

***Please Complete Other Side→**



Application for Family Support Services Respite Program UPDATED JANUARY 2017

***Application must be completely filled out, signed and accompanied by required documentation to be considered. Please see other side for documentation checklist.**

Name of Child _____ Date of Birth _____

Mother's First Name _____ Last Name _____

Father's First Name _____ Last Name _____

Mother's Home Address: Street _____ Apt # _____

City _____ State _____ Zip _____

Father's Home Address: Street _____ Apt # _____

City _____ State _____ Zip _____

Mother's Home Phone _____ Cell Phone _____

Email _____ Work Phone _____

Father's Home Phone _____ Cell Phone _____

Email _____ Work Phone _____

Do you currently have a child care **Provider or Program**? Yes No

Name of Program _____

Name of Child Care Provider/Program Director _____

Street Address _____

City _____ State _____ Zip _____

Phone Number _____ Fax Number _____

Email _____

If you need assistance completing this application please contact Alice Rosado at 845-425-0009 ext.495

Submit your application and proof of eligibility to:

Christina Espindola
Resource and Referral Coordinator
Child Care Resources of Rockland, Inc.
235 North Main Street, Suite 11
Spring Valley, NY 10977
(845) 425-0009 x610
Fax: (845) 425-5312
christinae@rocklandchildcare.org

For Official Use Only

Application Sent: _____

Completed application received: _____

Effective Date: _____

Program Contact Person: _____

Date Agreement Sent: _____

Date Agreement Received: _____

IEP 2015-2016 Y__ N__

TABS ID# _____



235 N. Main St., Ste.11 / Spring Valley, NY 10977
Phone (845) 425-0009 Toll Free (877) 425-0009 Fax (845) 425-5312
Business Hours: Mon-Fri 8:30am-5:00pm
Email info@rocklandchildcare.org
Website www.childcarerockland.org

Find Us On:



**Documentation Checklist for Family Support Services
Respite Program Application**

**The following documentation is required in order to determine eligibility for
the Family Support Services Respite Program.**

For funding thru The Office for People with Developmental Disabilities (OPWDD)

- Copy of child's complete, current IEP stating classification, including goals and objectives

- Copy of letter of Determination of Developmental Disability

- TABS ID#

***Release of Information**

I give permission to Child Care Resources of Rockland, Inc. to receive information from my child's school, child care provider and/or treating clinician in order to determine eligibility for the Respite Program and to better serve my child's needs.

Signature_____

Date_____