The Arc
Oneida-Lewis Chapter, NYSARC

Community and Family Services
Respite Care Home Application

Date of Application: _____

Name: _____
(Last) (First) (M.I.)

Address: _____
(Street)

_____
(City or Town) (County) (State) (Zip Code)

Phone: _____ _____
(home) (other)

Date of Birth: _____ Age: _____ Sex: ☐ Male ☐ Female

Diagnosis: _____

Medicaid #: _____

Mother: _____ Home Phone: _____
(Name) Cell Phone: _____
Work Phone: _____

Address: _____
(Street) (City/Town) (State) (Zip)

Father: _____ Home Phone: _____
(Name) Cell Phone: _____
Work Phone: _____

Address: _____
(Street) (City/Town) (State) (Zip)

Legal Guardian: _____ Home Phone: _____
(Name) Cell Phone: _____
Work Phone: _____

Address: _____
(Street) (City/Town) (State) (Zip)

Personal Habits:

Applicant's appetite is generally: ☐ poor ☐ average ☐ excessive
Applicant eats: ☐ rapidly ☐ average ☐ slowly
Self feeding: ☐ yes ☐ no
Is applicant able to cut food? ☐ yes ☐ no

If assistance is required, please explain: _____

Most liked foods: _____

Does applicant have a special diet? ☐ yes ☐ no

If yes, explain: _____

Applicant sleeps: ☐ Well/soundly ☐ poor/restlessly
Does applicant take nap? ☐ yes ☐ no
Does applicant practice any bedtime "rituals" (ie: prayers, reading, etc.)?
☐ yes ☐ no

If yes, describe: _____

Does applicant use bed rails? ☐ yes ☐ no
Does applicant sleepwalk? ☐ yes ☐ no

If yes, please elaborate: _____

Communication Skills:

How does the applicant express their needs and wants? _____

_____

Socialization Skills:

Describe the applicant's ability to get along with others:
☐ excellent ☐ good ☐ fair ☐ poor

Does applicant function best:
☐ individually ☐ in small groups ☐ in gender-specific group ☐ any

Has applicant ever been away from home before? ☐ yes ☐ no

How do you expect applicant to respond to being away from home? _____

_____

Do you anticipate problems of adjustment? ☐ yes ☐ no

If yes, what steps can staff take to remedy the situation? _____

_____

_____

Behavior Issues:

Does the applicant demonstrate any problematic behavior (biting, hitting, mood swings, temper tantrums, etc.)? ☐ yes ☐ no

If yes, list behavior(s) and what is done to diminish this behavior: _____

_____

_____

Mobility

Please check all that apply:

Walks ☐ yes ☐ no

- ☐ Alone
- ☐ Assisted
- ☐ Unsteady
- ☐ Uses walker
- ☐ Uses crutches or cane

Uses Wheelchair ☐ yes ☐ no

- ☐ Transfers Alone
- ☐ Transfers with one person
- ☐ Transfers with two people

Self-Help Skills:

Is applicant capable of being responsible for their personal effects (i.e.: clothing, toiletries, etc.)? ☐ yes ☐ no

Please check all that apply:

Toileting

- ☐ fully independent
- ☐ indicates need; has occasional accidents
- ☐ indicates need; needs assistance with hygiene afterwards
- ☐ indicates need; needs considerable assistance
- ☐ has accidents ☐day ☐ night
- ☐ night time incontinence
- ☐ Toileting Schedule: _____
- ☐ wears adult undergarments

Shampooing Hair

- ☐ fully independent
- ☐ needs minimal supervision
- ☐ needs considerable assistance

Combing / Brushing Hair

- ☐ fully independent
- ☐ needs minimal assistance
- ☐ needs considerable assistance
- ☐ Night time only

Preference (circle one): Bath or Shower

Showering
- ☐ fully independent
- ☐ needs minimal assistance
- ☐ needs supervision while in shower
- ☐ needs considerable assistance

Teeth Brushing
- ☐ fully independent
- ☐ needs minimal assistance
- ☐ needs considerable assistance

Dressing
- ☐ fully independent
- ☐ dresses independently, needs assistance selecting clothing
- ☐ dresses self with minimal supervision; needs reminders to zip or button clothing
- ☐ dresses with assistance
- ☐ needs considerable assistance

Shaving (male applicants only):

Does applicant need assistance with shaving? ☐ yes ☐ no

Menstruation (female applicants only):

If applicant menstruates, is there any unusual discomfort? ☐ yes ☐ no

Remedy: _____ Assistance needed? ☐ yes ☐ no

Safety:

Does applicant recognize fire or other emergencies? ☐ yes ☐ no

Please explain: _____

_____

Likes and Dislikes: List other information about the individual that the Respite Care Staff should be made aware of including habits, fears, hobbies, interests, etc.

