# Respite Provider Information Sheet

<table>
<thead>
<tr>
<th>PROVDER INFORMATION</th>
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<tbody>
<tr>
<td>Name</td>
<td>Email</td>
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<tr>
<td>Address</td>
<td>Web Address</td>
</tr>
<tr>
<td>Telephone</td>
<td>Phone</td>
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<tr>
<td>Fax</td>
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<tr>
<td>Contact Person</td>
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</tbody>
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**What are your eligibility requirements for respite care?**

**What populations do you serve? (Please circle all that apply)**
- Adults
- Pediatrics
- Alzheimer’s
- Behavioral disorders
- Chronic Disease
- Mental Health
- Developmental Disabilities
- Physical Disabilities
- Hospice
- Non-mobile
- Other

**What form(s) of payment do you accept? (Please circle all that apply)**
- Medicaid
- Private Pay
- Other

**During what time periods do you provide respite care? (Please circle all that apply)**
- Daytime only
- Nighttime only
- 24 hours

**Where do you provide respite? (Please circle all that apply)**
- In home
- Out of the home

**What services can you perform while providing respite (i.e. bathing, dressing, grooming, etc)?**
