Family Caregiver Last Name: ____________________________

Data Collection Form
Colorado Respite Care Program
Family Respite Voucher

Utilization of funds must be completed by expiration date on approval letter.
Notify Colorado Respite Care Program of any unused funds immediately.

Please send one completed Data Collection Form **per family served** to:

Elle Billman
Program Assistant
ebillman@eastersealscolorado.org

Easter Seals Colorado
393 S. Harlan St. Suite 108
Lakewood, CO 80226

Organizational Survey

Name of Organization: ______________________________ Phone: ___________________________

Organizational Contact: _____________________________ Email: ___________________________

What percent of your organization's budget is devoted to respite services for family caregivers? ______

What counties did you serve with this grant? ____

Data Collection Form for Family Served (please complete one per family)

Family Caregiver Last Name:___________________________
Family's city of residence: ___________________________
Family Email: ___________________________ Age/gender of primary caregiver(s): ______________
Age/gender of person with special needs: _________
Number of people in family: _______

List date(s), hours and rates, demonstrating use of respite care funds that your organization provided on behalf of the voucher from the Colorado Respite Care Project.

Date ______________ Number of Hours _____ Rate per hour $____ = Total Amount $______ Type of Respite ___________
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Total hours: ____ **Total $: _____**

Type of respite indicates whether care was in-home, center-based, etc.

Describe type of service provided to family. (i.e. in-home care, day program, etc.)

____
____
____
____

Type of Provider (individual, agency, etc.): _________________________________

Name of Provider: _________________________ **Phone Number of Provider**: ________________________

Respite provider's signature is required.
I confirm by my signature that services were provided as stated above for respite care.

_________________________ __________ ________________________________ __________
Family Caregiver Signature Date Respite Provider Signature Date