



RESPIRE FUND ADMISSION APPLICATION

Date:
Participant Name:
Date of Birth:
Address:
County:
Phone Number:
Email:

Record #:
Medicaid Number:
Social Security Number:
Referral Source:
Disability:

Resides With: (Give names of those who apply with their employer information if applicable)

Mother:
Employer:
Address:
Phone:

Siblings: List names, ages and disabilities (if any):
Pets: (Types and names)

Father:
Employer:
Address:
Phone:

Will your staff provide Medication Administration during work hours? YES NO
If no, who will administer medication?

Guardian:
Employer:
Address:
Phone:

Does applicant or siblings currently receive any services? Y N
If so, please list.
Additional Information

Primary Care Physician

Name of Physician:
Address:
Phone:

In the event of an emergency, Team Daniel will seek emergency care according to the information provided below unless otherwise directed. Who should be contacted in an emergency, if you are unable to be reached? (Please try to list one relative as one of the two contacts.)

1) Name of Relative:
Address:
2) Name:
Address:

Relationship to Participant:
Home Phone:
Work Phone:
Relationship to Participant:
Home Phone:
Work Phone:

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Please list the name of the hospital that you would prefer your loved one to be taken to in the event of an emergency and you are unable to be reached:

Hospital Name: _____ Phone: _____

Address: _____

MEDICAL PROFILE

Seizures Drug Allergies (List drugs and what kind of reaction occurred in comments) Heart Problems
 Vision Impairments Hearing Impairments Sensory Problems Breathing Difficulties Other _____

Comments: _____

MEDICATIONS

Does this person need medications? Yes No (If yes, please list names, doses, times, and why prescribed)

Name of Medication	Dose	Strength	Time	Who Prescribed?	Why Prescribed?
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_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Comments: _____

COMMUNICATION

What form of communication does this person use? Verbal Sign Language Assistive Device Nonverbal

Other _____

Comments: _____

BEHAVIOR

Friendly Enjoys Socializing Self Abusive Wanderer Enjoys Being Alone Other _____

Does this person have a Behavior Intervention Plan? YES _____ NO _____

Does the Plan include physical and/or chemical restraints? YES _____ NO _____

Does the person take medications for behavior management? YES _____ NO _____

Is this person free from harm or threat from harm? YES _____ NO _____

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Were there any substantiated abuse/neglect/exploitation involving this person over the past year?

YES _____ NO _____

Were there any Accident/Incident Reports involving harm to this person over the past year?

YES _____ NO _____

Comments: _____

PRIVACY/FREEDOM OF MOVEMENT

Does this person have the right to privacy and freedom of movement? YES _____ NO _____

If no, what are the restrictions?

_____ locked doors to leave/enter; _____ door alarm(s); _____ side rails; _____ supervision with hygiene;

_____ supervision with travel; _____ audio/visual monitor

Why is this restriction in place?

Is this restriction part of a Behavior Intervention Plan? YES _____ NO _____

If this is a restriction, what is the plan to reinstate this right?

MOBILITY

Does this person have the ability to move him or herself? Yes No

If yes, how? Ambulatory/Needs No Assistance Ambulatory/Sometimes Needs Assistance (Please explain in comments)

Crawls Non-Ambulatory/But Able To Transfer Self Other _____

Is there any equipment needed in their assistance with mobility? Yes No

If yes, what type? Walker Wheelchair Braces Other _____

Comments: _____

EATING

Feeds Self Needs Assistance (Please describe what type of assistance in comments)

What kinds of foods can or does this person eat? Eats Solid Food Blended Food Mashed Food Baby Food

Finger Food G-Tube Food Bottle Fed Other _____

Does this person have any food allergies or food difficulties? If so, please explain. _____

Comments: _____

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BATHING

How often? _____

What type of bathing? Bath Shower Sponge Bath Other _____

Does this person need assistance? Bathes Self Needs Assistance

If this person needs assistance, please explain how much? _____

Comments: _____

TOILETING

Does this person need assistance? Yes No

If yes, what type of assistance? Reminders Needs Full Assistance Wears Diapers Other _____

Comments: _____

RECREATIONAL ACTIVITIES

Please list activities this person enjoys below.

Comments: _____

VOCATIONAL/JOB

Name of Job/Occupation _____

How is this person compensated for labor he/she does? Salary _____ Hourly _____ Other _____

GUARDIANSHIP

Does the person have a guardian? YES _____ NO _____

If Yes, please note the following: Full Guardianship _____ Limited Guardianship _____

If Limited Guardianship, please select the areas:

_____ Financial; _____ Medical; _____ Legal; _____ Voting; _____ Residential/Vocational/Educational

Is this guardianship the least restricted and most appropriate and why?

If not, what is the plan to change this?



FINANCES

Does this person have control over all his/her finances? YES _____ NO _____

If no, what is the restriction(s)?

_____ Has a representative payee: _____ (Name of Payee)

_____ Has a dual signature on checks

_____ Checkbook retained by someone other than the person: _____ family; _____ agency; _____ other _____

Why is this restriction(s) in place?

What other alternatives to giving this person more control over his/her finances were considered and rejected?

If this is a restriction, what is the plan to reinstate this right?

FREEDOM OF EXPRESSION

Does this person have the same freedom of association and freedom of expression as other citizens? YES _____ NO _____

If no, who is restricted from associating with this person (note if there is a restraining order)?

_____ family member(s); _____ other people in the community; _____ voicing opinions freely and without fear of retaliation;

_____ accessing own records; _____ filing grievances; _____ belonging to groups/organizations (i.e. political/religious/social)

_____ other _____

Why is this restriction in place?

If this is a restriction, what is the plan to reinstate this right?

PERSONAL PROPERTY

Does this person have the right to receive, possess, and use lawful personal property? YES _____ NO _____

If no, what item(s) are restricted?

_____ hygiene supplies; _____ food; _____ bikes/motor vehicles; _____ clothing; _____ stereo equipment, radio, headsets, etc.;

_____ other _____

Why is this restriction in place?

If this is a restriction, what is the plan to reinstate this right?

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Do you have a will? YES NO Do you have a **living will** or a **health care power of attorney**? YES NO
Do you have a DNR (Do Not Resuscitate)? YES NO
Do you need assistance in obtaining one of the above mentioned documents? NO YES If yes, which document? _____

Any other comments you would like to make to help us better meet your needs: _____

I agree to receive Respite services from Team Daniel Foundation for my son/daughter according to the Team Daniel Respite Fund Policy. I give Team Daniel Foundation consent to mail, email, or fax my (or son/daughter's) PHI (Protected Health Information) as related to service delivery.

Participant/Legal Guardian's Signature

Date

Team Daniel Foundation Representative Signature

Date

If you are not registered to vote, would you like to do so today?
Already registered _____; Yes, I would like to register _____