

## House of New Hope Respite Care Report

**Office:**

<input type="checkbox"/> Foster Care 8135 Mt. Vernon Rd St. Louisville, Ohio 43071; Tel: 888.200.1296 Fax: 740.745.3429 <b>After hours: 888.200.1296, on-call</b>	<input type="checkbox"/> Community Respite Care Services 6434 E. Main Street, Reynoldsburg, OH 43088 Tel: 614.863.5555; Fax: 614.863.2570 <b>After hours: 614.774-1120, request          Program Coordinator</b>
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YOUTH'S NAME: \_\_\_\_\_ Age: \_\_\_\_\_

Dates of Respite Period: \_\_\_\_\_ TO \_\_\_\_\_

RESPITE CARE PROVIDER: \_\_\_\_\_

**Instructions:**

- 1) Please complete a separate Respite Care Report form for each youth.
- 2) Carefully answer each question, taking into account the entire respite period.
- 3) This report and your signed Respite Information Receipt are due to the office with your Invoice Log (as applies) within 48 hours from the end of the respite period.

**Part I**

QUESTION	YES	NO	COMMENTS
1. Did the youth follow the house rules and have appropriate behavior while in respite?			
2. Did the youth get along well with the other members of the household?			
3. Did the youth miss any scheduled appointments or school days? If yes, why?			
4. Did you and the youth discuss anything personal associated with his self-esteem, emotions, problem-solving, peer relations or family issues?			
5. Did the youth have contact with their primary caregiver? If yes, how did it go?			
6. What <b>activities in your home</b> did you do with the youth during his/her respite stay?			
7. What <b>activities in the community</b> did you do with the youth during his/her respite stay?			

**Part II**

**General progress on goals as outlined on Individual Service Plan (ISP):**

Example: \*To Improve Social Skills    \*To Improve Anger Management    \*To Reduce Stress/Anxiety

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Did this child take prescribed medication during his/her respite stay with you? YES NO  
 If yes, please complete medication log and submit to agency.

**Part III: REPORTABLE INCIDENTS**

Date	<b>Please list any and all incidents.</b> Incident Reports are to be completed and submitted within 24 hours of the incident to the HONH Clinician OR the Community Respite Services program coordinator.

**PART IV: FEEDBACK/SUGGESTIONS**

Note any suggestions that would have improved the respite stay:

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\_\_\_\_\_  
 Respite Care Provider

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 HONH staff

\_\_\_\_\_  
 Date

Youth's Name: \_\_\_\_\_