Respite Care Services Application

Funding for this project comes from the Carroll County Health Department Maternal Child Health Program through Grant #CH648C5N of the Office of Genetics and People with Special Health Care Needs

Name: First: ___________________________ **Middle**: ______________ **Last**: ______________________
DOB: __/__/____ **Age**: _____ **School or daycare**: ___________________________

Race: ☐American Indian or Alaska Native ☐Asian ☐ Black or African American
☐Native Hawaiian or other Pacific Islander ☐White ☐ Other
Are you Hispanic or Latino? Yes ☐ No ☐

Email: maria.carr@maryland.gov
CCHD Website: https://cchd.maryland.gov/
and download the application *OR*
Call: 410-876-4942 or 4949
Fax: 410-876-4959

Carroll County Health Department
Attention: Maria Carr, RN, BSN
Maternal Child Health/Nursing
290 South Center Street
Westminster, Maryland 21157

Eligibility Criteria for Child: (please check ALL that apply)
☐Birth to 21 years of age
☐Enrolled in school (including post-secondary education, pre-school, day care)
Yes ☐No☐
☐Reside in Carroll County
☐Without the funding would otherwise not be able to participate in respite care services
☐Have a **documented** developmental disability and/or behavioral or social/emotional disability
☐Does the child currently receive Special Education Services? Yes☐ No ☐
If yes: IEP Yes ☐No☐ or 504 Plan Yes☐ No☐
If no: Provide letter from health care provider which includes documented diagnosis ☐

Parent or Guardian Contact:
Name: ____ Relationship ________________________________
Address: ____
Phone: _____________________________ E-mail Address: ____

Respite Care Services Provider/Camp/Activity Information:
Name: ____
Address: ____
Phone: _____________________ Respite Care Services Provider/Camp Contact Person: ________________________
Dates of Respite Care Services/Camp/Activity: _________________________________ Cost: _____________________

The following supporting documentation MUST BE ATTACHED to this checklist:
☐Copy of Proof of Disability (i.e. IEP, 504 Plan, doctor letter, etc.)
☐Blank Copy of Camp Registration Form or Respite Care Services Activity*

We DO NOT enroll or register your child for camp. This must be completed by the Parent/Guardian. If the application is approved, a voucher is provided for up to $175 made payable to and only redeemable by the respite camp or respite care services provider. If you choose to register and submit payment for camp or respite care services prior to receiving your voucher, it is your responsibility to seek reimbursement from the camp or respite care services provider. CCHD will only make payment to the identified camp. A contact at the camp must be noted on this application in order to coordinate payment.

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CONSENT TO RELEASE INFORMATION

I, __________________________________, consent that Carroll County Health Department, Maternal Child Health/Nursing Program will review Respite Care Checklist and Supporting documentation to determine eligibility for respite funds. If approved, I further agree that Carroll County Health Department, Maternal Child Health/Nursing Program may forward the payment to the identified camp in order to be eligible for the grant program. Camper funds will be granted on a first come first serve basis. This consent will remain in effect for 1 (one) year or may be rescinded in writing at any time.

____ ____________________
Parent/Guardian Date

For CCHD Office Use Only
____ __________________
Signature Date
Approved ☐ Yes ☐ No Reason for denial: ____