Respite Coordination

Short-Term Relief for Unpaid, Live-In, Primary Caregivers

The Arc Montgomery County

FY25 APPLICATION FOR SENIOR RESPITE COORDINATION

For Senior Citizens Ages 60+

THIS APPLICATION IS VALID JULY 5, 2024–MARCH 1, 2025.

A. Complete this section about the senior citizen for whom respite coordination is being requested.
(Must attach copy of Maryland Driver's License or other MVA issued Maryland identification)

Name: _____
First *Middle* *Last*

Street Address: _____

City: _____ State: _____ Zip: _____

Race: ☐ White ☐ Black/African American ☐ Asian
☐ American Indian/Alaska Native ☐ Native Hawaiian or Pacific Islander ☐ Other _____

Ethnicity: ☐ Non-Hispanic or Latino ☐ Hispanic or Latino

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

Does the person receive Medicaid? Yes ☐ No ☐

B. Complete this section about the unpaid primary caregiver(s) who lives with the person listed in Section A.

Unpaid, Primary Caregiver #1 ***(Must attach copy of Maryland Driver's License or other MVA-issued Maryland identification)***

Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____ Phone: _____

Relationship to Person Listed in Section A: _____

Race: ☐ White ☐ Black/African American ☐ Asian
☐ American Indian/Alaska Native ☐ Native Hawaiian or Pacific Islander ☐ Other _____

Ethnicity: ☐ Non-Hispanic or Latino ☐ Hispanic or Latino

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

Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

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

Name *Relationship* *Date of Birth*

_____

_____

_____

D. Complete the following information about the person listed in Section A and his/her household environment.

Activities of Daily Living (provide additional details if needed)	*Manages Independently*	*Needs Supervision*	*Needs Assistance*	*Does Not Apply*
Bathing/Hair Care				
Shaving				
Skin Care				
Teeth Brushing				
Toileting				
Depends/Diapers				
Dressing				
Eating/Drinking				
Walking/Ambulating (uses cane, wheelchair or other support?)				
Stair Climbing				
Making Phone Calls				
Cooking/Meal Preparation				
Medication Reminder (no medication management or medication administration provided)				
Other (specify)				

Please Indicate Person's Overall Support Level	**Minimal** (needs little supervision)	**Moderate**	**Extensive** (needs close supervision)

Communication	
Is this person verbal?	☐ Yes ☐ No
What is this person's primary language?	
Does this person understand/speak English?	☐ Yes ☐ No
Does this person speak another language? If yes, which language?	☐ Yes ☐ No
Does this person use an alternate communication method (for example sign language, communication board, or other adaptive communication device)? If yes, describe.	☐ Yes ☐ No
Does this person use hearing aids?	☐ Yes ☐ No
Household Environment	
Does this person smoke?	☐ Yes ☐ No

Does anyone else in the home smoke?	☐ Yes ☐ No
Are there pets in the home? If yes, what kind and how many?	☐ Yes ☐ No
Is the entrance to the residence fully handicapped accessible to this person?	☐ Yes ☐ No
Are all the areas of the residence the individual uses fully handicapped accessible, including the bathroom?	☐ Yes ☐ No
Does this person need physical support to ensure his/her safety in navigating daily life activities? If yes, describe.	☐ Yes ☐ No
Medical Information	
Does this person have special dietary requirements or restrictions? If yes, describe.	☐ Yes ☐ No
Does this person use oxygen? If yes, describe.	☐ Yes ☐ No
Does this person wear a C-Pap or Bi-Pap while sleeping?	☐ Yes ☐ No
Does this person have a history of seizures? If yes, describe the type and frequency, and provide a copy of the seizure protocol. If yes, what is the date of the last seizure?	☐ Yes ☐ No
Does this person have allergies? If yes, describe the allergen and reaction, and provide a copy of the allergen protocol.	☐ Yes ☐ No
Has this person been hospitalized in the last year? If yes, describe the reason(s) for hospitalization and/or the situation which required hospitalization.	☐ Yes ☐ No
Does this person use special or adaptive equipment? If yes, describe (include walker, wheelchair, assistive technology, hearing aids, etc.)	☐ Yes ☐ No
Does this person require transferring by a support person or support staff? ***Please note that home health agencies will not provide total lift and transfer of any individual for safety reasons. ***	☐ Yes ☐ No