_____

_____

_____

_____

Program Information

Employment / Day Program:

Please check the appropriate boxes:

☐ Day Program ☐ Competitive Employment (where?) _____

☐ Workshop ☐School: _____

☐ Other: _____

Contact Person's Name: _____ Phone Number: _____

Other agencies providing services

Agency Contact Person Phone

_____

_____

_____

Medical Information

Medical Information:

Physician: _____ Telephone: _____

Medicaid #: _____ Medicare #: _____

Other Insurance: _____ Policy #: _____

Medical Conditions / diagnosis: _____

Allergies: _____

Reaction: _____

Medication

Please list the medication the application is currently taking

_____

_____

_____

_____

_____

_____

_____

Has applicant ever had a seizure? ☐ yes ☐ no

Are seizures controlled? ☐ yes ☐ no

Can individual recognize oncoming seizure? ☐ yes ☐ no

Please state type and date of last seizure: _____

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Community and Family Services
Respite Care Home
Alternate Placement Agreement

Applicant's Name: _____

If, in the judgment of the Respite Care Home Manager, the above-named individual's needs cannot be adequately accommodated in the Respite Care Home, the Alternate Placement below agrees to be responsible for the individual's welfare while the parents or primary caregiver are absent.

It is the responsibility of individual's primary caregiver to notify the Alternate Placement of their plans for the individual's visit prior to each stay at the Respite Care Home.

The Alternate Placement agrees to remain available by phone to the Respite Care Home staff for the duration of the individual's visit.

If the Alternate Placement is contacted by the Respite Care Home Manager or by his/her designee, the Alternate Placement will provide transportation for the individual from the Respite Care Home to his/her home.

_____
Name of Alternate Placement **(Please Print)**

_____
Relationship to Individual

_____
Address City/Town Zip

_____
Home Phone Hours Available

_____
Cell Phone Hours Available

_____
Work Phone Hours Available

_____ _____
Signature of person providing Alternate Placement Date

The Arc
Oneida-Lewis Chapter, NYSARC

Community and Family Services
Respite Care Home
Admission Agreement

This is the Admission Agreement between The Arc, Oneida-Lewis Chapter NYSARC Respite Care Home and _____
Name of Individual
and/or_____
Parent/Guardian
which outlines the individual's admission and visiting arrangement by the Respite Care Home, located at 668 Catherine Street Utica, New York, 13501 at (315) 735-4049.
This agreement shall be attached to the Application for Admission provided by The Arc Respite Care Home.

The parties of the Agreement understand that The Arc's Respite Care Home is a respite care facility providing room, board and personal services to the individual in accordance with the guidelines of the New York State Office of Persons with Developmental Disabilities (OPWDD).

The criteria for admission are:

1. Individual must be Medicaid Waiver eligible.
2. Individual must not have had instances of aggression towards others in the past year.
3. Individual must be able to respond to staff's guidance.
4. Individual must be capable of being evacuated in the event of an emergency either independently or with assistance from no more than 1 staff.
5. Individual must not require continuous 1:1 supervision.

The Respite Care Home will not be able to provide service to individuals requiring:

1. Assessment of glucose levels
2. Injections
3. Tube Feeding

The Respite Care Home will be responsible for provision of the following:

1. Room and board, including three meals daily and snacks.
2. 24-hour supervision with awake staff at all time.
3. Special diet as required by physician.
4. Assistance in obtaining access to necessary health services.
5. Supervised activities.
6. Oversight of health and self-care including medication administration by certified personnel.
7. Management and protection of individuals' personal property.
8. Provision of appropriate age / gender sleeping arrangements.
9. Provision of transportation to and from the Respite Care Home planned activities.

The individual (or responsible party) shall be responsible for the following:

1. A dated and signed physical examination and two mantoux (tuberculosis) clearances within one year. Thereafter, an annual physical exam and additional examinations considered necessary by the physician or The Arc's Respite Care Home staff.
2. A supply of personal clothing and personal toiletries.
3. Transportation to and from the Respite Care Home.
4. Payment of all medical expenses, including transportation for medical purposes.
5. Community outing costs.
6. A signed Alternate Placement Agreement.
7. Parent/Guardian will contact the Respite Care Home one week in advance to make a reservation for the individual's stay. Cancelations are requested as soon as possible. If three reservations are made but not upheld, the use of the Respite Care Home will be put on hold for administrative review.

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Respite Care Home
Guidelines for Respite Care

Illness

I. Any person with any of the following signs, symptoms or a diagnosis of an infection will be required to refrain from attending the Respite Care Home until they no longer pose a risk to others.

a) Fever of 101 degrees or above
b) Abnormal drainage from any open area (unless a culture proved negative)
c) Productive cough
d) Sore throat with swollen glands
e) Chills and sweats
f) Episodes of diarrhea and/or vomiting
g) Unexplained onset of rash

II. If a person, while staying at the Respite Care Home, shows any of the above listed symptoms their caregiver or other responsible party will be called so that he/she can be picked up to go home.
People with a diagnosed infection will not attend the Respite Care Home unless they have been on an antibiotic therapy for at least 24 hours and can show proof of such.