



COMMUNITY MENTAL HEALTH
CLINTON • EATON • INGHAM

CSDD RESPITE REQUEST FOR CAMP

Date: _____

Consumer Name: _____
Last Name First Name

Parent(s) Name: _____

Consumer Name: _____

Address: _____

Phone Number: _____

Name of Camp: _____
(Camps Must Be Located In Michigan)

Address of Camp: _____

Phone Number of Camp: _____

Cost of Camp: _____
(Respite Funds will not cover Registration or Activity Fees)

Dates Attending Camp: _____

*****YOU MUST SUBMIT A COPY OF THE REGISTRATION FORM*****

Parent Signature: _____

CC: Case Manager: _____

FOR OFFICE USE ONLY			
Consumer #: _____	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Non-Medicaid	Date Paid: _____
Funds Available: \$ _____	Co-Pay: \$ _____	Amount: \$ _____	