



# WASHOE COUNTY HUMAN SERVICES AGENCY

350 S. CENTER STREET  
RENO, NEVADA 89501-2103  
PHONE: (775) 337-4470  
FAX: (775) 337-4495

Date: \_\_\_\_\_

Name of Foster Parent making Request: \_\_\_\_\_

I am applying for alternate care funds to be paid to:

- Myself for a family vacation inclusive of my foster child(ren). (*"Inclusive Respite"*)
- A licensed foster parent to care for my foster child(ren) in my absence. (*"Paid Alternative Care"*)
- Other approved alternate care provider (direct care staff, babysitter, or licensed child care staff).

Name of Alternate Caregiver: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Dates: From \_\_\_\_\_ to \_\_\_\_\_ for a total of \_\_\_\_ days.

Foster Child Name(s)	Date of Birth	Assigned Caseworker

In selecting the care provider, I have considered the unique needs and behaviors of each child and have communicated the supervision requirements to maintain child safety. All medical, dental, and therapeutic appointments, as well as visitation and school transportation, have been arranged and covered. I have discussed these arrangements with the child's caseworker and have verified the care provider is in good standing with licensing and/or the child's caseworker and able to accommodate the additional children.

Thank you,

\_\_\_\_\_  
Foster Parent Signature

**\*\* FORM MUST BE SUBMITTED NO LATER THAN 1 WEEK BEFORE ALTERNATIVE CARE. Email to:**  
[HSA-RespiteRequests@washoecounty.gov](mailto:HSA-RespiteRequests@washoecounty.gov)

**\*\* IF USING MORE THAN ONE CARE PROVIDER, PLEASE USE SEPARATE FORMS**

## OFFICE USE ONLY

Approved  Denied  (explain) \_\_\_\_\_

Confirmed care performed & paperwork on file for payment



INTEGRITY



EFFECTIVE  
COMMUNICATION



QUALITY  
PUBLIC SERVICE

350 S. CENTER STREET, RENO, NV 89501

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