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

Applicant Name: ____________________________________________ Date: __________________

Sleeping

Usual Sleep time: ___________________ Awake time: ___________________

Please describe any sleep habits that we should be aware of: __________________________________
____________________________________________________________________________________
Are there any special devices 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.