UNITY HOUSE OF CAYUGA COUNTY, INC.

Residential Respite Admissions Policy

Updated 9/2013

Policy: It is the policy of Unity House of Cayuga County, Inc. to provide respite services to adults with mental retardation or developmental disabilities. This respite need may be anticipated or emergency status. Our goal is to provide quality oversight and support to individuals in a safe, clean, timely manner.

Admissions Criteria:

1. The individual referred for respite services must be eligible for service under the OPWDD and be Medicaid waiver enrolled. Unity House **must be** identified in the ISP (or on an addendum) as a waiver service.

2. A letter of eligibility and a Notice of Determination must accompany the initial admission application.

3. The individual must be 18 years of age.

4. The individual must be cleared psychiatrically and medically if the referral is generated by the Emergency Room. A clinical staff and physician must document in writing that the individual is not a danger to him/herself or others and is medically stable and appropriate for respite care.

5. Individuals requiring IV's, ports, or injections (including diabetes) that require RN coverage will be considered on a case-by-case basis and the availability of contract nursing from Gentiva or Stafkings.

6. Individuals must be living with family.

7. The Individual must have an established need for respite, therapeutic stay, trial visit or emergency housing.

8. The individual must be able to evacuate in the event of a fire.

9. There must be a current ISP, LCED and Service Coordinator.

10. The program will make the determination if there is evidence of a need for additional support or information from family or other service providers.

11. Primary care giver is responsible for maintaining a supply of medications. This includes enough meds to last throughout the individuals stay.

12. All medical issues or concerns will be directed to the Primary Care Physician both during business and after business hours.

13. All Medical and Psychiatric emergencies will be handled as per Unity House policy and procedure.

14. It is our goal to admit qualified individuals with an emergent need in less than three hours.

15. The MSC will provide a ***completed*** Respite Packet, a current ISP, Behavior Plan, if applicable, OPWDD Letter of Eligibility, Notice of Determination, current physical and copies of current prescriptions a ***minimum*** of one week prior to consumer's stay (unless this is an emergency situation). This allows staff to become familiar with the consumer and to effectively prepare for their stay.

16. Referrals will be reviewed by the Program Manager and Nursing Staff and admission will be determined on a case by case basis.

Unity House
Empowering Lives. Securing Futures.

UNITY HOUSE OF CAYUGA COUNTY, INC.
Referral and Respite Plan Initial and Annually

Today's Date _____
Name: _____ Birth date: _____
TABS#: _____
SSI#_____-____-_____ Medicaid Waiver eligible: yes no
Medicaid Waiver enrolled: yes no
Unity House listed on Medicaid Waiver in current ISP or an addendum: yes no

Primary Care Giver: _____
Address: _____
Phone:_____

Person to be contacted in case of an emergency:
1. Name: _____ Home #_____
Relationship_____ Work #_____
Cell#_____
2. Name: _____ Home #_____
Relationship_____ Work #_____
Cell#_____

Service Coordinator: _____ phone: _____

E-mail address: _____

Health Care Providers
Insurance Carrier:_____ Policy #: _____

Medicaid #: _____ Medicare #: _____

Current Diagnoses/DD: _____Diagnosis Axis 1 Code _____

Primary Physician: _____Phone: _____ Fax #_____

Dentist: _____ Phone: _____ Fax # _____

Pharmacy: _____ Phone: _____ Fax #_____

Pharmacy Address: _____

Other Physicians

Name:	Specialty:	Phone:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FIRE SAFETY

a. Level of Assistance: _____
b. Response to Fire Emergency (i.e.: recognizes need to evacuate when alarm sounds, may sleep through alarm, etc.) _____
c. Training Needed: _____
d. Handling of Matches/Lighters: _____
e. Adaptive Equipment: _____
f. Self-Evacuation Difficulties: _____

SUPERVISION LEVEL REQUIRED

a. Home alone status: _____
b. Outside: _____
c. Community access: _____
d. Supervision in the Community: _____
e. Supervision in the Home:_____
f. When is the person considered missing? _____
g. Swimming: _____
h. Travel safety needs (e.g. seatbelt harness, car seat, ability to fasten seat belt, need for a particular seat in the vehicle, etc): _____
   _____
   _____
i. Money Management skills: _____
j. Does the person have a budget? Yes ___ no ___
   If yes, how much when? _____
k. Smoking: __no __yes If yes, level of supervision: _____
   _____

BEHAVIORAL

a. Describe the person's general disposition (e.g. calm, outgoing, shy, over-active, etc.)_____
   _____
   _____
   _____

b. Does the person have Behavior Plan? Yes ____ no _____ **If yes, please provide with ISP**.

c. Describe any problematic behaviors, including severity and frequency:
   _____
   _____
   _____

d. Method of Intervention: _____
e. Fears: _____
f. Describe typical interaction with others: _____
   _____
g. Are there any special concerns or problems when in public or community settings? Outdoors? _____
   _____

HEALTH/MEDICAL/NUTRITION

Medical conditions: _____

Current Diagnoses/DD: _____

Height: _____ Weight: _____ Gender: _____
TB Status: _____ **Date of Last mantoux:** _____
Date of Last Tetanus Shot _____ Hepatitis Status: _____

Can the person give Informed Consent for Treatment? _____
Can the person give Informed Consent for First Aid? _____
Can the person give Informed Consent for Medications? _____
Is there a current or valid DNR in place? _____ Date reviewed: _____

Precautions

a. *Allergies* _____
Describe Allergic Reaction: _____

b. Choking Risk: __no __yes
Describe assistance required: _____

c. Seizures? __no __yes
If yes, describe (i.e., duration, what happens before and after, care to be given during and following the seizure) _____
_____
_____

d. PICA: __no __yes

e. Sun Sensitivity: __no __yes

f. Skin Integrity: _____

g. GI Problems: _____

h. Special Precautions (limitations on activities, weather precautions):
_____
_____

i. Special Health Care Needs, Recent Hospitalizations, Changes in Medical Status:
_____
_____

Medications:

Medication:	Dose:	Schedule:	Purpose:	Major Side Effects:
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Medication administration: ___independent ___staff supervision ___staff assistance

MEDICAL AIDS

Vision: _____ Hearing: _____ Mobility: _____

Catheter/Incontinence Products: _____

NUTRITION

Food Allergies: _____
Special Diet,/Restrictions/Consistency: _____
Diabetes Precautions: __no __yes
Special dining equipment and precautions: _____
Is there any difficulty with swallowing or choking?: _____
Food likes: _____
Dislikes: _____
Snacks/frequency: _____

DENTAL

Own teeth ___y___n If yes, condition _____
Dentures: ___upper ___lower ___partial
Oral hygiene ___independent ___with assistance ___dependent

COMMUNICATION

How does he/she communicate? _____
Key phrases or gestures: _____
How does the person express pleasure? _____
How does the person express pain or displeasure? _____

ADAPTIVE EQUIPMENT NEEDS (i.e. oxygen, suctioning, ostomy care, g-tube, etc.)

Equipment	How is it to be used	Time and duration of use
_____	_____	_____
_____	_____	_____
_____	_____	_____

Who should be contacted for repair or adjustment? _____
_____

SELF CARE/ACTIVITIIES OF DAILY LIVING (ADL's)

What, if any, assistance is needed in the following areas:

Hair care:	___independent	___with assistance	___dependent
Shaving:	___independent	___with assistance	___dependent
Menstrual care:	___independent	___with assistance	___dependent
Tooth brushing:	___independent	___with assistance	___dependent
Dress/undress:	___independent	___with assistance	___dependent
Toileting:	___independent	___with assistance	___dependent
Showering:	___independent	___with assistance	___dependent
	___morning	___evening	

Special instructions: _____
_____
_____

Recreation likes and dislikes: _____

SLEEPING

What kind of bed does the person sleep in at home? (Include bedrails, bed wedges, side rail, pads, hospital bed, bed padding, etc)_____
_____
_____

Usual bedtime _____ Usual wake up _____
Nap time _____
Sleep through the night? _____
What should be done if the person wakes up during the night? _____
_____
_____

RIGHTS PROTECTION/VULNERABILITY

a. Ability to give consent for sexual activity: _____
   _____
b. Ability to protect self from abuse: _____
   _____
c. Respect privacy: _____
   _____
d. Voting: ____ Yes _____ No
e. Attends Church: _____ Yes _____ No
   If yes, indicate denomination and church: _____

Special Safety Concerns: _____
_____

COMMUNITY ACTIVITIES

Name of school/work/day hab: _____
Address: _____
Phone: _____
Teacher/Supervisor: _____
Transportation Phone Number:_____
Transportation: Time of pick up: _____ Time of drop off: _____

Name of school/work/day hab: _____
Address: _____
Phone: _____
Teacher/Supervisor: _____
Transportation Phone Number:_____
Transportation: Time of pick up: _____ Time of drop off: _____

Community Activities (cont.)

Name of school/work/day hab: _____
Address: _____
Phone: _____
Teacher/Supervisor: _____
Transportation Phone Number:_____
Transportation: Time of pick up: _____ Time of drop off: _____

Name of school/work/day hab: _____
Address: _____
Phone: _____
Teacher/Supervisor: _____
Transportation Phone Number:_____
Transportation: Time of pick up: _____ Time of drop off: _____

All Services are aware of respite stay? _____ Yes _____ No

Unity House
Empowering Lives. Securing Futures.

Weekly Program/Service/Activity/ Routine

(include days and times of At-Home Res Hab, Day Hab, Employment, Classes, Olympics, Bowling, etc)

Sun	Mon	Tues	Wed	Thurs	Fri	Sat

Example:

Monday	Tuesday	Wednesday	Thursday	Friday
Day-Hab 9a to 2p	Work 8a to 1p	Day-Hab 9a to 2p	Dinner at Dad's 6pm	Day-Hab 9a to 2p
Class at college 5p to 7p		Swimming at 7p		

_____ _____

Signature and Title of Person Completing this form Date

_____ _____

Signature of Primary Caregiver/Legal Guardian Date

Note: This form must be completed for initial respite referral and updated before any subsequent visits.

UNITY HOUSE OF CAYUGA COUNTY, INC.

Authorization for Routine Medical and Dental Care and Treatment

I am next of kin, legal guardian or the authorized representative (Executive Director) for _____ and, as such, I authorize routine medical and dental care and treatment for him/her.

I understand that invasive elective procedures** require the informed consent of the parent, legal guardian or court of competent jurisdiction and that informed consent for invasive elective procedures in NOT being given by my signature on this form.

I further understand that emergency medical or dental care does not require authorization or informed consent.

_____	_____	_____
Signature	Date	Relationship
_____	_____	_____
Signature	Date	Relationship

** Invasive elective procedure is defined as a medical, dental, surgical or diagnostic intervention or procedure in which anesthetic is used or which involves a significant invasion of bodily integrity requiring an incision or producing substantial pain, discomfort, debilitation or having a significant recovery period, or any professional diagnosis or treatment for which informed consent is required by law.

UNITY HOUSE OF CAYUGA COUNTY, INC.
62 South St. Respite Services
MSC Sign-Off Form

____the consumer can access the respite apartment

____medical needs are provided for

____staff training provided

____staffing ratio is appropriate to meet individual's needs

Based on my observations at 62 South St. Respite, I believe this service can provide the appropriate level of care and is an appropriate place for _____ to respite.

_____ _____
MSC signature Date