Family Support Respite Request

Date: _____

Applicant Name: _____ Social Security: _____ DOB: _____

Parent/Guardian Name(s): _____

Address: _____

TCM: _____Phone: _____

Medicaid? ☐ Yes ☐ No FY25 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 2nd and 4th Friday of every month. Payments are processed on the 1st and the 15th 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________________