NYSCRC
New York State Caregiving & Respite Coalition

CAREGIVER RESPITE VOUCHER PROGRAM — INSTRUCTIONS

NYSCRC has two Respite Vouchers — one for Kinship Caregivers, and one for family caregivers of children and adults with chronic conditions. These instructions apply to both.

The program progresses in four steps: 1) you apply, 2) we review your application and, if approved, send you a voucher, 3) you sign a contract with your respite provider, 4) you submit timesheets. Over the course of the program, you will fill out the following forms:

- ☐ Eligibility Determination Form
- ☐ Application
- ☐ Program Agreement
- ☐ Respite Provider Contract
- ☐ W9 Form
- ☐ Check Request-Timesheet (Individual)
- ☐ Check Request-Timesheet (Agency)
- ☐ *Survey

Step One & Two:
Fill out and return to us these three forms: 1) **Eligibility Determination Form**, 2) **Application**, and 3) **Program Agreement**. Once we have reviewed the forms, we will send you a letter approving or denying your application (or asking for more information). The approval letter is your voucher.

Step Three:
After you have received your approval letter, you may begin arranging for respite. Please fill out and return to us the **Provider Contract** and **W9 form**. The contract is signed by both you (the primary family caregiver) and your helper, aide, or agency (respite provider). Regarding the W9 form, we must have one for either you or your respite provider. When writing out checks, our accounting office requires a W9.

Step Four:
Fill out and submit a **Timesheet**. The Timesheet must be signed by you and your respite provider, and the hours must fall within the 90-day voucher period. Note that we often call respite providers to confirm the hours worked.

Step Five:
Let us know how we did! We are still learning. Thank you in advance for filling out the **Survey** and helping us grow.
*Not all packets include a survey.

WHERE TO MAIL YOUR COMPLETED FORMS

Lifespan of Greater Rochester Inc./NYSCRC, Attn: Rebecca Hyde
1900 S. Clinton Avenue
Rochester, NY 14618

Or email forms to: rhyde@lifespan-roch.org / Or fax forms to: 585-244-9114 attn: Rebecca Hyde

Questions? Contact Rebecca at 585-287-6391; or Kristine at 585-368-5369.

NYSCRC
New York State Caregiving & Respite Coalition

Lifespan Long-term Chronic Care Caregiver Respite Voucher Program

Eligibility Determination Form

Caregiver/Applicant, please confirm with a check mark that **all three** apply:

1. ___ I am the primary family caregiver
2. ___ I live in New York State, and the person I'm caring for also 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 with a check mark that the **Care Recipient** meets **two** requirements below:

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

_____

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.

Lifespan Long-term Chronic Care
Caregiver Respite Voucher Program — Application

NYSCRC
New York State Caregiving & Respite Coalition

On this page, please tell us about yourself.

Caregiver/Applicant Information			
Name:			
Address:			
City:	**Zip:**	**County:**	**State:** NY
Email:			
I am caring for my:	**Phone**:		
☐ Spouse / Partner	Gender (caregiver): ☐ Female ☐ Male ☐ Other		
☐ Parent / Step-parent	Birthdate (caregiver):		Age:
☐ Grandparent	**Race of Caregiver/Applicant (check all that apply)**		
☐ Child	☐ American Indian/Native Alaskan	☐ Asian	
☐ Sibling	☐ Black or African American	☐ Hawaiian/Pacific Islander	
☐ Aunt / Uncle	☐ White-Hispanic	☐ White-Non-Hispanic	
☐ Friend	**Ethnicity of Caregiver/Applicant (check box)**		
☐ Other (specify)	☐ Hispanic/Latino	☐ Non-Hispanic/Latino	

Need for Respite Care	
1. Number of care recipients in the household: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ More than 5	
2. Is this request an emergency need?	☐ Yes ☐ No
If you answered yes, please describe in detail below:	
3. Have you received NYSCRC Respite Voucher Program funds in the past 90 days? If yes, please provide date of previous voucher: _____	☐ Yes ☐ No
4. How long have you been an informal unpaid caregiver? ☐ less than 6 mos. ☐ more than 6 mos. and less than 1 yr. ☐ 1-5 yrs. ☐ 5+ yrs.	
5. How long since you last had a break from caregiving? ☐ less than 6 mos. ☐ more than 6 mos. and less than 1 yr. ☐ 1-5 yrs. ☐ 5+ yrs.	
6. What has kept you from having breaks in the past? ☐ Money ☐ Timing ☐ Available Provider ☐ Transportation ☐Other:_____	

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New York State Caregiving & Respite Coalition

On this page, please tell us who you are caring for.

Care Recipient #1			
Name:			
Address:			
City:	**Zip:**	**County:**	**State:** NY
Birthdate:	**Age:**	**Gender**: □ Female □ Male □ Other	
Race of care recipient (check all that apply)			
□ American Indian/Native Alaskan		□ Asian	
□ Black or African American		□ Hawaiian/Pacific Islander	
□ White-Hispanic		□ White-Non-Hispanic	
Ethnicity of care recipient (check box)			
□ Hispanic/Latino		□ Non-Hispanic/Latino	
Special need or condition of the care recipient (*for data collection purposes only*)			
□ Brain Injury □ Emotional/Behavioral □ Intellectual/Developmental Disability (IDD)			
□ Memory Impairment □ Mental Health Disorder □ Neurological □ Physical			
□ Medical Supports Needed □ Special considerations needed (Behavior/Lift, etc.)			

