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Respite
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Voucher Program

Effective January 7, 2022

Eligibility

To be an eligible recipient of the Respite Voucher, both the primary family caregiver and care receiver must meet the specific criteria listed

Family Caregiver:

- The primary family caregiver must be unpaid
  - *Family caregivers who receive financial compensation to care for their loved one are not eligible. Examples include, but are not limited to, payments from the Department of Social Services (foster care, adoption subsidies, kinship care) and caregivers who are employed as their loved one's Personal Care Aid through a Medicaid Waiver*
- Be between the age of 18 and 54 years old.

Care Receiver:

- Not currently receiving care/support services

In order to provide relief for families with no structured assistance, caregivers of those enrolled in Medicaid waivers and other support programs are ineligible. Examples include, but are not limited to: HIV/AIDS Waiver, Community Choices Waiver, Intellectual Disability/Related Disabilities (ID/RD) Waiver, Head and Spinal Cord Injury (HASCI) Waiver, Community Supports Waiver, Ventilator Dependent Waiver for Adults, and Medically Complex Children's Waivers

- Unable to be left alone due to a disability, significant special needs, or terminal illness.
- Be no more than 59 years old, without a diagnosis of Alzheimer's or Dementia related illness.

Prioritization

Once eligibility is approved, accepted applications will be placed into priority for funding based on:

- Individuals who have not received a SCRC voucher within the past 24 months
- Individuals residing in underserved areas
- Individuals with the greatest economic need
- Individuals with limited English-speaking ability

Distribution

SCRC vouchers are distributed on "first come, first served" as funding is available.

- Family caregivers may receive one $500 voucher within a 12-month federal fiscal year, dependent on available funds. Subject to change based on available funding.
- Reimbursement for respite received via the voucher may take up to 45 days, but usually 2-3 weeks.
- All documentation/timesheets must be completed accurately before reimbursement is processed.

Usage & Expiration

Vouchers are used to assist in paying for short, temporary breaks from hands on caregiving and may not be used to:

- Pay the family caregiver directly for care that he/she provides
- Pay for a family member or friend residing in the same home / property to provide care
- Pay for care of loved one while the caregiver goes to work
- Reimburse the family caregiver for respite services which occurred before a voucher was issued
- Pay family and friends who are willing to provide respite, or are already helping, free of charge.

All vouchers expire after 60 days from the approval notification date.

- An additional 15-day extension may be granted upon request and at the discretion of SCRC.
- Any unused and/or expired voucher funds will be forfeited and allocated back into the program.

Application may be requested via phone 803.935.5027, email: respite@screspitecoalition or online https://www.screspitecoalition.org

South Carolina Respite Coalition

Respite Voucher Program Application

PLEASE PRINT CLEARLY AND COMPLETE EACH SECTION

Caregiver (CG) Information:

This is about YOU - the unpaid caregiver who is responsible for the care receiver.

Name _____ **DOB** _____ **Gender**_____

Street address _____ **City** _____ **State** _____ **Zip Code** _____

County _____Mailing address □same or _____State _____Zip Code _____

Primary Phone_____ **Email** _____

Preferred communication: ☐Phone ☐Email ☐Mail

Race: ☐White ☐Black/AA ☐Asian ☐Indian Asian ☐Pacific Islander ☐Amer. Indian/Alaskan ☐Other

Ethnicity: ☐Hispanic / LatinX ☐Not Hispanic / LatinX ☐Neither

How are you related to the person for whom you provide care? ☐Parent ☐Spouse ☐Grandparent ☐Legal Guardian ☐Other: _____

Do you receive any financial compensation from any of the following for the care you provide?

☐ CLTC Provider ☐ DDSN Personal Care Aide ☐ DSS Adoption / Foster Care Subsidy
☐ Kinship Care ☐ Other _____

Do you or have you served in the military?: ☐ No ☐Retired Military ☐Veteran ☐Currently Active

Marital Status: ☐Married ☐Single ☐Widowed ☐Divorced ☐Domestic Partner / Civil Union

Number of people in your household: _____

Monthly House Income:
☐Under $1,074 ☐$1,074-$1,452 ☐$1,453-$1,830 ☐$1,831-$2,208 ☐$2,209-$2,589 ☐$2,590+

Is a language other than English primarily spoken in your home? ☐Yes ☐No Please specify:_____

How many hours a day do you provide hands-on care? _____

How long have you provided care for the Care Receiver? (months / years) _____

Are you employed outside the home: ☐Full-time ☐Part-time ☐N/A

Have you applied or received a respite voucher from the SC Respite Coalition in the last 2 years? ☐Yes ☐No

How did you hear about SC Respite Coalition Lifespan Voucher? _____

Care Receiver (CR) Information

This is about the person for whom you provide care.

