

RESPITE PROVIDER INFORMATION SHEET

PROVIDER INFORMATION			
Name		Email	
Address		Web Address	
Telephone			
Fax			
Contact Person		Phone	
What are your eligibility requirements for respite care?			
What populations do you serve? (Please circle all that apply)			
	Adults	Pediatrics	Alzheimer's
	Behavioral disorders	Chronic Disease	Mental Health
	Developmental Disabilities	Physical Disabilities	Hospice
	Non-mobile	Other	
What form(s) of payment do you accept? (Please circle all that apply)			
	Medicaid	Private Pay	Other
During what time periods do you provide respite care? (Please circle all that apply)			
	Daytime only	Nighttime only	24 hours
Where do you provide respite? (Please circle all that apply)			
	In home	Out of the home	
What services can you perform while providing respite (i.e. bathing, dressing, grooming, etc)?			