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HURON RESPITE NETWORK
DIAGNOSIS ASSESSMENT FORM

Name of Adult/Child: ____________________
Date of Birth: ____________________
Parent/Guardian: ____________________
Address: ____________________

Purpose: Respite subsidy assists full time care providers caring for their dependent(s) who are children with developmental, physical and/or mental health disabilities and adults with developmental disabilities to access individualized respite that provides periodic and on going planned care in and out of their homes.

Eligibility: Children with a developmental, physical and/or mental health disability and adults with a developmental disability may be eligible for respite subsidy if they:

- are residents of Huron County
- reside at home with their families
- are not receiving funding through an existing service provider for respite supports

The Ministry of Community and Social Services defines the following:
"**Physical Disability** is a substantial restriction or lack of ability to perform an essential physical activity in a manner within their range considered normal for a person. This shall include individuals with other sensory impairments".

Developmental Disability is defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM IV), outlines the diagnostic criteria for developmental disability (mental retardation) as follows:

- significantly sub average intellectual functioning: an IQ of approximately 70 or below
- concurrent deficits or impairments in present functioning (the person's effectiveness in meeting the standard areas: communication, self care, home living, social/interaction skills, use of community resources, self direction, functional academic skills, work, leisure, health and safety.
- The onset is before the age of 18 years

Mental Health Disability is the presence of a moderate to severe mental health concern as defined by the DSM IV, within the child/youth resulting in significant disruption/reduced functioning/negative impact on the family

Please describe the severity of functional loss(es) (must be completed):

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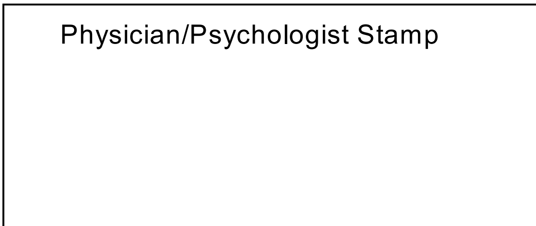
THIS FORM CONFIRMS THE DIAGNOSIS OF:

Developmental Disability _______ Physical Disability Mental Health Disability _____

Date last seen: ____________________

____________________ ____________________
Signature of Physician/Psychologist Date


Physician/Psychologist Stamp