RESPITE CARE PROGRAM

Respite care is a supportive service intended to provide short-term, temporary relief to the primary caregiver of an individual with a persistent or chronic physical or emotional disability.

HOW TO APPLY

The application packet for Respite Care is attached. The packet contains three sections, all of which must be completed and return to our office. If you have questions regarding how to fill out the application, call our office at (301) 909-2091. The sections are:

CLIENT INFORMATION FORM
DOCTOR'S STATEMENT AND RELEASE OF INFORMATION
INCOME INFORMATION FORM

Due to state regulations, applications cannot be processed without proper verification of income. Verification means the most recent pay stub, Social Security statement, or other statement of income. If no income verification is received the program will be required to charge the family the maximum fee.

APPLICATION CANNOT BE FAXED OR EMIALED. We do not except copies of an application that has been filled out. You MUST provide the original.

Mail applications to:

Attention: Respite Care Program
925 BRIGHTSEAT ROAD
LANDOVER, MD. 20785

HOW TO USE RESPITE CARE

Once the application is received by our office it will be processed, a letter will be mailed out and the recipient registered, if eligible. The family, caregiver, disabled individual, and/or the caseworker must then contact Respite Care Program to request specific days of care. Requests are handled by phone and should be made **2 weeks in advance**. Care will be provided in the home of the individual with disability or at an Adult Day Care Facility.

If you have any questions or concerns regarding the completion of the application or services rendered, please call our office at (301) 909-2091.

PRINCE GEORGES COUNTY
DEPARTMENT OF SOCIAL SERVICES
301.909.2091
925 BRIGHTSEAT ROAD
LANDOVER, MD, 20785
Attention: Respite Care Program

Respite Care Application

Today's Date: ______________

Name of person and/or agency making request: ______________________________

Phone number of person and/or agency making request: ______________________________

SECTION A. Complete this section about the individual you are caring for with an intellectual/developmental/functional disability

Name: ____
First Middle Last

Street Address: ____

City: ______________________ State: __________ Zip Code: ____________

Date of Birth: _____/_____/_______ (MM/DD/YYYY) Gender: ☐Male ☐Female

Ethnicity (check all that apply):

☐White/Caucasian ☐Black/African American ☐Hispanic or Latino

☐Non-Hispanic or Latino ☐Native Hawaiian/Pacific Islander ☐Asian

☐Other (specify): ☐Not Available/refused

Universal Respite Care Application Effective: 7/1/2019

SECTION B. Complete this section about the individual in Section A's primary caregiver(s) or parents/guardians. If the individual in Section A is 18 years of age or older, provide information about his/her family/unpaid caregiver(s). If the individual in Section A is under age 18, please provide information about his/her parents/guardians.

Family/unpaid caregiver #1 or parent/guardian #1

Name: ____
First Middle Last

Street Address:____

City: ______________________ State: __________ Zip Code: ___________

Phone: ______________________ Email Address: ______________________

Date of Birth: ____/____/_______ (MM/DD/YYYY) Gender: ☐Male ☐Female

Ethnicity (check all that apply):

☐White/Caucasian ☐Black/African American ☐Hispanic or Latino

☐Non-Hispanic or Latino ☐Native Hawaiian/Pacific Islander ☐Asian

☐Other (specify): ☐Not Available/refused

Employment status:

☐Full-time ☐Part-time ☐Not employed

Family/unpaid caregiver #2 or parent/guardian #2

Name: ____
First Middle Last

Street Address:____

City: ______________________ State: __________ Zip Code: ___________

Phone: ______________________ Email Address: ______________________

Date of Birth: ____/____/_______ (MM/DD/YYYY) Gender: ☐Male ☐Female

Ethnicity (check all that apply):

☐White/Caucasian ☐Black/African American ☐Hispanic or Latino

☐Non-Hispanic or Latino ☐Native Hawaiian/Pacific Islander ☐Asian

☐Other (specify): ☐Not Available/refused

Employment status:

☐Full-time ☐Part-time ☐Not employed

SECTION C. Complete this section about the other people who live in the same household as the individual in Section A

Name	Relationship to Individual Listed in Section A	Date of Birth

SECTION D. Provide an emergency contact in case the primary caregiver cannot be reached.

