INSTRUCTIONS

Respite for Children

1. Please fill out enclosed **Parent/Guardian Questionnaire** (Pages 2-7)

2. Upon completion, please sign and date. By signing the **Parent/Guardian Questionnaire** you affirm that the information provided is accurate and that you give permission for EOHHS to share this information with Respite providers during the referral process. A Respite Service referral will be made on your behalf by EOHHS to the first available provider. If you have a Respite provider preference, please choose on page 7.

3. Ask your child's physician to fill out and sign enclosed **"Physician Evaluation Form"** (Page 8)and return to us by fax (fax number 462-2939) or mail with the enclosed envelope.

4. We need Treatment Summaries or recent Evaluations from the following types of providers who may be providing services to your child:

   > Early Intervention
   > Special Education
   > Neurological
   > Psychiatric/Psychological Evaluation
   > Developmental Evaluation
   > Other as Applicable for your child

5. Please complete, sign and date **"Asset Transfer"** form (Page 9).

6. Any Questions? Please call Karen Sullivan, Respite Program Coordinator, at 462-0210.

Please gather these materials and submit them all together in attached envelope. Thank you.

PARENT/GUARDIAN QUESTIONNAIRE

Respite for Children Program
Center for Child and Family Health
RI Executive Office of Health and Human Services
Hazard Building (Bldg 074) -Ground Floor, 74 West Road
Cranston, R.I. 02920
Main Number (401) 462-5300

Purpose: The requested information is required to assist in the determination or redetermination of Level of Care (LOC) for a child's eligibility for the Respite for Children Program.

PLEASE COMPLETE, SIGN, AND RETURN TO THE ABOVE ADDRESS.

For help in completing this form, you may telephone Karen Sullivan, the Respite for Children Program Coordinator at 401-462-0210.

Non-English interpreters, American Sign Language (ASL) and alternate formats, including Braille and large print, can be provided at no cost, upon request.

1a. Applicant child's LAST name:	1b. Applicant child's FIRST name:	1c. Middle Name
2. Address of applicant child: *(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route, City State and Zip):*		
3. Applicant child's Social Security Number:	4. Applicant child's birthdate: (mm/dd/yyyy)	5. Applicant child's sex: ☐ Male ☐ Female
6a. Parent/Guardian/Adult representative contact for the applicant child: Name: _____ Relationship: _____	6b. Parent/Guardian/Adult representative Home & Daytime phone numbers: 1st :(_____)_____ 2nd :(_____)_____ Email address (if available): _____@_____ Interpreter Needed? ☐ Yes ☐ No ☐ ASL *If Yes, please indicate your need below:* Language needed : _____	
7a. Additional Parent/Guardian/Adult representative contact for the applicant child, *if applicable :* Name: _____ Relationship: _____	6b. Parent/Guardian/Adult representative Home & Daytime phone numbers: 1st :(_____)_____ 2nd :(_____)_____ Email address (if available): _____@_____ Interpreter Needed? ☐ Yes ☐ No ☐ ASL *If Yes, please indicate your need below:* Language needed : _____	

APPLICANT CHILD'S NAME:_____ DATE OF BIRTH:_____

Task	Independent	Needs some Help	Dependent	Notes
Bathing:				
Dressing:				
Skin Care:				
Grooming:				
Eating:				
Sleeping:				

Toileting: Is the Child over 3 years of age and toilet trained? ☐ YES ☐ NO

Understanding/Communication: Does your child have difficulties in the areas listed below in comparison to typically developing children of the same age? Please utilize the notes section to describe any changes that occurred in the past 12 months.

Area	Yes	No	Notes
Understanding and responding to immediate family, other children, other adults:			
Communication/Speech:			
Laming and Playing:			
Growth and Development:			
Social Development:			
Movement and Mobility			
Fine Motor Function (eating, writing, puzzles):			
Gross Motor Function (sitting, walking, running, jumping, riding bike):			
Vision:			
Hearing:			

APPLICANT CHILD'S NAME:_____ DATE OF BIRTH:_____

10. Behavior: Describe how the applicant child shows affection, shares feelings, gets along and cooperates with others:

11. Does the applicant child exhibit any behavior(s) that may be a safety risk to him/herself or others? If yes, what modifications and accommodations are needed to ensure the child's safety?

12. Medication: List all of the applicant child's current medications and dosages:

Medication	**Dosage**

13. Home Health Services:

Please check the 'Yes' box if the applicant child *is receiving* in home services. ☐ Yes ☐ No

Please check below which services the am llicant child *is receiving* in the home or school:

☐CNA or Home Health Aide ☐Personal Care Worker ☐Skilled Nursing ☐HBTS ☐EOS/CAITS/CFIT ☐PASS

14. List all of the applicant child's admission to a hospital, residential facility or Emergency Room in the last 12 months:

Hospital Name	Reason for Admission	Admission Date	Discharge Date
1.			
2.			
3.			

Please circle a CEDARR Family Center if your child is currently involved.

About Families CEDARR Empowered Families CEDARR Families First CEDARR Solutions CEDARR

APPLICANT CHILD'S NAME:_____ DATE OF BIRTH:_____

.5. Education: (Please answer for applicants 3 years of age and older):

1) Is tile applicant child currently enrolled in school? ☐ Yes ☐ No

If No, is he/she receiving home schooling? ☐ Yes ☐ No

If "No," explain why tile applicant child is not attending school or not receiving home schooling:

2) What is the applicant child's current grade in school or tile highest grade completed?_____

a. Does the applicant child presently have? (please check one): ☐ IEP ☐ 504 Plan

b. Is the applicant child receiving special education? ☐ Yes ☐ No

c. Does the child receive substantial supports in the school? ☐ Yes ☐ No

d. Is the applicant child having any major problems in school? ☐ Yes ☐ No

e. Has the applicant child been tested by the school? ☐ Yes ☐ No

f. Does school provide any of the following services to the applicant child? ☐ Yes ☐ No

Speech therapy ☐ Yes ☐ No

Physical therapy ☐ Yes ☐ No

Occupational therapy ☐ Yes ☐ No

Counseling ☐ Yes ☐ No

g. Does the applicant child require special transportation to or from school? ☐ Yes ☐ No

g. Does the child require a 1:1 aide on the school bus or m the classroom? ☐ Yes ☐ No

APPLICANT CHILD'S NAME:_____ DATE OF BIRTH:_____

I certify under penalty of perjury that my answers are correct, including intonation about citizenship and alien status, and complete to the best of my knowledge and belief. I know that under the state of Rhode Island General Laws, Section 40-6-15, a maximum fine of $1,000, or imprisonment of up to five (5) years, or both, may be imposed for a person who obtains or attempts to obtain, or aids or abets any person to obtain, public assistance to which s/he is not entitled, or who willfully fails to report income, resources or personal circumstances or increases therein which exceed the amount previously reported.

I agree to give the EOHHS accurate information, and I give the EOHHS permission to obtain any appropriate documentation in order to prove my statements.

I understand and agree to notify the DHS of any changes within ten (10) days. Iunderstand that under State and Federal law, there is a penalty for making false and misleading statements. I agree to cooperate fully with the State and Federal personnel conducting quality reviews.

I understand that Medical Assistance does not pay medical expenses that a third party is supposed to pay. I agree to provide the EOHHS with my and my spouse's valid Social Security Number(s), upon request, if the child is determined eligible. This information is for Third Party Liability use. Iunderstand that by signing below, Iam assigning the child's rights to any third party payment to the EOHHS, including payment for lawsuits, hospital and health insurance policies to cover benefits provided. Ialso understand that the EOHHS has a potential lien against the child's estate.

I know that the information I have given is confidential and used only for administration of the EOHHS programs. The EOHHS will not release information about me or the applicant child without my written consent except for the administration of the program and as provided in State law and regulations. Iknow that the child's eligibility will not be affected by race, color, national origin, disability, sex, age, or sexual orientation, except where this is Restricted by law. If the EOHHS finds my child ineligible, I may reapply at any time. I know that I have the right to appeal any agency decision or delays, and receive a hearing before an EOHHS Hearing Officer.

Sign, date and submit to RI EOHHS Respite For Children Program. Completed form must be submitted with original signatures.

_____ _____

SIGNATURE of Applicant Child's Parent/Guardian/Representative Date Signed

_____ _____

Please PRINT name Relationship to Applicant Child

Personally identifiable information on this form is used to help determine eligibility for the Rhode Island Respite for Children Program for a child with RI Medical Assistance. This information will be used only for this purpose.

APPLICANT CHILD'S NAME:_____ DATE OF BIRTH:_____

16. You know the applicant child best. Please provide information about the child's condition including any diagnoses, needs *(both met and unmet)* that haven't already been described or that has changed in the past 12 months.
**(If you need more space or want to write full summary on separate paper or computer, this is welcome)*

A Respite Service referral will be made on your behalf by EOHHS to the first available provider. If you have a Respite provider preference, please choose below.

- ☐ Access Point
- ☐ Autism Project
- ☐ Groden Center
- ☐ Momentum
- ☐ Northeast behavioral Associates
- ☐ Ocean State Behavioral
- ☐ Ocean State Community Resources
- ☐ Seven Hills

_____ _____
Parent/Guardian Signature* Date

*By signing above, you affirm that the information provided is accurate and that you give permission for EOHHS to share this information with the above listed Respite providers during the referral process.

Physician Evaluation Form

INSTRUCTIONS TO THE PHYSICIAN

The Respite for Children Program
Executive Office of Health and Human Services
Center for Child and Family Health
Hazard Building, Ground Floor (Building74) 74 West Road
Cranston, RI 02920
Main Number (401) 462-5300

PHYSICIAN EVALUATION FOR RESPITE FOR CHILDREN PROGRAM

This form requires the signature of a physician, either a Medical Doctor (M.D.) or Doctor of Osteopathy (D.O.)

The RI Executive Office of Health and Human Services (EOHHS) requires a completed and signed Physician Evaluation for the Respite for Children Program. An original physician signature is required for this form and a postage paid return envelope has been provided for this form's return.

Purpose: This form shall be used to determine ne eligibility for a child with RI Medical Assistance under 21 years of age, and living at home for the Respite for Children Program. You may fax the completed signed form to (401) 462-2939, Attention: Respite Program Coordinator.

NAME OF APPLICANT CHILD		DATE SENT TO PHYSICIAN	
DATE OF BIRTH	CURRENT AGE	SEX	SOCIAL SECURITY NUMBER
ADDRESS OF APPLICANT CHILD Number and Street		City/Town and Zip Code	
1. PARENT/GUARDIAN NAME(S)		TELEPHONE NUMBER(S): Home:	Cell:
1. PARENT/GUARDIAN NAME(S)		TELEPHONE NUMBER(S): Home:	Cell:
Diagnosis(es) Primary	All Other Diagnosis(es)	Surgeries, Hospitalizations	
Physician Office Stamp Area (optional):		Signature of Physician (required) Printed Name of Physician	
Physician Telephone Number: _____ Physician Fax Number: _____		Date Completed (required)	

Asset Transfer Form

Child's Name: Child's MID #: _____

1. Have you, your spouse or anyone in your household given away, sold, deeded, or transferred to anyone or any entity, an property, cash, or other items of value that had been in your child's name, to anyone in the past (60) sixty months.

☐ Yes ☐ No

If yes, complete the boxes below.

Last Name	First Name	Initial	Resource Transferred
Amount Transferred $	Date Transferred ___/___/___	What did-you receive in return?	
Last Name	First Name	Initial	Resource Transferred
Amount Transferred $	Date Transferred ___/___/___	What did you receive in return?	

2. Is your child named as a beneficiary (primary, secondary, etc.) on any trust? ☐ Yes ☐ No

If yes, you must provide copies of the trust even if your child is not currently receiving any payments from the trust

Principal amount to your child	Date established	Amount of payments to your child	Frequency of payments
$	___/___/___	$	

3. Have you or your spouse, or anyone acting on your child's behalf (including a court) established a trust or put any mone into a trust for your child within the last sixty (60) months?

☐ Yes ☐ No

If yes, you must provide copies of that trust.

Established by	Date Established	Amount
	___/___/___	$

_____ Parent/Guardian Signature

_____ Date