Non-Emergency 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 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): _____

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 ☐

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 Elaine Bertolette: ebertolette@gatewaystbl.com

Any questions please call Elaine at (330) 792-2854 ext. 232.