Family Respite Care Application

Personal Information

Parent/Guardian Name: ____
Last First Middle

Address: ________________________ City: ____________________ State: ______

Phone: ____
Home Work Cell

E-mail Address: ____

Name of Person in care: ____
Last First Middle

Social Security #: ________________________ Birth Date: ________________________

Age Range: 0-13 ______ 13-18 _______ 18-65 ______ 65+______

Gender: M____ F_____

Optional: Ethnic Background

Asian American __ African American __ Hispanic/Latino __

Native American __ Caucasian __ Multiple Racial Heritage __

How can respite care help your family? ____

____

____

What special qualifications would you like in a provider? __________________________

____

____

What barriers exist to using respite care?(Behavioral problems, scheduling, etc.) _________

____

____

Schedule Preferred

Days ___ Evenings ___ Nights ___ Weekends ___

Regular ___ Occasional ___ Emergency/ Short notice ___

Please note preferred times: ___________________________________

Transportation

Will you need transportation? Y ___ N ___

Any special requirements? Wheelchair ___ Child Car Seat ___

Other: ____

Payment/ Resources

How much can you pay? _______ Hr _______ Day

Does client receive any of the following?

__ Oregon Health Plan __Medicaid medical __Social Security benefits

__Medicare __Private Insurance __Mental Health (GOBHI)

__Child Welfare __Self-Sufficiency __Seniors and People with Disabilities

__DD Family Support 0-18 __ DD family Support 18+ __ Child Care Resource & Referral

__ Head Start __ Safety Net __ Home Health/Hospice

__ Oregon Project Independence __ Family Caregiver Support

Other: ____

Contact Person: ____

Care Setting

Your Home ___ Provider's Home ___ Activities/ Outings ___ Center Based ___

If care will be in clients home, please fill out the following section.

Please list all other family members who will be present:

Name	Age	Special Need	Will this person also be receiving care? Y/N

Do you have pets? Y __ N __

Please Describe: (kind of pet, size, indoor or out etc.) ______________________________

Does client prefer a non-smoking environment? Y ___ N ___

Any Allergies Y ___ N ___

Please Describe: ____

What is the family's primary language? ____

Do you have a current care provider? Y___ N ____

Name: ___________________________ Phone: _____________________________________

Is Client enrolled in School program? Y ___ N ____

Name of school: ____

Contact Person: ____

Client Special Needs:

__Developmental

__ Physical

__Emotional/behavioral

__ Elderly fragile

__Chronic illness/ medical fragility

__Alzheimer /other related disorder

__At risk of abuse or neglect

__Other special need

Briefly describe clients special need: ____

Referrals made

Provider name	Date	Accepted?	Comments