

WAIVER RESPITE REFERRAL FORM

Date _____ Person Referred: _____

Address: _____ Date of Birth: _____

_____ Home Phone: _____

Primary Support Name: _____ Relationship: _____ Phone: _____ Email: _____

Secondary Support Name: _____ Relationship: _____ Phone: _____ Email: _____

1. Briefly describe the person's strengths, interests, and level of independence.

2. Please check with service(s) you are interested in.

Respite Recreation Onsite Respite

3. Please indicate the days of the week and times that you are interested in service.

Monday _____ Friday _____

Tuesday _____ Saturday- Recreational Respite offered only

Wednesday _____ Sunday- Recreational Respite offered only

Thursday _____

3. What are the needs of the person and his/her family? Please list any barriers to meeting those needs.

4. How would this service be helpful for future plans of the person and his/her family?

5. Please list any other information that might have an impact on this service; for example, any medical and behavioral needs, geographical location, or other family circumstances. Describe what service the person needs.

<p>Care Manager: _____ Cell Phone: _____</p> <p>Email: _____</p> <p>Agency Affiliate: _____</p> <p>Phone Number/Extension: _____</p>	<p style="text-align: center;"><i>For Wait List Information - Staff Only</i></p> <p>Service _____</p> <p>Approx. # Units _____</p>
--	--

***** Please attach copies of: Eligibility Letter, NOD, ISP, including Support Plans, initial and current LCED, Medicaid card, psychological, and DDP 2 *****

Please return completed application to: Arc of Onondaga Attn: Ruth Ann Riposa 600 S. Wilbur Ave Syracuse, New York 13204

ruthann.riposa@arcon.org Phone: (315) 476-7441 x 1170 Fax: (315) 476-1582