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| 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 |
|  |  |  |  |
|  |  |  |  |
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|  |  |  |  |
| 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 [ ]  NoIf 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 [ ]  NoIf 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 ParticipationDescribe 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 |
|  |
| NAME | TYPE OF CONTACT APPROVED**[ ]**  Visit **[ ]**  Telephone | TELEPHONE NUMBER |
| 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 |