



Lifespan Respite of Multnomah County
421 SW Oak Ave, Suite 510
Portland, OR 97204
503-988- 4790

Financial Assistance Application

The purpose of the financial assistance fund is to provide a subsidy for caregivers to assist with the cost of qualified respite care services for family members. Basic criteria to receive financial assistance are as follows:

Rules for Respite Fund Distribution:

1. Recipients of financial assistance are the parents or guardians of children between the ages of 0 to 18 years of age. Family must live in Multnomah County.
2. The respite care stipend is designated to provide care for a child in the family with an emotional, behavioral, developmental or physical disability. The respite stipend may also provide care for a child who has a parent with a disability or chronic illness and/ or grandparents raising their grandchildren.
3. Formal diagnosis is not necessary for the family to receive the funds.
4. If appropriate, the respite care money can pay for siblings of the child with the disability to receive respite care at the same time.
5. The respite care provider must be from the Multnomah County Lifespan Respite list of approved respite care providers. (This list includes but is not limited to providers referred by Multnomah County Child Care Resource and Referral and providers maintained by The Arc of Multnomah-Clackamas.)
6. The family is responsible for hiring the respite care provider. The family and the provider negotiate the rates.
7. The respite care provider is not considered to be an employee of Multnomah County. Multnomah County and Lifespan Respite Care Network assume no responsibility / liability for what transpires between the family and the respite care provider they choose to hire.
8. Household Income of applicants must be within 225 % of the poverty level. (See Chart On Reverse Side of This Page).

9. All respite payments will be made directly to respite care provider by Multnomah County Lifespan after the service has been provided.
10. Multnomah County Lifespan Respite Care Network has a limited amount of funds acquired through donations. Families who fill out this application will be entered in a monthly drawing. Families selected from the drawing will receive the amount of \$200 to be used toward respite care services with in a six month time period. Funds not used within the six month period are forfeited.

# of People in Your Family:	Household Annual Income is Below:	Or Household Monthly Income is Below:
2	\$ 28,867	\$ 2,405
3	\$ 36,202	\$ 3,016
4	\$ 43,575	\$ 3,631
5	\$ 50,872	\$ 4,239
6	\$ 58,207	\$ 4,850
7	\$ 65,542	\$ 5,461
8	\$ 72,877	\$ 6,073



Please complete the following questions and return this form to:
Lifespan Respite of Multnomah County
421 SW Oak Ave, Suite 510
Portland, OR 97204
503-988-4790

Parent or Guardian Information

Date: _____

Name _____

Address _____
Street City Zip

E-mail Address _____ Phone _____

Household Monthly Income \$ _____ (this is the income of all household members)

Number of People in Household _____

Relationship to Child: ___ Parent ___ Grandparent Raising Grandchild
___ Foster Parent ___ Other: _____

Child's Information

Name of child for whom you are seeking respite assistance funding:

Child's Date of birth: _____

Describe disability and/or specific care requirements for this person:

Where Did You Here About this Fund? ___ Lifespan Respite Care Network
___ Oregon Post Adoption Resource Center ___ Providence Swindell's Center
___ The Arc of Multnomah-Clackamas ___ Other _____

***Please make sure you sign the Waiver of Liability and Release of Limited Information on reverse side of this paper.* Thank you.**

Services and Benefits Eligible for: (Mark all that apply.)

- | | |
|---|---|
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> DD Family Support Services |
| <input type="checkbox"/> Medicare | <input type="checkbox"/> Social Security Benefits (SSI or SSDI) |
| <input type="checkbox"/> Oregon Health Plan | <input type="checkbox"/> Family Caregiver Support Program |
| <input type="checkbox"/> Head Start | <input type="checkbox"/> Mental Health through Oregon Health Plan |

Optional Information:

Ethnicity of Parent or Guardian:

- | | |
|--|--------------------------------|
| <input type="checkbox"/> Black / African American | <input type="checkbox"/> Asian |
| <input type="checkbox"/> American Indian / Alaskan Native | <input type="checkbox"/> White |
| <input type="checkbox"/> Native Hawaiian or Other Pacific Islander | |

Is the Parent or Guardian of Hispanic or Latino Origin?

- Yes, Hispanic or Latino
 No, Not Hispanic or Latino

Waiver of Liability and Release of Limited Information

- (1) I, _____, have been fully informed of the scope of the Lifespan Respite Care Program, and I understand that this agency is only acting as a referral service between those individuals and families seeking respite care and those individuals willing to provide such care. I understand that respite care providers are not employees or agents of the Lifespan Respite Care Network in Multnomah County.
- (2) I have read the Rules for Respite Fund Distribution. All information I have provided on this form is current and accurate.

I have read and fully understand the above information.

Signature

Date