



2026-2027 Lifespan Caregiver Respite Voucher

Respite is a short break for caregivers from their caregiving duties. This program provides support for people who do not qualify for other respite/caregiving services of any kind.

This program provides a respite voucher to you, as the caregiver, so you can take a break.

This program is self-directed. That means you and your care recipient (when possible), choose the kind of respite you want. You may choose friends/family, a day program or get care from a home health agency.

Eligibility - Care Recipient Must Meet All of the Following Criteria:

- Have a diagnosis of dementia, Parkinson's, a traumatic brain injury, neurodegenerative disease or show moderate cognitive decline (waiting on diagnosis) and;
- Need assistance with two or more activities of daily living, such as toileting, eating, showering, dressing/grooming, mobility, transferring, and;
- Be **60 years of age or older UNLESS** they have
 - early onset dementia diagnosis, Parkinson's, traumatic brain injury, or neurodegenerative disease (e.g. Huntington's, Multiple Sclerosis) **Must be over 18** years of age
- **Cannot** be receiving other paid respite/caregiving services from any government or insurance funding, and;
- Provide picture ID and live in New Mexico and live at home or at caregiver's home

Caregiver Must Meet All of the Following Criteria:

- Be the primary caregiver and provide more than 16 hours of care per week.
- Provide a medical needs verification form for their care recipient (such as notes from a doctor's office visit, care notes) **or** proof of diagnosis.
- Take Zarit Burden survey at time of application and 90 days after getting the voucher.
- Turn in a completed/signed time sheet to be provided by New Mexico Caregivers Coalition / Office of Alzheimer's Disease and Dementia Care.
- Complete and turn in caregiver survey to be provided by New Mexico Caregivers Coalition / Office of Alzheimer's Disease and Dementia Care.
- Provide picture ID and live in New Mexico.

Voucher must be used within 90 days.

- Only **one** voucher will be issued per household

Questions? Write Respite@nmdcc.org or call Andrea at 505-867-6046

Effective 10/2026

2026-2027 Caregiver Lifespan Respite Application

Care Recipient Information

Name _____

Address _____

City _____ County _____ Zip _____

Date of Birth _____ SSN _____

Home Phone _____ Race/Ethnicity _____ Gender _____

Primary Caregiver Information (Participant)

Name _____ ID Number and type: _____

Address _____

City _____ County _____ Zip _____

Home Phone _____ Cell Phone _____ Email address _____

Race/Ethnicity _____ Gender _____

Relationship to care recipient: Married to ☐ Domestic Partner: Live together ☐ Live separately ☐

Parent ☐ Child ☐ Sibling ☐ Other, write in: _____

Work: Full Time Job ☐ Part- Time Job ☐ On disability ☐ Retired ☐ No job ☐

Did you decrease your work hours to provide care? Y ☐ N ☐ Quit your job to provide care? Y ☐ N ☐

Are you raising children under 18? Y ☐ No ☐

Reason for respite (check all that apply): To prevent burnout ☐ I am getting burned out ☐

I am burned out ☐ Physical and/or mental health is being affected ☐ I can't normally afford respite ☐

I need time to myself to (check all that apply): Rest/sleep ☐ Exercise ☐

Take care of errands/ chores/ appointments ☐ Do something fun/meaningful/special that I enjoy ☐

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Zarit Caregiver Burden Pre-Assessment

Caregiver Name: _____

Date: _____

The following is a list of statements that reflect how people sometimes feel when taking care of another person. You must complete this Pre-Assessment as a condition of award.

If you choose to complete electronically, go to: <https://forms.gle/Me7idQEPsYVgHfFo6>

After reading each statement, indicate how often you experience the feelings listed by **circling or putting an X under the number that best corresponds to the frequency of these feelings.**

	Never	Rarely	Sometimes	Frequently	Nearly Always
1) Do you feel that because of your relative that you don't have enough time for yourself?	0	1	2	3	4
2) Do you feel stressed between caring for your relative and trying to meet other responsibilities (work, home)?	0	1	2	3	4
3) Do you feel strained when you are around your relative?	0	1	2	3	4
4) Do you feel uncertain about what to do about your relative?	0	1	2	3	4

Note: The Pre-Assessment above may be completed online at: <https://forms.gle/Me7idQEPsYVgHfFo6>

A Post-Assessment will be required 90 days after receiving your voucher. You must complete that Post-Assessment to remain eligible for future programming.

Mail your application, Pre-Assessment (unless you complete it online), Care Notes from recent visit (or Respite Care Voucher Medical Needs Verification) to:

***New Mexico Caregivers Coalition, P.O. Box 297, Bernalillo, NM 87004 or email to respite@nmdcc.org
Questions? Write Respite@nmdcc.org or call Andrea at 505-867-6046***

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Respite Care Voucher Medical Needs Verification
(to be used if Care Notes from Doctor visit not available)

Dear Provider:

Your client/patient's primary caregiver is applying for a respite voucher. This gap program provides a voucher for caregivers who do not receive any type of funding to pay for respite services.

We require this form to be completed by the indicated professionals to verify a dementia, Parkinson's, traumatic brain injury **OR** severe cognitive impairment that has not yet been or is in process of getting a diagnosis. Care recipient must need assistance with two or more activities of daily living (ADLs).

Patient/Client Name: _____

Caregiver Name: _____

Address: _____

City _____ **Zip Code** _____ **Phone** _____ **Email** _____

Please mark dx: Alzheimer's ☐ Vascular ☐ Lewy Body ☐ Mixed ☐ Parkinson's ☐

Traumatic Brain Injury ☐ Other _____

Frontal Temporal Degeneration: Behavioral ☐ Primary Progressive Aphasia ☐ Movement Disorder ☐

Please mark all assistance with ADLs that apply:

Toileting ☐ Bathing ☐ Dressing/ Grooming ☐ Walking ☐ Eating ☐ Transferring/Mobility ☐

THIS SECTION MUST BE COMPLETED BY ONLY ONE OF THE FOLLOWING:

PHYSICIAN, NURSE PRACTITIONER, SOCIAL WORKER, CARE NAVIGATOR or CASE MANAGER

Provider Name and Profession: _____

Agency: _____

Provider address and phone number: _____

Signature and date: _____

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Timesheets
(required after receiving voucher to prove funds were used for respite care)

Fill out and return to Respite@nmdcc.org. Timesheets are required to remain eligible for future programming.

Time Sheet 1

Date _____ Number of respite hours provided _____ Amount paid _____

Check the type of respite you had:

In home: Family/ Friend ☐ Professional ☐ Out of Home: Family/Friend House ☐ Day Center ☐

Respite Provider: Print and sign name _____

Agency Name (if used) _____ Day Center Name (if used) _____

Caregiver Print and Sign _____

Time sheet 2

Date _____ Number of respite hours provided _____ Amount paid _____

Check the type of respite you had:

In home: Family/ Friend ☐ Professional ☐ Out of Home: Family/Friend House ☐ Day Center ☐

Respite Provider: Print and sign name _____

Agency Name (if used) _____ Day Center Name (if used) _____

Caregiver Print and Sign _____

Time sheet 3

Date _____ Number of respite hours provided _____ Amount paid _____

Check the type of respite you had:

In home: Family/ Friend ☐ Professional ☐ Out of Home: Family/Friend House ☐ Day Center ☐

Respite Provider: Print and sign name _____

Agency Name (if used) _____ Day Center Name (if used) _____

Caregiver Print and Sign _____