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| 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** | | |  | 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.”** |
| 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?** | | |
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| 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.** | | | | | | |
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| 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.** | | |

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|  | 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)  (     ) | | | |
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| **Scheduled dates / times of respite** | | | | | | | | | | | |
| FROM | | TIME | | | TO | | | | TIME | | |
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| **Part 1. To be completed by Respite Provider after reviewing application and talking with individual / family.** | | | | | | | | | | | |
| Type of assistance that will be provided to take oral medications (check only one) | | Staff will keep all medications secured and administer medications under Nurse Delegation.  Staff will keep all medications secured and provide supervision for oral medications.  Staff will provide reminders only for medications which will not be secured by staff.  Individual does not have any oral medications.  Other (describe): | | | | | | | | | |
| Type of assistance that will be provided to take topical medications and/or tube feeding (check only one) | | Staff will keep medications secured and administer topical medications / treatments / tube feeding under Nurse Delegation.  Staff will keep medications secured and provide supervision for topical medications.  Staff will provide reminders for topical medications which will not be secured.  Individual does not have any topical medications or tube feeding needs.  Other (describe): | | | | | | | | | |
| Type of assistance that will be provided in performing personal hygiene and activities of daily living | | Staff will provide full physical support for hygiene and activities and daily living  Staff will provide some physical support for hygiene and activities and daily living  Staff will provide prompting for hygiene and activities and daily living  Staff will not provide support for hygiene and activities and daily living  Other (describe): | | | | | | | | | |
| Required staff supervision during day and evening hours within the home (check only one) | | Staff will provide 1:1 supervision  Staff will remain close enough to hear individual at all times  Staff will always be nearby and available, but do not need to stay directly with individual at all times  Individual may be left unattended for up to **Number of hours** (must include time) | | | | | | | | | |
| Required supervision during nighttime (check only one) | | Nighttime will staff stay in the respite home and provide 1:1 supervision  Staff will remain close enough to hear individual at all times  Nighttime staff supervision based from respite home, staff may be out of the home for up to **Time** (must include time)  Nighttime staff will be not be based from respite home, but will check in at least once every **Time** (must include time) | | | | | | | | | |
| Required staff supervision while in the community (check only one) | | Staff will accompany individual in the community and provide 1:1 supervision  Staff will accompany individual in the community; may share supervision with other individuals  Individual can safely access community without staff supervision | | | | | | | | | |
| Activities to be offered / available within the home (check all that apply) | | Games  Puzzles  Cooking  Video games  Music  TV / Movies  Crafts  Internet access  Computer  Other (list): | | | | | | | | | |
| Items individual will bring for in-home entertainment | |  | | | | | | | | | |
| Activities to be offered / available within the community (check all that apply) | | Library  Bowling  Walk in park / neighborhood  Out to eat Shopping  Out to movies  Worship services  Other (list): | | | | | | | | | |
| Spending money / gift cards individual will bring for their cost of community events | | Ledger to be kept  Receipts to be kept  Individual able to manage their own money, no ledger or receipts required  Other (describe): | | | | | | | | | |
| Transportation to be provided during respite stay (check all that apply) | | Agency-owned vehicles  Staff-owned vehicles  Generic public transportation  Specialized public transportation  Walking to nearby areas  Other (describe): | | | | | | | | | |
| Mealtime supports, allergies, and/or accommodations | | None  Tube feeding only  Liquid / soft / puree diet  Food cut into bite-sized pieces  Diabetic  Needs staff supervision and assistance while eating  Other (describe): | | | | | | | | | |
| Medical devices to be used during visit based on assessed need (instructions for use to be provided to staff) | | None  Hoyer lift  Bed rails  Helmet  Other (describe): | | | | | | | | | |
| Necessary environmental safety accommodations | | None  Cleaning supplies locked  Other (describe): | | | | | | | | | |
| Other items individual will bring with them (check all that apply) | | Medications  Wheelchair  Walker  Briefs  Toiletries  Communications  Other medical device / equipment: | | | | | | | | | |
| For communication device if applicable, indicate staff support and instruction for use of device | | Staff will not provide support for use of communication device  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 | | | | |
| **Part 2. To be completed by parent / guardian / caregiver after reviewing Respite Agreement.** | | | | | | | | | | | |
| Medication changes since initial respite application completed | | None  List: | | | | | | | | | |
| Health, behavioral or other changes since initial respite application completed | | None  List: | | | | | | | | | |
| Any other identified needs and/or changes required to respite agreement:  None  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): | | | | | | | | | | | |
| **Signatures** | | | | | | | | | | | |
| PARENT / GUARDIAN / CAREGIVER’S SIGNATURE DATE | | | | | | PRINTED NAME | | | | | DATE SUBMITTED TO DDA CASE RESOURCE MANAGER |
| PROVIDER’S SIGNATURE DATE | | | | | | PRINTED NAME | | | | |
| **Part 3. To be completed by all staff after reviewing respite agreement and before working alone with individual.** | | | | | | | | | | | |
| Staff signatures below are required prior to working alone with an Overnight Planned Respite Services client and indicate that they have read, understood, and agree to support services as outlined in the Overnight Planned Respite Services agreement: | | | | | | | | | | | |
| PRINTED NAME | | | | STAFF SIGNATURE | | | | | | DATE | |
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