NYSCRC
New York State Caregiving & Respite Coalition

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

Lifespan Long-term Chronic Care Caregiver Information			
Caregiver Name:			
Address:			
City:	**Zip:**	**County:**	**State:** NY
Email:			
Relationship to Person Receiving Care:	**Phone**:		
☐ Spouse / Partner	Gender: ☐ Female ☐ Male ☐ Other		
☐ Parent / Step-parent	Birthdate:	Age:	
☐ Grandparent	**Race of Primary Caregiver (check all that apply)**		
☐ Guardian	☐ American Indian/Native Alaskan	☐ Asian	
☐ Sibling	☐ Black or African American	☐ Hawaiian/Pacific Islander	
☐ Aunt / Uncle	☐ White-Hispanic	☐ White-Non-Hispanic	
☐ Friend	**Ethnicity of Primary Caregiver (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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Please Note: Each care recipient who will receive respite care must be listed below. If you need to list additional recipients, please use the form **Additional Care Recipients** located in your packet.

Care Recipient Information - #1	
Care Receiver 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 person needing care (*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 Information - #2	
Care Receiver 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 person needing care (*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.)

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Please Note: Each provider listed below must receive, fill out, and return a W9 form to NYSCRC if that provider will receive payment directly from NYSCRC. The Provider Contract must also be completed for that provider. If there is no W9 on file for that individual provider, the Accounting Department will not make a payment.

Respite Service Provider Information			
Provider Name:			**W9:** ☐ Yes ☐ No
Address:			
City:	**Zip:**	**State:**	**Phone:**
Rate of Service $_____________ per hour		**Anticipated total amount of voucher to be used $__________**	
Describe service:			

Respite Service Provider Information			
Provider Name:			**W9:** ☐ Yes ☐ No
Address:			
City:	**Zip:**	**State:**	**Phone:**
Rate of Service $_____________ per hour		**Anticipated total amount of voucher to be used $__________**	
Describe service:			

Respite Service Provider Information			
Provider Name:			**W9:** ☐ Yes ☐ No
Address:			
City:	**Zip:**	**State:**	**Phone:**
Rate of Service $_____________ per hour		**Anticipated total amount of voucher to be used $__________**	
Describe service:			