Respite Needs Assessment

Person's Name: ___________________________ Service Coordinator: _____________________________

Parent/Guardian: _________________________ Date: ____

General Information

1. What purpose does respite care serve for your family?

2. When do you foresee using respite care providers? *(ie. Amount of time, time of day, vacation only?)*

3. Preferred environment for care to be provided in: (please check all that apply)
   ☐ The family's home ☐ The Community ☐ The Provider's home

4. Others living in the home:

Name (include any nicknames)	Relationship	Age	Sibling care required	Sex
			☐ Yes ☐ No	☐ M ☐ F
			☐ Yes ☐ No	☐ M ☐ F
			☐ Yes ☐ No	☐ M ☐ F
			☐ Yes ☐ No	☐ M ☐ F
			☐ Yes ☐ No	☐ M ☐ F
			☐ Yes ☐ No	☐ M ☐ F

5. Are there any pets in your home:

Type of animal	Name of pet	Important things to know

6. Does your family receive MA Personal Care? ☐ Yes ☐ No

7. Providers should be willing to be employed by the following personal care agency:
   ☐ Catalyst Home Health ☐ Community Living Alliance (CLA) ☐ N/A

Person-Specific Information

Strengths of the person needing care:

Preferred skill set of respite care provider: (what makes a good match.)

Needs Summary

Activities:

Home Favorite things to do:	**Level of supervision while at home:** ☐ Requires to people in the home. ☐ Within eye sight at all times. ☐ Within hearing distance. ☐ Can be left alone for short periods of time. (5 minutes or less) ☐ Can be left alone. Needs periodic check-ins. ☐ Will let the Provider know if something is wrong. ☐ Can play in their yard independently. ☐ Provider must go outside with the person.
Community Favorite places to go and things to do:	**Level of supervision while in the community:** ☐ Requires two people for safety reasons. ☐ Requires someone within arm's reach. ☐ Within eye sight at all time. ☐ Within hearing distance. ☐ Can be left alone for short periods of time. (5 minutes or less) ☐ Can be left alone but needs periodic check-ins. ☐ Will let the provider know if something is wrong.
Transportation Requirements ☐ Driving is required! (All providers must be cleared to drive by UCP. Failure to follow UCP's driving policy will result in disciplinary steps.) ☐ Provider should be prepared to ride the bus.	☐ Can sit in seat of their choice, including the front. ☐ Should sit in back passenger side of the car. ☐ Child locks should be engaged on doors and windows. ☐ Person uses specialized harness for safety.
Safety Concerns	
Level of and ways to engage the person in activities:	

Comments:

Communication:

Expressive Skills:	**Receptive Skills:**
☐ Speech is understood by those outside the family. ☐ Uses complete sentences. ☐ Uses single words. ☐ Uses personalized communication (gestures, sounds) ☐ Uses sign language ☐ Non-verbal	☐ Comprehends verbal language. ☐ Comprehends written language. ☐ Depends on visual cues or schedules. ☐ Modeling from others to enhance comprehension. ☐ Physical prompts (hand-over-hand) to enhance comprehension.
Equipment: ☐ PECS (Picture Exchange System ☐ Portable Electronic Communication Device Brand and Model: ______________________________ ☐ Specialized Computer Equipment: ______________________________ ☐ Other: ______________________________	

Comments:

Mobility:

☐ Person is independent ☐ Uses walker/cane ☐ Person wears AFOs ☐ Gait belt Provider must be able to lift a minimum of ______lbs.	☐ Uses an electric wheelchair ☐ Uses a manual wheelchair ☐ Requires full assistance with transfers ☐ Can weight bear ☐ Can walk with assistance
*If transfer is required, please describe the support necessary:	
*Please list any equipment that a Provider may be expected to use: (hoyer lift, gait trainer, etc.)	

Comments:

Personal Care

Provider may need to assist the individual with **bathrooming**: ☐ Yes ☐ No

Bathrooming	Is the person on a specific schedule? If so, what is it?
☐ Person is completely independent with all tasks. ☐ Person is fairly independent but needs assistance with: ☐ Hand washing ☐ Wiping ☐ Menses care ☐ Clothing ☐ Other: ________________ ☐ Person requires verbal prompting. ☐ Person requires full assistance. ☐ Person wears: ☐diapers ☐pull ups ☐depends ☐ Person uses the following adaptive equipment: ________________ ☐ Person has needs related to a catheter.	How will the Provider know the person needs to use the bathroom? Are there any helpful strategies to use?

