Respite Assessment

Name of Parent(s)/Guardian of child:______________________________

Name of child:______________________ Child's Date of Birth:______________

Child's Address:______________________________

Home Telephone Number:______(__________)______________________

Cell Phone Number: ______(__________)______________________

Parent/Guardians E-mail address:______________________________

Do you currently receive respite? Yes No

If yes, number of hours allocated monthly? ______________________

Region 10 Support Coordinator:______________________________

Do you have Medicaid? Yes No Medicaid #: ______________________

If no, have you applied? Yes No Date NH Medicaid application completed? ______________

Is your child in a Residential Placement paid for by your school district? YES NO

Please *circle* ALL that apply:

Two parent family Parent with health issues

Single parent family Parent(s) over the age of 60

Total score: ______________

Please *circle* ONE regarding the person applying for respite:

0-3 years old 4-6 years old 7-12 years old 13-21 years old Adult over the age of 21

Total score: ______________

Please *check* ALL that apply and explain on the space given:

_____ Sleep disorder (please specify): ______________________

_____ Is over the age of 6 AND Requires assistance with personal needs (toileting, bathing, etc)

_____ Is over the age of 6 AND has Safety Concerns: ______________________

_____ Medical issues(please specify):______________________

_____ Behavioral challenges (please specify):______________________

Total score: ______________

Please *circle* ALL that apply:

Receives a full day program or full day of school   Receives a ½ day program or ½ day of school services

Adult (over the age of 21) without any funded services

Total score: ____________________

Please *check* ALL that apply:

_____ Receives CNA/VNA/LNA Services (Please include # of hours:________)

_____ Respite from another agency (Please include # of hours:________)

Please *check* ALL that apply:

In-Home Support Services__________   Family Centered Early Supports & Services____________________

521 Services ____________________   Residential Services/School Residential Services________________

Other funded Supports (please list):____

____

Comments or Questions (Is there anything that you would like to share with us that is not on this assessment?)

____

____

Name of person completing this form: ____

Please print name here: ____

Date this application was completed: ____

For Office Use Only

*Score of Assessment:*____________________   *Date Added to Waiting List:*____________________

*Amount of hours allocated:*_______________   *Date Allocated/removed from WL:*________________

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Director of Family Services Signature

revised 08/10

revision 03 KAJ 06/2012