MARC
METROPOLITAN ATLANTA
RESPITE COOPERATIVE

Dear Family,

Enclosed please find an application for respite services and general information about the Metropolitan Atlanta Respite Cooperative (MARC). The application is universal among all the MARC agencies, so each family will only need to complete one application to access all of the respite options.

Once the application has been received by Georgia Community Support & Solutions, Inc. the family will be contacted to schedule a home visit. The home visit provides us with the opportunity to meet your family, discuss the program's many options for respite care, and to answer any questions the family may have.

It is very important that the family include documentation of a developmental disability and proof of income. The application will not be processed and a home visit cannot be scheduled until documentation is provided.

We appreciate you patience, as we receive many applications daily.

If you have any questions or concerns regarding the application process, please do not hesitate to call (404) 634-4222 for more information.

Please don't hesitate to call if you have any questions.

Sincerely,

Respite Program Staff

METROPOLITAN ATLANTA RESPITE COOPERATIVE (MARC)

A group of agencies including Georgia Community Support & Solutions, Inc.(GCSS), ARC/Cobb, The Marcus Jewish Community Center of Atlanta (MJCC), Douglas County Retardation Association (DCRA), Metro Atlanta Respite and Developmental Services (MARDS), and Jewish Family and Career Services (JF&CS) have banded together to form a respite cooperative in order to expand and create respite care choices in the Metropolitan Atlanta area for families of individuals with disabilities. The philosophy of the cooperative is based on two principals: 1) Families have different needs for respite care and should have options in their community to meet these needs and 2) Families of individuals with developmental disabilities, regardless of their severity, should be provided with as many options as possible for accessing respite care. The program is based on a family choice model. Eligible families are able to choose respite care from the MARC pool of providers or any resource they know, formal or informal, in order to receive subsidized respite care. This can include agencies that are not participating in the cooperative or individuals that they know as long as enrollment criteria is met (for example: friends of the family, teachers, extended family, etc.) The only criteria placed on a family choosing a provider is that they cannot live in the same home and they must have a fingerprint/criminal records check, current first aid, and CPR certification. Formal providers would include agencies enrolled that are not a part of the MARC Cooperative. They must meet formal provider enrollment criteria.

Because the service is based on family preference:

- Families can choose any agency or provider they want.
- Families can choose to use any or all respite options: staff trained for the specific needs of the individual will be placed in that option.
- Respite care is arranged by issuing a voucher requested by the family or the agency that is providing respite care.

The currency agency options are:

MARC AGENCIES	TYPE OF RESPITE	OFFICE LOCATION
Jewish and Family Career Services	In Home and Host Family (in your home or in a provider's home)	4549 Chamblee Dunwoody Rd Atlanta, GA 30338-6210 770-677-9341
ARC Cobb/The ARC Respite House	Group Respite Home (call for address)	615 Roswell Street NE Suite 150 Marietta, GA 30060 770-427-8401
Marcus Jewish Community Center of Atlanta -The Orkin Home	Group Respite Home (call for address)	5342 Tilly Mill Rd. Dunwoody, GA 30338 770-395-2601/2601
Douglas County Retardation Association-Robert Chadwick Home	Group Respite Home (call for address)	PO Box 1318 Douglasville, GA 30138 770-942-1131
Metro Atlanta Respite and Developmental Services	Facility Based Weekend Respite	1335 Kimberly Rd. SW Atlanta, GA 30331 404-691-5570
*Georgia Community Support and Solutions (Lead Agency)	In Home and Host Family RRA Home/Richard's Home (call for address)	1945 Cliff Valley Way, Ste. 220 Atlanta, GA 30329 404-634-4222

Currently, there are three levels of subsidies (fees) based on the level of care required by the individual. MARC agencies, in conjunction with the family, assess the individual and assign a level of care required by the individual.

DESCRIPTIONS OF LEVELS OF CARE

LEVEL I:
Requires supervision only for safety issues/companionship--No behavior issues.
Includes: Medication assistance and apnea monitoring

LEVEL II:
Requires assistance in meeting the five (5) basic needs:
Includes: Feeding, Bathing, Dressing, Toileting, and Transferring--can be total care and/or minor behavior issues

LEVEL III:
Medically involved or excessive behavioral issues
Medical needs include: Tracheotomy suctioning, sterile procedures, any medically invasive care, but not treatment
Behavioral needs include: Behaviors that are considered aggressive, self-abusive, or destructive. Behaviors must be considered extensive and a barrier to typical respite care--examples are excessive biting, hair pulling, hitting, etc.

