Alabama Lifespan Respite Resource Network®
Emergency Respite 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:			
Caregiver birthdate: ____/____/_____ MM DD YYYY Care recipient over 60? ☐ Yes ☐ No		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	
Income Range: Is your gross monthly income above $972.50? ☐ 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 age 18 and under.	

Description of emergency:

_____
_____
_____
_____

Third Party Verification:

_____ _____
Agency Name Date

_____ _____
Representative Signature Printed Name

Dates respite is needed:_____

By signing below, I confirm I have read and understand the Emergency Respite guidelines.

_____ _____
Caregiver Signature Date