ANNE GRADY RESPITE DEPARTMENT
1525 EBER ROAD
HOLLAND, OHIO 43528
419-866-6500

RESPITE SERVICES APPLICATION

Upon completion of this application, you will be contacted by a representative of Noah's House/Adult Respite. An appointment and tour will be set up at that time. This process will take approximately one hour. Should you have any questions or concerns, please feel free to contact us.

Application Date:_____
Person/Agency Responsible for Referral:_____
Valid Email Address:_____@_____.____
Address:_____ Phone:_____
Reason for Respite:_____

I. **IDENTIFICATION:**
Name of Applicant:_____ Date of Birth:_____
Address:_____County of Residence:_____
City: _____ State:_____ Zip Code:_____
Phone:_____ Other phone:_____
Race:_____ Religion:_____ Sex:_____ Hair Color:_____
Eye Color:_____ Height:_____ Weight:_____ Language:_____
Identifying marks:_____

II. **SUPPORTIVE RELATIONSHIPS:**

A. Father's name:_____ Birthdate:_____
Address:_____ Phone:_____
Employed by:_____ Phone:_____
Employer address:_____

B. Mother's name:_____ Birthdate:_____
Address:_____ Phone:_____
Employed by:_____ Phone:_____
Employer address:_____

C. Parent's Marital Status: Married Single Widowed Divorced

D. Legal Guardian:_____
Valid Email Address:_____@_____.____

E. Emergency contacts:
Name:_____ Relationship:_____
Address:_____
Phone:_____ Other phone:_____

F. Emergency Contacts (continued):

Name:_____ Relationship:_____

Address:_____

Phone:_____ Other phone:_____

Name:_____ Relationship:_____

Address:_____

Phone:_____ Other phone:_____

G. Next of Kin not listed above:

Name:_____ Relationship:_____

Residence:_____Phone:_____

Name:_____ Relationship:_____

Residence:_____Phone:_____

Name:_____ Relationship:_____

Residence:_____Phone:_____

III. **FINANCIAL:**

_____ SSI - Amount _____ _____ SSA - Amount _____

_____ Waiver - Name _____ _____ Other - _____

Medicare #:_____ Medicaid #:_____

Insurance: _____

Funding Source For Respite: _____

Social Security #: _____ Name of SASS: _____

Other Applicable Caseworker: _____

Please attach a current copy of all insurance cards

IV. **MEDICAL:**

A. Diagnosis/Condition:_____

_____

B. Past Surgeries: _____

_____

C. Medications/Treatments:_____

_____

C. Special Medical Equipment:_____

_____

D. Allergies:_____

_____

E. Physical Limitations:_____

_____

F. Name of Primary Care Physician:_____

Address:_____ Phone:_____

H. Hospital Of Choice: _____

I. Date of Last Tetanus Shot: _____

J. Has the applicant been hospitalized in the past 12 months? YES OR NO

K. Medical Assessment:
Please answer Yes or No to the following questions:

1. Is the applicant able to identify medication(s)? _____
2. Is the applicant able to indicate why he/she takes medication? Example: for seizures, I get upset easily. _____
3. Can the applicant correctly indicates dose of medication? Example: 25mg, 1 pill, 1 of these little cups filled up to this line. _____
4. Can the applicant indicate health changes or when not feeling well? Example: taking a new pill and now my stomach hurts. _____
5. Is the applicant able to indicate what to do when meds are low? Example: ask staff, go to pharmacy. _____
6. Is the applicant able to indicate what time to take medications either by clock or related to a specific routine in day. Example: after breakfast, before bedtime, 8am. _____
7. Is the applicant physically able to get medications(s) from storage, get medication(s) out of container, and physically take or apply medication? _____

V. **DEVELOPMENTAL ABILITIES:**

Ambulation/Mobility:

_____ walks alone
_____ walks with assistance
_____ sits alone
_____ sits with support in special chair
_____ crawls/moves around on floor
_____ uses walker/crutches
_____ uses wheelchair/moves independently
_____ uses wheelchair needs assistance

Eating:

_____ drinks independently
_____ drinks from cup with assistance
_____ eats independently with utensils
_____ eats using fingers/hands
_____ eats with assistance
_____ needs to be fed
_____ chews, eats regular food
_____ needs special diet – Explain:_____

_____

_____ fed by other than oral means – Explain:_____

_____

Toileting:

_____ uses bathroom independently
_____ indicates need to use bathroom
_____ incontinent - wears diapers
_____ able to use bathroom during day
_____ constipation is a problem
_____ able to use bathroom during night
_____ wipes independently
_____ needs assistance with wiping
_____ uses urinal / bedpan
Other:_____

Dressing:

_____ dresses independently
_____ dresses with assistance
_____ needs assistance with fasteners
_____ needs complete assistance

Personal Hygiene:

_____ bathes/showers independently
_____ brushes teeth independently
_____ needs assistance with bathing/showering
_____ needs assistance with tooth brushing

Communication:

_____ uses speech to communicate
_____ uses some words/phrases
_____ understands simple requests
_____ gestures/vocalizes
_____ uses a communication board or device
_____ no effective communication

Sleeping:

_____ sleeps in bed with side rails
_____ sleeps in bed
_____ sleeps through night
_____ does not sleep through night

What supervision level does the applicant need in their own home. Please circle one:

the kitchen: visual 5 minute checks 10 minute checks 15 minute checks 30 minute checks
the living area: visual 5 minute checks 10 minute checks 15 minute checks 30 minute checks
the bathroom: visual 5 minute checks 10 minute checks 15 minute checks 30 minute checks
while sleeping: 30 minute checks 1 hour checks 2 hour checks

VI. BEHAVIORAL CONCERNS:

Does applicant have any of the following behavioral concerns?

_____ aggression
_____ elopement (leaving the area)
_____ sexual deviance
_____ self-injury
_____ other behavioral issues
_____ property destruction

If you marked any of the above, please explain applicant's behavioral concerns, frequency, and intensity, as well as any interventions used.

Frequency: Daily_____ Weekly_____ Monthly_____

Intensity: Moderate_____ Mild_____ Severe_____

Describe:_____
_____
_____
_____
_____

Does applicant have a behavior program in place? _____ Yes _____ No
If yes, what is the name of the Behavior Support Specialist:_____

VII. **OTHER:**

A. What does applicant do during normal course of day?_____

_____

B. Does applicant attend school, day program, camp? If so, please include name, location, and drop off and pick up times:_____

_____

C. What are some of the applicant's likes/favorite activities?_____

_____

D. Dislikes:_____

E. Does the applicant like to swim? _____ Are they able to swim? _____
Are they able to use swimming pool and spa?_____
Do they need a life jacket?_____

F. When and how often is applicant in need of respite services?

_____ Weekday Comments:_____
_____ Weeknights Comments:_____
_____ Weekends Comments:_____
_____ Emergency Comments:_____
_____ Vacation/Week stays Comments:_____
_____ Other _____

G. When is the best time to contact you to schedule a tour and/or an appointment?_____

_____

H. How did you hear about Anne Grady's respite program?_____

_____

Please note any additional information that you think would be helpful for us to know to provide services to the applicant.

_____
_____
_____
_____
_____
_____