Washington State Department of Social & Health Services
Transforming lives

DEVELOPMENTAL DISABIITIES ADMINISTRATION (DDA)

Planned Respite Application

for Overnight Planned Respite Services and Planned Respite Service at RHC

Please attach current DDA Assessment Details, valid consent (DSHS 14-012), and any other relevant information such as a PBSP, FA, etc. Upon completion, CRM must submit to ARSC@dshs.wa.gov.

CLIENT'S NAME	ADSA ID	☐ Male ☐ Female	DATE OF BIRTH	AGE

NAME(S) CLIENT PREFERS TO BE CALLED

Does this individual have a court appointed guardian? ☐ No ☐ Yes (if yes, complete the information below)

NAME OF COURT APPOINTED GUARDIAN	GUARDIAN TELEPHONE (WITH AREA CODE) ( )

PRIMARY CAREGIVER'S NAME	PRIMARY TELEPHONE (WITH AREA CODE) ( )

EMAIL ADDRESS	ADDRESS	CITY	STATE	ZIP CODE

EMAIL ADDRESS ☐ Via email ☐ Via Paper	INTERPRETER SERVICES ☐ No ☐ Yes; specific language:

INTERPRETER SERVICES
☐ No ☐ Yes; specify language:

Backup Caregiver

This person should be available in the event of an emergency and the primary caregiver is unable to be reached.

NAME	RELATIONSHIP TO CLIENT	TELEPHONE (WITH AREA CODE) ( )

DDA CRM	REGION	TELEPHONE (WITH AREA CODE) ( )

Current Setting

☐ Family Home ☐ Hospital ☐ Lives with Individual Provider ☐ Other:

Although note a requirement, indicating vaccination status can expediate the referral process.
COVID-19 vaccination? ☐ Yes ☐ No
Recommended booster per CDC guidelines? ☐ Yes ☐ No

OPRS Requested Location(s) and Dates (please select only one location)

At the time of request, please verify the location and dates are available on the OPRS calendar.

☐ Spokane ☐ Bellingham ☐ Lynnwood ☐ Tacoma ☐ Olympia ☐ Vancouver
☐ Bismark
☐ Lidgerwood

RHC Planned Respite: If requesting more than one RHC for consideration, please indicate first, second, and third choice in the prior approval in CARE.

☐ Yakima Valley School ☐ Lakeland Village ☐ Fircrest School

DATES OF REQUESTED RESPITE	TRANSPORTATION PROVIDED BY:
to	
to	
to	

Dates are not finalized until request has been approved by the HQ Respite Coordinator / ARSC designee.

Social Summary

Reason for request, identifying if the primary caregiver will be out of town and/or unavailable during the requested stay:

Behaviors

Please check any behaviors the respite provider should be aware of OR None (if applicable):

- ☐ Anorexia
- ☐ Biting
- ☐ Bulimia
- ☐ Elopement
- ☐ Encopresis / enuresis
- ☐ Head banging
- ☐ Inappropriate sexual behaviors
- ☐ Loud vocalizations
- ☐ Physical aggression
- ☐ PICA
- ☐ Property destruction
- ☐ Self-injurious behaviors
- ☐ Sensory / noise / touch
- ☐ Suicidal attempts / threats
- ☐ Verbal Aggression
- ☐ Wandering / not exit-seeking
- ☐ None
- ☐ Other

Support Needs

Describe daytime and community supervision needs (earshot, line of sight, how long can the individual be left alone in a secure area with activity):

Describe nighttime support needs:

Restrictions in place at current residence (door / window alarms, food restrictions, other):

Describe any accessibility support needs and adaptive equipment required (ramp, wheelchair / ramp, roll-in shower, shower chair, Hoyer lift):

Describe any medical support needs, including those related to seizures, diabetes, feeding tubes, colostomy bags, trachs, etc.:

Select the highest type of assistance needed to take medications and/or apply medicated ointments or drops, including vitamins) OR ☐ None (if applicable):

☐ Supervision only ☐ Verbal Prompts ☐ Hand in cup ☐ Crushed in food ☐ Physical assistance
☐ Medications administered via g-tube ☐ Other:

Other Information

List any other pertinent information including preferred activities, likes / dislikes, strengths, abilities: