Respite Stay Request Questionnaire

Respite Dates: From: Click or tap to enter a date. To: Click or tap to enter a date.

Requested Location: Click or tap here to enter text.

Name:Click or tap here to enter text.

Age:Click or tap here to enter text. DOB: Click or tap to enter a date.

Sex: M☐ F☐ Other:Click or tap here to enter text.

Medicaid: Click or tap here to enter text. Medicare: Click or tap here to enter text. SS#: Click or tap here to enter text.

Guardian Contact info: Name: Click or tap here to enter text. Phone: Click or tap here to enter text. EmailClick or tap here to enter text. Address: Click or tap here to enter text.

Other Emergency Contact info: Name: Click or tap here to enter text. Phone: Click or tap here to enter text. EmailClick or tap here to enter text. Address: Click or tap here to enter text.

SSA: Name: Click or tap here to enter text. County: Click or tap here to enter text.Phone: Click or tap here to enter text. EmailClick or tap here to enter text.

Respite will be paid by: Level 1 Waiver ☐ IO Waiver ☐ Other☐ :Click or tap here to enter text.

Medical Information:

Covid vaccinated? Yes ☐ No ☐

Medication (Check one): (attach list of medications)

☐No medication is to be administered during stay

☐Medication will be provided in a pharmacy labeled container for duration respite stay

☐A signed Dr. order will be provided in order for Gateways to fill medication through our pharmacy

How do they complete medication administration? Independent ☐ Verbal prompts☐ Total assist☐

Medication Route (check all the apply) – Oral☐ Topical ☐ Injection ☐ Gastronomy ☐

Advanced Directives: DNR Yes ☐ No ☐ DNRCC: Yes ☐ No ☐ If yes, attach documentation

Seizure D/O: Yes ☐ No ☐ Details: (frequency/duration/PRN): Click or tap here to enter text.

Vagus nerve stimulator: Yes ☐ No ☐

Tracheostomy: Yes ☐ No ☐

Ileostomy/ Colostomy: Yes ☐ No ☐

PICC line/IV: Yes ☐ No ☐

Diabetic: Yes ☐ No ☐ How is the Diabetes treated?

Diet/exercise only Yes ☐ No ☐ Finger stick? Yes ☐ No ☐ Oral medications Yes ☐ No ☐ Finger stick Yes ☐ No ☐ Injection Yes ☐ No ☐ sliding scale Yes ☐ No ☐

Allergies Yes ☐ No ☐ Details: Click or tap here to enter text.

O2, CPAP, aerosol treatment, breathing issues? Yes ☐ No ☐ Details: Click or tap here to enter text.

Ambulation method: Click or tap here to enter text.

Fall Risk: Yes ☐ No ☐ Details: Click or tap here to enter text.

Diet type: NPO☐ Pleasure Feed only ☐ Oral☐ Tube Feed☐ Type:Click or tap here to enter text.

Diet Texture: Regular ☐ Chopped☐ Chopped/ Ground Meat ☐ Ground☐ Puree ☐

ADA☐ NAS☐ Gluten Free☐ Other:Click or tap here to enter text.

Beverage Thickness: Regular thin☐ Nectar☐ Honey☐ Puree☐

Choking risk Yes ☐ No ☐ Details: Click or tap here to enter text.

Feeding Assistance Needed: independent ☐ Verbal/Physical Assistance☐ Total Feed☐

Adaptive equipment: Click or tap here to enter text.

Toileting Assistance Needed: Independent ☐ Verbal/Physical Assistance☐ Total Assist☐

Continent of Bowel/ Bladder Yes ☐ No ☐ Details: Click or tap here to enter text.

Catheter Yes ☐ No ☐

Depends/Pull ups use: Yes ☐ No ☐ Size and Schedule: Click or tap here to enter text.

Rights Restrictions:

Manual Restriction: Yes ☐ No ☐ Details: Click or tap here to enter text.

Mechanical Restriction: Yes ☐ No ☐ Details: Click or tap here to enter text.

Chemical: Yes ☐ No ☐ Details: Click or tap here to enter text.

Other Restrictions: Yes ☐ No ☐ Details: Click or tap here to enter text.

Supervision level needed during:

Eating: Independent☐ Auditory ☐ Visual ☐ Total ☐ 1:1 ☐

Personal hygiene: Independent☐ Auditory ☐ Visual ☐ Total ☐ 1:1 ☐

Community: Independent☐ Auditory ☐ Visual ☐ Total ☐ 1:1 ☐

At home in bedroom: Independent☐ Auditory ☐ Visual ☐ Total ☐ 1:1 ☐

At home in common area: Independent☐ Auditory ☐ Visual ☐ Total ☐ 1:1 ☐

Communication: Verbal☐ Sign Language☐ Written ☐Vocalizations ☐Non-Verbal☐

Behavioral Concerns:

Elopement☐ Sexually issues ☐ Cannot be in a co-ed home☐ Physical aggression☐

Self-Injurious☐ Verbal Aggression☐ Property destruction☐ Other:Click or tap here to enter text.

Give Detail: (include frequency and duration of incidents) Click or tap here to enter text.

Sleeping needs:Click or tap here to enter text.

Day Program: Name of Day Program: Click or tap here to enter text.Contact Name: Click or tap here to enter text. Phone: Click or tap here to enter text. EmailClick or tap here to enter text. Address: Click or tap here to enter text.

Transportation Service: Name of Agency: Click or tap here to enter text.Contact Name: Click or tap here to enter text. Phone: Click or tap here to enter text. EmailClick or tap here to enter text. Address: Click or tap here to enter text.

Times Pick Up: Click or tap here to enter text. Drop off:Click or tap here to enter text.

Other Pertinent information: Click or tap here to enter text.

SSA Responsibilities:

Copy of ISP sent to Gateways: Yes ☐ No ☐

A statement of support from the CB that verifies the payment source and that the individual and their team agrees to the service was sent to OSSAS@dodd.ohio.gov Yes ☐ No ☐

Consent provided to Gateways prior to stay:
☐Authorization to Obtain info Consent
☐Authorization to Release info Consent
☐Clothing Personal Effects Consent
☐Psychotropic/medication Consent
☐Emergency Medical Authorization Consent
☐Acknowledgement of Rights Consent
☐Rights Restrictions Consent

Who should we notify if Respite Stay is approved/denied? Name: Click or tap here to enter text. County: Click or tap here to enter text.Phone: Click or tap here to enter text. EmailClick or tap here to enter text.

Please send this to Kristie Rossi krossi@gatewaystbl.com

Any questions please call Kristie at 330-565-9411