

**Horizons Residential Care Center  
RESPIRE CARE APPLICATION**

101 Horizons Lane, Rural Hall, NC 27045  
336-767-2411 (Main Office) 336-661-2185 (Fax)

**Daryl Miles**, Director of Respite Services, 336-705-0805 (cell)  
**darylm@horizonscenter.org**

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

1. 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:

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How does applicant respond to taking medications:

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FEEDING:

Does individual feed self? \_\_\_\_\_ Does individual need assistance with feeding? \_\_\_\_\_

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Food consistency: solid \_\_\_\_\_ chopped/cut up \_\_\_\_\_ mashed \_\_\_\_\_ pureed \_\_\_\_\_

Any special dietary needs: \_\_\_\_\_

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Does individual drink from a cup? \_\_\_\_\_

Does individual need assistance with drinking? \_\_\_\_\_

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Any known food allergies? \_\_\_\_\_

Any foods individual cannot or will not eat? \_\_\_\_\_

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

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ARM/HAND USE:

Does individual use both arms/hands functionally? \_\_\_\_\_

Right or Left handed? \_\_\_\_\_

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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) \_\_\_\_\_

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Does individual indicate the need to use the bathroom? \_\_\_\_\_

Explain (words/gestures used): \_\_\_\_\_

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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: \_\_\_\_\_

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AMBULATION:

Is individual able to walk? \_\_\_\_\_

If yes, does individual walk independently? \_\_\_\_\_

Does individual need assistance with walking? \_\_\_\_\_

Describe level of assistance needed? \_\_\_\_\_

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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?

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Any special instructions for lifting/transferring? \_\_\_\_\_

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\* behavioral issues? \_\_\_\_\_ If yes, please describe: \_\_\_\_\_

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**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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**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:

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**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: <input type="checkbox"/> Positive <input type="checkbox"/> Negative
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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.

<u>IMMUNIZATION</u>	<u>DATE GIVEN</u>
DPT (diphtheria, pertusis, tetanus) 1 <sup>ST</sup>	_____
2 <sup>ND</sup>	_____
3 <sup>RD</sup>	_____
Boosters	_____
POLIO 1 <sup>ST</sup>	_____
2 <sup>ND</sup>	_____
3 <sup>RD</sup>	_____
Boosters	_____
RUBELLA (German Measles)	_____
RUBEOLA (Red Measles)	_____
MUMPS	_____
TETANUS	_____
INFLUENZA	_____
OTHERS	_____
_____	_____
_____	_____
_____	_____

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date