Division of Provider Services and Quality Assurance

Arkansas Lifespan Respite Voucher Application

Welcome to the **Arkansas Lifespan Respite Voucher Program**! This program is a resource for family caregivers who have limited access to respite care and/or other supports through current systems. The purpose of the program is to meet planned respite needs for unserved and underserved family caregivers by providing financial assistance to access respite. (NOTE: This program may not be used to provide ongoing, continuous, or full-time supervision/care for a person with special needs during caregiver's work hours, etc.)

Application Instructions:

Caregivers of individuals of all ages and special health care needs are welcome to apply. Examples of special needs are developmental disabilities; traumatic brain injuries, physical disabilities; chronic illness; physical, mental or emotional conditions that require supervision; cognitive impairments such as Alzheimer's disease or dementia; or persons at risk of abuse & neglect.
Fill out the application and return it via email, fax, or postal mail, along with a W-9 form. All sections of the application must be complete in order for your application to be reviewed for consideration. Applications are accepted on a continuous cycle. If you provide care to more than one care recipient, complete one application for each individual; however only one award will be granted per household.

Voucher awards are distributed on a first come-first served basis. Voucher funds can only be used for respite services within the award term. No funds are guaranteed. Any unused funds at the end of the award term will be returned to DHS.

You may submit your completed application and W-9 form to:

Postal mail: Division of Provider Services & Quality Assurance
ATTN: Arkansas Lifespan Respite Voucher Program
P.O. Box 1437, Slot S428
Little Rock, AR 72203-1437

Email/Scan: ARLifespan.Respite@dhs.arkansas.gov
Fax: (501) 682-8155
Questions: (866) 801-3435

Qualifications:

Caregivers of individuals who need support with personal care, supervision, and monitoring, may find themselves in need of respite (or short breaks) from time to time. Applicants must meet the following criteria to qualify for a respite voucher:
Eligibility Checklist: *Must meet all listed requirements to be considered for voucher funds*

☐ The family caregiver provides unpaid care for a family member, friend, or neighbor (broadening the definition of "family"); both individuals live in Arkansas.

☐ Family caregiver provides full-time care (40 hours or more) weekly.

☐ The care recipient has a **"special need"** (please see explanation box on the following page).

☐ The caregiver can utilize the respite voucher over an approximately 90-day period, or by the expiration date on award letter. *Please note unused funds must be returned.*

☐ The family is not currently receiving any respite care through other funding or programs (i.e., Medicaid waiver, Area Agency on Aging voucher). *This voucher is designed as a Payer of Last Resort. The family caregiver can receive a respite voucher if on a funding wait list or respite is unavailable on their current service program or has been denied respite services with their current service program.*

Important Program Information:

Vouchers are financial assistance to support **unpaid family caregivers** in accessing respite. All eligibility criteria must be met, and applications must be complete. Award letters will be distributed upon approval for voucher funding. Follow instructions on the award letter to utilize the respite voucher.

Voucher recipients may choose their own respite provider and schedule services within the award term noted on the letter. This may be a licensed service provider within the State of Arkansas, family, friend, etc. YOU are responsible for selecting, hiring, and training a respite care provider of your choice, at a time that is convenient for you and the care recipient. You may also use a community respite program (i.e., weekend respite program, therapeutic summer camp, adult day program). The respite provider you choose ***MUST be at least 18 years old and cannot be someone who currently resides in the same home as the care recipient***. The respite provider cannot be a legal guardian or Power of Attorney to the care recipient. The Arkansas Department of Human Services, Division of Provider Services and Quality Assurance, or any of its affiliates cannot be held liable for respite provider actions. **Funds may only be used for services that occur between the award date and expiration date**, approximately 90 days. Funds cannot be used for existing balances of services outside the award term. Funds may only be used for the care recipient on the application. Funds may not be used to reimburse household expenses or daycare; funds must be used for payment of an individual respite care provider or an organization that provides respite.

Vouchers will be awarded on a **first-come, first-served basis** to those who qualify with priority given to applicants in financial hardship. Voucher awards are set at **$300.00 per award term**. You may apply a maximum of 4 times in one calendar year. Eligible families who have not previously received a voucher will be given priority. Families may receive a **maximum of $1,200.00 from this program in one calendar year**.

