Respite Request Questionnaire

Name:____

Address:______________________________________

City, State, Zip:__________________________________

Contact Telephone Numbers:

Home:____

Cell(s):_______________________________________

Work:____

Email Address:__________________________________

Please list all persons residing in the home, age, and relationship to head of household:

Name	Age	Relationship

Type of Respite Care Needed:

- ☐ Emergency Respite (less than two weeks notice)
- ☐ Traditional Respite (more than two weeks notice)

Time(s) of Respite Care Needed:

☐ One-day only (no overnight)

Hours:____

☐ Day respite only, multiple days in a row (no overnight)

Dates:____

Hours:____

☐ Weekend respite (including overnight)

Dates:____

☐ Week respite (including overnight)

Dates:____

☐ More than one-week respite (including overnight)

Dates:____

Children needing respite care: (please check all that apply)

☐ Birth-2 years
☐ 3-5 years
☐ 6-9 years
☐ 10-13 years
☐ 14 years and older

☐ One child only
☐ Sibling group up to:
  ☐ 2-3 children
  ☐ 4 or more children

☐ Traditional children (no special needs)
☐ Children with minimal medical needs (medication, breathing treatments, etc.)
☐ Children with major medical needs (requiring full time medical assistance)
☐ Children with minimal behavioral needs
☐ Children with major behavioral needs (requiring full time commitment)

☐ Foster
☐ Kinship
☐ Guardianship (This type of respite will not receive any financial compensation from the State.)
☐ Adopted (This type of respite will not receive any financial compensation from the State.)

Children needing respite care: **(please list children and needs individually)**

Name:____ **Age:**__________

Race: ☐ African American ☐ Caucasian ☐ Hispanic
☐ Asian ☐ Interracial ☐ Other

Special Needs: (please list all known allergies to food, animals, medications, etc.)

____

____

____

Medications used: (please list medication schedule):

Medication	Dosage	Schedule

Attends (pre)school at:_________________________________ **Phone number:**__________________

****

Name:____ **Age:**__________

Race: ☐ African American ☐ Caucasian ☐ Hispanic
☐ Asian ☐ Interracial ☐ Other

Special Needs: (please list all known allergies to food, animals, medications, etc.)

____

____

____

Medications used: (please list medication schedule):

Medication	Dosage	Schedule

Attends (pre)school at:_________________________________ **Phone number:**__________________

Children needing respite care: **(please list children and needs individually)**

Name:____ **Age:**________

Race: ☐ African American ☐ Caucasian ☐ Hispanic
☐ Asian ☐ Interracial ☐ Other

Special Needs: (please list all known allergies to food, animals, medications, etc.)

____

____

____

Medications used: (please list medication schedule):

Medication	Dosage	Schedule

Attends (pre)school at:_______________________________ **Phone number:**________________

****

Name:____ **Age:**________

Race: ☐ African American ☐ Caucasian ☐ Hispanic
☐ Asian ☐ Interracial ☐ Other

Special Needs: (please list all known allergies to food, animals, medications, etc.)

____

____

____

Medications used: (please list medication schedule):

Medication	Dosage	Schedule

Attends (pre)school at:_______________________________ **Phone number:**________________

Children needing respite care: (please list children and needs individually)

Name:____ **Age:**__________

Race: ☐ African American ☐ Caucasian ☐ Hispanic
☐ Asian ☐ Interracial ☐ Other

Special Needs: (please list all known allergies to food, animals, medications, etc.)

____

____

____

Medications used: (please list medication schedule):

Medication	Dosage	Schedule

Attends (pre)school at:______________________________ **Phone number:**________________

****

Name:____ **Age:**__________

Race: ☐ African American ☐ Caucasian ☐ Hispanic
☐ Asian ☐ Interracial ☐ Other

Special Needs: (please list all known allergies to food, animals, medications, etc.)

____

____

____

Medications used: (please list medication schedule):

Medication	Dosage	Schedule

Attends (pre)school at:______________________________ **Phone number:**________________

I understand that Central Missouri Foster Care and Adoption Association will not be responsible for the reporting of Respite Units used by family seeking respite.

☐ Yes ☐ No

I understand that Central Missouri Foster Care and Adoption Association (CMFCAA) will use this questionnaire for matching purposes only as a part of CMFCAA's Respite Exchange Program. It is the responsibility of Respite Provider and the family seeking respite care to communicate, secure the respite dates, provide the transportation, and to agree upon and conduct all other respite needs.

☐ Yes ☐ No

I understand that Central Missouri Foster Care and Adoption Association will use the information on this questionnaire to notify a Respite Provider of the need for respite. I give CMFCAA permission to share the information on this application with a licensed Respite Provider upon my request.

☐ Yes ☐ No

I understand that Central Missouri Foster Care and Adoption Association will contact me with a Respite Provider's contact information, after the Respite Provider has agreed to offer respite care.

☐ Yes ☐ No

________________________________ ____________________

Signature Date

________________________________ ____________________

Signature Date