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

Family Intake

Welcome to Lifespan Respite! We are pleased that you have chosen to enroll with our information and referral program.

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

Please complete the following questions, sign and return by fax or mail to the above address.

Your name:___________________________ Phone: ________________ Date________________

Name of Person needing care:____________________________________

Mailing Address:_______________________________________City:_____________ Zip:________

E Mail Address:____

Primary language spoken in home:_____________What other languages do you speak?__________

Your Respite Care Needs:

How many individuals in your home need care at one time? _________________________
(this can be other family members such as siblings or other individuals with special needs - please fill out a separate form for each individual needing respite)

Where would you prefer to have care provided? ___Providers home ___Family's home
___Center Based ___ Foster Care/Group Home ___Camp/Recreation ___Other-Specify__________

Does anyone smoke in your home? ___Yes ___No
Would you prefer to have a non-smoking provider? ___Yes ___No

When would you like to have respite? Days: ___S ___ M___ T___W ___ TH___ F___ S
Hours: From ___________am/pm: To __________am/pm Flexible?____

Information on person needing care:

Age of person needing care:________DOB _____________________ M_____ F_______
Type of disabling condition of person needing care____
____
Do you have special equipment in your home to assist in the care of this person? ___Yes ___No
Specify:____

Race/Ethnicity of person needing care (Optional)
Asian American _____ African American _____ Hispanic/Latino _____
Native American _____ Caucasian _____ Multiple-Racial Heritage _____
Other (specify) _______________________________

Level of skill and experience needed (see Level of Care Chart):
Care Level: ____Level I (Basic)____Level II (Moderate)____Level III (Intense, skilled care needed)

Care Categories: *(Check all that apply)*
___Medically Fragile ___Physical Disability ___Emotional/Mental Disability
___Developmental Disability ___Seizure Disorder ___At risk of Abuse/Neglect
___Hearing Impairment ___Visual Impairment ___Speech/Lang Impaired
___Alzheimer=s/Dementia ___Stroke ___Other Health Related
___Infectious diseases___TBI ___Hospice

Specific Care Needs:
___Female Care Needs ___Male Care Needs ___Toileting Assistance
___Assist w/Medications ___Special Feeding ___Adaptive Equipment
___Immobile ___Heavy Lifting ___Constant Supervision
___Sign Language ___Bilingual ___Non-smoking
___Allergies (foods, pets, etc) ___Verbal Aggression ___Physical Aggression
Explain allergies:____
___Transportation ___________________________Other (specify)

Transportation: Will you be asking your caregiver to provide transportation? ___Yes___No
If yes, will you be using your car or the caregiver's car? ____My car ____Caregiver's car
Note: Families are encouraged to request proof of liability insurance - for home and vehicle.

Current Assistance:
Are you (or your person needing care) currently receiving assistance from any of the following:
___SSI ___Oregon Health Plan ___Mental Health thru OHP
___DD Family Support Svc (0-17) ___ DD In-Home Svcs (Children, intensive, CIIS)
___DD In-Home Svc (Adults Comp) ___Crisis/Diversion Svcs (children & Adults)
___Disability Services Office ___Brokerage Services ___Family Caregiver Support Prg (OAA)
___Developmental Disability Services ____OPI (Or Project Independence) ___Veterans Benefits
___Lifespan Respite Managed stipend funds Other (explain)_____________________________

Lifespan Respite

Consent for Respite Care Services and Release Form

The undersigned have been fully informed of the scope and nature of Lifespan Respite, a program of the The Arc of Jackson County, known as The Arc.

I understand Lifespan is acting only as a referral service between those individuals seeking services and those individuals willing to provide services. The referred Provider is not an employee of Lifespan nor The Arc and assumes no responsibility for provider's actions or inactions. I understand it is my responsibility to interview and/or screen providers prior to their providing services.

I am aware of the concern and risk involved in caring for individuals with special needs. I understand the person receiving care by a care provider referred by Lifespan, may suffer an illness or injury.

I hereby agree to waive, release, discharge and hold The Arc of Jackson County and The Arc's Lifespan Respite program harmless from any and all claims, demands, actions, or suits which may arise or in any manner relate to conduct of a provider who referred to the undersigned by Lifespan. This waiver and release includes, but is not limited to claims for personal injury, property damage, and any other claims based upon negligent, intentional, or reckless conduct of a provider.

I have read the foregoing release and understand its contents.

____

Signature of Parent/Guardian **Date**

____

Signature of Person Receiving Care if over 18 **Date**

Level of Care Determination Chart

Note: Individuals needing care may or may not have all the care needs reflected in the given care chart, or they may have needs in multiple care levels. Please circle each level of the category to identify care needs.

Category	Level I Basic	Level II Moderate	Level III Intense
Feeding	Independent; functions close to age level; needs meal prep & serving	Verbal cueing; Close supervision for stuffing, choking etc.	Food pump; g-tube; Cannot feed self
Bathing	With minimal support	Verbal cueing; close supervision	Unable to assist; sponge bath
Dressing	Independent w/minor support (selection of clothing)	Verbal cueing; Some assistance w/ closures	Unable to assist care provider
Toileting	Only needs reminders; Child (0-10) diapering	Verbal cueing; some assistance; adult diapering	Needs full assistance with personal care; catheter care
Mobility	Independent Age appropriate with minor supports	Help with transfers; stand by assist; cane, braces, walker	Unable to help with positioning or movement; wheelchair
Medication	Able to take oral meds with direction	Close supervision required; multiple meds	Requires med mgmt.; injections; suppositories
Medical Supervision	None/age appropriate	Needs preventative monitoring; oxygen therapy	Special equipment monitoring; Trach care; contagious diseases
Communication	Age appropriate	Speech Impaired Visually Impaired Hearing Impaired	Requires special skills-interpreter; sign language; pic symbols
Behavior	Age appropriate	Needs some management; verbal cueing; responsive to direction	Self-injurious; aggressive; wanderer; runner; screamer; no safety concepts; requires 1:1 supervision
Seizures	None	Active medical supervision; semi-controlled w/ meds	Uncontrolled; multiple types; long duration; history