MARYLAND DEPARTMENT OF HUMAN SERVICES

DEPARTMENT OF SOCIAL SERVICES
LDSS Phone Number:
LDSS Address
Respite Contact

Respite Care Application

Today's Date: _____

Name of person and/or agency making request: _____

Phone number of person and/or agency making request: _____

SECTION A. Complete this section about the individual you are caring for with an intellectual/developmental/functional disability

Name: _____
First Middle Last

Street Address:_____

City: _____ State: _____ Zip Code: _____

Date of Birth: ____/____/_____ (MM/DD/YYYY) Gender: ☐Male ☐Female

Ethnicity (check all that apply):

☐White/Caucasian ☐Black/African American ☐Hispanic or Latino

☐Non-Hispanic or Latino ☐Native Hawaiian/Pacific Islander ☐Asian

☐Other (specify): ☐Not Available/refused

SECTION B. Complete this section about the individual in Section A's primary caregiver(s) or parents/guardians. If the individual in Section A is 18 years of age or older, provide information about his/her family/unpaid caregiver(s). If the individual in Section A is under age 18, please provide information about his/her parents/guardians.

Family/unpaid caregiver #1 or parent/guardian #1

Name: _____
First Middle Last

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email Address: _____

Date of Birth: _____/_____/_____ (MM/DD/YYYY) Gender: ☐Male ☐Female

Ethnicity (check all that apply):

☐White/Caucasian ☐Black/African American ☐Hispanic or Latino

☐Non-Hispanic or Latino ☐Native Hawaiian/Pacific Islander ☐Asian

☐Other (specify): ☐Not Available/refused

Employment status:

☐Full-time ☐Part-time ☐Not employed

Family/unpaid caregiver #2 or parent/guardian #2

Name: _____
First Middle Last

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email Address: _____

Date of Birth: _____/_____/_____ (MM/DD/YYYY) Gender: ☐Male ☐Female

Ethnicity (check all that apply):

☐White/Caucasian ☐Black/African American ☐Hispanic or Latino

☐Non-Hispanic or Latino ☐Native Hawaiian/Pacific Islander ☐Asian

☐Other (specify): ☐Not Available/refused

Employment status:

☐Full-time ☐Part-time ☐Not employed

SECTION C. Complete this section about the other people who live in the same household as the individual in Section A

Name	Relationship to Individual Listed in Section A	Date of Birth

SECTION D. Provide an emergency contact in case the primary caregiver cannot be reached.

Name: _____
First Middle Last

Relationship to Individual Listed in Section A: _____

Street Address:_____

City: _____ State: _____ Zip Code: _____

Home Phone: _____Work Phone: _____

Mobile Phone: _____Email Address: _____

SECTION E. Provide information about the individual listed in Section A's limitations and medical conditions/diagnoses.

List any additional chronic medication conditions:

_____

_____

_____

_____

Please specify the limitations experienced by the individual listed in Section A. Please check "yes" or "no."

Limitations	
Self-Care	☐ Yes ☐ No
Receptive and expressive language	☐ Yes ☐ No
Learning	☐ Yes ☐ No
Mobility	☐ Yes ☐ No
Self-direction	☐ Yes ☐ No
Capacity for independent living	☐ Yes ☐ No
Economic self-sufficiency	☐ Yes ☐ No

Please specify the amount of help the individual listed in Section A needs for the activities listed below.

Activities of Daily Living	Manages Independently	Needs Supervision	Needs Assistance	Does Not Apply
Bathing and grooming (e.g, shaving, brushing teeth and hair, washing face)				
Dressing				
Toileting/ incontinence/ diapers/Depends				
Eating and drinking				
Walking/ Ambulation (uses cane, walker, wheelchair)				
Making phone calls				
Cooking/meal preparation				
Transferring (from bed to chair)				
General supervision				
Medication administration				

Section F. Please provide information about the individual in Section A's behaviors.

