Alabama Lifespan Respite Resource Network®
DMH Application

Caregiver Information:

Name:			**MALE or FEMALE**
Mailing Address:			
City:	**State:**	**Zip:**	**County:**
Phone Number:		**Email:**	

Who do you care for?

Name:		**MALE or FEMALE**
Date of Birth:	**Age:**	
Diagnosis (Must indicate intellectual disability):		
Relationship to the person you care for:		

Please circle any respite services you are currently receiving:

Medicaid Waiver
Alabama Cares Voucher Program
UCP Hearts Voucher Program
Alabama Head Injury Foundation

Please read carefully and initial each blank below:

____ I understand that in order to receive reimbursement for respite services, my voucher form must be completed and returned by the due date provided.
____ I understand that I am responsible for selecting and training a trustworthy respite provider who is 18 years of age or older and living outside of the care recipient's home. Alabama Respite nor UCP will be held responsible for any actions taken by my selected respite provider.
____ I understand that the reimbursement check will be mailed to the address submitted on the voucher form, and that there is a 60-90 day waiting period before I receive reimbursement.
____ I agree to use the funds ONLY for respite care.

PLEASE PROVIDE PROOF OF INTELLECTUAL DISABILITY

Caregiver Signature: _____ Date: _____

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