ALABAMA LIFESPAN RESPITE

Respite Voucher Application

CAREGIVER INFORMATION		
Last Name:	**First Name:**	**MI:**
Street Address:	**Mailing Address (if different):**	
City: **State:** **Zip:**	**City:** **State:** **Zip:**	
County:	**Home Phone:** ( ) **Other Phone:** ( )	
Email address:		
Birthdate: ____/____/_____ MM DD YYYY	**Gender:** ☐ Male ☐ Female	

Race:

☐ Caucasian/White
☐ African-American/Black
☐ Alaska Native
☐ American Indian
☐ Asian
☐ Native Hawaiian
☐ Pacific Islander
☐ Other

Ethnicity:

☐ Not Hispanic/Latino
☐ Hispanic/Latino

Living Arrangement:

Does the care recipient live with you? ☐ Yes ☐ No

Income Range: Is your gross monthly income above $1,005.00? ☐ Yes ☐ No

You are:

☐ Husband
☐ Wife
☐ Son/Son-in-law
☐ Daughter/Daughter-in-law
☐ Other Relative
☐ Grandparent
☐ Parent
☐ Other Non-Relative

Check if one of the following applies to Care Recipient:

☐ Care Recipient has a dementia-related diagnosis.
☐ Care Recipient is an adult child with a disability between 19 and 59 years of age.
☐ Care Recipient is a child with a disability between the ages of 0 and 18 years of age.

Alabama Lifespan Respite Resource Network
1856 Keats Drive
Huntsville, AL 35810
Phone: 256-859-4900
Fax: 256-859-4332
www.alabamarespite.org

ALABAMA LIFESPAN RESPITE

Please circle any respite services you are currently receiving:

- Medicaid Waiver Home Based Services (Personal Care, Homemaker, Companion, etc.)
- Alabama Cares Voucher Program
- UCP Hearts Voucher Program
- Alabama Head Injury Foundation
- ALS
- VA
- OTHER: _____

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. Neither 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.

Third Party Verification:

Contact Name:	**Agency:**
E-Mail address:	**Phone Number:**

Is the third-party a (circle one):

Social Worker Medical Office Staff State Agency Minister
Hospital School Teacher Non-Profit Agency

Other (describe):

Caregiver Signature: _____ **Date:** _____

OFFICE USE ONLY:

☐ DMH CHILD ☐ DMH ADULT ☐ UNIVERSAL

Alabama Lifespan Respite Resource Network
1856 Keats Drive
Huntsville, AL 35810
Phone: 256-859-4900
Fax: 256-859-4332
www.alabamarespite.org