DEVELOPMENTAL DISABIITIES ADMINISTRATION (DDA)

Respite Application

for Overnight Planned Respite (OPRS), Emergent and/or Planned Short-Term Stay Services at an RHC

Please attach current DDA Assessment Details, valid DSHS consent form 14-012, and any other relevant information such as a PBSP, FA, Psychiatric evaluation, hospital records, etc. Submit to ARSC@dshs.wa.gov for review.

INDIVIDUAL'S NAME	☐ Male ☐ Female	DATE OF BIRTH

NAME(S) INDIVIDUAL PREFERS TO BE CALLED

Does this individual have a court appointed guardian? ☐ Yes (if yes, complete the information below) ☐ No

NAME OF COURT APPOINTED GUARDIAN	GUARDIAN TELEPHONE (WITH AREA CODE) ( )
PARENT / PRIMARY CAREGIVER'S NAME	TELEPHONE (WITH AREA CODE) ( )
WORK TELEPHONE (WITH AREA CODE) ( )	EMERGENCY TELEPHONE / CELL ( )

ADDRESS	CITY	STATE	ZIP CODE

CURRENT LIVING STATUS

☐ Family home
☐ Hospital (admitted)
☐ Hospital emergency room
☐ Jail
☐ Own home (Supported Living)
☐ Adult Family Home
☐ Group Home
☐ Psychiatric setting
☐ Other (specify):

DDA CRM	TELEPHONE (WITH AREA CODE) ( )

Requested dates for planned respite / STS: Please include number of days utilized to date this calendar year **including** the number of days currently being requested.

Type of Respite:

☐ Overnight Planned Respite (please select specific location):
☐ Spokane ☐ Olympia ☐ Shoreline ☐ Yakima ☐ Bellingham
Total number of days utilized this calendar year: ______ days

☐ RHC Planned Short-term Stay services (include in social summary if a specific RHC is being requested and why)
Total number of days utilized this calendar year: ______ days

☐ RHC Emergent Short-term Stay services (requires regional management approval)

DATES OF REQUESTED RESPITE / STS	TRANSPORTATION PROVIDED BY:
to	
to	
to	

Dates are not finalized until request has been approved by respite committee.

Social Summary

Reason for referral (please include resources used to date, alternatives explored, description of current behaviors, pertinent mental health information, and discharge plan):

Please check any behaviors the respite provider should be aware of:

- ☐ Anorexia
- ☐ Biting
- ☐ Bulimia
- ☐ Elopement
- ☐ Encopresis / enuresis
- ☐ Head banging
- ☐ Inappropriate sexual behaviors
- ☐ Loud vocalizations
- ☐ Physical aggression
- ☐ PICA
- ☐ Property destruction
- ☐ Self-injurious behaviors
- ☐ Sensory / noise / touch
- ☐ Verbal Aggression
- ☐ Wandering
- ☐ None
- ☐ Other

Support Needs

Daytime, nighttime, and community supervision needs (earshot, line of sight, how long can the individual be left alone in a secure area with activity, etc.):

Restrictions in place at current residence (door / window alarms, food restrictions, other):

Please describe any accessibility needs (ramp, roll-in shower, shower chair, Hoyer lift, etc.):

Describe what type of assistance is needed to take medications and/or apply medicated ointments or drops (including vitamins):

- ☐ Supervision only
- ☐ Verbal Prompts
- ☐ Hand in cup
- ☐ Crushed in food
- ☐ Physical assistance
- ☐ Medications administered via g-tube
- ☐ Individual does not have any oral / topical medications
- ☐ Other:

Backup Caregiver

This person should be available in the event of an emergency and the primary caregiver is unable to be reached.

NAME	RELATIONSHIP TO CLIENT	TELEPHONE (WITH AREA CODE)
		( )

Other Information

List any other pertinent information including preferred activities, likes / dislikes, strengths, abilities: