Seniors in Service

1380 Greg Street #231, Sparks, NV 89431 www.seniorsinservicenevada.org

Seniors in Service engages vibrant and experienced volunteers
to enrich Northern Nevada communities one life at a time.

Fiscal Year
July 1, 2024 – June 30, 2025

Respite Voucher Application

Barbara Lewison Email: barbara@sisnv.org
Ph# 775-358-2768 Fax 775-358-3633

Office Use Only	
Voucher#	
Approved	
Packet	
QB	
SAMs ID#	

Patient's Legal Name: ________________________________ DOB: __________

Address: ______________________________ City: __________ Zip: ________

Mailing Address *(if Different)* ____________________ City: __________ Zip: ________

County: ____________________ Phone: ______________________

Gender: ( ) Male ( ) Female ( ) Other **Status:** ( ) Single ( ) Married/Partner ( ) Divorced ( ) Widowed
Primary Language: ( ) English ( ) Spanish ( ) Other (specify) ____________
Ethnicity: ( ) Caucasian ( ) Hispanic ( )African American ( )Native Hawaiian/Pacific Islander
( ) Asian ( ) American Indian/Native Alaskan ( ) Other ____________

Are you on the State of Nevada Medicaid? ( ) Yes ( ) No
Are you a Veteran / served in Armed Forces? ( ) Yes ( ) No

Live-in Caregiver's Legal Name: __________________________ DOB: __________

Phone: ____________________ Email:__________________________________

Alternate/Emergency Contact: __________________ Relationship: ________ Ph# ________

Gender: ( ) Male ( ) Female ( ) Other **Status:** ( ) Single ( ) Married/Partner ( ) Divorced ( ) Widowed
Primary Language: ( ) English ( ) Spanish ( ) Other (specify) ____________
Ethnicity: ( ) Caucasian ( ) Hispanic ( )African American ( )Native Hawaiian/Pacific Islander
( ) Asian ( ) American Indian/Native Alaskan ( ) Other ____________
Relationship to Patient: ( ) Spouse/Partner ( ) Child ( ) Parent ( ) Other *(specify)* ____________
How Long have you been caring for this person: ____ years ____ months?

YES	NO	
( )	( )	Do you live in the same household as Patient?
( )	( )	Have you received a Respite Voucher from Seniors in Service in prior years?
( )	( )	Have you received a Respite Voucher from the Alzheimer's Assoc. in prior years?

( ) **Proof of Residency** is attached for **Patient** and **Caregiver**. *Documentation proving that caregiver and care receiver reside at the same physical address. Photocopies of driver's licenses will suffice.*

How did you hear about our Program? ______________________________________

OR referred by: ____________________ ____________________ ____________
Social Worker Name *Agency Name* *S.W. Ph#*

Monthly Income & Expenses

This section is required but is used for statistical purposes only and will not affect eligibility.

Patient Information:

Rent/Mortgage: _____ Utilities: _____ Taxes: _____ Prescriptions: _____ Therapy: _____
Transportation: *(including auto insurance, fuel, taxi, public transportation)* _______ Other: __________
Medical Expenses: *(including Doctor visits, insurance premiums and co-pays)* ______
Out-of-Pocket Respite Care: *(other than Seniors in Service Voucher)* ______

Total Monthly Income: _______________ **Total Monthly Expenses:** ______________

Office Use Only:
Annual Income: __________ Expenses: __________ Net Income: ________ *< 300% PGL ( ) Yes ( ) No*

Caregiver Information:

Employment Status: ( ) Full-time ( ) Part-time ( ) Retired ( ) Homemaker ( ) Unemployed
( ) Under $8000 ( ) $8001 - $11,999 ( ) $12,000 - $14,999 ( ) $15,000 - $19,999
( ) $20,000 - $29,999 ( ) $30,000 - $39,999 ( ) Other _____

How Many people reside in the home? ________

The Patient has a condition that requires assistance for their safety and wellbeing. ( ) Yes ( ) No

Is the Patient able to leave home without assistance? ( ) Yes ( ) No

Which services are you currently using?
( ) In Home Care - Agency ( ) In Home Care - Individual ( ) Adult Day Care ( ) Hospice

When do you anticipate using respite care? _______________________________

Caregiver Respite Survey

An additional Survey will be provided at the end of each Fiscal Year.

Current Level of Stress	( ) High	( ) Medium	( ) Low
Your Ability to Take Time for Yourself	( ) Poor	( ) Fair	( ) Good
Current Emotional Health	( ) Poor	( ) Fair	( ) Good
Access to Caregiver Support	( ) Poor	( ) Fair	( ) Good

Comments regarding your needs as a caregiver: ____

____

____

Chronic Illnesses Affecting Patient:

( ) MS Date Diagnosed? _____ ( ) Para/Quadriplegic Date Diagnosed? _____
( ) ALS Date Diagnosed? _____ ( ) Respiratory/COPD Date Diagnosed? _____
( ) Brain Injury Date Diagnosed? _____ ( ) Alzheimer's/Dementia Date Diagnosed? _____
( ) Parkinson's Date Diagnosed? _____ ( ) Cancer Type? ____________________________
( ) Stroke/CVA Date of Last Stroke/CVA: ___________
( ) Other impairment ____
Ambulation: ( ) Walker ( ) Wheelchair ( ) Cane ( ) Other ____________________

ADLs – Activities of Daily Living. *Select level of assistance provided by caregiver.*

Eating:		( ) None	( ) Supervised	( ) Hands on Assist	
Bathing:		( ) None	( ) Supervised	( ) Hands on Assist	
Dressing		( ) None	( ) Supervised	( ) Hands on Assist	
Toileting:	( ) Incontinent	( ) None	( ) Supervised	( ) Hands on Assist	
Getting in and out of Bed or Chair:		( ) None	( ) Occasional	( ) Always	( ) Bed-Bound

