

Children's Respite Application

Initial Request Updated Request

TYPE OF RESPITE REQUESTED:

Enhanced Respite Services (ERS)

Is the family open to accessing ERS outside of the region? Yes No

Dedicated Respite

Waiver Funded Respite in a licensed setting

Please attach DDA assessment details, IEP, PBSP, valid consent for release of information (please include "Other DSHS contracted providers: Licensed Staffed Residential" on the consent), and any other relevant information.

INDIVIDUAL'S NAME	DATE OF BIRTH	ADSA ID NUMBER	REGION
ADDRESS	CITY	STATE	ZIP CODE

PARENT / GUARDIAN		TELEPHONE NUMBER
WORK TELEPHONE	EMERGENCY TELEPHONE / CELL	BACKUP CAREGIVER TELEPHONE / CELL (IF PARENT / GUARDIAN UNAVAILABLE)
ADDRESS	CITY	STATE ZIP CODE

DDA CRM	TELEPHONE NUMBER
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Proposed Dates / Times of Respite* (This is only to be used if accessing dedicated or waiver funded respite)

	FROM	TIME	TO	TIME
1.				
2.				
3.				

* Times / dates are not finalized until the request has been formerly approved. Emergencies and crises' may supersede and/or impact previously planned respite.

Education

SCHOOL'S NAME	SCHOOL DISTRICT
ADDRESS	CITY STATE ZIP CODE
TEACHER'S NAME	WORK TELEPHONE

Does the child attend a full-school day (six hours)? Yes No

Briefly describe school supports:

Medical

PROVIDER ONE ID			
CURRENT MEDICATIONS	DOSE	FREQUENCY	REASON PRESCRIBED
PRN MEDICATIONS	DESCRIBE PROTOCOL FOR USE		

Describe what type of assistance is needed to take medications: <input type="checkbox"/> Prompts <input type="checkbox"/> Hand in cup <input type="checkbox"/> Crushed in food <input type="checkbox"/> Physical assistance <input type="checkbox"/> Other:	
ALLERGIES (DESCRIBE)	
DIETARY RESTRICTIONS / FOOD PREFERENCES (DESCRIBE)	
SEIZURE DISORDER <input type="checkbox"/> Yes <input type="checkbox"/> No	
Describe type, frequency, last seizure and prescribed seizure protocol (if any):	
PRIMARY PHYSICIAN	TELEPHONE NUMBER
DENTIST	TELEPHONE NUMBER
OTHER PHYSICIAN(S) (SPECIFY TYPE)	TELEPHONE NUMBER
Describe how the client indicates they are experiencing pain:	
Describe speech and communication abilities including support needs such as: PECS, Visual schedule, communication device, etc.:	
Behavioral	
<input type="checkbox"/> Wandering / Elopement <input type="checkbox"/> Throwing objects <input type="checkbox"/> Self-injurious behaviors <input type="checkbox"/> Hiding <input type="checkbox"/> Property destruction <input type="checkbox"/> Physically assaultive <input type="checkbox"/> Darts into traffic <input type="checkbox"/> Stimulus <input type="checkbox"/> Fecal issues <input type="checkbox"/> Opens moving car door <input type="checkbox"/> Sensory / noise / touch <input type="checkbox"/> Inappropriate urination <input type="checkbox"/> PICA (eats inedible objects) <input type="checkbox"/> Bulimia <input type="checkbox"/> Loud vocalizations <input type="checkbox"/> Ingests hazardous substances <input type="checkbox"/> Anorexia <input type="checkbox"/> Biting <input type="checkbox"/> Fire setting <input type="checkbox"/> Head banging <input type="checkbox"/> Inappropriate sexual behaviors	
What are things to avoid (loud music, touch, food, etc.)?	
What safety issues are of concern to you?	
Supervision Requirements: Describe the level of supervision for health and safety: minimal, line of sight, one to one, awake staff, etc.	
Are alarms currently being used in your home? If so, please describe.	
Community Supervision Needs (1 to 1 in community due to challenges, can be supervised with other children):	

Note: Children with violent sexual issues or clients on the community protection database may not be eligible for respite services. A client with inappropriate sexual behaviors may be required to have a current risk assessment or individual with challenging needs assessment completed prior to the approval for respite.

From the start to the end of a typical day, describe the client's routines and preferences including times client awakens and goes to bed, mealtimes, bathing/showering times. Please indicate how a typical day is spent:

6 – 7 a.m.

7 - 8 a.m.

8 - 9 a.m.

9 - 10 a.m.

10 - 11 a.m.

11 a.m. - Noon

Noon – 1 p.m.

1 - 2 p.m.

2 - 3 p.m.

3 - 4 p.m.

4 - 5 p.m.

5 - 6 p.m.

6 - 7 p.m.

7 - 8 p.m.

8 - 9 p.m.

9 - 10 p.m.

10 - 11 p.m.

11 p.m. - Midnight

Recreation / Activities / Community Participation
Describe personal preferences in the following areas.

Recreational and leisure activities:

Preferred environments (favorite places, busy or quiet places, being alone, specific places to avoid):

In-home activities: Describe preferred activities and those to avoid in the home. (TV, computer, art, games, etc.)

Any cultural or religious support requirements?

Visitors - List people who are allowed to visit your child during the respite stay.

NAME	TYPE OF CONTACT APPROVED <input type="checkbox"/> Visit <input type="checkbox"/> Telephone	TELEPHONE NUMBER
ADDRESS	CITY	STATE ZIP CODE

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Application Review and Signatures

NAME OF PERSON COMPLETING FORM	SIGNATURE	DATE
VPS COORDINATOR/DESIGNEE SIGNATURE		DATE