INSTRUCTIONS

Respite for Children Yearly Recertification

1. Fill out the enclosed **Parent/Guardian Questionnaire** (Page 2-7).

2. Please have your Respite provider complete and sign the enclosed "**Eligibility Assessment: Level of Care Recertification**" (Page 9) and return it to us by fax (fax number 462-2939) or mail with the enclosed envelope.

3. Please complete, sign and date "**Asset Transfer**" form (Page 10).

4. Please complete, sign and date "**Notification of Recipient Choice**" form (Page 8).

5. Any Questions?
   - Families with children covered by Neighborhood Health Plan of RI or United Healthcare seeking respite services should reach out to their health plan or a respite agency directly.
   - Families with children covered by Fee for Service Medicaid, Katie Beckett and SSI (Anchor Card) seeking respite services should reach out to EOHHS/Kim Splendorio, 401-462-2090.

Please gather these materials and submit them all together in attached envelope. Thank you.

PARENT/GUARDIAN QUESTIONNAIRE
RECERTIFICATION

Respite for Children Program

Purpose: The requested information is required to assist in the determination or redetermination of Level of Care (LOC) for a child's eligibility for the Respite for Children Program.

PLEASE COMPLETE, SIGN, AND RETURN TO THE ABOVE ADDRESS.

For help in completing this form, you may telephone EOHHS/Kim Splendorio, at 401-462-2090.

Non-English interpreters, American Sign Language (ASL) and alternate formats, including Braille and large print, can be provided at no cost, upon request.

la. Applicant child's LAST name:	lb. Applicant child's FIRST name:	lc. Middle Name
2. Address of applicant child: *(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route, City State and Zip):*		
3. Applicant child's Social Security Number:	4. Applicant child's birthdate: (mm/dd/yyyy)	5. Applicant child's sex: ☐ Male ☐ Female
6a. Parent/Guardian/Adult representative contact for the applicant child: Name: _____ Relationship: _____	6b. Parent/Guardian/Adult representative Home & Daytime phone numbers: 1st :(_____)_____ 2nd :(_____)_____ Email address (if available): _____@_____ Interpreter Needed? ☐ Yes ☐ No ☐ ASL *If Yes, please indicate your need below:* Language needed : _____	
7a. Additional Parent/Guardian/Adult representative contact for the applicant child, *if applicable :* Name: _____ Relationship: _____	6b. Parent/Guardian/Adult representative Home & Daytime phone numbers: 1st :(_____)_____ 2nd :(_____)_____ Email address (if available): _____@_____ Interpreter Needed? ☐ Yes ☐ No ☐ ASL *If Yes, please indicate your need below:* Language needed : _____	

APPLICANT CHILD'S NAME:_____ DATE OF BIRTH: _____

8. Daily Care Activities; Please check-off in the correct column to identify if the child is Independent (I), Needs some help (N), or is Dependent (D) on you or others to complete the activities listed below, as expected of a child of the same age. Please use the note section to describe any changes that occurred in the past 12 months.

Task	Independent	Needs some help	Dependent	Notes
Bathing:				
Dressing:				
Skin Care:				
Grooming (i.e. brushing teeth, combing hair):				
Eating:				
Sleeping:				

Toileting: Is your child over 3 years of age and toilet trained? ☐ YES ☐ NO

9. Understanding/Communication: Does your child have difficulties in the areas listed below in comparison to typically developing children of the same age? Please use the notes section to describe any changes that occurred in the past 12 months.

Area	Yes	No	Notes
Understanding and responding to immediate family, other children, other adults:			
Communication/Speech:			
Learning and Playing:			
Growth and Development:			
Social Development:			
Movement and Mobility			
Fine Motor Function (eating, writing, puzzles):			
Gross Motor Function (sitting, walking, running, jumping, riding bike):			
Vision:			
Hearing:			

APPLICANT CHILD'S NAME:_____ DATE OF BIRTH: _____

10. Behavior: Describe how the applicant child shows affection, shares feelings, gets along and cooperates with others:

11. Does the applicant child exhibit any behavior(s) that may be a safety risk to him/herself or others? If yes, what modifications and accommodations are needed to ensure the child's safety?

