

**HSCSN REQUEST FOR RESPITE CARE SERVICES**

This form must be completed by the Caregiver or Care Manager. Respite care must be requested at least three (3) weeks in advance for shifts of more than 12 hours or requested 10 (ten) days in advance for shifts of 12 hours or less. You can complete the form over the phone with your HSCSN Care Manager or Home Care Agency. The form can be downloaded from the [HSCSN website](http://www.hschealthplan.org/RespiteBenefitForm). **If you have any questions, please contact your HSCSN Care Manager at 202-467-2737.**

IMPORTANT TO NOTE: This form is required for all respite care requests. Please complete all sections in the form in order to receive respite benefits.

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| **REQUEST SUBMISSION DATE:** | |
| **ENROLLEE** | **CAREGIVER** |
| **Enrollee Name:** | **Name of Caregiver:** |
| **Enrollee Medicaid ID: DOB:**  **Age:** | **Caregiver Phone#:** |
| **Responsible Adult while Caregiver is Unavailable (This information is required):** | |
| **Name of Responsible Adult:**  **Responsible Adult Phone#:** | |
| **Reason for Respite Care Request (please provide the reason why you are requesting respite services):**  **Vacation  Break from caregiving  Attend to needs of another family member**  **Other Reason(s):**    **Please note that Respite *C*are is not covered while a parent is working or in school.** | |
| **Requested Dates for Respite Care (Maximum of 7 consecutive days)**  **Start Date/Time: End Date/Time: Total Number of Days:**  **Other Comments (please give any additional information):** | |
| **For HSCSN Internal Use Only:**  **Respite Care Services Request:  Complete  Incomplete (not approved)  Not Eligible**  **Staffing Available:  Yes  No Name of Agency:**  **Alternative Date(s):** | |

***12/2022***

**For more information, visit** [**hscsnhealthplan.org**](https://hscsnhealthplan.org)**.**

**For reasonable accommodations, please call (202) 467-2737.**

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