Name _____ **DOB** _____ **Gender** _____

Care Receiver's Primary Diagnosis: _____

Do you live with this person? ☐ Yes ☐ No If no, how far to CR's home:_____ (miles) _____ (minutes)

Does this person live alone? ☐ Yes ☐ No

CR Address (if different from yours): _____ City: _____

Race: White Black/AA Asian Indian Asian Pacific Islander Amer. Indian/Alaskan Other

Ethnicity: ☐ Hispanic / LatinX ☐ Not Hispanic / LatinX ☐ Neither

Does the CR receive any support services? ☐ Medicaid ☐ Medicare ☐ DDSN ☐ CLTC ☐ Baby Net
☐ Early Intervention ☐ ABA Therapy ☐ Other Services: _____

If under 21, does the CR attend school? ☐ Yes ☐ No **If an adult, has the CR served in the military?** ☐ Yes ☐ No

Besides you, does anyone else provide care to the care receiver? ☐ Yes ☐ No

Is there any other program that has provided respite services within the last 12 months? ☐ Yes ☐ No

If you are awarded a voucher, who would you like to provide care while you take a break from caregiving?

☐ an In-Home Agency that bills SCRC directly for services. Preferred Agency _____

☐ an Adult Day Care that bills SCRC directly for services. Preferred Day Center _____

☐ at home with a private provider that I find, employ and pay out of pocket to give me a break. The SCRC will then reimburse me directly within 30-60 days after the care has occurred.

What do you hope to get from having a voucher for respite? ***Check all that apply***

☐ just some time to myself ☐ a vacation ☐ a good night's sleep

☐ some time with other family or friends without my loved one with special needs

☐ catch up on medical and other appointments for me Other: _____

CAREGIVER ASSESSMENT

Bakas Caregiver Outcome Scale							
As a result of Providing Care for the Patient:	Changed for the **worst**			No change	Changed for the **best**		
1. My self esteem	-3	-2	-1	0	1	2	3
2. My physical health	-3	-2	-1	0	1	2	3
3. My time for family activities	-3	-2	-1	0	1	2	3
4. My ability to cope with stress	-3	-2	-1	0	1	2	3
5. My relationship with friends	-3	-2	-1	0	1	2	3
6. My future outlook	-3	-2	-1	0	1	2	3
7. My ability to pay the bills	-3	-2	-1	0	1	2	3
8. My emotional well-being	-3	-2	-1	0	1	2	3
9. My time for social activities with friends	-3	-2	-1	0	1	2	3
10. My relationship with my family	-3	-2	-1	0	1	2	3
11. My ability to buy necessities	-3	-2	-1	0	1	2	3
12. My relationship with the patient	-3	-2	-1	0	1	2	3
13. In general, how has your life changed as a result of taking care of the patient?	-3	-2	-1	0	1	2	3

UCLA Three-Item Scale			
	Hardly Ever	Some of the Time	Often
How often do you feel that you lack companionship?			
How often do you feel left out?			
How often do you feel isolated from others?			

How many dependent adults do you care for, including the care receiver mentioned above? # _____
Do any of these individuals have a diagnosed disability or special need? # _____

How many dependent children do you care for (including the care receiver), under the age 18? # _____
Do any of your other children have a diagnosed disability or special need? # _____

How many hours in a week...
do you get a break from caregiving? _____ hours a week
would provide you with adequate time to yourself while being a caregiver? _____ hours a week

MAIL, EMAIL OR FAX ALL 4 FULLY COMPLETED* PAGES TO: P.O. Box 493, Columbia, SC 29202

respite@screspite.org FAX 803.935.5229

* NOTE: We cannot determine eligibility with an incomplete application

Respite
Coalition

Respite Voucher Health Care Provider
Medical/Special Needs Certification

Respite = regular, short term breaks for the primary caregiver of someone of any age with special needs.

The South Carolina Respite Coalition is the only statewide, non-profit organization working on respite for all family caregivers no matter their age. With grant funds we can provide limited respite vouchers. Your patient/client's family has requested funds for respite. The signatures below indicate their consent to have you release this information.

Name _____ Date: _____

Circle One: Parent Guardian Spouse Family Caregiver

Signature: _____

Name _____ Date of birth: _____

(care receiver)

Signature (if able) _____ Date: _____

Address: _____ Phone: _____

THIS SECTION TO BE COMPLETED BY A MEDICAL PROFESSIONAL ONLY

(Doctor, Nurse Practitioner, RN, Physician Assistant, Licensed Social Worker, trained DDSN Case Managers. We cannot accept certification by CNAs.)

1) Please indicate the ability level (0 – 5) for each activity: 0 = independent --------→ 5 = totally dependent
Feeding ____ Ambulation _____ Transferring _____ bathing _____ Dressing _____ bedbound [ ] no [ ] yes

2) This care receiver/patient is [ ] incontinent [ ] bladder [ ] bowel [ ] self-toileting [ ] too young to train yet

4) Due to cognitive or other mental, emotional, or behavioral issues, the care receiver requires moderate to substantial supervision because their behavior poses a health or safety hazard to them self or others.
Yes [ ] No [ ] Cognitive Diagnosis: _____

5) In your professional opinion is this care receiver able to be left alone without supervision or assistance for any length of time (i.e. several hours)? Yes [ ] no [ ] overnight? Yes [ ] no [ ]

6) PRIMARY diagnosis _____

7) SECONDARY and/or CO-OCCURING conditions _____

If this patient is an infant, child or adolescent, does s/he require care beyond which a typical babysitter can provide?
Yes [ ] No [ ] If yes, please briefly describe the skill set needed to safely care for this patient _____
_____

Completed by Professional (printed name): _____
Title: _____ discipline: _____
Name of practice: _____
Address: _____ phone: _____
City: _____ zip code: _____ e-mail: _____ fax: _____

Professional Signature: _____ date: _____