Subsidy (fee) schedule per hour*

LEVELS	HOME BASED	FACILITY BASED
I	$6.00	$7.00
II	$7.00	$8.00
III	Range from $8.00-$12.00	Range from $8.00-$12.00

*In a 24 hour period, there is a cap of 10 hours. Any amount used over 10 hours will still be considered 10 hours

Families are responsible for a percentage of the cost of respite. The family's subsidy rate is determined by the age of the individual needing care, the level of care that is needed, the family's annual income, and the number of people living in the home. The cost per hour (determined by the level of care above) is multiplied by the assigned subsidy rate (determined by the following chart). For example, a family of four has an income of $30,000 per year and level of care needed is level 2, the family is responsible for 30% of the cost of care per hour of 30% or $7.00 per hour for home based respite. This comes to $2.10 per hour and if respite is used for over 10 hours, the maximum a family would pay would be $21.00 for the entire day up to 24 actual hours.

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SUBSIDY RATES

	NO. OF FAMILY MEMBERS		
ANNUAL INCOME	**4 or more**	**3**	**2 or less**
$0.00 - $12,999	10.00%	12.00%	14.00%
$13,000 - $16,999	16.00%	18.00%	20.00%
$17,000 - $20,999	22.00%	24.00%	26.00%
$21,000 - $24,999	28.00%	30.00%	32.00%
$25,000 - $28,999	34.00%	36.00%	38.00%
$29,000 - $32,999	40.00%	42.00%	44.00%
$33,000 - $36,999	46.00%	48.00%	50.00%
$37,000 - $40,999	52.00%	54.00%	56.00%
$41,000 - $44,999	58.00%	60.00%	62.00%
$45,000 - $48,999	64.00%	66.00%	68.00%
$49,000 - $52,999	70.00%	72.00%	74.00%
$53,000 - $56,999	76.00%	78.00%	80.00%
$57,000 - $60,999	82.00%	84.00%	86.00%
$61,000 - $64,999	88.00%	90.00%	92.00%
$65,000 - $68,999	94.00%	96.00%	98.00%
$69,000 and Over	100.00%	100.00%	100.00%

All respite is arranged and tracked through a voucher system. This system allows Georgia Community Support and Solutions to monitor and collect data. Most importantly it is used to monitor who is using respite, how much respite is being used, and who is providing the respite. It is suggested that families limit their use of respite to twenty-five (25) hours per month with a **maximum** of three hundred (300) hours per fiscal year or as the budget may allow. Families do not have to use respite every month, however, if it is not used one month, it does not carry over to the next month. **Respite is on a first come, first serve basis depending on the budget.**

Voucher Process

- Respite is requested by the family either through GCSS or another MARC agency.
- If approved, a voucher for the respite sit is issued and sent to the family or the MARC agency. It is recommended that families schedule respite up to 30 days in advance. Families may access twenty-five (25) hours of respite per month, budget permitting.
- After the respite occurs, the voucher is signed by both the family and the provider verifying that all given information is correct.
- The voucher is then returned to Georgia Community Support and Solutions for redemption.
- The voucher is redeemed and logged against the family's budget.

OTHER INFORMATION

- As stated, levels of care will be assigned by the intake agency based upon the application and the intake information. The level of care is subject to change over time based upon different programs and the individual's needs.

- Although the Cooperative has developed policies and guidelines, each individual MARC agency reserves the right to maintain its own standards and policies for operation.

- Family and Provider applications are universal throughout the Cooperative. These applications may be shared with other agencies in the MARC Cooperative when consent for release has been given on the information release in the application or the family may call in the request verbally.

- Individuals over the age of 18 are considered to be a family of one. The subsidy rate is based upon the individual's income (SSI).

- Respite is scheduled on a first come, first serve basis. At least 24 hour notice is needed when scheduling respite. Respite may be approved as much as **30** days in advance.

