Horizons Residential Care Center
RESPITE CARE APPLICATION

101 Horizons Lane, Rural Hall, NC 27045
Matthew James, 336-767-2411, ext. 2071 (Main Office) 336-661-2185 (Fax)

APPLICANT INFORMATION

Full Name: _____
Name called: _____

Date of Birth: _____ Sex: ☐Male ☐Female Race: _____

Place of Birth: City_____ State: _____ County: _____

Is applicant: ☐Natural born ☐Adopted ☐Foster Child

Is applicant: ☐Ambulatory ☐Non-ambulatory Social Security Number:_____

Is applicant currently living with both parents? _____ If no, with whom? _____

Applicant's Current Street Address: _____

City: _____ State: _____ Zip Code: _____ Phone: _____

Other persons living in the home (Names & Ages):

_____

_____

Level of Intellectual Disability: ☐Mild ☐ Moderate ☐ Severe ☐ Profound ☐ N/A

Other Diagnoses/Developmental Disabilities/Delays:

_____

Referral Source: _____

Date of last Psychological evaluation: _____ Where? _____

FAMILY INFORMATION

Mother's Name: _____

Address:

_____

Phone #: _____ (home) _____ (work) _____ (cell)

Occupation: _____ Employer: _____

Marital Status: ☐Married ☐Separated ☐Divorced ☐Widowed ☐Single

Father's Name: _____

Address:

_____

Phone #: _____ (home) _____ (work) _____ (cell)

Occupation: _____ Employer: _____

Marital Status: ☐Married ☐Separated ☐Divorced ☐Widowed ☐Single

LEGAL STATUS

Is applicant a minor (under age 18)? ☐ Yes ☐ No Custodian: _____
Is client legally competent? ☐ Yes ☐ No If no, date of adjudication: _____
Type of guardianship:

_____

Name & Relationship of guardian: _____
Address: _____ Phone #: _____

OTHERS AUTHORIZED TO TAKE APPLICANT FROM RESPITE CARE

336. Name & Relationship to Applicant:

_____

Address:

_____

Phone # _____ Any other info _____
2. Name & Relationship to Applicant: _____
Address:

_____

Phone # _____ Any other info _____

IN CASE OF AN EMERGENCY, WHO CAN BE CONTACTED IF PARENTS CANNOT BE REACHED? **WE MUST HAVE AT LEAST ONE (1) EMERGENCY CONTACT!**

Name: _____ Relationship: _____
Address:

_____

Phone: _____ (home) _____ (work) _____ (cell)

Name: _____ Relationship: _____
Address:

_____

Phone: _____ (home) _____ (work) _____ (cell)

EMERGENCY INFORMATION

Doctor or clinic: _____
Address:

_____

Office phone: _____ After hour's emergency phone: _____

Hospital preference: _____ Phone #: _____
Address:

_____

Dentist: _____ Phone #: _____

Address:

_____

Insurance Company: _____
Group name: _____
Group number or Medicaid Number: _____
Policy Number: _____
Name of person on insurance card: _____

MEDICAL INFORMATION

Does applicant have any of the following:

* known allergies? _____ If yes, please describe: _____

_____

* history of seizures? _____ If yes, please describe the type, frequency, and duration: _____

_____

* visual impairment? _____ If yes, please describe: _____

_____

* hearing impairment? _____ If yes, please describe: _____

_____

If applicant is female and has started her menstrual cycle, describe how you handle:

_____

Does applicant have any other frequent illnesses or problems such as colds, earaches, skin problems, high fevers, diarrhea, etc. _____ If yes, please describe: _____

_____

Does applicant receive medical attention more than quarterly from a doctor or nurse? ☐ Yes ☐ No

Does applicant receive services from any of the following? If so, how often?

SERVICE	FREQUENCY (How often?)
Nurse	
Occupational Therapist	
Physical Therapist	
Speech Therapist	
Psychologist	
Psychiatrist	
Other (specify)	
Other (specify)	

MEDICATIONS

Is applicant currently on any prescription or over the counter medications? ☐ Yes ☐ No

If yes, please list the name of each medication, how much medication is given each time, when each medication is given, and what is the purpose of each medication (must be complete for consideration):

Name of Medication	Dosage of Medication	Times of Medication	Purpose of Medication

Describe any special procedures for giving medications:

_____

_____

How does applicant respond to taking medications:

_____

_____

FEEDING:

Does individual feed self?_____ Does individual need assistance with feeding?_____

