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☐

Section 1

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 # _____

Section 2

2.a ☐ Adult Family Care Providers licensed by NJ DOH, per N.J.A.C. 8:43B*

2.b ☐ Medicaid Provider # _____

Section 3

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_____