- Respite is not to be used for day care or after school care. It is to provide an occasional break in care taking responsibilities.

- Emergency/Crisis respite care is available for participants who are enrolled and are eligible to receive respite services. For this service please contact your coordinator or call (404) 634-4222. If it is after regular working hours please call (404) 362-8077 and the answering service will activate the pager system.

- If a voucher is not returned within **30** days of the respite sit, the voucher will become void.

- **All vouchers must be signed by both the provider and the family**. If a voucher is sent without both signatures it will not be redeemed and will be returned to the provider or family in order to obtain the signature that is needed.

- We cannot receive faxed signed vouchers.

- All requests must come from the family and all vouchers must be mailed to the family.

- Families and providers have the right to submit complaints without fear of discrimination or retaliation and to have them investigated within a reasonable period of time. When a complaint is submitted, both parties involved in the complaint will be questioned regarding the issue. Further action will be taken as deemed necessary by a coordinator.

- All complaints may be submitted to any Respite Coordinator at Georgia Community Support and Solutions, 1945 Cliff Valley Way, Ste. 220, Atlanta, GA. 30329 or call (404) 634-4222.

- Any questions regarding licensing or questions/concerns regarding the funding may be directed to Georgia Community Support and Solutions Respite Program, (404) 634-4222 or the appropriate Regional Board:

Cobb/Douglas Regional Board	(770) 916-2100 or (770) 387-5411
Gwinnett/Rockdale/Newton/ DeKalb/Fulton Regional Board	(404) 463-6367

MARC
METROPOLITAN ATLANTA RESPITE COOPERATIVE

Today's Date:_____

PARTICIPANT INFORMATION

Name of Family Member_____

Social Security # _____ Birthdate _____

Address:_____
Street Address City
_____
State Zip Code County

Race_____Sex_____Hair Color_____ Height_____ Weight_____
Eye Color_____

Disability(ies) of the Participant: _____

Please give a brief description of the participant's condition and special needs:
_____
_____
_____

Legal Status of Participant:_____
(minor, competent adult, or incompetent adult)

Relation to Responsible Party:_____

RESPONSIBLE PARTY INFORMATION

Name of Parent/Legal Guardian_____

Address: _____
Street Address City
_____
State Zip Code County

Birth Date:_____ Marital Status:_____

Occupation:_____ Employer:_____

Home Phone:(___)_____ Work Phone:(___)_____ Fax: (____)_____
Car Phone:(___)_____ Pager:(___)_____
e-mail address: _____

OTHER RESPONSIBLE PARTY INFORMATION

Name_____

If other parent/guardian is restricted from visiting or picking the child up, a copy of a court order must be on file with that agency. If parent is non-custodial check here_____.

Address:_____
Street Address City

_____
State Zip Code County

Birth Date:_____ Marital Status:_____

Occupation:_____ Employer:_____

Home Phone:(___)_____ Work Phone:(___)_____ Fax:(___)_____
Car Phone:(____)_____ Pager:(____)_____
e-mail address: _____

Other Household Members Living with Participant:

Name	Age	Relationship to Participant	Staying during Respite

Person(s) to Contact in case of Emergencies:

Name	Phone Number	Relationship

Does the Participant have seizures? Yes_____ No_____ If yes, describe the seizure activity (include length, frequency):

_____

_____

_____

Does anything ever occur to warn you of a seizure? Please describe:_____

_____

What does the participant do after the seizure (for example--sleep):_____

_____

Does the participant use adaptive equipment (e.g. communication device, wheelchair, etc.)? Yes_____ No____ If yes please describe:_____

_____

Special Instructions for use and storage_____

_____

For how long and at what times is this equipment used?_____

_____

How long has the participant been using this equipment?_____

Who may we contact for repairs in the event of an emergency?_____

COMMUNICATION

How does the participant communicate? Please check all that apply.

Can talk without difficulty ○
Can talk with some difficulty ○
Makes sounds that are understandable to the parent ○
Uses Sign Language ○
Uses communication device ○
Signboard ○
Augmentative Communication ○

Other: (Please List) ○

_____

_____

Communicates with facial expressions ○
Does not communicate ○
Other: _____ ○
_____

How well does the participant understand what is said to him/her?

