Likes:

Include what is important to the person, what "works," what brings them joy, areas where they excel, what really makes them happy.

Person's Name

Required Supervision:

Include how closely staff should supervise person. Where should staff physically be in relation to individual? How long can person be left alone in a secure area for activity? Nighttime supervision? Community supervision?

Dislikes:

Include things that make the person uncomfortable, that they don't respond well to, that may elicit a negative response, ways of interacting or other things that "don't work."

Risks!

Include all risks that present immediate life threatening danger to the client or others. Include things that should be restricted, supervision protocols, special dietary needs or behavioral triggers and techniques.

Skills and Abilities:

Include things the person is really good at, types of things they do well, special talents – especially those things that may not be readily apparent.

Communication Style:

Include how the person best communicates and the manner they prefer others to communicate with them. If they use technology, include how to use it.

Overnight Planned Respite Services Individualized Agreement

INDIVIDUAL'S NAME			
ADDRESS	CITY	STATE ZIP CODE	
PARENT / GUARDIAN'S NAME			TELEPHONE NUMBER (WITH AREA CODE) ( )
WORK TELEPHONE (WITH AREA CODE) ( )	EMERGENCY TELEPHONE / CELL (WITH AREA CODE) ( )		BACKUP CAREGIVER TELEPHONE / CELL (IF PARENT / GUARDIAN UNAVAILABLE) ( )
ADDRESS	CITY	STATE ZIP CODE	
CASE RESOURCE MANAGER'S NAME			TELEPHONE NUMBER (WITH AREA CODE) ( )

Scheduled dates / times of respite

FROM	TIME	TO	TIME

Part 1. To be completed by Respite Provider after reviewing application and talking with individual / family.

Type of assistance that will be provided to take oral medications (check only one)	☐ Staff will keep all medications secured and administer medications under Nurse Delegation. ☐ Staff will keep all medications secured and provide supervision for oral medications. ☐ Staff will provide reminders only for medications which will not be secured by staff. ☐ Individual does not have any oral medications. ☐ Other (describe):
Type of assistance that will be provided to take topical medications and/or tube feeding (check only one)	☐ Staff will keep medications secured and administer topical medications / treatments / tube feeding under Nurse Delegation. ☐ Staff will keep medications secured and provide supervision for topical medications. ☐ Staff will provide reminders for topical medications which will not be secured. ☐ Individual does not have any topical medications or tube feeding needs. ☐ Other (describe):
Type of assistance that will be provided in performing personal hygiene and activities of daily living	☐ Staff will provide full physical support for hygiene and activities and daily living ☐ Staff will provide some physical support for hygiene and activities and daily living ☐ Staff will provide prompting for hygiene and activities and daily living ☐ Staff will not provide support for hygiene and activities and daily living ☐ Other (describe):
Required staff supervision during day and evening hours within the home (check only one)	☐ Staff will provide 1:1 supervision ☐ Staff will remain close enough to hear individual at all times ☐ Staff will always be nearby and available, but do not need to stay directly with individual at all times ☐ Individual may be left unattended for up to **Number of hours** (must include time)
Required supervision during nighttime (check only one)	☐ Nighttime will staff stay in the respite home and provide 1:1 supervision ☐ Staff will remain close enough to hear individual at all times ☐ Nighttime staff supervision based from respite home, staff may be out of the home for up to **Time** (must include time) ☐ Nighttime staff will be not be based from respite home, but will check in at least once every **Time** (must include time)
Required staff supervision while in the community (check only one)	☐ Staff will accompany individual in the community and provide 1:1 supervision ☐ Staff will accompany individual in the community; may share supervision with other individuals ☐ Individual can safely access community without staff supervision

Activities to be offered / available within the home (check all that apply)	☐ Games ☐ Puzzles ☐ Cooking ☐ Video games ☐ Music ☐ TV / Movies ☐ Crafts ☐ Internet access ☐ Computer ☐ Other (list):
Items individual will bring for in-home entertainment	
Activities to be offered / available within the community (check all that apply)	☐ Library ☐ Bowling ☐ Walk in park / neighborhood ☐ Out to eat ☐ Shopping ☐ Out to movies ☐ Worship services ☐ Other (list):
Spending money / gift cards individual will bring for their cost of community events	☐ Ledger to be kept ☐ Receipts to be kept ☐ Individual able to manage their own money, no ledger or receipts required ☐ Other (describe):
Transportation to be provided during respite stay (check all that apply)	☐ Agency-owned vehicles ☐ Staff-owned vehicles ☐ Generic public transportation ☐ Specialized public transportation ☐ Walking to nearby areas ☐ Other (describe):
Mealtime supports, allergies, and/or accommodations	☐ None ☐ Tube feeding only ☐ Liquid / soft / puree diet ☐ Food cut into bite-sized pieces ☐ Diabetic ☐ Needs staff supervision and assistance while eating ☐ Other (describe):
Medical devices to be used during visit based on assessed need (instructions for use to be provided to staff)	☐ None ☐ Hoyer lift ☐ Bed rails ☐ Helmet ☐ Other (describe):
Necessary environmental safety accommodations	☐ None ☐ Cleaning supplies locked ☐ Other (describe):
Other items individual will bring with them (check all that apply)	☐ Medications ☐ Wheelchair ☐ Walker ☐ Briefs ☐ Toiletries ☐ Other medical device / equipment:

Overnight planned Respite Service Provider review and signature

SIGNATURE OF PERSON COMPLETING FORM DATE	PRINTED NAME

Part 2. To be completed by parent / guardian / caregiver after reviewing Respite Agreement.

Medication changes since initial respite application completed	☐ None ☐ List:
Health, behavioral or other changes since initial respite application completed	☐ None ☐ List:

Any other identified needs and/or changes required to respite agreement: ☐ None ☐ Yes (please describe):

I understand that there are some known risks with the use of medical devices. After considering the anticipated benefits and safety risks, I consent for the staff to use the following medical devices: ☐ None ☐ Hoyer lift ☐ Bed rails ☐ Helmet ☐ Other (please describe):

Signatures

PARENT / GUARDIAN / CAREGIVER'S SIGNATURE DATE	PRINTED NAME	DATE SUBMITTED TO DDA CASE RESOURCE MANAGER
PROVIDER'S SIGNATURE DATE	PRINTED NAME	

Part 3. To be completed by all staff after reviewing respite agreement and before working alone with individual.

Staff signatures below are required prior to working alone with an Overnight Planned Respite Services client and indicate that they have read, understood, and agree to support services as outlined in the Overnight Planned Respite Services agreement:

PRINTED NAME	STAFF SIGNATURE	DATE