

**New Avenues to Independence, Inc.**  
**TRANSITIONAL RESPITE PROGRAM**

**Instructions for Completing Application**

Although the nature of Respite Services tends to be emergency-based, certain information is necessary so that we can make an accurate determination of the types of services the individual will need.

It is with this in mind that we ask you to fill out the attached application as specifically as possible. The application can be completed by more than one individual (i.e. guardian, family member, Support Administrator, caregiver), but please be sure to list all those who contributed in completing the application.

Please include any medical reports, therapy evaluations, social service reports, ISP's, educational/vocational reports, or other pertinent information. It is particularly important to indicate the level of supervision the individual will require. Please refer to the Basic Daily Rate form included with the packet. By providing current and critical information at the time of the application, we will be better able to make a timely decision.

Please note there are two releases that accompany the application. Both releases must be signed/dated and returned with the completed application.

The completed application should be forwarded to the Transitional Respite Manager or the Program Director. You may fax the application, but remember to bring the original application/releases should the individual be enrolled in Respite. In addition, if applicant currently has/or had an IHP, ISP or IEP, please provide a copy with the completed application.

**Application Process**

Once the application is received, the Respite Team will convene in as timely a manner as possible to determine the appropriateness for enrollment. The Transitional Respite Coordinator will contact the referring party with the outcome. If additional information is requested, it is the responsibility of the referring party to obtain the requested information. If an individual is accepted for respite services but cannot be enrolled (unit is at capacity, etc.) at the time of referral, we will keep the referring party updated about vacancies as they occur.

**Enrollment**

Whenever possible, enrollment should take place between Monday through Wednesday, before noon. If it is a County Board referral, we request that the individual's Support Administrator be present at the time of enrollment. If the individual has a legal guardian, the legal guardian must accompany the individual in order to sign releases, or have made arrangements to sign the releases prior to enrollment.

**Please bring the following at the time of enrollment:**

Original Physician's Orders:	<b>Orders MUST be signed by a physician licensed in the State of Ohio.</b> The orders must contain the name, dosage and frequency of <b>any and all</b> medications the individual is receiving, including over the counter non-prescription medications. You <b>MUST</b> use the Physician's Order Form included with the application.
30-day Medication Supply:	Medication should be packaged in its original container and <b>reflect the physician's orders</b> . Medication brought in which is not according to/included on the Physician's Order Form cannot be given. Current Medicaid Card/Health Insurance Card. Should you wish to have our pharmacy provide medication, we require a minimum of 24 hours notice prior to enrollment. <b>PLEASE NOTE:</b> if medications are initially brought from home, all refills will be through Parkway Pharmacy to ensure safety and proper usage.
Clothing/Spending Money:	Please see information included with the application regarding the recommended clothing/personal items.
Appliances:	Eyeglasses, wheelchair, hearing aid, etc. Recommendations for use and care of

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	appliances should be provided as part of the application process.
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**Questions concerning enrollment, the application or the application process should be directed toward:**

**Tasha Barnett  
Transitional Respite Coordinator  
216-481-1909, extension 252**

**or**

**Daryl Weiland  
Program Director  
216-481-1909, extension 238**

**NEW AVENUES TO INDEPENDENCE  
17608 Euclid Avenue  
Cleveland, Ohio 44112-1216  
Phone: (216) 481-1907  
Fax: (216) 481-2050**

**Basic Services**

The services listed below are included in the Base Daily Rate Transitional Services Contract.