_____

_____

Food consistency: solid_____ chopped/cut up_____ mashed_____ pureed_____

Any special dietary needs:_____

_____

Does individual drink from a cup?_____

Does individual need assistance with drinking?_____

_____

Any known food allergies?_____

Any foods individual cannot or will not eat?_____

Describe any problems chewing, swallowing, choking, or eating inedible items:_____

_____

_____

ARM/HAND USE:

Does individual use both arms/hands functionally?_____

Right or Left handed?_____

TOILETING:

Is individual toilet trained?_____

If so, does he/she: go alone_____need reminders_____go on a schedule_____

If on a schedule, please list times:_____

Does individual need assistance with:

getting on/off toilet?_____

Wiping?_____

If not toilet trained, does individual:

wear diapers?_____
Wear training pants?_____
Require adaptive equipment?_____(please specify)_____
_____
Does individual indicate the need to use the bathroom?_____
Explain (words/gestures used):_____
_____
List any special problems or procedures used for toileting:_____
_____
_____

DRESSING:
Does individual dress him/her self?_____
How much assistance is needed?_____
_____
_____

GROOMING:
Does individual need help with:
Brushing teeth_____ combing hair_____ shaving_____ Using deodorant_____
Any special instructions: _____

BATHING:
Is individual able to bathe self?_____ How much assistance is needed?_____
_____
_____

SLEEPING:
Approximate bedtime:_____ awakes:_____ naptime:_____length:_____
Any resistance going to bed?___ Describe:_____
_____
Sound sleeper?_____ Restless?_____ Wakes up at night?__ Gets out of bed?_____
Does individual sleep alone or with others?_____
Type of bed used:_____ Rails?_____
_____
Describe any special needs or routines for bedtime:_____
_____
_____

LEISURE ACTIVITIES:
Does individual play or interact with others?_____ Or prefers to play alone?_____
Favorite toy or type of toy:_____
Favorite activities:_____
_____

COMMUNICATION: (check all that apply)

_____Well developed speech	_____Uses gestures
_____Uses single words	_____Makes sounds
_____Difficult to understand	_____Follows simple commands

_____Uses sign language _____Understands simple questions
_____Points to wants _____Does not communicate

Additional information concerning individual's communication skills:_____

_____

_____

AMBULATION:
Is individual able to walk?_____

If yes, does individual walk independently?_____

Does individual need assistance with walking?_____

Describe level of assistance needed? _____

_____

_____

If individual CANNOT walk, can he/she: Stand_____ Crawl/roll_____

Does individual use any kind of adaptive equipment such as a wheelchair, walker, or orthopedic appliances?

_____

_____

_____

Any special instructions for lifting/transferring?_____

_____

_____

_____

* behavioral issues? _____ If yes, please describe: _____

_____

_____

BEHAVIOR CHECKLIST

often	some times	never			often	some times	never	
			Nervousness					Smoking
			Shyness					Tongue sucking
			Showing off					Destroys property
			Lying					Attacks care giver
			Mouthing objects					Hurts pets
			Refusing to obey					Self-injurious
			Fighting					Throws up food
			Temper tantrums					Sets fires
			Sleeplessness					Grinds teeth

			Nightmares					Strong fears
			Bed wetting					Whining
			Selfishness					Stealing
often	**some times**	**never**			**often**	**some times**	**never**	
			Jealousy					Displays unusual behaviors
			Plays with genitals					Cursing
			Withdrawn					Makes loud noises
			Undresses inappropriately					Spitting
			Running away					Short attention
			Displays inappropriate sexual behaviors					Wanders off

Is individual easy to manage at home?_____ In public?_____
Describe any destruction of property or aggression towards self or others:_____
_____
_____

Does individual require any protective devices to prevent injury or interventions such as being restrained, time out, etc.?_____ If yes, please describe:
_____
_____

Can individual respond to verbal or physical redirection?_____
A reward system_____ consequence?_____

How is individual usually disciplined and by whom?_____
_____
_____

What types of discipline are most effective?_____
_____

EDUCATION / DAY PROGRAMMING

Does applicant presently attend any program(s) or school(s) in your community? _____
Example: public schools, workshop, day program, etc.

Name of school/program: _____

Address: _____

Contact Person (teacher/job coach):_____ Phone:_____

Days per week:_____ Hours per week:_____ Date enrolled:_____

Does applicant require a one-on-one when present at school/day program? _____

If applicable, what is the reason for having one-on-one supervision while at school/day program?

