"A field of choices...
Where abilities grow"

CDDO of Butler County

Family Support Respite Request

Date: _____

Applicant Name: _____ Social Security:_____ Age:_____

Parent/Guardian Name(s): _____

Address: _____

TCM: _____Phone: _____

Medicaid? YES ☐ NO ☐ FY19 Respite Funding Used: $ _____ Funding Requested: $ _____

Name of Respite provider: _____ Age _____

Relationships to applicant: _____ Hrs/Mo _____ X Rate of Pay_____ = _____

Persons living in the home and relationship to applicant	Name	Relationship	Age

Explanation of Need:

<u>**Family Support Respite Schedule**</u>

NAME: DOB:

	MONDAY Date:__________	**TUESDAY** Date:__________	**WEDNESDAY** Date:__________	**THURSDAY** Date:__________	**FRIDAY** Date:__________	**SATURDAY** Date:__________	**SUNDAY** Date:__________
Start Time							
Stop Time							

Activities of natural supports:

	MONDAY Date:__________	**TUESDAY** Date:__________	**WEDNESDAY** Date:__________	**THURSDAY** Date:__________	**FRIDAY** Date:__________	**SATURDAY** Date:__________	**SUNDAY** Date:__________
Start Time							
Stop Time							

Activities of natural supports:

	MONDAY Date:__________	**TUESDAY** Date:__________	**WEDNESDAY** Date:__________	**THURSDAY** Date:__________	**FRIDAY** Date:__________	**SATURDAY** Date:__________	**SUNDAY** Date:__________
Start Time							
Stop Time							

Activities of natural supports:

	MONDAY Date:__________	**TUESDAY** Date:__________	**WEDNESDAY** Date:__________	**THURSDAY** Date:__________	**FRIDAY** Date:__________	**SATURDAY** Date:__________	**SUNDAY** Date:__________
Start Time							
Stop Time							

Activities of natural supports:

By signing this form, I confirm I provided care to the above named individual, in the family home, while the parents were unavailable. I have reviewed this form with the family and they approve the documentation be submitted to the CDDO for review and reimbursement. Funding Committee meets the 2nd and 4th Friday of every month. Payments are processed on the 1st and the 15th of every month. Completed funding requests are due to the CDDO no later than 12:00pm, the Thursday prior to funding committee. Please visit the CDDO website for exact funding committee dates.

Signature of Care Provider____Date_______________