E. Complete the following information about other support services provided to the person listed in Section A.

Adult Day/Medical Day (Day/Work/ /Medical Day)

Does this person attend a day program? ☐ Yes ☐ No
If yes, provide the following information:

☐ Private Pay ☐ County/State/Federal Grant ☐ Medicaid Waiver

Days Attending and Number of Hours Each Day *(mark all):* ☐ Saturday _____ ☐ Sunday _____

☐ Monday _____ ☐ Tuesday _____ ☐ Wednesday _____ ☐ Thursday _____ ☐ Friday _____

Agency Name: _____

Mailing Address: _____

Contact Person: _____ Phone: _____

Contact Email: _____

Medicaid Services

Does this person receive ANY Medicaid services or is this person on a waiting list to receive Medicaid waiver services? ☐ Yes ☐ No
If yes, attach a copy of the service plan for ALL Medicaid services received.

In Home Services or Programs (Personal Support/Personal Care Attendant/Nursing)

Does this person receive additional support services (including those provided at home like IHAS, Hospice or Home Health)? If yes, provide the following information: ☐ Yes ☐ No

☐ Private Pay ☐ County/State Grant ☐ Medicaid Waiver

Days Receiving Support and Number of Hours Each Day *(mark all):* ☐ Saturday _____ ☐ Sunday _____

☐ Monday _____ ☐ Tuesday _____ ☐ Wednesday _____ ☐ Thursday _____ ☐ Friday _____

Agency Name: _____

Mailing Address: _____

Contact Person: _____ Phone: _____

Contact Email: _____

Certification of Acknowledgement and Understanding

The following statements include:

1) your duties and obligations regarding respite coordination;
2) information how respite coordination operates;
3) information about how, when and where respite coordination is delivered,
4) your affirmation that neither you nor any relative are receiving payment to support the person listed in Section A; and
5) your consent to release information for the purpose of determining eligibility for respite coordination.

Please read each statement carefully, then initial beside each statement to indicate your understanding and acknowledgement. Then sign and date the final page of this application where indicated.

1. Your Duties and Obligations With Regard To Respite Coordination

Caregiver Initials:	***I have attached all necessary supporting documents to this application. I understand that if the supporting documents are not attached, and/or if the application is incomplete, IT WILL NOT BE PROCESSED and will be returned to me by email or mail.***
Caregiver Initials:	I understand there is no guarantee that respite will be provided to me simply because I have submitted this application. I have made a copy of my application and supporting documents for my own records.
Caregiver Initials:	I understand that respite is designed to give the unpaid, primary caregiver living in the same residence short-term relief. It is not a substitute for ongoing care. I understand that respite cannot be used for regular, long-term, or continuing care, or to allow the unpaid primary caregiver to regularly go to work.
Caregiver Initials:	I understand that the respite program coordinated by The Arc Montgomery County **is not an entitlement program or a financial assistance program**. **Respite coordination is not guaranteed** to any particular group or segment of the population.
Caregiver Initials:	I understand that approved eligibility may result in respite hours being available to support my family member. Approved eligibility will not result in a monetary payment to the primary caregiver or relatives.
Caregiver Initials:	I understand that respite coordination does not guarantee services based upon my personal scheduling requirements, my family's medical needs, or the ability of the aides to complete their job safely in my home.
Caregiver Initials:	I understand that the respite program has two levels of care (Level I and Level II), and that the information provided on the Physician's Health Form determines the level of care required.
Caregiver Initials:	I understand that in-home Level II respite care must be provided by a licensed health care practitioner, such as a Licensed Practical Nurse (LPN) or Registered Nurse (RN).

2. How Respite Coordination Operates

Caregiver Initials:	I understand that The Arc Montgomery County does not directly provide respite care. I must choose a respite provider from among a consortium of pre-screened agencies.
Caregiver Initials:	I understand that I cannot receive respite while the person listed in Section A or Section B is in a hospital, rehabilitation center, or residential program.
Caregiver Initials:	I understand that I may be required to obtain an updated Physician's Health Form for the person(s) receiving respite care if a hospitalization occurs.

