



**DELAWARE LIFESPAN RESPITE NETWORK  
APPLICATION FOR FINANCIAL ASSISTANCE**

**4. A. Please list by either name or service provider any funding sources from which you are currently eligible to receive respite services, and**

**B. Also, please indicate the total amount per year you are eligible to receive from each source:**

	Name of Funding Source	Amount Eligible to Receive Each Year
Source 1.	_____	_____
Source 2.	_____	_____
Source 3.	_____	_____
If none, please note here: _____		

**5. In order to provide the best possible assistance to you, please provide a brief explanation of how you currently access respite services and how you pay for them.**

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**6. Explain why you need financial assistance from the Delaware Lifespan Respite Network if you are eligible for respite services from other funding sources.**

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**7. Eligible persons may receive up to \$500.00 per care recipient per year in financial assistance as funds are available. Please indicate below the total amount of funds you are requesting. Total funds requested:**

**\$ \_\_\_\_\_**

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**8. Do you need assistance with locating a respite provider? Yes\_\_\_\_\_ No\_\_\_\_\_**

**9. Please give a brief explanation of how you currently locate and hire respite care providers.  
(i.e. private pay individuals, family members, neighbors, home health agencies, through school, etc.)**

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**10. Care Provider Requirements**

I agree to follow the care provider requirements listed below.

The care provider:

- a. is 19 years of age or older
- b. has provided either a Social Security number or a tax ID (EIN) number
- c. is NOT the caregiver's spouse/partner or care recipient's parent
- d. is NOT the care recipient's regular care provider, unless being used for additional hours of respite care beyond the normal care schedule

**11. IMPORTANT Notices and Guidelines:**

- a. Respite funds are not for child day care payment
- b. Payment for respite care will be made after the respite has been provided
- c. Invoice Forms are to be submitted at least once a month
- d. All Invoice Forms must be either mailed or hand delivered to the address on the Invoice Form (Invoice Forms will not be accepted by fax or email)
- e. I am responsible for informing the Delaware Lifespan Respite Network of any address, email, or telephone number changes
- f. I will not submit a claim for respite funds for my regular work hours

\_\_\_\_\_ **I have read and understand the Care Provider Requirements and Notices and Guidelines and agree to follow them**

\_\_\_\_\_ **I do not agree**

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If you have any questions concerning the application process or any of the Notices and Guidelines, please call 302-324-4444 for assistance with your questions. Thank you.

**12. Parent/Caregiver Verification Information**

**Questions with an "\*" requires an answer**

\*Name: \_\_\_\_\_  
\*Address 1: \_\_\_\_\_  
Address 2: \_\_\_\_\_  
\*City: \_\_\_\_\_  
\*State: \_\_\_\_\_  
\*Zip Code: \_\_\_\_\_  
\*Primary Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_  
Email Address: \_\_\_\_\_

PLEASE MAIL THIS APPLICATION TO:

**Delaware Lifespan Respite Network  
61 Corporate Circle  
New Castle DE 19720-2439**

Thank you for your application for financial assistance for respite services. A staff member from the Delaware Lifespan Respite Network will be contacting you.