RESPITE CARE PROGRAM APPLICATION

Please print in black or blue ink.

Caregiver Information *(Person Requesting Respite Services)*

Name (first middle last)**:** ____

Mailing Address: ____

City: ______________________________ **State**: ______ **Zip Code:** ____________________

County of Residence: ___________________ **Contact Telephone:** (_____)________-________

E-mail Address: ____________________________________ **Fax: :** (_____)________-_______

Self-Declared Annual Household Income of Caregiver:

☐ Under $20,000 ☐ $20,001 to $40,000 ☐ $40,001 to $60,000 ☐ Over $60,000

Relationship to Care Receiver:

☐ Aunt/Uncle ☐ Grandparent ☐ Daughter/Son ☐ Parent/ Step-Parent

☐ Sibling ☐ Spouse ☐ Other, specify _________________________

Why Are You Requesting Respite? (required*)* _______________________________________

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Caregiver Information

Age of Caregiver: _______________ **Education** (highest grade completed): _______________

Race/Ethnicity (check one):

☐ African American ☐ Hispanic/Latino ☐ Caucasian

☐ Native American ☐ Multiracial

☐ Asian ☐ Pacific Islander

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Applicant's Name (first middle last): ______________________________

Employment:

- ☐ Full time employed (35 or more hours/week)
- ☐ Full time student
- ☐ Part time employed (less than 35 hours/week)
- ☐ Part time student
- ☐ Unemployed
- ☐ Other (specify) ______________

Gender: ☐ **Male** ☐ **Female**

Does the Caregiver live with the Care recipient? ☐ Yes ☐ No

Number of Household Members: ☐ Adults ☐ Children under 18

Care Receiver Information *(child or adult needing care)*

Name (first middle last)**:** ______________________________

County of Residence: ______________________________

Self-Declared Annual Household Income of Care recipient:

☐ Under $20,000 ☐ $20,001 to $40,000 ☐ $40,001 to $60,000 ☐ Over $60,000

Race/Ethnicity (check one)**:**

- ☐ African American
- ☐ Hispanic/Latino
- ☐ Caucasian
- ☐ Native American
- ☐ Multiracial
- ☐ Asian
- ☐ Pacific Islander

Age of Care Receiver: ______________

Gender: ☐ **Male** ☐ **Female**

The Care Receiver… (check all that apply)

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- ☐ Has special/chronic health care needs
- ☐ Has Alzheimer's Disease or other Dementia
- ☐ Has developmental disabilities
- ☐ Is enrolled in a Medicaid waiver program such as Community Based Alternatives (CBA) or Community Living Assistance and Support Services
- ☐ Receives Supplemental Security Income (SSI)
- ☐ Is an elderly, dependent, adult (age 60 or older)
- ☐ Has Acquired Brain Injury
- ☐ Is a Grandchild being raised by a Grandparent
- ☐ Has deficits in two or more activities of daily living (e.g., feeding, toileting, mobility, dressing)

Applicant's Name (first middle last): ____

The Applicant recognizes and agrees that the Area Agency on Aging, the Texas Department on Aging and all other agencies participating in this program are providing no direct or indirect services; and, the applicant shall hold harmless and indemnify these agencies for any damages or liabilities it incurs arising from this agreement. Completion of this application does not guarantee delivery of services.

____ ____________________________

Caregiver's Signature **Date**

Mail this form to: Caregiver Program, P.O. Box 60050, San Angelo, TX 76906

Questions? Call (325) 223 5704 or Toll Free (877) 944-9666

For Office Use only: ***Is this application approved?*** ❑ ***Yes*** ❑ ***No***

If not approved, why: ____

AAA: ______________________ ***Application Number:*** ____________________

Is this an emergency request? ❑ ***Yes*** ❑ ***No***

Reason for Emergency: ____

Does the person requiring care receive Medicaid waiver Services? ❑ ***Yes*** ❑ ***No***

Does the person requiring care have deficits in two or more ADLs? ❑ ***Yes*** ❑ ***No***

Authorizing Signature: ____________________________ ***Date:*** ________________