

Lifespan Respite Care

Family Intake Form

415 Main Street
Klamath Falls, OR 97601
541-850-5200

Family member/Primary Caregiver Information:

Name of Person Seeking Respite: _____ Date: _____
Site - Address: _____ City: _____ Zip: _____
Mailing Address: _____ City: _____ Zip: _____
Contact Name: _____ Phone: (HM) _____ (Cell) _____
Contact Name: _____ Phone: (HM) _____ (Cell) _____

REQUIRED INFORMATION: Date of Birth _____

Optional: The following 2 questions are optional. The information is used to better tailor a match between you and individuals providing respite care, and for statistical reporting purposes.

Race/Ethnicity:

Alaskan Native American Indian Asian, Pacific Islander
 Black Hispanic (Mexican) Hispanic (other)
 Southeast Asian White Other

Material Status: Single Married Separated Divorced Widowed

Relationship to the individual needing care:

Self Spouse Parent Sibling Child Friend Foster

Where do you need care to be provided

Provider's Home
 Family's Home (live-out)
 Family's Home (live-in)
 Foster Care/Group Home
 Center Based
 Camp/Recreation
 Other

DAY(s) when care is needed:

Su M T W TH F Sa

Hours:

From: ___ am/pm To: ___ am/pm

Are these hours flexible? _____

Type of Schedule

Full Time
 Part Time

Day Schedule

All Day
 Evening
 Overnight
 Morning
 Afternoon
 Weekend
 Vacations/Holidays

Special Schedule

Drop In
 Hourly
 Temp/Emergency
 Sick Care
 24 Hour

Please check all that apply to the individual needing care:

Name of individual needing care: _____

Social Security Number: _____

DOB: _____

(Required Information)

CARE CATEGORY:

- Child (0-17)
- Adult (18-55)
- Elderly (56 +)

CARE GROUP:

- Medical Fragile
- Mental/Emotional Disability
- Physical Disability
- Development Disability
- Speech/Lang Impairment
- Hearing Impairment
- Visual Impairment
- Seizure Disorder
- Alzheimer's
- Health Related
- At Risk of Abuse & Neglect
- Hospice/Terminally Ill
- Other _____

LEVEL OF CARE NEEDED:

- Level 1 Basic
- Level 1 Moderate
- Level 2 Intense

CARE NEEDED:

- Female Needing Care
- Male Needing Care
- Assist with Meds
- Adaptive Equipment
- Toiling Assistance
- Special Feeding
- Immobile
- Heavy Lifting
- Constant Supervision
- Verbally Aggressive
- Physically Aggressive
- Bilingual
- Sign Language
- Non Smoking
- No Pets
- Transportation

(CARE LEVELS SEE PAGE 4)

PAYMENT INFORMATION:

(please indicate the amount you are able to pay for Respite Care Services)

\$____Hour \$____Day \$____Overnight \$____Weekend

Would you like information regarding possible financial assistance? YES____ NO____

Does the individual needing care receive: __SSI __Medicare __Medicaid/OHP

Agencies you are currently receiving services from:

AFS SDSD SCF Voc Rehab Head Start Mental Health
 Dvmtl Disb Other

How did you learn about Lifespan?

Public Health Agency Social Service Agency Doctor
 Hospital School Church
 Crisis Center Support Group Newspaper
 Friend/Relative Self Referred Other

Additional comments and information that may help Lifespan better match your needs with an appropriate Respite Provider. (Diets, adaptive equipment, etc.)

Lifespan Respite Care

WAIVER OF LIABILITY AND RELEASE OF LIMITED INFORMATION

1) I, _____ have been fully informed of the scope of the Lifespan Respite Care Program, and I understand that this agency is only acting as a referral service between those individuals seeking respite care and those individuals willing to provide such care. I understand that respite care providers are not employees or agents of Lifespan Respite Care/SPOKES Unlimited.

I understand that should I (or my child or person for whom I am arranging care) become ill or injured while under the care of a respite care provider, and this occurs through no negligence of the respite care provider, I will hold them blameless for such illness or injury. I authorize any Respite care provider referred by Lifespan Respite Care Program to obtain emergency medical treatment and/or transportation that may be necessary. If expenses are incurred for such emergency medical transportation (i.e. ambulance), medical treatment and/or medication, I understand that Lifespan Respite Care/SPOKES Unlimited is not responsible for payment.

I also agree that Lifespan Respite Care/SPOKES Unlimited will not be held responsible or liable, in any way whatsoever, as a result of any incident which may be construed to adversely affect the health, safety or welfare of myself (or my child or other person for whom I am arranging care) further, I hereby release Lifespan Respite Care, it's agents, employees and assignees from any and all liability of whatsoever nature and kind, and whatsoever occurring, relating to the care of myself (or child or other person for whom I am arranging care). This statement shall be valid unless revised or revoked in writing by me.

2.) I understand that in order for Lifespan Respite Care to provide the most appropriate referrals, there may be times when information about my care needs or the care needs of my child or other person for whom I am arranging care my be discussed with providers. This information will be of a general nature and at no time will my name, address or phone number be disclosed.

I have read and fully understand the above information and agree to such.

Consumer Signature

Date

If physically unable to sign, please mark with and X and have someone witness and sign below.

Witness Signature

Date

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LEVEL OF CARE

KEEP FOR

YOUR INFORMATION

Determination Chart

Note: Individuals needing care may or may not have all the care needs reflected in a given Care Level or may have needs in multiple care levels.

	Level I Basic	Level II Moderate	LEVEL III Intense
Feeding	Independent Functions close to age Level	Verbal Cueing Close supervision for stuffing, choking, etc.	Food pump Gastrostomy tube
Bathing	With Minimal Support	Verbal Cueing Close supervision	Sponge bath Unable to assist
Dressing	Supervision	Verbal Cueing Some assistance with closures	Unable to assist
Toileting	Only need reminders	Walk through toileting	6+ / > 50# & NIT needs diapering
Medication	Able to take oral medications with direction	Multiple medication Close supervision required	Injections Suppositories Hands on assistance with oral medications
Behavior	Responsive to verbal behavior management	Responsive to combination of verbal and physical management	Self-injurious Aggressive Runner/screamer/crier No safety concepts 1:1 supervision
Mobility	Independent Age appropriate with minor supports	Helps with transfers, pivoting, positioning	Inability to help with positioning or movement
Medical Supervision	None/age appropriate	Preventive monitoring Equipment monitoring	Trach care Monitors (apnea, heart, lung) Contagious diseases (HIV/CMV/etc)
Communication	Age appropriate	Survival signs Communication boards	Conversational sign language Interpreter (for family communications) Facilitated communication
Seizures	Febrile only (1-2x) Totally controlled (none within last 6 months)	Semi-controlled, occasional breakthrough, active medical supervision	Uncontrolled Multiple types Long duration History of status episodes

This chart was adapted from resources provided by
ARC Multnomah County