Georgia Community Support & Solutions, Inc. DBA

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State Funded Respite

Intake Application

3301 Buckeye Road, STE 700, Atlanta GA 30341

Phone (404) 634-4222

Revised

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Respite Intake Application

Thank you for applying for funds through the InCommunity Respite Program. Please note that Respite funds are intended to be used as a means of support for you and your love one. Please print clearly and fill out all pages, including your signature at the end of the application. Any application not completed in full will delay the processing of the application.

Section I: Demographic Information

Date of Application: _____

Individual Name: _____

Family/Caregiver Name: _____

Relationship to the Individual: _____ Age of Caregiver: _____

Do you have a spouse, partner, other children or people living in the home? _____

Legal Guardian of the Individual (Parent of a Minor Child/Guardianship of an Adult Individual):

_____

Mailing Address:

County of Residence: _____

Mailing Address: _____

Phone: _____

City, State, Zip: _____

Social Security Number: _____ Medicaid Number:_____

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Gender: Male: _____ Female: _____ DOB:_____

Race:

American Indian or Alaska Native _____ Asian or Pacific Islander _____

African American _____ Caucasian/Anglo _____

Multi-Racial/Ethnic Group _____ Hispanic or Latino _____

Other _____

Section II: Diagnostic Information

Developmental Disability Diagnosis:

Check which of the following disability categories is most relevant to the identified individual:

_____ Autism Spectrum Disorder

_____ Neurological Impairment (Prior to age 22)

_____ Intellectual Disability

_____ Developmental Delay (0 – 8)

_____ Cerebral Palsy

_____ Traumatic Brain Injury (Prior to age 22)

_____ Muscular Dystrophy

_____Other (please state) _____

Age at Time of Diagnosis: _____

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Age at Time of Diagnosis: _____

Section III: Supporting Documentation:

Documentation of Diagnosis is required. Please attach a copy of the most recent psychological evaluation or Individual Education Plan (IEP), and/or any other evaluations/documentation with diagnostic information. Failure to provide supporting documentation will result in the application not being considered.

Check the supporting documentation attached to this application:

_____ DBHDD I&E Assessment

_____ Social Security Disability Determination (SS)

_____ Current Physical Examination and TB screening **(Required)**

_____ Psychological Evaluation or School IEP **(Required)**

_____ Financial Documentation (Pay Stubbs, W2, Social Security Award letter)

_____ Current Photograph **(Required)**

_____ Copy of Birth Certificate **(Required)**

_____ Copy of Social Security Card **(Required)**

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Section IV: Current Service Information

Please check all current services that the identified individual is receiving:

_____ New Options Waiver (NOW)

_____ Comprehensive Waiver (COMP)

_____ Currently on DBHDD Planning List

_____ DBHDD State Funded Services

_____ DFCS

_____ Other (please state) _____

Section V: Agreement Section

I understand to be eligible for the InCommunity Respite Program the applicant must be diagnosed with a developmental disability prior to the age of 22 and live in a family member's home or live independently. I hereby confirm that the information given at the time of application is true and accurate to the best of my knowledge.

Responsible Party Printed Name:

_____

Responsible Party Signature:

_____

Date: _____

Revised
8/1/18

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RESPITE CARE VOUCHER PROGRAM

WAIVER AND RELEASE

As a voluntary participant in the Georgia Community Support and Solutions Respite Care Voucher Program, ("Program"), I understand and acknowledge that the Georgia Community Support and Solutions ("GCSS") is not involved and has not been involved in any way with the selection of the respite care provider or respite care agency which will provide respite care to my family member. I also understand and acknowledge that GCSS has not evaluated, tested, or screened the care provider or respite care agency, and that GCSS makes no representations about the care provider or his or her capability or suitability.

I accept that it is my responsibility as a family member in using this program to select a respite care provider or agency to provide respite to my family member with a disability. I understand that it is my responsibility also to determine the suitability of the respite care provider or respite care agency to provide adequate care to my family member, to acquaint them with the particular needs of my family member receiving respite care and provide evaluation and supervision of all respite care received by my family member. Therefore, on my own behalf and on behalf of my family, I freely and voluntarily accept all risk of personal injury and property damage arising from my family's participation in the Program.

In consideration of my being allowed to participate in the Program and to receive a respite care voucher, I hereby release and discharge GCSS, its officers, directors, employees, agents, and successors, from any and all claims losses and demands whatsoever that I or my family may hereafter have for injuries or property arising or resulting from my and my family's participation in the Program, all of which claims I hereby waive. I waive my and my family's rights with the full knowledge that GCSS assumes no liability or responsibility for personal injury or property damage arising from my family's participation in the Program and that GCSS will not compensate me or my family in any way for any loss or injury I or my family may sustain. I understand and agree that this waiver and release will be fully binding on me, all members of my family, our estates, and our heirs, and that neither I nor any member of my family nor anyone claiming through me or any member of my family will have any legal right assert a claim against GCSS or its officers, directors, employees, and agents or any of their successors, relating to me and my family's participation in the Program.

