Brain Injury Alliance of NKY
WWW.BIANK.ORG

Respite Assistance Program (RAP) Application

Name: _____ Date of brain injury: _____

Phone Number: _____ Date of Birth/Age:_____

Email Address: _____ Medicaid Number (if applicable):_____

Address: _____

Skip this section if you are filling out this application for yourself. If someone is assisting with this application, please provide additional details here:

Name of person assisting with application: _____

Phone number: _____
Address: _____
Email Address: _____

Relationship to applicant: _____

Are you this applicant's primary caregiver and/or the responsible party for seeking out and paying for respite services: Yes No

Please note: The responsible party will need to sign this application.

1. Description of Brain Injury:

    a. I have attached the proof of brain injury by a medical provider to this document (please note if you answer "No" this application will be denied) ____ Yes ____No

2. Description of physical and cognitive needs:

3. Does the survivor require 24/7 Supervision?
    ____ Yes ____ No

4. Is the survivor homebound?
    ____ Yes ____ No

5. If the survivor is not homebound, BIANK requires a visit or phone call to one of the local day programs (verified by picture or confirmation from day program), prior to approving in-home care. I understand this clause.
   ____ Yes ____ No ____ Survivor is homebound

6. Does the survivor receive financial aid from any of the Brain Injury Waivers? (Acquired Brain Injury Waiver, Acquired Brain Injury Long Term Care Waiver, Home and Community Based Waivers, or the Michelle P. Waiver). Unfortunately those who receive services from the waiver will not qualify for our Respite Assistance Program.
   ____ Yes ____ No

7. Has this request been funded elsewhere (ex: insurance, other non-profit organizations, or donations)?
   ____ Yes ____ No

8. What county does the survivor live in?

9. Is this request for services already received?
   ____ Yes ____ No

   a. If you answered “Yes” to question 9, please attach a bill, invoice, or receipt to this application. I have attached a copy of the bill, invoice or receipt to this application.
      _____Yes _____No

Applicant Attestation

I hereby affirm that all information provided in this application is current, complete, and accurate to the best of my knowledge.

I understand that I am the responsible party, and that any contract I enter with a respite care provider is done of my own free will. BIANK is not responsible for the service I receive, my experience, or the expenses I incur as a result of seeking out these services. I understand that this application does not guarantee approval.

Should I be approved, I may be required to follow up with proof that I received respite care services if I have not already done so.

I understand that if the survivor becomes eligible for services under any applicable waiver program, financial assistance through BIANK’s Respite Program will be discontinued.

I further acknowledge my responsibility to promptly notify BIANK should the survivor qualify for such waiver services.

I understand if services are not used, applicant will no longer qualify for the Respite Program, in order to allow funding for future applicants.

Signature of Applicant/Responsible Party: _____

Printed Name: _____