Functionally Disabled Respite Care Program

DELMARVA COMMUNITY SERVICES
P.O. Box 592 / Cambridge, MD 21613
(410) 221-1940 (410) 376-3144
(410) 476-3105 1-800-439-1222

APPLICATION FOR RESPITE CARE

(Functional Disabilities Program)

Date of application _____
County of Residence _____

CLIENT INFORMATION:

Client Name: _____ Sex: M F Race: _____
Address: _____ Date of Birth: _____
_____ Phone: _____
SSN: _____
Medicare #:_____ Secondary:_____ Other Ins._____
Marital Status: Married____ Separated ___ Divorced ___ Single ____ Widowed _____
Emergency Contact: _____ Phone: _____
Relationship: _____

CAREGIVER INFORMATION:

Spouse/Primary Caregiver: _____
Address: _____
_____
Phone: _____(home) _____ (work)
Relationship to client: _____
Second Emergency Contact: _____ Phone:_____
Relationship: _____

FAMILY INFORMATION:

Living Arrangements: With Spouse___ Spouse and children ___ Children ___ Other Relatives ___
Others (not related) ___ Personal Care Provider ____ Alone ___

Number of individuals living in client's place of residence: ____

Name	Date of Birth	Relation
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Does Client have a Guardian/ Power of Attorney/ Representative Payee? N ___ Y___ , if yes, please specify: _____
_____

CLIENT _____

SERVICES INFORMATION:

What other services is client receiving? (Check all that apply.)

____ Adult Day Care ___ days/week _____ other
____ Home Health ____ hrs/day ____ days/ week _____ other
____ Home Aid/Chore Service ___hrs/day ___ days/week _____ other
____ Help from family ____ hrs/day ____ days/week _____ other
____ Help from friends ____ hrs/day ____ days/week _____ other
____ Medical Supplies _____ specify
____ Meals on Wheels ____ days/week
____ Prescription Assistance
____ Domiciliary Care
____ Public Assistance
____ Food Stamps
____ Hospice
____ Other _____ specify

Describe how much out-of-pocket cost, if any, is incurred through the use of the services checked:
_____
_____

What agencies are providing services?
Dept. of Social Services ____ Contact person: _____ Phone: _____
Health Department ___ Contact person: _____ Phone: _____
Hospice ___ Contact person: _____ Phone: _____
Other _____
Contact Person: _____ Phone: _____

Does the primary caregiver have any specific needs that are not currently being addressed: N___ Y___
Please explain: _____
_____

How did you heard about this program? _____

CLIENT _____

INCOME INFORMATION:

In order to qualify for Respite Care, it is necessary to complete the information below. ***Verification of income is required.*** Examples of proper verification are income tax returns, copies of benefit checks, statement of benefits, etc. Please attach all verifications to application. Income and other information in this application will be updated once a year. Please report any major changes in the client's income (either up or down) of more than $50 per month to the Respite Care Coordinator (410)221-1940.

	Client	***Spouse***
Social Security		
Retirement Pension		
Veteran's Pension		
Supp. Sec. Inc. - SSI		
Salary or Wages		
Public Assistance		
Unemployment Comp.		
Alimony		
Workman Compensation		
Other Income (List income from any other sources: interest, dividends, rentals, royalties, trusts, estates, etc.)		

Total Income: $ _____ /month x 12 = _____ Annual Income

MEDICAL EXPENSES for the client that are related to the disability and are not covered by any insurance or other coverage and incurred within the past 12 months. (Cost of in-home care and day care ***cannot*** be counted as an expense. You can count deductibles and co-payments for hospital stays and doctor visits, insurance premiums, out-of-pocket for prescriptions, over the counter medications related to the disability, medical equipment and supplies related to disability, including incontinent supplies.)***Please attach receipts***.

Type of Expense	***Frequency***	***Cost***	***Date***

Attach separate sheet if necessary. Please attach receipts.

Total Medical Expenses: $ _____

CLIENT _____

MEDICATION INFORMATION:

Medication	***Dose***	***Rate/times given***	***Reason***

Height: _____ **Weight:** _____

DISABILITY/HEALTH INFORMATION:

Disability:
Briefly describe the client's disability (include any type of dementia or memory loss). _____
_____
_____

Seizures:
____ none ____ grand mal _____ petite mal
Frequency: _____ Description: _____
What do you usually do? _____

Allergies:
Describe any allergies to food, medication, plants, animals, etc.
_____
_____

Other health conditions:
Describe any other health conditions that might cause problems. Heart conditions, lung conditions, diabetes, breathing problems, constipation, etc.
_____
_____

List any conditions requiring special care: _____
_____

CLIENT _____

FUNCTIONAL ASSESSMENT:

Please mark for each statement the description which best describes the amount of help the person you care for needs on a typical day:

Question	***Does by self***	***Needs some assistance***	***Cannot perform by self***
1. Does client need help with light chores around the house?			
2. Does client need help with grocery shopping?			
3. Does client need help preparing a light meal, i.e. sandwich?			
4. Does client need help in getting to places outside of walking distance?			
5. Does client need help eating?			
6. Does client need help getting dressed or changing nightclothes?			
7. Does client need help bathing?			
8. Does client need help with maintaining appearance? (combing hair, shaving, etc.)			
9. Does client need help getting to and from toilet?			
10. Does client need help taking own medication?			
11. Does client need help getting into or out of bed or chair?			
12. Does client need help walking?			
13. Does client need help using the telephone?			
14. Does client need help with handling own money?			
15. Does client need help with planning and decision making?			

_____

CLIENT _____

OTHER INFORMATION:

1. Does client wake up during the night? ____No _____Yes. If so, what should be done? _____
_____

2. Does client take a nap? ___No ___Yes. If so, how often? _____

TOILET HABITS:
____ continent
____ incontinent of urine
____ incontinent of bowels
____ incontinent of both urine and bowels
____ wears protective undergarments

MOBILITY:
____ walks independently
____ walker
____ cane
____ wheelchair, sometimes
____ wheelchair, at all times
____ other, please explain

COMMUNICATION:

____ communicates in sentences or phases
____ uses some words
____ does not speak
____ speaks but is difficult to understand
____ uses sign language

____ understands all commands
____ understands most commands
____ understand some commands
____ does not understand commands

Is client sociable? _____
Does client smoke? _____
Describe client's personality or outstanding characteristics: _____
_____

Does client have any behaviors that a careworker should know about? _____
_____
What do you usually do? _____
_____
Additional comments: _____
_____

I affirm that all information given in this application is true to the best of my knowledge.
Signature: _____ Relationship:_____ Date: _____

FOR OFFICE USE ONLY

Income	
Medical Deductions	
Adjusted Income	

Eligibility: _____% subsidy paid by DCS

Agency Family Agreement

The Delmarva Community Services, Inc. (DCS, Inc.) is the administrating agency for the Eastern Shore Respite Care Program, which offers financial reimbursement for respite care services to an applicant, the applicant's family, or an appropriate representative. Your initials in the blanks in front of the numbers signify you understand and agree with the content of each paragraph. This agreement must be signed, dated and each paragraph initialed in order to receive reimbursement for respite care services.

_____1. As the acting representative for _____, I understand that I have the option to recruit my own care worker. If I do not have my own care worker(s) I may voluntarily interview, recruit, and choose a care worker from names I have requested from The Functionally Disabled Respite Care Program or another health or social agency. This care worker is not an employee or agent of Delmarva Community Services, Inc./Functionally Disabled Respite Care Program and has not had a criminal background check. I agree that I will not hold Delmarva Community Services, Inc./Functionally Disabled Respite Care Program liable for anything, which affects the health, safety or welfare of the individual receiving services. I as acting representative take full responsibility for monitoring and supervising the care worker(s) I select.

_____2. I understand that _____ will or I will be reimbursed for these services if we choose and we are responsible for paying the care worker. I further understand that the Eastern Shore Respite Care Program will be responsible for payment only if the Respite Care office has given prior approval. Approval of respite care services will be based on the amount of time allotted per individual and availability of funds.

_____3. Delmarva Community Services' staff has explained that I need to consult a tax advisor to receive advice concerning my tax responsibilities.

_____4. The Respite Care staff has explained one of the options for income tax reporting; the Household Employee's Tax Form, and I will discuss this and any other options with a tax advisor.

_____5. I understand that I take full responsibility for monitoring, hiring, firing, training and tax reporting of the care workers.

_____6. The services requested will be specifically provided to _____. This agreement is valid for respite care services that occur within a one-year period beginning _____ and ending _____.

Signature _____Date _____

Relationship to client _____

FAMILY DESIGNATED CAREWORKERS

I/we _____ have chosen to use the care worker(s) designated below, who I/we have contracted with to provide respite care services to _____ _____.

1. _____
Name of Careworker
_____
Address
_____
City, State, Zip Daytime phone number

2. _____
Name of Careworker
_____
Address
_____
City, State, Zip Daytime phone number

3. _____
Name of Careworker
_____
Address
_____
City, State, Zip Daytime phone number

4. _____
Name of Careworker
_____
Address
_____
City, State, Zip Daytime phone number

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2450 Cambridge Beltway

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Phone 410-476-3105 (Upper Shore)
410-221-1940 (Mid-Shore)
410-376-3144 (Lower Shore)
1-800-439-1222 (Toll Free)

CONSENT FOR RELEASE OF INFORMATION

I, _____, as acting representative for _____, hereby authorize the Delmarva Community Services, Inc./Respite Care Program to receive information verifying income status, benefits, including Social Security, SSI, Veteran's Administration, pensions, medical expenses and insurance, disability, medical history, and any other facts concerning _____ eligibility for benefits.

I also authorize any person, partnership, corporation, association or agency possessing information on the above stated materials to release such information to the Delmarva Community Services, Inc./Respite Care Program.

I also authorize the Delmarva Community Services, Inc./Respite Care Program to contact any person, partnership, corporation, association or agency that has provided written verification of _____ eligibility for assistance.

A COPY OF THIS FORM SHALL BE AS VALID AS THE ORIGINAL

_____ _____
Signature Date

DOCTOR'S STATEMENT

DIRECTIONS FOR PHYSICIAN: An application has been made for respite care for the individual named below. In order to provide respite services, information regarding the individual's disability and level of care is needed. Please answer the following questions and return to **Delmarva Community Services, Inc., Respite Care Program, P.O. Box 592, Cambridge, MD 21613** (410) 221-1940 or Fax (410) 943-3536

Client's name: _____ SSN: _____
Date of Birth: _____
Address: _____

Primary disability diagnosis: _____
Age of onset _____
Secondary diagnosis (s): _____
_____
Does the individual have any cognitive impairments? ___No ___Yes, explain _____
_____

Is the primary condition likely to improve? ___No ___Yes, please give details of prognosis _____
_____

In attempting to assess the degree of care and attention needed, please indicate if the person requires:
A. Supervision of activities of daily living? ___No ___Yes, please describe _____
_____

B. Personal care? ___No ___Yes, please describe _____
_____

C. Skilled Nursing Care? ___ No ___Yes, please describe (tube feeding, wound care, etc.)
_____

Medications and reasons prescribed: _____
_____

Special needs of the individual: _____
_____

Additional comments: _____
_____

Name of physician (print): _____
Address: _____
Phone: _____

Signature of physician: _____ **Date:** _____