Voucher funding will be made payable to you, the primary caregiver, and not to the respite care provider. YOU are responsible for payment to your respite care provider. DHS does not provide or arrange for respite care. You are responsible for negotiating the rate of pay with the respite care provider you select. You may pay more than the voucher amount received from DHS, but you will be responsible for making up the difference between the amount approved through the Arkansas Lifespan Respite Voucher Program and what you have agreed to pay the provider. (For example, if your total respite cost is $400, you will have to pay the additional $100, since the maximum amount of the voucher funding is $300 through the Respite Voucher Program.)

Criteria for awards and use of the vouchers are subject to change. **Funding is limited, and no awards are guaranteed.** Refer to the *Frequently Asked Questions* available online or by request for more information.

Special Need:

As described by the Lifespan Respite Act of 2006, "special need" means:

Adult: An individual 18 years of age or older who requires care or supervision to:

1. Meet the person's basic needs;
2. Prevent physical self-injury or injury to others; or
3. Avoid placement in an out-of-home, long-term care setting

Child: An individual less than 18 years of age who requires care or supervision beyond that required of children generally to:

1. Meet the child's basic needs; or
2. Prevent physical injury, self-injury, or injury to others.

Next Steps:

You may be contacted upon receipt of application for information clarification. Please write legibly and provide accurate contact details. The Arkansas Lifespan Respite Program will contact you to announce your award status. Follow directions on the award letter to use the respite voucher. At the completion of voucher services or award term, the family caregiver will complete a Voucher Service Report and a Satisfaction Survey Questionnaire that the Division of Provider Services and Quality Assurance will provide. These forms and any other required documentation must be received to be considered for additional funding.

For additional and/or updated information about this respite voucher program and other respite resources, you may contact the Choices in Living Resource Center at (866) 801-3435 or visit the Caregiver Resources website, https://ar.gov/arlifespanrespite.

Voucher funding made available through the Lifespan Respite Program Grant initiative awarded to Arkansas Department of Human Services - Division of Provider Services and Quality Assurance by the Administration for Community Living (ACL), Grant # 90LRLI0045.

ARKANSAS DEPARTMENT OF HUMAN SERVICES
Division of Provider Services & Quality Assurance

Arkansas Department of Human Services

LIFESPAN RESPITE VOUCHER PROGRAM APPLICATION

(See instructions. If you need assistance completing this application: call 1-866-801-3435 for a Resource Counselor).

Do you need an interpreter? ☐ Yes ☐ No If yes, what language do you prefer:

Please include W-9 form with application.

Section 1: CARE RECIPIENT INFORMATION *(Person with special need requiring full time ongoing 24/7 care or supervision)*

Name:	**Date of Birth:**	**Gender:** ☐ Male ☐ Female

Living Arrangements:
☐ Lives alone ☐ With spouse only ☐ With spouse & other relatives
☐ With other relatives ☐ With grandparent(s) ☐ With non-relative(s)
☐ With parent(s) ☐ With son or daughter ☐ With grandchild ☐ With sibling(s)
Total # of persons living in household?

Social Security Number:

Medicaid Number: (*if applicable*)

Care Recipient Race/Ethnicity:
☐ Native American or Alaska Native ☐ Asian or Asian American ☐ Black or African American
☐ Native Hawaiian or Pacific Islander ☐ White/Caucasian ☐ Hispanic or Latino
☐ Marshallese ☐ Other/Unknown:

Mailing Address: **PO Box # *(if applicable)***

City:	AR	**Zip Code:**	**County:**

Does the Care Recipient need help with any self-care activities: ***(check all that apply)***

☐ Bathing ☐ Toileting ☐ Grooming ☐ Household Chores ☐ Dressing ☐ Transferring ☐ Mobility
☐ Meal Prep ☐ Feeding ☐ Medication ☐ Manage Finances ☐ Grocery/Shopping ☐ Transportation ☐ Run Errands
☐ Provide Companionship ☐ Communication Skills ☐ Specialized Medical Care (suctioning, tube feeding, physical therapy)
☐ Manage Challenging Behaviors ☐ Other: _____

Diagnosis of Care Recipient: _____

Attach documentation to support diagnosis. (For example- letter from therapist or healthcare provider, current medical reports or IEP)

Check all needs experienced by Care Recipient that requires supervision:
☐ Cognitive Impairment or Dementia ☐ Functional Limitations due to Aging ☐ Physical Disability
☐ Behavioral Challenges ☐ Learning Disability ☐ Other: *(please specify)*
☐ Developmental and/or Intellectual Disability ☐ Mental Health Issues _____

Is the Care Recipient receiving any care through Medicaid or any other program that provides respite care? *(anything that could be considered a break from caregiving)*
☐ Yes- If yes, what service(s)? _____ Agency? _____ Funding Source? _____
☐ No, he/she is receiving no other services at this time that would be considered respite.

