Citizens Options Unlimited

Respite 2022

Thank you for applying to Respite connections 2022. Please ensure that you have read the information on www.citizens-inc.org/respiteconnections/ prior to applying. We want to ensure you understand the structure of this program. The information you provide in this application is what we use to support the applicant. Please ensure that all the information is accurate. Family Support Services Department at 516-293-2016x5140

Name of applicant *

First Name Last Name

Date of Birth

Month Day Year

Medicaid Number

TABS ID

Name of Parent or representative

First Name Last Name

Phone Number 1 *

Area Code Phone Number

Phone Number 2 *

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Area Code Phone Number

Email Address *

example@example.com

Email Address 2 *

example@example.com

Address

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Does the applicant live at home with Family?

YES
NO

Does the applicant reside in an IRA or ICF with an Agency?

YES
NO

if so, What Agency?

Care Manager Name

First Name Last Name

Care Manager Phone Number

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Area Code

Care Manager Email

example@example.com

Email

example@example.com

Self Direction -Broker's Name

First Name Last Name

Broker's Phone Number

Area Code Phone Number

Broker's E-mail

example@example.com

Please Provide the Day program The applicant attends

Day Program Number

Area Code Phone Number

Day Program Email

example@example.com

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Schedule

Wednesday-Friday 4pm-9pm

Saturday & Sunday 9am-4pm

Please select the days the participant wishes to attend:

- Wednesday 4pm - 9pm
- Thursday 4pm -9pm
- Friday 4pm - 9pm
- Saturday 9am - 4pm
- Sunday 9am -4pm

Medical Information

Does the applicant suffer from Seizures?

- YES
- NO

Does the applicant need an Rescue Medication? If so, Please note that we can not administer medications and will dial 911, should the seizure approach 5 minutes.

Do you consent to the above protocol?

- YES
- NO

Is the participant ambulatory ? Please choose the best option below:

- Can walk independently
- Cannot walk without assistance
- Uses a wheelchair with assistance
- Uses a wheelchair Independently
- Uses a walker Independently

Does the participant use Adaptive Equipment? If so, please list below:

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What level of support is needed during Meals? Please select below:

- Can eat independently
- Can eat with assistance
- Can not feed himself / herself

Does the participant follow a special diet order with food consistencies? if so, Please select below:

- Whole food
- 1/2 an inch
- 1/4 of an inch
- Ground
- Puree

Does the participant follow a special diet order with liquid consistencies? if so, Please select below:

- Regular Thin liquid
- Nectar
- Honey
- Pudding

Does the participant have a history of choking?

- YES
- NO

Does the participant have any allergies? if so, please list below:

What level of support is needed with toileting?

- Independent
- Needs assistance with changes
- Needs Prompting to use the bathroom
- Can not toilet on their own
- Assistance during Menses

Has the participant tested positive for Covid -19 in the past 5 days or been exposed to a positive person and/or have any symptom

- YES
- NO

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Please provide any medical information that is important about the participant below:

Behavioral

Strengths

What strengths do you observe with this applicant? Indicate 'yes' for all that apply

Able to discuss their wants and needs

YES
NO

Likes to be helpful

YES
NO

Responsible with own schedule

YES
NO

Good Sense of humor

YES
NO

Enjoys Learning new things

YES
NO

Does the applicant engage in behavior that can be harmful to self? If so, please explain

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Does the applicant eat inedible objects? If so, please explain

Does the mouth objects (puts objects in his /her mouth, licks them, chew on them, etc.)

Does the participant have a behavior support plan?

YES
NO

Unmet Need Indicators

How might the applicant demonstrate an unmet need? Select "yes" for all that apply.

Attention Seeking

YES
NO

Disrobing

YES
NO

Verbal Aggression

YES
NO

Perseverating

YES
NO

Wandering/Eloping

YES
NO

Any other indicators? If so, please explain

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What types of situations are likely to upset the applicant and result in challenging behavior? If not applicable, please list NA.

What are the 'warning signs' that the applicant might display to indicate they are agitated? If not applicable, please list NA.

What will the applicant do or say to indicate that they are happy? If not applicable, please list NA.

What things make the applicant the most happy (people, activities, food, etc.)?

What will the applicant do or say to indicate that they are unhappy?

How does the applicant communicate that he/she wants something?

How does the applicant communicate that he/she does NOT want something? If not applicable, please put NA.

Are there any specific routines/rituals that the applicant must follow?

Calming Approaches

What approaches usually work best to help the applicant calm down? Please indicate yes / no.

Verbal Calming

YE

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NO

Redirection

YES
NO

Distraction to another topic

YES
NO

Taking a break

YES
NO

Time to himself/herself

YES
NO

Having someone to talk to

YES
NO

Finding a quiet space

YES
NO

Music/ Books/Etc.

YES
NO

Going for a walk

YES
NO

Any other approaches? If so, please explain

Tools

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What tools might help the applicant do well? Indicate 'yes' for all that apply.

Visual Schedule

YES
NO

Sensory Items (chewables, fidgets etc.)

YES
NO

Environmental sweeps

YES
NO

Reinforcement Schedule

YES
NO

If/ then strategies

YES
NO

PECS

YES
NO

Prescribed adaptive equipment for behavioral challenges (protective mittor helmet, seatbelt lock, etc.)

YES
NO

Any other tools? If so, please explain

Does the applicant understand personal space?

YES
NO

Does the applicant touch others without the other person's consent? (i.e. excessive hugging,

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kissing, etc.)?

YES
NO

How best does the applicant's primary caregiver(s) manage any sexual behaviors? If not applicable, please list NA.

YES
NO

Does the applicant currently have a Behavior Support or Behavior Monitoring Plan in place at school/day program?

YES
NO

Please give us a brief description of the participant and include information that is necessary to support the participant's needs.

Please specify what types of behaviors, triggers or environments that has a negative affect on the participant:

Documentation Checklist - Please ensure that you submit the following with this application

Update Life plan : Citizens Options unlimited listed in sections 1, 3 & 4.
Approved Budget if self directed
Updated Medical
Immunizations
2 series PPD or QuantiFERON TB
Behavior Support Plan

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