



NEBRASKA RESPITE NETWORK
1-866-RESPITE

APPLICATION FOR RESPITE PROVIDER

Office Use only

Date Received: ____/____/____

Background Check Completed: ____/____/____

Date Entered: ____/____/____

Please return to:

Nebraska Respite Network
Southwest Service Area
404 West 10th St / PO Box 1235
McCook NE 69001

Date: ____/____/____ County: _____

Name: _____ Former names: _____

Physical Address: _____ City: _____ ST: _____ Zip code: _____

Mailing Address: _____ City: _____ ST: _____ Zip code: _____

Phone # (Home) ____-____-____ (Work) ____-____-____ (Cellular) ____-____-____

Email Address (if applicable): _____

Can we contact you via e-mail? Yes No

Fee rates: \$____.____ hourly \$____.____ daily \$____.____ overnight \$____.____ weekend **negotiable**

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

Are you willing to travel to provide respite? Yes No

What is the maximum distance from your home address that you would travel to provide respite?

10 miles 25 miles 50 miles over 50 miles

Is your home barrier free? Yes No

Will you transport client? Yes No

REFERENCES: List (3) personal or business references, no relatives:

1. Name: _____ Phone #: _____
 Address: _____
 City: _____ State: _____ Zip code: _____
2. Name: _____ Phone #: _____
 Address: _____
 City: _____ State: _____ Zip code: _____
3. Name: _____ Phone #: _____
 Address: _____
 City: _____ State: _____ Zip code: _____

Please check the funding sources you are approved to accept as payment:

- | | | |
|--|---|--|
| <input type="checkbox"/> Disabled Persons & Family Support | <input type="checkbox"/> Medicaid Waiver | <input type="checkbox"/> SSI/DCP |
| <input type="checkbox"/> Early Intervention Waiver | <input type="checkbox"/> Medically Handicapped Children | <input type="checkbox"/> Stipend |
| <input type="checkbox"/> Emergency/Crisis Funds | <input type="checkbox"/> Private Pay | <input type="checkbox"/> TITLE XX |
| <input type="checkbox"/> Foster Care | <input type="checkbox"/> Respite Subsidy | <input type="checkbox"/> Volunteer |
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> Social Services Block Grant | <input type="checkbox"/> I want to become approved |

Please check the types of care you would be able/willing to provide:

- | | | |
|--|--|--|
| <input type="checkbox"/> Adult Day Care | <input type="checkbox"/> Daily Living Assistance | <input type="checkbox"/> Non-skilled Companion |
| <input type="checkbox"/> Assisted Living | <input type="checkbox"/> In Client's Home | <input type="checkbox"/> Nursing Home |
| <input type="checkbox"/> Child Care | <input type="checkbox"/> In Provider's Home | <input type="checkbox"/> Skilled Nursing |

Which ADL's are you able/willing to help with: ADL's (Activities of Daily Living)

- Toileting- assists with cleaning, ostomy care, and changing disposables
- Mobility – assist with wheel chair re-positioning
- Bathing – body washing, shampooing, drying
- Dressing – dress, and undress, assist with TED hose
- Dietary – help prepare meals, cut food, and assist with feeding, special diet, food allergies
- Transferring – help transfer from one place to another, can use hoist lift
- Grooming – shaving, washing, combing hair, denture care

Please check the Behavioral/Emotional conditions you would be willing to work with:

- | | | |
|-------------------------------------|---|---|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Reactive Attachment Disorder |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Self-Abusive |
| <input type="checkbox"/> Bipolar | <input type="checkbox"/> Person who is non-verbal | <input type="checkbox"/> Temper Tantrums |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Physically Aggressive – biting, fighting | <input type="checkbox"/> Wandering |

Please check the medical conditions you are willing to work with:

- | | | |
|--|--|---|
| <input type="checkbox"/> Arthritis or other joint problems | <input type="checkbox"/> Feeding Tubes | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Blood problems, such as anemia or sickle cell disease | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Severe Allergies |
| <input type="checkbox"/> Breathing problems such as Asthma or COPD | <input type="checkbox"/> Nebulizer | <input type="checkbox"/> Spinal Cord Injuries |
| <input type="checkbox"/> Catheters | <input type="checkbox"/> Oxygen | <input type="checkbox"/> Tracheotomy |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Recovering from Surgery | |

Please check the following conditions you are willing to work with:

- | | | |
|--|--|--|
| <input type="checkbox"/> Alzheimer's/Dementia | <input type="checkbox"/> Fetal Alcohol Syndrome | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Autism / Autism spectrum disorder | <input type="checkbox"/> General Physical Disabilities | <input type="checkbox"/> Quadriplegia |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hearing Impairment/ hearing aids | <input type="checkbox"/> Speech and language delayed |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Intellectual Disability/Developmental Delay | <input type="checkbox"/> Stiff Persons Syndrome |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Traumatic Brain Injury |
| <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Visual Impairment |

Please check the ages you are willing to work with:

- | | | |
|-------------------------------------|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> 0-2 years | <input type="checkbox"/> 19-35 years | <input type="checkbox"/> 65-74 years |
| <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 any languages that you speak: English Other (please indicate language)

Please check when you are able to provide services:

- | | | |
|--------------------------------------|---|------------------------------------|
| <input type="checkbox"/> Daytime | <input type="checkbox"/> Evenings | <input type="checkbox"/> Overnight |
| <input type="checkbox"/> Emergencies | <input type="checkbox"/> Extended Periods | <input type="checkbox"/> Weekends |

How did you hear about the Nebraska Respite Network?

- Presentation
- Newspaper
- TV/Cable/Radio (please circle)
- Brochure/Poster
- Newsletter
- Referral
- Friend/Relative
- Internet
- Other _____

RELEASES:

I understand that as a condition of my applying to be a respite provider, my name will be checked against the Nebraska Department of Health and Human Services Adult/Child Protective Services Central Registers and National Sex Offender Registry, as well as having my criminal background checked. A check of these registers is necessary to ensure that I have met provider standards. The purpose of these checks will be to determine if my name is being maintained on either register as a result of previous abuse/neglect allegations, which have not been determined to be unfounded and to determine if my criminal background passes Network guidelines. To the best of my knowledge, I do not have a conviction of prior history of adult or child abuse/neglect or maltreatment. Neither have I been convicted of a crime involving moral turpitude.

I _____ (**PRINT NAME**), hereby apply to be an approved respite provider with Nebraska Respite Network. In making application for approval it is understood that:

I/We give the Agency permission to contact law enforcement personnel and references about my/our character and background as it affects the provision of care for children/youth/adults.

I/We understand and give permission to have my/our names checked with the State Central Registry of child/adult abuse and neglect.

I/We understand and give permission to have my/our names checked with the National Sex Offender Registry and submit to a statewide criminal background check.

I (the applicant) give the Agency permission to enter information, as needed, into the eLifespan information and referral system.

I further state that any information that I give in the investigation of my application will be true and correct to the best of my/our knowledge.

If you are providing respite in your home, the following information must be completed and signed by any person 19 or older living in the household, even if they are not applying to provide respite. If you are providing respite outside of your home, only the applicant needs to complete and sign.

Applicant's Signature	_____/_____/_____ Date of Birth	_____/_____/_____ Date Signed
Household member's Signature	_____/_____/_____ Date of Birth	_____/_____/_____ Date Signed
Household member's Signature	_____/_____/_____ Date of Birth	_____/_____/_____ Date Signed

United States Citizenship Attestation for the purpose of complying with Neb. Rev. Stat. §§ 4-108 through 4-114, I attest as follows:

I am a citizen of the United States; OR I am a qualified alien under the federal Immigration and Nationality Act.

My immigration status and alien number are as follows: _____



Division of Children and Family Services

State of Nebraska

Dave Heineman, Governor

AGENCY REQUEST FOR INFORMATION FROM THE NEBRASKA ADULT AND CHILD ABUSE AND NEGLECT REGISTER/REGISTRY

The State of Nebraska approved this form, any alteration will invalidate it.

I hereby request information from the Nebraska Adult and Child Abuse and Neglect Registry. I agree to use the requested information to determine whether to hire or retain the individual to provide care, custody, treatment, transportation or supervision of children or vulnerable adults.

Agency Name/ Fax: Respite Network – Southwest Service Area/ Fax 308-345-4289

Address and Phone Number: 404 W 10th St., PO Box 1235 McCook, NE 69001/Phone 308-345-4990

I hereby authorize the Division of Children and Family Services to disclose whether I have an Adult and/or Child Abuse and Neglect Register/Registry record to the above-named agency.

Print Full Legal Name: (applicant) _____

Signature (applicant)

Date

Current Address: _____
(Street/City/State/Zip)

Applicant Date of Birth

Applicant Social Security Number

Other names previously used such as former married names, maiden name and nick names. Please Print.

Names and birth dates of your children and children who have lived with you. Please Print.

Any Address at which you have resided during the past 20 years. Please Print.