Does this individual exhibit difficult behaviors?

☐ Yes, please describe:

☐ No

Does this individual exhibit behaviors that endanger himself/herself or other individuals?

☐ Yes (describe behaviors):

☐ No

Does this individual have a behavior plan?

☐Yes (provide a copy of the plan)

☐No

Has this individual attempted suicide in the last year?

☐Yes (provide details):

☐No

Please indicate individual's overall behavioral support level.

☐Minimal (needs little supervision)

☐Moderate

☐Extensive (needs close supervision)

SECTION G. PLEASE COMPLETE ONLY IF PERSON IN SECTION A IS 18 YEARS OF AGE OR OLDER

Please provide information about any other formal support services the individual in Section A receives?

Does the individual in Section A attend an adult day/medical day program?

☐If yes, indicate days and hours per day attended below

☐No

☐Monday (# of hours): _____ ☐Tuesday (# of hours): _____

☐Wednesday (# of hours): _____ ☐Thursday (# of hours): _____

☐Friday (# of hours):_____ ☐Saturday (# of hours): _____

☐Sunday (# of hours): _____

Adult Medical Day Contact Information

Adult/Medical Day Program Name: _____

Mailing Address: _____

Contact Person: _____

Phone: _____

Email: _____

Does the individual in Section A receive in-home services such as personal support, personal care attendant services or nursing?

☐ If yes, indicate days and hours per day attended below

☐ No

☐ Monday (# of hours): _____ ☐ Tuesday (# of hours): _____

☐ Wednesday (# of hours): _____ ☐ Thursday (# of hours): _____

☐ Friday (# of hours):_____ ☐ Saturday (# of hours): _____

☐ Sunday (# of hours): _____

Support Services Contact Information

Program Name: _____

Mailing Address: _____

Contact Person: _____

Phone: _____

Email: _____

Do you work with a Coordinator of Community Services or case manager?

☐ Yes, please provide contact information (below).

☐ No

Coordinator of Community Services Contact Information

Program Name: _____

Mailing Address: _____

Contact Person: _____

Phone: _____

Email: _____

Does the individual in Section A receive any Medicaid waiver services?

☐ Yes (please describe): _____

☐ No

Are there any other federal, state or county agencies from which you are receiving services such as IHAS?

☐ Yes (please provide names of providers): _____

☐ No

Is funding available for respite to the individual in Section A or parent through any other program?

☐ Yes (please explain): _____

☐ No

Are you on a waiting list for additional services?

☐ Yes (please explain): _____

☐ No

SECTION H. PLEASE COMPLETE ONLY IF PERSON IN SECTION A IS UNDER 18 YEARS OF AGE

Does the individual in Section A attend school or a child care program?

☐ If yes, indicate days and hours per day attended below

☐ No

☐ Monday (# of hours): _____ ☐ Tuesday (# of hours): _____

☐ Wednesday (# of hours): _____ ☐ Thursday (# of hours): _____

☐ Friday (# of hours):_____ ☐ Saturday (# of hours): _____

☐ Sunday (# of hours): _____

School/Day Care Contact Information

School/ Day Care Name: _____

Mailing Address: _____

Contact Person: _____

Phone: _____

Email: _____

SECTION I. Your Respite Preferences

Specify your preference of location of respite care (check all that apply)

☐ In-home

☐ Adult medical day care

☐ Camp

☐ Therapeutic programs

☐ Respite approved facility (e.g., assisted living, nursing home)

How did you learn about respite services?

☐Local Department of Social Services

☐Website

☐Family/friend

☐Home health agency

☐Other (specify):

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Individual in Section A's Disability:

☐Developmental

☐Functional

Application Status:

☐Approved

☐Incomplete

☐Denied

Number of hours approved: _____

INSERT COUNTY NAME Department of Social Services
Multi-Agency Consent for the Release of Confidential Information

(Name of Consumer)	(Record #)	(DOB)	___-___-___ (SSN)

The purpose of this form is to allow me to choose how my services are coordinated. I understand that this is my decision to make and that I can change my mind. If I change my mind, I need to make a written request to cancel this consent. This request will go to the agency or program's Medical Record or Health Information Department for processing. I also understand that I can ask a staff member to assist me with this process. If I have a legal guardian, my guardian may sign or cancel this consent on my behalf.

