South Carolina Respite for the Lifespan
Respite Voucher Program
Application Form
(respite = breaks from care giving)

PLEASE PRINT CLEARLY

PARENT/GUARDIAN/FAMILY CAREGIVER INFORMATION

First Name _____ Last Name _____
Street or PO Box Address _____City _____
State ____ Zip_____ County _____ E-mail address _____
Home Phone (____) _____ Work Phone (____)_____ Cell (____)_____
Relationship to care receiver_____ How long have you been providing care? _____
Is this 24 hours for you? ____yes ____no. I also work ___ yes ___no. How many hours a day do you do personal, "hands on" care? _____ Describe care:_____
_____(continue on back if needed)
For respite I usually: _____
____ I have had no respite. Family income 2012: $ _____ total in household _____

CARE RECEIVER (PERSON NEEDING CARE):

First Name _____ Last Name_____ Date of Birth _____
Address (if not same) _____ City _____
State ___ Zip_____ County _____ Email address: _____
Phone(s) (____)_____# of days each week we will want to use day care: _____
We can not use day care ___ Why not? _____
Preferred schedule – circle all that apply: M T W Th Fri 1/2 days 5+hrs Saturday evening
Special dates we need respite, if any: _____
Transportation plan: ___ will be brought by someone ___ need van ____ ride van one way ___ both ways
Race _____ Gender ____ Disability/diagnosis _____
Self toileting: ___ yes ___ no Use adult brief: ___yes ___no incontinent of __bowel ___bladder
Use: __ cane __ walker __ wheelchair __ bedbound. Diet: diabetic? __Yes __ no other: _____

Doctor: _____ MOST Important -Fax: (___) _____
Address: _____City _____
State ____ Zip_____ Phone (___) _____

Please check all that apply to you:
_____ I am not eligible for CLTC services
_____ I have Medicaid for medical care
_____ I am a veteran
_____ Still on the CLTC waiting list
_____ I receive medical services from a VA Center
_____ I have used Adult Day Care before (list which one): _____
_____ I have received a respite voucher from the Alzheimer's Association
_____ I have received respite from the Family Caregiver Support Program

I give permission for the S.C. Respite Coalition to contact the doctor and respite providers (adult day care or in-home care organizations) so that those who will be involved with the care can work together on a respite plan.
Submitted by (Caregiver signature): _____

Fax to: SC Respite Coalition at 803-777-1576 or mail to P.O. Box 493, Columbia, S.C. 29202. If you have questions, e-mail screspitecoalition@yahoo.com or call: 1-866-345-6786.