



Provider Intake Form
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<input type="checkbox"/> Fingerprints
<input type="checkbox"/> Orientation

LIFESPAN RESPITE
Program of The Arc of Jackson County
 2860 State Street
 Medford, Oregon 97504
 541-821-8764 (Phone)
 541-776-6215 (Fax)
 www.thearcjackson.org

Welcome to Lifespan Respite! We are pleased that you are interested in providing respite care services in our area and have chosen to enroll with our information and referral program.

Lifespan maintains a database of self-employed respite care providers, center-based programs and community based respite that is available to provide respite care and related services to families and individuals in our community. *Referred providers are not employees of the Lifespan Respite program or The Arc of Jackson County.*

Please complete the following questions and mail or fax the completed form to the above address.

Date: _____

Name: _____

Phone: _____ (H) _____ (W) _____ (C)

Physical Address: _____ City: _____ Zip: _____

Mailing Address: _____ City: _____ Zip: _____

Email Address: _____

Race/Ethnicity (Optional)

Asian American _____ African American _____ Hispanic/Latino _____
 Native American _____ Caucasian _____ Multiple-Racial Heritage _____
 Other (specify) _____

Primary Language: _____ What other languages do you speak? _____

How long have you lived in Oregon? _____ Other states you have lived in? _____

Your Respite Care Services:

How many individuals are you willing to care for at one time? _____
 (this can be other family members such as siblings)

Where are you willing to provide care? Your home Family's home Center Based
 Foster Care/Group Home Camp/Recreation

If you checked own home, please list other household members: _____

Have any of the above named household members been convicted of a crime: If Yes, please explain: _____

Does anyone smoke in your home? ___Yes ___No
Are you willing to work in a home that has smokers in it? ___Yes ___No

Availability: Days: ___S___M___T___W___TH___F___Sun
Hours: From _____am/pm: To _____am/pm Flexible?_____

Are you available: ___Full time ___Part time ___Weekends ___Holidays

Special Schedule: ___ Drop-In ___ Hourly ___ Temp/Emergency ___ Sick Care ___ 24 hr

Check care group & level your willing to serve:

Care Group: ___ Children 0-18 ___ Adults 18-55 ___ Seniors 56 & older

Care Level: ___ Level I (basic) ___ Level II (Moderate) ___ Level III (Intense)

(see attachment for definition of care levels)

Check Care Experience in the following areas:

	Length of Experience	Check if Able to Provide-
Medically Fragile (Heart Disease, CF, Metabolic, etc.)	_____	_____
Physical Disability (MS, MD, Stroke, Spina Bifida, CP)	_____	_____
Emotional/Mental Disability (ADHD, Bipolar, etc)	_____	_____
Developmental Disability (MR/DD, Autism, TBI, etc)	_____	_____
Seizure Disorder	_____	_____
Hearing Impaired/Sign Language	_____	_____
Visually Impaired/Braille	_____	_____
Speech/Language Impaired	_____	_____
Alzheimer=s/Dementia/Memory Disorders	_____	_____
Female Care Needs/Personal Hygiene	_____	_____
Male Care Needs/personal hygiene	_____	_____
Assist w/Medications	_____	_____
Special Feeding (tube feeding, special diets, etc)	_____	_____
Adaptive Equipment (assistive living devices, etc)	_____	_____
Heavy Lifting	_____	_____
Verbally Aggressive	_____	_____
Physically Aggressive	_____	_____
Allergies (foods, pets, etc.)	_____	_____
Abuse or neglect	_____	_____
Other (specify) _____	_____	_____

Comments: _____

Care Experience: ___ Independent ___ Foster Home ___ Group Home
___ Assisted Living ___ Crisis Care ___ Recreational

Transportation: Are you willing to assist with transportation if needed? ___Yes ___No

If yes, do you want to use your own car ___ or the family=s car ___

Do you have: ___ Valid Drivers License ___ Auto insurance ___ Seat Belts ___ Air Bags

(Note: Families are encouraged to request proof of liability insurance for home and vehicle.)

How far are you willing to travel to provide care?

