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:

<table>
<thead>
<tr>
<th>JACC</th>
<th>Service/Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>J1210</td>
<td>8 hour day</td>
</tr>
<tr>
<td>J1215</td>
<td>8 hour night</td>
</tr>
<tr>
<td>J1220</td>
<td>Day &gt;8&lt;12 hours</td>
</tr>
<tr>
<td>J1225</td>
<td>Night &gt;8&lt;12 hours</td>
</tr>
<tr>
<td>J1230</td>
<td>&gt;12&lt;24 hours</td>
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</tbody>
</table>
IN-HOME RESPISTE 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

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

Section 2

2.a ☐ Homemaker Agency with Health Care Service Firm License from the NJ 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____________