JFI Respite Care Application Form

____
Name of person to be cared for

____
Date of Birth

____
Address

____
Telephone No.

____
Name of Primary Family Caregiver / Relationship

____
Address (If different from above)

____________________   ___________________
Telephone (Home)   (Work)

Doctor: _______________________ Phone: __________________________

Emergency contacts (Individuals available to care for the person in the event of an emergency:
Name: __________________ Phone: _______________________________
Name: __________________ Phone: _______________________________

Names of people in the home, ages, and relationship to person to be cared for
Name: ___________________ Age: ________ Relationship _____________
Name: ___________________ Age: ________ Relationship _____________
Name: ___________________ Age: ________ Relationship _____________

Name of day program or school: _____________________________________
Phone: _____________________ Location (City): _____________________

Disability: ______________________ Diagnosis: ________________________
Height: _______________ Weight: ________________

Does the individual need assistance with the following (yes / no):
Bathing: ________   Eating / Drinking: __________
Skin / Hair: __________   Transfer (from bed to chair): __________
Shaving: __________   Walking: __________
Toileting: __________   Climbing Stairs: ________
Dressing: __________   Supervision: ___________
Diapering: __________   Taking Meds: __________
Meal Prep: __________

Indicate yes or no to the following:
Does the client use sound judgement? _________
Can client answer / make telephone calls? _________
Could client get out of house in case of fire? _________
Can client be left alone for short periods? _________

Does individual use (indicate yes or no)?
Cane __________ Braces __________ Bedside commode __________
Walker __________ Wheelchair __________ Hoyer Lift __________
Other ____________________

Describe any chronic medical problems(s) that the care provider should be aware of and any special instructions: ____
____

List any medications and the purpose for which each is taken:
____
____

Does the person have allergies? Yes _____ No _____
Is there a history of seizures? Yes _____ No _____
If yes, please indicate how often and how recently:_____________________________
____
Does the individual display inappropriate behavior(s)? Yes _____ No _____
If yes, please describe: ____
____

Give special feeding instructions or list any special diet: ________________________
____

Give special instructions for toileting: ____
____

Describe any difficulties regarding sleeping / bedtime / nighttime: _________________
____
Activities / Interests of the individual: ____

____

____________________________ ________________
Signature of Applicant Date

____________________________ ________________
Staff Date