Individual Respite Provider Application

Aging & Disability Resource Center Directory Montana-ADRC.com

*Name of Individual Respite Provider _____

Address _____

*City, Zip Code _____

*Phone #_____ *Email Address_____

Business URL _____

*Certifications: ☐ CPR/First Aid ☐ Dementia Capable ☐ Nurses Aid ☐ Other: _____

Comfortable with pets: ☐ Yes ☐ No Pet Note: _____

*Caregiving experience: Years_____ Months_____

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*Available Hours & Days:_____

*Service Delivery Area (by county)_____

*Ages Served_____

*Type of Respite (check all that apply): ☐ Adult in-home respite ☐ Adult out-of-home respite
☐ Children's in-home respite ☐ Children's out-of-home respite
☐ Alzheimer's or Dementia respite

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*Describe your relevant experience and interests. Include target population(s) i.e. Alzheimer's, intellectual or physical disability, etc. Feel free to use additional paper if more space is needed.

*How would you like to be contacted (check all that apply): ☐ email ☐ Call to schedule appointment

*Method of Payment Accepted: ☐ Cash/Check ☐ Payment Plan ☐ Other_____

*Languages Available: ☐ English ☐ American Sign Language ☐ Spanish ☐ Other: _____

_____ _____ _____

Signature Title Date

***required**

Please return completed form to:

Developmental Education Assistance Program (DEAP)
2200 Box Elder Suite 151
Miles City, MT 59301

Attn: Vicki Clear (406) 851-5321 or 800-224-6034 – vclear@deapmt.org

Thank you for your interest in providing respite to Montana's caregivers!

MONTANA LIFESPAN RESPITE