CMFCAA
Central Missouri Foster Care & Adoption Association

RESPITE REQUEST FORM

Please complete the form and click the "submit" button below. A respite specialist will be in contact once the form is received.

Should you have any questions,please contact us at *TessaLake@CMFCAA.com* or 573-298-0258

PERSONAL INFORMATION	
Name:	Email:
Address:	City, State:
Zip code:	Cell(s):
Home phone:	

FAMILY INFORMATION	*List all the members of your family residing in your home below*	
Name	Age	Relationship to head of household

TYPE OF RESPITE CARE NEEDED	TIME(S)
☐ **EMERGENCY RESPITE (LESS THAN TWO WEEKS NOTICE)**	☐ One-day only (no overnight) Hours:_____
	☐ Day respite only, multiple days in a row (no overnight) Dates:_____ Hours:_____
☐ **TRADITIONAL RESPITE (MORE THAN TWO WEEKS NOTICE)**	☐ Weekend respite (including overnight) Dates:_____
	☐ Week respite (including overnight) Dates:_____
	☐ More than one-week respite (including overnight) Dates:_____

CHILDREN IN NEED		
	☐ Traditional children (No special needs)	☐ Minimal medical needs (Medication, breathing, etc.)
☐ Major Medical Needs (requires full time assistance)	☐ Minimal behavior needs	☐ Major behavior needs (Requires full time commitment)

☐ Foster	☐ Guardianship (No financial compensation from State)
☐ Kinship	☐ Adopted (No financial compensation from State)

CHILDREN NEEDING RESPITE CARE

Name:	Age:
Race: ☐ African American ☐ Caucasian ☐ Hispanic ☐ Asian ☐ Interracial ☐ Other	
Special needs:	
Medication:	**schedule:**
Attends school at:	Phone number:

Name:	Age:
Race: ☐ African American ☐ Caucasian ☐ Hispanic ☐ Asian ☐ Interracial ☐ Other	
Special Needs:	
Medication:	**Schedule:**
Attends School at:	Phone Number:

Name:	Age:
Race: ☐ African American ☐ Caucasian ☐ Hispanic ☐ Asian ☐ Interracial ☐ Other	
Special Needs:	
Medication:	**Schedule:**
Attends School at:	Phone Number:

I understand that Central Missouri Foster Care & 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 & Adoption Association 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 & 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 & 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:_____

DON'T FORGET ABOUT OUR MONTHLY RESPITE EVENTS

THE CENTRAL MISSOURI
Foster Care & Adoption ASSOCIATION

STAY CONNECTED

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