IADLs – Instrumental Activities of Daily Living. *Select level of assistance provided by caregiver.*

Meal Preparations:	( ) None	( ) Supervised	( ) Hands on Assist
Housework:	( ) None	( ) Supervised	( ) Hands on Assist
Laundry:	( ) None	( ) Supervised	( ) Hands on Assist
Shopping:	( ) None	( ) Supervised	( ) Hands on Assist
Use the Telephone:	( ) None	( ) Supervised	( ) Hands on Assist
Managing Medication:	( ) None	( ) Supervised	( ) Hands on Assist
Managing Money:	( ) None	( ) Supervised	( ) Managed by Caregiver
Use Transportation Services:	( ) None	( ) Supervised	( ) Hands on Assist

Office Use Only: ADLs: ___ IADLs: ___

Additional Information you would like us to consider: ________________________________
____

By signing below, the caregiver agrees that this information is accurate and true. Caregivers agree to provide Seniors in Service with any changes as they become aware of such changes.

____ Date: ___________

*(Signature of Live-In **Caregiver**)*

Residency Statement:

The Patient, ______________________, has lived in Nevada for ____ years and ____ months.

____ Date: ___________

*(Signature of Live-In **Caregiver**)*

I, *(Print Patient's Name)*____________________________________, give my permission for any representative of Seniors in Service to communicate with various service agencies, physicians and/or organizations to which I have been referred or that I am currently receiving services. This release allows Seniors in Service to give and receive verbal and/or written information about myself.

____ Date: ___________

*(**Patient Signature** OR Power of Attorney signature)*

Release of Information

Patient - Release of Information

Please complete the information on the top half of this page and have the patient's physician or medical provider complete the bottom portion and return it to Seniors in Service. Approval cannot be completed until we receive the physician or medical provider's statement.

I agree to the release of medical information on:

Patient Name: ____ DOB: ___________

Patient's Signature: ____ Date: _______

(Patient Signature or Caregiver Signature if Patient unable to sign, check box below accordingly)

Please check if the patient provided verbal consent instead of signature. ☐

Physician's Statement

Physician: An application has been submitted for our Respite Voucher Program for the individual named above. To provide financial assistance, information regarding your patient's medical condition and required level of care is needed. Please complete the following information and return to:

Seniors in Service - 1380 Greg Street, Suite 231, Sparks, NV 89431
Ph# 775-358-2768 Fax: 775-358-3633 Email: barbara@sisnv.org

Physician / Medical Provider Name: ____

Agency Name: ____

Address: ____

Ph# ________________________ Fax# _____________________

Primary Diagnosis: ____

Comments: ____

Criteria: A person diagnosed with a medical/chronic condition who requires supervision/care and assistance in multiple areas of daily living (i.e., bathing, feeding, walking, etc.)

( ) Patient and Live-in Caregiver would benefit from Respite Care Services.
( ) Patient and Live-in Caregiver **do not** meet criteria for Respite Care Services currently.

Physician/Medical Provider Signature ___________________________________ Date: ______

Seniors in Service welcomes donations to support this program.
Services will not be denied to those who choose not to donate.

Respite Voucher Program - Policy Statement

To provide respite vouchers to qualifying live-in caregivers throughout Northern Nevada. "Respite is for the caregiver and "Care" is for the person requiring medical supervision/care. Respite is a form of temporary relief for the live-in caregiver. If you do not take time off while caring for your loved one, you can burn out. The use of respite services is a way to reduce stress so you can be a better caregiver.

Definitions: For the purposes of this program, the following terms are defined:

- Respite: "Time off" for the primary caregiver of a person who is not safe when left alone or cannot be left alone due to a verifiable medical/chronic condition.
- Primary Caregiver: A person who has assumed the responsibility for managing and providing day-to-day care of a person and **who lives in the same household** as the person requiring care.
- Care Receiver: The person diagnosed with a medical/chronic condition and who requires supervision/care and assistance in multiple areas of daily living (i.e., bathing, feeding, walking, etc.). Please note that any diagnosis of Alzheimer's or dementia must be referred to the Alzheimer's Association of Northern Nevada, as we cannot duplicate services.
- Respite Voucher: The respite voucher is a means to provide reimbursement to the live-in primary caregiver or professional agency for paid respite care.
- Seniors in Service: We provide respite voucher services to qualifying live-in caregivers throughout Northern Nevada and south to Tonopah.

Eligibility Criteria:

- Care Receiver is at least 60 years of age.
- Care Receiver lives in the community but not in assisted living, care facility or nursing home.
- Care Receiver has a functional impairment that necessitates someone to provide for safety and well-being to remain living at home. (Dementia/Alzheimer's is managed through the Alzheimer's Association, (775) 786-8061.
- Care Receiver needs supervision and/or hands on assistance with most ADL's.
- Care Receiver has a family member, friend or other unpaid caregivers as primary caregiver to maintain safety and wellbeing.

Caregiver must reside in the same residence as the Care Receiver.

Photo identification required.

Care Receiver lives in one of the following counties: Carson City, Churchill, Douglas, Elko, Eureka, Humboldt, Lander, Lyon, Mineral, Nye, Pershing, Storey, Washoe and White Pine.
We target and give priority to Care Receivers whose net income meets 300% of DHHS poverty guidelines, but services are available to those who exceed low-income guidelines.

Please contact Seniors in Service at (775) 358-2768

This program is funded by the State of Nevada Aging and Disability Services Division.
The Respite Program is contingent upon funds availability and applicant's eligibility. Those who qualify for this grant and are selected to receive assistance will be notified by phone and mail.