



## Family Support Respite Request

Date: \_\_\_\_\_

Applicant Name: \_\_\_\_\_ Social Security: \_\_\_\_\_ DOB: \_\_\_\_\_

Parent/Guardian Name(s): \_\_\_\_\_

Address: \_\_\_\_\_

TCM: \_\_\_\_\_ Phone: \_\_\_\_\_

Medicaid?  Yes  No      FY24 Respite Funding Used \$ \_\_\_\_\_ Funding Requested \$ \_\_\_\_\_

Name of Respite provider: \_\_\_\_\_ Age \_\_\_\_\_

Relationships to applicant: \_\_\_\_\_ Hrs \_\_\_\_\_ X Rate of Pay \_\_\_\_\_ = \$ \_\_\_\_\_

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

Explanation of Need:

## Family Support Respite Schedule

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ Month: \_\_\_\_\_

	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 2<sup>nd</sup> and 4<sup>th</sup> Friday of every month. Payments are processed on the 1<sup>st</sup> and the 15<sup>th</sup> 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 \_\_\_\_\_