

# Autism Spectrum Disorder (ASD) Respite Funding: Application Form 2010-2011

- Please complete and return this form by **April 09, 2010**. Applications received at our office after this date cannot be considered for funding but will be kept on file. *For important information that will help you complete this application, please refer to the accompanying Guide. A representative from Service Coordination des services will call you to review your application.*

<b>Child's Last Name:</b>	<b>Date of birth:</b>	
<b>Child's First Name:</b>	<b>Male:</b> <input type="checkbox"/>	<b>Female:</b> <input type="checkbox"/>
<b>Family Contact:</b>		
<b>Relationship (e.g. Parent):</b>		
<b>Telephone:</b>	<b>Email:</b>	
<b>Address:</b>		<b>Postal Code:</b>

1. Is the applicant (the child) a client of one of these designated agencies/central points of access?

If yes, indicate which one and complete the application. Please be advised that to keep the process fair and equitable we will not be considering any client information already on file.

- Service Coordination des services
- SD&G Developmental Services Center
- Prescott-Russell Services to Children and Adults
- Developmental Services FCS Renfrew County

***\*If no, please complete the application and send with documentation confirming diagnosis to your designated agency/local access mechanism. Documentation includes: a psychological assessment, a physician's letter and/or other documentation which clearly states a diagnosis for your child..***

Please note: A representative from the appropriate agency listed above will call you to review your application after it has been received.

2. Has the applicant been diagnosed with Autism Spectrum Disorder?      Yes     No

Please specify:     Autism                       PDD NOS                       Asperger Syndrome

**Respite Plan – How you would use the ASD Funding if your application was approved.**

3. Please outline your request for **Respite**. (Refer to Item #6 in the Guide for help in completing this section.)

In the box below, please provide information regarding the respite plan and the related cost:  
 o include the name of the agency, camp, provider or special needs worker where possible;  
 o the fee (if applicable) and/or the number of hours, cost per hour and number of weeks.  
 If you do not have this information, provide an estimate.

**(Note: Although very important, ABA or IBI therapy is not included in respite options.)**

*Example – Applicant A:*

Camp Sunny Days July 15 to July 31 <sup>st</sup> 2010	\$500
Special Needs Worker – in home –2 hours per week \$15 per hour for 40 weeks	<u>\$1200</u>
*A mark is put in the boxes for 'In Home' and 'Summer Camp'. TOTAL	\$1700

*Example – Applicant B:*

Two weeks respite required for parent to have surgery. Respite provided by John Smith, special needs worker, out of home @ \$1000 per week from Sept. 11<sup>th</sup> to Sept. 24<sup>th</sup> 2010.  
 \*A mark is put in the box for 'Out of Home'. TOTAL \$2000

<input type="checkbox"/> In Home <input type="checkbox"/> Out of Home <input type="checkbox"/> Camp (Winter/Spring Break) <input type="checkbox"/> Summer Camp
<b>TOTAL COST:</b>

4. Please identify current financial supports:  
*\*this question is asked for statistical purposes only and will not affect decision making in regards to your funding request*

- SSAH (Special Services at Home)
- ACSD Assistance for Children with Severe Disabilities
- Other \_\_\_\_\_

5. Please describe the challenges presented by your child. (Refer to Item #7 in the Guide for help in completing this section.)

Only fill in sections of the table below for the specific challenges which apply to your child. Include information on who supports the child with the challenge, i.e. yourself, special needs worker or other professional (could be more than one) and how often this challenge occurs.

**Frequency:** How often does this challenge occur?

- 1 = monthly, but not weekly
- 2 = weekly, but not daily
- 3 = daily, but not hourly
- 4 = hourly or more frequently

**Supports:** Who is helping out?

- F = family members (including extended family)
- S = special needs workers
- P = professionals
- O = other

Challenge	Frequency	Description of challenges/supports required	Supports
Communication needs			
Safety concerns Running away			
Self injury			
Aggression			
Hyperactivity			
Tantrum/Anger Management			

Medical condition (as diagnosed by doctor)			
Secondary diagnosis (as diagnosed by psychologist or other specialist)			
Other			

6. Please check the box that indicates your child's main daily activity. (Refer to Item #8 in the Guide for help in completing this section, especially if your child is preschool age or is home-schooled.)

Daily Supports	Full Day	More than half a day	Half Day	Less than half a day	No day supports
Pre-school age and at home					
Day Care (formal or informal)					
Nursery/Preschool					
School					
Home schooled					
Other (specify): _____					

7. How many people live in your household? Children \_\_\_\_\_ Adults \_\_\_\_\_

8. How many of the persons in your household noted in question 7 have a challenge which requires your support? Children \_\_\_\_\_ Adults \_\_\_\_\_

**(Do not include yourself or the child for whom you are completing this application – caregiver information is in question 9)**

Please describe the challenges. (Example: one sibling has a learning disability or there is an elderly grand-parent with a medical condition.)

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**Caregiver Information**

9. The following information is in regards to the caregiver(s);

- Single caregiver/parent
- Primary caregiver(s) are over 65 years of age
- Primary caregiver has no support from other caregiver(s) (husband, wife, partner)
- Primary caregiver(s) also has challenges (developmental disability, ASD, etc...)
- Primary caregiver(s) has mental health challenges
- Primary caregiver(s) has medical / health diagnosis
- Primary caregiver(s) has physical / mobility limitations
- Primary caregiver(s) has no informal supports (relatives, neighbors, friends)
- Primary caregiver(s)'s employment is compromised due to level of care needs

10. Any additional information you wish to provide:

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11. Referral source (where did you obtain this application):

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**Signature of Caregiver:** \_\_\_\_\_

**Date:** \_\_\_\_\_