By checking yes, I am allowing these providers to communicate and exchange information needed to coordinate and continue care, treatment and services. If I check no, I do not want the information exchanged with that provider.

Yes	No	Provider/Agency Name
☐	☐	
☐	☐	
☐	☐	
☐	☐	
☐	☐	

Yes	No	Types of Information	Yes	No	Types of Information
☐	☐	Demographic	☐	☐	Lab/X-Ray Reports
☐	☐	Assessments	☐	☐	Admit/Discharge Dates
☐	☐	Physical Exam	☐	☐	Release/Discharge Summary
☐	☐	Treatment Plan(s)	☐	☐	Housing Information
☐	☐	Medications	☐	☐	
☐	☐	Other: Please describe:			

Date, Event or Condition when Consent Expires: _____. In the event no date/event/or condition is specified, this consent expires one year from the date of signing.

I understand that treatment services are NOT contingent upon or influenced by my decision to permit the information to be released.

I understand that the information and records disclosed pursuant to this consent may be protected under 42 CFR Part 2, governing Alcohol and Drug Abuse patient records, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and 45 CFR parts 160 and 164, State Confidentiality laws and regulations, and cannot be released without my consent unless otherwise provided for by the regulations. State and Federal regulations prohibit any further disclosure of such information and records without my specific written consent unless otherwise permitted by such regulation.

The information I authorize for release may include records that may indicate the presence of a communicable or venereal disease, which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS).

Signature of Consumer	Date	Witness (optional)	Date
_____	_____	_____	_____

Signature of legal guardian, if required	Date	Relationship to consumer
_____	_____	_____

MARYLAND DEPARTMENT OF HUMAN SERVICES

DEPARTMENT OF SOCIAL SERVICES
LDSS Phone Number
LDSS Address
Respite Contact

Respite Care Application: Physician's Statement

Dear Primary Physician:

The patient listed below has applied for respite care services offered through (LDSS/GRANTEE NAME). The State of Maryland requires that a Physician's Statement be completed by the patient's healthcare provider to certify the patient's need for respite care.

We appreciate you taking the time to complete this form.

Today's Date: _____

Patient's Name: _____

Date of Birth: _____/_____/_____ (MM/DD/YYYY)

Patients Primary Diagnosis (check all that apply)

Condition	Yes	No
Allergies		
Autism		
Behavioral Problems		
Blindness/Visual Impairment		
Cancer		
Cerebral Palsy		
Cystic Fibrosis		
Deafness/Hearing Impairment		
Dementia/Alzheimer's Disease		
Diabetes		
Epilepsy/Seizure Disorder		
Head Injury		
Heart Condition		
Intellectual/Developmental Disability		
Lupus		
Mental Illness		
Multiple Sclerosis		
Neurological Impairment		
Parkinson's Disease		
Sickle Cell Disease		
Speech/Language Impairment		
Spina Bifida		
Spinal Cord Injury		
Stroke		
Other (specify):		
Other (specify):		
Other (specify):		

Please list any medications taken by the patient and the purpose of each medication. Attach additional sheets, if necessary.

Medication Name	**Medication's Purpose**

Does the patient require help with his or her activities of daily living?

☐ Yes, please provide details: _____

_____

_____

☐ No

Please specify the limitations experienced by the individual listed in Section A. Please check "yes" or "no."

Limitations	**Yes**	**No**
Self-Care		
Receptive and expressive language		
Learning		
Mobility		
Self-direction		
Capacity for independent living		
Economic self-sufficiency		

Does the patient require skilled care that should be delivered by a skilled healthcare professional (such as medication administration, G-tube feeding, injections, catheter care, etc.)?

