



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 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 <i>Complete each section</i>	Sources of community support during the past 12 months	Sources of community support during the past 12 months
<p><u>Section 1</u></p> <p>___ Child or youth with special health care need has more than one significant physical, behavioral, or complex medical diagnosis. and/or</p> <p>___ More than one family member living in the home needs extra care and support.</p> <hr/> <p><u>Section 2</u></p> <p>___ Primary caregiver is in good health. or</p> <p>___ Primary caregiver is in poor physical or emotional health.</p> <hr/> <p><u>Section 3</u></p> <p>___ Number of adults available to help care for the child or youth with special health care needs. and</p> <p>___ Total number of individuals living in the household and _____ Total gross household income</p>	<p><u>Section 4</u> Check off all that apply</p> <p>___ Family receives <u>direct funding</u> from the Department of Children and Families (DCF).</p> <p>___ Family receives <u>direct funding</u> from the Department of Developmental Services (DDS).</p> <p>___ The child or youth receives Voluntary Services from DCF or DDS.</p> <p>___ The child received Birth to Three Services.</p> <p>___ The child or youth received respite services at a DDS Respite Center.</p> <p>___ The family received a subsidized adoption.</p> <p>___ The child or youth is on the Katie Beckett Waiver or other waiver.</p> <p>___ The child is enrolled in TRICARE and the Extended Care Health Option (ECHO).</p>	<p><u>Section 4 continued</u> Check off all that apply</p> <p>___ The child or youth has home health aides or nursing services on a weekly basis</p> <p>___ The child or youth receives extended day services from school or a community group</p> <p>___ The family received camp funds from _____</p> <p>___ The family received respite funds from _____</p> <p>___ Received regular caregiver support from a community group or foundation</p> <p>Please list below any other information you wish to share. _____</p> <p>_____</p> <p>_____</p>

*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