

Office Use Only
Date Received: ___/___/___
Background Checks Completed: ___/___/___
Date Entered: ___/___/___
[] Approved ___/___/___ to ___/___/___
[] Denied

Please return to:

[] 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
[] Other, please specify/describe

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 you willing to work with:

- Toileting Bathing Dietary Grooming
 Mobility Dressing Transferring

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

- ADD/ADHD Mental Disorders Self-Abusive
 Anxiety Non-Verbal Temper Tantrums
 Depression Oppositional Defiant Disorder Wandering
 Fetal Alcohol Syndrome Physically Aggressive
 Hyperactivity Reactive Attachment Disorder

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

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

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

- 0-2 years 19-35 years 65-74 years All Ages
 3-5 years 36-50 years 75-84 years
 6-18 years 51-64 years 85 and over

Language(s) spoken (check all that apply):

- English Spanish Other (please list) _____

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

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

Does your agency conduct background checks for your staff and/or volunteers? Yes No

Will staff be providing unsupervised respite supports to Respite clients? Yes No

If background checks are not complete for staff and/or volunteers, separate applications for individual providers will need to be completed and submitted to the Nebraska Lifespan Respite Network. Applications can be found at:

<https://respite.ne.gov/individual-application>

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, age 14 or older if providing respite care, 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. In accordance with Title 464 NAC 1.019.01 DEPARTMENT DISCRETION. The Department retains the authority to deny payment to a recipient's choice of provider in the following circumstances:
 - a. The provider engages in fraudulent billing;
 - b. The provider has committed fraud in other Department programs;
 - c. The provider has been convicted of abuse or neglect of a vulnerable adult or child;
 - d. The provider has been convicted of a violent crime;
 - e. The provider has been convicted of child pornography;
 - f. The provider has been convicted of domestic abuse or assault;
 - g. The provider has been convicted of shoplifting after age 19 and within the last three years;
 - h. The provider has a conviction for felony fraud in the past 10 years;
 - i. The provider has a conviction for misdemeanor fraud in the past five years;
 - j. The provider has a conviction for possession controlled substances within the last 10 years;
 - k. The provider has a conviction for manufacturing of a controlled substances within the last 10 years;
 - l. The provider has a conviction for prostitution or solicitation of prostitution within the last five years;
 - m. The provider has a conviction for robbery or burglary within the last 10 years;
 - n. The provider has a conviction for rape or sexual assault;
 - o. The provider is a registered or required to be registered on a State or National Sex Offender Registry or Repository;
 - p. The provider has a conviction for any crime against a child or vulnerable adult;
 - q. The provider has a conviction for kidnapping;
 - r. The provider has a conviction for animal cruelty, abuse, or neglect;
 - s. The provider has a conviction for arson;
 - t. The provider has convictions for driving under the influence within the last five years;
 - u. The provider has two or more pending driving under the influence charges; or
 - v. The provider has convictions for any other crimes jeopardizing the safety of a child or vulnerable adult.

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 below to locate the county you live in and send this complete paper document to a respite coordinator in your region listed below. To e-file your applications please attach application form in an email addressed to your local regional coordinator below.

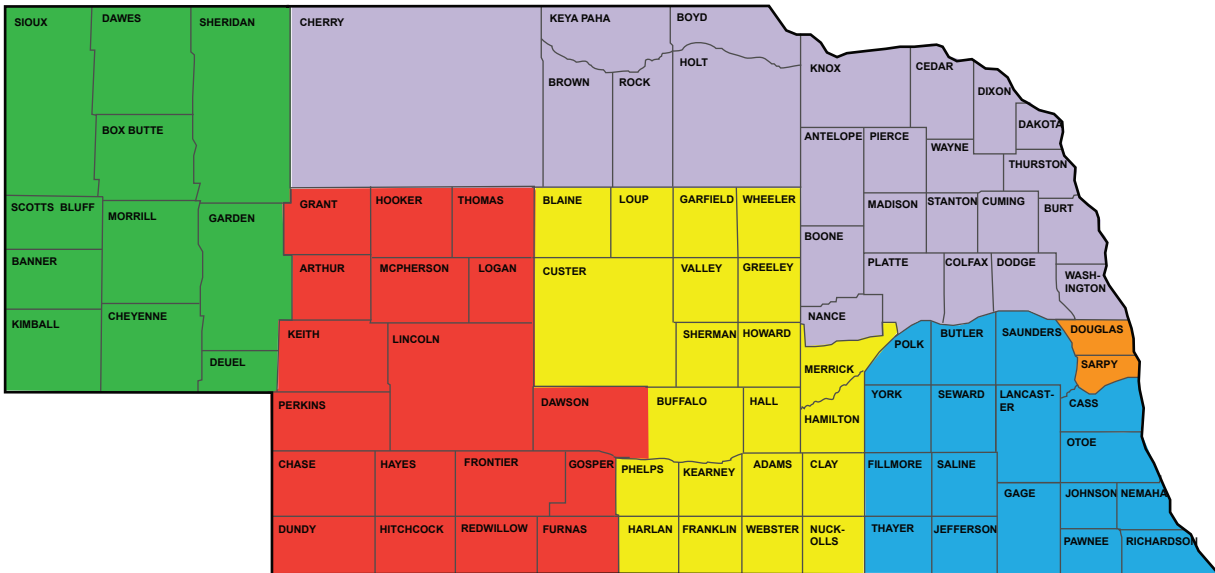
Nebraska Department of Health and Human Services Nebraska Lifespan Respite Network

dhhs.ne.gov/respite

respite.ne.gov

Hanna Quiring, Program Coordinator
DHHS - Division of Children & Family Services
Lifespan Respite Subsidy Program and
Disabled Persons & Family Support Program
Nebraska State TSB Building, 1410 M St.
PO Box 98933
Lincoln, NE 68509-8933
(531) 530-7011
hanna.quiring@nebraska.gov

Jan Drewel, Social Services Worker
DHHS - Division of Children & Family Services
Lifespan Respite Subsidy Program and
Disabled Persons & Family Support Program
PO Box 98933
Lincoln, NE 68509-8933
(402) 471-9188
dhhs.respite@nebraska.gov



Western Service Area (Local Respite Network)
Panhandle Partnership for Health and Human Services
Chadron, NE
(308) 432-8190 specialprojects@wchr.net

Southwest Service Area (Local Respite Network)
Southwest NE Public Health Department
McCook, NE
(308) 345-4990 respite@swhealth.ne.gov

Eastern Service Area (Local Respite Network)
The Munroe-Meyer Institute UNMC
Omaha, NE
(402) 559-5732 eastrespite@unmc.edu

Southeast Service Area (Local Respite Network)

Northern Service Area (Local Respite Network)
Munroe-Meyer Institute UNMC
Omaha, NE
northrespite@unmc.edu

Central Service Area (Local Respite Network)
Independence Rising
Kearney, NE
(402) 309-4344 respite@irnebraska.org

Employer Engagement
Kim Falk, Lead Respite Coordinator
UNMC-MMI
(402) 559-4951 kim.falk@unmc.edu

UNL-CCFL (Center on Children, Families & the Law)
Charlie Lewis, Project Director
(402) 472-9815 clewis@unl.edu
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402-472-9827 jessica.cook@unl.edu