

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.

DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)
**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.

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

Activities to be offered / available within the home (check all that apply)	<input type="checkbox"/> Games <input type="checkbox"/> Puzzles <input type="checkbox"/> Cooking <input type="checkbox"/> Video games <input type="checkbox"/> Music <input type="checkbox"/> TV / Movies <input type="checkbox"/> Crafts <input type="checkbox"/> Internet access <input type="checkbox"/> Computer <input type="checkbox"/> Other (list):
Items individual will bring for in-home entertainment	
Activities to be offered / available within the community (check all that apply)	<input type="checkbox"/> Library <input type="checkbox"/> Bowling <input type="checkbox"/> Walk in park / neighborhood <input type="checkbox"/> Out to eat <input type="checkbox"/> Shopping <input type="checkbox"/> Out to movies <input type="checkbox"/> Worship services <input type="checkbox"/> Other (list):
Spending money / gift cards individual will bring for their cost of community events	<input type="checkbox"/> Ledger to be kept <input type="checkbox"/> Receipts to be kept <input type="checkbox"/> Individual able to manage their own money, no ledger or receipts required <input type="checkbox"/> Other (describe):
Transportation to be provided during respite stay (check all that apply)	<input type="checkbox"/> Agency-owned vehicles <input type="checkbox"/> Staff-owned vehicles <input type="checkbox"/> Generic public transportation <input type="checkbox"/> Specialized public transportation <input type="checkbox"/> Walking to nearby areas <input type="checkbox"/> Other (describe):
Mealtime supports, allergies, and/or accommodations	<input type="checkbox"/> None <input type="checkbox"/> Tube feeding only <input type="checkbox"/> Liquid / soft / puree diet <input type="checkbox"/> Food cut into bite-sized pieces <input type="checkbox"/> Diabetic <input type="checkbox"/> Needs staff supervision and assistance while eating <input type="checkbox"/> Other (describe):
Medical devices to be used during visit based on assessed need (instructions for use to be provided to staff)	<input type="checkbox"/> None <input type="checkbox"/> Hoyer lift <input type="checkbox"/> Bed rails <input type="checkbox"/> Helmet <input type="checkbox"/> Other (describe):
Necessary environmental safety accommodations	<input type="checkbox"/> None <input type="checkbox"/> Cleaning supplies locked <input type="checkbox"/> Other (describe):
Other items individual will bring with them (check all that apply)	<input type="checkbox"/> Medications <input type="checkbox"/> Wheelchair <input type="checkbox"/> Walker <input type="checkbox"/> Briefs <input type="checkbox"/> Toiletries <input type="checkbox"/> Communications <input type="checkbox"/> Other medical device / equipment:
For communication device if applicable, indicate staff support and instruction for use of device	<input type="checkbox"/> Staff will not provide support for use of communication device <input type="checkbox"/> Staff will provide support for use of communication device If support is provided, staff instructions include:

Overnight planned Respite Service Provider review and signature

SIGNATURE OF PERSON COMPLETING FORM	DATE	PRINTED NAME
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Part 2. To be completed by parent / guardian / caregiver after reviewing Respite Agreement.

Medication changes since initial respite application completed	<input type="checkbox"/> None <input type="checkbox"/> List:
Health, behavioral or other changes since initial respite application completed	<input type="checkbox"/> None <input type="checkbox"/> List:
Any other identified needs and/or changes required to respite agreement: <input type="checkbox"/> None <input type="checkbox"/> 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):