	Service Coordination
1.	Coordinate the referral process, supervise provision of services as identified in ISP/IHP, act as contact person for contractors of optional services, interface with County Board Support Administrator, assist with transition plan, and interface with family members.
	Respite Care Specialists
2.	Provides assistance with activities of daily living skills (including but not limited to personal grooming and hygiene, home management, financial management and other services identified in ISP or IHP).
	Staff Supervision
3.	Provides appropriate staffing ratio during waking hours (16) and sleep hours (8) as determined by the ISP/IHP. Basic supervision ratio may be increased, if the need for this has been identified but this will result in an additional charge over and above the basic rate.
	Nursing Services Provided by an LPN/DODD Certified Staff
4.	Administers medication (oral, topical and rectal), orders medications from pharmacy, accompanies consumers to medical appointments, may provide sex/health education classes to consumers, provides education to consumers on self-administration of medications/treatments, and provides medication storage.
	Recreation
5.	Provides transportation to and from community events including religious services, and provides recreational opportunities on NATI's main campus.
	Food Services
6.	Provides nutritious meals according to any diet restrictions/orders.

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<b>TRANSITIONAL RESPITE SERVICES</b>							
Authorization to Release Information							
Consumer:							
I,	Consumer/Guardian	,authorize NEW AVENUES TO INDEPENDENCE to release the					
following information/reports:							
				to	Agency/Individual		
in order to assist with placement and/or diagnostic services.							
Client/Consumer	Date:	MM		DD		YY	
Guardian	Date:	MM		DD		YY	
Witness	Date:	MM		DD		YY	
Witness	Date:	MM		DD		YY	

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<b>TRANSITIONAL RESPITE SERVICES</b>							
Authorization to Obtain Information							
Client/Consumer							
<p>I give permission to NEW AVENUES TO INDEPENDENCE (NATI) to review the information contained in NATI's Transitional Respite Services Application. In addition, I authorize NATI to request additional information, if needed, to assist NATI's interdisciplinary team in providing services. (If additional information is requested the information below needs to be filled out).</p>							
Information Requested	Name of Agency Supply Information						
Client/Consumer	Date:	MM		DD		YY	
Guardian	Date:	MM		DD		YY	
Witness	Date:	MM		DD		YY	
Witness	Date:	MM		DD		YY	

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NATI's Transitional Respite Services Application					
<b>Applicant's Name:</b>				<b>Date of Referral:</b>	
<b>I.</b>	<b>Identifying Information</b>				
<b>Current Address:</b>					
<b>Phone Number:</b>					
<b>Date of Birth:</b>		<b>Age:</b>		<b>SSN:</b>	
<b>Referring County:</b>		<b>Support Administrator:</b>			
<b>Phone Number:</b>					
<b>Guardian:</b>		<b>Relationship:</b>			
<b>Phone Number:</b>					
<b>Person(s) Completing Form:</b>					
<b>Describe the nature of request for transitional respite services:</b>					
<b>Is your request for services emergency-based? If so, please explain:</b>					
<b>Projected entry date and length of stay (up to 90 days maximum):</b>					
<b>Diagnoses: (include level of mental retardation and/or any developmental disabilities such as Cerebral Palsy, Autism, and Epilepsy. Also include psychiatric diagnosis if there is one)</b>					
<b>Are there any significant ongoing medical concerns, including substance abuse? If so, please describe:</b>					
<b>Mobility: Is this individual ambulatory/non-ambulatory? Describe any adaptive appliances/transportation modifications needed to assist with this individual's mobility.</b>					

