Easter Seals
Serving
DC | MD | VA

Dear Caregiver,

Attached is an application for the Easter Seals Serving DC|MD|VA Central Maryland Respite Care Program. The Central Maryland Respite Care Program provides financial reimbursement for money spent on in-home care, adult daycare, or a short stay in a licensed facility such as a group or nursing facility for residents of Baltimore City, Baltimore County, Anne Arundel County, Carroll County, Harford County, and Howard County.

The program was developed for temporary relief of unpaid caregivers of persons with functional disabilities. After you arrange and pay for respite services, you will be reimbursed on a monthly basis until you reach your maximum hours for the fiscal year (62.5). You will be required to submit a timesheet of the hours of respite used for each month.

Starting July 1st, 2014, we will be able to provide each eligible caregiver with up to 62.5 hours of reimbursement at $8.00 an hour, totaling $500.00. ***The reimbursements are paid out on a first come, first served basis.***

In order to be considered for admission to the Central Maryland Respite Care Program, you must return completed **Program Application, Doctor's Statement, Authorization to Obtain Medical Information, Proof of Income, and Agency Family Agreement** to:

Easter Seals Serving DC|MD|VA
Central Maryland Respite Care Program
Attn: Jessica Linnenkamp
1420 Spring Street
Silver Spring, MD 20910

Incomplete paperwork may deem you ineligible to enroll in the program.

Once your application has been received and processed, you will be notified by letter of your eligibility. Enrollment is on a first come first served basis and/or until all funds are allocated. If you have any further questions, please contact Jessica Linnenkamp at 301.920.9769 or by email at jlinnenkamp@eseal.org.

Sincerely,

Central Maryland Respite Care Program

Paperwork Submission Check List

Before sending us your paperwork, please be sure you have filled out the following forms completely. Please **return the forms listed below along with this checklist** to ensure all forms have been sent to Easter Seals Serving DC|MD|VA Central Maryland Respite Care Program.

☐ **Application**

☐ **Agency Family Agreement**

☐ **Proof of Income (ex: copy of— statement of Social Security benefits, retirement, pension, etc.)**

You are required to complete the Authorization to Obtain Medical Information, and the *physician is required to fill out the Doctor's Statement.*

☐ **Authorization to Obtain Medical Information**

☐ **Doctor's Statement**

Please submit all completed paperwork to:

Easter Seals Serving DC|MD|VA
Central Maryland Respite Care Program
Attn: Jessica Linnenkamp
1420 Spring Street
Silver Spring, MD 20910

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Central Maryland Respite Care Program Application

Date of Application (mm/dd/yyyy): _____

I. Client/Person with Functional Disabilities' Information (Please Print)

Last Name: _____ **First Name:** _____

Gender: Male Female

Address: _____

City: _____ **State:** ***MD*** **Zip Code:** _____

County (Please circle which county the client lives in):

Harford County Baltimore County Baltimore City

Howard County Anne Arundel County Carroll County

Home Phone: _____ **Cell Phone:** _____

SSN (last 4 numbers): _____ **Date of Birth** (mm/dd/yyyy): _____

Ethnicity (Please circle one):

African-American Hispanic/Latino White with Hispanic Origin Caucasian

Asian Asian-American Native-American Other

Health Insurance (Please circle one):

Medicaid Medicare Medicaid/Medicare

None Other: _____

Client's Household Size (Please list the names, ages, and gender of all members in the client's household):

Name (Last, First)	Age	Gender (M/F)	Relation

Current Respite Services Being Used (Please circle one):

Adult Day Program Respite Care Worker Nurse

Adult Foster Care Other: _____ None

If currently using a Respite Care Worker and/or Nurse, please provide following information:

Last Name: _____ **First Name:** _____

Phone: _____ **Age** (mm/dd/yyyy): _____

Does the Respite Care Worker and/or Nurse live in the home with the client?

Yes No

If not currently using respite services, do you need assistance finding a program or Respite Care Worker?

Yes No

How did you hear about our program?