Care Recipient #2			
Name:			
Address:			
City:	**Zip:**	**County:**	**State:** NY
Birthdate:	**Age:**	**Gender**: □ Female □ Male □ Other	
Race of care recipient (check all that apply)			
□ American Indian/Native Alaskan		□ Asian	
□ Black or African American		□ Hawaiian/Pacific Islander	
□ White-Hispanic		□ White-Non-Hispanic	
Ethnicity of care recipient (check box)			
□ Hispanic/Latino		□ Non-Hispanic/Latino	
Special need or condition of the care recipient (*for data collection purposes only*)			
□ Brain Injury □ Emotional/Behavioral □ Intellectual/Developmental Disability (IDD)			
□ Memory Impairment □ Mental Health Disorder □ Neurological □ Physical			
□ Medical Supports Needed □ Special considerations needed (Behavior/Lift, etc.)			

On this page, please tell us who you plan to hire.

We use the term "respite provider" to refer to the person you intend to hire. Note, you cannot hire a respite provider who lives in the same household as you or the care recipient.

Respite Provider #1		
Name:		
Address:		
City:	**Zip:**	**State:**
Phone #:		**Email:**
Describe service:		

Respite Provider #2		
Name:		
Address:		
City:	**Zip:**	**State:**
Phone #:		**Email:**
Describe service:		

Respite Provider #3		
Name:		
Address:		
City:	**Zip:**	**State:**
Phone #:		**Email:**
Describe service:		

Lifespan Long-term Chronic Care Caregiver Respite Voucher Program (LCRVP)

Agreement

Please Read and Initial Each Statement Below:

_____ The information included in the Voucher Program (LCRVP) application is true and complete. If I gave any false information, my application may be denied.

_____ I have read and understand the LCRVP policies and procedures.

_____ I understand my signature below approves a release of information to NYSCRC, for program purposes only.

_____ I understand the use of all funds available to me through the LCRVP is to pay respite workers or respite programs for respite services provided to me during the voucher period. I understand that these funds cannot be used for any other purpose. I am also responsible for any respite service charges over the voucher limit I am awarded.

_____ I understand that I am responsible for hiring the respite worker(s) of my choice and am responsible for negotiating the rate of pay for respite services. I am also responsible for providing any training or instruction that the respite worker(s) of my choice may need when providing care.

_____ I will sign and submit respite timesheets promptly. Any unspent balance of my respite voucher will be returned if I have not made prior arrangements for services by the end of the voucher period.

_____ I agree to regular program monitoring, including a phone call to my respite worker or respite program to confirm the hours worked. I will complete and return the required surveys. I also understand that the Respite Voucher Program is a pilot program only, and no continuation of respite services will extend beyond the program.

_____ If I have falsely used the voucher funds, I may be responsible for repayment of the full amount of the voucher funds. If I have left the program or the care recipient and I have moved out of New York State, I may be responsible for repayment of any unused funds. The decision will be at the discretion of the NYSCRC Kinship Voucher Program Director.

Indemnification. By signing below, I attest the information contained in the voucher application is true and accurate. I further recognize and agree that the New York State Caregiving & Respite Coalition is **NOT** providing any direct or indirect services. I shall hold harmless and indemnify NYSCRC and Lifespan of Greater Rochester and any of its representatives for any damages or liabilities I incur arising from this agreement. The completion of this application does not guarantee the approval of the voucher request.

_____ _____

Caregiver/Applicant Signature Date

_____ _____

NYSCRC Program – Office Personnel Signature Date

Lifespan Long-term Care Caregiver Respite Voucher Program

Provider Contract

Caregiver/Applicant: _____

Respite Provider: _____

The respite provider agrees to provide services assisting

(Name of care recipient) _____ while providing the primary caregiver with a short break. This may include helping the care recipient participate in activities in and outside of the home, such as recreation and leisure activities, the development of new skills, and managing personal care needs. It is expected that the respite provider will assist the individual in a positive manner that keeps him/her safe. There may be other duties/activities that are required from time to time. At no time will the respite provider leave the person being supported alone.

Contract Period: Respite support will be provided for dates and times agreed upon, and within the 90-day voucher period. Termination of employment by the respite provider requires written notice within a minimum of _____ days. Should the family decide to terminate employment, they will give the provider __**3**__ days' notice.

Rate of Pay: Both the caregiver/applicant and the respite provider have agreed upon the rate of pay. The rate is noted on the timesheets.

Hours of service: Both the primary caregiver and the respite provider have agreed upon the days and hours of care and this information will be documented on the Lifespan Long-term Care Caregiver Respite Voucher Program Check Request/Timesheet form. This form will be submitted to NYSCRC along with any invoices for payment. If the days and hours of service are changed by either party, it is agreed that both parties will give ample consideration and notice to ensure that both can make necessary accommodations.

