



## YMCA RESPITE CLIENT INFORMATION PACKET

Primary Kinship Caregiver/Guardian Data (Please Print)

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

<b>*First Name:</b>	
<b>Middle Initial:</b>	
<b>*Last Name:</b>	
<b>*Birthdate:</b>	
<b>Age:</b>	
<b>*What is your Gender? (check only one)</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Genderqueer/ Gender Non-Binary <input type="checkbox"/> Not Listed, please specify: <hr/> <input type="checkbox"/> Declined/ not stated
<b>*What was your sex at birth? (Check only one)</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Declined to State
<b>*How do you describe your sexual orientation or sexual identity (Check only one)</b>	<input type="checkbox"/> Straight/ Heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Gay/ Lesbian/ Same-Gender Loving <input type="checkbox"/> Questioning/ Unsure <input type="checkbox"/> Not Listed, please specify: <hr/> <input type="checkbox"/> Declined/ not stated
<b>Home Address</b>	
<b>Street:</b>	
<b>City:</b>	
<b>*Zip Code &amp; State:</b>	
<b>*Home Phone #</b>	
<b>*Cell Phone #</b>	
<b>Email:</b>	
<b>*Rural</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State

<b>*Lives Alone?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State
<b>*Race?</b>	<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Other Race <input type="checkbox"/> Multiple Race <input type="checkbox"/> Declined to State <b>Asian:</b> <input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian <b>Hawaiian/Other Pacific Islander:</b> <input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Declined to state
<b>*Ethnicity:</b>	<input type="checkbox"/> Non Hispanic/Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Declined to State
<b>*Household Monthly Income:</b>	
<b>*Federal Poverty Level (FPL)</b>	<input type="checkbox"/> At or Below FPL <input type="checkbox"/> Above FPL <input type="checkbox"/> Declined to State
<b>*Relationship to Child(ren)</b>	<input type="checkbox"/> Grandparent <input type="checkbox"/> Other Relative <input type="checkbox"/> Non-Relative <input type="checkbox"/> Declined to State
<b>*Relationship Status</b>	<input type="checkbox"/> Single (Never Married) <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Declined to State
<b>*Employment</b>	<input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Declined to State
<b>How did you hear about the Program?</b>	<input type="checkbox"/> None <input type="checkbox"/> Kinship Navigator/ Case Manager <input type="checkbox"/> Kinship Support Group

**Kinship Caregiver 2  
(Spouse or other adult in the household)**

<b>Name:</b>	
<b>Age:</b>	
<b>Phone #</b>	
<b>Relationship to Child(ren)</b>	<input type="checkbox"/> Grandparent <input type="checkbox"/> Other Relative <input type="checkbox"/> Non-Relative <input type="checkbox"/> Declined to State

<b>Race:</b>	<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Other Race <input type="checkbox"/> Multiple Race <input type="checkbox"/> Declined to State <b>Asian:</b> <input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian <b>Hawaiian/Other Pacific Islander:</b> <input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander
<b>Ethnicity</b>	<input type="checkbox"/> Non Hispanic/Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Declined to State
<b>Federal Poverty Level (FPL)</b>	<input type="checkbox"/> At or Below FPL <input type="checkbox"/> Above FPL <input type="checkbox"/> Declined to State

### 1. Child

<b>*First Name:</b>	
<b>*Last Name:</b>	
<b>*Birthdate:</b>	
<b>Age:</b>	
<b>School- Grade</b>	
<b>*What is your Gender? (check only one)</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Genderqueer/ Gender Non-Binary <input type="checkbox"/> Not Listed, please specify: <hr/> <input type="checkbox"/> Declined/ not stated
<b>*What was your sex at birth? (Check only one)</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Declined to State
<b>*How do you describe your sexual orientation or sexual identity(Check only one)</b>	<input type="checkbox"/> Straight/ Heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Gay/ Lesbian/ Same-Gender Loving <input type="checkbox"/> Questioning/ Unsure <input type="checkbox"/> Declined/ not stated <input type="checkbox"/> Not Listed, please specify: _____
<b>*Rural</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State

<b>*Lives Alone?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State	
<b>*Race?</b>	<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Other Race <input type="checkbox"/> Multiple Race <input type="checkbox"/> Declined to State <b>Asian:</b> <input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian <b>Hawaiian/Other Pacific Islander:</b> <input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Declined to state	
<b>*Ethnicity:</b>	<input type="checkbox"/> Non Hispanic/Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Declined to State	
<b>*Federal Poverty Level (FPL)</b>	<input type="checkbox"/> At or Below FPL <input type="checkbox"/> Above FPL <input type="checkbox"/> Declined to State	
<b>*Relationship Status</b>	<input type="checkbox"/> Single (Never Married) <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Declined to State	
<b>Relationship to Caregiver?</b>		
<b>What type of Legal Rights do you have for this child?</b>	<input type="checkbox"/> Legal Guandianship <input type="checkbox"/> Power of Attorney <input type="checkbox"/> Foster Care <input type="checkbox"/> Informal ( No formal legal rights)	
<b>Does the Child have Special Needs such as Mental or physical disability?</b>	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<b>Type of Special Need:</b>
<b>How long have you been the primary caregiver of the child/ren?</b>		<b>Status of Biological Parents?</b>

