

HURON RESPITE NETWORK

APPLICATION FOR IN HOME RESPITE PROVIDERS

NAME: _____ **DATE OF BIRTH:** _____

ADDRESS: _____ **POSTAL CODE:** _____

HOME PHONE: _____ **BUSINESS PHONE:** _____

EMAIL ADDRESS: _____

AREAS OF INTEREST:

Where are you willing to provide service?

In your home _____ In the home of the individual requesting respite _____

North Huron _____ Central Huron _____ South Huron _____ Other _____

Which individuals would you be willing to provide service to?

Infants _____ Children _____ Teens _____ Adults _____ Older Adults _____

Male _____ Female _____ Smoker _____

Developmental Disabilities _____ Physical Challenges _____

Behavioral Concerns _____ Medically Fragile _____

Requires Personal Care _____ Mental Health Concerns _____

Dual Diagnosis _____ Memory Loss _____

Are there any challenges (i.e. specific behaviors, physical limitations, communication, administering of medication, etc.) that you would not be ready to deal with? Please describe

When are you available to provide service?

During the week _____ Weekends _____ Times available _____

Would you be willing to provide respite on an emergency basis?

Yes _____ No _____

Are you interested in participating in a classified ad on respiteservices.com for Huron County?

Yes _____ No _____

VOLUNTEER WORK:

Please describe any volunteer or community work that you have participated in.

Describe any volunteer or work related skills, experiences, or training that relates to providing respite services.

EMPLOYMENT DATA:

Present Employer: _____ Position Title: _____

Address: _____

Duties/Responsibilities: _____

Phone Number : _____ Supervisor: _____

Date Started: _____ Date: Ended: _____

1. Previous Employer: _____ Position Title: _____

Address: _____

Duties/Responsibilities: _____

Phone Number : _____ Supervisor: _____

Date Started: _____ Date: Ended: _____

2. Previous Employer: _____ Position Title: _____

Address: _____

Duties/Responsibilities: _____

Phone Number : _____ Supervisor: _____

Date Started: _____ Date: Ended: _____

May we approach: Present Employer for a reference: Yes _____ No _____

Previous Employer for a reference: Yes _____ No _____

FAMILY BACKGROUND

1. Do you have any pets? Inside the home _____ Outside your home _____
Have your pets been vaccinated in the last year? Yes _____ No _____

2. Is your home wheelchair accessible? (Please indicate with a yes or no.)
Entrance _____ Bathroom _____ Sleeping Area _____ Family Area _____

3. How many family members/people do you have living in your home?
Family _____ Foster children _____ Other occupants _____

4. Others living in your home (over the age of 16)

Name	Year of Birth	Relationship	Male/Female
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

5. Others living in your home (under the age of 16)

Name	Year of Birth	Relationship	Male/Female
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

6. Does anyone in your home have health problems that may limit your activities. List any health concerns which would hamper your ability to provide care? (i.e. lifting, toileting, feeding, bathing)

HURON RESPITE NETWORK
RESPITE PROVIDER
REFERENCES

Please give the names of three (3) individuals who know your family, only one of whom is a relative, that we may contact in regards to this application.

Name _____ Phone _____

Mailing Address _____ **Postal Code** _____

Relationship _____ Length of time you have known them _____

Name _____ Phone _____

Mailing Address _____ **Postal Code** _____

Relationship _____ Length of time you have known them _____

Name _____ Phone _____

Mailing Address _____ **Postal Code** _____

Relationship _____ Length of time you have known them _____

The following agencies are participating members of the Huron Respite Network: Community Living - Central Huron, Community Living - South Huron, Wingham and District Community Living Association, Familyhome Program, Community Support for Families, Children's Aid Society, Huron Safe Homes for Youth, Huron Perth Crisis Intervention Program, Community Care Access Centre, Canadian Mental Health Association and Anago Resources Inc.

I give permission for this application to be shared with participating Network agencies with the exception of:

Date: _____ Signature _____

Return to: Respite Coordinator
Huron Respite Network
15 Rattenbury Street East
PO Box 1581
Clinton ON N0M 1L0