Horizons Residential Care Center
RESPITE CARE APPLICATION

101 Horizons Lane, Rural Hall, NC 27045

Director of Respite Services
admissions@horizonscenter.org
336-767-2411 ext. 2075

APPLICANT INFORMATION

Full Name: ____
Name called: ____

Date of Birth: ____________________ Sex: ☐Male ☐Female Race: ___________________

Place of Birth: City_________________________ State: _________ County: ___________________

Is applicant: ☐Natural born ☐Adopted ☐Foster Child

Is applicant: ☐Ambulatory ☐Non-ambulatory Social Security Number:_______________

Is applicant currently living with both parents? _______ If no, with whom? ______________________

Applicant's Current Street Address: ____

City: ____________________ State: ______ Zip Code: ___________ Phone: ___________________

Other persons living in the home (Names & Ages):

____

____

Level of Intellectual Disability: ☐Mild ☐ Moderate ☐ Severe ☐ Profound ☐ N/A

Other Diagnoses/Developmental Disabilities/Delays:

____

Referral Source: ____

Date of last Psychological evaluation: _______________ Where? _____________________________

FAMILY INFORMATION

Mother's Name: ____

Address: ____

Phone #: ____________________ (home) ____________________ (work) _______________ (cell)

Occupation: ______________________________ Employer: ________________________________

Marital Status: ☐Married ☐Separated ☐Divorced ☐Widowed ☐Single

Father's Name: ____

Address: ____

Phone #: ____________________ (home) ____________________ (work) _______________ (cell)

Occupation: ______________________________ Employer: ________________________________

Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single

LEGAL STATUS

Is applicant a minor (under age 18)? ☐ Yes ☐ No Custodian: ______________________________
Is client legally competent? ☐ Yes ☐ No If no, date of adjudication: _____________________
Type of guardianship:
____
Name & Relationship of guardian: ____
Address: ____ Phone #: ____________________

OTHERS AUTHORIZED TO TAKE APPLICANT FROM RESPITE CARE

1. Name & Relationship to Applicant: ____
Address: ____
Phone # _______________________ Any other info ____
2. Name & Relationship to Applicant: ____
Address: ____
Phone # _______________________ Any other info ____

IN CASE OF AN EMERGENCY, WHO CAN BE CONTACTED IF PARENTS CANNOT BE REACHED? **WE MUST HAVE AT LEAST ONE (1) EMERGENCY CONTACT!**

Name: ____ Relationship: _________________________
Address: ____
Phone: ____________________ (home) ____________________ (work) ____________________ (cell)

Name: ____ Relationship: _________________________
Address: ____
Phone: ____________________ (home) ____________________ (work) ____________________ (cell)

EMERGENCY INFORMATION

Doctor or clinic: ____
Address: ____
Office phone: _________________________ After hour's emergency phone: __________________

Hospital preference: ___________________________________ Phone #: _______________________
Address: ____

Dentist: ____ Phone #: _______________________
Address: ____
Insurance Company: ____
Group name: ____
Group number or Medicaid Number: ____
Policy Number: ____
Name of person on insurance card: ____

MEDICAL INFORMATION

Does applicant have any of the following:

* known allergies? _____ If yes, please describe: ____

____

* history of seizures? _____ If yes, please describe the type, frequency, and duration: _______________

____

* visual impairment? _____ If yes, please describe: ____

____

* hearing impairment? _____ If yes, please describe: ____

____

If applicant is female and has started her menstrual cycle, describe how you handle:

____

Does applicant have any other frequent illnesses or problems such as colds, earaches, skin problems, high fevers, diarrhea, etc. _____ If yes, please describe: ____

____

Does applicant receive medical attention more than quarterly from a doctor or nurse? ☐ Yes ☐ No

Does applicant receive services from any of the following? If so, how often?

SERVICE	FREQUENCY (How often?)
Nurse	
Occupational Therapist	
Physical Therapist	
Speech Therapist	
Psychologist	
Psychiatrist	
Other (specify)	
Other (specify)	

MEDICATIONS

Is applicant currently on any prescription or over the counter medications? ☐ Yes ☐ No

If yes, please list the name of each medication, how much medication is given each time, when each medication is given, and what is the purpose of each medication (must be complete for consideration):

Name of Medication	Dosage of Medication	Times of Medication	Purpose of Medication

Describe any special procedures for giving medications:

____

____

How does applicant respond to taking medications:

____

____

FEEDING:

Does individual feed self?________________ Does individual need assistance with feeding?___________

____

____

Food consistency: solid_____ chopped/cut up___________ mashed____________ pureed____________

