



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

In-Home 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: _____

Tentative In-Home Respite Schedule: (Please Circle)

Monday Tuesday Wednesday Thursday Friday Saturday Sunday

Please indicate hour preference: AM: _____ PM: _____
(e.g. PM: 4:30-7:30)

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 them self 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 recreation/respice programs? Yes No
If yes, please list the name of the facility and type of program

Is the individual a member of a Community Club/Association? Yes No
If yes, what borough? What organization?

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 and Psycho-Social within the last 3 years**
- 3 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**

Parent or Guardian Agreement

I _____ the parent or legal guardian of _____ enroll my child in the Mercy Home’s In Home Respite Program and abide by the rules of the agency regarding the program. I understand that my child will participate in the program on a varied and flexible schedule based on my needs. It is my responsibility to let the Director of Support Programs know when a service is not needed. I also understand the Director of Support Programs needs at least 24 hours notice if a service date needs to be cancelled and/or rescheduled. I understand that my child will be participating in activities both in the community and in my home. I have met with agency personnel and accept the rules and regulations established by the agency.

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

MEDICAL EMERGENCY CONSENT

In case of emergency during the In-Home Respite, 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