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RESPITE Application Form

Please return to: Clearbrook Respite Coordinator: Michelle Bosco
1835 W Central Rd, Arlington Heights. Illinois
(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: (City, State & Zip Code)____

County:______________________________

Referred by: ____

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: (City, State & Zip Code): ____

____

Rev 6/8/2021

Is Applicant own guardian?

☐ Yes ☐ No (please indicate below)

Name(s) of Guardian: ______________________________

Type of Guardianship: ______________________________

Are you receiving any of the following services currently? Please check all that applies.

- ☐ DHS 24 hour CILA
- ☐ DHS Family CILA
- ☐ DHS Home Based Services
- ☐ DHS Developmental Training Services (DT only)
- ☐ Division of Rehabilitation Services (DRS) – Home Health
- ☐ Division of Rehabilitation Services (DRS) – Vocational Services
- ☐ Grant funded Voucher respite from another agency
- ☐ Grant funded In Home (87D) respite from another agency
- ☐ McHenry County Health Board Voucher Respite funding from another agency
- ☐ DCFS therapeutic day care services
- ☐ HFS Division of Specialized Care for Children (DSCC) waiver services
- ☐ HFS Division of Specialized Care for Children (DSCC) non waiver services
- ☐ Not sure
- ☐ None

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) ______________________________

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

MEDICAL CONDITIONS/NEEDS:

What is the applicant's primary diagnosis? ______________________________

Any secondary diagnosis? ______________________________

Ambulation: ☐ Walks ☐ Wheelchair ☐ Walker

Allergies (specific): ______________________________

Intolerances: ______________________________

MEDICATION:

	Dose	Time

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:

<table>
<tr><td colspan="2">FOR CLEARBROOK RESPITE PROGRAM USE ONLY</td></tr>
<tr><td colspan="2">Program and hours approved:</td></tr>
<tr><td>Discussion notes to determine need:</td><td>Action taken:
☐ Approved
☐ Denied
☐ Date if action:</td></tr>
<tr><td>Clearbrook respite coordinator authorizing signature:</td><td>Date:</td></tr>
</table>

State of Illinois
Department of Human Services

Release of Information

I authorize the release of medical, financial, personal and other program information by

__________Clearbrook_______________ agency, the fiscal/employer agent and by the Illinois Department of Human Services (DHS). This information may be released for the purposes of determining my eligibility for programs, planning my services and supports and monitoring my service delivery. The information may also be used to audit agencies providing my services and to review programs. Information may be released only if it is necessary to accomplish these purposes.

This release is valid until ____ **(Expiration Date).**
(Must be completed)

Agencies authorized to receive this information are the:

* U.S. Department of Health and Human Services;
* U.S. Social Security Administration;
* Illinois Departments of Human Services, Healthcare and Family Services, and Public Health;
* Other Illinois state agencies that operate a Medicaid Home and Community-Based Services waiver program;
* Illinois State Board of Education; and
* Local agencies under contract with DHS for the provision of service coordination, employer agent services or other supports and services which are involved in my individual service plan.

I understand that I have the right to look at and copy information about me that is released. I also understand that I have the right to refuse to release information but that DHS may still release information according to the Confidentiality Act and the federal Health Insurance Portability and Accountability Act (HIPAA).

Name of Individual (print or type): ____________________________________

Signature of Individual or authorized representative: _________________________

Signature of Witness: ____Date: ________________

CONFIDENTIALITY OF INFORMATION - Information received about the individual is to be handled in accordance with the requirements of the Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110) and the federal Health Insurance Portability and Accountability Act (HIPAA).

(formerly DMHDD - 1214)