EPILEPSY FOUNDATION WESTERN/CENTRAL PENNSYLVANIA

APPLICATION FOR RESPITE CARE SERVICES

Primary Contact Information – Who Will Coordinate Care For the Family?

First Name:		Last Name:	
Relationship to Applicant:			
Address:			
City, State Zip:			
Best Phone Number to Contact You:			
Email Address:			

Person in Need of Care

First Name:		Last Name:	
Age:		Date of Birth:	
Address (if different from above):			
City, State Zip:			
Phone :			
Email :			
Primary Insurance Company Name:			
Primary Insurance Company Policy Number:			
Secondary Insurance Company Name:			
Secondary Insurance Company Policy Number:			

Insurance Information will only be used in case of an emergency and/or in order to secure additional and/or future respite care/nursing services for your family and will not be used without your prior knowledge.

If applicant is a minor:

Full Name of Father:		Phone:		E-mail:	
Full Name of Mother:		Phone:		E-mail:	
Best Phone Number to Reach Parent:					
Best Email to Reach Parent:					

Liability Release:

I declare that the information provided on this application is true and complete to the best of my knowledge and is being provided to the Epilepsy Foundation Western/Central Pennsylvania (EFWCP) for the purpose of receiving financial assistance consideration to enable respite care services. I understand that a maximum of 25 hours within a 1-year period will be authorized under this program. I understand that the individuals who are providing in-home respite care services are not employees of the EFWCP and therefore, the EFWCP cannot be held liable for their actions or inactions. The undersigned hereby releases, remise, and forever discharges the EFWCP and its agents, directors, officers, volunteers, and employees from any and all liabilities, causes of action, demands, rights, claims, costs, expenses, attorney fees, from all losses, damages, claims, costs, expenses and liabilities, including attorney fees, for injury to person or property arising in connection with my participation in EFWCP Inc. voluntary respite care program. The undersigned, further agrees to indemnify the EFWCP and its agents, directors, officers, volunteers, and employees against all claims, suites, demands, and expenses arising out of injury or damage to any property or person during the time of service. The undersigned further declares that they are assuming the risk of participation in the EFWCP respite program. There may be other risks not known to us or not reasonably foreseeable at this time. I assume all the foregoing risks, accept personal responsibility for any damages incurred by my family member.

Signature: *(Program participant)*		**Date:**	
Signature: *(Legal guardian if a minor)*		**Date:**	
Signature: *(Primary contact)*		**Date:**	

Please submit all forms to the EFWCP:

By fax:
(412) 322-7885

By e-mail:
jhinds@efwp.org

By mail:
Epilepsy Foundation Western/Central PA
Attn: Jordan Hinds
1501 Reedsdale Street, Suite 3002
Pittsburgh, PA 15233