

**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:	Email:	Reason for emergency respite:
City/Zip:	Phone:	
County/Region:	Fax:	
Interviewer name/title:	Website:	Authorized signature:
Type of Request: <input type="checkbox"/> Initial <input type="checkbox"/> Revision <input type="checkbox"/> 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:	<input type="checkbox"/> Male <input type="checkbox"/> Female	First request for ER: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please list date and amount of previous award: Date: Amount:
Race: <input type="checkbox"/> White alone <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian alone <input type="checkbox"/> American Indian and Alaska Native alone <input type="checkbox"/> Two or more races <input type="checkbox"/> Some other race alone <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino		Employed: <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Not employed
Address:		Phone:
City/Zip:		Email:
County of Residence:		Do you live with the care recipient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Relationship to care recipient:		
Hours spent caregiving each week: <input type="checkbox"/> Under 5 <input type="checkbox"/> 5-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 20+ <input type="checkbox"/> Full time 24/7		
Household income: <input type="checkbox"/> Less than \$14,999 <input type="checkbox"/> \$15,000 - \$24,999 <input type="checkbox"/> \$25,000 - \$50,000 <input type="checkbox"/> Above <input type="checkbox"/> Unemployed		

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

Care recipient name:		Age:	Date of birth:
SSN:		Race: <input type="checkbox"/> White alone <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian alone <input type="checkbox"/> American Indian and Alaska Native alone <input type="checkbox"/> Two or more races <input type="checkbox"/> Some other race alone <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Below Poverty: <input type="checkbox"/> Yes <input type="checkbox"/> No		
On State Funded Waiver Program: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Type of Waiver:  Which State Agency:			
Address (if different):  City/Zip:  County:		Living arrangements: <input type="checkbox"/> With caregiver in home of care recipient <input type="checkbox"/> With caregiver in caregiver's home <input type="checkbox"/> With other family member or friend <input type="checkbox"/> Lives alone	
<input type="checkbox"/> Townhouse <input type="checkbox"/> Apartment <input type="checkbox"/> Single Family Home		Primary diagnosis/disease/disability:	
Home phone:		Comments:	
Cell phone:			
Email:			

**SECTION D: ADDITIONAL RESOURCES**

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

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**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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> None <input type="checkbox"/> Hospital <input type="checkbox"/> Long term care facility <input type="checkbox"/> Use alternate caregiver (when possible) <input type="checkbox"/> Other:	
Location where respite care will be provided: <input type="checkbox"/> In home of caregiver <input type="checkbox"/> In home of care recipient <input type="checkbox"/> Adult day center <input type="checkbox"/> Child day care <input type="checkbox"/> Adult nursing home <input type="checkbox"/> Other:	
<b>PLEASE FILL OUT THE FOLLOWING DETAILS OF THE RESPITE CARE YOU ARE REQUESTING:</b> (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:	<input type="checkbox"/> Hourly: <input type="checkbox"/> Day rate:

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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):**

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

Primary Caregiver Signature

**X**

Date

**SUBMIT ALL NECESSARY DOCUMENTATION TO:**

Illinois Respite Coalition  
 Attn: Anita Mazique, Statewide Respite Coordinator  
 6650 W. Irving Park Rd.  
 Chicago, IL 60634

Phone: (773) 205-3627 Fax: (773) 205-3631 Email: [maziquea@maryvilleacademy.org](mailto:maziquea@maryvilleacademy.org)

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**SECTION G: AUTHORIZATION FOR EMERGENCY RESPITE SERVICES:**

<b><u>FOR LIFESPAN RESPITE PROGRAM USE ONLY</u></b>	
Number of hours approved:	
Discussion notes to determine need:	Action taken: <input type="checkbox"/> Approved <input type="checkbox"/> Denied <input type="checkbox"/> Date of action:
Lifespan respite authorizing signature:	Date: