

Family Respite Care Services
Reye Jean Timmer Memorial Fund Application

Caregiver's Names: _____ Date: _____

Care Recipient (child/individual): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: () _____ Other Phone: () _____

Caregiver's Age: _____ DOB: _____ Care Recipient (child) Age: _____ DOB: _____

Please indicate area of family income (or care recipient):

___ \$0-10,000 ___ \$10-15,000 ___ \$15-25,000 ___ \$25-35,000 ___ \$35-45,000 ___ \$45,000+

Household size (include self): _____

Sex of Caregiver: ___ M ___ F Sex of Care Recipient: ___ M ___ F

Race of Caregiver

Race of Care Recipient

___	White	___
___	African American	___
___	Latino	___
___	Oriental	___
___	Asian	___
___	Native American (Indicate if Tribal)	___
___	Other: _____	___

Special Need:

___ DD ___ Physical Disability ___ Mental Illness ___ Risk of Abuse/Neglect
___ Multiple Disabilities ___ Emotional/Behavioral (Type: _____)
___ Chronic Illness/Medically Fragile

Other Family Members (*Attach information for more than 2 members*):

1. Name: _____

DOB: _____ Sex: ___ M ___ F

2. Name: _____

DOB: _____ Sex: ___ M ___ F

Cargiver lives: ___ With care recipient only
___ With care recipient and other family members
(*See above for other members requiring care*)

--Funded by the Reye Jean Timmer Memorial Fund --

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Other Services (Indicate if on Waiting List with *):

- | | | |
|--|--|---|
| <input type="checkbox"/> COP/CIP (<i>circle</i>) | <input type="checkbox"/> W-2 | <input type="checkbox"/> Katie Beckett |
| <input type="checkbox"/> Family Support | <input type="checkbox"/> SSI | <input type="checkbox"/> Medical Assistance |
| <input type="checkbox"/> Badger Care | <input type="checkbox"/> Wraparound | <input type="checkbox"/> Daycare Assistance |
| <input type="checkbox"/> ABC Healthy Families | <input type="checkbox"/> Benefit Specialist | <input type="checkbox"/> Housing |
| <input type="checkbox"/> NCIL | <input type="checkbox"/> Economic Support/County | |

How Long on Waiting List? _____

Other Service not listed: _____

County Case Manager(s): _____ Phone: () _____

Briefly describe why you are requesting funding from the Reye Jean Timmer Memorial Fund:

Was this a self-referral? YES NO

How did you find out about our program?

Signature of Applicant: _____ Date: _____

Please return your completed application to:
Family Respite Care Services
205 N. Main St Suite 106
Janesville, WI 53545

Program Information Only

Program Information:
Identifying # _____ Recipient SS# ____ / ____ / _____
Date of Interview: _____ Date of Follow-up: _____

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