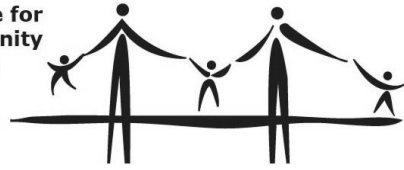




Alliance for
Community
Respite
Care



Funding Form

Name: _____

Date: _____

Address: _____

Phone Number: _____

Are you registered with a Base Service Unit? Yes No

If yes, please check one:

A. Staunton Clinic

B. Chartiers Center

C. UPMC Behavioral Health

D. Mercy Behavioral Health

E. Mon-Yough Community Services, Inc.

F. Family Links at Parent & Child Guidance

G. Mon Valley Supports Coordination

H. Allegheny East MH/MR Center

I. Other: _____
(please indicate)

What is the name of the Case Manager or Independent Supports Coordinator you work with:

Name: _____ Phone: _____

Do you receive any funding that can be used for respite care? Yes No

Signature: _____ Date: _____