This Date of _____, 20_____

_____ _____

Print Family/Participant's Name Signature

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Demographic Information

COMMUNICATION

How does the participant communicate?
(*Please check ☑ all that apply*).

Can talk without difficulty ( )
Can talk with some difficulty ( )
Makes sounds that are understandable to the parent ( )
Uses Sign Language ( )
Uses communication device ( )

Signboard ( )
Augmentative Communication ( )

Other: (Please List) ( )

_____

_____

Communicates with facial expressions ( )
Does not communicate ( )
Other: _____ ( )

_____

How well does the participant understand what is said to him/her?
(*Please check ☑ all that apply*).

Has no problem with understanding ( )
Requires simple one or two step instructions ( )
Needs gestures to understand ( )
Doesn't understand language ( )
Uses facial expression to understand ( )
Other means of understanding:

_____

_____

Sleep Habits

When is wake up time? _____
When is bed time? _____
When is nap time? _____

Sleeping Arrangements
(*Please check ☑ all that apply*).

Sleeps in a regular bed ( )
Sleeps in a crib ( )
Sleeps in a bed w/ rails ( )
Sleeps in a hospital bed ( )
Other (please describe) ( )

_____

_____

PARTICIPANT PREFERENCES

Does the participant have a certain schedule of activities? If yes, please list times and activities.

_____

_____

_____

Does the participant have favorite activities? Please list.

_____

_____

Does the participant have favorite foods? Please list

_____

_____

Are there certain foods or activities to avoid? Please list

_____

_____

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Does the participant have specific fears that staff or care providers should know about (e.g. dogs, loud noises)

_____

_____

_____

Are there any specific house rules or other: requirements to be enforced by the respite care provider/agency?

_____

_____

_____

PERSONAL CARE NEEDS

(*Please check ☑ all that apply*).

Mobility

Walks independently	( )
Crawls	( )
Uses walker or crutches	( )
Walks w/ assistance	( )
Uses wheelchair independently	( )
Can sit w/out wheelchair	( )
Uses wheelchair w/assistance	( )
Requires transfers	( )
Uses stroller/travel chair	( )

Toileting

Independent	( )
Bladder Control	( )
Bowel Control	( )
Needs assistance	( )
Wears diapers/attends	( )
Toilets on a schedule	( )

(Schedule)_____

_____

Needs enema	( )
Requires catheterization	( )

Hygiene

(*Please check ☑ all that apply*).

Prefers Shower( ) Bath	( )
Washes independently	( )
Cannot wash self	( )
Needs assistance	( )

Please explain:_____

_____

Shampoos hair	( )
Cannot Shampoo hair	( )
Needs assistance	( )
Brushes/combs hair	( )
Cannot brush/comb hair	( )
Needs assistance	( )
Brushes teeth	( )
Cannot brush teeth	( )
Needs assistance	( )

Please explain:_____

_____

Shaving	( )
Needs assistance	( )
Menstruation	( )
Needs assistance	( )

Feeding

Eats independently	( )
Drinks independently	( )
Bottle fed	( )
Blended or special diet	( )
G, J, or NG tube fed	( )
Feeds self w/ spoon	( )
Feeds self w/ fork	( )

Must have food cut( )

Needs assistance with w/ utensils	( )
Needs other assistance	( )

Please explain:_____

_____

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Feeding Difficulties
(*Please check ☑ all that apply*).

Tongue thrust ( )
Gag reflex ( )
Swallowing difficulties ( )
Difficulty chewing ( )
Other ( )
Explain:_____
_____

Dressing

Dresses independently ( )
Needs assistance ( )
Please explain:_____
_____

Other Needs

Behavior

Hitting, biting, or fighting ( )
Self abusive behavior (
Running away ( )
Hyper/Overactive behaviors ( )
Other ( )
Please explain:_____
_____

Medical Needs

Has a G-tube ( )
Has a J-tube ( )
Has a NG-tube ( )
Is on a apnea monitor ( )
Has a tracheotomy ( )
Requires shallow suction ( )
Requires deep suction ( )
Oxygen dependent ( )
Ventilator dependent ( )
Requires injections ( )
Other ( )
Please explain:_____
_____

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Upon completion of this application please send the information to the following address:

InCommunity

3301 Buckeye Rd Suite 700

Atlanta, GA 30341

Attn: Respite Services

Office (404) 634-4222

Fax (404) 634-1324

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Section VI:

For Internal Office Use Only

Date Application Reviewed and Approved for Renewal _____

Disposition for Respite Services:

( ) Eligible Status Verified:

( ) Level of Care I_____ II _____ III _____

( ) Hourly Rate _____

( ) Not eligible – State Reason

_____

_____

Date of Notification: _____

InCommunity Staff's Name: _____

Title: _____

Respite Manager Signature: _____ Date: _____