Respite Child Care Program
Special Needs Support Center
12 Flynn Street
Lebanon, NH 03766
603-448-1268

Special Needs Support Center *of the Upper Valley*
Application for Respite Care, 2009-2010
(must be completed and signed by the parent/guardian)

Name of Parent/Guardian: ____

Family Address: ____

Town: ________________________ State: _____ Zip: _______ County: _________

Home Phone: __________________ Work: __________________ Cell: _____________

Please check one: initial application _____ renewal ____ Today's Date: __________

A. Children in family (please list all not just those who need respite care)

1. Child: ______________________________ DOB: ________ Male ____ Female _____

2. Child: ______________________________ DOB: ________ Male ____ Female _____

3. Child: ______________________________ DOB: ________ Male ____ Female _____

4. Child: ______________________________ DOB: ________ Male ____ Female _____

B. Other family members:

1. ___________________________________ relationship: __________________

2. ___________________________________ relationship: __________________

3. ___________________________________ relationship: __________________

C. Reason for seeking help with respite care (please explain briefly about issues such as personal stress, financial stress, parenting challenges, changes in family circumstance):

____

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More questions on the reverse side

D. Which of your children need respite care? What is each child's need for service? Please tell us the ***amount of care*** you are seeking (in hours), ***the time frame*** (for example, weekdays, evenings), ***frequency*** (for example every week, once per month), and ***the location*** that you would prefer the care to happen in (your home or provider's). List all children needing care, and note the specific care requirements for each:

1. Child: ______________________________ Respite care details for this child:

____

2. Child: ______________________________ Respite care details for this child:

____

3. Child: ______________________________ Respite care details for this child:

____

E. Do any of your children have special needs? Please tell us a little about these children so that we may help you establish good care arrangements for them:

____

F. Is your child on a plan? If yes, please circle which type: IFSP IEP 504

G. Additional information to help us provide you with respite:

Do you need help paying for respite care? ________________________________

If yes, is there an hourly rate that you can contribute? ____________________

Do you have a provider in mind? Who? __________________________________

Please note: The Respite Care Program reserves the right to deny a contract or refuse payment when we think that funds are not being used for their intended purpose.

Are you hoping to have us find a provider for you? _______________________

Please tell us who referred you to the program: ___________________________

Is another agency already helping you with respite or attempting to help you?
Yes _____ **No** ______ **If yes, may we contact them?** _______________________
Name of contact person, agency name, and phone number:
____

****Parent's signature:** _____________________________________ **Date:** ______
(or guardian's)

Your signature confirms that you want our help in paying for and/or finding care. It also allows us to share your family's names, contact information, and some limited information about your child's needs with a possible provider.