## 2. Child

<b>*First Name:</b>	
<b>*Last Name:</b>	
<b>*Birthdate:</b>	

<b>Age:</b>	
<b>School-Grade:</b>	
<b>*What is your Gender? (check only one)</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Genderqueer/ Gender Non-Binary <input type="checkbox"/> Not Listed, please specify: <hr/> <input type="checkbox"/> Declined/ not stated
<b>*What was your sex at birth? (Check only one)</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Declined to State
<b>*How do you describe your sexual orientation or sexual identity( Check only one)</b>	<input type="checkbox"/> Straight/ Heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Gay/ Lesbian/ Same-Gender Loving <input type="checkbox"/> Questioning/ Unsure <input type="checkbox"/> Declined/ not stated <input type="checkbox"/> Not Listed, please specify:_____
<b>*Rural</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State
<b>*Lives Alone?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State
<b>*Race?</b>	<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Other Race <input type="checkbox"/> Multiple Race <input type="checkbox"/> Declined to State <b>Asian:</b> <input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian <b>Hawaiian/Other Pacific Islander:</b> <input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Declined to state
<b>*Ethnicity:</b>	<input type="checkbox"/> Non Hispanic/Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Declined to State
<b>*Federal Poverty Level (FPL)</b>	<input type="checkbox"/> At or Below FPL <input type="checkbox"/> Above FPL <input type="checkbox"/> Declined to State
<b>*Relationship Status</b>	<input type="checkbox"/> Single (Never Married) <input type="checkbox"/> Married <input type="checkbox"/> Separated

	<input type="checkbox"/> Domestic Partner <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Declined to State	
<b>Relationship to Caregiver?</b>		
<b>What type of Legal Rights do you have for this child?</b>	<input type="checkbox"/> Legal Guardianship <input type="checkbox"/> Power of Attorney <input type="checkbox"/> Foster Care <input type="checkbox"/> Informal ( No formal legal rights)	
<b>Does the Child have Special Needs such as Mental or physical disability?</b>	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<b>Type of Special Need:</b>
<b>How long have you been the primary caregiver of the child/ren?</b>		<b>Status of Biological Parents?</b>

### 3. Child

<b>*First Name:</b>	
<b>*Last Name:</b>	
<b>*Birthdate:</b>	
<b>Age:</b>	
<b>School-Grade:</b>	
<b>*What is your Gender? (check only one)</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Genderqueer/ Gender Non-Binary <input type="checkbox"/> Not Listed, please specify: <hr/> <input type="checkbox"/> Declined/ not stated
<b>*What was your sex at birth? (Check only one)</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Declined to State
<b>*How do you describe your sexual orientation or sexual identity( Check only one)</b>	Straight/ Heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Gay/ Lesbian/ Same-Gender Loving <input type="checkbox"/> Questioning/ Unsure <input type="checkbox"/> Declined/ not stated <input type="checkbox"/> Not Listed, please specify: _____

<b>*Rural</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State	
<b>*Lives Alone?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State	
<b>*Race?</b>	<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Other Race <input type="checkbox"/> Multiple Race <input type="checkbox"/> Declined to State <b>Asian:</b> <input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian <b>Hawaiian/Other Pacific Islander:</b> <input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Declined to state	
<b>*Ethnicity:</b>	<input type="checkbox"/> Non Hispanic/Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Declined to State	
<b>*Federal Poverty Level (FPL)</b>	<input type="checkbox"/> At or Below FPL <input type="checkbox"/> Above FPL <input type="checkbox"/> Declined to State	
<b>*Relationship Status</b>	<input type="checkbox"/> Single (Never Married) <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Declined to State	
<b>Relationship to Caregiver?</b>		
<b>What type of Legal Rights do you have for this child?</b>	<input type="checkbox"/> Legal Guardianship <input type="checkbox"/> Power of Attorney <input type="checkbox"/> Foster Care <input type="checkbox"/> Informal ( No formal legal rights)	
<b>Does the Child have Special Needs such as Mental or physical disability?</b>	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<b>Type of Special Need:</b>
<b>How long have you been the primary caregiver of the child/ren?</b>		<b>Status of Biological Parents?</b>

#### 4. Child

<b>*First Name:</b>	
---------------------	--

<b>*Last Name:</b>	
<b>*Birthdate:</b>	
<b>Age:</b>	
<b>School-Grade:</b>	
<b>*What is your Gender? (check only one)</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Genderqueer/ Gender Non-Binary <input type="checkbox"/> Not Listed, please specify: <hr/> <input type="checkbox"/> Declined/ not stated
<b>*What was your sex at birth? (Check only one)</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Declined to State
<b>*How do you describe your sexual orientation or sexual identity(Check only one)</b>	<input type="checkbox"/> Straight/ Heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Declined/ not stated <input type="checkbox"/> Gay/ Lesbian/ Same-Gender Loving <input type="checkbox"/> Questioning/ Unsure <input type="checkbox"/> Not Listed, please specify:
<b>*Rural</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State
<b>*Lives Alone?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No    * How many people in the home_____  <input type="checkbox"/> Declined to State
<b>*Race?</b>	<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Other Race <input type="checkbox"/> Multiple Race <input type="checkbox"/> Declined to State <b>Asian:</b> <input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian <b>Hawaiian/Other Pacific Islander:</b> <input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Declined to state
<b>*Ethnicity:</b>	<input type="checkbox"/> Non Hispanic/Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Declined to State
<b>*Federal Poverty Level (FPL)</b>	<input type="checkbox"/> At or Below FPL <input type="checkbox"/> Above FPL <input type="checkbox"/> Declined to State



<b>*Relationship Status</b>	<input type="checkbox"/> Single (Never Married) <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Declined to State
<b>Relationship to Caregiver?</b>	
<b>What type of Legal Rights do you have for this child?</b>	<input type="checkbox"/> Legal Guandianship <input type="checkbox"/> Power of Attorney <input type="checkbox"/> Foster Care <input type="checkbox"/> Informal ( No formal legal rights)
<b>Does the Child have Special Needs such as Mental or physical disability?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>How long have you been the primary caregiver of the child/ren?</b>	<b>Type of Special Need:</b>  <b>Status of Biological Parents?</b>