RESPITE REQUEST FORM

Agape is responsible for the arrangement and payment of one hundred forty-four (144) hours or six (6) days of respite care[+] per state fiscal year (July through June) for each of its licensed family foster care homes.

Name of foster family requesting respite:

Dates of Respite – FROM

TO

Emergency contact name & telephone #:

Name of child needing respite:

Gender:

Age:

DOB:

CPS Participant ID:

CMDP #:

CPS Case Manager Name:

Phone:

Respite Provider Name

Phone:

Address:

City, State, Zip:

License ID:

Licensing Agency:

Special needs/and or requirement for foster child's care, including behavior management needs:

_____

Diagnoses, disabilities or medical concerns:

_____

Medications/Feedings (Please attach 24 hour schedule if necessary and include name of medication(s), dosage/times, and purpose.)

_____

Foster Care Parent Signature: _____ Date _____

By signing this form, I have informed the respite provider of all information needed to care for my FC child.

Respite Provider Signature: _____ Date _____

By signing this form, I understand the needs and services required for caring for child placed in my home for respite care.

******Please note it is both the responsibility of the family requesting respite and the respite provider to make sure this form is completed PRIOR to respite.******

We respectfully request that this completed form be provided to Agape fourteen days before the requested date of respite care.

[+] Respite care shall be provided by licensed foster parents authorized (licensed) to provide respite care (to be confirmed by licensing agency), by a certified In-Home Respite Provider as defined by Article 58, or by licensed child placing agencies providing shelter care services. Other child supervision arrangements do not qualify as respite care.

P O Box 50246
Phoenix, AZ 85076
Phone (480) 272-7994 Fax (480) 323-2064

RESPITE CONFIRMATION FORM

Name of respite provider:
Phone:
Mailing Address:
City, State, Zip:
Date respite care began:
Time care began (i.e. 6:00 p.m.)
Date respite care ended:
Time care ended (i.e. 10:00 a.m.)
Name of child who received respite:
Name of child's foster family:

Thank you for helping care for this child.

Please complete this form and return it to Agape
within five business days after your respite services end.
This Confirmation Form will serve as your INVOICE.
Agape provides compensation for respite care at $1.00 per hour.
($1.50 per hour for children who are medically fragile).

A compensation check for the service you provide will be mailed to you
on the first day of the month following your services.

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