**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