RURAL RESPITE/RAVE 2010-2011
APPLICATION

Parent(s)/Guardian (Primary Caregiver) ______________________________

Physical Address ______________________ City ______________ State ____ Zip ________

Mailing Address ______________________ City ______________ State ____ Zip ________

County of Residence ______________ ________ E-Mail ______________________

Home phone ______________ Cell ______________ Work phone ______________

Marital Status: S M D W Ethnicity: __African American __Caucasian __Hispanic __Multiracial __Native American __Other

What is the reason or reasons you are requesting respite services (what would you like to do with your respite time)? ______________________________

____

Funds Requested $ __________ (not to exceed $600.00 per family)

Who referred you to this program? ______________________________

Number of family members in household: ______ Adults ______ Children (under 18)

Please list everyone in your household and complete for each person in your home:

First name	*Last name*	*Gender*	*DOB*	*Ethnicity (Please circle)*	*Disability*
		M F	/ /	African American Native American Caucasian Hispanic Multi-Racial, Other	
		M F	/ /	African American Native American Caucasian Hispanic Multi-Racial, Other	
		M F	/ /	African American Native American Caucasian Hispanic Multi-Racial, Other	
		M F	/ /	African American Native American Caucasian Hispanic Multi-Racial, Other	
		M F	/ /	African American Native American Caucasian Hispanic Multi-Racial, Other	
		M F	/ /	African American Native American Caucasian Hispanic Multi-Racial, Other	

RESPITE IS BEING REQUESTED FOR: (If you have more than one family member with a disability please provide information for each individual). Space is provided on reverse side of this sheet

Name ______________________________ DOB __/__/___ Sex: M / F Age of onset of disability _____

Relationship to Applicant: ____Child ____Foster/Adoptive Child _____Sibling _____Grandchild _____Spouse

Major Disabling Condition: __ Intellectual Disability __Mental Illness __Neurological Impairment __Orthopedic Impairment ___Deafness/Hearing Impairment __TBI __SED __ Multiple Disabling Conditions ___Autism ___Medically Fragile ___FAS ___Other ______________________________

**** Applications will not be approved without documentation of disability.****

**** documentation must be within the past two years. ****

APPLICATION CONTINUES ON REVERSE SIDE

ACKNOWLEDGEMENT:

I attest that the information included in this application is true and complete. I understand that any falsification of information may result in the termination of services.

The applicant recognizes and agrees that he or she is responsible for hiring and paying for the respite services. The Nevada Northern Nevada RAVE Family Foundation Rural Respite(RAVE), Nevada Department of Human Resources (DHR), and the Children's Trust Fund are providing the funding to pay for respite services, but do not provide those services directly or indirectly. The applicant recognizes and agrees that these entities are not liable for any damages that may result from the services, and holds them harmless from the same.

________________________________ ________________________
Parent/Caregiver's Signature Date

Mail this form with documentation of disability to:

Rural Respite/RAVE
P. O. Box 2072
Sparks, NV. 89432
775-851-9255 Voicemail

CONTINUE ONLY IF MULTIPLE FAMILY MEMBERS HAVE DISABILITIES

RESPITE IS BEING REQUESTED FOR:

Name____DOB__/__/___Sex: M / F Age of onset of disability_____

Relationship to Applicant: ____Child ____Foster/Adoptive Child _____Sibling _____Grandchild _____Spouse

Major Disabling Condition: __ Intellectual Disability __Mental Illness __Neurological Impairment __Orthopedic Impairment ___Deafness/Hearing Impairment __TBI __SED __ Multiple Disabling Conditions ___Autism ___Medically Fragile ___FAS Other ____

RESPITE IS BEING REQUESTED FOR:

Name____DOB__/__/___Sex: M / F Age of onset of disability_____

Relationship to Applicant: ____Child ____Foster/Adoptive Child _____Sibling _____Grandchild _____Spouse

Major Disabling Condition: __ Intellectual Disability __Mental Illness __Neurological Impairment __Orthopedic Impairment ___Deafness/Hearing Impairment __TBI __SED __ Multiple Disabling Conditions ___Autism ___Medically Fragile ___FAS Other ____

RESPITE IS BEING REQUESTED FOR:

Name____DOB__/__/___Sex: M / F Age of onset of disability_____

Relationship to Applicant: ____Child ____Foster/Adoptive Child _____Sibling _____Grandchild _____Spouse

Major Disabling Condition: __ Intellectual Disability __Mental Illness __Neurological Impairment __Orthopedic Impairment ___Deafness/Hearing Impairment __TBI __SED __ Multiple Disabling Conditions ___Autism ___Medically Fragile ___FAS Other ____