_____

_____

II. Primary Caregiver's Information

Last Name: _____ **First Name:** _____

Gender: Male Female

Address: _____

City: _____ **State:** ***MD*** **Zip Code:** _____

County (Please circle which county the caregiver lives in):

Harford County Baltimore County Baltimore City

Howard County Anne Arundel County Carroll County

Other: _____

Home Phone: _____ **Cell Phone:** _____

SSN (last 4 numbers): _____ **Date of Birth** (mm/dd/yyyy): _____

Relationship to Client: _____

Ethnicity (Please circle one):

African-American Hispanic/Latino White with Hispanic Origin Caucasian

Asian Asian-American Native-American Other

III. Client's Emergency Contact (Other than primary caregiver)

Last Name: _____ **First Name:** _____

Home Phone: _____ **Cell Phone:** _____

Relationship to Client: _____

IV. Income Information (Please Print)

Please complete the information below, about the client's **gross yearly income**. **Verification of income is required. You must submit a copy of a bank statement, W-2, or a statement from Social Security in order to verify income.** Income and other information in this application will be updated once a year. Please report any major changes in the client or caregiver's income (either up or down) of more than $50 per month to the DHR Project Manager.

	Client	Spouse
Social Security		
Retirement Pension		
Supp. Sec. Inc. – SSI		
Salary or Wages		
Public Assistance		
Unemployment Comp.		
Alimony		
Workman Compensation		
Other Income (List income from any other sources: interest, dividends, rentals, royalties, trusts, estates, ect.)		

Total Income: $_____/month x 12 = _____ Annual Income

MEDICAL EXPENSES: Please list all medical expenses related to the client and their functional disability that are not covered by any insurance or other coverage, and incurred within the **past year**. (Cost of in-home care and day care ***cannot*** be counted as an expense.) You may estimate if you don't have the exact figure.

Deductibles and co-payments, to include hospital stays, doctor's visits and insurance premiums: $_____

Out of pocket cost for prescriptions, over the counter medications, and preparations related to disability: $_____

Out of pocket cost of medical equipment and supplies, to include incontinence supplies: $_____

V. Functional Assessment (Please circle the <u>best</u> answer):

1. **Does the client need help with light chores around the house?** Yes No
2. **Does the client need help with grocery shopping?** Yes No
3. **Does the client need help preparing a light meal (i.e. a sandwich)?** Yes No
4. **Does the client need help with transportation (i.e. public transportation, car)?** Yes No
5. **Does the client need help eating?** Yes No
6. **Does the client need help getting dressed or changing nightclothes?** Yes No
7. **Does the client need help bathing?** Yes No
8. **Does the client need help with combing their hair, shaving, brushing teeth, etc.?** Yes No
9. **Does the client need help getting to and from the toilet?** Yes No
10. **Does the client need help getting into or out of bed or a chair?** Yes No
11. **Does the client need help walking?** Yes No
12. **Does the client need help taking his/her own medication?** Yes No
13. **Does the client need help using the telephone?** Yes No
14. **Does the client need help with handling his/her own money?** Yes No
15. **Does the client need help with planning and decision making?** Yes No

Caregiver <u>must provide a copy</u> of this Functional Assessment to the client's physician in order for the physician to accurately document the client's functional disability and level of care.

Serving DC | MD | VA

Jessica Linnenkamp | DHR Project Manager
1420 Spring Street, Silver Spring, MD 20910
Direct 301.920.9769 | Fax: 301.578.4152
www.eseal.org | @ESealsDCMDVA |

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Agency Family Agreement

The Easter Seals Serving DC|MD|VA, 1420 Spring Street Silver Spring, Maryland 20910 is the administrating agency for the Central Maryland Respite Care Program, which offers financial reimbursement for respite care services to an applicant, the applicant's family, or an appropriate representative. Your initials in the blanks in front of the numbers signify that you understand and agree with the content of each statement listed below. This agreement must be signed, dated, and each statement initialed in order to receive reimbursement for respite care services.

Please Initial →

_____ 1. As the acting representative for _____, I understand that I have the responsibility of recruiting my own Respite Care Worker (RCW). If I do not have my own RCW I may request information and a list of resources from the Central Maryland Respite Care Program in order to assist the caregiver in my recruitment process. This RCW is not an employee, agent, or representative of Easter Seals Serving DC|MD|VA, Central Maryland Respite Care Program and has not had a criminal background check. I agree that I will not hold Easter Seals Serving DC|MD|VA, Central Maryland Respite Care Program liable for anything, which affects the health, safety or welfare of the individual receiving services. I, as acting representative, take full responsibility for monitoring and supervising the RCW(s) I select.

Please Initial →

_____ 2. I understand that I must provide a copy of the Functional Disabilities Assessment to the client's physician, and that what I have indicated as the client's functional disability must be verified and documented by the physician.

