HELPING HANDS of VEGAS VALLEY
2320 Paseo Del Prado B-204, Las Vegas, NV 89102
(702) 507-1848 or Fax (702) 728-2963 cory.lutz@hhovv.org

RESPITE CARE VOUCHER PROGRAM

Dear Applicant:

Thank you for your interest in the Helping Hands of Vegas Valley Respite Care Voucher Program. The program is designed to serve those who are in need of a break from being a care giver and designed to reach as many people as possible.

Our respite program, funded by the State of Nevada Aging & Disability Services Division, provides short-term relief from the physical, emotional and daily demands of caring for an individual in the home. Respite funds must be used to obtain needed services to provide a break from caregiving. This is ***NOT*** a housekeeping voucher. Services that can be paid for through the respite program include:

- **Facility Overnight Stay** – Short term stay in a facility to provide a break from caregiving
- **In Home Care** – Services may include personal care, companionship and homemaking duties
- **Adult Day Care** – Provides supervised activities and socialization

Please complete and return the entire application, making sure that all sections of the application are filled out before mailing it back to our office. ***We are unable to process an incomplete application.*** Please print clearly and include signatures where indicated. Further, once approved you must select a respite provider from our approved list of licensed agencies, which will be sent with approval. Approval of respite is dependent upon available funding.

Once approved, both the agency provider and the caregiver will be sent a voucher for respite services in a designated amount. The agency provider will invoice Helping Hands of Vegas Valley directly. The voucher must be used within **90 days** of being issued. Helping Hands of Vegas Valley will not be responsible for charges that exceed the voucher amount or those that fall outside of the authorized dates. **Once the voucher has expired, any remaining funds will automatically be returned to the respite program**. If for some reason, you are unable to utilize the awarded respite funds, please notify the undersigned as soon as possible, so that the funds can be redistributed to another family in need.

Please retain this page for your own records. If you have questions about filling out the application, please call me at **702.507.1848**. Or you can e-mail me at: cory.lutz@hhovv.org.

Sincerely,

Cory Lutz
Respite Care Coordinator

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Application Check List:

Please Complete and return the following with this page:

☐ **Proof of Address (only the following will be considered)**
- Either a NV ID or NV Driver's License must be submitted for both caregiver and recipient.
  - The addresses for the Caregiver and Recipient/Patient must be the same, **and** match the address on the application.
  - The copies we receive must be clear and all information visible for the ID to be considered.
- A rental or utility bill
- Verification of voter's registration or other official documentation.

☐ **Completed and signed Application Page**

☐ **Completed and signed Certificate of Eligibility**

☐ **Completed and signed Release of Liability**

If you do not submit a complete application, including proof of address, your application will be set aside and not processed. We will not contact you if your application is incomplete.

To my knowledge I am submitting a complete application for the Helping Hands Respite Voucher Program. I understand that if approved, we will have 90 days to complete the voucher, ***with no extensions***.

If approved, you will receive your voucher via mail or email.

Signature of Caregiver: _____

Date: _____

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Respite Voucher Application

Patient/Client
LEGAL NAME (First/Last): _____

NICKNAME: _____ ☐ MALE ☐ FEMALE

DATE OF BIRTH: ____/____/____ PHONE NUMBER: (____) _____

PHYSICAL ADDRESS: _____ MAILING ADDRESS: (If Different) _____

☐ **Veteran** ☐ **Veteran Dependent** ☐ **U.S. Citizen** ☐ **No Current Address/Residence**

CAREGIVERS CONTACT INFORMATION ***(Attach additional papers if more than one person):***

NAME (First/Last): _____ RELATIONSHIP: _____

HOME PHONE: (____) _____ WORK OR CELL PHONE: (____) _____

E-Mail: _____ ☐ Mail or ☐ Email documents (you must be able to print out)

Patient /Recipient's Information:

☐**Married** ☐**D** ☐**W** ☐**Single** ☐**Separated**

ETHNICITY
☐ HISPANIC OR LATINO ☐ NON-HISPANIC OR LATINO

RACE
☐ WHITE, CAUCASIAN ☐ ASIAN
☐ BLACK / AFRICAN AMERICAN ☐ HISPANIC
☐ AMERICAN INDIAN / ALASKAN NATIVE
☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
☐ OTHER _____

If you do not speak English, what is your primary language? _____

According to the current Federal Poverty Guidelines, YOUR (Senior and spouse, if applicable only) INCOME IS:
(see back of page for current Poverty Guidelines)

A. POVERTY: ☐ BELOW **OR** ☐ ABOVE
B. 300% Supplemental Security Income:
☐ BELOW **OR** ☐ ABOVE

DO YOU:
1. LIVE ALONE?..... ☐ Yes ☐ No
2. HAVE A DISABILITY? ..... ☐ Yes ☐ No
3. CONSIDER YOURSELF FRAIL? .... ☐ Yes ☐ No

ARE YOU:
1. UNABLE TO LEAVE YOUR HOME WITHOUT ASSISTANCE (Homebound)?..... ☐ Yes ☐ No
2. ON STATE MEDICAID? ..... ☐ Yes ☐ No

WHICH OF THE FOLLOWING IS THE PATIENT *UNABLE* TO PERFORM WITHOUT ASSISTANCE?