12. Medication: List all of the applicant child's current medications and dosages:

Medication	**Dosage**
_____	_____
_____	_____
_____	_____

13. Home Health Services:

Please check the 'Yes' box **if** the applicant child *is receiving* in home services. ☐ Yes ☐ No

Please check below which services the am1licant child *is receiving* in the home or school:

☐ CNA or Home Health Aide ☐ Personal Care Worker ☐ Skilled Nursing ☐ HBTS ☐ EOS/CAITS/CFIT ☐ PASS

14. List all of the applicant child's admission to a hospital, residential facility or Emergency Room in the last 12 months:

Hospital Name	Reason for Admission	Admission Date	Discharge Date
1.			
2.			
3.			

Please circle a CEDARR Family Center if your child is currently involved.

About Families Cedar Empowered Families Cedar Lifespan Cedar RIPIN Cedar Solutions Cedar

APPLICANT CHILD'S NAME:_____ DATE OF BIRTH: _____

15. Education: (Please answer for applicants 3 years of age and older):

1) Is the applicant child currently enrolled in school? ☐ Yes ☐ No

If No, is he/she receiving home schooling? ☐ Yes ☐ No

If "No," explain why the applicant child is not attending school or not receiving home schooling:

_____

_____

2) What is the applicant child's current grade in school or the highest grade completed?

a. Does the applicant child presently have? (please check one): ☐ IEP ☐ 504 Plan

b. Is the applicant child receiving special education? ☐ Yes ☐ No

c. Does the child receive substantial supports in the school? ☐ Yes ☐ No

d. Is the applicant child having any major problems in school? ☐ Yes ☐ No

e. Has the applicant child been tested by the school? ☐ Yes ☐ No

f. Does school provide any of the following services to the applicant child?

Speech therapy	☐ Yes ☐ No
Physical therapy	☐ Yes ☐ No
Occupational therapy	☐ Yes ☐ No
Counseling	☐ Yes ☐ No

g. Does the applicant child receive special transportation to or from school? ☐ Yes ☐ No

h. Does your child require a 1:1 aide on the school bus or in the classroom? ☐ Yes ☐ No

APPLICANT CHILD'S NAME:_____ DATE OF BIRTH: _____

16. You know the applicant child best. Please provide information about the child's condition including ICD-10, needs *(both met and unmet)* that haven't already been described or that has changed in the past 12 months.

**(If you need more space or want to write full summary on separate paper or computer, this is welcome)*

_____ _____

Parent/Guardian Signature* Date

APPLICANT CHILD'S NAME:_____ DATE OF BIRTH:_____

I certify under penalty of perjury that my answers are correct, including information about citizenship and alien status, and complete to the best of my knowledge and belief. I know that under the state of Rhode Island General Laws, Section 40-6- 15, a maximum fine of $1,000, or imprisonment of up to five (5) years, or both, may be imposed for a person who obtains or attempts to obtain, or aids or abets any person to obtain, public assistance to which s/he is not entitled, or who willfully fails to report income, resources or personal circumstances or increases therein which exceed the amount previously reported.

I agree to give the EOHHS accurate information, and I give the EOHHS permission to obtain any appropriate documentation in order to prove my statements.

I understand and agree to notify the EOHHS of any changes within ten (10) days. I understand that under State and Federal law, there is a penalty for making false and misleading statements. I agree to cooperate fully with the State and Federal personnel conducting quality reviews.

I understand that Medical Assistance does not pay medical expenses that a third party is supposed to pay. I agree to provide the EOHHS with my and my spouse's valid Social Security Number(s), upon request, if the child is determined eligible. This information is for Third Party Liability use. I understand that by signing below, I am assigning the child's rights to any third party payment to the EOHHS, including payment for lawsuits, hospital and health insurance policies to cover benefits provided. I also understand that the EOHHS has a potential lien against the child's estate.

I know that the information I have given is confidential and used only for administration of the EOHHS programs. The DRS will not release information about me or the applicant child without my written consent except for the administration of the program and as provided in State law and regulations. I know that the child's eligibility will not be affected by race, color, national origin, disability, sex, age, or sexual orientation, except where this is restricted by law. If the EOHHS finds my child ineligible, I may reapply at any time. I know that I have the right to appeal any agency decision or delays, and receive a hearing before an EOHHS Hearing Officer.

Sign, date and submit to RI EOHHS Respite for Children Program. Completed form must be submitted with original signatures.

_____ _____

SIGNATURE of Applicant Child's Parent/Guardian/Representative Date Signed

_____ _____

Please PRINT name Relationship to Applicant Child

Personally identifiable information on this form is used to help determine eligibility for the Rhode Island Respite for Children Program for a child with RI Medical Assistance. This information will be used only for this purpose.

RESPITE FOR CHILDREN WAIVER

NOTIFICATION OF RECIPIENT CHOICE

RECIPIENT NAME: _____

ADDRESS: _____

Soc. Sec. Number: _____

Recipient Notification

I understand that my child has been assessed and found to require the services provided in a Hospital, Nursing Facility or Intermediate Care Facility for the Mentally Retarded (ICF/MR). I have been offered a choice between in-home community-based care and in- patient care in a hospital, nursing facility, or ICF/MR for my child. I have chosen:

In-Home Community-Based Care (Respite)

OR

Placement in a Hospital, Nursing Facility, or ICF/MR.

_____ _____

Signature of Recipient or Parent/Guardian Date

_____

Print Name of Recipient or Parent/Guardian

Children's Respite Program

Eligibility Assessment: Level of Care Recertification

NAME: Last: _____ First: _____

Med. Asst. #: _____

DOB: ____/____/____ Sex: Male ☐ Female ☐

Diagnoses: Primary _____

Diagnoses: All Other: _____

Level of Care Criteria:

1.	Is the child receiving (or requires) Specialized Interventions that are of extended duration? (i.e. PT, OT, SLP, HBTS, PASS, Behavior Therapy, Private Duty nursing, CNA etc.)	Y	N
2.	Does the child exhibit an "extreme" or "marked" functional impairment(s) in the following areas? (Consider functional ability of a typically developing peer)		
	a. Self-Care	Y	N
	b. Learning-Cognition	Y	N
	c. Social Interaction	Y	N
	d. Language-Communication	Y	N
	e. Mobility	Y	N
	f. Self-Direction	Y	N
	g. Safety Skills	Y	N
	h. Health and Physical Well-Being	Y	N
3.	Has the child's condition or functional abilities changed in the past 12 months?	Y	N

Form Completed by: _____

Print Name and Degree (Respite Agency)

Signature: _____ Date: _____

Note: Please attach child's most recent Respite Safety Plan

Asset Transfer Form

Child's Name: Child's MID #: _____

1. Have you, your spouse or anyone in your household given away, sold, deeded, or transferred to anyone or any entity, any property, cash, or other items of value that had been in your child's name, to anyone in the past (60) sixty months.

☐ Yes ☐ No

If yes, complete the boxes below.

Last Name	First Name	Initial	Resource Transferred
Amount Transferred	Date Transferred	What did-you receive in return?	
$	___/___/___		
Last Name	First Name	Initial	Resource Transferred
Amount Transferred	Date Transferred	What did you receive in return?	
$	___/___/___		

2. Is your child named as a beneficiary (primary, secondary, etc.) on any trust? ☐ Yes ☐ No

If yes, you must provide copies of the trust even if your child is not currently receiving any payments from the trust

Principal amount to your child	Date established	Amount of payments to your child	Frequency of payments
$	___/___/___	$	

3. Have you or your spouse, or anyone acting on your child's behalf (including a court) established a trust or put any money into a trust for your child within the last sixty (60) months?

☐ Yes ☐ No

If yes, you must provide copies of that trust.

Established by	Date Established	Amount
	___/___/___	$

_____ _____

Parent/Guardian Signature Date