



Office Use only

Date Received: ____/____/____
Background Checks Completed: ____/____/____
Date Entered: ____/____/____
• Approved ____/____/____ to ____/____/____
• Denied

Please return to:

AGENCY RESPITE PROVIDER APPLICATION

Initial Application Annual Update

Agency Name (DBA, if applicable): _____ Contact Name, Title: _____

Mailing Address: _____ City, State, Zip + 4: _____

Location(s) of Facility or Service _____ City, State, Zip + 4: _____

Business Telephone ____-____-____ (Cell) ____-____-____ (Fax) ____-____-____

Email: _____ Can we contact you via email? Yes No

Website: _____ Counties Served: _____

Rates: \$____ hourly \$____ daily \$____ overnight \$____ weekend ____ volunteer

Number of years' experience caring for others: 0-1 1-2 3-4 5-6 7-10 10+ years

Agency Description: _____

Type of Agency* (please check all that apply):

*** If applicable, provide facility license number. Also include current dates for any DHHS Provider Agreement(s) and indicate DHHS Division responsible (MLTC, CFS, DD, and/or BH). NIS Address Book # _____**

- Adult Day Service or Adult Day Health Care _____
- Adult Protective Services Provider _____
- Assisted Living Facility _____
- Child Care Center/Facility _____
- Community Non-Profit Agency/Advocacy Organization _____
- Developmental Disabilities Community Supports Provider _____
- Home Health Agency _____
- Hospice/Palliative Care Provider _____
- Nursing or Rehabilitation Facility _____
- Respite Care Facility _____

Please check where you are willing to provide respite:

Care Recipient's Home Provider's Home/Facility Community Setting

Are you willing to travel to provide respite or transport care recipient to appointments, etc.? Yes No

If yes, maximum distance from your address:

10 miles 25 miles 50 miles over 50 miles

Please check Activities of Daily Living (ADLs) you are willing to work with:

- | | | | |
|------------------------------------|-----------------------------------|---------------------------------------|-----------------------------------|
| <input type="checkbox"/> Toileting | <input type="checkbox"/> Bathing | <input type="checkbox"/> Dietary | <input type="checkbox"/> Grooming |
| <input type="checkbox"/> Mobility | <input type="checkbox"/> Dressing | <input type="checkbox"/> Transferring | |

Please check the Emotional and Behavioral Impairments you are willing to work with:

- | | | |
|----------------------------------------------------------|--------------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Reactive Attachment Disorder |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Non-Verbal | <input type="checkbox"/> Self-Abusive |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Oppositional Defiant Disorder | <input type="checkbox"/> Temper Tantrums |
| <input type="checkbox"/> Fetal Syndrome Alcohol Syndrome | | <input type="checkbox"/> Wandering |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Physically Aggressive | |

Please check the Medical and Health Impairments and/or Specific Disabilities you are willing to work with:

- | | | |
|-------------------------------------------------------------------------------------|----------------------------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> ALS/Lou Gehrig's Disease | <input type="checkbox"/> Hearing Impairment/ Hearing Aids | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Alzheimer's/Dementia | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Severe Allergies |
| <input type="checkbox"/> Autism / Autism Spectrum Disorder | | <input type="checkbox"/> Speech and Language Delays |
| <input type="checkbox"/> Arthritis or other Joint Problems | | <input type="checkbox"/> Spinal Cord |
| <input type="checkbox"/> Blood problems, such as Anemia or Sickle Cell Disease | | <input type="checkbox"/> Stiff Person's Syndrome |
| <input type="checkbox"/> Breathing problems such as Asthma, COPD or Cystic Fibrosis | | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Intellectual Disability/Developmental Delay | <input type="checkbox"/> Tracheotomy |
| <input type="checkbox"/> Catheter Care | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Traumatic Brain Injury |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Visual Impairment |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Paraplegia/Quadriplegia | |
| <input type="checkbox"/> Feeding Tube | <input type="checkbox"/> Parkinson's Disease | |

Please check the ages you are willing to work with (check all that apply):

- | | | | |
|-------------------------------------|--------------------------------------|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> 0-2 years | <input type="checkbox"/> 19-35 years | <input type="checkbox"/> 65-74 years | <input type="checkbox"/> all ages |
| <input type="checkbox"/> 3-5 years | <input type="checkbox"/> 36-50 years | <input type="checkbox"/> 75-84 years | |
| <input type="checkbox"/> 6-18 years | <input type="checkbox"/> 51-64 years | <input type="checkbox"/> 85 and over | |

Please list languages you (or your staff) speak: English _____

How did you hear about the Nebraska Lifespan Respite Network (check all that apply)?

