Respite Care Program

October 2025 to June 2026

Provider Information Form

List up to three registered children in the same household.	
Child's Name:	
Child's Name:	
Child's Name:	
Respite Provider Information	
The Respite provider cannot be the parent of a child who is currently registered to receive Respite services.	
Name:	I am age 18 or older. Yes ____ No _____
Address: Street Address, Apt #, Floor	
City, State, Zip Code: (Must be a PA resident.)	Email address:
Home Telephone #:	Cell Phone #:
Relationship to child:	
Are you currently a Behavioral Health Professional/Provider (TSS, BSC, case manager, therapist, etc.)? Yes _____ No _____ If yes, which agency? _____	
Where will Respite services be provided? Provider's home _____ Child's home_____	
Not including the Respite provider, how many members of the Respite provider's household are ages 14 and older? _____ List household members below.	
Household member name:	
Household member name:	
Household member name:	
Parent/Guardian Name_____ Signature_____ Date_____ **Print**	
Respite Provider Name_____ Signature_____ Date_____ **Print**	

Email completed form to **Respite.DBHIDS@Phila.gov**. or mail to DBHIDS Respite Program, 801 Market Street, 7th Floor, Philadelphia, PA 19107 ATTN Valarie Oulds. You will receive an email to **confirm receipt of this document.**

Please note: It is the sole responsibility of the sender to encrypt and/or provide proper security measures when sending documents via email.

Date approved _____