Connecticut Medical Home Initiative for Children and Youth with Special Health Care Needs *
Respite Family Needs Checklist

Complete this form if your child or youth ***is age 14 or under*** and has a ***diagnosed*** medical, behavioral, or physical need that requires more care and support than that of their peers.

Child's Name ______________________________ **Parent Name**___________________________________ **Social Security #**__________________
Address____ **Town/City**_______________________________ **State/ZIP**__________________

Respite is care that is provided, in or out of the home, for the purpose of providing relief to the family/caregiver from the daily responsibilities of care for the child/youth with special health care needs. Respite services are family-directed, using the respite service provider and location of the family's choice.
**Contact your care coordinator for more information about respite, ask for the Get Creative About Respite manual, or view it on-line at WWW.FAVOR-CT.ORG*

Caregivers available to meet needs
Complete each section

Section 1

___ Child or youth with special health care need has **more than one** significant physical, behavioral, or complex medical diagnosis.

and/or

___ **More than one** family member living in the home needs extra care and support.

Section 2

___ Primary caregiver is in good health.

or

___ Primary caregiver is in poor physical or emotional health.

Section 3

___ Number of adults available to help care for the child or youth with special health care needs.

and

___ Total number of individuals living in the household

and

____________________Total gross household income

Sources of community support during the past 12 months

Section 4 *Check off all that apply*

___ Family receives direct funding from the Department of Children and Families (DCF).

___ Family receives direct funding from the Department of Developmental Services (DDS).

___ The child or youth receives Voluntary Services from DCF or DDS.

___ The child received Birth to Three Services.

___ The child or youth received respite services at a DDS Respite Center.

___ The family received a subsidized adoption.

___ The child or youth is on the Katie Beckett Waiver or other waiver.

___ The child is enrolled in TRICARE and the Extended Care Health Option (ECHO).

Sources of community support during the past 12 months

Section 4 continued *Check off all that apply*

___ The child or youth has home health aides or nursing services on a weekly basis

___ The child or youth receives extended day services from school or a community group

___ The family received camp funds from _________________________

___ The family received respite funds from__________________________

___ Received regular caregiver support from a community group or foundation

Please list below any other information you wish to share. ____________________________________

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*The Connecticut Medical Home Initiative for Children and Youth with Special Health Care Needs is a program supported by the State of Connecticut Department of Public Health. Information is available on the web at www.ct.gov/dph/medicalhome