• **Red Mountain Family Services, Inc.** ◆ PO Box 67197 ◆
Albuquerque ◆ N.M. ◆ 87193-7197 ◆ 505.994.0364 fax 505.994.0384

Respite Request Form

Respite must be requested 2 weeks prior to the date unless it is an emergency
If this form is not completed correctly, respite will not be able to be set up

Today's Date:_____ Current Placement:_____
Child's Name:_____ Name: _____
Date of Birth: _____ Phone #:_____
SS #: _____
TFC Level: _____

Respite Request Dates: Is your respite book up to date? Yes or No
Drop off date: _____
Pick up date: _____
Amount of nights the child will be on respite: _____
****Respite CAN NOT EXCEED 2 nights without approval by RMFS management team and the custody holder.**

Transportation Plan (to be completed by a RMFS staff, and confirmed with the TFP and Respite provider):
Drop off time: _____ Pick Up time: _____
Where is the drop off site: _____
Where is the Pickup Site: _____
Who is dropping off the TFC child: _____
Who is picking up the TFC child: _____

Please list any appointments, visits, adoption events, etc. that the client has scheduled during the requested respite (name, date, time and address, as needed).

_____
_____

For transporting to therapy, school, and other appointments:
Location of the appointment/school: _____
Times of the appointment/school: Begin: _____ End: _____
Who is transporting to the appointment/School: _____
Who is transporting from the appointment/School: _____

Please list any appointments, visits, adoption events, etc. that the client has scheduled during the requested respite (name, date, time and address, as needed).

_____
_____

Client's current behaviors that respite provider needs to be aware of: (please include any sexual issues, aggression, suicidal/homicidal thought/threats, etc).

_____
_____

Please list the current medication the TFC child is taking, as well as how they are given and when they are given. List the side effects of each medication.

_____

_____

_____

Preferred Respite Providers (TFC Family that they have done well with in the past)
Name: _____Name: _____

Respite Provider (to be filled out by Treatment Foster Parent Liaison)
Name: _____

____TFP Liaison checked in with assigned TC to confirm/verify information concerning TFC child including medication changes and behaviors.