___ Less than 10 miles round trip
___ Less than 50 miles round trip

___ Less than 30 miles round trip
___ More than 50 miles round trip

Fees for Service:

Level I (Basic) \$ ___ hr \$ ___ day \$ ___ overnight \$ ___ weekend
Level II (Mod) \$ ___ hr \$ ___ day \$ ___ overnight \$ ___ weekend
Level III(Intense) \$ ___ hr \$ ___ day \$ ___ overnight \$ ___ weekend

Are you a Volunteer? _____

Other fees: _____ meals _____ mileage _____ late pick-up _____ other

Relevant Professional Licensure or Certification (including CPR and 1st Aid):

<u>Name of License or Certification</u>	<u>License/Certificate #</u>	<u>Exp date</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

References (keep on file per family request):

Name Phone Number

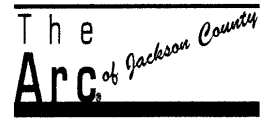
Name Phone Number

Name Phone Number

In a brief paragraph, explain why someone should hire you as a care provider:



Lifespan Respite Provider Policies Agreement



I agree to the following statements:

1. To complete initial orientation. _____initials
2. To obtain a Criminal History Records Check, including fingerprinting if I have not lived in Oregon for less then five years. _____initials
3. To agree for my name to be run through the State of Oregon Child Welfare Registry if I identify working with children. _____initials
4. To agree for my name, phone number and pertinent respite information be posted on The Arc's website. _____initials

Acknowledgments:

As a provider, I acknowledge I am not covered by any insurance through or under the policies of The Arc of Jackson County or The Arc’s Lifespan Respite program, including but not limited to liability, worker’s compensation, and health and accident insurance coverage. I understand that I will be solely responsible for the defense and/or payment of any and all claims arising out of my serving as a provider. _____initials

As a provider, I acknowledge and agree I do not have an employer/employee relationship with The Arc of Jackson County, referred to as The Arc, or The Arc’s Lifespan Respite program, referred to as Lifespan. I am not providing service to The Arc of Jackson County Lifespan Respite program and do not expect to receive compensation from the Arc. _____initials

As a provider, I acknowledge and agree that The Arc of Jackson County or The Arc’s Lifespan Respite program does not guarantee amount of services contracted with each provider. _____initials

As a provider, I acknowledge and understand any information received by The Arc of Jackson County, referred to as The Arc, or The Arc’s Lifespan Respite program, known as Lifespan, on the application, through references, evaluations, or in the interviewing process, may be shared with families inquiring about respite services through The Arc’s Lifespan Respite program. _____initials

As a provider, I acknowledge and understand The Arc’s Lifespan Respite program may contact my references, and contact law enforcement agencies regarding my background through a criminal history records check and/or fingerprints. _____initials

Policy Statements

CONFIDENTIALITY POLICY:

“All families have the right to have all of their records and activities remain confidential. This extends to discussion with other staff, providers, and their immediate families. Breach of confidentiality is a violation of the law. Written permission must be obtained to discuss, photograph, or write about any individual or family, except in the case of abuse and neglect in the protection of the individual being cared for. The confidentiality of information given to The Arc’s Lifespan Respite program will be respected and maintained to the extent the law allows.”

I have read and understand the above Confidentiality Policy statement and agree to abide by it. _____initials

ABUSE REPORTING POLICY:

“Respite care providers, volunteers, and staff are required by law to report any suspected cases of abuse or neglect of any individual under the age of 18 to the local branch of Services to Children and Families and any individual 18 and older to the local branch Senior and Disability Office. If the individual is developmentally disabled or a mental illness, the report should be made to the local Developmental disabilities program or the Mental Health department. The report should be made immediately. All reports are kept confidential. Anyone acting in good faith will have immunity from liability. Failure to report is a Class I misdemeanor.

I have read and understand the above Abuse Reporting Policy statement and agree to abide by it. _____initials

Release:

I release and discharge The Arc of Jackson County, referred to as The Arc, Lifespan Respite program, known as Lifespan Respite, and agree to indemnify, defend, and hold The Arc and Lifespan harmless from and against all claims, demands, actions, and suits, of any kind or nature, which I, or any other person or entity, or heirs, successors, or assigns of such person or entities, might have relating in any manner to my services as a Provider, including but not limited to claims for personal injury or property damage. _____initials

Signature of Provider

Date