Send forms to:

CHILDREN & FAMILIES FIRST
2005 Baynard Blvd., Wilmington, DE 19802

Or fax forms to 302-479-1577

If you have questions, please call 800-734-2388.

Respite Care Information Form

Please Print or Type Responses

COMPANY/AGENCY NAME: _____

IS YOUR ORGANIZATION: _____**Public** _____**Private**

PHYSICAL ADDRESS: _____

_____ _____ _____
(city) (state) (zip code)

MAILING ADDRESS: _____
(If different from above)

_____ _____ _____
(city) (state) (zip code)

COUNTY: _____

TELEPHONE NUMBER: (_____)_____ **ALTERNATE NUMBER:** (_____)_____

FAX NUMBER: (_____)_____

CONTACT NAME: (for those seeking services) _____ **TITLE:** _____

DIRECTOR/MANAGER/OWNER NAME: _____ **TITLE:** _____

WEBSITE:_____ **E-MAIL ADDRESS: (for those seeking services)** _____

LICENSE NUMBER: _____ **EXPIRATION DATE:**_____

REGULATORY AGENCY: _____

Languages spoken (other than English): _____
_____

Age range that you serve: From: _____ To: _____

Indicate the types of disabilities you may be able to accommodate: (check all that apply)

_____ ADD or ADHD	_____ Developmental delays	_____ Diabetes
_____ Feeding tube	_____ Hearing impaired	_____ Heart/Apnea monitor
_____ Learning Disabilities	_____ Nebulizer	_____ Physically Challenged
_____ Seizures	_____ Sight impaired	_____ Speech impaired
_____ Autism	_____ Memory impaired	_____ Medication assistance
_____ Wheelchair access	_____ Behavior disorders	_____ Traumatic brain injury

Can you provide emergency respite care?**:** _____Yes _____No

Please share any additional pertinent information about the respite care services you provide: _____
_____
_____
_____
_____

List all the counties in which you provide service**:** _____

_____

_____

List fees charged for your services**:** _____

_____

_____

Are you an approved provider for: _____Medicare _____Medicaid

Days/hours respite care services are offered:

Monday	From:	_____	To:	_____
Tuesday	From:	_____	To:	_____
Wednesday	From:	_____	To:	_____
Thursday	From:	_____	To:	_____
Friday	From:	_____	To:	_____
Saturday	From:	_____	To:	_____
Sunday	From:	_____	To:	_____

Do you offer extended care options:

_____ weekend

_____ week

_____ 2 – 4 weeks

_____ month or more

_____ unlimited

_____ summer camp

Additional comments about service availability**:** _____

_____

_____

Explain eligibility requirements for respite care:

___Age eligibility _____

___Income eligibility_____

___Gender eligibility_____

___Medicaid eligibility _____

___Other (specify) _____

How many respite care clients do you serve annually: (check range that applies)

_____ 1 – 25 _____ 26 – 50 _____ 51 – 75 _____ 76 – 100

_____ 101 – 200 _____ 201 – 300 _____ 301 – 400 _____ 401 – 500

How many respite care clients do you turn away annually: (check range that applies)

_____ 1 – 25 _____ 26 – 50 _____ 51 – 75 _____ 76 – 100

_____ 101 – 200 _____ 201 – 300 _____ 301 – 400 _____ 401 – 500

Why were you unable to serve them?: (check all that apply)

_____ Client unable to pay _____ No vacancies

_____ Special needs could not be met _____ Client declined service

_____ Behavioral issues _____ Funding ran out

_____ Other: (explain) _____

_____