Please Initial →

_____ 3. I understand that I will be reimbursed for these services and that I am responsible for paying the care worker. I further understand that the Central Maryland Respite Care Program will be responsible for payment only if the Respite Care Office has given prior approval. In order to receive approval for reimbursement I must submit my timesheet by the **2nd Friday of each month**. Approval of respite care services will be based on the amount of time allotted per individual and availability of funds. I understand that I have **90 days** from the date printed on the reimbursement check to cash the reimbursement check. Failure to do so will result in the loss of that month's reimbursement which cannot be recouped in the month's that follow.

Please Initial →

_____ 4. Easter Seals Serving DC|MD|VA staff has explained that I need to consult a tax advisor to receive advice concerning my tax responsibilities.

Please Initial

→ _____ 5. I understand that if the client's functional ability/disability changes, I must notify Easter Seals Serving DC|MD|VA in writing within **90 days** of the change in function. I also understand that if there is a change in the client's monthly gross income I must notify Easter Seals Serving DC|MD|VA in writing within **90 days** of the change in income.

Please Initial

→ _____ 6. I understand that I take full responsibility for monitoring, hiring, firing, training, and tax reporting of the care workers. I further understand that if there is an incident of alleged abuse or neglect I must report the incident to the Maryland State Department of Human Resources as soon as I am made aware, and I will promptly notify Easter Seals Serving DC|MD|VA in writing about the alleged abuse.

Please Initial

→ _____ 7. The services requested will be specifically provided to _____. This agreement is valid for respite care services that occur within **one fiscal year**. I understand that at the end of each fiscal year I must go through an application renewal process in order to be considered to receive respite care services from the Central Maryland Respite Care Program for the following fiscal year.

_____	_____	_____
(Client's Printed Name)	(Client's Signature)	(Date)
_____	_____	_____
(Caregiver's Printed Name)	(Caregiver's Signature)	(Date)

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AUTHORIZATION TO OBTAIN MEDICAL INFORMATION

I, _____ hereby authorize **Easter Seals**
(Client)
Serving DC|MD|VA 1420 Spring Street Silver Spring, Maryland 20910 to contact:

_____ _____
(Doctor/Clinician's Name) *(Practice Name)*

_____

_____
(Doctor/Clinician's address)

_____
(Doctor/Clinician's Phone Number)

when necessary in order to obtain/verify medical information relating to my functional disabilities.

I understand that the information being requested will be used by Easter Seals Serving DC|MD|VA to assist in determining the agency's ability to provide assistance to me. I understand that all information shared with Easter Seals Serving DC|MD|VA will be treated in a strictly confidential manner, and any disclosure of my information to any other agency will require my additional authorization. I understand that authorization is extended for this request only and at this time only. I understand that I have the right to revoke this authorization in writing at any time except to the extent that action on this authorizations has already occurred (i.e. the information was already distributed).

(Client's Printed Name)	(Client's Signature)	(Date)
(Caregiver's Printed Name)	(Caregiver's Signature)	(Date)

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PLEASE INCLUDE THIS PAGE IN ATTACHED ENVELOPE

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DOCTOR'S STATEMENT

DIRECTIONS FOR THE PHYSICIAN: An application has been made for respite care for the individual named below. In order to provide respite services, information regarding the individual's functional disability and level of care is needed. A functional disability is defined as a severe, chronic disability, which is attributable to a mental or physical impairment or combination of these impairments, is likely to continue indefinitely, and results in substantial function limitations in three or more areas of major life activity (self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency). Please answer the following questions and return to: **Easter Seals Serving DC|MD|VA, Central Maryland Respite Care Program, Attn: Jessica Linnenkamp 1420 Spring Street Silver Spring, Maryland 20910; Phone: (301) 920-9769; Fax: (301) 578-4152.** We have included a pre-addressed and stamped envelope for you (the physician) to return this statement directly to Easter Seals.

Last Name: _____ **First Name:** _____

Date of Birth (mm/dd/yyyy): _____

Primary Functional Disability: _____ **Age of Onset:** _____

Secondary Functional Disability (if applicable): _____

Is the primary condition likely to improve?: Yes No

In attempting to assess the degree of care and attention needed, please indicate if the person requires:

1. **Supervision of activities of daily living?** Yes No
2. **Personal Care?** Yes No
3. **Skilled Nursing Care?** Yes No

Signature of Physician: _____ Date: _____
Name of Physician (please print): _____
Practice: _____
Address: _____
Phone: _____