Has no problem with understanding ○
Requires simple one or two step instructions ○
Needs gestures to understand ○
Doesn't understand language ○
Uses facial expression to understand ○
Other means of understanding:
_____

_____

Sleep Habits

When is wake up time? _____
When is bed time? _____
When is nap time? _____

Sleeping Arrangements

Sleeps in a regular bed ○
Sleeps in a crib ○
Sleeps in a bed w/ rails ○
Sleeps in a hospital bed ○
Other (please describe) ○

_____
_____

PARTICIPANT PREFERENCES

Does the participant have a certain schedule of activities? If yes, please list times and activities.

_____

_____

_____

Does the participant have favorite activities? Please list.

_____

_____

Does the participant have favorite foods? Please list

_____

_____

Are there certain foods or activities to avoid? Please list

_____

_____

Does the participant have specific fears that staff or care providers should know about (e.g. dogs, loud noises)

_____

_____

_____

Are there any specific house rules or other: requirements to be enforced by the respite care provider/agency?

_____

_____

_____

PERSONAL CARE NEEDS

Mobility

Walks independently ○
Crawls ○
Uses walker or crutches ○
Walks w/ assistance ○
Uses wheelchair independently ○
Can sit w/out wheelchair ○
Uses wheelchair w/assistance ○
Requires transfers ○
Uses stroller/travel chair ○

Toileting

Independent ○
Bladder Control ○
Bowel Control ○
Needs assistance ○
Wears diapers/attends ○
Toilets on a schedule ○
(Schedule)_____

_____

Needs enema ○
Requires catheterization ○

Hygiene

Prefers Shower( ) Bath ○
Washes independently ○
Cannot wash self ○
Needs assistance ○
Please explain:_____

_____

Shampoos hair ○
Cannot Shampoo hair ○
Needs assistance ○
Brushes/combs hair ○
Cannot brush/comb hair ○
Needs assistance ○
Brushes teeth ○
Cannot brush teeth ○
Needs assistance ○
Please explain:_____

_____

Shaving ○
Needs assistance ○
Menstruation ○
Needs assistance ○

Feeding

Eats independently ○
Drinks independently ○
Bottle fed ○
Blended or special diet ○
G, J, or NG tube fed ○
Feeds self w/ spoon ○
Feeds self w/ fork ○
Must have food cut( )

Needs assistance with w/ utensils ○
Needs other assistance ○
Please explain:_____

_____

Feeding Difficulties

Tongue thrust
Gag reflex
Swallowing difficulties
Difficulty chewing
Other
Explain:_____
_____

Dressing

Dresses independently
Needs assistance
Please explain:_____
_____

Other Needs

Behavior

Hitting, biting, or fighting
Self abusive behavior
Running away
Hyper/Overactive behaviors
Other
Please explain:_____
_____

Medical Needs

Has a G-tube
Has a J-tube
Has a NG-tube
Is on a apnea monitor
Has a tracheotomy
  Requires shallow suction
  Requires deep suction
Oxygen dependent
Ventilator dependent
Requires injections
Other
Please explain:_____
_____

When do you think you will use respite care?

Weekdays_____ Vacations_____
Weeknights_____ Overnights_____
Weekends_____ Other_____
Please Specify_____
_____
_____

What type of respite do you think you will use most?

Group Respite Home_____ In another family's Home_____
Group Respite Facility_____ Only from a provider you know_____
In-Your-Home_____ Other_____
Please Specify:_____
_____
_____

If you choose facility based respite options, do you have transportation?_____

Are there other services that you are interested in and/or would like to see developed? Please check the services that you see a need for in relation to your family member with a disability. This information will be used in data collection and reporting family needs in the Metro Atlanta area.

Residential Living Alternatives
Group Home_____
Supported Living Options_____
Institution_____

Recreation Programs
With other people with a disability_____
Based on the individual_____

Advocacy Programs_____

Lifelong Service Coordination_____

Other:_____

Employment Services
Workshop_____
Mental Retardation Service Center_____
Supported Employment_____
Competitive Employment_____

Child/Adult Care_____
Child Day Care_____
After school Care_____
Summer Camp_____
Summer Day Programs_____
Adult Day Programs_____

Seniors with Disabilities Programs_____
Integrated Senior Services_____
Specialized Senior Programs_____
_____

Would you agree, with prior notice and approval, to discuss with other families the care your family member received from individual care providers and agency programs?