- | | | |
|---------------------------------------------------------|------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Presentation | <input type="checkbox"/> Brochure/Poster | <input type="checkbox"/> Friend/Relative |
| <input type="checkbox"/> Newspaper | <input type="checkbox"/> Newsletter | <input type="checkbox"/> Internet |
| <input type="checkbox"/> TV/Cable/Radio (please circle) | <input type="checkbox"/> Referral | <input type="checkbox"/> Other _____ |

Nebraska Lifespan Respite Network Provider Standards:

By signing this Application the Applicant understands that as a condition of applying to be a Lifespan Respite Network-Approved Provider, compliance with Provider Standards is required:

1. Ensure individual provider, household member age 19 or older if providing respite in the applicant's home, or agency staff person having direct care recipient contact has been cleared with the DHHS Child Abuse/Neglect Central Registry, the DHHS Adult Protective Services Central Registry, State Patrol Sexual Offenders Registry and the State Patrol Criminal History Check. Agency applicant will maintain results of these checks in the employee personnel files and make available to the Department.
2. Agency provider is licensed and/or certified as required by state law.
3. Provide respite services as an independent contractor recognizing that the provider is not an employee of the Department or State.
4. Respect the care recipient's rights to confidentiality and safeguard confidential information.
5. Acknowledge responsibility for the care recipient's safety and property.
6. Have knowledge, experience, and / or skills to perform the task(s) agreed upon to safely provide respite care.
7. Assure that any suspected abuse or neglect will be immediately reported to law enforcement and / or the Abuse-Neglect hotline (1-800-652-1999).
8. Acknowledge Lifespan Respite Network application will be denied or approval immediately terminated when individual respite provider, household member age 19 or older if providing respite in the applicant's home, or agency staff is found to have a criminal history that includes conviction of any unlawful act endangering the health or safety of another individual. Such convictions include crimes against a child or vulnerable adult, crimes involving intentional bodily harm, crimes involving the sale, distribution or procurement of a controlled substance, or crimes involving moral turpitude on the part of the individual. These crimes include but are not limited to:
 - a. Aggravated or armed robbery;
 - b. Assault, first or second degree;
 - c. Child abandonment;
 - d. Child abuse;
 - e. Child molestation or debauching a minor;
 - f. Child neglect;
 - g. Commercial sexual exploitation of a minor;
 - h. Domestic violence;
 - i. Exploitation of a minor involving drug offenses or conviction of drug offenses that involved a minor;
 - j. Felony controlled substances offenses, other than possession;
 - k. Felony violation of custody;
 - l. Incest;
 - m. Kidnapping;
 - n. Murder, first or second degree;
 - o. Sexual abuse of a minor;
 - p. Sexual assault;
 - q. Sexual exploitation of a minor, including child pornography; or
 - r. Voluntary manslaughter.
9. Acknowledge Lifespan Respite Network application will be denied or approval immediately terminated when individual respite provider, household member age 19 or older if providing respite in the applicant's home, or agency staff is found to have a has a criminal history that includes conviction in the last 20 years of:
 - a. Arson;
 - b. Criminal non-support;
 - c. Felony possession of controlled substance offenses;
 - d. Felony theft; or
 - e. Robbery.

The 20-year disqualification begins the date the conviction became final. Any time the individual is incarcerated, either in jail or a state or federal correctional facility, is not included in the calculation of the 20-year period of disqualification. If the individual has more than one conviction, the 20-year disqualification begins the date the most recent conviction became final.
10. Acknowledge Lifespan Respite Network application will be denied or approval immediately terminated when individual respite provider, household member age 19 or older if providing respite in the applicant's home, or agency staff is found to have a criminal history that includes conviction in the last five years of:
 - a. Burglary;
 - b. Driving under the influence: two or more convictions;

- c. Felony bad check writing;
- d. Misdemeanor controlled substances offenses;
- e. Misdemeanor contributing to the delinquency of a child; or
- f. Misdemeanor theft.

The five-year disqualification begins the date the conviction became final. Any time the individual is incarcerated, either in jail or a state or federal correctional facility, is not included in the calculation of the five-year period of disqualification. If the individual has more than one conviction, the five-year disqualification begins the date the most recent conviction became final.

I certify that I have read and understand the standards as stated and referenced above and agree to comply with all Provider Standards.