Any special dietary needs:____

____

Does individual drink from a cup?____

Does individual need assistance with drinking?___________________________________

____

Any known food allergies?____

Any foods individual cannot or will not eat?______________________________________

Describe any problems chewing, swallowing, choking, or eating inedible items:_____________________

____

____

ARM/HAND USE:

Does individual use both arms/hands functionally?________________________________

Right or Left handed?____

TOILETING:

Is individual toilet trained?________________

If so, does he/she: go alone____________need reminders____________go on a schedule___________

If on a schedule, please list times:____

Does individual need assistance with:

getting on/off toilet?____

Wiping?____

If not toilet trained, does individual:

wear diapers?____

wear training pants?____

require adaptive equipment?________(please specify)_____________________________

____

Does individual indicate the need to use the bathroom?_____________________________

Explain (words/gestures used):____

____

List any special problems or procedures used for toileting:______________________________________
____
____

DRESSING:
Does individual dress him/her self?____
How much assistance is needed?____
____
____

GROOMING:
Does individual need help with:
Brushing teeth______ combing hair______ shaving____________ Using deodorant_________
Any special instructions: ____

BATHING:
Is individual able to bathe self?___________ How much assistance is needed?_______________
____
____

SLEEPING:
Approximate bedtime:__________________ awakes:___________ naptime:__________length:_______
Any resistance going to bed?___ Describe:____
____
Sound sleeper?____________ Restless?__________ Wakes up at night?__ Gets out of bed?__________
Does individual sleep alone or with others?______________________________________
Type of bed used:____ Rails?_______________________
____
Describe any special needs or routines for bedtime:_______________________________
____
____

LEISURE ACTIVITIES:
Does individual play or interact with others?______ Or prefers to play alone?_________________
Favorite toy or type of toy:____
Favorite activities:____
____

COMMUNICATION: (check all that apply)

______Well developed speech
______Uses single words
______Difficult to understand
______Uses sign language
______Points to wants
______Uses gestures
______Makes sounds
______Follows simple commands
______Understands simple questions
______Does not communicate

Additional information concerning individual's communication skills:____________________________

____

____

AMBULATION:

Is individual able to walk?____

If yes, does individual walk independently?____

Does individual need assistance with walking?_______________________________________

Describe level of assistance needed? ____

____

____

If individual CANNOT walk, can he/she: Stand________________ Crawl/roll______________________

Does individual use any kind of adaptive equipment such as a wheelchair, walker, or orthopedic appliances?

____

____

____

Any special instructions for lifting/transferring?______________________________________

____

____

____

* behavioral issues? _____ If yes, please describe: ____

____

____

BEHAVIOR CHECKLIST

often	some times	never			often	some times	never	
			Nervousness					Smoking
			Shyness					Tongue sucking
			Showing off					Destroys property
			Lying					Attacks care giver
			Mouthing objects					Hurts pets
			Refusing to obey					Self-injurious
			Fighting					Throws up food
			Temper tantrums					Sets fires
			Sleeplessness					Grinds teeth
			Nightmares					Strong fears
			Bed wetting					Whining
			Selfishness					Stealing

often	some times	never			often	some times	never	
			Jealousy					Displays unusual behaviors
			Plays with genitals					Cursing
			Withdrawn					Makes loud noises
			Undresses inappropriately					Spitting
			Running away					Short attention
			Displays inappropriate sexual behaviors					Wanders off

Is individual easy to manage at home?__________________ In public?____________________________
Describe any destruction of property or aggression towards self or others:__________________________
____
____

Does individual require any protective devices to prevent injury or interventions such as being restrained, time out, etc.?_______ If yes, please describe:
____
____

Can individual respond to verbal or physical redirection?____
A reward system____________________________________ consequence?___________________

How is individual usually disciplined and by whom?____
____
____

What types of discipline are most effective?____
____

EDUCATION / DAY PROGRAMMING

Does applicant presently attend any program(s) or school(s) in your community? _____________________
Example: public schools, workshop, day program, etc.

Name of school/program: ____

Address: ____

Contact Person (teacher/job coach):________________________________ Phone:____________________

Days per week:________________ Hours per week:___________ Date enrolled:_____________________

Does applicant require a one-on-one when present at school/day program? __________________________

If applicable, what is the reason for having one-on-one supervision while at school/day program?

____
____
____

CASE MANAGEMENT INFORMATION

Does applicant have a care coordinator? ☐ yes ☐ no

Name & Telephone # of Case Manager: ______________________________

Client ID Number/Record Number: ______________________

Innovations Waiver? ☐ yes ☐ no **or** B3 funding? ☐ yes ☐ no

List any equipment that would accompany your family member while she or he is in weekend Respite Care:

____

____

____

Please give any other information you think will be helpful for your family member while she or he is in Respite Care:

____

____

____

____

Describe any goals you would like to see applicant strive for while in Respite Care:

____

____

____

The respite program currently operates from 8am-8pm on Saturdays and 8am-4pm on Sundays (with the exception of holidays). How would you like to use Respite Care?

