Access Services
strengthening communities

Request for Respite Application

Contact Information

Child's Name _____ Date of Birth: _____ SSN: _____

Parents/Guardians: _____

Siblings: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Email(s): _____

Child Information

Sex: _____ Race: _____ Ethnicity: _____

Height: _____ Weight: _____ Hair Color: _____ Eye Color: _____

Religious Preference: _____

Allergies: _____

Dietary Restrictions? _____

Emergency Contact (Not in Home)

Name: _____ Relationship to Child: _____

Address: _____ Phone: _____

Secondary Emergency Contact

Name: _____ Relationship to Child: _____

Address: _____ Phone: _____

Referral Source Contact Information

Name: _____ Agency: _____

Address: _____

Title/Position: _____ Program: _____

On-Call Number (if applicable): _____ Phone: _____

Fax: _____ Email: _____

Additional Supports

	Name of Agency and Contact Name	Email	Phone	On-Call Number
Case Manager				
Supports Coordinator				
Family-Based Services (IBHS, ACT, or CCT)				
Psychiatrist/Specialist				
Outpatient Medication Management				
Other (Juvenile Probation/Probation, Children and Youth, etc.)				

Family/Household Information

Names of Family Members (list all):	Relationship to Child(ren)	Phone Numbers

Number of Household Pets

Dogs: ____ Cats: ____ Other: _____

Does anyone in the household smoke tobacco/nicotine? ○ Yes ○ No

School Information

School/Day Program Name: _____

School District: _____ Contact Person: _____

Phone: _____ Email: _____

Current Grade: _____

Special Education (check all that apply):

☐ Autistic Support ☐ Emotional Support ☐ Learning Support ☐ Life Skills ☐ Other

Medical Care Provider Information

Primary Care Physician: _____

Address: _____ Phone: _____

Hospital Closest to Home: _____

Address: _____ Phone: _____

Insurance Information

Medical Assistance Number: _____ Insurance Carrier: _____

Other Insurance Information:

Mental Health Conditions/Diagnoses

Please note that a current and documented mental health diagnosis is needed to be eligible for respite services.

DSM Code: _____ ICD-10 Code: _____

DSM-5 Diagnosis:

Medications

Please note: Respite Caregivers do not administer medications. Children must be able to administer medications on their own with supervision. Medications must be sent with the child in the original pharmacy bottle. No over-the-counter PRN medication can be taken unless it is included on this list.

Medication	Dose	Frequency	Reason

Family History

Has this family had any police involvement in the past 6 months? ⊙ Yes ○ No

Has this family ever been involved with domestic violence? ⊙ Yes ○ No

Has the referred child ever been the victim of physical abuse or neglect? ⊙ Yes ○ No

Has the child ever been the victim or perpetrator of sexual abuse? ⊙ Yes ○ No

Does the family currently have any children and youth involvement? ⊙ Yes ○ No

If answered yes to any of the above, please explain:

Respite Request Details

Type of Respite Desired:

☐ Hourly/In Child's Home ☐ Overnight/In Provider's Home ☐ First Available

How does this family envision utilizing respite services (weekends, weekdays, days, evenings, etc.)?

How will respite benefit your family?

Safety Support Plan

The referring agency, family, or County Crisis Provider will provide on-call crisis intervention and supports while the child is receiving respite care.

Exclusion Criteria

All referrals will be reviewed on a case-by-case basis.

Transportation

Please note that it is the responsibility of the family to transport the child to and from out-of-home respite. If transportation to Respite will be a barrier please note that here.

Request/Application for Services Checklist

- ❑ Respite Referral Form/ Application for Services (includes child's Medical Assistance #).
- ❑ Proof of Diagnosis in the form of one of the following: Psychological Evaluation, diagnostic Evaluation, IEP, Written Order, signed doctor's letter

After the application and proof of diagnosis is received, someone will be in touch to discuss next steps!

Acknowledgement

By signing below, I acknowledge that this information will be used to find an appropriate respite provider for this child and will be released to the respite provider so that they can best meet the needs of the child.

Verification of Custodial Rights

Please check the box next to the statement that best describes your situation and sign below.

- ❑ *In signing below, I verify that I have sole legal custody, and as such can make decisions regarding the treatment and care received. I can provide a copy of a custody order or other legal verification to support this claim.*
- ❑ *In signing below, I have joint/shared legal custody with another individual who does not live in my home. Access Services has my full permission to reach out to the guardian to receive the expressed consent of the other legal guardian.*
- ❑ *In signing below, I verify that the identified individual lives in the home with biological parents or adoptive parents.*
- ❑ *In signing below, I verify that none of the scenarios above relate to my current situation and will explain further. I can provide a copy of a custody order or other legal verification to support this claim. Explain:*

_____ _____

Signature of Individual (14 years and up) Date

_____ _____

Signature of Parent/Guardian Date

_____ _____

Signature of Witness Date

Once completed, please email to ChildrensRespite@accessservices.org.