

Respite Contract Services Agreement & Responsibilities



Terms of Agreement

The agreement for providing emergency respite care will begin on 11/16/2025 (start date) and will be finished on 11/21/2025 (end date) for a total of 120 (total hours worked) hours.

The respite worker will be paid at an hourly rate of \$ _____ (hourly rate) per hour, OR a daily rate 370 (daily rate) totaling up to \$ 1,850 (total amount) upon the completion of services. **The program maximum is \$500, any amount over \$500 is the family's responsibility to pay. Please fill either hourly rate or daily rate as it applies.**

The Emergency Reimbursement paperwork, including the **reimbursement request, timesheet, participation survey, and a form of identification for all individuals involved**, will be submitted to the Statewide Coordinator within two weeks of the final date of service, prior to receiving payment.

- If paperwork is not completed within the two-week deadline and the family caregiver has not requested an extension with the Illinois Respite Coalition, all payment responsibility for the emergency respite funding falls onto the family caregiver.
- Any hours or funds in excess of what was approved by the IRC can fall onto the family to reimburse.

I acknowledge that I have been provided by the Illinois Respite Coalition with information on how to conduct a background check for the respite worker through the Illinois Department of Public Health Healthcare Worker Registry, the Child Abuse and Neglect Tracking System (CANTS), and the Illinois and National Sex Offender Registry.

- The family caregiver is responsible for the selection of the Respite Worker and for verifying that they are trained and have not been convicted of abuse or neglect.

I, Robert Dunlap (family caregiver), agree to the terms of this document and enter into agreement to receive emergency respite care from Valley Hi Nursing + Rehabilitation (respite provider), with funding provided by the Illinois Respite Coalition's Emergency Respite Care Program. I acknowledge that I am participating in this program voluntarily, and I hereby release, indemnify and hold forever harmless the Illinois Respite Coalition and the Illinois Department of Human Services for any liability or responsibility whatsoever in connection with said services.

Respite Provider

Date

11/17/25

Family Caregiver

Date

11-16-25

EMERGENCY RESPITE CARE APPLICATION

SECTION A: Agency/Provider Information

(This section only to be filled out by an agency and if payment will be going to an agency)

Agency submitting request: Valley Hi Nursing + Rehabilitation

Date of request: 11/17/2025

Street Address: 2406 Hartland Rd

City, Zip Code, County/Region: Woodstock, IL 60098
815-338-0312

Phone #: 815-334-2811 Email: ajrank@mchenrycountyil.gov

Fax Number: 815-338-0458 Website: www.vhnursing.com

Reason for emergency respite: Caregiver (in-home) Robert "Bob" Dunlap
works full time; Diane is causing late arrivals, early departures,
and distractions (much more so than before). She only has ~20 hours/wk
Type of request: Initial ☒ Revision ☐ Cancellation ☐ of day care.

Reason for revision or cancellation: _____

Comments: Carol Diane Gray is having a respite stay Nov 16-21.
Her DON is 57. She requires 24/7 accompaniment and assistance
for all tasks. Bob is asking others to pay for this as she nor he
have the funds. She is on Medicaid.

Agency Representative Name / Title (Print): _____

Agency Representative Signature [Signature] Date 11/17/25

SECTION B: Primary Care Information

Caregiver name: Robert E. Dunlap Date of birth: 12/1/1963

Gender Identity: Male

Employed: Full time ☒ Part time ☐ Not employed ☐

Street address: 26131 W. Elm Tree Rd

City, Zip Code: Antioch 60002 County: Lake County

Phone #: 847-254-1136 Email: dunlap-robert@sbcglobal.net

Race (Mandatory per state guidelines):

☐ Asian Only ☒ Caucasian Only ☐ American Indian or Alaska Native Only

☐ Black or African American ☐ More than one race ☐ Only one race

☐ Hispanic or Latino ☐ Not Hispanic or Latino

Relationship to care recipient: Significant other

Do you live with the care recipient? ☒ Yes ☐ No

Hours spent caregiving each week :

☐ Under 5 ☐ 5-10 ☐ 11-20 ☐ 20+ ☒ Full time 24/7 (minus ~19 hrs - 20 hrs of day care per week)

Household income (Mandatory per state guidelines):

☐ Less than \$14,999 ☐ \$15,000-\$24,999 ☐ \$25,000-\$50,000 ☒ Above

☐ Unemployed

Secondary/Alternate Caregiver name: Ellen Harris

Secondary/Alternate Caregiver phone #: 979-235-9961

Is this your first request for Emergency Respite? ☒ Yes ☐ No

If no, what is the date of previous award: _____ Amount of previous award: _____

SECTION C: Care Recipient Information (person needing direct care)

Care Recipient Name: Carol Diane Gray

Date of Birth: 8/2/1962 Gender Identity: Female

Street Address: 26131 West Elm Tree Rd

City, Zip Code, County: Antioch, 60002, Lake County

____ Townhouse ____ Apartment ☒ Single family home

Phone #: 847-800-8450 Email: n/a

Below Poverty: ☒ Yes ____ No

State Funded Waiver Program: ____ Yes ☒ No

Type of Waiver: _____ Which State Agency: _____

Race (Mandatory per Illinois state guidelines):

____ Asian Only ☒ Caucasian Only ____ American Indian or Alaska Native Only

____ Black or African American ____ More than one race ____ Only one race

____ Hispanic or Latino ____ Not Hispanic or Latino

Living arrangements:

____ With caregiver in home of care recipient ☒ With caregiver in caregiver's home

____ With other family member or friend ____ Lives alone

Primary diagnosis/disease/disability: Early onset Alzheimer's/dementia

Please note any allergies or intolerances: n/a (other than dust allergies)

Comments: She is mostly mute but understands and can

answer yes/no questions. She has very minimal assets,
some SSI assistance of ~ \$600/mo that is consumed on
food, supplements, etc. (her only income), and is on
Medicaid. She has gained weight and has sore knees,
she is unstable but can walk slowly with assistance
for short distances. Needs assistance to toilet, brush teeth, change clothes,

SECTION D: Additional Resources

(Please list additional resources/services the care recipient is receiving.)

~20 hrs/wk in-home day care through Can't Keepers,
paid through Medicaid/MCO is Meridian: M, W, F 9-1:15;
Th 9:15-5 (no care Tuesday Saturday or Sunday)

SECTION E: Emergency Respite Care Services (use additional pages if needed)

Why does the caregiver need emergency respite services? He must focus on his

work without interruption to make up for weeks now of

Diane not tolerating being at his work with him well (anymore).

They both need a break. We are seeking more day care (DON
re-evaluation requested), so that he does not lose his job.
How will the services benefit the caregiver? What will they be doing during their respite time?

He will be at work without interruption and catch up on
some tasks at home. Hopefully he goes out some with
friends, too, one night. He works full time.

Does the caregiver typically receive respite services from another program? _____ If so, which
program? (only Medicaid/Meridian as described above)

Is there any other available source of funding for respite besides Emergency Respite? _____

Please list any other funding sources that were explored for this request: Bob is

reaching out to others, such as her sister, for help

(financial, energy, time) and she flew up from Texas to help
her get into respite stay).

In your opinion, would the care recipient be "at risk" if the caregiver did not receive these

services? Y If so, how (i.e. left alone, risk of institutionalization, etc)? Diane is

totally dependent on Bob. If he lost his job, then
she would need immediate institutionalization.

Without emergency respite care, what alternate choices would the caregiver have for services?

☐ None ☐ Hospital ☒ Long term care facility (on waitlist)

☐ Use alternate caregiver (when possible) Other: _____

Location where respite care will be provided:

☐ In home of caregiver ☐ In home of care recipient ☐ Child day care

☒ Adult day center ☒ Adult nursing home Other: _____

PLEASE FILL OUT THE FOLLOWING DETAILS OF THE RESPITE CARE YOU ARE REQUESTING: (this may be changed or answered upon arrival)

Amount of Respite Care Needed (hours/days): 24/7/5

Time(s) and Date(s) of Services: 11/16-11/21 (^{11/16} ~noon to noon ^{11/21})

Respite Care Rates Requested: (hours of daily rate times the numbers of hours/days needed):

Hourly rate: _____ Daily rate: \$370 (minimum)

Information of person to provide care:

Name Valley Hi Nursing + Rehabilitation Phone # 815-338-0312

Email address: ajrank@mchenrycountygil.gov

Information of agency to provide care:

Agency name: Valley Hi Nursing + Rehabilitation

Phone # 815-338-0312 Tax ID: 360006623

Agency contact person (name/title): Amanda Rank / Christine Ribar

SECTION F: Criteria for Respite Funds (Check all that apply):

☒ Care recipient is living in a non-institutional setting

☒ Care recipient's health and safety are "at risk" (job loss would be devastating)

☒ Care recipient requires trained respite worker

☒ Care recipient cannot be cared for by an untrained neighbor, friend, or family member

(Ellen Harris felt she could no longer care for her alone after last caregiver break she gave Bob + Diane in Spring 2025)

☒ Care recipient cannot be left alone at any time

☒ Care recipient can receive respite care safely

☐ Child with special needs

☒ Adult with special needs (early onset Alzheimer's/dementia)

☐ Other, explain: _____

☐ Caregiver illness (physical, mental, emotional)

☐ Caregiver hospitalization/doctor appointment

☐ Illness of a loved one

☐ Funeral/wake

☐ Drug/alcohol abuse counseling/support

☒ Preparation for care recipient to transition between living arrangements (we are preparing Diane for transition, too)

★ ☒ Risk of loss of employment (she has become restless and will not go/stay at Bob's office with him for long)

☐ Work related situation/function

☐ Other family emergency or need

By signing below, I certify that I have read and understand the Emergency Respite Program Requirements & Instructions. I hereby affirm that all information provided within this application is accurate and precise. I give my consent for the IRC Coordinator to verify whether or not my household is receiving supports from any other agency or provider, paid or unpaid. I also provide consent to the IRC Coordinator to share my demographic/household information with the Illinois Department of Human Services (IDHS) for reporting purposes required by the IRC and IDHS. I acknowledge that any attempt to provide inaccurate or untruthful documentation may disqualify me from receiving funding from the IRC now or in the future.

Caregiver Signature Robert E. Dwyer Date 11-16-25

SUBMIT ALL NECESSARY DOCUMENTATION TO:

Illinois Respite Coalition/Attn: Tammy Foster
Email: tfoster@illinoisrespitecoalition.org
Fax: 312.463.4730
Phone: 866-455-7377 ext 105 - For Spanish: ext 103