Washington State Department of Social & Health Services
Transforming lives

DEVELOPMENTAL DISABILITIES 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 | ADSA ID | ☐ Male ☐ Female | DATE OF BIRTH | AGE |
|---|---|---|---|---|
| | | | | |

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

| 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 ☐ Lynnwood ☐ Vancouver ☐ Tacoma
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 (used for only emergent and planned STS)**

Reason for request (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: