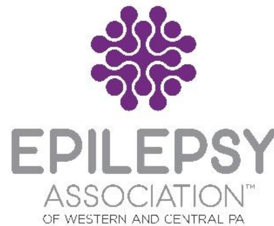

EPILEPSY ASSOCIATION OF WESTERN AND CENTRAL PA

APPLICATION FOR RESPITE CARE SERVICES

PROGRAM OVERVIEW:

Respite is defined as "temporary relief for family caregivers from ongoing responsibility of caring for an individual of any age with special needs" (Tipler, 2010). The Epilepsy Association of Western and Central PA (EAWCP) is pleased to provide this temporary respite care program to families or individuals who are primary care takers for children and adults who have uncontrolled seizures. This program will allow caretakers to take some scheduled time off from the demands of caring for a loved one.

PROGRAM GUIDELINES:

- This is a temporary pilot or test program and may not become a permanent program of the EAWCP.
- The purpose of this program is simply to provide caretakers with a brief or intermittent break for themselves. ***This program does NOT provide on-going care.*** The EAWCP will make every effort to work with program participants to refer and link participants to another source of on-going care services but makes no promises or commitments that on-going care can be identified, secured or provided.
- A maximum of 25 hours of care will be provided for an individual within a 1-year period.
- Working with the EAWCP staff, you will choose a respite care provider that can accommodate your needs, age, location, etc. When you have determined an appropriate provider, the EAWCP will authorize funding for respite care services.
- Payment for services will be made only to and directly to the provider of the services.
- Respite care services are provided ONLY for the program participant. Other accommodation should be made for anyone else who may be present during the time of service. (For example, if you have other children present who may need care.)
- The primary caregiver for the program participant will be asked to participate in a pre-service and post-service survey so that the EAWCP can collect information that will make it possible to measure program outcomes, monitor the quality of services provided and continuously improve our program. (This information will be kept in strict confidence and will not be used by any agency other than the EAWCP. The EAWCP does not trade, rent, sell or share the names, addresses or emails of our constituents.)

ELIGIBILITY / SELECTION PROCESS:

- The program participant must reside in the Western and Central Pennsylvania service territory (see attached map of counties).
- The program participant must apply prior to the respite date for pre-approval.
- The program participant should have an active diagnosis of epilepsy/seizure disorder documented by a physician.
- The program participant's physician must provide a letter that indicates a diagnosis of epilepsy or seizure disorder, and a recommendation for respite care services. The physician can either be the neurologist or a primary care provider. The physician should currently be providing medical care for the patient's seizures/epilepsy and have full knowledge of the program participant's seizure history. The letter can either be sent directly by the health care provider to the EAWCP, or the applicant may send it to the EAWCP after receiving it from the physician.

Please submit all forms to the EAWCP:

By fax:
(412) 322-7885

By e-mail:
rchattaway@eawcp.org

By mail:
Epilepsy Association of Western and Central PA
Attn: Rebecca Chattaway
1501 Reedsdale Street, Suite 3002
Pittsburgh, PA 15233

EPILEPSY ASSOCIATION OF WESTERN AND CENTRAL PA
APPLICATION FOR RESPITE CARE SERVICES
(★= required information)

★Primary Caregiver (Who Will Coordinate Care for the Family?)

First Name:		Last Name:	
Relationship to Applicant:			
Address:			
City, State Zip:		County:	
Best Phone Number to Contact You:			
Email Address:			

★Applicant (Who Is Receiving Care?)

First Name:		Last Name:	
Age:		Date of Birth:	
Address (if different from above):			
City, State Zip:		County:	
Phone :			
Email :			
Primary Insurance Company Name:			
Primary Insurance Company Policy Number:			
Secondary Insurance Company Name:			
Secondary Insurance Company Policy Number:			

Insurance Information will only be used in case of an emergency and/or in order to secure additional and/or future care for your family and will not be used without your prior knowledge.

If applicant is a minor:

Full Name of Father:		Phone:		E-mail:	
Full Name of Mother:		Phone:		E-mail:	
Best Phone Number to Reach Parent:					
Best Email to Reach Parent:					

★Liability Release:

I declare that the information provided on this application is true and complete to the best of my knowledge and is being provided to the Epilepsy Association of Western and Central PA (EAWCP) for the purpose of receiving financial assistance consideration to enable respite care services. I understand that a maximum of 25 hours within a 1-year period will be authorized under this program. I understand that the individuals who are providing in-home respite care services are not employees of the EAWCP and therefore, the EAWCP cannot be held liable for their actions or inactions. The undersigned hereby releases, remise, and forever discharges the EAWCP and its agents, directors, officers, volunteers, and employees from any and all liabilities, causes of action, demands, rights, claims, costs, expenses, attorney fees, from all losses, damages, claims, costs, expenses and liabilities, including attorney fees, for injury to person or property arising in connection with my participation in EAWCP voluntary respite care program. The undersigned, further agrees to indemnify the EAWCP and its agents, directors, officers, volunteers, and employees against all claims, suites, demands, and expenses arising out of injury or damage to any property or person during the time of service. The undersigned further declares that they are assuming the risk of participation in the EAWCP respite program. There may be other risks not known to us or not reasonably foreseeable at this time. I assume all the foregoing risks, accept personal responsibility for any damages incurred by my family member.

Signature: *(Program applicant)*		**Date:**	
Signature: *(Legal guardian if a minor)*		**Date:**	
Signature: *(Primary contact)*		**Date:**	