Is the Care Recipient at high risk for out of home placement/facility care? (such as a nursing home, foster care, mental health institution, group home) ☐ Yes ☐ No

Is the Care Recipient a Veteran? ☐ Yes ☐ No

Section 2: PRIMARY CAREGIVER INFORMATION (Parent, Spouse, other Family/Friend providing on going care)

Name:	**Gender:** ☐ Male ☐ Female	**Age:** ☐ 18 or younger ☐ 19-59 ☐ 60-75 ☐ 76+	**Are you a veteran?** ☐ Yes ☐ No

Caregiver Race/Ethnicity:
☐ Native American or Alaska Native ☐ Asian or Asian American ☐ Black or African American
☐ Native Hawaiian or Pacific Islander ☐ White/ Caucasian ☐ Hispanic or Latino
☐ Marshallese ☐ Other/Unknown:

Caregiver's relationship to the Care Recipient is:
☐ Adoptive Parent ☐ Friend ☐ Legal Guardian ☐ Partner ☐ Biological Parent
☐ Foster Parent ☐ Sibling ☐ Power of Attorney ☐ Daughter/Son (in-law)
☐ Grandchild ☐ Grandparent ☐ Spouse ☐ Other (*please specify)*

Mailing Address *(if different than Care Recipient)*
Street: _____ PO Box # *(if applicable)*_____ Apt #:_____
City: _____ State _____ Zip Code: _____ County: _____

Landline Phone Number:	**Cell Phone Number:**	**Consent to text**: ☐ Yes ☐ No Cell Carrier:

Consent to contact via email: ☐ Yes ☐ No	**Primary Caregiver Email:**

Do you prefer communication via: ☐ Email ☐ Email & Text ☐ Mail ☐ Mail & Text ☐ Phone

Time spent caregiving each week: ☐ Less than 5 Hours ☐ 5 – 10 Hours ☐ 11 – 20 Hours ☐ 20 – 40 Hours ☐ 40+ Hours ☐ Full-Time 24/7	**How "stressed" are you as a result of caring for the care recipient:** ☐ Not at all stressed ☐ Slightly stressed ☐ Moderately stressed ☐ Very stressed ☐ Extremely stressed
Health of Primary Caregiver at time of request (check one): ☐ Good ☐ Fair ☐ Disabled ☐ Critical	
Primary Caregiver employed: ☐ Full Time (32+) ☐ Part Time (<32) ☐ Not Employed/Retired ☐ In School Part Time ☐ In School Full Time	

In the last six months, has one or more family caregivers needed to miss work due to unpaid family caregiving responsibilities:
☐ Yes ☐ No ☐ Primary Caregiver not employed
If Yes, how many days have you missed:

Other type of services I'm interested in for the Care Recipient: ☐ Medicaid or State Plan Services provided through DHS
☐ In-Home Hourly Care ☐ Temporary Overnight Care ☐ Adult Day Care ☐ Social Outing/Community Activity
☐ Crisis Care ☐ Other *(please specify)*: ☐ I need more information about choices

I have received a Lifespan Respite Voucher in the past? ☐ Yes ☐ No ☐ *I have received voucher(s) from other sources*	**How long since you last received a break from caregiving?** ☐ Less than 6 months ☐ 6 months- 1 year ☐ 1-5 years ☐ 5+ years	**How long have you been an unpaid primary caregiver?** ☐ Less than 6 months ☐ 6 months- 1 year ☐ 1-5 years ☐ 5+ years

What has kept you from having breaks in the past? (*please rank in order of significance)*
_____ Money _____ Transportation _____ Timing _____ Available Provider _____ Other:

Section 3: LIVING ARRANGEMENTS *(List all who live in the household of Care Recipient)*