Activities of Daily Living (ADLs)
Without assistance, I am unable to:
☐ Bathe ☐ Get Dressed
☐ Eat ☐ Use the Bathroom
☐ Walk ☐ Transfer In or Out of a Bed or Chair
☐ **None – I can perform these activities**

☐ I was provided with the *Notice of Privacy Practices*

Instrumental Activities of Daily Living (IADLs)
Without assistance, I am unable to:
☐ Prepare Meals ☐ Do Light Housework
☐ Take Medication ☐ Do Heavy Housework
☐ Manage Money ☐ Use the Telephone
☐ Shop ☐ Use Transportation Services
☐ **None – I can perform these activities**

Caregiver resides in the same household as the recipient. ☐ **Yes** ☐ **No**
By signing below, the caregiver agrees that the information provided is accurate and agrees to provide Helping Hands of Vegas Valley with information for verification purposes to determine need. **Any information subsequently found to be false may void the grant.**

Signature of Caregiver: _____ **Date:** _____

Reviewed by HHOVV Employee: _____ **Date:** _____

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
2017 FEDERAL POVERTY GUIDELINES

A.	Poverty Guidelines *48 Contiguous States and D.C.*		B. Social Security Administration *Supplemental Security Income (SSI)* Senior/Client *only*
	Annual Income	Monthly Income* (Senior and Spouse only)	Per Month
1	$ 12,060	$ 1,005.00	If the ***Senior*** makes less than $2205.00/ month, please mark that they are ***below*** 300% SSI.
2	$ 16,240	$ 1,353.33	
3	$ 20,420	$ 1,701.67	
4	$ 24,600	$ 2,050.00	If the ***Senior*** makes more than $2205/month, then please mark that they are ***above*** 300% SSI.
5	$ 28,780	$ 2,398.33	
6	$ 32,960	$ 2,746.67	
7	$ 37,140	$ 3,095.00	
8	$ 41,320	$ 3,443.33	Calculation: SSI rate for 2017 (https://www.ssa.gov/OACT/COLA/SSI.html), $735 x 300% = $2,205
For family units with more than 8 members, add the following amount for each additional family member: $4,180 per year			Thank you.
SOURCE: *Federal Register* / Vol. 82, No. 19 / January 31, 2017 / pp. 8831 – 8832 https://www.federalregister.gov/articles/2016/01/25/2016-01450/annual-update-of-the-hhs- poverty-guidelines *Monthly income was calculated by dividing the Poverty Guideline, which is an annual figure, by 12 (months).			

CERTIFICATE OF ELIGIBILITY

FOR RESPITE CARE VOUCHER PROGRAM

_____(Caregiver) has requested financial aid for respite care for their loved one.

This statement is to certify that_____(Recipient) is in my care and is in need of continuous supervision.

This statement must be signed by a licensed healthcare practitioner, who is responsible for recipient's diagnosis and ongoing care such as a physician, nurse or social worker. This information will be verified.

_____ _____

Signature (Dr., Nurse or SW) (Stamps not accepted) **Printed Name**

_____ _____

Date **State License # (Required)**

_____ _____

Company / Organization name **Phone #**

_____

Street Address

_____

City, State, ZIP

Recipient's Primary Diagnosis:

_____

_____

_____

VOUCHER INFORMATION

(This must be signed in order to process the application)

Select the type of respite you would like to receive (If known at this time, if *not* list will be provided with approval):

☐ In home care ☐ Adult Day Care ☐ Facility Overnight Stay

Provider Requested: _____

An agency/provider must be selected. If you do not know which agency you will use, we will provide you a list upon approval of the voucher. The provider must be chosen from our approved provider list.

Caregiver's Signature:_____Date:_____

RELEASE OF LIABILITY

(This must be signed in order to process the application)

I_____(Caregiver) hereby agree to accept a voucher through Helping Hands of Vegas Valley respite care program to provide services for _____ _____ (Care Recipient). I understand it is my responsibility not to exceed the amount of the voucher, and that I am responsible for any service charges in excess of the voucher amount.

