RESPITE INTAKE APPLICATION

3301 BUCKEYE ROAD, SUITE 700

ATLANTA, GA 30341

PHONE (404) 634-4222 FAX (404) 634-1324

Thank you for applying for respite through the InCommunity Respite Program. Respite services provides brief periods of support or relief for families or other unpaid caregivers of individuals with disabilities. Respite is provided in the following situations:

1. When a family or caregiver are in need of support or relief in order to get a break for periods of time during the day or overnight.

2. When the participant needs relief or a break from the caregiver.

3. When relief from caregiving is necessitated by unavoidable circumstances, such as a family emergency.

Respite is intended to be a short-term service for a participant who requires a period of structured support, or when respite services are necessitated by unavoidable circumstances, such as a family emergency.

Respite may be provided as in-home support (when the agency is approved by DBHDD for in home respite) (In the participant's home) and/or out-of-home (participant receives service outside of their home and in the home of an approved provider).

Please print clearly and fill out all pages, including your signature at the end of the application. If any part of this application is not completed in full will delay the processing of this application which result in this application being denied.

SECTION I: DEMOGRAPHIC INFORMATION

Date of Application:

_____

Individual Name:

_____

Individual Age:

_____

Family/Guardian Name:

_____

Relationship to the Individual:

_____

Do you have spouse, partner, other children or family living in the home?

_____

If so, please list those people:

_____

_____

_____

Do you have legal guardianship of the individual?

_____

Mailing Address:

County of Residence:

_____

Permanent Address:

_____

City, State, Zip:

_____

Phone:

_____

_

Social Security Number: _____ Medicaid number:

_____

Gender: Male: _____ Female: _____ DOB: _____

Race: American Indian or Alaska Native ____ Asian or Pacific Native ____

African American or Black ___ Caucasian or White ___ Hispanic or Latino __

Multi-Race/Ethnic Group ____ Other _____

SECTION II: DIAGNOSTIC INFORMATION

DEVELOPMENTAL DISABILITY DIAGNOSIS:

Check which of the following disability categories is most relevant to the identified individual:

_____ Autism Spectrum Disorder

_____ Neurological Impairment (Prior to age 22)

_____ Intellectual Disability

_____ Developmental Delay

_____ Cerebral Palsy

_____ Traumatic Brain Injury (Prior to age 22)

_____ Muscular Dystrophy

_____ Other (Please specify)

_____

AGE AT TIME OF DIAGNOSIS: _____

SECTION III: SUPPORTING DOCUMENTATION

EVERY INDIVIDUAL THAT APPLIES FOR RESPITE MUST BE ENROLLED IN OUR FAMILY SUPPORT PROGRAM: Please make sure you have completed the family support application and received an approval. You must attach the approval with this application.

PLEASE CHECK AND PROVIDE SUPPORTING DOCUMENTATION ATTACHED TO THIS APPLICATION:

_____ Current photo of the individual receiving services

_____ Birth Certificate

_____ Social Security Card

_____ Medicaid Card

_____ Approval letter from Family Support

These documents are required to receive respite services, your application will not be processed without the required documents. We will not accept only a number; you must provide a copy of the actual card.

SECTION IV: CURRENT SERVICE INFORMATION

Please check all current services that the identified individual is receiving:

_____ Now or Comp Waiver through DBHDD

_____ Currently on DBHDD planning list (assigned a PLA)

_____ Family Support services from another Agency

_____ GAAP or Source Waiver

Please list any other services that the identified individual receives that are not listed above:

_____

_____

_____

SECTION V: AGREEMENT SECTION

I understand to be eligible for InCommunity Respite Program, the applicant must be diagnosed with a developmental disability prior to the age of 22. Documentation must show disability. The identified individual lives with me and I am legally responsible for their safety, care, and welfare. I hereby confirm that the information that I have provided on this application is true and accurate to the best of my knowledge.

Responsible Party:

_____

Responsible Party Signature:

_____

WAIVER AND RELEASE

I accept that it is my responsibility as a family member in using this program to select a respite care provider to provide respite to my family member with a disability. I understand that it is my responsibility also to determine the suitability of the respite care provider to provide adequate care to my family member, to acquaint them with the particular needs of my family member receiving respite care and provide evaluation and supervision of all respite care received by my family member. Therefore, on my own behalf and on behalf of my family, I freely and voluntarily accept all risk of personal injury and property damage arising from my family's participation in the Program.

In consideration of my being allowed to participate in the Program and to receive a respite care voucher, I hereby release and discharge InCommunity (GCSS), its officers, directors, employees, agents, and successors, from any and all claims' losses and demands whatsoever that I or my family may hereafter have for injuries or property arising or resulting from my and my family's participation in the Program, all of which claims I hereby waive. I waive my and my family's rights with the full knowledge that InCommunity (GCSS) assumes no liability or responsibility for personal injury or property damage arising from my family's participation in the Program and that InCommunity (GCSS) will not compensate me or my family in any way for any loss or injury I or my family may sustain. I understand and agree that this waiver and release will be fully binding on me, all members of my family, our estates, and our heirs, and that neither I nor any member of my family nor anyone claiming through me or any member of my family will have any legal right assert a claim against InCommunity (GCSS) or its officers, directors, employees, and agents or any of their successors, relating to me and my family's participation in the Program.

