



**Hillsborough County Dept. of Children's Services
In-Home Respite Care Program for Families with Developmentally Disabled Children
Application for Participation**

On behalf of my/our child, we are requesting participation in the Hillsborough County In-Home Respite Care Program.

Child's Name: _____

Date of Birth: _____ SSN: _____

Address: _____

Street address

City State Zip

Parent/Legal Guardian: _____
(Primary Contact)

Address: _____

Street address

City State Zip

Phone Number: (home) _____ (work) _____ (cell) _____
(parent/guardian phone 1) _____ (e-mail) _____

Parent/Legal Guardian: _____

Address: _____

Street address

City State Zip

Phone Number: (home) _____ (work) _____ (cell) _____
(parent/guardian phone 2) _____ (e-mail) _____

Emergency Contact: _____ Relationship: _____

Address: _____

Street address

City State Zip

Phone Number: (home) _____ (work) _____ (cell) _____

Please provide all records from licensed providers, e.g. physician or psychologist, which indicate your child's qualifying diagnosis. Attach any ESE or Therapeutic treatment records along with your child's current IEP. Also, provide any information from providers indicating your child's service and respite needs. Diagnostic reports should be no more than two years old.

Describe your child's medical condition. Please indicate all special medical needs:

Please list reports accompanying application.

Name of Licensed Provider, e.g. Physician/Psychologist, etc.	Provider Phone Number	Date of Report
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_____	_____	_____
_____	_____	_____

Please list any other ESE or Therapeutic Services that your child is currently receiving:

_____	_____	_____
_____	_____	_____

Please provide medical examination report(s) from primary care physician. Physical examination must have been done within the last year.

Name of Physician	Provider Phone Number	Date of Report
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_____	_____	_____
_____	_____	_____

Please describe any behavioral difficulties that your child has. Please describe any behavior that is potentially harmful to him or herself or others:

Respite care currently being provided.

Name of Care Provider	Relationship to child	# hours/week
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_____	_____	_____
_____	_____	_____

Signature of legal guardian

Relationship

Print Name

Date

- Acceptance to the In-Home Respite Care Program and eligibility for future service is contingent upon the accuracy of the information submitted. Persons requiring accommodations in order to read or complete this application should contact 264-3807, x122, x124, or x105.
- The information contained in this application is solely for eligibility determination for the In-Home Respite Program for Children with Developmental Disabilities and will be maintained in strict confidence. Any release of this information will be made only with a signed release form from the legal guardian.
- This program is for families who are not currently receiving respite services from another agency. This program is not designed to provide respite care to children who have medically complex conditions or who have significant behavior problems.



HILLSBOROUGH COUNTY DEPARTMENT OF CHILDREN'S SERVICES
3110 CLAY MANGUM LANE, TAMPA, FL 33618
RELEASE OF INFORMATION

I hereby authorize _____ Dept. of Children's Services
Name of Organization
_____ 3110 Clay Mangum Lane
Address
_____ Tampa, Florida 33618
City, State, Zip

to release, furnish and share, as itemized below, information pertaining to my minor children (ward) and for family to obtain respite services:

_____ Minor Child's Name _____ DOB

To/from _____ Achieve Tampa Bay
Name of Person or Agency
located at: _____ 2215 East Henry Avenue, Tampa, Florida 33610
Address

INFORMATION TO BE RELEASED:

- ___ Application for services
- ___ Medical, Health, Developmental Records
- ___ School\Educational Records
- ___ Psychological and\or Psychiatric Records
- ___ Social History
- ___ Ongoing verbal communication\consultation
- ___ Services received
- ___ Other _____

For the purpose of: _____

I understand this information cannot be released elsewhere without my informed and written consent. I understand that I can revoke the privilege to have this information, or further information, released at any time, per my written request.

I hereby release Hillsborough County, its agents and employees, from all legal responsibility or liability that may arise from the release of such information.

I understand that the validity of this release expires with my family's discharge from the In-Home Respite Care Program.

Signature of Parent\Legal Guardian _____ Date

Signature of Witness _____ Date