The Arc of Howard County
Respite Care Application

Name of Applicant: _____ Age: _____ Male/Female: _____

Address: _____

Phone: _____ Social Security Number: _____

Date of Birth: _____ Height: _____ Weight: _____

Primary Diagnosis: _____

Parents/ Guardian/ Primary Caregiver: _____

Address: _____ Apt/Suite #: _____

State: _____ Zip code: _____ County: _____

Home Phone: _____ Cell: _____ Work: _____

Other Household Members:

NAME	RELATIONSHIP	AGE

Gross Annual Household Income: $_____

Applicant's School/ Day or Work Program: _____

Contact Person: _____ Phone: _____

***Please Attach a Recent Photo of Applicant**

Primary Care Information:

Doctor: _____ Phone: _____ Fax: _____

Doctor's Office Address: _____

Emergency Contacts:

NAME	ADDRESS	PHONE #

FOOD and DRINKS:

Likes: _____

_____

Dislikes: _____

_____

Any Food Allergies: Yes or NO: _____ If Yes, Please list:_____

_____

Is there any behavioral issue's involved with food? Yes or No: _____

If Yes, Please Explain: _____

_____

_____

_____

ACTIVITIES:

Applicant likes to ride in cars/vans? Yes or No: _____

Places applicant loves to go in community? _____

When out in the community; are there any behaviors we should be aware of? (Ex. eloping)

Yes or No: _____ If Yes, Please explain: _____

_____

_____

Does applicant enjoy outdoor activities? Yes or No: _____ If Yes, please list: _____

_____

If Applicable does applicant enjoy physical activities? Yes or No: _____ If Yes, please list:

_____

_____

What other activities does the applicant enjoy doing? _____

_____

_____

Does applicant like noisy places? Yes or No: _____

Does applicant like animals? Yes or No: _____

COMMUNICATION and BEHAVIOR

How does applicant express what he/she want? _____

Does applicant use sign language? Yes or No: _____

How is positive behavior reinforced with applicant? _____

_____

_____

Does applicant engage in any undesirable/ disruptive acts? Yes or No: _____

I discourage these behaviors by: _____

_____

Some things that might upset my family member are: _____

_____

When my family member is upset, he/she may: _____

_____

The best way to calm or comfort is: _____

_____

Applicant Information Summary

Please answer YES or NO to the questions below. There is a space at the bottom to give additional detailed responses.

YES	NO	CONDITION	YES	NO	CONDITION
		Does the applicant take any medication? (Physician Medical Order Form required. See attached.)			Hearing Impairment?
		Are there any conditions that may affect breathing?			Vision Impairment?
		Are there any conditions that may affect the heart?			Speech Impairment?
		Are there any conditions that may affect mobility?			Mobility Impairment?
		Are there any conditions that may affect eating or swallowing?			Specialized Diet/Consistency?
		Are there any conditions that may affect digestion?			Difficulty Drinking?

		Are there any conditions that may affect going to the bathroom?			Constipation/Diarrhea?
		Are there any psychiatric diagnoses?			Sleep Disorder/ Trouble Sleeping?
		Neurological Conditions?			Communicable Disease?
		Combative/Aggressive Behaviors?			Anxiety/Agitation?
		Self Injurious Behaviors?			Other:
		Seizure Disorders?			Other:

Please provide a detailed response to any of the above that are checked "YES":

_____

_____

_____

_____

Health History:

TO BE COMPLETED BY LICENSED MEDICAL PERSONNEL

Diagnosis:
Nature of Disability:

Health Examination (☐-satisfactory * X-unsatisfactory * O-not examined)

Eyes	Lungs		Posture		Balance
Nose	Abdomen		Speech		Coordination
Ears	Genitalia		Circulation		Spacticity
Throat	Skin		Sensation		Heart
Extremities		Height		Weight	
Motion Limitations			Osteoporosis		

General Overall Health of Participant:
Participant is Under Care of Physician for the Following Condition(s):
Current Treatment at the Time of this Report Include the Following:

Seizures: Please complete if the participant is currently having seizures, or has a history of seizures.

Type of Seizure:	
Date of Last Seizure:	Average Duration of Seizure:
Frequency of Seizures:	
Seizure Triggers:	
Is the participant currently taking medication to control seizures? Yes_____ No_____ (Please list all medications on attached Physicians Medication Order Form)	

Allergies: Please list all known allergies of participant.

Medication Allergies:	Please Describe Reaction and Management of the Reaction:
Food Allergies:	
Other Allergies:	

Specialized Health Care Procedure

Does the participant require a specialized health care procedure during the care visit (for example: tube feeding, nebulizer treatments,etc)?

Yes_____ No_____ If yes, please complete the following:

Name of Procedure:
Description of Procedure:

Precautions Staff Must Be Aware of Before, During and After the Procedure:

Physicians Authorization (MUST Be Signed By Physician)

I have examined the participant herein described and reviewed the Health History. It is my opinion that this individual is able to participate in all program activities except as noted.

_____

Signature of Physician *Date*

_____

Printed Name of Physician *Office Phone Number*

_____

_____

_____

Address of Physician and FAX Number

Please Return Completed Paperwork To: The Arc of Howard County
11735 Homewood Road
Ellicott City, MD 21042
Attn: Respite Care Program

The Arc of Howard County Respite Care Program
Participant Health Release Form

Family to Complete This Page:

Dear Physician,

As the parent/guardian of the individual listed below, I authorize the release of the attached medical information. The individual named below

is applying for Respite Care Services at The Arc of Howard County.

_____
Signature of Parent/Guardian

_____
Date

Participant Information:

Name of Participant:		
Address:		
Sex:	Birth Date:	Age:
Custodial Parent/Guardian:	Home Phone:	Work Phone:
Secondary Parent/Guardian:	Home Phone:	Work Phone:

Health Insurance Information:

Name of Insurance Company:	
Address:	
Name of Policy Holder:	Relationship to Participant:
Group Number:	Policy Holder ID Number:

Photo Release

I, _____, hereby give The Arc of Howard County permission to use my photograph in publications that promote, represent and/or celebrate the organization. I also give permission to display my photograph in The Arc office. I understand these brochures, newsletters, and pamphlets will be distributed throughout the community in an effort to educate and inform the public about the advocacy and support we offer to individuals with developmental disabilities.

_____
Individual's Signature

_____
Date

Parent Signature Date

Statement of Accuracy and Permission to Obtain Medical Care

I, _____, hereby note that the information listed on the application in regards to _____ is accurate to the best of my knowledge. In the unlikely event of a medical emergency, I understand that every effort will be made to contact me. In the event that I cannot be reached, I hereby give permission for the agent of The Arc of Howard County to secure and authorize proper treatment for the above individual.

Individual's Signature Date

Parent Signature Date

Respite Care Coordinator Signature Date