ALABAMA LIFESPAN RESPITE

Respite Application and Enrollment Form

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 ☐ Asian ☐ African-American/Black ☐ Native Hawaiian ☐ Alaska Native ☐ Pacific Islander ☐ American Indian ☐ 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 ☐ Other Relative ☐ Wife ☐ Grandparent ☐ Son/Son-in-law ☐ Parent ☐ Daughter/Daughter-in-law ☐ Other Non-Relative Do you provide more than 80 hours of care each week? ☐ YES ☐ NO	**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.	

WHO DO YOU CARE FOR?

Name:	**MALE or FEMALE**
Date of Birth:	**Diagnosis:**
Relationship to the person you care for:	

Please flip over to complete application.

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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: (Someone that can/will verify you are a caregiver)

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:** _____

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