

# Respite Subsidy Application

## Respite Subsidy Program Across the Lifespan



**Section 1 GENERAL INFORMATION**

Name of Person with Special Needs			Birthdate	Age
Mailing Address			Social Security Number	
City	County	Zip Code	Telephone	
Caregiver's Name (person residing with above named person as the usual caregiver)			Relationship to Person with Special Needs	

Indicate the total number of people who live in the household of the person with special needs.

Name	Date of Birth	Relationship to person with special needs

**Section 2 DISABILITY**

1. Please describe the person's special needs. Include the person's medical diagnosis, if known. Attach additional sheet, if necessary.

2. Explain Caregiver's need for respite (relief time away from caregiving responsibilities).

**Section 3 SUPPORT SERVICES**

1. Are you now receiving any financial assistance for respite?     Yes     No  
 If yes: Who pays for the respite? \_\_\_\_\_

2. Is the person with special needs receiving services from: (check all that apply)  
 Health Insurance     Medicaid     Developmental Disabilities System  
 If yes: Name of health insurance company \_\_\_\_\_

**Section 4 RESOURCES/ASSETS**

List any cash, checking accounts, stocks, bonds, whole life insurance, certificates of deposit, etc., and any assets that can be converted to cash.

Include assets belonging to person with special needs, their spouse and children under 19. If a person with special needs is under 19, include parents and siblings under 19.

Asset	Whose is it?	Amount

**Section 5 INCOME**

List all gross income (before deductions). Include person with special needs, their spouse and children under 19.  
 If person with special needs is under 19, include parents and siblings under 19.

Income Type	Kind of Income	Amount	How Often is it Received	Who Receives it
Wages, Self-Employment				
Assistance Programs (Social Security, SSI, ADC, Veterans)				
Interest, Dividends				
Child Support, Alimony				
Other:				

**Section 6 DISABILITY-RELATED EXPENSES**

List all disability-related expenses the person with special needs has to pay in a year's time. Do not include amounts covered by insurance or other benefit program(s). Examples of expenses: doctor visits, prescriptions, diapers, medical transportation, wheel chairs, lifts, loans for architectural modification. Do not include expenses of other family members.

What Expense	How Much Cost	How Often	Whose Expense

**Section 7 AGREEMENT AND SIGNATURE**

I understand that my statements may be checked, and if I have given false statements or information, I may be found guilty of fraud.

I understand that whenever there are any changes in the information I have given, I must immediately report them to the Nebraska Department of Health & Human Services.

I understand that if I do not think my request is handled correctly, I have the right to file an appeal.

I understand that the Nebraska Department of Health and Human Services may need to contact other agencies and individuals to determine my financial eligibility and to verify my need for the support for which I am applying, or to make referrals to assist me in obtaining services. I authorize the release of this confidential information.

**Payments for benefits may be delayed if you did not complete Social Security number for person with special needs.**

Signature of Person with Special Needs or Parent or Guardian		Date Signed	
Signature of Person Who Helped Complete this Application, If Applicable		Date	
Address	City	State	Telephone

Send completed application to: Nebraska Health & Human Services System  
 Home & Community Services  
 P.O. Box 95026  
 Lincoln, NE 68509-5026

Questions? Call toll-free: 1-800-358-8802 or in Lincoln: 471-9310