

**Advocates for Developmental Disabilities**  
**APPLICATION FOR RESPITE CARE/SPECIAL SITTERS FUNDS**  
**(Please Print)**

Name of individual care was provided for: \_\_\_\_\_

Primary Diagnosis: \_\_\_\_\_

Age of individual: \_\_\_\_\_ (is not used to determine grant eligibility)

Have you checked with your County of Financial Responsibility for funding? Yes \_\_\_\_\_ No \_\_\_\_\_

Date of Service: \_\_\_\_\_

Total amount paid to provider/sitter: \_\_\_\_\_

Total amount requested: \_\_\_\_\_

Name and address of person to be reimbursed: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

By signing below, I agree that I have read the criteria for Advocates for Developmental Disabilities Respite Care/Special Sitters Fund and that the disability defined above is true and I (we) cannot financially afford the above listed request.

**Signatures:**

\_\_\_\_\_  
Provider/Sitter

\_\_\_\_\_  
Family