COMMUNITY ACTION TEAM
SENIOR, RESPITE & VETERAN SERVICE PROGRAMS

Application: ❑New ❑ Renewal
Date: ______________________
Review Date: _______________
Area: _____________________
OAA ❑ UW ❑ Lifespan ❑

APPLICATION:
IN-HOME RESPITE SERVICE PLAN

CLIENT/CAREGIVER (this is the un-paid family caregiver)

Name: ____
Mailing Address: ___________________________________
Street Address: ____
City: ____ State: ___________ Zip: ___________
Telephone: _____________________________ Alternate Phone: ___________________________
DOB: ____________ SS# ______________________ Referral Source: ________________________
How long have you been providing care? ____

PROVIDER (this is the paid provider through a CAT respite program)

Name: ____ Provider # ________________________
Mailing Address: ____
Street Address: ____
City: ____ State: ____________ Zip: ____________
Telephone: ____________________________ Alternate Phone: ____________________________

AUTHORIZATION & FINANCIAL

Effective Date: ________________________ Expiration Date: _________________________
Stipend Authorization per Year: $________
Billing Schedule: Once per Month or Upon Use of Stipend
Termination Date: ____________________ Unused Stipend Amount: $_____________

Program Director/Coordinator Signature Date

Client/Caregiver Signature Date

Provider Signature Date

CARE RECIPIENT (this is the person receiving care from the un-paid family caregiver)

Name: ________________________________ Relationship to caregiver: ______________

Address & Phone: ____
(if different than caregiver)

____

DOB: __________ SS# (opt) ________________ Diagnosis: _______________________

ATTENDING PHYSICIAN

Name: ______________________________ Telephone: __________________________

Address: ____

City: ____ State: _________ Zip: _________

EMERGENCY CONTACT (other than caregiver)

Name: ______________________________ Telephone: __________________________

Address: ____

City: ____ State: _________ Zip: _________

TYPE OF CARE NEEDED (please mark all that apply)

Bathing ❑ Dressing ❑ Mobility ❑ Bowel/Bladder Care ❑ Basic Hygiene ❑ Eating ❑

Medications ❑ Cooking ❑ Housekeeping ❑ Transportation ❑ Grocery Shopping ❑

Cognitive Problems ❑ Aggression to others ❑ Complex Medical Care (tube feeding, etc.) ❑

Other: ____

Are Universal Precaution supplies available? _____________________________________

CARE TIMES

When would you like respite care to start? _______________________________________

Days: Mon ❑ Tues ❑ Wed ❑ Thurs ❑ Fri ❑ Sat ❑ Sun ❑ Varies ❑

Times: ____________________________ (mark typical hours/days – note if bi-weekly, etc.)

Comments: ____

NOTE: Maximum hours are 4-5 hours per month for most programs.

Information: *(used for grant funding information only)*

Number in Household: ________

Monthly Income: $___________

Primary Language: ___________

Ethnicity:
❑ Hispanic/Latino
❑ Not Hispanic/Latino
❑ Not Reported

Race:
❑ Asian
❑ American Indian/Alaskan Native
❑ Native Hawaiian/Pacific Islander
❑ White
❑ Other
❑ Unknown/Not Reported

Definition: Respite care is designed to provide a "break" for an unpaid family caregiver by supplying a trained, paid care provider. Respite care is designed to be a short term solution to the family care needs situation.

Purpose: This form is designed to evaluate your family care giving situation so as to provide the right kind of Respite service to the most families, for the least possible cost, based on limited Respite funding.

Please answer the following questions as they apply to your current care needs situation:

1. **Why are you requesting respite care at this time?** ______________________________

____

2. **Are you the only family caregiver providing care at this time?** Yes _____ No _____

If no, please explain: ____

____

3. **Are there other family members available to provide you with some care giving relief?** Yes _____ No _____ If yes, please explain: ______________________________

____

4. **Have you looked at other volunteer care giving resources, such as friends, church members, etc.?** Yes _____ No _____ If yes, what resulted: ______________________

____

5. **What is your expectation about job duties a paid care provider will assist you with in regards to respite care?** ____

____

____

____

____

6. **How long do you anticipate that your respite care needs will exist?** ______________

____

7. **Are there any additional needs or concerns you would like addressed?**

☐ **Care Giver Support Groups** ☐ **Counseling**

Other Needs: ____

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ADDITIONAL REMARKS:

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Please return completed application to:

Senior, Respite and Veteran Services Program
Community Action Team, Inc.
125 N. 17th Street
St. Helens, OR 97051