Application for Hope Respite Care

A. Complete this section about the child with an intellectual/developmental disability

Name: _____
First Middle Last

Street Address: _____

City: _____ State: _____ Zip: _____

Race:
- ○ White
- ○ American Indian/Alaska Native
- ○ Asian
- ○ Black/African American
- ○ Native Hawaiian or Pacific Islander
- ○ Hispanic or Latino
- ○ Other _____

Gender: Male Female Date of Birth (MM/DD/YYYY): _____/_____/_____

SSN:_____ RIN: _____

Please explain reason for respite care. Is this an emergency? _____

_____

_____

B. Complete this section about the Parent/Guardian of the child in Section A

Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____ Phone: _____

C. Complete this section about other people who live in the household

Name	Relationship	Date of Birth

D. Complete the following information about the person listed in Section A

Communication		
Is the child verbal?	Y	N
What is the child's primary language?		
Does the child speak/understand English?	Y	N
Does this person use an alternative communication method (for example sign language, communication board, device, iPad, etc)? If yes, describe:		
Does the child use hearing aids?	Y	N
Does the child need physical support to ensure his/her safety?	Y	N

Activities of Daily Living (provide additional details if needed)	*Independent*	*Needs Supervision*	*Needs Assistance*	*N/A*
Bathing/Hair Care				
Shaving				
Skin Care				
Teeth Brushing				
Menstrual Care				
Toileting/Diapers/Pull-ups				
Dressing				
Eating/Drinking				
Walking/Ambulating (uses cane, wheelchair, support?)				
Stair Climbing				
Making Phone Calls				
Cooking/Meal Prep				
Medication Administration				

Please describe some of the child's favorite things (music, toys, tv shows, foods, interests, etc.)

Medical Information		
Does the child have special dietary requirements or restrictions? If yes, describe.	Y	N
Does the child wear a C-Pap or Bi-Pap while sleeping?	Y	N
Does the child use oxygen? If yes, describe?	Y	N
Does the child have a history of seizures? If Yes, describe type and frequency. Provide Copy of seizure protocol. If Yes, what is the date of the last seizure?	Y	N
Does the child have allergies? If yes, describe the allergen and reaction, and provide a copy of any allergen protocol.	Y	N
Does the child use special or adaptive equipment? (Include walker, wheelchair, technology, hearing aides, etc.) Describe.	Y	N
Does the child require transferring by another person?	Y	N
Has the child been medically hospitalized in the last year? If yes, describe reason and/or situation that required hospitalization.	Y	N
Is the child up to date on vaccinations? *Please attach immunization record*.	Y	N

What is the child's full diagnosis?

Behavior Information		
Does the child have a behavior plan? If yes, attach a copy.	Y	N
Does the child exhibit behavior that endangers himself or others? If yes, describe:	Y	N
Has the child had suicide attempts or ideations?	Y	N
Has the child been psychiatrically hospitalized? If yes, describe reason and/or situation that required hospitalization.	Y	N

Behavior Exhibited	*Yes*	*No*	*Frequency*	*Additional Description*
Yelling/Shouting/Screaming				
Biting				
Hitting				
Scratching				
Pinching				
Pushing				
Hair Pulling				
Spitting				
Throwing/Breaking Objects				
Pica				
Body Slamming				
Bullying/Intimidation				
Theft				
Fearfulness				
Restlessness				
Pacing				
Wandering/Elopement/Night Walking				
Aggression				
Inappropriate Sexual Behavior				
Food Stealing				
Food Stuffing/Risk of Choking				

Please Indicate Child's Overall Support Level	**Minimal** (needs little supervision)	**Moderate**	**Extensive** (needs close supervision)

E. Complete the following information about other services provided to the child

Out of Home Support (Child Care/School
Does this child attend a child care or school program? YES NO If Yes, then: Days Attending and # of Hours Each Day (mark all that apply) ○ Mon _____ ○ Fri _____ ○ Tue _____ ○ Sat _____ ○ Wed _____ ○ Sun _____ ○ Thu _____ Child Care/School Name: _____ Contact Person: _____ Phone: _____ Contact Email: _____
Does this child receive 1:1 support in a child care or school program? Yes No
Does this child have an IEP/ISP? Yes No If yes, attach to this application.

In Home Services or Programs (Personal Support/Personal Care)
Does this person receive additional support services (including those provided at home)? Yes No If yes, then: Days Attending and # of Hours Each Day (mark all that apply) ○ Mon _____ ○ Fri _____ ○ Tue _____ ○ Sat _____ ○ Wed _____ ○ Sun _____ ○ Thu _____ Agency Name: _____ Contact Person: _____ Phone: _____ Contact Email: _____
Additional Supports (please describe additional family information that impacts your needs)

What is your plan in the event of an emergency in which your child must leave respite care prior to planned discharge?
DO NOT LEAVE THIS SECTION BLANK.

Where did you learn about Hope's Respite Care Services (please circle)?

Internet Search	Website	Social Media	Family/Friend
Agency (specify)	News Source (specify)	Medical Professional	Other (specify)

What dates are you targeting for the child's stay?	
From:	To:

Certification of Acknowledgement and Understanding

The following statements include:

1. information on how Hope's Respite Program operates;
2. information about how, when, and where respite care is delivered;
3. your duties and obligations regarding the respite services program;
4. your consent to release information for determining eligibility for respite services.

Please read each statement carefully, then initial beside each statement to indicate your understanding and acknowledgement. Sign and date where indicated.

Caregiver Initials:	
	I have attached all necessary supporting documents to this application. I understand that if the supporting documents are not attached, and/or if the application is incomplete, IT WILL NOT BE PROCESSED.
	I understand there is no guarantee that respite will be provided to me simply because I have submitted this application. I have made a copy of my application and supporting documents for my own records.
	I understand that respite is designed to give the live-in, unpaid primary caregiver short term relief. It is not a substitute for child care.
	I understand that Hope's Respite Program is not an entitlement program or a financial assistance program. Benefits are not guaranteed to any group or segment of the population.
	I understand that respite care cannot be used in lieu of child care or school when those programs are closed (with the exception of holidays and breaks).
	I understand that Hope will only provide respite to the child enrolled in the respite program. Hope is not allowed to care for other children or adults who are in the home.

This application provides information about your eligibility for Hope Respite Care. This service is provided based on true, accurate information. This information may be verified with public and private agencies and businesses. You must report any changes to the information provided on this form within 10 days of the change. If you knowingly provide false information, impersonate another person, omit information, or willfully fail to report change, you will be subject to disqualification and denial of services. Hope Respite Care program reserves the right to deny any applicant or terminate Hope Respite Services at any time.

Consent to release information: By signing below, I hereby authorize Hope to contact, review, and obtain records maintained by any person, partnership, corporation, association or governmental agency for establishing proof of eligibility for respite care.

_____ _____

Signature of unpaid, live-in, primary caregiver Date

If you need assistance completing this application, please call us at 217.585.5437.

Application Checklist

Please include ALL documents as outlined below; without these documents, your application WILL NOT BE PROCESSED.

- Complete Application
- Physician's Health Form (signed by physician)
- Immunization Record
- HIPAA Policy and Procedure
- Current IEP/ISP
- Behavior Plan, Seizure Protocol, Allergen Protocol (if applicable)
- Full List of Medication Including Dosage, Time Administered, and How Administered