NEW YORK CITY EARLY INTERVENTION PROGRAM

RESPITE SERVICES APPLICATION

Date of Application: ____/____/____

(Print or Type)
CHILD'S NAME *(Last, First and Middle):* _____

EI #: _____ **DOB:** ____/____/____ **Borough of Residence:** _____

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

☐ Yes ☐ No

Parent/Caregiver's Name *(Last, First)*: _____

Relationship: _____ Home #: (___)_____ Other #: (___)_____

Child's Address: _____ Apt. #: _____

Borough: _____ State: _____ Zip: _____

Primary Language spoken in the home: _____ Second Language: _____

Current IFSP dates: ____/____/____ to ____/____/____

Service Coordinator: _____ SC ID #: _____

SC Provider Agency: _____

SC Phone #: _____ Fax # : _____

REQUESTED METHOD OF RESPITE SERVICE

☐ IN-HOME
☐ IN-HOME SPECIALIZED CARE

NOTE: Method of respite requested is for informational purposes only.

INTERNAL USE ONLY

☐ Approved ☐ Denied

Provider Agency: _____ Agency EI #: _____

Authorization time period for service: ____/____/____ to ____/____/____

Number of hours authorized per month: _____

EIOD Signature: _____ Date: ____/____/____

NEW YORK CITY EARLY INTERVENTION PROGRAM

RESPITE SERVICES APPLICATION

Child's Name: _____ EI #: _____

STATEMENT OF UNDERSTANDING

I/We have reviewed the Respite Services Fact Sheet for Families with my/our 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 services.

2) Early Intervention cannot support long-term and ongoing respite needs.

3) Approved respite must be used during the respite authorization time period.

4) The tasks a respite worker can perform are limited to care related to my child(ren) enrolled in the New York City Early Intervention Program. (See Respite Services Fact Sheet for Families)

5) If my child(ren) is currently receiving respite services and is discharged from the New York City Early Intervention Program for any reason, respite services will terminate along with all other services on the date of discharge.

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: ____/____/____

PARENT/CAREGIVER SIGNATURE: _____ DATE: ____/____/____

This application is complete and accurate to the best of my knowledge. I have explained the purpose of respite to the family, discussed the regulatory criteria and assisted in completing the application. I have reviewed the Respite Fact Sheet for Service Coordinators and understand my responsibilities.

SERVICE COORDINATOR SIGNATURE: _____ DATE: ____/____/____

For EIP Use Only

NEW YORK CITY EARLY INTERVENTION PROGRAM

RESPITE SERVICES APPLICATION

Child's Name: _____ EI #: _____

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 an additional page if necessary.

1. Describe the severity of the child's developmental disability and/or the diagnosed conditions 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(s)/caregiver(s) are applying for respite services and how they plan to use them, specifying any other stressors in the home.

4. Out-of-home placement:
   a. Is there an imminent risk of out-of-home placement? Explain.

   b. Has there been contact with ACS regarding this family? ☐ No ☐ Yes
      If yes, is this case ☐ Current or ☐ Past Explain.

For EIP Use Only

NEW YORK CITY EARLY INTERVENTION PROGRAM

RESPITE SERVICES APPLICATION

Child's Name: _____ EI #: _____

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

- ☐ Family members _____
- ☐ Extended family including friends _____
- ☐ Community/religious groups _____
- ☐ Nursery school/ EI center-based services _____
- ☐ Day care/family day care/babysitting arrangements _____
- ☐ Care-at-Home services (covered by Medicaid waiver), nursing or HHA
  If child has nursing or homemaker services, describe coverage and provider:
  _____
- ☐ Other _____

6. Indicate the names and birth dates of all other children in the home and specify any special needs they may have. If any child is receiving Early Intervention services, indicate that child's EI #.

NAME	DOB	SPECIAL NEEDS–SPECIFY	EI #

7. Document other considerations relevant to the request for respite services that are not addressed by the previous questions. (Attach any supporting documentation such as medical information, etc.)

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