



**Home Information**

Does recipient live with:  Both Parents  Single Parent  
 Foster Home  Group Home  Spouse  
Other: \_\_\_\_\_

Siblings living at home: (if applicable)  
Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_  
Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_  
Will siblings be home when Respite Care is provided? \_\_\_\_\_  
Number of individuals with a disability in home:  1  2  3 or more  
Pets in the home: \_\_\_\_\_

**Programs / Services**

Please list all programs & services in which your family currently participates.  
SSI: \_\_\_\_\_  
Social Security: \_\_\_\_\_  
Medical Assistance/Title XIX: \_\_\_\_\_  
COP: \_\_\_\_\_  
CIP: \_\_\_\_\_  
COP Waiver: \_\_\_\_\_  
Family Support: \_\_\_\_\_  
Other: \_\_\_\_\_  
Other: \_\_\_\_\_

**Emergency Contacts**

If parents/guardian cannot be reached, list contacts in order of preference or your cell phone/pager numbers.

Name: \_\_\_\_\_ Telephone \_\_\_\_\_  
Name: \_\_\_\_\_ Telephone \_\_\_\_\_  
Name: \_\_\_\_\_ Telephone \_\_\_\_\_

**Recipient Information**

Name: \_\_\_\_\_  
(Last) (First) (MI)  
Age: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: Male Female  
Disability: \_\_\_\_\_

## Personal Care

### Means of Movement

Walks Alone                       Walks with help                       Uses Wheelchair

### Toileting

Is the recipient independent in using the bathroom?                       Yes                       No  
Please list all toileting aids (diapers, catheter, urinal, etc.)

\_\_\_\_\_

\_\_\_\_\_

### Vision

Good Vision                       Legally Blind                       Blind one eye L/R  
 Color Blind                      Special Equipment: \_\_\_\_\_

### Hearing / Language

Normal Hearing                       Deaf                       Deaf one ear L/R  
Special Equipment: \_\_\_\_\_

Can the recipient understand & respond to questions? \_\_\_\_\_  
How does the recipient communicate his/her needs & wants? (sign language, lip read, etc.) \_\_\_\_\_

### Cognitive Ability

Level the recipient is functioning at: \_\_\_\_\_  
Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Dressing/Hygiene

Dresses independently                       Dresses with help                       Needs total care  
 Cooperates while being dressed

### Bathing

Needs Total Care                       Prefers Shower                       Prefers Bath  
 Washes independently                       Requires help  
 Independent in brushing teeth                       Requires help  
 Combs/brushes hair independently                       Requires help  
 Independently attends menstrual hygiene                       Requires help

### Mealtime

Does the recipient feed him/herself?                       Yes                       No  
Does the recipient drink from a cup?                       Yes                       No  
Does the recipient require tube feeding?                       Yes                       No  
Special diet? \_\_\_\_\_

\_\_\_\_\_

Allergies? \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Special Physical Needs**

Is the recipient prone to seizures?            \_\_\_ None    \_\_\_ Uncontrolled  
\_\_\_ Controlled w/ Medication

If the recipient has seizures, please give a general description, frequency and length of seizures: \_\_\_\_\_  
\_\_\_\_\_

Any conditions the respite care worker should be aware of such as cardiovascular or respiratory problems, allergies, hyperactivity, etc.?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Behavior**

\_\_\_ Usually easy going            \_\_\_ Shy/Withdrawn            \_\_\_ Wary of new situations  
\_\_\_ Suicidal                        \_\_\_ Underactive                \_\_\_ Plays well with others  
\_\_\_ Physically aggressive        \_\_\_ Self abusive                \_\_\_ Overactive  
\_\_\_ Needs direction/supervision            \_\_\_ Verbally aggressive/demanding

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How does the recipient handle frustration? \_\_\_\_\_

How does the recipient respond to new people? \_\_\_\_\_

How does the recipient respond to change? \_\_\_\_\_

When behavior difficulties are happening (aggression, temper tantrums, non-compliance, etc.) describe what works to resolve the issue: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I (We) consent to the release of the information contained in this summary by Dodge County Lifespan Respite Network to prospective Respite Care Providers. I understand that this information will be used only as necessary to provide Respite Care Providers with background information to enable them to provide a continuum of care for this recipient. I hereby hold harmless and will not attempt to take legal action against Dodge County Lifespan Respite Network, their agents, representatives, staff and volunteers. I hereby give my consent for Dodge County Lifespan Respite Network to use any photos or video of my family member for use in promoting advocacy and awareness of Dodge County Lifespan Respite Network and their services through newspapers, websites and other printed materials.

08/09

Date \_\_\_ / \_\_\_ / \_\_\_                        Signature \_\_\_\_\_

Date \_\_\_ / \_\_\_ / \_\_\_                        Signature \_\_\_\_\_