**I'm requesting respite care for my client (s) for the following dates:**

| Name of client | Date | Time | Date | Time | Total days |
|---|---|---|---|---|---|
| _____ | _____/_____ | | TO _____/_____ | | _____ |
| _____ | _____/_____ | | TO _____/_____ | | _____ |
| _____ | _____/_____ | | TO _____/_____ | | _____ |

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_____ _____

**HCTC Provider's Name** _____

_____ _____

**Phone number(s)** **Address**

_____ _____

**Respite Provider's Name** _____

_____ _____

**Phone number(s)** **Address**

**Current respite balance:** **Days (_____)**

**Special instructions (school, appointments, visitations, etc):** _____

**Licensing Worker/Consultant Signature:** _____ **Date:** _____

**Supervisor Signature (if needed):** _____ **Date:** _____

**NOTES:**_____

_____

_____

_____

This form is turned into your licensing specialist a minimum of 2 weeks prior to your requested respite dates. Your licensing worker will staff this with the HCTC team and make any further recommendations at that time.

Rev. 03/2012