / health care provider named below to verify the diagnosis of (Name of Care Recipient / Patient) _____ (Birth Date): _____ to the Alzheimer's Association Desert Southwest Chapter.

Caregiver's Signature: _____ Today's Date: _____

To be completed by Physician / Health Care Provider: Please complete the following information to verify the diagnosis of Alzheimer's disease or a related form of dementia. The statement is to be signed by a licensed healthcare practitioner who is responsible for the diagnosis and ongoing care of the care recipient / patient, such as a physician or nurse.

_____ _____

Signature *Printed Name*

_____ _____

Date *State License # (Required)*

_____ _____

Practice / Organization Name *Phone #*

_____

Street Address

_____

City *State* *Zip*

Physician / Healthcare Providers, please, remit completed form to:

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