☐ Yes, please provide details: _____

_____

_____

☐ No

If the patient requires assistance with medication administration, is his/her family able to administer the medication during the period of time in which respite services are provided?

☐ Yes, please provide details: _____

_____

_____

☐ No

Please provide details and treatment protocols for allergens and seizures.

_____

_____

Please provide details regard the patient's dietary needs (e.g., special diet or dietary modifications).

Signature of Physician: _____

Date: _____

Address: _____

Phone number: _____

Official Stamp:

MARYLAND DEPARTMENT OF HUMAN SERVICES

DEPARTMENT OF SOCIAL SERVICES
LDSS Phone Number
LDSS Address
Respite Contact

Respite Application: Financial Disclosure Form for Adults

Applicant's Name: _____

Today's Date: _____

In order for us to determine your subsidy for respite care, please complete this form and attach verification of income. Your subsidy is based upon on the disabled adult's total gross income minus documented out-of-pocket medical expenses. Total gross income is the total income the disabled adult receives before deductions such as taxes.

Due to state regulations, applications cannot be processed without proper verification of income. Please attach verification of income such as recent pay stubs and Social Security statements, and SNAP and housing benefits.

Sources of Income

Income Category	**Disabled Adult's Monthly Income**	**Verification Source**
Social Security		
Employment/Salary		
Veterans Benefits		
Railroad Retirement		
Civil Service		
Pensions		
Alimony		
Rental Income		
Interest Income		

Annuities		
Housing Vouchers		
Food Stamps		
Other: please provide details		

Please list the disabled person's out-of-pocket medical expenses for the last 12 months. Examples of out-of-pocket expenses include medicals expenses not covered by insurance such as co-pays and deductibles. Medical expenses include doctors' visits, prescription and over-the-counter medications, and assistive equipment. Please attach supporting documentation such as receipts or statements of service.

Applicant's Out-of-Pocket Medical Expenses

Description of Expense	**Unreimbursed Amount**	**Verification Source**

FOR RESPITE SERVICES USE ONLY
Total income: $ Subsidy rate %: Approved subsidy $:

MARYLAND DEPARTMENT OF HUMAN SERVICES

DEPARTMENT OF SOCIAL SERVICES
LDSS Phone Number
LDSS Address
Respite Contact

Respite Application: Financial Disclosure Form for Children Ages 17 AND Under

Applicant's Name: _____

Today's Date: _____

In order for us to determine your subsidy for respite care, please complete this form and attach verification of income. Your subsidy is based upon your household's total gross income minus documented out-of-pocket medical expenses for the disabled child. Total gross income is the total income your household receives before deductions such as taxes.

Due to state regulations, applications cannot be processed without proper verification of income. Please attach verification of income such as recent pay stubs and Social Security statements, and SNAP and housing benefits.

Sources of Income

Income Category	Client's Monthly Income	Other Family Members' Monthly Income	Verification Source
Social Security/Social Security Disability/Supplemental Security Income			
Employment/Salary			
Veterans Benefits			
Railroad Retirement			
Civil Service			
Pensions			
Alimony			

Child support			
Rental Income			
Interest Income			
Annuities			
Housing Vouchers			
Food Stamps			
Other: please provide details			

Please list the disabled child's out-of-pocket medical expenses for the last 12 months. Examples of out-of-pocket expenses include medicals expenses not covered by insurance such as co-pays and deductibles. Medical expenses include doctors' visits, over-the-counter and prescription medications, and assistive equipment. Please attach supporting documentation such as receipts or statements of service.

Client's Out-of-Pocket Medical Expenses

Description of Expense	**Unreimbursed Amount**	**Verification Source**

FOR RESPITE SERVICES USE ONLY
Total income: $ Subsidy rate %: Approved subsidy $: