# **New Jersey Department of Human Services**

## **Division of Aging Services**

**Provider Application Section III: Services**

**FACILITY-BASED 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.

Other service Definition (Specify): FFP (Federal Financial Participation) will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

**Service Limitations/Exclusions Include:**

* FFP will not be claimed for the cost of room and board except when provided, as part of respite care furnished in a facility approved by the State that is not a private residence.
* Room and board charges are included in Institutional Respite rate.
* Respite in a Medicaid certified Nursing Facility is limited to 30 days per recipient per waiver year.

# **Billing Codes:**

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

J1285 Nursing Facility Respite

 Assisted Living residence Respite

 Adult Family Care Respite

 Comprehensive Personal Care Home Respite

**FACILITY-BASED RESPITE CARE SERVICES 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 3[ ]

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| **Section 1** |

|  |  |
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| 1.a |[ ]  Assisted Living Residences or Assisted Living Programs or Comprehensive Personal Care Homes, licensed by NJ DOH, per N.J.A.C. 8:36\* |
| 1.b |[ ]  Medicaid Provider # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Section 2** |

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| 2.a |[ ]  Adult Family Care Providers licensed by NJ DOH, per N.J.A.C. 8:43B\* |
| 2.b |[ ]  Medicaid Provider # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Section 3** |

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| 3.a |[ ]  Nursing Facilities licensed by NJ DOH, per N.J.A.C. 8:39\* |
| 3.b |[ ]  Medicaid Provider # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

\*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\_\_\_\_\_\_\_\_\_\_\_\_