Yes_____ No_____
How were you referred to the MARC program?_____

Referral Name:_____

Address:_____

Phone : ( )_____

I hereby confirm that the information given at the time of application is true to the best of my knowledge.

Signature of Parent/Guardian:_____

Parent/Guardian Name (Print):_____

Relationship to the Participant:_____

Other Parent/Guardian Signature:_____

Parent/Guardian Name (Print):_____

Relationship to the Participant:_____

Participant Signature:_____

Participant Name (Print):_____

Date:_____

****Remember to attach documentation of disability and documentation of income.***

OPTIONAL: We would like to include a recent photograph of the respite participant in his/her permanent respite file. Please attach a photograph with the participant's name written on the back.

METROPOLITAN ATLANTA RESPITE COOPERATIVE

FINANCIAL INFORMATION STATEMENT

I, _____ acknowledge that my **annual**
(Your name)

net family income is _____. I understand that this information will be

used in determining subsidies for the MARC Respite Program.

Please attach a copy of **one** of the following for **all** primary caregivers if your child or family member is **under** the age of 18.

_____ Most recent tax return indicating net annual income

_____ Most recent pay stub for **each** primary caregiver

Please check here if the participant is over the age of 18 _____. If your child or family member is over the age of 18, please include a copy of social security income documentation.

Please check the number of family members currently living in your home:

_____ 2 or less _____ 3 _____ 4 or more

_____
Signature of Parent/Guardian/Primary Caretaker

_____
Printed Name of Parent/Guardian/Primary Caretaker

_____
Date

_____ _____
Printed Name of Family Member Date of Birth

METROPOLITAN ATLANTA RESPITE COOPERATIVE (MARC)
INFORMATION RELEASE

Participant Name: _____

Address: _____

_____

Date of Birth: _____

I hereby authorize Georgia Community Support & Solutions, Inc to release information on my family's respite care application to the following respite program(s) in order to subsidize or provide care to my family member.

Cobb/ARC	☐ yes ☐ no
Atlanta Jewish Community Center	☐ yes ☐ no
Metropolitan Atlanta Respite and Developmental Services	☐ yes ☐ no
Jewish Family & Career Services	☐ yes ☐ no
Douglas County Retardation Association	☐ yes ☐ no
Other:_____	☐ yes ☐ no

_____

Please note: Only consented agencies will receive this application.

I further understand that I can withdraw this consent at any time except to the extent that action has been taken.

I authorize the use of information contained on my application to be used as part of group statistics to determine future and ongoing community needs. Under this authorization, I understand that my family name will not be released as part of these statistics.

☐ Yes ☐ No

I understand that I can withdraw this consent at any time except to the extent that action has been taken.

Signature of Participant/Parent/Guardian:_____

Participant/Parent./Guardian Name (please print):_____

Date:_____

GEORGIA COMMUNITY SUPPORT AND SOLUTIONS
RESPITE CARE VOUCHER PROGRAM

WAIVER AND RELEASE

As a voluntary participant in the Georgia Community Support and Solutions Respite Care Voucher Program, ("Program"), I understand and acknowledge that the Georgia Community Support and Solutions ("GCSS") is not involved and has not been involved in any way with the selection of the respite care provider or respite care agency which will provide respite care to my family member. I also understand and acknowledge that GCSS has not evaluated, tested, or screened the care provider or respite care agency, and that GCSS makes no representations about the care provider or his or her capability or suitability.

I accept that it is my responsibility as a family member in using this program to select a respite care provider or agency to provide respite to my family member with a disability. I understand that it is my responsibility also to determine the suitability of the respite care provider or respite care agency to provide adequate care to my family member, to acquaint them with the particular needs of my family member receiving respite care and provide evaluation and supervision of all respite care received by my family member. Therefore, on my own behalf and on behalf of my family, I freely and voluntarily accept all risk of personal injury and property damage arising from my family's participation in the Program.