This Date of _____, 20_____

Print Participant's name:

_____

Print Responsible Party's name:

_____

Responsible Party's Signature:

_____

DEMOGRAPHIC INFORMATION

Sleeping Arrangements

Communication

How does the participant communicate?
(*Pleas***e** *check* ☑ *all that apply***).**

Can talk without difficulty ( )
Can talk with some difficulty ( )
Makes sounds that are understandable to the parent ( )
Uses Sign Language ( )
Uses communication device ( )

Signboard ( )
Augmentative Communication ( )

Other: (Please List) ( )

_____

_____

Communicates with facial expressions ( )
Does not communicate ( )
Other: _____ ( )
_____

How well does the participant understand what is said to him/her?
(*Pleas***e** *check* ☑ *all that apply***).**

Has no problem with understanding ( )
Requires simple one or two step instructions ( )
Needs gestures to understand ( )
Doesn't understand language ( )
Uses facial expression to understand ( )
Other means of understanding:

_____

_____

Sleep Habits

When is wake up time? _____
When is bed time? _____
When is nap time? _____

Does the participant have specific fears that staff or care providers should know about (e.g. dogs, loud noises)

_____

(*Pleas***e** *check* ☑ *all that apply***).**

Sleeps in a regular bed ( )
Sleeps in a crib ( )
Sleeps in a bed w/ rail ( )
Sleeps in a hospital bed ( )
Other (please describe) ( )

_____

_____

PARTICIPANT PREFERENCES

Does the participant have a certain schedule of activities? If yes, please list times and activities.

_____

_____

_____

Does the participant have favorite activities? Please list.

_____

_____

Does the participant have favorite foods? Please list

_____

_____

Are there certain foods or activities to avoid? Please list

_____

_____

Name: _____

Date: _____

Hygiene

(*Pleas***e** *check* ☑ *all that apply***).**

`Prefers Shower( ) Bath ( )
Washes independently ( )

_____

_____

Are there any specific house rules or other: requirements to be enforced by the respite care provider/agency?

_____

_____

_____

PERSONAL CARE NEEDS

(*Please check* ☑ *all that apply***).**

Mobility

Walks independently	( )
Crawls	( )
Uses walker or crutches	( )
Walks w/ assistance	( )
Uses wheelchair independently	( )
Can sit w/out wheelchair	( )
Uses wheelchair w/assistance	( )
Requires transfers	( )
Uses stroller/travel chair	**( )**

Toileting

Independent	( )
Bladder Control	( )
Bowel Control	( )
Needs assistance	( )
Wears diapers/attends	( )
Toilets on a schedule	( )

(Schedule)_____

_____

Needs enema	( )
Requires catheterization	( )

Feeding Difficulties

(*Please check* ☑ *all that apply***).**

Tongue thrust	( )
Gag reflex	( )
Swallowing difficulties	( )
Difficulty chewing	( )
Other	( )

Explain: _____

_____

Cannot wash self	( )
Needs assistance	( )

Please explain:_____

_____

Shampoos hair	( )
Cannot Shampoo hair	( )
Needs assistance	( )
Brushes/combs hair	( )
Cannot brush/comb hair	( )
Needs assistance	( )
Brushes teeth	( )
Cannot brush teeth	( )
Needs assistance	( )

Please explain:_____

_____

Shaving	( )
Needs assistance	( )
Menstruation	( )
Needs assistance	( )

Feeding

Eats independently	( )
Drinks independently	( )
Bottle fed	( )
Blended or special diet	( )
G, J, or NG tube fed	( )
Feeds self w/ spoon	( )
Feeds self w/ fork	( )
Must have food cut	( )
Needs assistance with w/ utensils	( )
Needs other assistance	( )

Please explain: _____

_____

Dressing

Dresses independently ( )
Needs assistance ( )
Please explain: _____
_____

Other Needs

Behavior

Hitting, biting, or fighting ( )
Self-abusive behavior ( )
Running away ( )
Hyper/Overactive behaviors ( )
Other ( )
Please explain:_____
_____

Medical Needs

Has a G-tube ( )
Has a J-tube ( )
Has a NG-tube ( )
Is on a apnea monitor ( )
Has a tracheotomy ( )
Requires shallow suction ( )
Requires deep suction ( )
Oxygen dependent ( )
Ventilator dependent ( )
Requires injections ( )
Other ( )
Please explain: _____
_____

INSTRUCTIONS ON HOW TO REQUEST VOUCHERS

Name of the individual- Full name

Name of the provider-Full name

Date of respite sit- All dates

Time of respite sit- The beginning time and the end time

Where the site will occur-In home or out of home

Type of sit-Daily sit (meaning individual days) or Continuous sit (meaning round the clock multiple days)

Please send request to respite@incommunityga.org and please adhere to policy-

Voucher request must be 72 hours prior to respite sit and all weekend request must be in by the close of business on Thursdays.

NO VOUCHERS WILL BE COMPLETED FOR THE SAME DAY OF RESPITE. NO VOUCHERS WILL BE CREATED ON FRIDAYS…. NO VOUCHERS WILL BE BACK DATED- NO EXCEPTIONS

Only under extreme emergencies will these rules be broken and it is up to the Respite Manager to may that exception.

This is for ALL respite participants for 2022-2023 fiscal year.

InCommunity
Embracing the abilities in all of us.

Upon completion of this application, please send the information to the following address:

InCommunity

3301 Buckeye Road, Suite 700

Atlanta, GA 30341

Attn: Latarsha Hardy

Respite Email: respite@incommunityga.org

Latarsha Hardy: latarsha.hardy@incommunityga.org

Direct Line: (470) 357-6483