State Funded Respite

Intake Application

1945 Cliff Valley Way, STE 220, Atlanta GA 30329

Phone (404) 634-4222

Respite Intake Application

Thank you for applying for funds through the InCommunity Respite Program. Please note that Respite funds are intended to be used as a means of support for you and your love one. Please print clearly and fill out all pages, including your signature at the end of the application. Any application not completed in full will delay the processing of the application.

Section I: Demographic Information

Date of Application: _____

Individual Name: _____

Family/Caregiver Name: _____

Relationship to the Individual: _____

Do you have a spouse, partner, other children or people living in the home? _____

Legal Guardian of the Individual (Parent of a Minor Child/Guardianship of an Adult Individual):

_____

Mailing Address:

County of Residence: _____

Mailing Address: _____

Phone: _____

City, State, Zip: _____

Social Security Number: _____ Medicaid Number:_____

Gender: Male: _____ Female: _____ DOB:_____

Race:

American Indian or Alaska Native _____ Asian or Pacific Islander _____

African American _____ Caucasian/Anglo _____

Multi-Racial/Ethnic Group _____ Hispanic or Latino _____

Other _____

Section II: Diagnostic Information

Developmental Disability Diagnosis:

Check which of the following disability categories is most relevant to the identified individual:

_____ Autism Spectrum Disorder

_____ Neurological Impairment (Prior to age 22)

_____ Intellectual Disability

_____ Developmental Delay (0 – 8)

_____ Cerebral Palsy

_____ Traumatic Brain Injury (Prior to age 22)

_____ Muscular Dystrophy

_____Other (please state) _____

Age at Time of Diagnosis: _____

Section III: Supporting Documentation:

Documentation of Diagnosis is required. Please attach a copy of the most recent psychological evaluation, Individual Education Plan (IEP), and/or any other evaluations/documentation with diagnostic information. Failure to provide supporting documentation will result in the application not being considered.

Check the supporting documentation attached to this application:

_____ DBHDD I&E Assessment

_____ Social Security Disability Determination (SS)

_____ Current Physical Examination and TB screening (**Required**)

_____ Psychological Evaluation and School IEP **(Required)**

_____ Financial Documentation (Pay Stubbs, W2, Social Security Award letter)

_____ Current Photograph (**Required**)

_____ Copy of Birth Certificate **(Required)**

_____ Copy of Social Security Card **(Required)**

Section IV: Current Service Information

Please check all current services that the identified individual is receiving:

_____ New Options Waiver (NOW)

_____ Comprehensive Waiver (COMP)

_____ Currently on DBHDD Planning List

_____ DBHDD State Funded Services

_____ DFCS

_____ Other (please state) _____

Section V: Agreement Section

I understand to be eligible for the InCommunity Respite Program the applicant must be diagnosed with a developmental disability prior to the age of 22 and live in a family member's home or live independently. I hereby confirm that the information given at the time of application is true and accurate to the best of my knowledge.

Responsible Party Printed Name:

_____

Responsible Party Signature:

_____

Date: _____

RESPITE CARE VOUCHER PROGRAM

WAIVER AND RELEASE

As a voluntary participant in the Georgia Community Support and Solutions Respite Care Voucher Program, ("Program"), I understand and acknowledge that the Georgia Community Support and Solutions ("GCSS") is not involved and has not been involved in any way with the selection of the respite care provider or respite care agency which will provide respite care to my family member. I also understand and acknowledge that GCSS has not evaluated, tested, or screened the care provider or respite care agency, and that GCSS makes no representations about the care provider or his or her capability or suitability.

I accept that it is my responsibility as a family member in using this program to select a respite care provider or agency to provide respite to my family member with a disability. I understand that it is my responsibility also to determine the suitability of the respite care provider or respite care agency to provide adequate care to my family member, to acquaint them with the particular needs of my family member receiving respite care and provide evaluation and supervision of all respite care received by my family member. Therefore, on my own behalf and on behalf of my family, I freely and voluntarily accept all risk of personal injury and property damage arising from my family's participation in the Program.

In consideration of my being allowed to participate in the Program and to receive a respite care voucher, I hereby release and discharge GCSS, its officers, directors, employees, agents, and successors, from any and all claims losses and demands whatsoever that I or my family may hereafter have for injuries or property arising or resulting from my and my family's participation in the Program, all of which claims I hereby waive. I waive my and my family's rights with the full knowledge that GCSS assumes no liability or responsibility for personal injury or property damage arising from my family's participation in the Program and that GCSS will not compensate me or my family in any way for any loss or injury I or my family may sustain. I understand and agree that this waiver and release will be fully binding on me, all members of my family, our estates, and our heirs, and that neither I nor any member of my family nor anyone claiming through me or any member of my family will have any legal right assert a claim against GCSS or its officers, directors, employees, and agents or any of their successors, relating to me and my family's participation in the Program.

This Date of _____, 20_____

_____ _____

Print Family/Participant's Name Signature

Upon completion of this application please send the information to the following address:

InCommunity

1945 Cliff Valley Way Suite 220

Atlanta, GA 30329

Attn: Respite Services

Office (404) 634-4222

Fax (404) 634-1324

Section VI:

For Internal Office Use Only

Date Application Reviewed: _____

Disposition for Respite Services:

( ) Eligible Status Verified:

( ) Level of Care I_____ II _____ III _____

( ) Hourly Rate _____

( ) Not eligible – State Reason

_____

_____

Date of Notification: _____

InCommunity Staff's Name: _____

Title: _____

Respite Manager Signature: _____ Date: _____