

# **RESPITE CARE PROGRAM**

**Respite care is a supportive service intended to provide short-term, temporary relief to the primary caregiver of an individual with a persistent or chronic physical or emotional disability.**

## **HOW TO APPLY**

**The application packet for Respite Care is attached. The packet contains three sections, all of which must be completed and return to our office. If you have questions regarding how to fill out the application, call our office at (301) 909-2090 and (301) 909-2091. The sections are:**

**CLIENT INFORMATION FORM  
DOCTOR'S STATEMENT AND RELEASE OF INFORMATION  
INCOME INFORMATION FORM**

**Due to state regulations, applications can not be processed without proper verification of income. Verification means the most recent pay stub, Social Security statement, or other statement of income. If no income verification is received the program will be required to charge the family the maximum fee. Mail applications to:**

**RESPITE CARE PROGRAM  
805 BRIGHTSEAT ROAD  
LANDOVER, MD. 20785**

## **HOW TO USE RESPITE CARE**

**Once the application is received by our office it will be processed and the recipient registered, if eligible. The family, caregiver, disabled individual, and/or the caseworker must then contact Respite Care Program to request specific days of care. Requests are handled by phone and should be made 1-2 weeks in advance. Care will provided in the home of the individual with disability.**

**If you have any questions or concerns regarding the completion of the application or services rendered, please call our office at (301) 909-2090 and (301) 909-2091.**

**RESPITE CARE PROGRAM  
APPLICATION FORM**

\_\_\_\_\_  
Name of person to be cared for

\_\_\_\_\_  
Referred by

\_\_\_\_\_  
Birthdate

\_\_\_\_\_  
Race

\_\_\_\_\_  
Marital Status

\_\_\_\_\_  
Sex

\_\_\_\_\_  
Social Security No.

\_\_\_\_\_  
Address

( )  
\_\_\_\_\_  
Telephone No.

Did the disabled person ever serve in the Military ( Y / N ): \_\_\_\_\_ if yes, is the disability service related ( Y / N ): \_\_\_\_\_

\_\_\_\_\_  
Name of Primary family or unpaid caregiver

\_\_\_\_\_  
Relationship to Disabled Individual

\_\_\_\_\_  
Address ( if different from above)

\_\_\_\_\_  
Telephone (home)

\_\_\_\_\_  
Telephone (work)

Doctor: \_\_\_\_\_ Telephone: \_\_\_\_\_

Emergency contacts (individuals available to care for the person in the event of an emergency):

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Names of other people in the home, their ages, and their relationship to the person to be cared for:

\_\_\_\_\_  
Are there pets in the home? (what kind?) \_\_\_\_\_

Name of day program or school: \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_ Location (city): \_\_\_\_\_

Days of attendance at day program or school: \_\_\_\_\_

What hours? \_\_\_\_\_

Your preference for location of respite care (check as many as appropriate):

Your home \_\_\_\_\_ Home of Careworker \_\_\_\_\_ ARC home \_\_\_\_\_

Nursing Home \_\_\_\_\_ Other \_\_\_\_\_

Disability / Diagnosis of the Individual: \_\_\_\_\_

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

Does the individual need assistance with (indicate yes or no):

Bathing: \_\_\_\_\_

Eating / Drinking: \_\_\_\_\_

Skin / Hair: \_\_\_\_\_

Transfer (from bed to chair): \_\_\_\_\_

Shaving: \_\_\_\_\_

Walking: \_\_\_\_\_

Toileting: \_\_\_\_\_

Climbing Stair: \_\_\_\_\_

Dressing: \_\_\_\_\_

Supervision: \_\_\_\_\_

Diapering: \_\_\_\_\_

Taking Medications: \_\_\_\_\_

Preparing Meals: \_\_\_\_\_

Does the individual have problems with (indicate yes or no):

Does client make sound judgements? \_\_\_\_\_

Can client answer / make telephone calls? \_\_\_\_\_

Could client get out of house in case of fire? \_\_\_\_\_

Can client be left alone for short periods? \_\_\_\_\_

Does the individual use ( indicate yes or no):

Cane \_\_\_\_\_

Braces \_\_\_\_\_

Bedside commode \_\_\_\_\_

Walker \_\_\_\_\_

Wheelchair \_\_\_\_\_

Hoyer Lift \_\_\_\_\_

Other \_\_\_\_\_

Describe any chronic medical problem(s) that the careworker should be aware of and any special instructions: \_\_\_\_\_

List any medications and the purpose for which each is takes (continue on back if necessary): \_\_\_\_\_

Does the person have allergies? Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes, to what:

---

Is there a history of seizures? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please describe, including how often and how recently: \_\_\_\_\_

Does individual display inappropriate behavior (s)? Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes, Please describe: \_\_\_\_\_

Give special feeding instructions or list any special diet: \_\_\_\_\_

Give specific instructions for toileting: \_\_\_\_\_

Describe any difficulties regarding sleeping/bedtime/nighttime: \_\_\_\_\_

---

Activities /Interests of the individual: \_\_\_\_\_

**RESPIRE CARE PROGRAM  
INFORMATION FORM**

Please complete this form and attach verification of income, in order for us to determine if there will be a fee for Respite Care.

- Due to state regulations, applications can not be processed without proper Verification of income.
- If no income verification is received, the program will be required to charge the Family the maximum fee!!!

\*\*\*VERIFICATION means the most recent pay stub, Social Security statement, or other statement of income.

GROSS INCOME means the total amount of income BEFORE deductions

Fees are based upon Total Gross Income Minus Documented Uncovered Medical Expenses for the Disabled Individual. Fees are based on a sliding fee scale and can range from 0 to the full amount of respite.

