NASSAU COUNTY DEPARTMENT OF HEALTH
Respite Services Application

Date: _____

Child's Name: _____

DOB: _____

Is this child one of multiple children in the family receiving Early Intervention services?

Yes ☐ No ☐

Parent Name and address: _____

_____

Current IFSP dates: _____

Current IFSP services: _____

_____

Early Intervention Official Designee (EIOD) Name:_____

Service Coordinator/Agency: _____

Service Coordinator Phone Number: _____

INTERNAL USE ONLY:

Approved: ☐ Denied: ☐

Authorization Time Period: _____

Number of hours per week: _____

EIOD Signature: _____

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Child's Name: _____

Instructions: If this application is for a family with more than one child receiving Early Intervention services, answer questions 1 and 2 for each child. Attach additional pages if necessary.

1. Describe the severity of the child's developmental disability and/or the diagnosed condition and needs, including a description of relevant medical conditions.

2. How do the child's needs affect the primary caregiver's ability to maintain the household and manage his/her needs and the needs of others in the family? Give specific examples.

3. Indicate why the parent/ caregiver is applying for respite services and how they plan to use them, specifying any other stressors in the home.

4. Is there a risk of out-of-home placement? Explain.

5. Which of the following supports are available to the family? Describe type and frequency.

    a. Family members: _____
    b. Community/religious groups: _____
    c. Nursery school/Daycare: _____
    d. Babysitting arrangements: _____
    e. Care at Home Services, nursing, Health Home: _____
    f. Other: _____

6. Indicate the names and birth dates of all other children in the home and specify any special needs they may have.

7. Document other considerations relevant to the request for respite services that are not addressed by the previous questions.

8. Describe how the Service Coordinator is assisting the family in accessing other forms of respite or support.

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Respite Services Statement of Understanding

I/We have reviewed the Respite Services application with my service coordinator and understand its contents including the following:

1. Respite is a temporary service intended for immediate and short-term relief of the caregiving responsibilities for a child(ren) receiving Early Intervention.
2. Early Intervention cannot support long term and ongoing respite needs.
3. Approved respite must be used during the respite authorization time period and cannot be carried over into another IFSP period.
4. If my child (ren) is currently receiving respite services and is discharged from early intervention for any reason, respite service will terminate along with all other services on the date of discharge.
5. Immediate family members (siblings) and extended family members (grandparents, aunts, uncles, cousins, etc.) cannot be reimbursed for respite services.

This application is complete and accurate to the best of my/our knowledge. I/We understand that respite services may be modified or terminated if inaccuracies are subsequently noted.

Parent/Caregiver Signature: _____Date: _____

This application is complete and accurate to the best of my knowledge. I have explained the purpose or respite to the family, discussed regulatory criteria and assisted in completing the application.

Service Coordinator Signature: _____ Date: _____