VASSAR-WARNER HOME

# APPLICATION FOR RESPITE

Full Name of Applicant _____ Date of Application _____

Address _____

City _____ State _____ Zip _____

Current Home Phone Number _____

Date of Birth _____ Social Security Number _____

Medicare # _____ Other Medical Ins. (type and #)
_____

Full Name of Immediate Caregiver _____

Address_____

City _____ State _____ Zip _____

Home Phone Number _____ Work Phone Number _____

Emergency Contact:

Name _____

Phone Number _____

Name and Address of Applicant's Personal Physician

Name_____

Address_____

City _____ State _____ Zip _____

Do you have any health conditions that require on-going medical treatment? Y / N
(Circle One)

If yes, please list here _____

Please list dates you are interested in Respite: From_____ to _____.

The Vassar-Warner Home Respite Program is available to anyone age 60 or over who meets the requirements of the NYS Dept. of Health for Adult Home level of care and is approved by the Home's Case Manager and Personal Care Supervisor. The cost is $150.00 per day.

A Medical Evaluation Form, (DOH-3122), is required to be completed by your physician in your presence within 30 days prior to your respite admission date.

Applicant's Signature _____ Date _____

Caregiver's Signature _____ Date _____