CMH

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 #:_____ ☐ Medicaid ☐ Non-Medicaid Date Paid:_____

Funds Available: $_____ Co-Pay: $_____ Amount: $_____

Revised February 2012