

APPLICATION FOR RESPITE CARE PROGRAM

(Please Print or Type)

PARENT/FAMILY MEMBERS NAME: _____

ADDRESS: _____ CITY: _____

ZIP CODE: _____ HOME PHONE: _____ WORK PHONE: _____

| NAME OF CHILD OR ADULT WITH SPECIAL NEEDS | DIAGNOSIS or Adoption Status | SOURCE Of Diagnosis | DOB | SSN | IEP Y/N | R | S |
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The child's or adult's diagnosis and source of diagnosis must be listed above. **Documentation of the child's or adult's diagnosis, or adoption, must accompany this application form.** A copy of any document containing the diagnosis and name of the physician or therapist issuing the diagnosis should be sufficient for children or adults with a developmental disability, and children with developmental delays, or chronic medical conditions. If the child has a serious emotional disturbance, or the adult has a severe and persistent mental illness, a summary evaluation form available at <http://dhs.sd.gov/dd/respite/> or from the Department of Human Services (1-800-265-9684) should also be completed by the therapist and returned with the application.

Family member's relationship to child or adult with special needs: _____

Are any of the children in your family adopted? _____ (yes or no)

Does your child or adult with special needs reside in your home the majority of the year? ____ (yes or no) If no, please explain: _____

Briefly describe how your child's or adult family member's special needs affect him/her and your family on a daily basis: _____

A qualifying family may receive services up to \$575 for one eligible child or adult per year, and \$200 for each additional eligible child or adult, up to a maximum of \$975 per year, per family. What amount of respite care do you request for your family for this year?

I understand for a child or adult to be eligible for the Respite Care Program they must have a developmental delay (children only) or disability, a serious emotional disturbance, a severe and persistent mental illness, a chronic medical condition (children only), traumatic brain injury or be adopted; and must reside within a family member's home.

I hereby attest that my child(ren), or adult family member, meets the eligibility requirements for the Respite Care Program.

SIGNATURE _____ DATE _____