

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

Respite Family Needs Checklist

8/31/15



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

