AHRC new york city

BED BASED APPLICATION ADDENDUM
FOR FREE-STANDING RESPITE AND CAMPING

Name of individual: _____

Date of Birth: _____

Client ID:_____ **Tabs ID:**_____

SLEEPING HABITS AND ROUTINES

The individual's usual bedtime is _____ and usually gets up at _____ .

Does the individual have any sleep problems (unable to sleep, bed wetting, etc)?

_____
_____
_____

Gets out of bed during the night:

☐ Rarely ☐ Sometimes ☐ Always

Requires repositioning during the night_____
Please explain:

_____
_____
_____

Has individual ever attended a sleep away program? ☐ Yes ☐ No
If yes, please explain type of program and general reaction.

_____
_____
_____

SOCIAL SKILLS

Does the individual have friends, peers?

_____
_____
_____
_____

Individual is currently working towards goals outlined in a behavioral plan:

☐ Yes ☐ No

Note to RIC: If Yes, please ask for a copy of the Behavior Plan.

Received Behavior Plan? ☐ Yes ☐ No

Does the individual present any of the following behaviors (please check all that are applicable)

☐ Hitting ☐ Property Destruction
☐ Spitting ☐ Window Breaking
☐ Self-injurious ☐ Throwing Objects

Other (describe):

_____
_____
_____

Who does the individual spend most of his or her time with?

_____
_____
_____

How does the individual greet someone or show someone that they like them?

_____
_____
_____

What does the individual do if he or she does not like another person?

_____
_____
_____

Does individual seek contact with others? If so, check all that are applicable.

☐ Peers ☐ Authoritative Figures ☐ Adults
☐ Siblings ☐ Prefers to be alone

Comments:

_____
_____
_____

How does the individual let someone know that he or she is becoming upset, or doesn't like an activity?

_____
_____
_____

What makes the individual really happy? (Foods, activities, certain people or places):

_____
_____
_____

Interests: (c*heck all that apply)*

☐ Dance ☐ Drawing ☐ Photography ☐ Pool ☐ Running
☐ Gardening ☐ Reading ☐ Acting ☐ Cooking
☐ Basketball ☐ Boating ☐ Animal Care ☐ Singing
☐ Music ☐ Writing ☐ Soccer ☐ Horses

Other: _____

Favorite leisure activity is:

_____

While on vacation individual is most looking forward to:

_____
_____
_____

Does individual have any known fears? If so, please explain:

_____
_____
_____

Are there situations which are likely to upset the individual (please describe)?

_____
_____
_____

What does the primary caregiver do to calm the individual or to make the behaviors stop?

_____
_____
_____

Sexual Activity

Is the individual sexually active? ☐ Yes ☐ No

Does individual display any sexual behaviors? ☐ Yes ☐ No

If yes, please explain:

_____
_____
_____

How does caregiver typically handle sexual behavior(s)?

_____
_____
_____

Community Awareness/Activities

Is individual familiar with *(check all that apply):*

☐ Automobile ☐ Bus ☐ Subway/Public Transportation

Does the individual have any thing they are especially afraid of? Explain:

_____
_____
_____

EATING HABITS

Does individual require a special diet? If yes, please explain. ☐ Yes ☐ No

_____
_____
_____

Does individual display any of the following behaviors: *(check all that are applicable)*

☐ Excess eating ☐ Food stealing ☐ Choking
☐ Vomiting ☐ Throwing food ☐ Bulimia
☐ Eating too rapidly

Does the individual: *(check all that are applicable)*

☐ Feeds self independently ☐ Need verbal assistance
☐ Needs physical assistance ☐ Needs to be fed
☐ Uses all eating utensils ☐ Uses fork and spoon only
☐ Uses spoon only ☐ Can hold a cup
☐ Needs adaptive equipment (adaptive spoons, forks or plate guards). If yes, please explain and describe.

_____
_____
_____

Does individual need constant supervision while eating? ☐ Yes ☐ No
Does individual wear dentures? ☐ Yes ☐ No
Does individual have difficulty with chewing? ☐ Yes ☐ No

Does individual “stuff” food? ☐ Yes ☐ No

General appetite is:
☐ Fair ☐ Average ☐ Excessive

What are the individual's favorite foods?

_____
_____
_____

What are the individual's least favorite foods?

_____
_____
_____

TOILETING SKILLS: (Female Only)

Independent with menstrual care _____

Some assistance required with menstrual care _____

Total assistance needed with menstrual care _____

MOBILITY

Walks independently _____

Requires occasional physical assistance walking over uneven ground, upstairs and over difficult terrain _____

Utilizes cane or walker (please circle if applicable)

Requires direct physical assistance of one person while walking at all times _____

Uses splint for wrist/arm _____

AFOs _____

Scoliosis vest _____

For participants who use a wheelchair:

Wheelchair for long distances only _____

Wheelchair at all times ☐ Manual ☐ Electric

During transport (to camp):

Must remain in wheelchair for the duration of 2-3 hour trip _____

Can transfer to a seat on the bus –able to sit independently _____

Can transfer to a seat on the bus - needs staff by their side _____

Dressing:

Independent, no assistance _____

Requires verbal prompting, assist with appropriate clothing selection _____

Physical support needed with buttons, zippers, tying shoes _____

Total assistance required with all tasks _____

GENERAL MEDICAL INFORMATION

CONDITION	YES NO	EXPLAIN
Allergies	☐ Yes ☐ No	
Breathing Problems	☐ Yes ☐ No	
Heart Problems	☐ Yes ☐ No	
Stomach or Digestive Problems	☐ Yes ☐ No	
Urinary Tract Problems	☐ Yes ☐ No	
Incontinency-Urine or Stool	☐ Yes ☐ No	
Chewing/Swallowing Problems	☐ Yes ☐ No	
Change in Diet	☐ Yes ☐ No	
Constipation	☐ Yes ☐ No	
Seizure Disorder	☐ Yes ☐ No	
Other Neurological	☐ Yes ☐ No	
Diabetes	☐ Yes ☐ No	

Hearing or Vision Problems	☐ Yes ☐ No	
Osteoporosis	☐ Yes ☐ No	
Skin Conditions	☐ Yes ☐ No	
Psychiatric Issues	☐ Yes ☐ No	
Blood Disorders	☐ Yes ☐ No	
History of Falls	☐ Yes ☐ No	
Injuries	☐ Yes ☐ No	
Hospitalizations	☐ Yes ☐ No	
ER Visits	☐ Yes ☐ No	
Any Other Illness	☐ Yes ☐ No	

If in the judgment of the Director of Respite Services, the above mentioned individual is unable to function adequately in the Respite Facility, the alternate placement person below agrees to be responsible for the individual's welfare while the Primary Caregiver is absent. If the Director of Respite Services contacts the alternate placement person, he/she will provide transportation, <u>as soon as possible</u>, for the individual to his/her own home or be ready to receive the individual when transported by Respite Staff.

NAME OF ALTERNATE PLACEMENT PERSON

(* Please provide alternate placements that reside outside of the home.)

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Work Phone: _____

Signature: _____ Date: _____

NAME OF ALTERNATE PLACEMENT PERSON

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Work Phone _____

Signature: _____ Date: _____

Completed by: _____

Relationship: _____

Date: _____