RESPITE CARE APPLICATION AND REFERRAL

DEPARTMENT OF HEALTH AND HUMAN SERVICES
WEST CENTRAL HUMAN SERVICE CENTER
SFN 371 (4-2024)

Clear Fields

Name of Worker Who Referred Family	Agency	Telephone Number

* You cannot be discriminated against in any manner related to the receipt of these services administered by this agency on the grounds of race, color, national origin, sex, or nature of handicap. The disclosure of your date of birth and social security number is voluntary and withholding this information will in no way affect your eligibility for services. The information is used for identifying information and statistical purposes and will in no way affect your family's eligibility for services.

Child(ren) Respite Care is being requested for

NAME OF CHILD	BIRTHDATE	SEX	RACE	*SOCIAL SECURITY NUMBER

Parent(s)/Caregiver(s)

Name	Date of Birth	Race	Home Telephone Number		Work Telephone Number
Address		City		State	ZIP Code
Name	Date of Birth	Race	Home Telephone Number		Work Telephone Number
Address		City		State	ZIP Code

Are parents the primary caregivers? ☐ Yes ☐ No - List Primary Caregiver:			Telephone Number
Address	City	State	ZIP Code

List Other Persons in Household (Include children and adults)

NAME	AGE	RELATIONSHIP	COMMENTS

Do other household members or other persons provide any care for the child(ren)?
☐ No ☐ Yes - Describe:

Is this child currently receiving services through the ND Partnership Program? ☐ No ☐ Yes - Name of Care Coordinator:
Is this child on the waiting list for the ND Partnership Program? ☐ No ☐ Yes - When was application made?

List Other Services involved with child(ren) or family (Physicians, therapist, special education, juvenile court, etc.)

NAME	AGENCY	SERVICE/COMMENT

Reasons why respite care services are being requested. Include specific behaviors, diagnoses and medications.

I authorize the release of any or all of the above information in regard to Respite Care Services, through this agency for referral to another agency for services and/or the respite care provider. This release is valid until the service is terminated or one year from the date of signature, whichever comes first.

Applicant (Parent/Guardian) Signature	Date
Applicant (Parent/Guardian) Signature	Date

Send Applications to:

West Central Human Service Center
1237 W Divide Ave, Suite 5
Bismarck, ND 58501