

Respite Care Provider Application

Personal Information

Name: _____

Address: _____
Last First Middle (or facility name) City State

Phone: _____

E-mail Address: _____
Home Work Cell

Date: _____

Preferences for providing care:

Age group 0-12 13-17 18-64 65+

Sex Male Female

Schedule available:

Days Evenings Nights Weekends

Regular Occasional Emergency/ Short notice

Times you are not available: _____

Are you currently available? Yes No

Location Desired

La Grande Union Cove Elgin

Imbler North Powder Anywhere in Union County

Transportation

Would you be willing to provide transportation? Yes No

Would a collapsible wheelchair fit in your car? Yes No

Fee Schedule

How do you wish to be paid?

Fixed rate _____ Negotiable Volunteer

Why do you wish to be a Respite Care Provider?

Care Setting

Where do you wish to provide care?

Your Home Clients Home Center Based Activities/ Outings

(If in your home, please fill out next section)

If you wish to provide care in your home

The law requires all household members over 18 to have current criminal background checks.

List other household members over 18 _____ **Date of last background check** _____

Are you a licensed care provider? Yes No What type of license? _____

Do you live in _____ House Apartment
Homeowner/ Renter Liability Insurance Yes No

Sleeping Accommodations for another person? Yes No
Please Describe _____

Secured Fenced Yard? Yes No **Nearby Park?** Yes No

Pets Yes No Please Describe _____

Is your home a non-smoking environment? Yes No

Any Allergies Yes No
Please describe _____

Training and Education

- CNA Certified Nursing Assistant
 - LPN Licensed Practical Nurse
 - RN Registered Nurse
 - BA/ BS Degree
 - Hospice Training
 - Sign Language
 - EMT Emergency Medical Technician
 - Registered Child Care Provider
 - Adult Foster Care
 - CEP Client employed Provider
 - Other Special Needs Training (describe) _____
- CDA Child Development Assoc.
 - ECE Early Childhood Ed.
 - CPR Training
 - First Aid Training
 - Physical Therapy
 - CMA Certified Medication Aide
 - E-Force Training
 - Foster Parent
 - Abuse/Neglect Training
-

Do you have a current Criminal Background Check?

- Yes No Date Approved _____

Through which Agency? SPD CCRR Family Support SCF Hospitals Schools Other _____

What is your Primary Language? English Spanish Other _____
Do you speak any other languages? Please Describe _____

How much can you lift? <20 lbs 20 - 50 lbs 50-100 lbs >100 lbs
Any physical limitations? Yes No Describe _____

Do you have any experience with the following disabilities;

- Developmental - Chronic illness/ medical fragility
 - Physical Alzheimer/ other related disorder
 - Emotional/ behavioral At risk of abuse or neglect
 - Elderly fragile Other special need
- Briefly describe: _____

Education

	School Name/Location	Year Graduated	Degree/Certification
High School	_____		
College	_____		
Other Specialized School	_____		

Skills List

Please check the highest levels for which you are experienced in providing care.