Duties and Responsibilities: Please list below the detailed duties and responsibilities agreed upon by the primary caregiver and the respite care provider.

_____

_____

_____

_____

Repayment of Funds: If it is determined that NYSCRC's Lifespan Voucher funds are received or used fraudulently, the primary caregiver and the respite provider will be held accountable, including but not limited to repaying voucher funds and/or suspension from the program.

PROVIDER CONTRACT

The parties have agreed to the terms and conditions on the: _____ day of the month of _____ in the year _____.

Caregiver/Applicant (printed name): _____

Caregiver/Applicant (signature): _____

Respite Provider (printed name): _____

Respite Provider (signature): _____

Phone: _____

Email: _____

To be signed by Lifespan/NYSCRC	
Ann Marie Cook, President/CEO	Date
Rebecca Hyde, NYSCRC Program Coordinator	Date

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

► **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ► _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ►

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here	**Signature of U.S. person** ►	**Date** ►

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and

4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting,* later, for further information.

Note: If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien;
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States;
- An estate (other than a foreign estate); or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.

In the cases below, the following person must give Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States.

- In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the entity;
- In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the trust; and
- In the case of a U.S. trust (other than a grantor trust), the U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person, do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (see Pub. 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items.

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

2. The treaty article addressing the income.

3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity, give the requester the appropriate completed Form W-8 or Form 8233.

Backup Withholding

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 24% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, payments made in settlement of payment card and third party network transactions, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,

2. You do not certify your TIN when required (see the instructions for Part II for details),

3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See *Exempt payee code,* later, and the separate Instructions for the Requester of Form W-9 for more information.

Also see *Special rules for partnerships,* earlier.

What is FATCA Reporting?

The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all United States account holders that are specified United States persons. Certain payees are exempt from FATCA reporting. See *Exemption from FATCA reporting code,* later, and the Instructions for the Requester of Form W-9 for more information.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account; for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

NYSCRC
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Lifespan Long-term Care Caregiver Voucher Program

Check Request/Timesheet — Individual Respite Providers

Fill out the entire timesheet, and please remember to sign and date it on page 2. Missing information may delay payments.

Caregiver/Applicant:	**Respite Provider:**
Name_____	Name_____
Address_____	Address_____
City, State, Zip _____	City, State, Zip _____
Phone _____	Phone _____

The check should be made out to **(please circle one): the caregiver/applicant the respite provider

Respite care was provided for_____ on the following dates:
(Name of person receiving care)

TIMESHEET FOR RESPITE SERVICES PROVIDED						
Date Service Provided	**Time Started**	**Time Ended**	**Total Hours**	**Hourly Rate of Pay**	**Total Dollar Amount**	**Office Use Only**
Totals						

Caregiver/Applicant, *Please read the following, and then sign and date:*

The above services have been received and all information is correct. As a primary caregiver I have read the above information and do not hold Lifespan/NYSCRC responsible for the hiring or services provided by any individual I choose to hire.

Caregiver/Applicant, print:_____

Caregiver/Applicant, signature: _____ Date: _____

Respite Provider, *Please print name, & sign and date below:*

Respite Provider, print:_____

Respite Provider, signature: _____ Date: _____

Email address: _____

*Completed timesheets may be mailed to:

Lifespan of Greater Rochester, Inc./NYSCRC, Attn: Rebecca Hyde,
1900 S Clinton Ave., Rochester, NY 14618

Or email them to: rhyde@lifespan-roch.org or fax to: (585) 244-9114

Lifespan Long-term Care Caregiver Voucher Program

Check Request/Timesheet — Agencies, Facilities, & Organizations

Please mail completed check request/timesheet to: Lifespan of Greater Rochester, Inc./NYSCRC, Attn: Rebecca Hyde, 1900 S Clinton Ave., Rochester, NY 14618, or Email to: rhyde@lifespan-roch.org or Fax to: (585) 244-9114

**Only complete this page if Lifespan/NYSCRC is to pay the respite care provider agency directly.

TO BE COMPLETED BY RESPITE CARE PROVIDER AGENCY

Agency Name:	
Address:	
City, State, Zip:	Phone: Email Address:
Program Name:	
Program Date(s)/Time(s)	
Total Cost of Program: $_____ Total Amount Requested: $_____	

Acknowledgment

By circling "was" or "will be" as applicable and signing below: I attest that respite care **was** / **will be** provided for the primary caregiver and care recipient for the date(s) and time(s) identified above. By signing below, I agree to hold harmless and indemnify Lifespan of Greater Rochester, Inc./NYSCRC and any of its representatives for any damages or liabilities it incurs arising from this agreement. The Agency agrees to inform NYSCRC if the care recipient did not attend the full program or if the care recipient attended a partial program or if the care recipient was withdrawn from the program prior to the start date.

_____

Respite Provider — Company (print name)

_____ _____

Respite Provider — Company Representative/Contact (print name) Date

_____ _____

Respite Provider — Company Representative/Contact (signature) Date

_____ _____

Caregiver/Applicant (signature) Date