_____

_____

_____

_

CASE MANAGEMENT INFORMATION

Does applicant have a care coordinator? ☐ yes ☐ no

Name & Telephone # of Case Manager: _____

Client ID Number/Record Number: _____

Innovations Waiver? ☐ yes ☐ no **or** B3 funding? ☐ yes ☐ no

List any equipment that would accompany your family member while she or he is in weekend Respite Care:

_____

_____

_____

Please give any other information you think will be helpful for your family member while she or he is in Respite Care:

_____

_____

_____

_____

Describe any goals you would like to see applicant strive for while in Respite Care:

_____

_____

_____

The respite program currently operates from 8am-8pm on Saturdays and 8am-4pm on Sundays (with the exception of holidays). How would you like to use Respite Care?

Center Based Frequency:

☐ Occasionally (3-6 times a year)
☐ Once a month
☐ Twice a month
☐ More than twice a month

Signature of person completing application:_____

Date: _____

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RESPITE CARE SERVICES
103 Horizons Lane, Rural Hall, NC 27045
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336-661-2185 (Fax)

PHYSICIAN'S ORDERS

North Carolina State Licensure regulations require that a physician's order be obtained for each medication administered at the Center, including over-the-counter medications. Please complete the form below, sign and date it.

WE WILL NOT BE ABLE TO GIVE ANY MEDICATION WITHOUT THIS PHYSICIAN'S ORDER.

Name of client: _____ Date of last Exam: _____

Please specify any medical problems that this client has which may affect his/her temporary care at Horizons Respite Services and what precautions should be taken:

_____

What medication does this client currently take?

MEDICATION	DOSAGE	TIME(S)	REASON	POSSIBLE SIDE EFFECTS

Does this client safely self-medicate without assistance? _____

Which of the following nonprescription medications do you authorize PRN?

YES	NO	Medication	Symptoms	Dosage as per package?
___	___	Acetaminophen	Fever, Pain	_____
___	___	Milk of Magnesia	Constipation	_____
___	___	Kaopectate	Diarrhea	_____
___	___	Robitussin	Cough	_____
___	___	Benadryl	Runny nose	_____
___	___	Dimetapp	Nasal Congestion	_____
___	___	Phenergen	Vomiting	_____
___	___	Ibuprofen	Menstrual Cramps	_____
___	___	Pepto Bismol	Stomach Ache	_____

Physician's Name and Office (Please Print): _____

Address: _____

Office Phone #: _____ Emergency Phone: _____ Fax #: _____

Physician's Signature: _____ Date: _____

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HORIZONS RESPITE CARE is a support service to families in our community caring for a person with developmental or intellectual disabilities living at home. The program provides temporary care for these individuals so that their family can take a break from the demands of caring for someone with a disability. We are required to maintain the following information on each program participant in order to be in compliance with state regulations governing our license.

CLIENT'S ANNUAL PHYSICAL EXAMINATION FORM

Name: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female Height: _____ Weight: _____

Tuberculin Skin Test: ☐ Positive ☐ Negative

Diagnoses: _____

*****ALLERGIES: THE ABOVE CLIENT IS KNOWN TO BE ALLERGIC TO:*****

Restrictions: _____

Comments: _____

Has the client received any immunizations this year: ☐ no ☐ yes If yes, please complete the attached Immunization Record.

I have examined the above-named individual and find him/her in satisfactory condition for participation in Horizon's Respite Care Program.

Physician's Name and Office (Please Print): _____

Address: _____

Office Phone #: _____ Emergency Phone: _____ Fax #: _____

Physician's Signature: _____ Date: _____

IMMUNIZATION RECORD

WE MUST HAVE THIS INFORMATION. ALL PROGRAM PARTICIPANTS ARE REQUIRED TO PROVIDE PROOF OF IMMUNIZATIONS.

IMMUNIZATION		DATE GIVEN
DPT (diphtheria, □ertussis, tetanus)	1ST	_____
	2ND	_____
	3RD	_____
	Boosters	_____
POLIO	1ST	_____
	2ND	_____
	3RD	_____
	Boosters	_____
RUBELLA (German Measles)		_____
RUBEOLA (Red Measles)		_____
MUMPS		_____
TETANUS		_____
INFLUENZA		_____
OTHERS		
_____		_____
_____		_____
_____		_____

_____

Physician's Signature

_____

Date

SUBMIT