

APPLICATION FOR RESPITE PROVIDER



**NEBRASKA
RESPITE
NETWORK**
SOUTHWEST SERVICE AREA

308.345.4990
1.866.RESPITE

Office Use only

Date Received _____

Background Check Received _____

Date Entered _____

Please return to:

**Nebraska Respite Network
Southwest Service Area**

P O Box 1235

McCook NE 69001

respite@swhealthdept.com

Date _____ County: _____

Applicant _____ Former names _____

Address _____ City/State/Zip _____

Phone # (H) _____ (W) _____

Cellular: _____ Can you be contacted at work? Yes No

Email Address (if applicable): _____

Can we contact you via e-mail Yes No

I would like to be part of the 2-1-1 system and internet. Yes No

This section is optional for you to complete.

High school/GED

College: Degree (major/minor) or what studies:

Present occupation, if applicable:

Current position: _____

Employed by _____

Address _____

How long _____

Attended Respite Training: Yes No

Where: _____

Year: _____

Would you be interested in future training?

Yes No

What topics would interest you?

Do you have Accreditation for:

Medication Aide Yes No

CPR/First Aid Yes No

RN Yes No

LPN Yes No

How did you learn about this Respite Program?

Presentation

Brochure/Poster

Friend/Relative

Newspaper

Newsletter

Radio

TV/Cable

Referral

Internet

Other _____

Do you speak a language other than English? Yes No Which language(s) _____
Years experience of providing respite services _____

REFERENCES: List (3) personal or business references, no more than one relative:

1. Name _____
 Address _____
 City/State/Zip _____
2. Name _____
 Address _____
 City/State/Zip _____
3. Name _____
 Address _____
 City/State/Zip _____

RELEASES:

I _____ (**PRINT NAME**), hereby apply to be an approved respite provider with Nebraska Respite Network. In making application for approval it is understood that:

I/We give the Agency permission to contact law enforcement personnel and references about my/our character and background as it affects the provision of care for children/youth/adults.

I/We understand and give permission to have my/our names checked with the State Central Registry of child/adult abuse and neglect.

I (the applicant) give the Agency permission to enter information, as needed, into the IRis information and referral system.

I further state that any information that I give in the investigation of my application will be true and correct to the best of my/our knowledge.

If you are providing respite in your home, the following information must be completed and signed by any person 19 or older living in the household, even if they are not applying to provide respite.

| | | |
|-------------------------------------|---------------|-------------|
| <i>Applicant's Signature</i> | Date of Birth | Date Signed |
| Household member's signature | Date of Birth | Date Signed |
| Household member's signature | Date of Birth | Date Signed |

Have you had any experience with the following? (Experience not necessary for approval)

Please check Yes or No.

| | No | YES | IF YES, PLEASE DESCRIBE |
|--|----|-----|-------------------------|
| Wheel chair users | | | |
| Toileting | | | |
| Transferring/lifting/ positioning | | | |
| Catheter | | | |
| Feeding tubes | | | |
| Physical disabilities | | | |
| Seizures | | | |
| Communication devices | | | |
| Sign language | | | |
| Person who is non-verbal | | | |
| Speech delayed | | | |
| Visual impairment | | | |
| Hearing impairment | | | |
| Self-abusive behavior | | | |
| Behaviors | | | |
| Physically aggressive behavior | | | |
| ADHD | | | |
| Mental retardation | | | |
| Autism | | | |
| Alzheimer's or other forms of dementia | | | |

EXPERIENCE:

Have you cared for a family member/friend with special needs? Yes No

Briefly describe any *other* volunteer, personal or job experience and/or training you may have in working with children, adults or elderly with special needs:

| Check boxes for times you may have available | MON | TUES | WED | THURS | FRI | SAT | SUN |
|--|-----|------|-----|-------|-----|-----|-----|
| DAYTIME | | | | | | | |
| EVENINGS | | | | | | | |
| OVERNIGHTS | | | | | | | |
| EXTENDED PERIODS | | | | | | | |
| EMERGENCIES | | | | | | | |

I am interested in providing respite as follows: (Check the following categories of interest)

Ages: 0-18 19-59 60 or older

Disabilities/special needs you would work with:

- | | | |
|---|---|--|
| <input type="checkbox"/> Families in crisis | <input type="checkbox"/> Chronic Illness | <input type="checkbox"/> Medical Needs |
| <input type="checkbox"/> Alzheimer's/dementia | <input type="checkbox"/> Developmental Disabilities | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Behavioral | <input type="checkbox"/> Frail Elderly | <input type="checkbox"/> Physical Disabilities |

Locations you would provide respite services:

- In Client's Home Out of Client's Home (*Is your home barrier free?*) Yes ___ No ___

Counties/Towns willing to serve: _____

Funding sources you would be willing to accept for payment: _____

- Government/State Funded Private Pay Volunteer, if needed

Fee rate: \$_____ hourly \$_____ daily \$_____ overnight \$_____ weekend _____ ***negotiable***

Paid Providers: Any fees charged are negotiated between the provider and family caregiver requesting respite. If you are unsure of the rates you would require, please think about a range that you feel comfortable with and negotiate with the family. Your rates may change due to the varying needs of families.)

Transportation, you do not have to drive to provide respite:

- Would you provide transportation? Yes No
- Are you willing to travel to provide respite? Yes No
- Less than 10 miles 26-50 miles
 11-25 miles over 50 miles

United States Citizenship Attestation Form

For the purpose of complying with Neb. Rev. Stat. §§ 4-108 through 4-114, I attest as follows:

I am a citizen of the United States.

— OR —

I am a qualified alien under the federal Immigration and Nationality Act, my immigration status and alien number are as follows: _____, and I agree to provide a copy of my USCIS documentation upon request.

I hereby attest that my response and the information provided on this form and any related application for public benefits are true, complete, and accurate and I understand that this information may be used to verify my lawful presence in the United States.

| | |
|-------------------|--------------------------------|
| PRINT NAME | <hr/> (first, middle, last) |
| SIGNATURE | <hr/> <hr/> |
| DATE | <hr/> <hr/> |



AGENCY REQUEST FOR INFORMATION FROM THE NEBRASKA ADULT AND CHILD ABUSE AND NEGLECT REGISTER/REGISTRY

I hereby request information from the Nebraska Adult and Child Abuse and Neglect Registry. I agree to use the requested information to determine whether to hire or retain the individual to provide care, custody, treatment, transportation or supervision of children or vulnerable adults.

Agency Name/ Fax: Respite Network – Southwest Service Area / FAX: 308-345-4289

Address and Phone Number: 404 W 10th ST., P O Box 1235 McCook, NE. 69001/Phone: 308-345-4990

I hereby authorize the Division of Children and Family Services to disclose whether I have an Adult and/or Child Abuse and Neglect Register/Registry record to the above-named agency.

Print Full Legal Name: (applicant) _____

Signature (applicant)

Date

Current Address: _____
(Street/City/State/Zip)

Applicant Date of Birth

Applicant Social Security Number

Other names previously used such as former married names, maiden name and nick names. Please Print.

Names and birth dates of your children and children who have lived with you. Please Print.

Any Address at which you have resided during the past 20 years. Please Print.

