Washington State Department of Social & Health Services
Transforming lives

Children's Respite Application

☐ Initial Request ☐ Updated Request

TYPE OF RESPITE REQUESTED:
☐ Enhanced Respite Services (ERS)
☐ Dedicated Respite
☐ Waiver Funded Respite in a licensed setting

Please attach DDA assessment details, IEP, ABA or behavior support plan, valid consent for release of information (please include "Other DSHS contracted providers: Licensed Staffed Residential" on the consent), and any other relevant information.

INDIVIDUAL'S NAME	DATE OF BIRTH	ADSA ID NUMBER	REGION

ADDRESS	CITY	STATE	ZIP CODE

PARENT / GUARDIAN	PRIMARY TELEPHONE NUMBER (WITH AREA CODE)

EMAIL ADDRESS	EMERGENCY TELEPHONE / CELL	BACKUP CAREGIVER TELEPHONE / CELL (IF PARENT / GUARDIAN UNAVAILABLE)

MAILING ADDRESS IF DIFFERENT THAN ABOVE ☐ SAME AS ABOVE CITY STATE ZIP CODE

DDA CRM NAME AND TELEPHONE NUMBER	RECEIVE RESPITE POST-STAY SURVEY FOR ENHANCED RESPITE SERVICES ONLY ☐ Via Email ☐ Via Paper

Is the family willing to travel to Eastern or Western Washington to access Enhanced Respite Services? ☐ Yes ☐ No

INTERPRETER SERVICES
☐ No ☐ Yes; specific language:

Requested Respite Dates* (This is only to be used if accessing dedicated or waiver funded respite)

	FROM	TO	TRANSPORTATION PROVIDED BY:
1.			
2.			
3.			

* Requested respite dates are not finalized until the request has been formerly approved. Unscheduled emergencies may supersede and/or impact previously respite.

Education

SCHOOL'S NAME	SCHOOL DISTRICT

ADDRESS	CITY	STATE	ZIP CODE

TEACHER'S NAME	WORK TELEPHONE

Does the child attend a full-school day (six hours)? ☐ Yes ☐ No

Medical

PROVIDER ONE ID

CURRENT MEDICATIONS	DOSE	FREQUENCY	REASON PRESCRIBED

PRN MEDICATIONS	DESCRIBE PROTOCOL FOR USE

Describe what type of assistance is needed to take medications and/or apply medicated ointments or drops (including vitamins):

☐ Supervision only ☐ Verbal prompts ☐ Hand in cup ☐ Crushed in food ☐ Physical assistance

☐ Medications administered via g-tube ☐ Individual does not have any oral / topical medications

☐ Other:

ALLERGIES (DESCRIBE)

DIETARY RESTRICTIONS / FOOD PREFERENCES (DESCRIBE)

SEIZURE DISORDER? IF YES, PLEASE DESCRIBE TYPE, FREQUENCY, LAST SEIZURE AND INCLUDE A PRESCRIBED SEIZURE PROTOCOL (IF ANY)

☐ Yes ☐ No

PRIMARY PHYSICIAN	TELEPHONE NUMBER
DENTIST	TELEPHONE NUMBER
OTHER PHYSICIAN(S) (SPECIFY TYPE)	TELEPHONE NUMBER
OTHER MEDICAL OR BEHAVIORAL HEALTH PROVIDER (SPECIFY TYPE)	TELEPHONE NUMBER
OTHER MEDICAL OR BEHAVIORAL HEALTH PROVIDER (SPECIFY TYPE)	TELEPHONE NUMBER

Describe how the client indicates they are experiencing pain:

Describe speech and communication abilities including support needs such as: PECS, Visual schedule, communication device, etc.:

Behavioral

☐ Wandering / Elopement	☐ Throwing objects	☐ Self-injurious behaviors
☐ Hiding	☐ Property destruction	☐ Physically assaultive
☐ Darts into traffic	☐ Stimulus	☐ Fecal issues
☐ Opens moving car door	☐ Sensory / noise / touch	☐ Inappropriate urination
☐ PICA (eats inedible objects)	☐ Bulimia	☐ Loud vocalizations
☐ Ingests hazardous substances	☐ Anorexia	☐ Biting
☐ Fire setting	☐ Head banging	☐ Inappropriate sexual behaviors

What is the most concerning behavior displayed at home, in the community and at school?

What are things to avoid (loud music, touch, food, etc.)?

What safety issues are of concern to you?

Supervision Requirements:
Describe the level of supervision for health and safety: minimal, line of sight, one to one, awake staff, etc.

Are any restrictive procedures or physical interventions being used in your home to modify challenging behavior (arm splints, helmets, harness, etc.)? ☐ Yes ☐ No

If yes, please describe. Please note that respite providers may need to request written instructions from the treating professional on the use of protective equipment such as helmets, arm splints, etc.

Is a behavior support plan being utilized at home or school? ☐ Yes ☐ No
If yes, please provide a copy of the plan to be included with the respite application.

Are alarms currently being used in your home? If so, please describe.

Community Supervision Needs (1 to 1 in community due to challenges, can be supervised with other children):

Daily Routines:
Please describe in as much detail as possible each daily routine.

Morning Routine: Please describe the client's routines and preferences including times of day the routine occurs, mealtimes, bathing / showering times.

Evening Routine and Bedtime: Please describe the client's routines and preferences including times of day the routine occurs, mealtimes, bathing / showering times.

Typical School Day Routine: Please describe the client's routines and preferences.

Non-school Day Routine: Please describe the client's routines and preferences.

Recreation / Activities / Community Participation
Describe personal preferences in the following areas.

Preferred recreational and leisure activities in the community:

Preferred activities in the home and community. Activities to avoid in the home and community.

Any cultural or religious support requirements? If yes, please describe.

Visitors - List people who are allowed to visit your child during the respite stay.

NAME	TYPE OF CONTACT APPROVED ☐ Visit ☐ Telephone	TELEPHONE NUMBER
ADDRESS	CITY	STATE ZIP CODE

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ADDRESS	CITY	STATE ZIP CODE

Application Review and Signatures

NAME OF PERSON COMPLETING FORM (IF DIFFERENT THAN THE PARENT)	SIGNATURE	DATE
PARENT SIGNATURE (IF SOMEONE COMPLETED THIS FORM ON YOUR BEHALF)		DATE