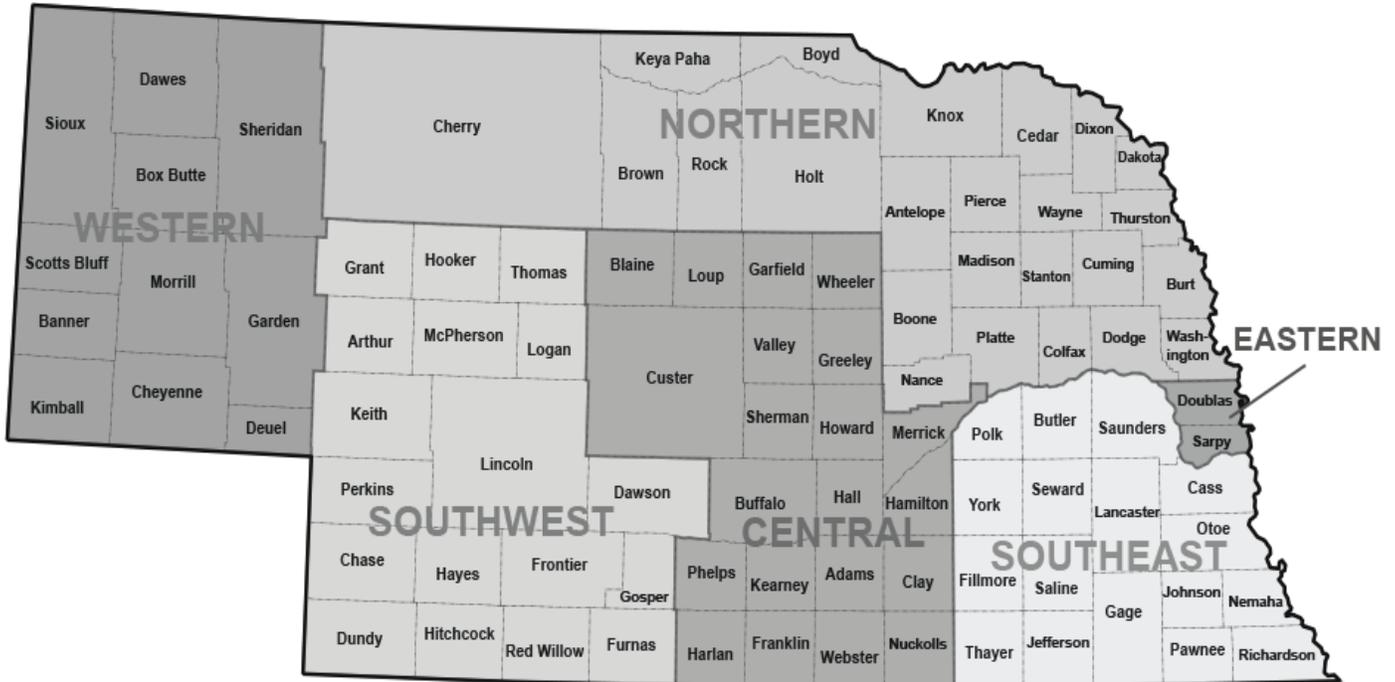
Agency Representative, Title

Printed Name

____/____/____
Date (Month, Day, Year)

I give permission to include my information on the Official Nebraska Government Website, Nebraska Resource and Referral System (NRRS) Provider Listing for Respite Resources. If you mark "NO" your information will remain private through the Nebraska Lifespan Respite Network secure online system. YES NO

How to submit your application



The mailing address is different for each region of Nebraska. Using the map above locate the county you live in and send this complete paper document to a respite coordinator in your region listed below. To efile your applications please attach application form in an email addressed to your local regional coordinator below.

<p>Respite Coordinator Eastern Region 985450 Nebraska Medical Center Omaha, NE 68198-5450 Email: edbennett@unmc.edu</p>	<p>Respite Coordinator Northern Region 626 N Street Loup City, NE 68853 Email: pjensen@centralnebraskacap.com</p>
<p>Respite Coordinator Southeast Region 1701 S. 17th St., Suite 2D Lincoln, NE 68502 Email: mary@ywcalincoln.org</p>	<p>Respite Coordinator Western Region 300 Shelton Street Chadron, NE 69337 Email: specialprojects@wchr.net</p>
<p>Respite Coordinator Central Region 626 N Street Loup City, NE 68853 Email: lhovie@centralnebraskacap.com</p>	<p>Respite Coordinator Southwest Region 404 W 10th Street McCook, NE 69001 Email: respite@swhealth.ne.gov</p>