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<b>Applicant's Name:</b>							
<b>II.</b>	<b>Current Living Arrangement – Individual lives with:</b>						
	<b>Natural Parent(s)</b>		<b>Other Relative</b>				
	<b>Foster Parent(s)</b>		<b>Hospital-Reason hospitalized:</b>				
	<b>Residential Facility</b>		<b>Own Home (rented, leased, owner)</b>				
<b>Name of person or Residential Facility/Hospital:</b>							
<b>Incarceration/Name of correctional facility:</b>							
<b>Conviction(s) dates of incarceration:</b>							
<b>Who is the emergency contact person(s)?</b>							
<b>Name</b>				<b>Relationship</b>			
<b>Address</b>							
<b>Phone</b>		<b>Home</b>				<b>Business</b>	
<b>Other agencies/professionals presently involved with individual:</b>							
<b>Will the individual require supervision greater than 1:2 during waking hours and/or 1:4 during sleep hours?</b>							
						<b>YES</b>	<b>NO</b>
<b>If yes, please indicate what ratios are necessary and why:</b>							
<b>A.</b>	<b>During awake hours:</b>				<b>sleep hours:</b>		
<b>B.</b>	<b>In home:</b>				<b>outside home:</b>		
<b>C.</b>	<b>Additional information</b>						
<b>III.</b>	<b>Current Health Insurance Information</b>						
<b>Is the individual covered under?</b>							
<b>A.</b>	<b>Medicaid</b>		<b>YES</b>		<b>NO</b>	<b>#</b>	
<b>B.</b>	<b>Medicare</b>		<b>YES</b>		<b>NO</b>	<b>#</b>	
<b>C.</b>	<b>Private Health Insurance</b>		<b>YES</b>		<b>NO</b>	<b>#</b>	
<b>D.</b>	<b>Other</b>						
<b>E.</b>	<b>Is the individual currently receiving medication that is NOT covered by above insurance?</b>						
	<b>YES</b>		<b>NO</b>		<b>If yes, what method of payment will be arranged during the individual respite stay?</b>		

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<b>Applicant's Name:</b>									
<b>III.</b>	<b>Current Health Insurance Information (cont'd)</b>								
	<b>F.</b>	<b>Is assistance being requested with the financial management of Social Security benefits during transitional housing stay</b>				<b>YES</b>		<b>NO</b>	
		<b>Describe:</b>							
	<b>G.</b>	<b>Is there any "patient liability"?</b>				<b>YES</b>		<b>NO</b>	
		<b>If so, how much?</b>							
<b>IV.</b>	<b>Background Information</b>								
	<b>A.</b>	<b>Family</b>							
	<b>1.</b>	<b>Are there involved family member(s)?</b>				<b>YES</b>		<b>NO</b>	
		<b>Name(s):</b>			<b>Relationship</b>				
		<b>Address:</b>							
		<b>Phone:</b>							
	<b>2.</b>	<b>Are family members or significant others interested in maintaining contact/visitation during transitional housing stay?</b>				<b>YES</b>		<b>NO</b>	
	<b>3.</b>	<b>Are there any family members or other(s) who have restrictions on visitation/contact with the referred individual?</b>				<b>YES</b>		<b>NO</b>	
		<b>If so, specify relation &amp; extent of restriction. (If a court ordered restriction applies, a copy of the court order should accompany this application):</b>							



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<b>Applicant's Name:</b>			
<b>IV.</b>	<b>Background Information (cont'd)</b>		
<b>B.</b>	<b>Behavior/Mental Health Issues (cont'd)</b>		
	<b>4.</b>	<b>Has the individual ever received ongoing psychiatric services?</b>	
		YES	NO
		If so, please summarize:	
	<b>5.</b>	<b>Has the individual ever been convicted of a crime?</b>	
		YES	NO
		If so:	
		NATURE OF CRIME(S)	NAME OF CORRECTIONAL FACILITY
		LENGTH OF INCARCERATION	
<b>C.</b>	<b>Past Residential Placements</b>		
	<b>NAME OF FACILITY/HOME</b>	<b>DATES</b>	<b>REASON FOR LEAVING</b>
<b>D.</b>	<b>Activities</b>		
	<b>1.</b>	<b>List Individual's Hobbies/Interests:</b>	
	<b>2.</b>	<b>Describe the individual's routine daily events:</b>	

