*Please Complete Other Side→

Application for Family Support Services Respite Program

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

Name of Child _____ Date of Birth_____

Parent/Guardian First Name_____ Last Name_____

Parent/Guardian Home Address: _____ Apt. #_____

City _____ State_____ Zip_____

Parent/Guardian Home Phone_____ Cell Phone_____

Email_____ Work Phone _____

Parent/Guardian First Name_____ Last Name_____

Parent/Guardian Home Address: _____ Apt. #_____

City _____ State_____ Zip_____

Parent/Guardian 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:
Alice Rosado
Resource & Referral Coordinator

Child Care Resources of Rockland, Inc.
235 North Main Street, Suite 11
Spring Valley, NY 10977
(845) 425-0009 x421
Fax: (845) 425-5312
alicer@rocklandchildcare.org

For Official Use Only

Application sent:_____ Completed Application Received_____

Effective Date_____ Program_____

Contact Person/Phone Number_____

Date Agreement sent_____ Agreement received_____

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

Documentation Checklist for Family Support Services
Respite Program Application

The following documentation is required 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