DIRECTIONS FOR COMPLETION OF RESPITE CARE APPLICATION

PARENT/FAMILY MEMBER'S NAME
Enter the name of the parent of family member with whom the child(ren) or adult needing care resides. This person will be the contact person for the representatives of the Department of Human Services.

ADDRESS, CITY AND ZIP CODE
Enter the mailing address, city, and zip code fore the above named person.

HOME PHONE
Enter the home phone number for the above named person.

WORK PHONE
If it is permissible to contact you at work, enter the work phone number for the above named person.

NAME OF CHILD(REN) OR ADULT NEEDING CARE
Enter the full name of the child(ren) or adult needing care. Eligible care needs are defined as a developmental delay, developmental disability, a serious emotional disturbance, a severe and persistent mental illness, a chronic medical condition, or a traumatic brain injury.

DIAGNOSIS or ADOPTION STATUS
Enter the child(ren)'s or adult's diagnosis, or child(ren)'s adoption status. For example: mental retardation, attention deficit disorder, juvenile diabetes, etc.

SOURCE
Enter the name of the professional that determined the diagnosis. For example, psychologist, psychiatrist, therapist, physician. If you feel your child or adult family member is eligible, but do not have a diagnosis, please call 1-800-265-9684 for further assistance.

DOB
Enter the child(ren)'s or adult's date of birth.

IFSP/IEP Y/N
If the child(ren) is on an Individual Family Services Plan (IFSP) or Individual Education Plan (IEP), enter Y or yes. If the child(ren) is not on an Individual Family Services Plan (IFSP) or Individual Education Plan (IEP), enter N or no.

RACE
Enter W for White, B for Black, H for Hispanic, AI or AN for American Indian or Alaskan Native, a or PI for Asian of Pacific Islander. This information is optional, it will be used for statistics and future program planning.

SEX
Enter M for Male, F for Female. This information is optional, it will be used for statistics and future program planning.

FAMILY MEMBER'S RELATIONSHIP TO CHILD OR ADULT NEEDING CARE
Identify relationship, e.g., mother, father, brother, sister, etc., - also identify if child or adult needing care is a foster child or adult in adult foster care.

DESCRIBE HOW YOUR CHILD'S OR ADULT'S NEEDS AFFECT HIM/HER AND YOUR FAMILY ON A DAILY BASIS
In a brief paragraph, describe the needs of child or adult and how they affect the child or adult family member and family.

AMOUNT OF RESPITE CARE REQUESTED
Within service/dollar limits listed per child or adult, identify amount of respite care requested.

Submit the complete application form with documentation of diagnosis to:

Respite Care Program
Department to Human Services/Division of Developmental Disabilities
E. Hwy. 34; Hillsview Plaza
c/o 500 E. Capitol
Pierre, SD 57501

FOR ASSISTANCE PLEASE CALL 1-800-265-9684