

# Family Respite Care Services Intake Form

## SECTION 1

Caregiver's Name: \_\_\_\_\_

Child Name (recipient): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Day Time Phone Number: ( ) \_\_\_\_\_

Cell Phone (if different): ( ) \_\_\_\_\_

Caregiver's Age: \_\_\_\_\_ DOB: \_\_\_\_\_ Child's Age: \_\_\_\_\_ DOB: \_\_\_\_\_

Caregiver's Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Please indicate family income:

\$0-\$10,000  \$10-\$15,000  \$15-\$25,000  \$25-\$35,000  \$35-\$45,000  over \$45,000

Household size: \_\_\_\_\_

Sex of caregiver:     M     F

Sex of child:     M     F

### Race

Caregiver

Child

___	___	White (Non-Hispanic)
___	___	African America
___	___	Latino
___	___	Oriental
___	___	Native American
___	___	Other: _____

Please indicate child's special need:

DD

Physical Disability

Risk of abuse or neglect

Multiple disabilities

Emotional/Behavior     Type: \_\_\_\_\_

Chronic illness

Child Lives: (*please check one*)  Caregiver only      Caregiver and other family members

# Family Respite Care Services Intake Form

List of other children in home:

Name	Age & DOB	Special Needs

Other Services: *(Please indicate if on waiting list with a W)*

- COP/CIP       W-2       Family Support       Katie Becket       SSI  
 Medical Assistance       Badger Care       Wraparound       Daycare Assistance       Housing  
 ABC Healthy Families       Benefit Specialist       Economic Support       NCIL

\*How long on waiting list (if applicable): \_\_\_\_\_

Other Services not listed: \_\_\_\_\_

Name of Case Manager: \_\_\_\_\_

If you need information on programs available to you please indicate:    YES    NO *(Please circle one)*

Which programs are of interest:  
\_\_\_\_\_  
\_\_\_\_\_

Briefly describe why you are in need of respite care:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How did you hear of our program? \_\_\_\_\_

# Family Respite Care Services Intake Form

## SECTION 2

What are your reasons for requesting respite care at this time? (*Check all that apply*)

Stress on caregiver

Fatigue

Need to do errands

Need to look for employment

Family concerns

Care for child has increased

Caregiver has health problems (*please indicate*): \_\_\_\_\_

Other: \_\_\_\_\_

In the past six months, have there been any changes in you life or the child's? YES NO

\_\_\_\_\_

\_\_\_\_\_

Are you currently experiencing any emotional concerns or difficulties? YES NO

How long have you been caring for child? \_\_\_\_\_ years \_\_\_\_\_ months

How many days during the week do you provide care? \_\_\_\_\_ days

How often is your sleep interrupted by the needs of the child? \_\_\_\_\_

When you provide care for the following need are tasks involved?

Bathing

Dressing

Feeding

Laundry

Cleaning

Errands

Supervision

Toileting

Medication

Shopping

Transportation

If you live with child, how long can you leave him/her? \_\_\_\_\_ hours \_\_\_\_\_ cannot be left alone

Please indicate your stress levels prior to receiving respite care: (*1 being low / 10 being high*)

1 2 3 4 5 6 7 8 9 10 (*please circle one*)

# Family Respite Care Services Intake Form

## SECTION 3

Do you have informal support (*unpaid people how help you*)?      YES    NO

*if so, who?*

Name	Relation to Child	How Often
_____	_____	_____
_____	_____	_____
_____	_____	_____

If these people are not available to help you, have you any other people (paid or unpaid) you can call on for help?      YES                  NO

*if yes, please indicate:* \_\_\_\_\_

Do you receive paid help for any of the following:

in-home nurses       IDS       Other: \_\_\_\_\_

*if so, how often:* \_\_\_\_\_

Have you ever attended a group that offers training, support and/or counseling for caregiver?

- YES, I have attended or am now attending
- NO, I have never attended a group
- I would like to attend and would like information on one
- I am not interested

Are you able to attend any organizations like church, civic groups, etc. that you are involved in?

YES      NO      if no, is the reason related to your caregiving?      YES      NO

Current Employment Status:

Full-time     Part-time     Work-at-home     Retired     Never employed  
 Looking for work     stopped to give care to child

Has your ability to work been affected by your caregiving for your child?      YES      NO

Do you feel your employer is empathetic to your caregiving situation?      YES      NO

*Explain:* \_\_\_\_\_  
\_\_\_\_\_

# **Family Respite Care Services**

## **Intake Form**

Do you feel your co-workers are empathetic to your caregiving?      YES      NO

*Explain:* \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What services would help you to provide more productive support for your child?

- |  |   |  |                                   |
|--|---|--|-----------------------------------|
| <input type="checkbox"/> Respite Care              | <input type="checkbox"/> Personal Care          | <input type="checkbox"/> Legal support/information |                                   |
| <input type="checkbox"/> Transportation Assistance | <input type="checkbox"/> Home Modification      | <input type="checkbox"/> Chore Services            | <input type="checkbox"/> Day Care |
| <input type="checkbox"/> Adaptive Aid              | <input type="checkbox"/> RN, PT, or OT Nurs     | <input type="checkbox"/> Nutrition counseling      |                                   |
| <input type="checkbox"/> Mentor                    | <input type="checkbox"/> Support from my doctor | <input type="checkbox"/> Support from my dentist   |                                   |

What information do you think will better help you care for your special needs child?

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Disease Specific Information | <input type="checkbox"/> Behavior Information       | <input type="checkbox"/> Guardianship/Estate help |
| <input type="checkbox"/> Assistance with IEP          | <input type="checkbox"/> Medication Information     | <input type="checkbox"/> Med Dispensing System    |
| <input type="checkbox"/> Transportation               | <input type="checkbox"/> Behavior Modification Info | <input type="checkbox"/> Community Resources      |

If there is any other information that you would like for Respite Care Services to know or information you would like to request, please indicate:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Applicant: \_\_\_\_\_

Date: \_\_\_\_\_

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