Categories	Level 1/ Basic; Client needs...	Level 2/ Moderate; Client Needs...	Level 3/ Intense; Client Needs...	Willing to Learn?
Feeding	<input type="checkbox"/> No help <input type="checkbox"/> Supervision	<input type="checkbox"/> Verbal cueing <input type="checkbox"/> Close supervision for choking	- Fed by hand <input type="checkbox"/> Food pump <input type="checkbox"/> Gastronomy tube	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bathing	<input type="checkbox"/> Stand by assistance	<input type="checkbox"/> Verbal cueing <input type="checkbox"/> Close supervision	<input type="checkbox"/> Bathed totally	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dressing	<input type="checkbox"/> Supervision <input type="checkbox"/> No help	<input type="checkbox"/> Verbal cueing <input type="checkbox"/> Close supervision	- Dressed totally	<input type="checkbox"/> Yes <input type="checkbox"/> No
Toileting	<input type="checkbox"/> Verbal reminders <input type="checkbox"/> No help	<input type="checkbox"/> Cues and some assistance <input type="checkbox"/> Diapering	<input type="checkbox"/> Total assistance	<input type="checkbox"/> Yes <input type="checkbox"/> No
Medication	<input type="checkbox"/> No help to take oral medications	<input type="checkbox"/> Multiple medications <input type="checkbox"/> Close supervision when taking medication	<input type="checkbox"/> Injections <input type="checkbox"/> Suppositories <input type="checkbox"/> Oral medications to be administered	<input type="checkbox"/> Yes <input type="checkbox"/> No
Behavior	<input type="checkbox"/> Verbal management only	<input type="checkbox"/> Combination of verbal & physical management (Extremely active or non- compliant)	Management for; <input type="checkbox"/> Self abusive <input type="checkbox"/> Verbally abusive <input type="checkbox"/> Physically aggressive <input type="checkbox"/> Wandering 1:1 supervision	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mobility	<input type="checkbox"/> Stand by assist <input type="checkbox"/> No help	<input type="checkbox"/> Wheelchair/special equipment <input type="checkbox"/> Help with transfer pivoting, positioning	<input type="checkbox"/> Total transfer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Medical	<input type="checkbox"/> None/ Age appropriate	<input type="checkbox"/> Equipment monitoring	<input type="checkbox"/> Trach care <input type="checkbox"/> Catheter care <input type="checkbox"/> Hospice <input type="checkbox"/> Monitors <input type="checkbox"/> (Has) contagious disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Communication	<input type="checkbox"/> None/Age appropriate	<input type="checkbox"/> Conversational sign language <input type="checkbox"/> Interpreter (for family communication) <input type="checkbox"/> Help with other speech disorder	<input type="checkbox"/> Communication board <input type="checkbox"/> Other communication devices	<input type="checkbox"/> Yes <input type="checkbox"/> No
Seizures	<input type="checkbox"/> No help/ mild or controlled if present.	<input type="checkbox"/> Active supervision/ seizures semi-controlled occasional breakthrough	<input type="checkbox"/> Active medical supervision /seizures uncontrolled, multiple types, long duration	<input type="checkbox"/> Yes <input type="checkbox"/> No
Memory Loss	<input type="checkbox"/> Only needs reminders	<input type="checkbox"/> Close supervision	<input type="checkbox"/> Constant supervision	<input type="checkbox"/> Yes <input type="checkbox"/> No

References

List three references. Include former employers or families for whom you provided care.
Please give current addresses and phone numbers

Name: _____
Address: _____
Phone: _____
How long have you known this person? _____
What is your relationship with this person? _____

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Signature of Applicant

Date

Provider Responsibilities

Anyone with the desire to provide care for someone with special needs can apply to be a respite care provider. The individual must be at least 18 years old, be literate and capable of understanding written and oral communication with families/caregivers. He/she must be able to respond appropriately to emergency situations, possess physical health, mental health, and good personal character determined necessary by Lifespan Respite of Union County to provide care for special needs clients. Both paid and volunteer providers will be recruited for the Lifespan Respite of Union County. New providers will be entered into the Lifespan Respite of Union County database only after meeting the program screening requirements. Individuals will remain on the database until they request to be removed, they fail to respond to semi-annual update requests, or if deemed necessary by the Lifespan Respite Of Union County Advisory Council.

Providers are also responsible for:

- Obtaining necessary information about the family.
- Providing information about yourself to the family.
- Being dependable, arriving on time and ready to work.
- Providing reliable, safe and quality services to the family.
- Maintaining confidentiality about the person being cared for, and their family.
- If in your home, making sure that it is a safe and healthy environment.
- Respecting the family values, rules and home environment.
- Completing paperwork, and maintaining any record keeping required by law, and the respite program.
- Knowing when to report abuse and neglect of children, adults with disabilities, and older adults.

Confidentiality Agreement, Release of Information & Release of Liability

I agree to keep confidential all medical and personal information regarding individuals receiving care and families I meet through the Lifespan Respite Care Network. I will not discuss such information with my family, friends or casual acquaintances.

In signing this application, I affirm that the information given here is correct. The information that I have provided here may be verified by contacting persons or organizations named on this intake form, and I hereby release and agree to hold harmless from liability any person or organization (named or unnamed) providing information concerning me to the Lifespan Respite Care network.

I understand that Lifespan will conduct a criminal background check, and any other record check deemed appropriate before my name is referred to possible employers (families and caregivers).

I understand that I am not applying for a job with the Center for Human Development, the State of Oregon, or the Lifespan Respite care Network. Referred providers are not employed by Lifespan Respite of Union County, and I hereby release Lifespan of any and all liability incurred as a result of any referrals through this network.

Signature

Date

The following agencies are among those that may be contacted to verify references and information given by provider on this application:

Seniors and People with Disabilities
Child Welfare Services
Self Sufficiency
Center for Human Development, Inc.
Child Care Resource and Referral
Community Connection
Baker-Union Educational Service District