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: _______
Preparring 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: ______________________________________
RESPITE 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__________________
__________________________________            _________          _______________________
__________________________________            _________                 ____________________
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 thee 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
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: ( ) ________________________________