# **New Jersey Department of Human Services**

## **Division of Aging Services**

**Provider Application Section III: Services**

**IN-HOME RESPITE CARE SERVICES**

***Read carefully the description of services and requirements.***

***If you do not qualify, please do not apply.***

**Definition:**

Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.

**Service Limitations/Exclusions Include:**

An enrollee receiving respite is not eligible for the following services while receiving respite care:

* Homemaker
* Environmental Accessibility Modifications
* Chore
* Attendant Care
* Home Delivered Meals
* Home-Based Supportive Care

# **Billing Codes:**

***JACC*** ***Service/Unit***

J1210 8 hour day

J1215 8 hour night

J1220 Day >8<12 hours

J1225 Night >8<12 hours

J1230 >12<24 hours

**IN-HOME RESPITE CARE PROVIDER QUALIFICATIONS**

The applicant must submit evidence that it meets **all** items within the following section(s).

Please check off **ONE** section in which you are applying

Section 1[ ]  Section 2[ ]

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| **Section 1** |

|  |  |
| --- | --- |
| 1.a |[ ]  Medicare Certified Home Health Agency licensed by NJ DOH, per N.J.A.C. 8:42\* |
| 1.b |[ ]  Evidence of Liability Insurance and Worker’s Compensation Coverage |

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| **Section 2** |

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| 2.a |[ ]  Homemaker Agency with Health Care Service Firm License from theNJ DL&PS, per N.J.A.C.13:45B\* |
| 2.b |[ ]  Accredited by National Home Caring Council, Commission on Accreditation for Home Care Inc., The Joint Commission, and/or the Community Health Accreditation Program\* |
| 2.c |[ ]  Evidence of Liability Insurance and Worker’s Compensation Coverage |

\*Submit photocopy as evidence.

**Check all evidence submitted with application.**

Incomplete applications and / or applications submitted without required

documentation and evidence will be returned.

**CERTIFICATION**

For the purpose of establishing eligibility to receive direct payment for services to recipients under the New Jersey JACC Program, I certify that the information furnished on this application is true, accurate, and complete. I am aware that if any of the statements made by me in this application are willfully false, I am subject to punishment, including but not limited to disqualification from the New Jersey JACC Program. I agree to notify the new Jersey Department of Human Services, Division of Aging Services of any changes in the information contained in this application.

Name and Title of Applicant Representative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_