DHR RESPITE CARE PROGRAM REDETERMINATION FY'16

OFFICE USE ONLY:
SERVICE PLAN

Dis: ____________________
Level: ____________________
Subsidy: ____________________

Please complete all sections of the form, front and back. We must have this form completed and signed in order to continue to receive Respite Services. ***This form does not automatically reserve respite hours for you. You must call our office to reserve time.***

Date: ______________________________

Name of person with developmental disability: ____

Full Address including zip code: ____

____
CITY STATE ZIP CODE

DOB ________________________________ Social Security # _________________________________

Home phone # _______________________________

With whom does the individual live? Parents ☐ Mother ☐ Father ☐ Relative ☐ Agency ☐ Foster care ☐

Parent/guardian/care provider's name: ____

Home phone _____________________ Cell phone _____________________ Work phone___________________

Email address _________________________________ May we send information via email? Yes ☐ No ☐

Number of people living in the home: ______ Please list all people living in the home:

____ Relationship _____________________________

____ Relationship _____________________________

____ Relationship _____________________________

____ Relationship _____________________________

(Use other side of paper, if necessary)

Does the individual have a Service Coordinator? Yes ☐ No ☐

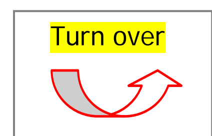
Name of Service Coordinator and phone number: ____

Emergency Contact

Name ____ Phone # ___________________

Address ____ Relationship ______________

____



Where does the individual go during the day?

Name of school/agency/program/job: ____

Contact person ________________________________ Phone _______________________

Are there other providers/agencies involved?

Name of program ____

Case Worker_________________________ Phone Number ________________ ext. __________

CARE REQUIREMENTS:

Please note changes in the care requirements for the individual in the past year.

____

MEDICAL INFORMATION:

Please note any changes in the individual's medical situation.

____

INCOME INFORMATION:

Part I: If the individual to be cared for is under the of age 18, please list gross income of all people living in the home including the individual. List all sources of income and amount.

If the gross income has changed in the past year, you are required to provide proof of income, including two paystubs per salary and copies of Award Letters.

	Individual	Care Provider	Other Person in Home	Other Person in Home	Other Person in Home
Gross wages from employment (indicate weekly, monthly or annual)					
SSA					
SSI					
TCA (Temporary Cash Assistance)					
Child support					
Other: pension, consulting, workman comp, etc.					

PART II: If the individual to be cared for is age 18 or above, please list the gross income of the individual and the person's spouse, if married. If the gross income has changed in the past year, you are required to provide proof of income, including two paystubs per salary and copies of Award Letters.

	Individual	Spouse (if applicable)
Gross wages from employment (indicate weekly, monthly or annual)		
SSA		
SSI		
TCA (Temporary Cash Assistance)		
Child support		
Other: pension, workman comp, etc.		

PART III: If the individual lives in a foster care home, write the name of the foster care agency, case worker and telephone number.

NAME OF AGENCY	CASE WORKER	PHONE NUMBER / EXT.

Signature of person completing form: ______________________ Relationship ________________

Date: _______________

Thank you for taking the time to update your application. Return this form via post mail to:

The Arc Northern Chesapeake Region
4513 Philadelphia Road
Aberdeen, MD 21001

or you may fax it to 410-893-3909.