



Hike 2 Heal

RESPIRE CARE VOUCHER PROGRAM

Dear Applicant:

Thank you for your interest in the Hike 2 Heal Respite Care Voucher Program. Respite care can make a difference in helping you take care of your loved one. If you are a caregiver, you are well aware of how stressful and overwhelming it can become at times. Depending on your personal situation, you may find yourself with little time for yourself, missing out on important appointments, and even neglecting your social life.

Seasoned caregivers know the secret to successful caregiving, is finding a balance between providing care and also caring for yourself. While it may feel like there is no time for you and your needs, it doesn't have to be that way. Respite care is an excellent and often necessary tool for caregivers.

Our respite program, funded by the Idaho Commission on Aging, provides short-term relief from the physical, emotional and daily demands of caring to attend Hike 2 Heal activities free of charge. Services that can be paid for through the respite program include:

- Facility Overnight Stay - Short term stay in a facility to provide a break from caregiving to attend overnight wilderness experiences.
- In Home Care - Services may include personal care, companionship and homemaking duties to attend overnight wilderness experiences, day or afternoon hikes.

Please complete and return the entire application, making sure that all sections of the application are filled out before submitting the application. Please print clearly and include signatures where indicated. Approval of respite is dependent upon available funding.

Once approved, both the respite provider and the caregiver will be sent a voucher for respite services in a designated amount for scheduled Hike 2 Heal activities. The selected provider will submit the voucher to Hike 2 Heal. Hike 2 Heal will not be responsible for charges that exceed the voucher amount or those that fall outside of the authorized dates. If for some reason, you are unable to utilize the awarded respite funds, please notify the undersigned as soon as possible, so that the funds can be redistributed to another family in need.

If you have questions about filling out the application, please call me at 208.718.1175. You can also email me at johnandjunesmission@gmail.com.

Sincerely,

Kelly Means, MPH

Vice President



Please complete and return the following with this page:

Completed Application

Completed and signed Release of Liability

Completed and signed Certificate of Eligibility for Continuous Supervision (only if requested)

To my knowledge I am submitting a complete application for the Hike 2 Heal Respite Care Voucher Program. I understand that if approved, the voucher may only be utilized on the dates and times indicated to participate in Hike 2 Heal activities.

If approved, you will receive your voucher via email.

Signature of caregiver: _____

Printed name of caregiver: _____

Date: _____



Contact Information

Applicant Name (Caregiver):

Applicant Address:

City

State

Zip

Applicant Phone Number:

Gender:

Age Range:

Race:

Ethnicity:

Military Status:

Care Recipient Information:

Name

Address:

City

State

Zip

Phone Number:

Gender:

Age Range:

Race:

Ethnicity:

Military Status:

Caregiver's relationship to Cancer Survivor:

If marked other, please describe:



Voucher Information:

I am requesting respite services to attend Hike 2 Heal:

Overnight backpacking trip or snowshoeing trip

Day hike

Afternoon hike

To attend the Hike 2 Heal activity marked above, please describe the level of care that is needed for the care recipient. Please include if a friend or family member can temporarily assume caregiver duties while the primary caregiver is away or if a trained professional will be hired for more complex situations.

To attend the Hike 2 Heal activity(s) marked above, how many hours of respite care services are you requesting? Please round to the nearest half hour.

Hours (Example: 2.5 Hours)

OR

Continuous supervision for overnight activity. *If continuous supervision is required, you must complete the Certificate of Eligibility for Continuous Supervision Form*



Hike²Heal

RELEASE OF LIABILITY

I _____ hereby agree to accept a voucher through Hike 2 Heal respite care program to provide services for _____. I understand it is my responsibility not to exceed the amount of the voucher, and that I am responsible for any service charges in excess of the voucher amount.

Hike 2 Heal assumes no liability or responsibility for injury, accident, or negligence by your chosen provider that may occur to _____ while services are received under this program.

Signature of caregiver: _____

Printed name of caregiver: _____

Date: _____



Hike 2 Heal

Certificate of Eligibility for
Continuous Supervision

Only Required for Continuous Respite Care Voucher for Overnight Hike 2 Heal Activity

If continuous supervision is necessary to attend an overnight activity, please print this form and have a licensed healthcare practitioner complete.

_____ (Name of Caregiver) has requested financial aid for respite care for their loved one while they attend a Hike 2 Heal activity.

This statement is to certify that _____ (Care Recipient) is in my care and is in need of continuous supervision.

This statement must be signed by a licensed healthcare practitioner who is responsible for recipient's diagnosis and ongoing care such as a physician, nurse, social worker. This information will be verified.

Signature (Dr. Nurse or SW) (Stamps not accepted)

Street Address

Printed name

City, State, ZIP

Date

Recipient's primary diagnosis (must be completed): _____

State License # (Required)

Company/Organization name

Phone number