Caregiver Initials:	I understand that if the person listed in Section A of this application is eligible for hospice services, Level I respite hours can be delivered in the home by an approved, licensed home health care agency.
Caregiver Initials:	I understand that I cannot be a respite provider to another family in the respite program, and that no other person in my household can be a respite provider to another family in the respite program.
Caregiver Initials:	I understand that the respite provider will provide care ONLY for the person(s) enrolled in the respite program. The respite provider is not allowed to care for other children or adults who are in the home. If this happens, all respite services will be immediately, and potentially permanently, discontinued.
Caregiver Initials:	I understand that only the approved respite facilities, therapeutic programs and in-home support providers on The Arc Montgomery County respite consortium may be utilized when payment is authorized through respite care subsidies.
Caregiver Initials:	If I choose to utilize a respite care provider not on The Arc Montgomery County Respite Consortium, I am personally responsible for any and all payments to that respite care provider. I understand that the Respite consortium members for The Arc Montgomery County changes frequently, and that I may be required to change respite care providers because of changes.

3. How, When and Where Respite is Delivered

Caregiver Initials:	I understand that **I must contact Respite@arcmontmd.org or 301.984.5777 x1204 before using respite hours, to request and receive the appropriate authorization.** Failure to follow this procedure will prevent payment to the respite provider. *If this happens, I will be liable for payment to the respite provider.*
Caregiver Initials:	I understand that I will be responsible for payment to the respite care provider for any hours worked beyond what is approved and allowed by The Arc Montgomery County.
Caregiver Initials:	I understand that respite care is limited to 10 hours per day in the home (between 6 am and midnight only) or at a therapeutic program and that respite providers will not be paid by The Arc Montgomery County for more than 10 hours per day.
Caregiver Initials:	I understand that *overnight* respite care must be provided at an approved respite care facility (which includes respite provided between midnight and 6 am).
Caregiver Initials:	I understand that I may not be approved for respite hours if the agency I select to provide respite care is not part of The Arc Montgomery County Respite Consortium. The Arc of Montgomery County and DHHS reserve the right to limit the number of consortium members.
Caregiver Initials:	I understand that if I receive IHAS (In-Home Aide Services), I must use my IHAS provider to deliver respite care. IHAS and Respite cannot be used in the same 24-hour period. IHAS recipients may only receive respite hours in the home.
Caregiver Initials:	I understand that if I have more than one senior enrolled, **a 50% reduced subsidy rate will apply. One caregiver must provide respite for multiple enrolled seniors at the same time on the same day**.
Caregiver Initials:	I understand that I, as the unpaid, primary caregiver living in the same household as the person in Section A, cannot receive payments from any federal, state or county agency, vendor, or program (including Medicaid, foster care, respite, etc.) to provide support services to anyone in my household. I also understand that no other person in my household can receive payments from any federal, state or county agency, vendor, or program (including Medicaid, foster care, respite, etc.) to provide support services to anyone in my household.
Caregiver Initials:	I understand that if the person listed in Section A or Section B of this application receives any county, state, federal or veteran funding for **in-home** support or services, he/she is NOT ELIGIBLE for respite. This includes services provided through Community First Choice, REM, Community Pathways, Family Supports Waiver, Maryland Community Support, Autism Waiver, etc.

Caregiver Initials:	I understand that respite hours cannot be used with grant-funded programs or services paid for by Montgomery County or the State of Maryland, including full or partial payments for Adult Day/Medical Day, camp, therapeutic programs, LISS or LEAP.
Caregiver Initials:	**I understand that respite is designed to give the primary caregiver a break. It is not a financial assistance program and will not result in payment to the primary caregiver or relatives.**
Caregiver Initials:	I understand that eligibility for a subsidy does not guarantee respite funds for each occasion, because of limited funding.
Caregiver Initials:	I understand that in order to ensure respite funding is available to eligible people and their families who have little or no services, limits will be placed on the number of respite hours available. **I understand that these limits may change at any time and respite hours are never guaranteed**.
Caregiver Initials:	I understand that changes to the respite program will occasionally occur based upon state, county and agency requirements, and I agree to comply with those changes or withdraw or cancel my application. I understand that all respite applications are subject to audit, with changes in status or approval based upon audit findings.
Caregiver Initials:	I understand that I must submit a NEW application each fiscal year, which includes ALL required supporting documents annually. Supporting documents must be up to date. If I am currently approved for respite coordination, my new application for the following fiscal year will receive priority review if submitted between May 15 and June 15. ***Failure to submit the renewal application will result in my file being closed effective August 1, 2024.***

4. Affirmation That You Are Not Receiving Payment to Support the Person In Section A

Caregiver Initials:

I affirm that, as the unpaid, primary caregiver living in the same household as the person in Section A:

1) **I do not work for or receive payments from any federal, state or county agency, vendor, or program (including Medicaid, foster care, respite, etc.) that pays me to support the person listed in Section A of this application; AND**
2) **No other relative or family member works for or receives payments from any federal, state or county agency, vendor, or program (including Medicaid, foster care, respite, etc.) to support the person listed in Section A of this application.**

This application provides information about your eligibility for respite care services and benefits. These benefits are provided at public expense, and you must provide true, accurate information. This information may be verified by public and private agencies and businesses. You must report any changes to the information provided on this form within 10 days of the change. If you knowingly give false information, impersonate another person, omit household members or parents/guardians, omit Medicaid services or any other funding sources, or willfully fail to report changes, you will be subject to disqualification and denial of services.

5. Consent to Release Information

By signing below, I hereby authorize the Montgomery County Department of Health and Human Services and The Arc Montgomery County to contact, review and obtain records maintained by any person, partnership, corporation, association, or governmental agency for the purpose of establishing proof of my eligibility for respite care benefits. A photocopy of this form is as valid as the original. See attached document.

Signature of Senior Citizen (Person in Section A) Date
(If person cannot sign, write "CANNOT SIGN' above.)

Signature of Unpaid, Primary Caregiver #1 (Person in Section B) Date

STOP!

Application Checklist

Please include ALL documents as outlined below; without these documents, your application is incomplete and WILL NOT BE PROCESSED.

- ☐ Completed Application for Respite Coordination (Seniors 60+)
- ☐ Physician's Health Form (must be completed by physician, signed, AND stamped). Not accepted from hospitals or rehab facilities.
- ☐ Seizure Protocol, and/or Allergen Protocol (if applicable)
- ☐ HIPAA Policy & Procedure Acknowledgement
- ☐ Consent to Application for Respite Coordination **must be completed and signed by Senior Citizen, if they cannot sign, write "Cannot Sign" on signature line.**
- ☐ Current valid Maryland Driver's License or other **MVA**-issued Maryland identification for Person in Section A **o r** a copy of social security award letter or income tax return with all financial information redacted may be accepted.
- ☐ Current valid Maryland Driver's License or other **MVA**-issued Maryland identification for Person(s) in Section B. Passports, utility bills and lease agreements are not acceptable forms of identification.

How did you learn about Respite Coordination?

☐ Internet Search ☐ Community Outreach ☐ Website ☐ Family/Friend

☐ Montgomery County Agency (specify) _____

☐ Home Health Care Agency (specify) _____

☐ Other (specify) _____

If you need assistance completing this application, please call our office at 301.984.5777 x1204.

Completed applications should be emailed in a single PDF file to Respite@arcmontmd.org.
If you cannot scan/email, please mail your application to the following address:

The Arc Montgomery County-Respite Coordination
7362 Calhoun Place, Rockville, Maryland 20855

PLEASE DO NOT USE FEDERAL EXPRESS, UPS, OR PRIORITY MAIL.
FAXED APPLICATIONS WILL NOT BE ACCEPTED.

Please note: The Arc Montgomery County may take up to 30 business days after receipt to process a completed application.

DO NOT FORGET TO INCLUDE THE DOCUMENTS LISTED IN APPLICATION CHECKLIST ABOVE OR YOUR APPLICATION WILL NOT BE PROCESSED AND RETURNED VIA EMAIL OR USPS.

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