ADVOCATES FOR
DEVELOPMENTAL DISABILITIES

APPLICATION FOR
RESPITE CARE/SPECIAL SITTERS FUND

Name of individual receiving care:

_____

Primary Diagnosis:_____

Age of individual:_____(is not used to determine grant eligibility)

Have you checked with your County of Financial Responsibility for funding? yes___ no___

Date of Service:_____

Total amount paid to sitter: _____ 25% Co pay (your payment):_____

Total amount requested: _____

Name and address of person to be reimbursed:

_____

_____

By signing below, I agree that I have read the criteria for Advocates for Developmental Disabilities Respite Care/Special Sitters Fund and that the disability defined above is true and I (we) cannot financially afford the above listed request.

Signatures:

_____
Provider/Sitter

_____
Family

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