In consideration of my being allowed to participate in the Program and to receive a respite care voucher, I hereby release and discharge GCSS, its officers, directors, employees, agents, and successors, from any and all claims losses and demands whatsoever that I or my family may hereafter have for injuries or property arising or resulting from my and my family's participation in the Program, all of which claims I hereby waive. I waive my and my family's rights with the full knowledge that GCSS assumes no liability or responsibility for personal injury or property damage arising from my family's participation in the Program and that GCSS will not compensate me or my family in any way for any loss or injury I or my family may sustain. I understand and agree that this waiver and release will be fully binding on me, all members of my family, our estates, and our heirs, and that neither I nor any member of my family nor anyone claiming through me or any member of my family will have any legal right assert a claim against GCSS or its officers, directors, employees, and agents or any of their successors, relating to me and my family's participation in the Program.

This_____day of _____, 200___

_____ _____

WITNESS FAMILY/PARTICIPANT SIGNATURE

_____

PRINTED FAMILY/PARTICIPANT NAME

METROPOLITAN ATLANTA RESPITE COOPERATIVE

EMERGENCY MEDICAL TREATMENT INFORMATION AND RELEASE

Participants Name_____SS #_____

Address_____

Date of Birth_____Age_____ Birthplace_____

Disability(ies)_____

Physician's Name_____Phone_____

Address_____

Preferred Hospital_____

Name of Insurance Company_____Policy Number_____

Medicaid #_____ Medicare #_____

Person(s) to Contact in Case of Emergencies:

Name	Phone	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies:

_____

_____

Other Health Information:_____

_____

I agree to allow my Respite Care Provider, at the expense of the undersigned, to institute emergency medical treatment through the designated physician or other recognized medical resource. When possible, my Respite Care Provider shall contact the undersigned prior to such action. Also, I agree to allow my Respite Care Provider to obtain emergency medical transportation, at the expense of the undersigned.

_____ _____

Signature of Participant/Parent/Guardian Date

PARTICIPANT AND FAMILY RIGHTS AND RESPONSIBILITIES
METROPOLITAN ATLANTA RESPITE COOPERATIVE

The Metropolitan Atlanta Respite Cooperative is a family centered program that allows families to assist in the identifying their need for services and involves families in the service design and implementation. The respite program does not discriminate because of race, color, sex, creed, religion, age, or national origin of the participant, family and/or provider.

As a family enrolled in the Metropolitan Atlanta Respite Cooperative, you and your family have the right to:

1. Participate in the preparation of the respite and be informed about the services;

2. Be promptly and fully informed of any changes in the respite program;

3. Accept and refuse respite services;

4. Be treated in such a manner as to assure their safety, health, and comfort and shall be treated as an individual with his or her strengths, unique characteristics and needs acknowledged and respected;

5. Has the right to the maximum amount of privacy consistent with age, level of functioning, and effective delivery of services; the participant has a right to respect and respect of their property;

6. Have the right to confidentiality of all records and activities, within legal limits;

7. Have the right to submit complaints without fear of discrimination or retaliation and to have them investigated within a reasonable period of time. All complaints may be submitted to any Respite Coordinator at Georgia Community Support and Solutions or (404) 634-4222. Any questions regarding licensing or questions or concerns regarding the funding streams may be directed to address previously stated or to the appropriate Regional Boards:

   Cobb/Douglas (770) 916-2100 or (770)-387-5411
   DeKalb/ Gwinnett/Rockdale/Newton/Fulton (404) 463-6367

8. Not be subjected to humiliation or mental or physical abuse in any fashion and must be accorded dignity at all times; shall not be exploited in any way;

9. Have the right to prompt and adequate medical treatment when needed;

10. Obtain a copy of the provider's most recent report of licensure inspection from the provider upon written request (reasonable photocopying fees may be charged).

As a family enrolled in the Metropolitan Atlanta Respite Cooperative, you and your family have the responsibility to:

1. Provide complete and accurate information to the best of your ability about your family member and the disability, the home situation, and any events which may effect the needed services;

2. Assure that financial obligations are fulfilled as promptly as possible; and

3. Be considerate of your respite provider.

I have received and reviewed the participant and family rights and responsibilities.

_____ _____

Family/Participant/Guardian Signature Date

03/13/03

FAMILY COPY

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METROPOLITAN ATLANTA RESPITE COOPERATIVE

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FAMILY COPY