Does the Care Recipient, if age 18 or under, have a parent living outside of the home: ☐ Yes ☐ No ☐ N/A (recipient older than 18)

Name:	**Age:**	**Relationship to Care Recipient:**

Section 4: INCOME *(Complete Column A if you are caring for someone 18 or older. Complete Column B if you are caring for someone under 18 years old.*

In the appropriate box list **all** Income- Taxable and non-taxable
(Married couples must report their combined income)
Income below is from past: ☐ YEAR ☐ 90 DAYS

COLUMN A Care Recipient (and Spouse) Income Information if the Care Recipient is 18 or older			COLUMN B Caregiver Income Information if the Care Recipient is under 18 years old	
List the number of dependents living in the household (including yourself/spouse):			List the number of dependents living in the household (including yourself/spouse):	
All Income Reported on Tax Return (as reported annual to the IRS)	$		All Income Reported on Tax Return (as reported annual to the IRS)	$
Social Security/SSI/SSDI (if not reported on tax return)	$		Social Security/SSI/SSDI (if not reported on tax return)	$
Other Income (if not reported on tax return)	$		Other Income (if not reported on tax return)	$

Section 5: Disability Related Expenses

List disability-related expenses not covered by any other source that the Care Recipient has to pay in a year's time.
Example of expenses: doctor visits, prescriptions, adult incontinence products, medical transportation, wheelchairs, lifts, loans for architectural modification. Do not include expenses of other family members:

Expense:	Cost:	How Often:

Section 6: AGREEMENT AND SIGNATURE

Please read the following carefully and initial each to show your understanding:

_____ *I attest that I am the Primary Caregiver of the Care Recipient listed in this application form, and I wish to enroll in the Arkansas Lifespan Respite Voucher Program. I understand that funding is based on a first-come-first-served basis until funds are depleted, and that funds are only to be used for respite services.*

_____ *I understand that I must provide the acceptable documentation of the Care Recipient's condition/disability with this application form and complete all additional required forms for the application to be processed.*

_____ *I understand and acknowledge that I am responsible for hiring an individual respite provider or respite provider organization of my choice and arranging for payment for any respite services received. I understand that I am responsible for negotiating the rate of pay with the identified respite service provider, and that I am responsible for any difference in the amount approved and the amount paid by me, if any.*

_____ *I understand that I must complete and submit a Voucher Service Report, signed by me, the Primary Caregiver, and the respite worker, to the Arkansas Lifespan Respite Voucher Program office no later than 10 business days after the end of my award term. Failure to provide the Voucher Service Report may result in 100% repayment of the funding.*

_____ *I am also responsible for providing any training or instruction that the respite provider(s) of my choice may need to provide services to the respite care recipient.*

_____ *I understand that information provided on this form, the W-9 form, and on the Voucher Service Report may be checked, and if I have given false statements or information, I may be found guilty of fraud. Fraudulent activity will result in 100% repayment of funding and inability to utilize the Arkansas Lifespan Respite Voucher Program in the future.*

_____ *I understand that whenever there are changes in the information I have given, I must immediately report them to the Arkansas Department of Human Services, Lifespan Respite Voucher Program Coordinator.*

_____ *I agree to complete and submit a W-9 form with my application in order for the program to set me up as a state vendor, in order to receive voucher funding.*

_____ *I understand that the Arkansas Department of Human Services may need to contact other agencies and individuals to determine my financial eligibility and to verify my need for the support for which I am applying, or to make referrals to assist me in obtaining services. I authorize the release of this confidential information.*

_____ *I have read the CLIENTS RIGHTS, and I understand those rights as presented to me. (A copy for your records was included in the packet and is available at https://ar.gov/arlifespanrespite under the respite tab.)*

I agree to the above conditions and that funds will be used ONLY for respite care.

Signature of Caregiver
Completing Application: _____ Date: _____ / _____/ _____

Send completed application and supporting documentation to:

Email *(recommended):*	**Mail:**	**Fax:**
ARLifespan.Respite@dhs.arkansas.gov	DHS- Arkansas Lifespan Respite Program P.O. Box 1437, Slot S428 Little Rock, AR 72203-1437	(501) 682-8155 Attn: AR Lifespan Respite

FOR INTERNAL USE ONLY	Approved Vendor #	Approval Date: / /	Expiration Date: / /