



Respite Scholarship Program July 2016 - June 2017

The Buncombe County Respite Scholarship Program works to increase the availability of quality respite care for children and their families in an effort to reduce the risk of abuse and neglect due to toxic risk factors such as: domestic violence, substance abuse, single parent household, social isolation/lack of support or children who have severe or chronic medical or mental illness.

Need Respite Care? Entering the 16th year, The Respite Program is here to help:

1. **Get Ready** ... Chose your Respite Provider

Parents are responsible for choosing and hiring their own Respite Provider(s). Respite providers work directly for parents to provide safe, structured and developmentally appropriate experiences for your children. In addition, parents provide orientation, supervision, and any necessary on-the-job training specific to the individualized needs of their child.

2. **Get Set** ... Apply for a Respite Care Scholarship

Through the generous support of The United Way of Buncombe County and The Department of Health and Human Services, Respite Care Scholarships will be available in 2016-2017 fiscal year for Buncombe County. Scholarships will allow parents to hire a Respite Provider directly. In this way, parents address their need for respite care on a prearranged basis, as a part of the normal, wrap-around services for children and families. Scholarship Applications must be completed and returned to Dawn Precour, Respite Coordinator

3. **Go** ... start-enjoying the benefits of respite!

Need more information?

Contact Dawn Precour, Program Coordinator at CARING for Children, 828-768-8077.

e-mail: dawn.precour@caring4children.org or go to www.caring4children.org

The Respite Scholarship Program works to build a comprehensive community-based system of care for school-aged children and adolescents. Respite is for a short term break for caregivers to rejuvenate and recuperate.

CARING For Children, Inc.

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Respite Scholarship Program Application July 2016 - June 2017

Date: _____

- 1. Child's Name: _____ Date of Birth: _____ Age : _____
- 2. Child's Name: _____ Date of Birth: _____ Age: _____
- 3. Child's Name: _____ Date of Birth: _____ Age: _____
- 4. Child's Name: _____ Date of Birth: _____ Age: _____

Parent / Guardian Name: _____ Date of Birth: _____

County of Residence: _____

Mailing Address _____ City _____ State _____ Zip _____

e-mail address: _____ Phone: _____

What is your preferred way for me to contact you? Text Call Email

Is there an open Child Protective Services case with DSS (Department of Social Services)? _____

How did you hear of The Respite Scholarship Program? _____

Is your child receiving funding for respite, or respite from any other resources? Explain:

Tell us why you need respite. Please describe your circumstances that represent the need for respite and how getting a break would be beneficial to you and your family.

Respite Provider --

Provider's Name _____

Address: _____

City, State, Zip _____ Phone Number: _____

If you have more than one provider – please list here:

Agreement and Release of Liability

(Mandatory in the event that Scholarship Application is awarded)

- USE OF RESPITE SCHOLARSHIP FUNDS**

If my application for respite scholarship funds is approved, I agree to use funds solely to help me pay for respite care according to the respite guidelines of the grant criteria. **The grant criterion stipulates that respite is to be used for the caregiver to receive a break.** *The state has made it very clear in the 2016-2017 fiscal year that respite is not to be used for parent appointments, surgery/recovery, going to work, attending school, etc. These situations require childcare or a babysitter. In addition, the scholarships are not to be used to pay for a special program for your child to attend or afterschool costs, etc. Also stressed is that no part of the scholarship is to be used to pay for dinner, movies, entertainment, etc. while you are getting a break. The entire amount is to pay your respite provider.*

I understand and agree to use respite funding to pay for a respite provider according to the above guidelines.

_____ Parent/Guardian Initials

- RELEASE OF LIABILITY**

I understand that CARING For Children, Inc. is in no way responsible for the direct delivery or supervision of my Respite Provider and that CARING For Children, Inc. is not responsible or liable for any act or omission by my Respite Provider, the parents, or the child(ren) involved.

_____ Parent/Guardian Initials

- CHOOSING AND EMPLOYING A RESPITE PROVIDER**

I understand that I am responsible to choosing, hiring, employing, orienting, scheduling, supervising, paying, and firing my own respite provider I understand that my Respite Caregiver will be employed or contracted solely by me, and furthermore that it is my responsibility to make sure that my Respite Provider is competent to care for my child(ren).

_____ Parent/Guardian Initials

- PAYMENT CONDITIONS**

I understand that I will be responsible for paying the rate for respite care as agreed upon by my Respite Provider and me. If my Request for Respite Scholarship funds is approved, CARING For Children, Inc. will issue a check to me for the allowable payment amount, and I understand that I will be responsible for paying the Respite Provider directly. I understand that if Respite Scholarship funds are insufficient to cover the entire cost of care, that I am nevertheless responsible for paying the entire cost of Respite Care.

_____ Parent/Guardian Initials

- QUARTERLY REPORTING**

I agree to participate in a phone survey and quarterly reports that will be mailed or emailed to me.

