Lifespan Long-term Chronic Care Caregiver Respite Voucher Program

Eligibility Determination Form

Caregiver/Applicant, please check that all three apply:

1. ___ I am the primary family caregiver
2. ___ The care recipient(s) lives in New York state
3. ___ I require respite in the absence of any other funding source. (i.e., Medicaid funded home and community-based services, or the Alzheimer’s Disease Caregivers Support Initiative).

AND:
Please confirm that the Care Recipient meets two requirements below (check if applicable):

1. ___ An adult (18+) or a child (under 18) with mental or physical impairment who needs daily care or supervision to meet their basic needs.
2. ___ Has not applied for nor received any other form of support through a NYS respite program.
3. ___ Applied for another support first, but was denied or put on a waiting list; doesn’t qualify for any other caregiver support programs or LTC support programs.

List by name any/all programs applied for, including those you were denied, and note the denial date.

1. ___________________________________________________________ Date __________
2. ___________________________________________________________ Date __________
3. ___________________________________________________________ Date __________

Caregiver/Applicant (print name): __________________________________________ Date: __________

Caregiver/Applicant (signature): __________________________________________

County: ___________________________ Phone: __________________________ Email: __________________________

*Referral Contact (print name): __________________________________________ Agency: __________

County: ___________________________ Phone: __________________________ Email: __________________________

*Please don’t skip the referral section. We are looking for a professional – such as a social worker or doctor -- that knows you and your family.