Name of the Disabled Person: \_\_\_\_\_

Address: \_\_\_\_\_  
                    Street                                    City                                    State                                    Zip Code

Birthdate: \_\_\_\_\_ Social Security No. \_\_\_\_\_

**INCOME:** Fill in either Part 1 or Part 2 below.

**Part 1:** If the individual to be cared for is UNDER age 18, or is claimed as a DEPENDENT on last years tax return, please list the gross income of all family members, including the person with a disability. List income by source and whether it is weekly, monthly, or annually.

\_\_\_\_\_  
\_\_\_\_\_

**Part 2:** If the individual to be cared for is age 18 or ABOVE, and NOT claimed as a dependent on anyone else's tax return, please list the gross income of the person, and the person's spouse, of applicable. List by source and whether income is weekly, monthly, or annually.

\_\_\_\_\_  
\_\_\_\_\_

**FAMILY COMPOSITION:** List all people living in the home by name, age and relationship to the person with a disability:

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

**RESPITE CARE PROGRAM**  
**(301) 909-2090**  
**(301) 909-2091**

**DOCTOR'S STATEMENT**

**TO RESPITE CARE APPLICANT:**

**Please complete this page and send to the person's doctor. Also, complete lines 1 and 2 only on the following page.**

**RELEASE OF MEDICAL INFORMATION**

I agree to the release of medical information on \_\_\_\_\_  
Name of Person

\_\_\_\_\_  
Address Birthdate

**To the Respite Care Program: Prince George's County**  
**Department of Social Services**  
**805 Brightseat Road**  
**Landover, Md. 20785**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Applicant/Caregiver

**The caregiver / client understands that the use of universal precautions is advised for the protection of both the individual and the careworker. The caregiver/client will be responsible for advising any family-designated careworker that universal precautions should be used.**

**The caregiver/client gives permission for the Respite Care Program to place the person in the care of another careworker if the assigned careworker cannot complete the respite period and the Respite Care Program has, after reasonable effort, been unable to contact either the caregiver or the emergency person.**

**For emergency respite care, 48 hours in advance of the service is required. Emergency care will be determined on a case by case basis.**

**Respite Care services is available if there are funds available.**

**DATE\_\_\_\_\_ SIGNATURE of Applicant/Caregiver\_\_\_\_\_**

**Please make a copy of this agreement for your records.**

## **AGREEMENT FOR RESPITE CARE SERVICES**

**IN APPLYING FOR RESPITE SERVICES FROM THE PRINCE GEORGE'S COUNTY DEPARTMENT OF SOCIAL SERVICES. THE APPLICANT AGREES TO FOLLOWING:**

**The caregiver/client will call the Respite Care Program with each respite request. The caregiver/client understands that program funds will not be able to pay for care which is not authorized ahead of time.**

**The caregiver/client will be responsible for the final decision as to whether to accept a particular careworker for a given respite period.**

**The caregiver/client will provide the Respite Care Program and the careworker with all the necessary facts regarding the person's diagnosis/disability in order to enable the careworker to take care of the person in a healthful, safe and responsible manner, including:**

**Instructions regarding care of the person and information about capabilities and Limitations. The careworker/client will give written authorization to the Careworker for the administration of medication.**

**Information as to how the caregiver can be contacted during the respite period, the Name and phone number of the person's doctor and an emergency contact.**

**Information regarding other household members, including those requiring care or Supervision during the respite period. The caregiver agrees to pay the respite care-Worker for anyone who requires supervision and/or care, and who is not eligible to Receive respite services.**

**The caregiver/client understands that the use of universal precautions is advised for the protection of both the individual and the careworker. The caregiver/client will be responsible for advising any family-designated careworker that universal precautions should be used.**

**The caregiver/client gives permission for the Respite Care Program to place the person in the care of another careworker if the assigned careworker cannot complete the respite period and the Respite Care Program has, after reasonable effort, been unable to contact either the caregiver, or the emergency person.**

**For emergency respite care, 48 hours in advance of the service is required. Emergency care will be determined on a case by case basis.**

**Respite Care services is available if there are funds available.**

**DATE \_\_\_\_\_SIGNATURE OF Applicant/Caregiver\_\_\_\_\_**

**Please make a copy for this agreement for your records**

RESPITE CARE PROGRAM  
(301) 909-2090  
(301) 909-2091  
**DOCTOR'S STATEMENT**

Person's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Address: \_\_\_\_\_

**To be filled in by the Doctor:**

An application has been made for respite care for the individual named above. In order to provide respite services, information regarding the disability, the health and medical problems, and the level of care of the individual is needed. Please answer the following questions and return the form to the address above. Please call if you have any questions.

Disability/Diagnosis: \_\_\_\_\_

In your professional judgement, is this disability likely to continue indefinitely? \_\_\_ Yes \_\_\_ No

**Does the person require: ( indicate yes or no )- use back for additional space.**

SUPERVISION OF ACTIVITIES OF DAILY LIVING? \_\_\_\_\_ If yes, please describe:

\_\_\_\_\_  
\_\_\_\_\_

PERSONAL CARE? \_\_\_ If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

SKILLED CARE? \_\_\_ If yes, Please describe: \_\_\_\_\_

\_\_\_\_\_

Medications and reasons prescribed: \_\_\_\_\_

\_\_\_\_\_

Special needs of the individual: \_\_\_\_\_

\_\_\_\_\_

Signature of Doctor: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Doctor (Please Print): \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone: (    ) \_\_\_\_\_