Name: ____
First Middle Last

Relationship to Individual Listed in Section A: ____________________

Street Address:______________________________________

City: ____________________ State: __________ Zip Code: __________

Home Phone: ____________________Work Phone: ____________________

Mobile Phone: ____________________Email Address: ____________________

SECTION E. Provide information about the individual listed in Section A's limitations and medical conditions/diagnoses.

List any additional chronic medication conditions:

____

____

____

____

Please specify the limitations experienced by the individual listed in Section A. Please check "yes" or "no."

Limitations	
Self-Care	☐ Yes ☐ No
Receptive and expressive language	☐ Yes ☐ No
Learning	☐ Yes ☐ No
Mobility	☐ Yes ☐ No
Self-direction	☐ Yes ☐ No
Capacity for independent living	☐ Yes ☐ No
Economic self-sufficiency	☐ Yes ☐ No

Please specify the amount of help the individual listed in Section A needs for the activities listed below.

Activities of Daily Living	Manages Independently	Needs Supervision	Needs Assistance	Does Not Apply
Bathing and grooming (e.g, shaving, brushing teeth and hair, washing face)				
Dressing				
Toileting/ incontinence/ diapers/Depends				
Eating and drinking				
Walking/ Ambulation (uses cane, walker, wheelchair)				
Making phone calls				
Cooking/meal preparation				
Transferring (from bed to chair)				
General supervision				
Medication administration				

Section F. Please provide information about the individual in Section A's behaviors.

Does this individual exhibit difficult behaviors?

☐Yes, please describe:

☐No

Does this individual exhibit behaviors that endanger himself/herself or other individuals?

☐Yes (describe behaviors):

☐No

Does this individual have a behavior plan?

☐ Yes (provide a copy of the plan)

☐ No

Has this individual attempted suicide in the last year?

☐ Yes (provide details):

☐ No

Please indicate individual's overall behavioral support level.

☐ Minimal (needs little supervision)

☐ Moderate

☐ Extensive (needs close supervision)

SECTION G. PLEASE COMPLETE ONLY IF PERSON IN SECTION A IS 18 YEARS OF AGE OR OLDER

Please provide information about any other formal support services the individual in Section A receives?

Does the individual in Section A attend an adult day/medical day program?

☐ If yes, indicate days and hours per day attended below

☐ No

☐ Monday (# of hours): _________

☐ Tuesday (# of hours): _________

☐ Wednesday (# of hours): _________

☐ Thursday (# of hours): _________

☐ Friday (# of hours): _________

☐ Saturday (# of hours): _________

☐ Sunday (# of hours): _________

Adult Medical Day Contact Information

Adult/Medical Day Program Name: ______________________________

Mailing Address: ______________________________

Contact Person: ______________________________

Phone: ______________________________

Email: ______________________________

Does the individual in Section A receive in-home services such as personal support, personal care attendant services or nursing?

☐ If yes, indicate days and hours per day attended below

☐ No

☐ Monday (# of hours): __________ ☐ Tuesday (# of hours): __________

☐ Wednesday (# of hours): __________ ☐ Thursday (# of hours): __________

☐ Friday (# of hours): __________ ☐ Saturday (# of hours): __________

☐ Sunday (# of hours): __________

Support Services Contact Information

Program Name: ______________________________

Mailing Address: ______________________________

Contact Person: ______________________________

Phone: ______________________________

Email: ______________________________

Do you work with a Coordinator of Community Services or case manager?

☐Yes, please provide contact information (below).

☐No

Coordinator of Community Services Contact Information

Program Name: ____________________

Mailing Address: ____________________

Contact Person: ____________________

Phone: ____________________

Email: ____________________

Does the individual in Section A receive any Medicaid waiver services?

