



Family Selected Respite Program

Intake form

The Case Manager will complete this form and submit to the SC Respite Coalition for processing. SCRC will not send a screening packet to the prospective respite caregiver unless all fields have been completed.

Household Employer Name: _____

Consumer Name: _____ Consumer Date of Birth: _____

Household Employer Email: _____

Household Employer Mailing Address:

Street Address: _____ City: _____ Zip: _____

Household Employer Phone Number: _____ Cell Home Work

How is the Household Employer Related to the Consumer? _____

Consumer County of Residence: _____

Respite Caregiver Name: _____

Respite Caregiver Email: _____

Respite Caregiver Phone Number: _____ Cell Home Work

Respite Caregiver Mailing Address:

Street Address: _____ City: _____ Zip: _____

How is the Respite Caregiver related to the Consumer? _____

How is the Respite Caregiver related to the Household Employer? _____

The Respite Caregiver MUST at least 18 years of age and be able to read, write and speak English.

Does this respite caregiver meet these requirements? _____

Case Manager Name: _____ Case Manager Phone: _____

Case Manager Email: _____

(Case Manager Signature)

Date

Please submit this form to SCRC via email to training@screspite.org

Office Use Only:

Label ___ (FCG) Spreadsheet ___ (BG) Spreadsheet ___ Screen Email Sent _____