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<b>Applicant's Name:</b>					
<b>IV.</b>	<b>Background Information (cont'd)</b>				
	<b>D.</b>	<b>Activities (cont'd)</b>			
		<b>3.</b>	<b>What types of recreational and community-based activities are enjoyed?</b>		
		<b>4.</b>	<b>Would this individual enjoy participating in swimming activities? What supervision/restrictions would apply?</b>		
		<b>5.</b>	<b>Any activity limitations? Please explain:</b>		
<b>V.</b>	<b>Communication Skills/Interpersonal Behavior</b>				
	<b>A.</b>	<b>What is the individual's level of communication?</b>			
	<b>B.</b>	<b>Uses sign language?</b>	<b>YES</b>		<b>NO</b>
	<b>C.</b>	<b>Uses gestures?</b>	<b>YES</b>		<b>NO</b>
	<b>D.</b>	<b>Communicates wants and needs?</b>	<b>YES</b>		<b>NO</b>
	<b>E.</b>	<b>Uses communication cards?</b>	<b>YES</b>		<b>NO</b>
	<b>F.</b>	<b>Uses adaptive communication devices (computer, boards)?</b>	<b>YES</b>		<b>NO</b>
<b>VI.</b>	<b>Educational/Vocational Information</b>				
	<b>A.</b>	<b>Is individual currently employed or enrolled in school?</b>	<b>YES</b>		<b>NO</b>
		<b>If so:</b>			
		<b>Name of school/employer:</b>			

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<b>Applicant's Name</b>	
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<b>VI.</b>	<b>Educational/Vocational Information (cont'd)</b>					
	<b>Contact person:</b>					
	<b>Phone #/Address:</b>					
	<b>B.</b>	<b>Mode of transportation:</b>				
	<b>B.</b>	<b>Days/Times worked/in school:</b>				
	<b>C.</b>	<b>Will the individual maintain his/her employment/educational placement while residing at NATI?</b>				
		<b>YES</b>	<input type="checkbox"/>	<b>NO</b>	<input type="checkbox"/>	<input type="checkbox"/>
	<b>D.</b>	<b>Do you need assistance with transportation to job or school placement?</b>				
		<b>YES</b>	<input type="checkbox"/>	<b>NO</b>	<input type="checkbox"/>	<b>Describe:</b>
	<b>E.</b>	<b>Please indicate special work/school needs (brings lunch, communication device, snack money, etc.)</b>				

<b>VII.</b>	<b>Adaptive Behavior and Daily Living Skills</b>				
	<b>A.</b>	<b>Domestic Skills: Does individual require assistance to perform the following tasks?</b>			
		<b>If so, describe the level of assistance needed:</b>			
		<b>1.</b>	<b>Meal preparation:</b>		
		<b>2.</b>	<b>Cleaning/Home Maintenance:</b>		
		<b>3.</b>	<b>Laundry/Clothing Care:</b>		
		<b>4.</b>	<b>Shopping:</b>		
		<b>5.</b>	<b>Money Management:</b>		

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<b>Applicant's Name</b>					
<b>VII.</b>	<b>Adaptive Behavior and Daily Living Skills (cont'd)</b>				
	<b>B. Self-Care/Hygiene:</b>				
	1.	Toileting: Uses Depends	YES	<input type="checkbox"/>	NO
	2.	Feeding:			
	3.	Oral Hygiene:			
	4.	Bathing/Grooming/Dressing:			
	5.	List any adaptive equipment used:			
	<b>C. Community Accessibility</b>				
	1.	Can the individual travel independently on RTA, call for cabs, etc?			
		YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
		Please describe:			
	2.	Is the individual aware of dangerous situations in the community?			
	3.	What level of supervision does the individual require in the community? Please describe:			
	4.	What telephone skills/emergency protocols is the individual familiar with?			
	<b>D. Sexuality Issues</b>				
		Is this individual sexually active?	YES	<input type="checkbox"/>	NO
		Would this individual benefit from Human Sexuality Training?	YES	<input type="checkbox"/>	NO
		If so, describe the needs:			

