RESPITE CARE PROGRAM

The Respite Care Program offers subsidies for short-term temporary care to provide a period of rest and renewal to family caregivers by temporarily relieving them of the demands and stresses of caregiving responsibilities. Respite Care is provided at planned intervals, in times of crisis, and on an as-needed basis. We serve children and adults with developmental disabilities and adults with functional disabilities and their families.

HOW TO APPLY

The application for Respite Care is attached. The packet contains three sections, all of which must be completed and returned to our office.

1. CLIENT INFORMATION
2. PHYSICIAN'S STATEMENT AND RELEASE FORM
3. 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.

If you have any questions regarding how to fill out the application, please call our Respite Care Coordinator at 301-909-2039 or email at pgcdss.respitecare@maryland.gov.

THE APPLICATION CANNOT BE FAXED

Please mail the completed application to:

Prince George's County
Department of Social Services
Attention: Respite Care
925 Brightseat Road
Landover, MD 20785

Or email to: pgcdss.respitecare@maryland.gov

Once the application is received by our office, it will be processed in 30 days, and a letter will be mailed to the applicant informing them of the status of their application.

PRINCE GEORGES COUNTY
DEPARTMENT OF SOCIAL SERVICES
301-909-2039
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

PRINCE GEORGES COUNTY
DEPARTMENT OF SOCIAL SERVICES
301-909-2039
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:

PRINCE GEORGES COUNTY
DEPARTMENT OF SOCIAL SERVICES
301.909.2091 / 301-909-2039
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, Social Security statements, 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 medical expenses not covered by insurance such as co-pays and deductibles. Medical expenses include doctors' visits, prescription, over-the-counter medications, and assistive medical 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 / 301-909-2039
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, Social Security statements, 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 medical 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 $: