**PLEASE PRINT**

|  |  |
| --- | --- |
| **Child’s Last Name:** | **Child’s First Name:** |
| DOB:  | GENDER (M/F): | RACE: | SS#: |
| Is the above child currently residing in an out-of-home placement such as residential, foster care or DHS custody? Yes \_\_\_\_ No \_\_\_\_ If yes, what type of placement? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Was child recently released from a crisis center? Yes \_\_\_\_\_ No \_\_\_\_\_ |
| How did you hear about this program? \_\_\_ BH Provider \_\_\_ Crisis Center \_\_\_ Flyer Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Primary Parent/Guardian:** | **Relationship to child:**  |
| Home Address: Street Address, Apt #, Floor  | City, State, Zip: |
| Home Phone #: | Cell Phone #: |
| Email Address: **(Required - DBHIDS will use this to contact you.**) |
| Person(s) authorized to deliver/pickup child: |
| **Emergency Contact:** | **Relationship to child:** |
| Home Address: Street Address, Apt #, Floor  | City, State, Zip: |
| Home Phone #: | Cell Phone # |
| Email Address: |
| **The signature of the parent/guardian verifies that the information provided is accurate and truthful, also that you have read, understand, and agree to follow the attached guidelines for the respite program.** |
| **Parent Signature:** | **Date:** |
| **The section below must be completed and signed by the Behavioral Health Tx Professional.** |
| **Behavioral Health Provider Agency:** |
| **Name of Tx Professional:** |
| Address: Street Address, Floor  | City, State, Zip: |
| Phone #: | Fax #: | Email Address:**Required** |
| Indicate Behavioral Health Services child is currently receiving: \_\_\_\_\_OP Therapy ­­­­­\_\_\_\_\_Family Therapy \_\_\_\_\_Family Based/Focused ­­­­ \_\_\_\_School Based Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Please spell out DSM diagnosis below.** |
| Primary: |
|  |
| Secondary: |
|  |
| **Behavioral Health Tx Professional Signature:** | **Date:** |
| **The signature of the behavioral health Tx professional verifies that the information provided is accurate and truthful and is required for Respite registration.** |
| **Completed documents can be emailed or sent via US mail.**Email completed document to: Respite.DBHIDS@Phila.gov. Please note: It is the sole responsibility of the sender to encrypt and/or provide the proper security measures when sending documents via email.Mail completed document to: DBHIDS Respite Care Program, 801 Market Street, 7th Floor, Philadelphia, PA 19107 Attn: Valarie Oulds |
| DBHIDS Respite Care Program, 801 Market Street, 7th Floor, Philadelphia, PA 19107, Phone: 215-685-4746 dbhids.org/children-s-services/respite/ (website) |
| **DBH Use Only** |

Respite\FY26\Registration Form FY26 Updated 05/29/2025