Helping Hands of Vegas Valley assumes no liability or responsibility for injury, accident, or negligence by your chosen provider that may occur to (Care Recipient) _____while services are received under this grant.

Caregiver's Signature:_____Date:_____

VERIFICATION OF INFORMATION

(This must be signed in order to process the application)

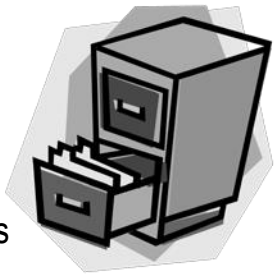
By signing below, the caregiver agrees that information provided is accurate and agrees to provide Helping Hands of Vegas Valley with information for verification purposes to determine need.
Any information subsequently found to be false may void grant.

Caregiver's Signature:_____Date:_____

State of Nevada
Department of Health and Human Services Aging and Disability Services Division

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.



Your health information is personal and private. The law says that we (the Aging & Disability Services Division) must protect this information. When you first asked for our help or services, you gave us information that helped us decide if you qualified. It became part of your file, which we keep in our offices. Also in your file is information that is given to us by hospitals, doctors and other people who treat you. A federal law says that we must give you this notice to help you understand what our legal duties are and how we will protect your health information.

When is it okay for us to share your health information?

If you sign a special form that tells us it is okay to share your health information with someone, then we will share it. You can cancel this at any time by notifying us in writing except if we have already shared the information. We do not use your information for marketing or share psychotherapy notes without your written approval.

When can we share your health information without your ok? Your information can be shared without your okay when we need to approve or pay for services. We can also share it when we review our programs and try to make them better. Under the law, these uses are called treatment, payment and health care operations.

The law says that there are some other situations when we may need to share information without your okay. Here are some examples.

For your medical treatment and payment

- When you need emergency care
- To tell you about treatment choices
- To remind you about appointments
- To help our business partners do their work
- To help review program quality

For your personal reasons

- To tell your family and others who help with your care things they need to know
- To be listed in a patient directory
- To tell a funeral director of your death
- If you have signed organ donation papers, to make sure your organs are donated according to your wishes

For public health reasons

- To help researchers study health problems
- To help public health officials stop the spread of disease or prevent an injury
- To protect you or another person if we think that you are in danger

Other special uses

- To help the police, courts and other people who enforce the law
- To obey laws about reporting abuse and neglect
- To report information to the military
- To help government agencies review our work and investigate problems
- To obey court orders

State of Nevada
Department of Health and Human Services
Aging and Disability Services Division

What are your rights?

- You can ask us not to share your information in some situations. However, the law says that we do not always have to agree with you.
- If you are reading this notice on the Internet or on a bulletin board, you can ask for a paper copy of your own.
- You can ask to look at your health information and get a copy of it. You may be charged a fee for the copies based on Division policy. However, you need to remember that we do not have a complete medical record about you. If you want a copy of your complete medical record, you should ask your doctor or provider of health care.
- If you think that something is missing or is wrong in your health record that we have, you can ask us to make changes.
- You can ask to have a copy of your health information provided in electronic format if it is available.
- You can ask us to give you a list of the times (after April 14, 2003) that we have shared your health information with someone else. This will not include the times we have shared your information for the purposes of treatment, payment or health care operations.
- You may ask to restrict the release of your health information to a health plan when you have paid out of pocket in full for items or services.
- You can ask us to mail health information to an address that is different from your usual address or to deliver the information to you in another way.

What if you have a complaint?

If you think that we have not kept our promise to protect your health information, you may complain to us or to the federal Department of Health and Human Services. Nothing will happen to you if you complain.

What are our responsibilities?

- We must keep your health information private except in situations like the ones listed in this notice.
- We must give you this notice that explains our legal duties about privacy.
- We must follow what we have told you in this notice.
- We must agree when you make reasonable requests to send your health information to a different address or to deliver it in a way other than regular mail.
- We must notify you if there is a breach of your unsecured health information.
- We will only use or share the minimum amount of your health information necessary to perform our duties.
- We must tell you if we cannot agree when you ask us to limit how your information is shared.

Contact Information

If you have any questions or complaints about our privacy rules, please contact us at: Aging & Disability Services Division Privacy Officer 3416 Goni Road, Suite D - 132 Carson City, NV 89706 (775) 687-4210	Or contact the Dept. of Health and Human Services at: Office for Civil Rights 90 7th Street, Suite 1-100 San Francisco, CA 94103 (415) 437-8310; (415) 437-8311 (TDD)

The Aging & Disability Services Division has the right to change this notice and change the way your health information is protected. If that happens, we will make corrections and send a new notice to you by mail and we will post it in our offices and on our web site at: http://aging.nv.gov

Revised ADSD 6/26/14