

## Respite Care Referral

Client Name	Client No.	Social Security No.	Date of Birth
Address			Telephone No.
Caretaker Name		Relationship to Client	

Sex <input type="checkbox"/> M <input type="checkbox"/> F	Race/Ethnicity <input type="checkbox"/> Anglo <input type="checkbox"/> Hispanic <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Other: _____		
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated			
Client Characteristics <input type="checkbox"/> Dementia <input type="checkbox"/> Physically Disabled <input type="checkbox"/> Mentally Ill <input type="checkbox"/> Mentally Retarded <input type="checkbox"/> Other: _____			
Reason for Respite <input type="checkbox"/> Caretaker Hospitalized/III <input type="checkbox"/> Family Emergency <input type="checkbox"/> Periodic Relief <input type="checkbox"/> Abuse/Neglect <b>Explain:</b>			

<p><b>I certify that the amount entered is an accurate statement of my monthly income, including the income of my spouse.</b></p>	<p>Certifico que la cantidad anotada es una declaración correcta del total de los ingresos mensuales míos y de mi esposa.</p>
<p><b>Monthly Income:</b> Ingresos Mensuales: <input style="width: 150px;" type="text"/></p>	<p style="text-align: center;">_____ <b>Signature-Client/Firma-Cliente</b></p>
	<p style="text-align: center;">_____ <b>Date/Fecha</b></p>

Comments:

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Agency Name	
Service <input type="checkbox"/> Nursing Home <input type="checkbox"/> Hospital <input type="checkbox"/> Personal Care Home <input type="checkbox"/> Adult Foster Home <input type="checkbox"/> In-Home Care <input type="checkbox"/> Sitter <input type="checkbox"/> Adult Day Health Care <input type="checkbox"/> Supportive Services	
Date(s) Services Needed	Quantity of Service Requested

_____ Signature-DADS Caseworker	_____ Date
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Address	Telephone
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