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<b>Applicant's Name</b>							
<b>VIII.</b>	<b>Therapeutic Services</b>						
	<b>Is this individual receiving any of the following therapeutic services?</b>						
	<b>THERAPY</b>	<b>YES/NO</b>	<b>REASON</b>	<b>NAME OF THERAPIST/AGENCY</b>			
	Speech						
	Physical Therapy						
	Occupational Therapy						
	Art Therapy						
	Music Therapy						
<b>IX.</b>	<b>Future Plans</b>						
	<b>A.</b>	<b>Please describe in detail what arrangements and what type of placement is being obtained for the referred individual:</b>					
	<b>B.</b>	<b>Name and telephone # of person responsible for coordinating future placement:</b>					
	<b>C.</b>	<b>Individual/Agency responsible for respite service payment:</b>					
	<b>D.</b>	<b>Contact Person/Title:</b>					
		<b>Billing/Mailing Address:</b>					
		<b>Phone #</b>		<b>Fax #</b>			
		<b>Source of Payment (check all that apply):</b>					
		<input type="checkbox"/> <b>Family Resources</b>	<input type="checkbox"/> <b>Board</b>	<input type="checkbox"/> <b>Waiver</b>	<input type="checkbox"/> <b>Mental Health</b>		
		<input type="checkbox"/> <b>Private</b>	<input type="checkbox"/> <b>Other</b>				
<i>Please attach any reports/evaluations that may be helpful to the Intake Committee</i>							
<b>My signature below indicates that the information provided is current and valid.</b>							
<b>Signature of person(s) completing form</b>			<b>Date</b>		<b>Telephone #</b>		

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<b>Applicant's Name</b>											
<b>MEDICAL SECTION</b>											
<i>Please complete this form to the extent that you are able. All areas accompanied by an asterisk are mandatory information and <b>must</b> be completed accurately and completely to be considered for admission to respite program. PLEASE PRINT ALL INFORMATION.</i>											
<b>Date:</b>											
<b>Name:</b>						<b>Sex:</b>					
<b>Address:</b>											
<b>Social Security No:</b>				<b>DOB:</b>	<b>MM</b>	<b>DD</b>	<b>YYYY</b>	<b>HT</b>		<b>WT</b>	
<b>Doctor:</b>			<b>Address:</b>				<b>Phone #:</b>				
<b>I.</b>	<b>Significant Family History</b>										
<b>Did anyone in your family ever have: (Please check)</b>											
		<b>Heart Disease</b>						<b>Diabetes</b>			
		<b>Kidney Problems</b>						<b>Cancer</b>			
		<b>Alcoholism</b>						<b>Epilepsy</b>			
		<b>Lung Problems</b>						<b>Tuberculosis</b>			
		<b>Mental Illness</b>						<b>Other</b>			
<b>II.</b>	<b>Consumer's Past Medical History</b>										
<b>Please check and include dates if possible</b>											
<b>A.</b>			<b>Rheumatic Fever</b>					<b>Arthritis</b>			
		<b>Asthma</b>						<b>Polio</b>			
		<b>Frequent Colds</b>						<b>Tuberculosis</b>			
		<b>Pneumonia</b>						<b>Eczema</b>			
		<b>Strep/Scarlet Fever</b>						<b>Chicken Pox</b>			
		<b>Pleurisy</b>						<b>Measles</b>			
		<b>Meningitis</b>						<b>German Measles</b>			
		<b>Diabetes</b>						<b>Cancer</b>			
		<b>Heart Disease</b>						<b>Chronic Ear Infection</b>			
		<b>Does applicant smoke?</b>						<b>Alcohol Abuse/Use</b>			
		<b>Other</b>						<b>Other</b>			