Comments:

Provider may need to assist the individual with **bathing**: ☐ Yes ☐ No

Bathing	Person requires assistance with the following:
Approx. Time: ________________ Person prefers: ☐ Shower ☐ Bath ☐ Person bathes independently. ☐ Person requires verbal prompting. ☐ Person requires full assistance.	Please explain any adaptive equipment used:

Comments:

Provider may need to assist the individual with **hygiene** tasks: ☐ Yes ☐ No

Brushing Teeth:	**Other:**
When: ________________ ☐ Person is independent. ☐ Person requires verbal prompting. ☐ Person requires some assistance. ☐ Person requires full assistance.	☐ Person requires assistance applying deodorant. ☐ Person requires assistance with shaving. ☐ Person needs help with brushing or combing. ☐ Other: ________________

Comments:

Provider may need to assist the individual with **dressing**: ☐ Yes ☐ No

Dressing:	**Some assistance is needed with:**
☐ Chooses own clothes. ☐ Dresses independently. ☐ Undresses independently. ☐ Needs complete assistance. ☐ Needs verbal prompts.	☐ Underwear ☐ Socks ☐ Shoes ☐ Pants ☐ Shirt ☐ Coat ☐ Hats ☐ Mittens ☐ Snap ☐ Buttons ☐ Zippers ☐ Needs help telling front from back of clothes.

Comments:

Mealtimes

Favorite foods: ______________________________

Foods to avoid: ______________________________

How does the person indicate they are hungry or thirsty? ______________________________

Person has the following **food allergies** and **dietary restrictions**:

____

Requires assistance with:	Uses adaptive equipment:
☐ Washing hands. ☐ Food preparation. ☐ Opening lids. ☐ Using silverware. ☐ Uses a G-tube. ☐ gravity ☐ pump ☐ Needs close supervision for choking. ☐ Will put too much food in their mouth. ☐ Requires full assistance. ☐ Can finger feed. ☐ Needs food cut into small pieces.	**Person can clean up:** ☐ Independently. ☐ With verbal prompting. ☐ With hand-over-hand assistance. ☐ Not an expectation at this time. ☐ Other:

Meal schedule:

Breakfast time: ____________ Lunch time: ____________ Dinner time: ____________

Snack times: ______________________________

Sleep

Wakes up around: ____________ Naptime: ____________ Bedtime: ____________ Person sleeps through the night? ☐ Yes ☐ No Unusual sleep habits:	Routines to follow: Strategies to help the person fall asleep or return to bed/sleep:

Comments:

Medical *(Medication Authorization Forms must be completed if the Provider is expected to participate in administration.)*

Person takes medications: ☐ Independently. ☐ Needs prompting. ☐ Provider administers. ☐ Does not take medication. Person has the following medical conditions which the provider should be aware of: Allergies:	Seizure Disorder: ☐ Yes ☐ No Type:____________ Frequency and Duration: Challenges that may occur: (attach a more detailed plan if necessary!) **Call 911 after:**

Behavior and Safety

☐ Respite Provider will be expected to manage challenging behavior: ☐ Yes ☐ No

☐ Respite Provider will be required to attend Managing Threatening Confrontations: ☐ Yes ☐ No

If "yes", Please explain:

Are there any restrictive measures used in the house? (escorts, holds, safe room, etc.):

*(*Most restrictive measures and holds require a behavior support plan detailing how the care provider needs to support someone safely through a challenging behavior.)*

Is Community Ties involved with the family: ☐ Yes ☐ No

Behavior:	**Always**	**Sometimes**	**Never**	**Explanation:**
Gets along well with peers	☐	☐	☐	____________
Enjoys social activities/gatherings	☐	☐	☐	____________
Can be a leader	☐	☐	☐	____________
Has good manners	☐	☐	☐	____________
Uses appropriate touch	☐	☐	☐	____________
Self abuses	☐	☐	☐	____________
Scratches or pinches others	☐	☐	☐	____________
Hits others	☐	☐	☐	____________
Bites others	☐	☐	☐	____________
Uses inappropriate language	☐	☐	☐	____________
Exhibits inappropriate sexual behavior	☐	☐	☐	____________
Does not like to be touched	☐	☐	☐	____________
Requires large personal space	☐	☐	☐	____________
Prefers to be alone	☐	☐	☐	____________
May run away or dart	☐	☐	☐	____________
Can cross the street alone	☐	☐	☐	____________
Understands danger	☐	☐	☐	____________

Triggers:

Effective strategies to help avoid challenging behavior:

Ways to calm when upset:

Comments:

Person's reaction to:

New people:

Animals or pets:

New environments:

Discuss the person's sense of safety or danger and ways the Provider can effectively support the person:

Training Plan:
Discuss how new Providers can expect to be trained n the following areas. Include who will be doing the training, additional training that might be necessary, and duration of training before they are expected to care for the individual independently.

Activities:

Communication:

Mobility: (Address transfers specifically if required.)

Personal Care:

Mealtime:

Sleep:

Medical: (Address training for seizure protocol)

Behavior: (Address training on behavior support plan)

I have read the above and feel like my questions have been answered. Should I have additional questions or feel that I need more training, I will contact my Service Coordinator at UCP. A copy of this form is kept in the Respite folder for review.

Provider's Signature: ____ Date: _________________________