# Respite Stay Request Questionnaire

Respite Dates: From: To:

Requested Location:

Name:

Age: DOB:

Sex: M ☐ F ☐ Other:

Medicaid: Medicare: SS#:

Guardian Contact info: Name: Phone:
Email: Address:

Other Emergency Contact info: Name: Phone:
Email: Address:

SSA: Name: County: Phone: Email:

Respite will be paid by: Level 1 Waiver ☐ IO Waiver ☐ Other☐ :

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 medical administration? Independent ☐ Verbal Prompts ☐ Total assist ☐
Medication Route (check all that apply) - Oral ☐ Topical ☐ Gastronomy ☐

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

Seizure D/O: Yes ☐ No ☐ Details: (frequency/duration/PRN):

Vagus nerve stimulator: Yes ☐ No ☐

Tracheostomy: Yes: ☐ No: ☐

Ileostomy/Colostomy: Yes: ☐ No: ☐

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:

O2, CPAP, aerosol treatment, breathing issues? Yes ☐ No ☐ Details:

Ambulation method:

Fall Risk: Yes ☐ No ☐ Details:

Diet Type: NPO ☐ Pleasure feed only ☐ Oral ☐ Tube Feed ☐ Type:

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

ADA☐ NAS☐ Gluten Free☐ Other:

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

Choking risk Yes ☐ No ☐ Details:

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

Adaptive equipment:

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

Continent of Bowel/ Bladder Yes ☐ No ☐ Details:

Catheter Yes ☐ No ☐

Depends/Pull ups use: Yes ☐ No ☐ Size and Schedule:

**Rights Restrictions:**

Manual Restriction: Yes ☐ No ☐ Details:

Mechanical Restriction: Yes ☐ No ☐ Details:

Chemical: Yes ☐ No ☐ Details:

Other Restrictions: Yes ☐ No ☐ Details:

**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:

Give detail: (include frequency and duration of incidents)

Sleeping needs:

Day Program: Name of Day Program: Contact Name:
Phone: Email: Address:

Transportation Service: Name of Agency: Contact Name:
Phone: Email: Address:

Times Pick Up: Drop off:

Other Pertinent information:

**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: County:
Phone: Email:

Please send this to Kristie Rossi krossi@gatewaystbl.com

Any questions please call Kristie at 330-565-9411