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<b>MEDICAL SECTION</b>					
<b>*B.</b>	<b>(Include dates if possible)</b>				
	<b>Past Surgical Operations/Hospitalization:</b>				
	<b>Past Injuries:</b>				
	<b>Recurring Medical Problems:</b>				
	<b>Past/Present Behavior/Psychiatric Problems:</b>				
	<b>Name of Psychologist/Psychiatrist:</b>				
<b>*C.</b>	<b>Does this individual currently have any of the following medical conditions? If so, please check.</b>				
		<b>Cerebral Palsy</b>		<b>Epilepsy</b>	<b>Diabetes</b>
		<b>Congestive Heart Failure</b>		<b>Hypertension</b>	<b>Arthritis</b>
		<b>Gastric Ulcer</b>		<b>Congenital Heart Anomalies</b>	<b>Duodenal Ulcer</b>
		<b>Asthma</b>		<b>ASHD</b>	<b>Bronchopulmonary Dysplasia</b>
		<b>Hypothyroidism</b>		<b>Emphysema</b>	<b>Chronic Kidney Disease</b>
		<b>Cardiovascular Disease</b>		<b>Pneumonia</b>	<b>Meningitis</b>
		<b>Lupus Erythematosus</b>		<b>Peripheral Vascular Disease</b>	<b>Varicose Veins</b>
		<b>Hemorrhoids</b>		<b>Gallbladder Disorders</b>	<b>Cerebrovascular Disease</b>
		<b>Leukemia</b>		<b>Obesity</b>	<b>Otitis Media</b>
		<b>Sickle Cell Anemia</b>		<b>Eczema</b>	<b>Parkinson</b>
		<b>Respiratory Disease</b>		<b>Respiratory Distress Syndrome</b>	<b>Alzheimer</b>
		<b>Scoliosis</b>		<b>Endometriosis</b>	
<b>*D.</b>	<b>Status of Ambulation</b>				
		<b>Independent</b>		<b>Semi-Independent (specify)</b>	
		<b>Non-Ambulatory</b>		<b>Crutches</b>	
		<b>Walker</b>		<b>Wheelchair</b>	
		<b>Cane</b>		<b>Braces/AFOs</b>	
		<b>Other</b>			

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<b>Applicant's Name</b>												
<b>MEDICAL SECTION</b>												
<b>E.</b>	<b>Does applicant have difficulty with:</b>											
	<b>Vision:</b>	<b>YES</b>	<input type="checkbox"/>	<b>NO</b>	<input type="checkbox"/>	<b>Date of last exam by eye doctor:</b>						
	<b>If yes, please describe:</b>											
	<b>Hearing:</b>	<b>YES</b>	<input type="checkbox"/>	<b>NO</b>	<input type="checkbox"/>	<b>Date of last evaluation:</b>						
	<b>If yes, please describe:</b>											
	<b>Speech:</b>	<b>YES</b>	<input type="checkbox"/>	<b>NO</b>	<input type="checkbox"/>	<b>If yes, please describe:</b>						
	<b>Eating:</b>	<b>YES</b>	<input type="checkbox"/>	<b>NO</b>	<input type="checkbox"/>	<b>If yes, please describe:</b>						
	<b>Ability to control urine:</b>						<b>YES</b>	<input type="checkbox"/>	<b>NO</b>	<input type="checkbox"/>		
	<b>If yes, please describe:</b>											
	<b>Ability to control bowels:</b>						<b>YES</b>	<input type="checkbox"/>	<b>NO</b>	<input type="checkbox"/>		
	<b>If yes, please describe:</b>											
<b>F.</b>	<b>Does applicant have need for the following: (Please Check)</b>											
	<input type="checkbox"/>	<b>Special Bathing Equipment</b>				<input type="checkbox"/>	<b>Diapers/Depends (Use/Frequency):</b>					
	<input type="checkbox"/>	<b>Eating Devices</b>				<input type="checkbox"/>	<b>Tracheostomy</b>					
	<input type="checkbox"/>	<b>Prosthesis (Dentures, etc.)</b>				<input type="checkbox"/>	<b>Hearing Aid</b>					
	<input type="checkbox"/>	<b>Pacemaker</b>				<input type="checkbox"/>	<b>Urinary Devices</b>					
	<input type="checkbox"/>	<b>Special Shoes</b>				<input type="checkbox"/>	<b>Vascular Devices</b>					
	<input type="checkbox"/>	<b>Eye Glasses</b>				<input type="checkbox"/>	<b>Ostomy</b>					
	<input type="checkbox"/>	<b>Gastrostomy (Type):</b>				<input type="checkbox"/>	<b>Respiratory Equipment</b>					
	<input type="checkbox"/>	<b>Other (Describe):</b>										
<b>G.</b>	<b>Female</b>											
	<b>Date of last Pelvic exam:</b>											
	<b>Date of last Pap smear:</b>				<b>Results:</b>							
	<b>Is menstruating?</b>	<b>YES</b>	<input type="checkbox"/>	<b>NO</b>	<input type="checkbox"/>	<b>Periods</b>	<b>Regular</b>	<input type="checkbox"/>	<b>Irregular</b>	<input type="checkbox"/>		
	<b>Date of last Menstrual Period:</b>											
	<b>Special Needs:</b>											
	<b>Gynecological History:</b>											

