MERCY HOME
243 Prospect Park West
Brooklyn, NY 11215
(718) 832-1075 Fax (718) 832-7612

Saturday Respite Program
Application Form

Date: ___________________

Name: ____

Current Address: ____

Telephone Number: ____

Date of Birth: _______________ **Age:** _______ **Social Security#:** ___________________

Medicaid Number: ________________________ **Medicare Number:** _______________

Other Insurance/Carrier: _______________________ **Policy Number:** ______________

Parent or Legal Guardian: ____

Emergency Contact Person: _____________________ **Relationship:** ________________

Contact Phone Number: ____

Medical Information

Physician's Name: ____

Address: ____

Telephone: ____

Primary Diagnosis: _________________________ **Secondary Diagnosis:** ____________

Is the individual currently taking any medication? (Circle one) Yes No

Name of Medication	Dosage & Times	Reason for Medication

Are there any physical or medical limitations that the service provider should be aware of? (Circle one) Yes No If yes, please indicate condition

____

____

____

Does the individual have:

A history of seizure (Circle one) Yes No
What kind of seizures and how often?

____

Allergies Yes No
What kind? ____
Asthma Yes No

If you answered yes to any of the above, please explain: ___________________________

____

____

How do you know if individual does not feel well? What signs, etc. does he/she use to let you know they do not feel well? (Pointing to area, hitting ear, yelling, etc.)

____

____

Does the individual use any adaptive equipment? (Circle one) Yes No
If yes, please indicate what kind of special equipment it is and what it is used for.

____

Does the individual wear glasses? (Circle one) Yes No
Does the individual use hearing aids? Yes No
Does the individual walk independently? Yes No
If no, please indicate what device the individual uses i.e. canes, wheelchair, etc.

____

Skills Assessment

Please check the appropriate response:

	Independent	Needs Supervision	Needs Assistance	Dependent
Eating				
Dressing				
Toileting				
Bathing				
Grooming				
Cooking				
Shopping				
Housekeeping				
Money skills				
Traveling				
Medication				
Fire Evacuation				
Telephone Usage				
Reading				
Writing				

Please describe how the individual handles crowds, loud noises, unfamiliar groups:

____

____

Behavior Assessment

Please describe individual's inappropriate behaviors (i.e. self abusive, self stimulating, etc.)

____

____

Does the individual display any of the following behaviors (Circle all that apply):

Excessive eating	food stealing	chokes easily	urinates	property destruction
Vomiting	refuses to eat	refuses to drink	eats very fast	window breaking
Eats very slowly	throws food	hitting	self injury	throws objects
Biting	cries easily	running away	spitting	repeats words or phrases
Head banging	kicking			

Does the individual have outbursts? (Circle one) **Yes** **No**
If yes, how frequent are these outbursts?

Daily **Weekly** **Monthly**

What kind of outbursts does the individual have?

____

Does the individual enjoy:
Group activities **Yes** **No**
Individual activities **Yes** **No**

Communication Skills

Is the individual (Circle one):	**verbal**	**non-verbal**	**hearing impaired**
Does the individual use sign?	**Yes**	**No**	
Use picture boards?	**Yes**	**No**	
Communication devices?	**Yes**	**No**	

If yes, what kind: ____

Dietary Needs

Does the individual have a restrictive diet? (i.e. low salt, low cholesterol, etc.)

____

____

Can the individual (circle all that apply):

Feed himself independently	**has difficulty swallowing**	**uses special devices**
Needs physical prompting	**has difficulty holding utensils**	**needs food cut**
Needs verbal prompting	**needs to be fed**	

Recreational and Social Activities

Does the individual attend any other recreation programs? **Yes** **No**
If yes, please list the name of the facility and type of program

____

____

Is the individual a member of any Special Olympics Program? **Yes** **No**
If yes, what borough? What sports?

____

____

Please check all of the following that apply:

Activity	Likes	Dislikes
Bowling		
Arts and crafts, if so what:		
Music Listens to: Interested in band?		
Dance		
Sports, if so what:		
Community outings Especially likes:		
Shopping		
Basic cooking, especially enjoys:		

Computer games		
Roller skating Can skate with one skate? Two skates? Needs assistance		
Swimming		
Movies		
Other (be specific)		

Please attach the following to the application:

1. **Current Physical evaluation completed within the last year including**
    - i. **Medical summary completed within 60 days**
    - ii. **Results of PPD screening within the year**
    - iii. **Hepatitis B status**
    - iv. **C-spine x-ray results with date, if individual is Down Syndrome**
    - v. **VDRL status**
2. **Current ISP/IEP, NOD (Notice of Decision), and Level of Care (LOC)**
    - a. ***Must be Medicaid Waiver eligible***
3. **Psychological and Psycho-Social Evaluations within the last 3 years**
    - a. **Copy of the goal programs from school or program including behavior profile.**
4. **Signed Parent Agreement**
5. **Current Black and White photo for identification purposes**

Mercy Home
243 Prospect Park West
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718-832-1075 Fax: 718-832-7612

Parent or Guardian Agreement

I _________________ the parent or legal guardian of _______________________________ enroll my son/daughter in Mercy Home's Saturday Adult Respite Program and abide by the rules of the agency regarding the program. I understand that my son/daughter will participate in the program from 10AM – 4PM and it is my responsibility to drop off my son/daughter at an appropriate time and pick him/her up no later than 4:15 PM. If I authorize another individual to drop off or pick up my son/daughter I will notify the agency, listing the person's name, address, and telephone number. I understand that my son/daughter will be participating in activities both in the community and at the site. I have met with agency personnel and accept the rules and regulations established by the agency regarding the respite program.

We understand that Mercy Home in performing its care, is acting in full reliance upon the completeness of the information given by us. We give our permission for Mercy Home to have access to this information and, upon the decision of the Director of Support Programs, for any other individuals needing access to this information.

______________________________________ _____________

Signature of Parent or Guardian **Date**

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MEDICAL EMERGENCY CONSENT

In case of emergency during the Respite Program, the Primary Care-Giver will be notified immediately. In the event that the Primary Care-giver cannot be reached, I hereby authorize Mercy Home or a representative thereof, to take ____________________
(Participant's Name)
to the nearest hospital for emergency treatment should the accompanying staff member deem it necessary, and I will accept the charges that may be incurred by such actions. I also hereby release Mercy Home from any and all responsibilities should an accident occur involving _____________________ for which Mercy Home has not shown legal
(Participant's Name)
negligence.

_____________________________________ ___________________

Signature of Parent or Guardian **Date**