Center Based Frequency:

☐ Occasionally (3-6 times a year)
☐ Once a month
☐ Twice a month
☐ More than twice a month

Signature of person completing application: ______________________________
(type name if submitting digitally)

Date: ____________________

Please note: The last three pages of this form cannot be submitted on-line and must be printed, completed and hard copies must be submitted.

Horizons Residential Care Center
RESPITE CARE SERVICES
103 Horizons Lane, Rural Hall, NC 27045
Daryl Miles, Director of Respite Services, (336) 705-0805
darylm@horizonscenter.org 336-661-2185 (Fax)

PHYSICIAN'S ORDERS

North Carolina State Licensure regulations require that a physician's order be obtained for each medication administered at the Center, including over-the-counter medications. Please complete the form below, sign and date it.

WE WILL NOT BE ABLE TO GIVE ANY MEDICATION WITHOUT THIS PHYSICIAN'S ORDER.

Name of client: ______________________________ Date of last Exam: ____________________

Please specify any medical problems that this client has which may affect his/her temporary care at Horizons Respite Services and what precautions should be taken:

____

____

____

What medication does this client currently take?

MEDICATION	DOSAGE	TIME(S)	REASON	POSSIBLE SIDE EFFECTS

Does this client safely self-medicate without assistance? ______________________________

Which of the following nonprescription medications do you authorize PRN?

YES	NO	Medication	Symptoms	Dosage as per package?
___	___	Acetaminophen	Fever, Pain	________________
___	___	Milk of Magnesia	Constipation	________________
___	___	Kaopectate	Diarrhea	________________
___	___	Robitussin	Cough	________________
___	___	Benadryl	Runny nose	________________
___	___	Dimetapp	Nasal Congestion	________________
___	___	Phenergen	Vomiting	________________
___	___	Ibuprofen	Menstrual Cramps	________________
___	___	Pepto Bismol	Stomach Ache	________________

Physician's Name and Office (Please Print): ______________________________

Address: ____

Office Phone #: ________________ Emergency Phone: ______________ Fax #: ______________

Physician's Signature: ______________________________ Date: ______________

Horizons Residential Care Center
RESPITE CARE SERVICES
103 Horizons Lane, Rural Hall, NC 27045
Daryl Miles, Director of Respite Services, 336-705-0805 (cell)
darylm@horizonscenter.org 336-661-2185 (Fax)

HORIZONS RESPITE CARE is a support service to families in our community caring for a person with developmental or intellectual disabilities living at home. The program provides temporary care for these individuals so that their family can take a break from the demands of caring for someone with a disability. We are required to maintain the following information on each program participant in order to be in compliance with state regulations governing our license.

CLIENT'S ANNUAL PHYSICAL EXAMINATION FORM

Name: ____

Date of Birth: ________________ Sex: ☐ Male ☐ Female Height: __________ Weight: ___________

Tuberculin Skin Test: ☐ Positive ☐ Negative

Diagnoses: ____

____

*****ALLERGIES: THE ABOVE CLIENT IS KNOWN TO BE ALLERGIC TO:*****

____

____

Restrictions: ____

____

Comments: ____

____

____

Has the client received any immunizations this year: ☐ no ☐ yes If yes, please complete the attached Immunization Record.

I have examined the above-named individual and find him/her in satisfactory condition for participation in Horizon's Respite Care Program.

Physician's Name and Office (Please Print): ____

Address: ____

Office Phone #: ______________________ Emergency Phone: _________________ Fax #: _________________

Physician's Signature: ____ Date: ___________________

IMMUNIZATION RECORD

WE MUST HAVE THIS INFORMATION. ALL PROGRAM PARTICIPANTS ARE REQUIRED TO PROVIDE PROOF OF IMMUNIZATIONS.

IMMUNIZATION		DATE GIVEN
DPT (diphtheria, pertusis, tetanus)	1ST	____________
	2ND	____________
	3RD	____________
	Boosters	____________
POLIO	1ST	____________
	2ND	____________
	3RD	____________
	Boosters	____________
RUBELLA (German Measles)		____________
RUBEOLA (Red Measles)		____________
MUMPS		____________
TETANUS		____________
INFLUENZA		____________
OTHERS		
________________________		____________
________________________		____________
________________________		____________

____

Physician's Signature

____

Date