*Please Complete Other Side→

Application for Family Support Services Respite Program

***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_____

Mother's Home Address: _____ Apt. #_____

City _____ State_____ Zip_____

Mother's Home Phone_____ Cell Phone_____

Email_____ Work Phone _____

Father's First Name_____ Last Name_____

Father's Home Address: _____ Apt. #_____

City _____ State_____ Zip_____

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 Christina Espindola at 845-425-0009 ext.610

Signature_____ Date_____

Submit your application and proof of eligibility to:
Christina Espindola
Resource & 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: _____

OPWDD ☐ TABS ID# ☐ DDP1 Yes ☐ No ☐ N/A

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_____

CHILD CARE RESOURCES OF ROCKLAND INCORPORATED
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: