Overnight Respite Application

Adapt Community Network
Overnight Respite
Welcome

Dear Parent/Guardian:

Prior to your loved one coming to our Bronx Overnight Respite Program, it is imperative that we receive all the documents listed below. All evaluations, permissions, and physician order forms, must be current (within the present year). All documents requested, are important in order to expedite the application process. Please do not send any application without the required paperwork that we request below.

- ☐ Completed Current Application (due annually)
- ☐ Consent for trips and pictures (due annually)
- ☐ Current Medical
- ☐ 2 Consecutive PPD readings (once submitted we will not request additional PPD)
- ☐ Current Medication/Feeding order including a required Tylenol order (as well as over the counter medications)
- ☐ Most recent Psychological
- ☐ Most recent Psychosocial
- ☐ Current ISP (yearly)
- ☐ Current ISP Addendum (for the first time applicants
- ☐ LOC eligibility determination form (yearly)
- ☐ Waiver documents including NOD
- ☐ Copy of Medicaid or insurance card.

Please note that an incomplete application will delay processing (that includes missing signatures)

All applications can be returned via the following methods

- **1822 Stillwell Avenue Bronx, N.Y 10469,**
- **Via email Sboodram@Adaptcommunitynetwork.org**
- **Via fax 718-881-5823.**

Sincerely,

Sita Boodram
Program Director
718-652-9790 Ext 6077

Overnight Respite Application

Applicant Name: ____ Date: ___________________

Date of Birth ___________________ ☐Male ☐ Female Social Security #:___________________

Address: _______________________________ City __________ State _______________Zip: _________

Cell Phone: ____________________ Home Phone: _____________________ Email: ________________

Medicaid #:_________________ Medicare #: _______________ Other insurance: __________________

Referring Coordinator: _____________________________ Agency: ____________________________

Telephone: ___________________________ Email: ____

Applicant Contact Information

Primary Guardian: ____________________________________ Relationship:_____________________

Home Address: ___________________________ City: ____________ State: _________ Zip: ________

Cell Phone: ____________________ Home Phone: _____________________ Email: ________________

Work Address: _____________________________ City: ____________ State: _________ Zip: ________

Cell Phone: ____________________ Home Phone: _____________________ Email: ________________

Alternative Guardian: __________________________________Relationship: _____________________

Work Address: _____________________________ City: ____________ State: _________ Zip: ________

Cell Phone: ____________________ Home Phone: _____________________ Email: ________________

Primary Care Provider (if different than family above) Relationship: ______________________________

Name: ____ Telephone: _____________________

Home Address: ___________________________ City: ____________ State: _________ Zip: ________

Members residing at home

Name: ________________________________ Age: _____________ Relationship: __________________
Name: ________________________________ Age: _____________ Relationship: __________________
Name: ________________________________ Age: _____________ Relationship: __________________
Name: ________________________________ Age: _____________ Relationship: __________________

EMERGENCY CONTACT MUST BE A PERSON THAT CAN BE DEPEND UPON TO CONTACT AND/OR PICK UP YOUR CHILD IN THE EVENT OF AN EMERGENCY

1st Emergency Contact Name: _________________________________ Relationship: ______________

Cell Phone: ____________________ Home Phone: _____________________ Email: ________________

Address: __________________________________ City: ____________ State: _________ Zip: ________

2nd Emergency Contact Name: _________________________________ Relationship: ______________

Cell Phone: ____________________ Home Phone: _____________________ Email: ________________

Address: _________________________________ City: ____________ State: _________ Zip: ________

Overnight Respite Application

Applicant Name: ____ **Date:** __________

Primary Medical Doctor: ____

Work Address: __________________________ City: __________ State: ________ Zip: _______

Cell Phone: __________________ Home Phone: __________________ Email: ______________

Allergies to medication/food?: ____

Vision: Impaired? ☐ Yes ☐ No Corrective Lenses

Hearing: Impaired? ☐ Yes ☐ No

Ambulatory: ☐ Walker ☐ Crutches ☐ Wheelchair ☐ Other, please explain: ________________

Nutrition

Diet Content/Consistency: __________________________

☐ Pureed ☐ Chopped ☐ Soft ☐ Regular ☐ Regular/cut-up ☐ Thickened liquids

Caloric Restriction ☐ No ☐ Yes, if yes please specify: ________________________________

Special Considerations? Techniques/Feeding equipment: ___________________________________

Appetite: ☐ Excellent ☐ Good ☐ Poor

Favorite foods: ____

Least favorite foods: ____

Any problems with constipation? ☐ Yes ☐ No

Please provide psychological evaluation completed within the past three (if there was no changes) along with application.

