EMERGENCY RESPITE CARE APPLICATION

SECTION A: AGENCY/PROVIDER INFORMATION
(only to be filled out if turned in by an agency)

Agency submitting request:		Date of request:
Address: City/Zip: County/Region:	Email: Phone: Fax:	Reason for emergency respite:
Interviewer name/title:	Website:	Authorized signature:
Type of Request: ☐ Initial ☐ Revision ☐ Cancellation		Print name/title:
Reason for revision or cancellation:		
Date of revision or cancellation:		
Comments:		Date signed:

SECTION B: PRIMARY CAREGIVER INFORMATION (list information of primary caregiver)

Caregiver name:	Age:	SSN:
Alternate caregiver name/phone:	☐ Male ☐ Female	First request for ER: ☐ Yes ☐ No If no, please list date and amount of previous award: Date: Amount:
Race: ☐ White alone ☐ Black or African American ☐ Asian alone ☐ American Indian and Alaska Native alone ☐ Two or more races ☐ Some other race alone ☐ Hispanic or Latino ☐ Not Hispanic or Latino		Employed: ☐ Full time ☐ Part time ☐ Not employed
Address: City/Zip: County of Residence:		Phone: Email: Do you live with the care recipient? ☐ Yes ☐ No
Relationship to care recipient:		
Hours spent caregiving each week: ☐ Under 5 ☐ 5-10 ☐ 11-20 ☐ 20+ ☐ Full time 24/7		
Household income: ☐ Less than $14,999 ☐ $15,000 - $24,999 ☐ $25,000 - $50,000 ☐ Above ☐ Unemployed		

EMERGENCY RESPITE CARE APPLICATION

SECTION C: CARE RECIPIENT INFORMATION (person needing direct care)

<table>
<tr><td colspan="2">Care recipient name:</td><td>Age:</td><td>Date of birth:</td></tr>
<tr><td colspan="2">SSN:</td><td colspan="2" rowspan="3">Race:

☐ White alone
☐ Black or African American
☐ Asian alone
☐ American Indian and Alaska Native alone
☐ Two or more races
☐ Some other race alone
☐ Hispanic or Latino
☐ Not Hispanic or Latino</td></tr>
<tr><td>Sex:
☐ Male
☐ Female</td><td>Below Poverty:
☐ Yes
☐ No</td></tr>
<tr><td colspan="2">On State Funded Waiver Program: ☐ Yes ☐ No

Type of Waiver:

Which State Agency:</td></tr>
<tr><td colspan="2" rowspan="3">Address (if different):

City/Zip:

County:

☐ Townhouse
☐ Apartment
☐ Single Family Home</td><td colspan="2">Living arrangements:
☐ With caregiver in home of care recipient
☐ With caregiver in caregiver's home
☐ With other family member or friend
☐ Lives alone</td></tr>
<tr><td colspan="2">Primary diagnosis/disease/disability:</td></tr>
<tr><td colspan="2">Please note any allergies or intolerances:</td></tr>
<tr><td colspan="2">Home phone:</td><td colspan="2" rowspan="3">Comments:</td></tr>
<tr><td colspan="2">Cell phone:</td></tr>
<tr><td colspan="2">Email:</td></tr>
</table>

SECTION D: ADDITIONAL RESOURCES

(please list additional resources/services the care recipient is receiving)

EMERGENCY RESPITE CARE APPLICATION

SECTION E: EMERGENCY RESPITE CARE SERVICES (use additional pages if needed)

Why does the caregiver need emergency respite services?
How will the services benefit the caregiver? What will they be doing during their respite time?
Does the caregiver typically receive respite services from another program? If so, which program?
Is there any other available source of funding besides Emergency Respite? ☐ Yes ☐ No Please list any other funding sources that were explored for this request:
In your opinion, would the care recipient be "at risk" if the caregiver didn't receive these services? If so, how (i.e. left alone, risk of institutionalization, etc)?
Without emergency respite care, what alternate choices would the caregiver have for services? ☐ None ☐ Hospital ☐ Long term care facility ☐ Use alternate caregiver (when possible) ☐ Other:
Location where respite care will be provided: ☐ In home of caregiver ☐ In home of care recipient ☐ Adult day center ☐ Child day care ☐ Adult nursing home ☐ Other:
PLEASE FILL OUT THE FOLLOWING DETAILS OF THE RESPITE CARE YOU ARE REQUESTING: (this may be changed or answered upon approval)

Amount of respite care needed (hours/days):	Respite care rates requested (hours or daily rate times the numbers of hours/days needed):
Time(s) and Date(s) of service:	☐ Hourly: ☐ Day rate:

EMERGENCY RESPITE CARE APPLICATION

Name of person to provide respite care:	SSN:
Name of agency to provide respite care:	Tax ID:
Agency contact person (name/title):	Phone (agency or respite provider):

SECTION F: CRITERIA FOR EMERGENCY RESPITE FUNDS (CHECK ALL THAT APPLY):

☐ Care recipient is living in a non-institutional setting ☐ Care recipient's health and safety are "at risk" ☐ Care recipient requires trained respite worker ☐ Care recipient cannot be cared for by an untrained neighbor, friend, or family member ☐ Care recipient cannot be left alone at any time ☐ Care recipient can receive respite care safely ☐ Child with special needs ☐ Adult with special needs ☐ Other, explain:	☐ Caregiver illness (physical, mental, emotional) ☐ Caregiver hospitalization/doctor appointment ☐ Illness of a loved one ☐ Funeral/wake ☐ Drug/alcohol abuse counseling/support ☐ Preparation for care recipient to transition between living arrangements ☐ Risk of loss of employment ☐ Work related situation/function ☐ Other family emergency or need

By signing below, I certify that I have read and understand the Emergency Respite Program Requirements & Instructions. I hereby affirm that all information provided within this application is accurate and precise. I give my consent for the IRC Coordinator to verify whether or not my household is receiving supports from any other agency or provider, paid or unpaid. I acknowledge that any attempt to provide inaccurate or untruthful documentation may disqualify me from receiving funding from the IRC now or in the future.

X _____ X _____

Primary Caregiver Signature Date

SUBMIT ALL NECESSARY DOCUMENTATION TO:

Illinois Respite Coalition
Attn: Tina Yurik, IRC Director
17314 S. Kedzie Ave
Hazel Crest, IL 60429

Phone: (630) 207-8479 Fax: (708) 335-0022
Email: ilrespitecoalition@gmail.com

EMERGENCY RESPITE CARE APPLICATION

SECTION G: AUTHORIZATION FOR EMERGENCY RESPITE SERVICES:

FOR LIFESPAN RESPITE PROGRAM USE ONLY	
Number of hours approved:	
Discussion notes to determine need:	Action taken: ☐ Approved ☐ Denied ☐ Date of action:
Lifespan respite authorizing signature:	Date: