UNITY HOUSE OF CAYUGA COUNTY INC.

Residential Respite Admissions Policy

Updated 9/3/08

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 office of mental retardation and developmental disabilities and be Medicaid waiver enrolled. Unity House **must be** identified in the ISP (or on an addendum) as a waiver service.

2. The individual must be 18 years of age.

3. 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.

4. 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.

5. Individuals may be living with family, independent in the community, or Family Care.

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

7. The individual must be Medicaid waiver eligible.

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

9. There must be a current ISP 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. Maximum length of stay is as follows:
    - Respite and therapeutic stay are limited to 30 consecutive days, not more that 42 days annually (calendar year).
    - Trial visits are limited to less than 7 days in a 6 month period

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

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

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

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

16. The MSC will provide a ***completed*** Respite Packet, a current ISP, Behavior Plan, if applicable, 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.

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

UNITY HOUSE OF CAYUGA COUNTY INC.
Referral and Respite Plan (IPOP)

Today's Date ________________
Name: _______________________________ Birth date: ____________
TABS#: ______________ Phone: ______________
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: ____
Rights information has been provided to the family. Initial_____date_____

Health Care Information:
Height: _________ Weight: _______ Gender: _____
TB Status: _______ **Date of Last mantoux:** ________
Date of Last Tetanus Shot ________ Hepatitis Status: _________
Allergies to Medication: ____
Other Allergies: ____
Describe Allergic Reaction: ____
Vision: _________ Hearing: _________ Mobility: ______________
Sun Sensitivity? _______________
Need for Medical Equipment/Treatment (i.e. oxygen use, suctioning, ostomy care, g-tube, etc. ____

Medications:

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

Medication administration: ___independent ___staff supervision ___staff assistance

Medical conditions: ____

Current Diagnoses/DD: ____

Does the person have a history of seizures? __no __yes If yes, describe (i.e., duration, what happens before and after, care to be given during and following the seizure)
____
____
____

Special Precautions (limitations on activities, weather precautions):
____
____
____

Special Health Care Needs, Recent Hospitalizations, Changes in Medical Status:
____
____

Health Care Providers

Insurance Carrier:______________________ Policy #: ________________________
Medicaid #: __________________________ Medicare #: _____________________

Primary Physician: _______________________Phone: _____________ Fax #____________

Dentist: _______________________________ Phone: _____________ Fax # ___________

Pharmacy: ______________________________ Phone: _____________ Fax #___________

Pharmacy Address: ____

Other Physicians

Name:	Specialty:	Phone:
______________________	____________________	___________________
______________________	____________________	___________________
______________________	____________________	___________________
______________________	____________________	___________________

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: _________

Oral Assessment

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

	Upcoming Appointments / Family Plans (during respite stay):

Date	Provider	Reason for appt.
__________	________________________	____________________________________
__________	________________________	____________________________________
__________	________________________	____________________________________
__________	________________________	____________________________________
__________	________________________	____________________________________
__________	________________________	____________________________________

Family / MSC responsible for appointments

Dining
Food Allergies: ____
Special Diet or Restrictions: ____
Special dining equipment and precautions: ____
Is there any difficulty with swallowing or choking?: ___________________________________
Food likes: ____
Dislikes: ____
Snacks/frequency: ____

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? _________________________
____
____

Personal Hygiene
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
Showers ___independent ___with assistance ___dependent
___morning ___evening
Special instructions:
____
____
____

Behavior/Personality
Describe the person's general disposition (e.g. calm, outgoing, shy, over-active, etc.)____
____
____
____

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

Describe any problematic behaviors, including severity and frequency:
____
____
____

Method of Intervention: ____
Fears: ____
Describe typical interactions with others: ___________________________________
____
Are there any special concerns or problems when in public or community settings? Outdoors?
____
____
____
Ability to give consent for sexual activity and self-protection from abuse skills:
____
____
Recreation likes and dislikes: ____
Money Management skills: ____
Does the person have a budget? Yes ___ no ___ If yes, how much when? ____________
____

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

Equipment	How is it to be used	Time and duration of use
___________________	________________________	___________________________
___________________	________________________	___________________________
___________________	________________________	___________________________

Who should be contacted for repair or adjustment? _____________________________
____

Safety Needs
Home alone status: ____
Results of Self-Preservation Assessment: ____________________________________
Special Safety Concerns: ____
Community access: ____
Supervision in the Community: ____

Supervision in the Home:____
When is the person considered missing? ____________________________________
Travel safety needs (e.g. seatbelt harness, car seat, ability to fasten seat belt, need for a particular seat in the vehicle, etc): ____
____
____

School/vocation

Name of school/work: _____________________________
Address: ____________________________________
Phone: _____________________________________
Teacher/Supervisor: ______________________________
Transportation Phone Number:________________________
Transportation: Time of pick up: _________ Location of pick up: ________
Time of drop off: ________ Location of drop off: ________
Name of Driver: _________________________
Lunch needed? Yes or No
If yes what is usually taken for lunch?_____________________________
Program notified of respite stay? Yes or no

Name of school/work: _____________________________
Address: ____________________________________
Phone: _____________________________________
Teacher/Supervisor: ______________________________
Transportation Phone Number:________________________
Transportation: Time of pick up: _________ Location of pick up: ________
Time of drop off: ________ Location of drop off: ________
Name of Driver: _________________________
Lunch needed? Yes or No
If yes what is usually taken for lunch?_____________________________
Program notified of respite stay? Yes or no

Day Habilitation/Service Providers

Name of school/work: _____________________________
Address: ____________________________________
Phone: _____________________________________
Teacher/Supervisor: ______________________________
Transportation Phone Number:________________________
Transportation: Time of pick up: _________ Location of pick up: ________
Time of drop off: ________ Location of drop off: ________
Name of Driver: _________________________
Lunch needed? Yes or No
If yes what is usually taken for lunch?_____________________________
Program notified of respite stay? Yes or no

Name of school/work: ____
Address: ____
Phone: ____
Teacher/Supervisor: ____
Transportation Phone Number:_________________________________
Transportation: Time of pick up: __________ Location of pick up: _________
Time of drop off: _________ Location of drop off: _________
Name of Driver: ___________________________________
Lunch needed? Yes or No
If yes what is usually taken for lunch?____
Program notified of respite stay? Yes or no

Other Community Activities
Name of school/work: ____
Address: ____
Phone: ____
Teacher/Supervisor: ____
Transportation Phone Number:_________________________________
Transportation: Time of pick up: __________ Location of pick up: _________
Time of drop off: _________ Location of drop off: _________
Name of Driver: ___________________________________
Lunch needed? Yes or No
If yes what is usually taken for lunch?____
Program notified of respite stay? Yes or no

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

**Note:

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 feel this service can provide the appropriate level of care and is an appropriate place for

___________________________________ to respite.

____ ________

MSC signature Date