Colorado Respite Care Program
Family Respite Voucher Application

Welcome to the **Colorado Respite Care Program 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.

Application Instructions:

Caregivers of individuals of all ages and special health care needs are welcome to apply. Fill out the application and return it via email, scan or postal mail. All sections of the application must be complete. Applications are accepted at all times. If you provide care to more than one care recipient, complete one application for each individual. One award will be granted per household.

Voucher awards will be distributed on the 1st and 15th of each month via postal mail. If these dates fall on a weekend or holiday, distribution will occur the following business day. Voucher funds can only be used with Approved Providers within the award term. No funds are guaranteed.

You may submit your completed application to:

Postal mail: Colorado Respite Care Program
ATTN: Elle Billman
393 S. Harlan St. Suite 108
Lakewood, CO 80226

Email/scan: ebillman@eastersealscolorado.org
Fax: (303) 233 - 1082
Questions: (303) 233 - 1666 x 225

Family Caregiver 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 Colorado.
- ☐ Family caregiver provides full-time care (40 hours or more) weekly.
- ☐ The care recipient has a **"special need"** (please see explanation box on following page).
- ☐ Respite services will be delivered by an Approved Provider*. The caregiver may not sign up for respite with an Approved Provider without **first being notified in writing of voucher award**.
- ☐ The caregiver is able to utilize the respite voucher over an approximately 120 day period, or by the expiration date on award letter. *Please note unused funds must be returned.*
- ☐ The family is not currently receiving any funding that can be used for respite care (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.

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 on the **1st and 15th** of each month via postal mail. Follow instructions on the award letter to utilize the respite voucher.

Voucher recipients select an **Approved Provider*** and schedule services within the award term noted on the letter. **Funds may only be used for services that occur between the award date and expiration date**, approximately 120 days. Funds cannot be used for existing balances or services outside the award term. Funds may only be used for the care recipient(s) on the application.

Vouchers will be awarded on a **first-come, first-served basis** to those who qualify. Voucher awards range from $250.00 - $1,000.00. Eligible families who have not previously received a voucher will be given priority. Families may receive a **maximum of $2,000.00 from this program in one calendar year.**

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 form 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.

Approved Providers:

A current list of Approved Providers will be included in award packet and is available online or by request. **Caregivers must agree to work with authorized Approved Provider agencies approved by the CRCP. Individual (independent) providers - including other family members, friends, or registered providers - may not be used for this respite voucher program.** Efforts may be made to contract with the agency of choice in areas that do not have an Approved Provider if eligibility requirements and time constraints are met. Payments will be made directly to providers from the CRCP.

Next Steps:

You may be contacted upon receipt of application for information clarification. Please write legibly and provide accurate contact details. The CRCP will contact you via postal mail to announce your award status. Follow directions on the award letter to use the respite voucher. At the completion of voucher services, the family caregiver will complete an online exit survey that the respite agency will provide. *A completed survey and required documentation must be received to be considered for additional funding.*

For additional and/or updated information about this respite voucher system and other respite resources, visit the Colorado Respite Care Program website, www.coloradorespitecoalition.org.

For more information, please contact Elle Billman at ebillman@eastersealscolorado.org or (303) 233-1666 x225.

Family Application for Colorado Respite Care Program Respite Voucher

Please print	**Family Caregiver** *(family, friend, or neighbor)*	**Care Recipient** *(individual in need of care)*
Name:		
Prefered name/pronouns:		
Date of Birth (DOB): MM/DD/YYYY	_____ ☐ Male ☐ Female ☐ Non-Binary	DOB: _____ ☐ Male ☐ Female ☐ Non-Binary
Mailing Address:		
City/Town:		
Zip Code:		
Home County:		
Phone Number:	☐ *Preferred*	
Alternate Phone:	☐ *Preferred*	
Email:	☐ *Preferred*	

1. Caregiver's relationship to care recipient**:** _____

2. I provide care, supervision, and/or monitoring **40 or more hours** per week. ☐ Yes ☐ No

3. Where did you learn about this program? *(website, organization, etc.)* _____

4. Name of individual who **referred** you: _____

5. Referral contact information**:** _____

6. May we contact the above individual for additional information within 365 days? ☐ Yes ☐ No

7. Name(s) of others I authorize to facilitate a respite voucher for me (case managers, referral source, family members who may speak on my behalf):_____

8. Please tell us why you need this respite voucher:

_____

_____

_____

_____

This application is true and accurate. I have completed all sections of the application. I have had the opportunity to review the instruction page accompanying it. Respite services will not be paid for without prior authorization by the Colorado Respite Care Program and completion of required documentation.

Signature: _____ _____
Date

Printed Name: _____

Please tell us a little more about yourself and your loved one. Information will not affect decisions made about eligibility, but may help the program with reporting requirements for funding sources.

Care Recipient Information

1. The individual I provide care/supervision for has *(check all that apply)*:

- ☐ Physical disability *(please specify)*
- ☐ Behavioral concern
- ☐ Mental health condition
- ☐ Medical support needs (medication reminders, etc.)
- ☐ Intellectual / developmental disability
- ☐ Memory condition (Alzheimer's, dementia, etc.)
- ☐ Another diagnosis (please list below)
- ☐ Assistance needs with one or more activities of daily living (feeding, dressing, bathing, etc.)

2. What, if any, diagnoses exist? _____

_____

3. The person cared for is currently receiving in-home or out-of-home respite within within past 60 days. ☐ Yes ☐ No

*If yes, name of program:*_____

4. The person cared for is currently receiving funding for respite care (i.e. Medicaid waiver, Area Agency on Aging, etc.) within past 60 days. ☐ Yes ☐ No

*If yes, name of program:*_____

Caregiver Information

1. Marital Status:

- ☐ Married / Committed partner in household
- ☐ Divorced / Separated
- ☐ Single
- ☐ Widowed

2. Income* Range:

- ☐ $0 – 30,000
- ☐ $30,001 – 59,999
- ☐ $60,000+

Income is not a factor for eligibility

3. Total number of people living in household:

_____

Caregiver Demographics

1. Home Location:

City: _____

County: _____

2. Race/Ethnicity: *(Check all that apply)*

- ☐ Hispanic / Latinx
- ☐ African American / Black
- ☐ American Indian / Alaska Native
- ☐ Arab American / Middle Eastern
- ☐ Asian
- ☐ Native Hawaiian / Pacific Islander
- ☐ White / Caucasian

3. Military Service:

- ☐ Active duty with _____
- ☐ Veteran

Care Recipient Demographics

1. Home Location:

City: _____

County: _____

2. Race/Ethnicity: *(Check all that apply)*

- ☐ Hispanic / Latinx
- ☐ African American / Black
- ☐ American Indian / Alaska Native
- ☐ Arab American / Middle Eastern
- ☐ Asian
- ☐ Native Hawaiian / Pacific Islander
- ☐ White / Caucasian

3. Military Service:

- ☐ Active duty with _____
- ☐ Veteran