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<b>Applicant's Name</b>										
<b>MEDICAL SECTION</b>										
<b>III.</b>	<b>*Allergies</b>									
	<b>A.</b>	<b>Foods</b>	<b>YES</b>	<input type="checkbox"/>	<b>NO</b>	<input type="checkbox"/>	<b>If yes, to what:</b>			
	<b>B.</b>	<b>Environmental Substances: (include Animals if applicable)</b>					<b>YES</b>	<input type="checkbox"/>	<b>NO</b>	<input type="checkbox"/>
		<b>If yes, to what:</b>								
	<b>C.</b>	<b>Medication Allergies:</b>								
<b>IV.</b>	<b>Skin Problems (List any below)</b>									
	<b>Skin Problems</b>					<b>Skin Problem Treatment</b>				
<b>V.</b>	<b>*Convulsions &amp; Epilepsy</b>									
	<b>Type and Frequency:</b>				<b>Length of seizures:</b>					
	<b>Age at onset and cause (if known):</b>			<b>Postictal behavior:</b>		<b>Date of last seizure:</b>		<b>Aura:</b>		
	<b>Procedures (including blood drawing): Does the consumer have any routine procedures</b>									
	<b>performed?</b>	<b>YES</b>	<input type="checkbox"/>	<b>NO</b>	<input type="checkbox"/>	<b>If yes, please specify procedure and frequency:</b>				
	<b>What is the consumer's usual reaction to this procedure?</b>									
	<b>List any helpful hints to ease anxiety or fear of procedure:</b>									

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<b>Applicant's Name</b>					
<b>MEDICAL SECTION</b>					
<b>VI.</b>	<b>*Current Medication Schedule</b>				
<b>Please attach a copy of current physician's orders for each medication listed below.</b>					
	<b>Name of Medication</b>	<b>Purpose of Medication</b>	<b>Dosage of Frequency</b>	<b>Time Medication is Taken</b>	<b>Name &amp; Phone Number of Prescribing Physicians</b>
<b>VII.</b>	<b>*Immunization Record (Indicate if medical or religious contraindications are present)</b>				
		<b>First</b>	<b>Second</b>	<b>Third</b>	<b>Booster</b>
	<b>D.P.T.</b>				
	<b>D.T. (Tetanus)</b>				
	<b>Polio</b>				
	<b>MMR</b>				
	<b>HIV</b>				
	<b>Hep B Vac.</b>				
	<b>Small Pox</b>				
<b>VIII.</b>	<b>*Please indicate dates of Mantoux (tuberculosis) skin tests if known.</b>				
	<b>Date of Step #1</b>		<b>Results</b>		
	<b>Date of Step #2</b>		<b>Results</b>		
	<b>Date of Chest X-Ray</b>		<b>Results</b>		
<b>If another type of tuberculosis testing has been completed please list name of test, date of test, result of test:</b>					
	<b>Date of Hep B Screening (if available)</b>		<b>Results</b>		

