

Family Enrollment Form  
Autism Respite Program  
Revised 01-14-11

Parent(s) Name(s) \_\_\_\_\_

Parent(s) Street Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Parent(s) Phone # \_\_\_\_\_

Parent(s) email address \_\_\_\_\_

Child/Dependent's  
Name: \_\_\_\_\_

**Yes**  **No** Child/Dependent has a documented diagnosis of autism.

**Yes**  **No** Is it true that the Child/Dependent receives no supported living, Individual Options Waiver, or Level One Waiver services?

Note: Initially there was a sliding scale fee based on family income. Effective 01.14.11, the 15.00 per hour is paid in full for the individual regardless the family's income. Also note that all three boxes must be checked "yes" for the child/dependent to be eligible to receive respite through this program.

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Please sign the Parent or Guardian Signature Form and mail it along with this enrollment form to The Intake Department at HCDDS / 1520 Madison Road / Cincinnati 45206 or fax to Intake at 559-6602.

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HCDDS OFFICE USE ONLY:

Eligibility confirmed by HCDDS Intake Dept. on \_\_\_\_\_ (date).

Verification Signature of HCDDS Intake staff \_\_\_\_\_