

**HELPING HANDS of VEGAS VALLEY**  
**APPLICATION For Respite**

For questions contact Helping Hands of Vegas Valley: (702) 633-7264

**NOTE:** Either a NV ID or NV Driver's License must be submitted with the application for both the Caregiver and Recipient (Patient). A utility bill with the persons' name or Social Security statement may be substituted in place of the NV ID.

<u>Caregiver</u> Last Name:		<u>Caregiver</u> First Name:		<u>Circle Sex</u> M F	Birth Date:
Address:			ZIP code	Telephone Number(s):	
				Email Address:	
Relation To Recipient		Declared <u>Caregiver</u> Income (All sources including Social Security) \$ _____ per /			
<u>Recipient (Patient)</u> Last Name:		<u>Recipient(Patient)</u> First Name:		<u>Circle Sex</u> M F	Birth Date:
Marital Status Circle: Married Single Divorced Widowed Separated					
<u>Total # in Household:</u>		Declared <u>Recipient</u> Income (Include Social Sec) \$ _____ per /			
<u>Primary Care Physician Name, Address &amp; Phone:</u>					
<u>Recipient's Primary Diagnosis:</u>					
List <u>ALL</u> Medical Insurances and Other Resources (Circle): Medicare Medicaid Hospice "CHIPS" <u>Others List:</u>					
<u>Ethnicity (General)</u> Caregiver=C Recipient=R C R <input type="checkbox"/> <input type="checkbox"/> Hispanic (Latino)  <input type="checkbox"/> <input type="checkbox"/> Not Hispanic (Latino)		<u>Ethnicity (Detail)</u> Caregiver= C Recipient= R C R C R <input type="checkbox"/> <input type="checkbox"/> Asian <input type="checkbox"/> <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> <input type="checkbox"/> White-Non Hispanic <input type="checkbox"/> <input type="checkbox"/> Black or African American <input type="checkbox"/> <input type="checkbox"/> White - Hispanic <input type="checkbox"/> <input type="checkbox"/> Some Other Race <input type="checkbox"/> <input type="checkbox"/> American Indian/ Alaskan Native <input type="checkbox"/> <input type="checkbox"/> Two (2) or More Races			

Yes  No Caregiver resides in the same household as the recipient.

By signing below, the caregiver agrees that information provided is accurate and agrees to provide Helping Hands of Vegas Valley with information for verification purposes to determine need. **Any information subsequently found to be false may void the grant.**

► Signature of Caregiver: \_\_\_\_\_ Date: \_\_\_\_\_ Page 1 of 3



# CERTIFICATE OF ELIGIBILITY

## FOR RESPITE CARE FINANCIAL AID

\_\_\_\_\_ (Caregiver)  
has requested financial aid for respite care for their loved one.

This statement is to certify that \_\_\_\_\_ (Recipient)  
is in my care and is in need of continuous supervision.

**This statement must be signed by a licensed healthcare practitioner, who is responsible for recipient's diagnosis and ongoing care such as a physician, nurse or social worker. This information will be verified.**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Printed Name**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**State License # (Required)**

\_\_\_\_\_  
**Company / Organization name**

\_\_\_\_\_  
**Phone #**

\_\_\_\_\_  
**Street Address**

\_\_\_\_\_  
**City, State, ZIP**



## RESPIRE CARE VOUCHER PROGRAM

# RELEASE OF LIABILITY

I \_\_\_\_\_ (Caregiver) hereby agree to accept financial aid from Helping Hands of Vegas Valley for the purpose of respite care. I have read the policies and admission contract and agree to abide by the terms therein.

I agree to not hold Helping Hands of Vegas Valley, Inc. responsible for injury that may occur to (Recipient), \_\_\_\_\_, during the time the financial aid is in effect.

► Caregiver's Signature: \_\_\_\_\_ Date: \_\_\_\_\_