_____ Parent/Guardian Initials

Name of Parent of Guardian _____

Signature _____ Date _____

This information is for demographic evaluation purposes only, not scholarship determination

Race/Ethnicity. (Please choose the ONE that best describes what you consider yourself to be)

- A Native American or Alaskan Native B Asian
C African American D African Nationals/Caribbean Islanders
E Hispanic or Latino F Middle Eastern
G Native Hawaiian/Pacific Islanders H White (Non Hispanic/European American)
I. Multi-racial J Other _____

Marital Status:

- A Married B Partnered C Single D Divorced E Widowed F Separated

Family Housing:

- A Own B Rent C Shared housing with relatives/friends
D Temporary (shelter, temporary with friends/relatives) E Homeless

Family Income:

- A \$0-\$10,000 B \$10,001-\$20,000 C \$20,001-\$30,000
D \$30,001-\$40,000 E \$40,001-\$50,000 F more than \$50,001

Highest Level of Education:

- A Elementary or junior high school B Some high school C High school diploma or GED
D Trade/Vocational Training E Some college F 2-year college degree (Associate's)
G 4-year college degree (Bachelor's) H Master's degree I PhD or other advanced degree

Which, if any, of the following do you currently receive? (Check all that apply)

- A Food Stamps B Medicaid (State Health Insurance) C Earned Income Tax Credit
D TANF E Head Start/Early Head Start Services F None of the above

Type of Services: Please check all services you are receiving. **(Check all that apply)**

- Parent Education Family Resource Center
 Parent Support Group Skill Building/Ed for Children
 Parent/Child Interaction Adult Education (i.e. GED/Ed)
 Advocacy (self, community) Job Skills/Employment Prep
 Fatherhood Program Pre-Natal Class
 Planned and/or Crisis Respite Family Literacy
 Homeless/Transitional Housing Marriage Strengthening/Prep
 Resource and Referral Home Visiting

Respite Care Indicators

Please check each statement that applies to your family:

- I am the primary parent/caregiver of the person I need respite for, and I am under age 18
- I am the primary parent/caregiver of the person I need respite for, and I am single
- I am the primary parent/caregiver of the person I need respite for, and I am age 60 or older
- I am the primary parent/caregiver of the person I need respite for, and I have a significant physical or mental health diagnosis.

Please provide detailed information about how this diagnosis affects your ability to care for the person you are seeking respite care for: _____

- I am the primary parent/caregiver of the person I need respite for, and I have a significant level of stress directly associated with the care of this person
- I am the primary parent/caregiver of the person I need respite for and I have a significant limitation in my ability to work or attend to other routine responsibilities due to the extensive needs of this person.
- Other persons in the household have a significant physical or mental disability. If so, explain how this impacts the need for respite care: _____

- My family occupies a residence that is too small for the number of people living here, or is beyond our financial means.
- My family has an inadequate level of income that has continued for more than 30 days.
- At least one member of my family has a history of problems with alcohol or drugs.
- My family has sought some type of out-of-home placement (foster care, adoption, psychiatric inpatient, assisted living or residential placement) for the person we need respite for.
- My family has no or very few outside family members or friends who help support us with the person we need respite care for.
- My family has experienced a recent history of marriage or family problems.
- My family has experienced a recent history of some kind of violence or abuse between family members.
- My family is currently receiving help from an agency designed to prevent or address abuse or neglect.
- My family has experienced the death of an immediate family member within the last 2 years. (Please indicate relationship of this person to person you need respite care for) _____

Please describe the stress you are experiencing and how it is impacting your life and family:

Rate this level of stress from 1 – 10 _____

With 1 being not very stressed to 10 being extremely stressed

Child's Name: _____ (use a separate sheet for each child)

Race/Ethnicity.

- A Native American or Alaskan Native
- B Asian
- C African American
- D African Nationals/Caribbean Islanders
- E Hispanic or Latino
- F Middle Eastern
- G Native Hawaiian/Pacific Islanders
- H White (Non Hispanic/European American)
- I. Multi-racial
- J Other _____

Your relationship to child A Birth parent B Adoptive parent C Grand/Great Grandparent
D Sibling E Other relative F Foster-parent G Other

If your child is not in school/preschool is he/she in daycare: _____ How many hours per week? _____

Is your child away from home in a joint or shared custody situation? No ____ Yes ____ How many hours/days _____

Please mark all that apply:

- Adopted
 - History of Abuse/Neglect
 - Exposure to domestic violence
 - Exposure to substance abuse
 - Attachment trauma
 - Exposed to drugs/alcohol during pregnancy
 - Homeless
- Autism
- Brain Injury
- Developmental Delay
- Hearing Impairment
- Learning Disability
- Special Educational Need
- Behavioral Issues
 - Verbal Aggression
 - Physical Aggression
 - Mood Shifts
 - Hyper-active
 - Disruptive Behaviors
 - Low Self Esteem
- Other Health Impairment
- Serious Emotional Disturbance
- Developmental Disability
- Visual Impairment
- Speech/Language Impairment
- Oppositional/Defiant
- Attention – Focus
- Sleep Difficulties
- Sad/Withdrawn
- Self-Injury
- Anger/Temper

Mental Health Diagnosis – Please list: _____

Medical diagnosis - Please list: _____

Please list other people and agencies involved in support of your child's well-being:

Therapist: _____ Case Manager: _____
 Psychiatrist/med management: _____ Pediatrician _____
 DSS Social Worker: _____ Other: _____

Please provide supporting documentation if available (evaluations, PCP, IEP, etc)