



COUNSELING/RESPITE PROGRAM APPLICATION FORM

DATE: _____

CAREGIVER INFORMATION

NAME: _____

RELATIONSHIP to the Care Receiver:

- Wife Husband Daughter/Daughter-in-Law Son/Son-in-Law Grandparent
 Grandchild Non-relative Other relative

ARE YOU A VETERAN: Yes No

Respite Provider needs:

- I have my own respite-care providers.
 I would like Teller Senior Coalition to provide a referral list of independent contractors.

How did you find out about the TSC Respite Program? _____

CARE RECIPIENT INFORMATION

NAME: _____

DATE OF BIRTH: _____ LAST FOUR DIGITS OF SSN: _____

RESIDENTIAL ADDRESS: _____

MAILING ADDRESS: _____

PHONE: _____ RURAL: YES

LIVING SITUATION: Lives alone With Spouse With relatives With Non-relatives

MARITAL STATUS: Married Single Widowed Legally Separated Divorced

ETHNICITY: Hispanic or Latino Not Hispanic or Latino

RACE: White Asian Native American African American Other Multi-race

VETERAN: Yes No

Respite applicants please complete side 2!!!!

Revised 07/02/2010



Respite Program Receipt and Release

In consideration of the receipt of a stipend of \$ _____, for the purposes of respite care for _____, I agree to the following:

1. I agree to use the stipend funds solely for the purpose of providing respite care in the following ways: 1) in-home services 2) adult day-care and 3) institutional respite care.
2. I understand that the Teller Senior Coalition, its agents, employees, and officers are not insurers or guarantors of the work or services performed, paid for pursuant to the Caregiver Respite Program application, nor responsible for the personal safety of any person and/or property affected by the stipend.
3. I further understand that I assume sole responsibility for incurring and paying all charges and for any and all damages of any kind to persons and/or property, which may arise as the result of the performance of the specified work herein.
4. I release the Teller Senior Coalition, its agents, employees, and officers from any and all liability that may arise as a result of the work performed in accordance with the Respite Program application and the funds issued pursuant to the stipend.

Client (Family Caregiver) Name _____ (Please print)

Client (Family Caregiver) Signature _____ Date _____

TSC Representative Signature _____ Date _____

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