☐Yes (please describe): ____________________

☐No

Are there any other federal, state or county agencies from which you are receiving services such as IHAS?

☐Yes (please provide names of providers): ____________________

☐No

Is funding available for respite to the individual in Section A or parent through any other program?

☐Yes (please explain): ____________________

☐No

Are you on a waiting list for additional services?

☐Yes (please explain): ____________________

☐No

SECTION H. PLEASE COMPLETE ONLY IF PERSON IN SECTION A IS UNDER 18 YEARS OF AGE

Does the individual in Section A attend school or a child care program?

☐ If yes, indicate days and hours per day attended below

☐ No

☐ Monday (# of hours): _________ ☐ Tuesday (# of hours): _________

☐ Wednesday (# of hours): _________ ☐ Thursday (# of hours): _________

☐ Friday (# of hours): _________ ☐ Saturday (# of hours): _________

☐ Sunday (# of hours): _________

School/Day Care Contact Information

School/ Day Care Name: ____

Mailing Address: ____

Contact Person: ____

Phone: ____

Email: ____

SECTION I. Your Respite Preferences

Specify your preference of location of respite care (check all that apply)

☐ In-home

☐ Adult medical day care

☐ Camp

☐ Therapeutic programs

☐ Respite approved facility (e.g., assisted living, nursing home)

How did you learn about respite services?

☐Local Department of Social Services

☐Website

☐Family/friend

☐Home health agency

☐Other (specify):

Client or Client's Representative Signature: ______________________________

Date:____________

FOR LDSS/GRANTEE USE ONLY

Individual in Section A's Disability:

☐Developmental

☐Functional

Application Status:

☐Approved

☐Incomplete

☐Denied

Number of hours approved: ____________

DHS
MARYLAND DEPARTMENT OF HUMAN SERVICES

Angela D. Alsobrooks
County Executive

Gloria Brown Burnett
Director

Department of Human Services
Prince George's County Department of Social Services

PRINCE GEORGES COUNTY
DEPARTMENT OF SOCIAL SERVICES
301.909.2091
925 BRIGHTSEAT ROAD
LANDOVER, MD, 20785
Attention: Respite Care Program

Respite Application: Financial Disclosure Form for Adults

Applicant's Name: ____

Today's Date: _____________

In order for us to determine your subsidy for respite care, please complete this form and attach verification of income. Your subsidy is based upon on the disabled adult's total gross income minus documented out-of-pocket medical expenses. Total gross income is the total income the disabled adult receives before deductions such as taxes.

Due to state regulations, applications cannot be processed without proper verification of income. Please attach verification of income such as recent pay stubs and Social Security statements, and SNAP and housing benefits.

Sources of Income

Income Category	**Disabled Adult's Monthly Income**	**Verification Source**
Social Security		
Employment/Salary		
Veterans Benefits		
Railroad Retirement		
Civil Service		
Pensions		
Alimony		
Rental Income		

Interest Income		
Annuities		
Housing Vouchers		
Food Stamps		
Other: please provide details		

Please list the disabled person's out-of-pocket medical expenses for the last 12 months. Examples of out-of-pocket expenses include medicals expenses not covered by insurance such as co-pays and deductibles. Medical expenses include doctors' visits, prescription and over-the-counter medications, and assistive equipment. Please attach supporting documentation such as receipts or statements of service.

Applicant's Out-of-Pocket Medical Expenses

Description of Expense	Unreimbursed Amount	Verification Source

FOR RESPITE SERVICES USE ONLY
Total income: $ Subsidy rate %: Approved subsidy $:

PRINCE GEORGES COUNTY
DEPARTMENT OF SOCIAL SERVICES
301.909.2091
925 BRIGHTSEAT ROAD
LANDOVER, MD, 20785
Attention: Respite Care Program

Respite Application: Financial Disclosure Form for Children Ages 17 AND Under

Applicant's Name: ____

Today's Date: _____________

In order for us to determine your subsidy for respite care, please complete this form and attach verification of income. Your subsidy is based upon your household's total gross income minus documented out-of-pocket medical expenses for the disabled child. Total gross income is the total income your household receives before deductions such as taxes.

