

Respite Application

for Overnight Planned, RHC Emergent and/or Planned Respite Services

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.

INDIVIDUAL'S NAME	<input type="checkbox"/> Male	DATE OF BIRTH
<input type="checkbox"/> Female		
NAME(S) INDIVIDUAL PREFERS TO BE CALLED		

PARENT / GUARDIAN'S NAME	TELEPHONE (WITH AREA CODE) ()
WORK TELEPHONE (WITH AREA CODE) ()	EMERGENCY TELEPHONE / CELL ()
BACKUP CAREGIVER TELEPHONE / CELL (IF PARENT / GUARDIAN UNAVAILABLE) ()	
ADDRESS	CITY
STATE ZIP CODE	

CURRENT LIVING STATUS		
<input type="checkbox"/> Family home	<input type="checkbox"/> Adult Family Home	<input type="checkbox"/> Other (specify):
<input type="checkbox"/> Hospital	<input type="checkbox"/> Group Home	
<input type="checkbox"/> Hospital emergency room	<input type="checkbox"/> Companion Home	
<input type="checkbox"/> Jail	<input type="checkbox"/> Psychiatric setting	
<input type="checkbox"/> Own home (Supported Living)		
DDA CRM	TELEPHONE (WITH AREA CODE) ()	

Requested dates for planned respite: 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):
 Shoreline Yakima
 Total number of days utilized this calendar year: _____ days

RHC Planned Respite (include in social summary if a specific RHC is being requested and why)
 Total number of days utilized this calendar year: _____ days

RHC Emergent

FROM	TRANSPORTATION PROVIDED BY:	TO	TRANSPORTATION PROVIDED BY:
DATE:		DATE:	
DATE:		DATE:	
DATE:		DATE:	

Dates are not finalized until request has been approved by respite committee.

Social Summary

Reason for referral (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:

- | | |
|---------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Property destruction | <input type="checkbox"/> Inappropriate sexual behaviors |
| <input type="checkbox"/> Physical aggression | <input type="checkbox"/> Encopresis / enuresis |
| <input type="checkbox"/> Verbal Aggression | <input type="checkbox"/> Loud vocalizations |
| <input type="checkbox"/> Sensory / noise / touch | <input type="checkbox"/> Biting |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> None |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Other |
| <input type="checkbox"/> Self-injurious behaviors | |
| <input type="checkbox"/> Head banging | |

Supervision Requirements

Daytime supervision needs (earshot, line of sight, how long can the individual be left alone in a secure area with activity, etc.):

Nighttime supervision needs (sleeps through night, frequently awakes, wanders, toileting support, etc.):

Community supervision needs:

Restrictions in place at current residence (door / window alarms, food restrictions, other):

Other Information

List any other pertinent information including preferred activities, likes / dislikes, strengths, abilities: