**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☐

### 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____________