Due to state regulations, applications cannot be processed without proper verification of income. Please attach verification of income such as recent pay stubs and Social Security statements, and SNAP and housing benefits.

Sources of Income

Income Category	Client's Monthly Income	Other Family Members' Monthly Income	Verification Source
Social Security/Social Security Disability/Supplemental Security Income			
Employment/Salary			
Veterans Benefits			
Railroad Retirement			
Civil Service			
Pensions			

Alimony			
Child support			
Rental Income			
Interest Income			
Annuities			
Housing Vouchers			
Food Stamps			
Other: please provide details			

Please list the disabled child's out-of-pocket medical expenses for the last 12 months. Examples of out-of-pocket expenses include medicals expenses not covered by insurance such as co-pays and deductibles. Medical expenses include doctors' visits, over-the-counter and prescription medications, and assistive equipment. Please attach supporting documentation such as receipts or statements of service.

Client's Out-of-Pocket Medical Expenses

Description of Expense	**Unreimbursed Amount**	**Verification Source**

FOR RESPITE SERVICES USE ONLY
Total income: $ Subsidy rate %: Approved subsidy $:

Angela D. Alsobrooks
County Executive

Gloria Brown Burnett
Director

Department of Human Services
Prince George's County Department of Social Services

PRINCE GEORGES COUNTY
DEPARTMENT OF SOCIAL SERVICES
301.909.2091
925 BRIGHTSEAT ROAD
LANDOVER, MD, 20785
Attention: Respite Care Program

Respite Care Application: Physician's Statement

Dear Primary Physician:

The patient listed below has applied for respite care services offered through Prince Georges County Department of Social Services. The State of Maryland requires that a Physician's Statement be completed by the patient's healthcare provider to certify the patient's need for respite care.

We appreciate you taking the time to complete this form.

Today's Date: _______________

Patient's Name: ____

Date of Birth: _____/_____/_______ (MM/DD/YYYY)

Patients Primary Diagnosis (check all that apply)

Condition	Yes	No
Allergies		
Autism		
Behavioral Problems		
Blindness/Visual Impairment		
Cancer		
Cerebral Palsy		
Cystic Fibrosis		
Deafness/Hearing Impairment		
Dementia/Alzheimer's Disease		
Diabetes		
Epilepsy/Seizure Disorder		
Head Injury		
Heart Condition		
Intellectual/Developmental Disability		
Lupus		
Mental Illness		
Multiple Sclerosis		
Neurological Impairment		
Parkinson's Disease		
Sickle Cell Disease		
Speech/Language Impairment		
Spina Bifida		
Spinal Cord Injury		
Stroke		
Other (specify):		
Other (specify):		
Other (specify):		

Please list any medications taken by the patient and the purpose of each medication. Attach additional sheets, if necessary.

Medication Name	Medication's Purpose

Does the patient require help with his or her activities of daily living?

☐ Yes, please provide details: ____

____

____

☐ No

Please specify the limitations experienced by the individual listed in Section A. Please check "yes" or "no."

Limitations	Yes	No
Self-Care		
Receptive and expressive language		
Learning		
Mobility		
Self-direction		
Capacity for independent living		
Economic self-sufficiency		

Does the patient require skilled care that should be delivered by a skilled healthcare professional (such as medication administration, G-tube feeding, injections, catheter care, etc.)?

☐Yes, please provide details: ____

____

____

☐No

If the patient requires assistance with medication administration, is his/her family able to administer the medication during the period of time in which respite services are provided?

☐Yes, please provide details: ____

____

____

☐No

Please provide details and treatment protocols for allergens and seizures.

____

____

Please provide details regard the patient's dietary needs (e.g., special diet or dietary modifications).

Signature of Physician: ____

Date: ____

Address: ____

Phone number: ____

Official Stamp: