Respite Care Application

Dear Parent/s:

Thank you for requesting a Respite Care Program Application. Please review and complete the entire application. Once complete mail, fax or email it back to:

United Parents
Attn: Respite Care Program Manager
391 South Dawson Drive, Suite 1A
Camarillo, CA 93012

Fax (805) 384-1080
habitia@unitedparents.org

Once your application is received, it will be reviewed and we will try to find a Respite Provider who we feel is a good match based on your application. United Parents currently has a waiting list and we will do our best to accommodate you with a Respite Provider as soon as possible. All families on the waiting list will be able to participate during our respite events. When we have a potential Respite Worker, we will contact you to schedule an appointment in your home where we will meet you and your child.

Please note that we have a current waiting list. During the time period that your family is on the waiting list, your child will be able to participate during our respite events. Notifications regarding our respite events will be sent via email or mail.

Please contact me if you have any questions.

Sincerely,

Hannah Abitia
Respite Care Program Manager

***Please Note* – Your child must be a client of Ventura County Behavioral Health (VCBH) to be eligible for this program at a reduced rate. If you are not a client of VCBH, please contact us about self-pay.**

Respite Care Application

Today's Date: _____

PARENT/GUARDIAN INFORMATION			
Mother's First and Last Name:	Marital status: Single☐ Married ☐ Divorced☐	Ethnicity: ☐Hispanic ☐ Caucasian ☐ American Indian ☐ Asian ☐ African American ☐ Other	
Street Address:	City:	State:	ZIP Code:
Home phone no.: ( )	Work Number: ( ) Extension:	Mobile Number: ( )	
Father's First and Last Name:	Marital status: Single☐ Married ☐ Divorced☐	Ethnicity: ☐Hispanic ☐ Caucasian ☐ American Indian ☐ Asian ☐ African American ☐ Other	
Street Address:	City:	State:	ZIP Code:
Home phone no.: ( )	Work Number: ( ) Extension:	Mobile Number: ( )	
Home Language: ☐English ☐ Spanish ☐Other	How did you hear about United Parents?	E-Mail Address:	

CHILD'S INFORMATION			
Child's First and Last Name:	Nickname:	DOB:	Age:
Is your child, your: ☐Foster Child ☐ Adopted Child ☐ Relative ☐ Natural Child ☐ Other, Please specify			
Ethnicity: ☐Hispanic ☐ Caucasian ☐ American Indian ☐ Asian ☐ African American ☐ Other, Please specify			
Child's primary language: ☐ English ☐ Spanish ☐Other, please specify			

SIBILINGS		
First and Last Name:	Relationship:	Age:
First and Last Name:	Relationship:	Age:
First and Last Name:	Relationship:	Age:

PLEASE LIST ANY OTHER ADULTS THAT ARE CURRENTLY LIVING IN THE HOUSEHOLD:		
First and Last Name:	Relationship:	Age:
First and Last Name:	Relationship:	Age:
First and Last Name:	Relationship:	Age:

391 S. Dawson Drive, Suite 1A * Camarillo, CA 93012 *Telephone: (805)384-1555 Fax: (805)384-1080
Website: www.unitedparents.org

Respite Care Application

IN THE PAST YEAR HAS THE CHILD BEEN PLACED OUT OF HOME IN A RESIDENTIAL TREATMENT FACILITY?

☐ No ☐ Yes If yes, where?

HAS YOUR CHILD HAD ANY HOSPITALIZATIONS?

☐ No ☐ Yes If yes, where?

WHAT ARE SOME OF YOUR CHILD'S FAVORITE ACTIVITIES, HOBBIES, INTERESTS, AND EXTRA CURRICULAR SCHOOL ACTIVITIES?

LIST ANY ACTIVITES, SPORTS, SUBJECTS THAT YOUR CHILD EXCELS AT:

ARE YOU WILLING TO SEND YOUR CHILD ON OUTINGS IN THE COMMUNITY?

☐ Yes ☐ No

DO YOU HAVE CONCERNS ABOUT LEAVING YOUR CHILD WITH SOMEONE ELSE?

WHAT ARE THE QUALITIES THAT ARE IMPORTANT TO YOU IN A RESPITE CARE WORKER?

ARE YOU INTERESTED IN RECEIVING CARE IN: (MARK ALL THAT APPLY)

1. Your home ☐ Yes ☐ No	2. Provider's home ☐ Yes ☐ No	3. Parks and Recreations ☐ Yes ☐ No
4. YMCA ☐ Yes ☐ No	3. Boys and Girls Club ☐ Yes ☐ No	4. ☐Other, please specify

TIME REQUESTED (PLEASE CHECK ALL THAT APPLY):

Monday-Friday	☐ Morning	☐ Afternoon	☐Evening
Saturday	☐ Morning	☐ Afternoon	☐Evening
Sunday	☐ Morning	☐ Afternoon	☐Evening

HOME RULE GUIDELINES

If you have established rules regarding the following, please briefly explain the rules:

1. Pets:
2. TV:
3. Homework:
4. Phone:
5. Transporting:
6. Shopping:

391 S. Dawson Drive, Suite 1A * Camarillo, CA 93012 *Telephone: (805)384-1555 Fax: (805)384-1080
Website: www.unitedparents.org

7. Other:
8. Other:
9. Are there any rooms in your home that are off limits? ☐ Yes ☐ No If yes, where
10. Are there any other rules that you want the provider to be aware of and to enforce? ☐ Yes ☐ No If yes, list below

EDUCATION

Name of school:			
Street Address:	City:	State:	ZIP Code:
Office Number: ( )	Fax Number: ( )		

1. Is the child/adolescent receiving any type of Special Education Services? ☐ Yes ☐ No If yes, list below
2. Has your child/adolescent repeated any grades ☐ Yes ☐ No
3. Does your child/adolescent like or dislike school? ☐ Like ☐ Dislike
4. Does your child/adolescent relate better to older of younger children? ☐ Older ☐ Younger

HEALTH

1. Are there any other health concerns that we need to be aware of? ☐ Yes ☐ No If yes, please explain below:
2 .Is there any special diet that your child is on? ☐ Yes ☐ No If yes, please explain below:
3 .What foods does your child enjoy?
4. Are there any foods that your child does not like? ☐ Yes ☐ No If yes, please explain below:

DENTIST

Dentist:	Office Number: ( )

391 S. Dawson Drive, Suite 1A * Camarillo, CA 93012 *Telephone: (805)384-1555 Fax: (805)384-1080
Website: www.unitedparents.org

MEDICAL INFORMATION

Child's Pediatrician:			
Street Address:		City:	
Office Number: ( )		Fax Number: ( )	
Medication #1:	RX#:	Dosage:	Time Given: ☐ AM ☐ PM
Is there any side effects? ☐ Yes ☐ No If yes, please explain			
What is the purpose of this medication?			
Medication #2:	RX#:	Dosage:	Time Given: ☐ AM ☐ PM
Is there any side effects? ☐ Yes ☐ No If yes, please explain			
What is the purpose of this medication?			

** Please use a separate sheet of paper if you need to list more medications.

1. Does your child have any know allergies? ☐ No ☐ Yes - If yes, to which?

What are the effects?

2. Is there any specific food allergies? ☐ Yes ☐ No - If yes, to which?

What are the effects?

3. What foods does your child enjoy?

MENTAL HEALTH-VENTURA COUNTY BEHAVIORAL HEALTH (V.C.B.H)

Name of Clinician:			
Street Address:	City:	State:	ZIP Code:
Office Number: ( )	Cell Number: ( )		

1. Record any therapeutic goals that are being worked on at home as well as in therapy.

391 S. Dawson Drive, Suite 1A * Camarillo, CA 93012 *Telephone: (805)384-1555 Fax: (805)384-1080
Website: www.unitedparents.org

Respite Care Application

Name of prescribing Psychiatrist at:			
Street Address:	City:	State:	ZIP Code:
Office Number: ( )	Fax Number: ( )		
Current Diagnosis:			

SOCIALIZATION

1. Describe how your child/adolescent interacts in social situations.
2. Does your child/adolescent engage in inappropriate behavior(s) to get attention? ☐ Yes ☐ No - If yes, how?

EMERGENCY INFORMATION

Please list two persons to call in case the parents cannot be reached:

1. First and Last Name:		Relationship to the child/adolescent:		
Street Address:	City:	State:	Zip Code:	Telephone Number ( )
2. First and Last Name:		Relationship to the child/adolescent:		
Street Address:	City:	State:	Zip Code:	Telephone Number ( )
In the event of emergency, Preferred Hospital:				
Is there Medical Insurance for the child? ☐ Yes ☐ No If yes, please provide the following				
Insurance Company:	Policy Number:			

"By signing this form, I certify that the information provided on this form is true and correct. I will notify United Parents if there are any significant changes immediately. By completing and signing this form, I give consent for the information contained herein to be disclosed to United Parents for Respite Care Services.

Parent Name: _____ Date: _____
(Print First and Last Name)

Signature: _____ Date: _____

391 S. Dawson Drive, Suite 1A * Camarillo, CA 93012 *Telephone: (805)384-1555 Fax: (805)384-1080
Website: www.unitedparents.org