SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
APPLICATION FOR RESPITE FUNDS

The purpose of Respite funding is to provide, when needed, financial assistance to families who care for a person with an intellectual or related disability, autism, or traumatic brain injury, spinal cord injury or similar disability in order to provide needed relief from the responsibilities of direct, hands-on caregiving and supervision. Respite funding is directed toward those families who incur additional expenses due to the person's disability. It is not intended to be used for typical expenses that are routinely incurred by families such as childcare/babysitting for children under age 12, etc. In accordance with state law, IFS-R funding is not an entitlement program or a general public assistance benefit.

Because these funds are limited, Respite funds are not available to:

- Those who are not DDSN eligible.
- Those who are enrolled in **any** Medicaid Home and Community Based Waiver.
- Those who are eligible for DDSN services in the "At-Risk" category (children three (3) to six (6) years).
- Those who receive Residential Habilitation.
- Those who reside in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or a Nursing Facility.
- Those in SC Department of Social Services Foster Care or Therapeutic Foster Homes.
- Those residing in a Psychiatric Residential Treatment Facility (PRTF).
- Those receiving State Funded Community Supports may not also receive IFS-R funds for Respite.

Respite funding is only available when the needed relief from caregiving and supervision cannot be paid for by the family, other public agencies or community resources or as a by-product of DDSN or other agency services/programs. Consideration must be given to all of the resources available to the family, even those resources that indirectly provide relief from caregiving and supervision.

DDSN Eligible Person's Name: ________________________________ Date of birth: ________________

Address: ____

Regarding the DDSN eligible person, he/she (check all that apply):

☐ Is individual Medicaid Eligible.
☐ Receives Children's Personal Care as a State Plan service.
☐ Receives Private Duty Nursing as a State Plan service.
☐ Receives Rehabilitative Behavioral Health Services (RBHS).
☐ Has Applied for Medicaid: Date of Application: ________________________
☐ Attends Public or Private School.
☐ Receives Homebound Instruction - If yes, specify instructional time per week: ________________________
☐ Is Homeschooled by Family.
☐ Enrolled/participates in a Day Program, Adult Activity Center or Work Program.
☐ Receives Adult Day Health Care services.
☐ Is awaiting enrollment in a DDSN-operated Waiver (ID/RD, HASCI, CS, PDD)
☐ Is enrolled/participates in a DHHS-operated (CLTC) Home and Community-based Waiver
(SC Choices, Medically Complex Children's Waiver, HIV/AIDS Waiver, Ventilator Dependent Waiver)

☐Is currently employed: ☐Full-time ☐Part-time

If the DDSN eligible person is a child between ages 4-12; does he/she:

☐Engage in inappropriate, disruptive behavior on a daily basis (hitting, kicking, running away, smearing feces, eating objects that are not food, etc.)

☐Have a complex medical condition or disabilities that makes care difficult (diaper changes/incontinence care, hands on feeding, etc.)

If yes to either question above, explain: ______________________________

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(attach additional pages if needed)

Who, other than the DDSN eligible person, lives in the home? List each person's relationship to the DDSN eligible person and his/her age (e.g., *Mother – age 39; Father –age 40; Sister – age 12*):

______________________ ______________________

______________________ ______________________

______________________ ______________________

Regarding the DDSN eligible person, who is his/her primary caregiver?

Name: ______________________ Relationship: ______________________

Age of Primary Caregiver: ____________

Who provides care when the primary caregiver noted above is not available?

Name	**Age**	**Relationship**

This application is for funding for Respite:

☐To be provided (one-time) during the temporary absence of the primary caregiver. Explain why the caregiver will be unavailable *(e.g., caregiver is having surgery, etc.)*: ______________________

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Approximate amount of Respite needed: ______________________________

Amount of Respite Funds requested: $______________

☐To be routinely provided:

Approximate amount of Respite needed per calendar month: ______________________

Amount of Respite Funds requested per calendar month: $____________

If needed for a portion of a calendar year, indicate time period/duration *(e.g., needed monthly for June, July and August only)*: ______________________________

Regarding the person completing this application:

Printed Name: ______________________________

Relationship to the DDSN Eligible Person: ______________________________

Contact Information:

Address: ______________________________

Telephone Number (s): ______________________________ Email Address: ______________________________

I certify that the above information is true and complete. I understand that submitting false information or use of Respite Funds for purposes other than as requested may result in termination of assistance and a payback of expended funds to DDSN.

______________________________ Date: ______________________________
Signature of Person Completing Application

Submit Completed Forms to the attention of Kim Lawer
Email: klawer@ddsn.sc.gov
Fax: (803) 898-2266