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<b>Applicant's Name</b>			
<b>DIETARY SECTION</b>			
<b>Diet prescribed by doctor:</b>			
<b>Reason:</b>			
<b>Food likes:</b>			
<b>Food dislikes:</b>			
<b>List any special needs:</b>			
<b>SIGNATURE OF PERSON WHO COMPLETED FORM</b>			
<b>RELATIONSHIP</b>			
<b>ADDRESS &amp; TELEPHONE # OF INDIVIDUAL (ABOVE)</b>			
<b>DATE</b>			
<b>FOR NATI USE ONLY:</b>			
<b>Date Application Received:</b>			
<b>Outcome/Decision:</b>			
<b>Denied (state reason):</b>			
<b>Accepted (indicate if on waiting list or projected date of entry):</b>			
<b>Checklist of Documents Received</b>			
	<b>Medical Exam</b>		<b>Psychiatric Evaluation</b>
	<b>Social History</b>		<b>Psychological Evaluation</b>
	<b>ISP/IHP/BSP(dated within last 18 months)</b>		<b>Therapy Report(s)</b>
	<b>Vocational/Educational</b>		<b>Medications</b>
	<b>Signed/dated MD orders</b>		<b>Complete NATI application</b>
<b>NEED RELEASE OF INFORMATION FORM(S) ATTACHED TO APPLICATION</b>			

**New Avenues to Independence, Inc.  
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<b>Applicant's Name</b>		
<b>Optional Services</b>		
<p>Listed below are optional services NEW AVENUES TO INDEPENDENCE offers, which may be purchased in addition to the basic services. Please indicate which services are being requested, and whether the request is for diagnostic evaluation and/or ongoing services. For each service requested describe in detail what you would like us to address. If ongoing services are requested, please indicate how often and for how long you are requesting the service. Please refer to the Transitional Respite Diagnosis/Evaluation hourly rates. Not all services requested will be provided due to insurance/billing issues. Requests will be decided on a case by case basis.</p>		
SERVICE	DIAGNOSTIC EVALUATION YES/NO	THERAPY REQUESTED YES/NO
Art Therapy		
Music Therapy		
Nutritional Services		
Occupational Therapy		
Physical Therapy		
Psychological Services		
Social Work		
Speech Therapy		
Audiological Services		
Specialized Medical Services		
Dental		
Neurology		
Podiatry		
Nursing		
Psychiatry		

**New Avenues to Independence, Inc.  
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<b>Applicant's Name</b>				
<b>PHYSICIAN'S ORDER FORM</b>				
<b>Consumer Name:</b>				
<b>Routine Medications (please list all medications including dosage, route, times of administration)</b>				
1.				
2.				
3.				
4.				
5.				
<b>As Needed Medications</b>				
1.				
2.				
3.				
4.				
5.				
<b>Routine and As-Needed Treatments</b>				
1.				
2.				
3.				
<b>Dietary Order:</b>				
<b>Activity Level/Restrictions:</b>				
<b>Administer TB skin Test Two-Step Mantoux (if applicable):</b>				
<b>Please list any medical appointments that are scheduled or need to be scheduled during consumer's stay at NATI Transitional Respite Unit.</b>				
<b>Physician name (printed);</b>			<b>Scheduled</b>	<b>Need to be scheduled</b>
<b>Physician signature:</b>			<b>Scheduled</b>	<b>Need to be scheduled</b>
<p>I give permission for this medication to be administered during NATI school/work/activities by a licensed nurse or certified MR/DD personnel as delegated by a NATI licensed nurse. I agree to notify NATI personnel of changes in prescriber's instructions or if medication is discontinued. In the event of an adverse reaction, the NATI nurse will be notified and/or prescriber at the number listed above.</p>			<b>Telephone Number:</b>	
<b>Physician Initials:</b>			<b>Date:</b>	
<b>Will above signing physician continue to follow consumer while at NATI?</b>			<b>YES</b>	<b>NO</b>