RESPITE CARE PLAN

Foster parents requesting respite: ___________________________________ Phone (______)________________

From ___________to ____________ Is the respite home approved by C.F.S.? π Yes π No

Respite Home ____ Phone (______)_______________

Client's name ____________________________________ Medicaid Number _____________________________

County ____________________________ Emergency Phone Number ____________________________________

County Social Worker _____________________________ Phone Number ________________________________

Where will child sleep? _____________________ Allergies: πYes π No Describe _______________________

Level of Supervision: π High π Moderate π Low Describe: ____

Appointments: ____

Medications: ____

Dosage and times given: ____

Contact not allowed with: ____

Contact allowed with: ____

Other information: ____

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Appointments: ____

Medications: ____

Dosage and times given: ____

Contact not allowed with: ____

Contact allowed with: ____

Other information: ____

Note: Please send a copy to the C.F.S. main office and give a copy to the respite care provider.

Respite Approved by: ____________________________________ Title ______________________________