

**House of New Hope
RESPITE INFORMATION RECEIPT**

**IMPORTANT: Please return to House of New Hope within 48 hours or FAX: (740) 745-3429
or EMAIL to criticalincidents@houseofnewhope.org**

Respite Caregiver Name: _____

Foster Child/Youth Name: _____ Date of Birth: _____

Foster Parent _____ Contact #: _____

House of New Hope Clinician:

County Caseworker: _____ Contact #: _____

Date(s) of Respite Provided: FROM _____ TO _____

Who is paying for this respite? HONH (emergency only) Foster Parent Other

I have received the following respite information: check all that apply

Respite Child/Youth Information (contains Individual Child Care Agreement information)

Child/Youth Demographic Information

Consent for Emergency Medical Treatment

Individual Service Plan (ISP)

Medicaid Card or Number

Medication Log

Medication Side Effect Information

Signature of Respite Caregiver: _____ Date: _____

-EMERGENCY CONTACT INFORMATION-

**In the event of an emergency day or night call
House of New Hope
(888) 200-1296 toll free or (740) 345-5437**

Address: 8135 Mt. Vernon Rd., St. Louisville, OH 43071