Seizures: ☐ Yes ☐ No

Seizure Type: _________ Duration of Seizures: ___________ Date of seizures this year: __________

Developmental Disability

☐ Developmental Disability ☐ Cerebral Palsy ☐ Intellectual Disability ☐ Epilepsy

☐ Autism ☐ Other Neurological Conditions: Please identity: _____________________________

Toileting

Toileting Assistance Needed? ☐ Yes ☐ No Diapers ☐ Yes ☐ No

Please describe the toileting plan: ____

____

Please send adequate amount of diapers, sanitary napkins, etc. for durations of stay

Skin integrity: ☐ Dry Normal ☐ Oily

Overnight Respite Application

Applicant Name: ____ **Date:** _________________

Prone for rashes or breakdown? ☐ Yes ☐ No If Yes explain: ____________________________________

____

Special Care Needs: ____

____

Susceptible or prone to falls? : ☐ Yes ☐ No If Yes explain: _____________________________________

Special equipment needed during shower? ☐ Yes ☐ No If yes, please specify: _____________________

____

Dressing: ☐ Complete help ☐ Partial Help ☐ Independent

Describe any special positioning or necessary equipment: ______________________________________

____

____

Behavior

Does applicant have a Behavior Plan? ☐ Yes ☐ No **Please attach formal behavioral plan.**

☐ Self injurious behavior ☐ Throws tantrums ☐ Scratches ☐ Hyperactive ☐ will strike out or attempt to hurt others ☐ bites ☐ Spitting ☐ Throws Objects ☐ Property Destruction

☐ Others please describe: ____

How does the consumer let someone knows that he or she is becoming upset, or doesn't like an activity?
____

What can lead to upsetting the consumer? And how do you calm he/she down? ___________________

____

Are there any physical or mechanical devices used to protect or restrain the individual? Yes No

If yes, please provide **script from doctor** and describe and provide a doctors order for usage: _________

____

____

Communication

☐ Verbal ☐ Non Verbal ☐ Uses Gestures if yes, please describe: ____________________

____

Does he/she use a device to communicate? ☐ Yes ☐ No

If yes, please describe: ____

____

Overnight Respite Application

ADAPT COMMUNITY NETWORK [we change]

Applicant Name: ____ **Date:** ________________

Sleeping

Usual Sleep time: ____________________ Awake time: __________________________________

Please describe any sleep habits that we should be aware of: __________________________________

____

Are there any special devises needed for protection while sleeping (bedrails, hospital bed, bumper, etc.)

____

Is there anything else Adapt Community Network should know about your loved one to make their stay with us better?

____
____
____
____

Signature of person completing the form: ____

Date: __________________________

Once your loved one has been approved to attend the Respite Program, you will be contacted by one of the administrative staff to schedule a trial date. Prior to the trial, you will be invited for a tour of the facility. We encourage that you bring your loved one with you during the tour for a meet and greet. Our staff is fully trained in CPR/First Aid and medication administration.

Upon arrival, we will complete a thorough body check, where a nurse will be present; and, which we also encourage family members to be present as well. Their bags will be checked and all clothing will be labeled, and medications will be verified, by medication order, for any prescriptions, which, you may have submitted to us prior to your loved one coming to our facility.

After your loved one has been admitted to our program as scheduled; if your loved one becomes ill/sick, we will notify a family member/legal guardian/or emergency contact listed on the application for your loved one to get picked up or transported home. This is to prevent anyone else at the Program from becoming infectious / contagious.

Our program only schedule three (3) months in advance in order to give all families an opportunity to utilize the program. Please keep in mind that we book on the first week of November for December, January, and February. The first week in February, we will book for March, April, and May. The first week of May, we will book for June, July, and August. The first week in August, we will book for September, October, and November. Please note there will be a yearly calendar mailed to all families with the actual date to call and book per borough. We will keep you informed of any changes regarding this schedule in the future.

We thank you and we welcome your loved one to our family.
If you have any questions, please feel free to contact us at 718-652-1902.