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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | DEVELOPMENTAL DISABIITIES ADMINISTRATION (DDA)  **Planned Respite Application**  **for Overnight Planned Respite Services and Planned Respite Service at RHC** | | | | | | | | | |
| Please attach current DDA Assessment Details, valid consent (DSHS 14-012), and any other relevant information such as a PBSP, FA, etc. Upon completion, CRM must submit to [ARSC@dshs.wa.gov](mailto:ARSC@dshs.wa.gov). | | | | | | | | | | |
| CLIENT’S NAME | | | | | | ADSA ID | | Male  Female | DATE OF BIRTH | AGE |
| NAME(S) CLIENT PREFERS TO BE CALLED | | | | | | | | | | |
| Does this individual have a court appointed guardian?  No  Yes (if yes, complete the information below) | | | | | | | | | | |
| NAME OF COURT APPOINTED GUARDIAN | | | | | | | | GUARDIAN TELEPHONE (WITH AREA CODE)  () | | |
|  | | | | | | | | | | |
| PRIMARY CAREGIVER’S NAME | | | | | | | | PRIMARY TELEPHONE (WITH AREA CODE)  () | | |
| EMAIL ADDRESS | | | ADDRESS CITY STATE ZIP CODE | | | | | | | |
| EMAIL ADDRESS  Via email  Via Paper | | | INTERPRETER SERVICES  No  Yes; specific language: | | | | | | | |
| INTERPRETER SERVICES  No  Yes; specify language: | | | | | | | | | | |
| **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)  () | | |
|  | | | | | | | | | | |
| DDA CRM | | | | | REGION | | | TELEPHONE (WITH AREA CODE)  () | | |
| **Current Setting** | | | | | | | | | | |
| Family Home  Hospital  Lives with Individual Provider  Other: | | | | | | | | | | |
| Although note a requirement, indicating vaccination status can expediate the referral process.  COVID-19 vaccination?  Yes  No  Recommended booster per CDC guidelines?  Yes  No | | | | | | | | | | |
| **OPRS Requested Location(s) and Dates (please select only one location)** | | | | | | | | | | |
| At the time of request, please verify the location and dates are available on the [OPRS calendar](https://teamshare.dshs.wa.gov/sites/redp/oprca/_layouts/15/start.aspx#/SitePages/Home.aspx).  Spokane  Bellingham  Lynnwood  Tacoma  Olympia  Vancouver  Bismark  Lidgerwood | | | | | | | | | | |
| **RHC Planned Respite:**  If requesting more than one RHC for consideration, please indicate first, second, and third choice in the prior approval in CARE.  Yakima Valley School  Lakeland Village  Fircrest School | | | | | | | | | | |
| DATES OF REQUESTED RESPITE | | | | TRANSPORTATION PROVIDED BY: | | | | | | |
| to | | | |  | | | | | | |
| to | | | |  | | | | | | |
| to | | | |  | | | | | | |
| **Dates are not finalized until request has been approved by the HQ Respite Coordinator / ARSC designee.** | | | | | | | | | | |
| **Social Summary** | | | | | | | | | | |
| Reason for request, identifying if the primary caregiver will be out of town and/or unavailable during the requested stay: | | | | | | | | | | |
| **Behaviors** | | | | | | | | | | |
| Please check any behaviors the respite provider should be aware of OR None (if applicable): | | | | | | | | | | |
| Anorexia  Biting  Bulimia  Elopement  Encopresis / enuresis  Head banging | | Inappropriate sexual behaviors  Loud vocalizations  Physical aggression  PICA  Property destruction  Self-injurious behaviors | | | | | Sensory / noise / touch  Suicidal attempts / threats  Verbal Aggression  Wandering / not exit-seeking  None  Other | | | |
| **Support Needs** | | | | | | | | | | |
| Describe daytime and community supervision needs (earshot, line of sight, how long can the individual be left alone in a secure area with activity): | | | | | | | | | | |
| Describe nighttime support needs: | | | | | | | | | | |
| Restrictions in place at current residence (door / window alarms, food restrictions, other): | | | | | | | | | | |
| Describe any accessibility support needs and adaptive equipment required (ramp, wheelchair / ramp, roll-in shower, shower chair, Hoyer lift): | | | | | | | | | | |
| Describe any medical support needs, including those related to seizures, diabetes, feeding tubes, colostomy bags, trachs, etc.: | | | | | | | | | | |
| Select the highest type of assistance needed to take medications and/or apply medicated ointments or drops, including vitamins) OR  None (if applicable):  Supervision only  Verbal Prompts  Hand in cup  Crushed in food  Physical assistance  Medications administered via g-tube  Other: | | | | | | | | | | |
| **Other Information** | | | | | | | | | | |
| List any other pertinent information including preferred activities, likes / dislikes, strengths, abilities: | | | | | | | | | | |