Respite Care Voucher Application PDF

Before you Start

Welcome to the Respite Care Voucher Application administered by BPA Health. This program provides short-term or temporary care for a youth with Serious Emotional Disturbance (SED) that is provided by someone other than the youth's primary caregiver (i.e. family, friend, neighbor).

To complete this application, you will be required to (1) submit a current mental health assessment of your child that has been signed by a qualified medical or behavioral healthcare provider and/or (2) functional assessment that identifies respite care on the child/youth's person-centered plan or treatment plan.

For assistance, please contact the Idaho Respite Care Program at 208-947-5154 or 1-866-617-3126.

Is the child for whom you are applying for funding covered by Medicaid?
○ Yes ○ No

Is the child for whom you are applying under the age of 18?
○ Yes ○ No

What is the age of the child for whom you are applying?

Is the child for whom you are applying a legal resident of the State of Idaho?
○ Yes ○ No

Demographic Information

Name of Applicant

First Last

Applicant is:
○ Parent ○ Legal Guardian

Region

Regions 1-7

for Idaho regions visit: https://healthandwelfare.idaho.gov/Medical/MentalHealth/tabid/103/Default.aspx

Phone

Email

Physical Address

Address Line 1

Address Line 2

City

State

Zip Code

Number of people residing in home:

While the Voucher Respite Program is sensitive to respecting the privacy of families applying for respite services, it is important that critical information be disclosed to ensure that respite providers have the information they need to be safe and to keep your children safe while providing respite services.

Is there anyone besides yourself you would like us to contact regarding your child's respite application (such as a case manager or family member)?
☐ Yes ☐ No

Additional Contacts

Item 1

Address

Address Line 1

Address Line 2

City

State

Zip Code

Email

Phone

Relationship

Child Information

To add multiple children, click +Add Child below.

Child Member 1

Gender

○ Male ○ Female

⊙

Confirmation of Child and Family Team Referral Upload

Please attach a copy of your child's assesment and CFT provider referral. You may do this by emailing the referral to respitecare@bpahealth.com or mail it to 8050 W. Rifleman St., Suite 100 Boise, ID 83704. **Please note: we must have an assesment and/or referral to authorize your voucher application.**

Name of CFT Referral Source

Does this child have a Case Manager and/or CFT Facilitator?

○ Yes ⊙ No

Case Manager/CFT Facilitator Information

Case Manager Name

First Last

Case Management Agency

Case Management Email **Case Management Phone**

- I agree to notify the BPA Health Respite Program if my child(ren)'s case manager or the agency providing case management changes.

Initial:

Please review the following policies, fill in information & initial where indicated.

PARENTAL RESPONSIBILITY

1. Choice of provider - BPA Health believes families should choose the respite provider most appropriate to the needs of their family. It is the parent's responsibility to select a provider prior to application.

2. Inform and train the provider about your child's needs - Parents know their children best. They are most able to inform a provider what their child(ren) requires. It is the parent who must fully inform the provider of

the child(ren)'s every need, including programs and treatments.

3. Instruct the provider regarding medications - Parents are responsible for informing their providers about their child(ren)'s medications and dosages.

4. Changes in special needs - Parents are responsible for reporting any changes in their child(ren)'s special needs, in the families' needs, residence, or telephone number.

Please Initial Here:

NOTICE OF CONFIDENTIALITY
While not a clinical provider, BPA Health complies with state and federal confidentiality laws that govern the release of information about medical and behavioral health. Our records consist only of the information you have shared with us as part of the application process. In this regard, BPA Health will maintain the privacy of your respite records with the following exceptions:

- There are concerns about or allegations of abuse or neglect of a child or a dependent adult;
- There are allegations or concern about the safety of a child or dependent adult;
- There are allegations or concerns about self-harm or harm to a child or dependent adult;
- There are other health or safety concerns that lead BPA Health to believe that the child or family is at risk because of an inability to care for the child or to care for themselves.

In all instances where a BPA Health staff person has any of the concerns listed above they will discuss them with a supervisor and if warranted, make a report to the Idaho Department of Health and Welfare and/or to law enforcement authorities.

Please Initial Here:

INFORMED CONSENT
I understand that I will be asked to (l) identify and select the respite care provider that I choose to provide respite care to me and my family, (2) comply with the plan of care provided by the CFT/Mental Health provider, and (3) that I will be required to ensure the respite care provider selected has the knowledge and skills to provide care and effectively address the youth's needs.

I understand that respite care is neither a clinical service nor a medical or treatment service, and is a program that I have voluntarily chosen to utilize in order to receive planned breaks from caring for my child(ren) with SED.

I understand the inherent risks associated with participation in respite care services and in asking another person to provide care to my child. I knowingly and voluntarily accept these risks and agree to provide BPA Health with a satisfaction survey before respite care begins and at least quarterly thereafter.

I acknowledge that I am solely responsible for medical or other costs arising out of any injury, illness, or property damage or loss sustained through my voluntary participation in this program. I also agree to provide necessary funds to include fees & travel costs for any activity in which I have asked the respite care provider to bring my child(ren).

Please Initial Here:

Payment Information

Send Check to:
○ Physical Address ○ Other Location

Make Checks Payable to:

Other Location

Address Line 1

Address Line 2

City | State | Zip Code

Signature

Date

Name

First | Last