# Eastern Shore Respite Providers
# Unified Application

Applicant's Name: _____

Address: _____

_____

DOB: _____ Sex: _____ Race: _____ SS#: _____

Insurance Name: _____ Insurance Number: _____

MA#: _____ Person completing this form: _____

Who does the individual currently live with? Parents ☐ Mother ☐ Father ☐ Relative ☐ Agency ☐ Foster Care ☐

Primary caregiver name: _____
Address: _____

_____

Phone: _____

Please list any other family members living in the home and their relationship:

_____ Relationship: _____
_____ Relationship: _____
_____ Relationship: _____
_____ Relationship: _____

**Emergency Contacts**:

Name: _____
Address: _____
Phone: _____ Cell: _____ Relationship: _____

Name: _____
Address: _____
Phone: _____ Cell: _____ Relationship: _____

**Where does the individual go during the day**:

(School/Day Program): _____
Address: _____
Contact person: _____

**Are there any other providers/agencies, funding, waiver programs involved**:

| Name of Program | Contact Person | Telephone |
|---|---|---|
| | | |

## Health Information

**Primary Diagnosis**
Please describe the applicant's medical or physical conditions and any other concerns that we should know about.

Seizures: _____ Frequency: _____ Description: _____

What is done for the individual if they have a seizure?

**List any allergies and reaction to each: (Medication, food, animals, latex)**

| Type of Allergy | Reaction |
|---|---|
| | |
| | |
| | |

**Current medications taken**:

| Type | Dosage-Frequency | Reason Taking |
|---|---|---|
| | | |
| | | |
| | | |

Does applicant require assistance taking medications properly?

No ☐ Reminder ☐ Staff Administer ☐

**Primary Physician's Name**: _____
Address: _____
Phone Number: _____
Last physical exam: _____

**Psychiatrist Name**: _____
Address: _____
Phone Number _____
Last time seen: _____

**Information about the Applicant**

**Communication**: (Check any which are appropriate and explain, if necessary.)

- ☐ communicates in sentences
- ☐ uses some words
- ☐ doesn't use words
- ☐ uses sign language
- ☐ uses a communication device
- ☐ understands most commands
- ☐ understands some commands
- ☐ does not understand commands

Comments:

**Eating Habits**: (Check those that apply and explain, if necessary.)

- ☐ independent
- ☐ dependent
- ☐ needs supervision for: _____
- ☐ assistance with preparation
- ☐ needs assistance eating

**Diet**: (Check those that apply and explain, if necessary.)

- ☐ regular
- ☐ chopped
- ☐ meats/food ground
- ☐ liquids thickened
- ☐ Other: _____

Restrictions:

Comments:

**Bathing/Hygiene**: (Check "I" for independent, "S" for supervised, "D" for dependent, or "N/A" for each)

- ☐ prefers bath or shower
- ☐ assistance in/out of tub
- ☐ dressing
- ☐ hair care
- ☐ shaving
- ☐ menstrual needs
- ☐ toothbrushing

Comments:

**Toileting**: (Check those that apply and explain, if necessary.)

- ☐ continent
- ☐ stress incontinence
- ☐ frequent UTI
- ☐ incontinent
- ☐ night time incontinence
  - uses Depends: ☐ at all times ☐ night time only ☐ at nap

Comments:

**Sleep Habits**:

Does individual have a bedtime? _____ What time? _____
Does individual take a nap? _____ What time? _____
Does individual wake up during the night? _____
If so, what should be done?

Comments:

**Mobility**: (Check any that are appropriate and comment, if necessary.)

☐ walks independently
☐ walks, but needs some assistance
☐ climbs steps
☐ wheelchair used sometimes
☐ wheelchair used at all times
☐ walker
☐ cane

If applicable, what assistance does the individual need in transferring?

Comments:

**Personal Information**:

Please list hobbies: _____
Is the individual social? _____
Does he/she like animals? _____
Does he/she have favorite TV shows or movies _____
Does he/she smoke? _____
Are there any fears we should be aware of: _____
Please describe the individual's personality traits:

Are there any behaviors a caregiver should be aware of?

Is there a formal behavior plan that would need to be followed? If so, who developed the plan?

FINANCIAL CHECKLIST

Applicant Name _____ Date of Birth_____

In order to qualify for Respite Care, it is necessary to complete the information below. **VERIFICATION OF INCOME IS REQUIRED. PLEASE ATTACH ALL INCOME VERIFICATION TO THE APPLICATION. IF THE APPLICANT IS UNDER THE AGE OF 18, PLEASE INCLUDE THE PARENT'S INCOME AND ANY INCOME THE APPLICANT RECEIVES. IF APPLICANT IS OVER THE AGE OF 18 OR A FOSTER CHILD, LIST THEIR INCOME ONLY.** Examples of proper verification are income tax returns, copies of benefit checks, statement of benefits, etc. Income and other information in this application will be updated once a year. Please report any major changes in the applicant's income (either up or down) of more than $50 per month to the Respite Care Coordinator. List below the monthly or yearly amount of all income.

| | Monthly | Yearly |
|---|---|---|
| Parent/ Guardian Salary | _____ | _____ |
| Social Security Income (SSI) | _____ | _____ |
| Social Security | _____ | _____ |
| Child Support | _____ | _____ |
| Alimony | _____ | _____ |
| Public Assistance | _____ | _____ |
| Veteran's Income | _ _____ | _____ |
| Workman Compensation | _____ | _____ |
| Other: List income from any other sources (rentals, trusts, royalties, estates, pensions, interest or dividends, etc.) | _____ | _____ |
| Total | _____ | _____ |

Describe any unusual financial circumstances that you are having right now such as hospital bills, etc. Please give details. Use the back of this page or a separate page if necessary. I affirm that all information given in this application is true to the best of my knowledge.

_____ _____

Signature of person completing application Date

Relation to applicant_____

**********

FOR OFFICE USE ONLY

Subsidy _____ Redetermination Date_____

**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 from another health or social agency. This care worker is not an employee or agent of Delmarva Community Services, Inc./ has not had a criminal background check. I agree that I will not hold Delmarva Community Services, Inc./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 CAREWORKER

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

_____.

FAMILY DESIGNATED CAREWORKER (S)

1. _____
Name of Careworker(s)

_____
Address

_____ _____
City, State, Zip Code Daytime telephone number

2. _____
Name of Careworker(s)

_____
Address

_____ _____
City, State, Zip Code Daytime telephone number

3. _____
Name of Careworker(s)

_____
Address

_____ _____
City, State, Zip Code Daytime telephone number

4. _____
Name of Careworker(s)

_____
Address

_____ _____
City, State, Zip Code Daytime telephone number

P.O. Box 592
Cambridge, MD 21613
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:** _____