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CLEARBROOK
Creating Opportunities for People with Disabilities

RESPITE Application Form

Please return to: Clearbrook Respite Coordinator: Michelle Bosco
1835 W Central Rd, Arlington Heights. Illinois, 60005
(847) 385-5335 or email at mbosco@clearbrook.org

☐ **Residential (24HR)** ☐ **IN - Home** ☐ **Voucher** ☐ **Group (day)**

PERSONAL INFORMATION FOR APPLICANT

Name: _____ Date of Birth: _____

Address: _____ County: _____

Check One:
☐ Living with Parent(s) ☐ Living in Other Community Facility

Other (Describe) _____

Client Home Phone: _____ Client Cell Phone: _____

Client Email Address: _____

Is applicant: ☐ Male ☐ Female Soc. Sec. No.: _____

Primary Language: _____ Secondary Language: _____

Guardian/Mother's Name: _____ Email: _____ Cell: _____

Address (if different from above): _____

Guardian/Father's Name: _____ Email: _____ Cell: _____

Address (if different from above): _____

Alternate Emergency Contact: _____ Relation to client: _____

Home Phone: _____ Cell phone: _____

Address: _____

Is Applicant own guardian?

☐ Yes ☐ No (please indicate below)

Name(s) of Guardian: _____

Type of Guardianship: _____

Does the applicant receive funding from Illinois Department of Human Services?

☐ Yes (please indicate below) ☐ No

If yes, please check:

☐ 24 hour CILA ☐ Family CILA ☐ DRS ☐ Home Based Services ☐ DT only ☐ Not Sure

Is an Independent Service Coordination Agency or any case manager connected to the applicant?

☐ Yes (please indicate below) ☐ No

Name: _____ Agency: _____

Email: _____ Phone Number: _____

RIN from Medicaid Card (If applicable please also provide a copy of the card) _____

Are you on the prioritization for urgency of need for services (PUNS) list?

☐ Yes ☐ No

Please fill out for VOUCHER respite ONLY

Family Banking Information

- Name of Account Holder_____
- Name of Bank_____
- Voided Check or letter from the bank_____(please include with application)
- Routing Number_____
- Bank Account Number_____

☐ Checking account ☐ Savings account

Please fill out for VOUCHER respite ONLY

Please choose level of care you prefer:

☐ Level 1- 30 hours per year at $14.00/hr. ☐ Level 2- 27 hours per year at $16.00/hr.

☐ Level 3- 24 hours per year at $18.00/hr.

Please fill out for In Home respite ONLY

- Staff Name:_____
- Staff Address:_____
- Staff Phone Number:_____
- Staff Email Address:_____

MEDICAL CONDITIONS/NEEDS:

What is the applicant's primary diagnosis? _____

Any secondary diagnosis? _____

Ambulation: ☐ Walks ☐ Wheelchair ☐ Walker

Allergies (specific): _____

Intolerances: _____

List specific medical instructions: _____

MEDICATION:

	Dose	Time

Primary Care Physician: _____ Phone: _____

RESPITE CARE SERVICES (use additional pages if needed)

Why does the caregiver need respite services?
How will the services benefit the caregiver? What will they be doing during their respite time?
Does the caregiver typically receive services from another program? If so, which program?
In your own opinion, would the care recipient be "at risk" if the caregiver didn't receive those services? If so, how (i.e. left alone, risk of institutionalization, etc.)?
Without respite care, what alternate choices would the caregiver have for services? ☐ None ☐ Hospital ☐ Long term care facility ☐ Use alternate caregiver (when possible) ☐ Other:

By signing below, I certify that I have read and understand the Respite Program Requirements & Instructions. I hereby affirm that all information provided within this application is accurate and precise. I give my consent for the Clearbrook Respite Coordinator to verify whether or not my household is receiving supports from any other agency or provider, paid or unpaid.

I acknowledge that any attempt to provide inaccurate or untruthful documentation may disqualify me from receiving funding from the Clearbrook now or in the future.

Signature of Person Completing Application _____Date:_____

Relation to Applicant _____

Signature of Guardian _____Date: _____

For Internal Use Only

RESPITE CARE APPLICATION

AUTHORIZATION FOR RESPITE SERVICES:

FOR CLEARBROOK RESPITE PROGRAM USE ONLY	
Program and hours approved:	
Discussion notes to determine need:	Action taken: ☐ Approved ☐ Denied ☐ Date if action:
Clearbrook respite coordinator authorizing signature:	Date: