Respite Program
Intake Information

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Discharge Summary

Initial Screening

Case # _________

Client Name: ____________________________________ Date _________________

DOB: _____________ Age: __________ Gender: _____________________________

Race: _______________________________ Religion: __________________________

School: _____________________________ Grade: ____________________________

Siblings: ____

Child's Home Address: ____

City: _______________________ FL. Zip: ____________________________________

Home Ph # _____________________________ Cell Ph# _________________________

Legal Guardian: _________________________ Relation to Child: ________________

Child Resides with (include Adults and children) _______________________________

____

Contact Email Address: ____

Emergency Ph #: ____

Eligibility Criteria:

Person is living inside Palm beach County ☐ Yes.

Person Served Is age birth to age 12 ☐ Yes.

Person served has diagnosis of developmental disability o

Developmental delay ☐ Yes.

Persons Authorized to discharge the child:

____

____

Reason(s) for Referral ____

Diagnosis from physician: ____

____

____

Program(s) Referred To:

☐ Respite ☐ Parent Training ☐ Parent Mentoring Network

Parent / Guardian/ Caregiver MUST Fill out a survey before leaves

Emergency Contact Information

Person Served: ____ Case #: __________

Personal Information	
Name	
Age	
Date of Birth (MM/DD/YYYY)	
SSN	
Address: Street, City, Zip	
Home/ Cell Phone	
Medical Information	
Physician name and phone number	
Allergies	
Medical conditions	
Current medications	
Current medications	
Emergency Contact	
Emergency Contact Name	
Relationship	
Phone Number(s)	
Legal Guardian/Parent Information	
Mother's Name	
Mother's Phone Number(s)	
Father's Name	
Father's Phone Number(s)	
Special Conditions	

I authorize Grandma's Place to use this medical information in the event of a medical emergency.

______________________________ ______________________________ ______________

Parent or Legal Guardian Name Parent or Legal Guardian Signature Date

Grandma's Place Representative ______________________________ Date___________

Respite Program Consent to Services

Person Served: ____ Case #: ____________

The main objective of Grandma's Place is to provide comprehensive services, which are sensitive to the needs of our client population.

I, ___________________________________an applicant for the services of Grandma's Place,

And if applicable,

I, ___________________________________ parent/guardian of the above named

applicant:

I/We authorized the staff of Grandma's Place to administer services.

I/We are voluntarily consenting to services in the Respite Program and this has been explained to me/us. My/Our questions and concerns have been answered and addressed.

I/We understand that all information will be shared with Grandma's staff Team.

I/We understand that all information will be shared with Youth Services Dept. of PBC

I/We understand that the Respite Program is required to comply with all laws, including reporting abuse and neglect.

I/We understand that Grandma's will do its best to provide quality services however, no guarantee can be made to me/us regarding the outcome of services.

All individual information will be safeguarded and will not be disclosed

❑ By signing below, I/ We agree that we/I have read, and understand, the above statements.

____ ____________________________

Parent/Legal Guardian Date

PRIVACY NOTICE

The following is a description of other possible ways in which we may and are permitted to use and/or disclose your protected health information without written authorization.

AS REQUIRED BY LAW We are required to disclose your protected health information to the Secretary of the U.S. Department of Health and Human Services when requested.

PUBLIC HEALTH ACTIVITIES We may disclose your information to public health authorities for public health activities including reports of child abuse or neglect and communicable disease exposures or to lessen serious and imminent treat to the healthor safety of a personor the public.

FAMILY INVOLVED IN YOUR CARE We may disclose to the patient's legal representative or to family members, other relatives or a close personal friend of the individual if the disclosure is directly to the care of the individual and in their best interests. Only the protected health information that is directly relevant may be disclosed.

HEALTH OVERSIGHT ACTIVITIES We may disclose your information for statistical and scientific research, provided the information is abstracted in such way as to protect your identity. Disclosure to government programs providing public benefit for eligibility or enrolment information among such government agencies.

JUDICIAL PROCEEDINGS Your medical information may be disclosed in response a legal process such as a court order, subpoenas and certain investigations do not require any permission from an individual, however, the individual must be notified in advance of disclosure. (45 CFR 164512)

LAW ENFORCEENT Disclosures for law enforcement purposes, including reporting certain wounds or other physician injuries ; identifying or locating a suspect, fugitive, material witness, missing person, or evidence ; reporting crimes in emergencies; or criminal conduct on the premises.

OTHER disclosure to coroners and medical examiners; disclosure to funeral directors; disclosure for cadaveric organ, eye or tissue donation; to comply with workman compensation

YOUR RIGHTS REGARDING YOUR PERSONAL INFORMATION

The following describes your rights regarding certain personal information that we maintain.

CONFIDENTIAL COMMUNICATION WITH YOU You may request we communicate with you at an address or phone number of your choice; but it must be reasonable request and may request that you put that in writing.

RESTRICTION ON USE OR DISCLOSURE You have the right to limit or restrict the release of your personal health information (PHI) too individuals/organizations for use other than "treatment, payment and health care operations". We will request that you put those restrictions in writing.
In your request tell us: (l) the type of information whose disclosure you want us to limit and (2) how you want to limit our use and/or disclosure of the information.

You are also allowed to limit or restrict the use or disclosure of your PHI for treatment, payment or healthcare operations", however we are not require to agree to those restrictions.
There are also cases where we are not allowed to release your personal health information without prior written authorization from you. You may revoke the written authorization any time, but must be in writing and will not take effect until such revocation is received by our agency. Examples are: For statistical and scientific research if your identity is included; use or disclosure of psychotherapy notes; and for marketing purposes.

INSPECTION AND COPIES OF INFORMATION You have the right to inspect information in your record, and may obtain a copy of it. Your request must be in writing and you must provide a reasonable time frame for us to comply. Internal

agency protocols will be adhered to. As permitted by law, we may deny your request to inspect and copy your protected health information in certain limited circumstances. If we deny access, you do have the right to appeal.

AMEND OR CORRECT INFORMATION If you believe that information we hold is incorrect or incomplete, you may request, in writing, that your information be amended and must have reasonable support. As permitted by law, deny your request in whole or part in certain circumstances. Examples would be: information is from another source outside our agency; the information is not protected health information; is by law not available for your inspection is accurate and complete.

SUMMARY OF DISCLOSURES You have the right to receive a summary of certain disclosures and might include disclosures made for the purpose of research, other than those you authorize in writing, or responses to court orders, subpoenas or warrants. You request must be in writing and cannot be prior to April 14, 2003 and for not more than a 6-year period from the date of your request.

YOUR RIGHT TO FILE A COMPLAINT

If you believe your privacy rights have been violated, you may file a complaint with our office and /or with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenues. S.W., Washington, D.C. 20201. Telephone number (202) 619-0257 or toll free at 877-696-6775. The complaint must be in writing, describe the acts or ommisions that you believe your privacy rights and be filed within 180 days of when you knew you should have known that the act or omission occurred. Your services wil not be affect and our agency will not retaliate against you for filing a complaint.

HOW TO CONTACT US

We have a designated Privacy Liaison:
Grandma's Place, Inc184 Sparrow Drive Royal Palm Beach, Fl 33411(561) 753-2226

____ ____________________

Parent/Guardian's Signature Date

Grandma's Place, Inc.
Client Rights Statement

All Grandmas' Place staff must be aware of Resident's Rights:

Chapter 393 of the Florida Statutes says that all residents have the right:

1. The right to be a child.
2. To dignity, privacy and humane care.
3. To religious freedom.
4. To services that protect personal liberty and provide the least restrictive environment to achieve treatment outcomes
5. To an appropriate, quality education and training service.
6. To social interaction and to participate in community activities.
7. To physical exercise and recreational opportunities.
8. To freedom from physical harm, abuse, neglect, physical and chemical restraint.
9. The Right to consent to or refuse treatment
10. A right not to be discriminated against due to a developmental disability.
11. The right to utilize the grievance procedure.

I, or my Parent/guardian, have received a copy of my rights and have had a chance to talk about them and completely understand my rights at any time.

______________________________	______________________________
Parent/Guardian's Signature/Date	Client's Signature/Date

Services and Emergency Care Release, Hold Harmless and Indemnification Agreement

Person Served: ____ Case #: _____________

By signing below, I, on behalf of myself, the above-named minor child or person served and our respective heirs, assigns and personal representatives, agree to release, hold harmless and indemnify Grandma's Place including its employees, staff, agents and officers (GP), from or for any and all liability, claims, losses, demands, expenses, and causes of action whatsoever for personal injury or property damage/loss of any kind resulting from or arising out of Grandma's Place services, any emergency care or transport provided to the above-named minor child, or the above named minor child's presence on or about Grandma's Place premises, except to the extent any such injury, damage or loss is caused by the gross negligence of Grandma's Place

______________________________ Parent/Guardian's Signature/Date

____ ___________________________ GP Representative Signature/Date

Permission to Photograph or Videotape

Person Served: ____ Case #: ____________________

I hereby give permission for my child

____ (Name),

DOB ____________________ to be photographed or videotaped and for the photograph(s) or video(s) to be used to raise awareness and/or funds to further the mission of the Grandma's Place. This permission may be withdrawn verbally or in writing at any time and is valid: (please check one)

❑ Indefinitely, until further notice

❑ Other: ___________________________

____________________________ ______________________________________

Parent or Legal Guardian Name GP Representative Signature

Comprehensive Assessment

Person Served ______________________________Case #. ________________________

Intake Date: _______________Time:_________ Discharge Date: _____________ Time: ____

DOB: _______________________ Sex: ❑ Male ❑ Female

Disability: ____

Referred By: ❑ Family & Friends ❑ Community Professionals ❑ 211
❑ Faith Community

Other ____

Reason for Referral: ____

Name of person providing information ____

Relationship to person served: ____

Communication/Language Skills:
My child can:

____

Cognitive:
My child can:

____

Social Skills:
My child can:

____

Gross Motor Skills:
My child can:

____

Respiratory

❑ Suctioning: ❑ Oral ❑ Tracheal ❑ Nasal (bulb ❑ Nebulizer (administer as per parents instructions)

❑ Maintain Aspiration precautions at all times

Equipment: ❑ Apnea monitor ❑ Pulse Oximeter ❑ CP

Behavior Checklist

Person. Served: ____ Case #: ____________

Person Completing Form: _________________________________ Date: _____________

DESCRIPTION OF THE BEHAVIORS:

Please list and describe behaviors in order of magnitude. List most destructive behaviors first. Write a detailed description of each behavior. For example: "Forcefully biting wrist" or "hitting head with closed fist".

Though the same behaviors may not always receive the same consequence, please list the most likely consequence of each behavior. Use the "Notes" section below to write any other pertinent information (e.g., when the behavior is more or less likely to occur).

Behavior	What it looks like	How Often?	Triggers (What happens immediately before behavior?)	Consequences (What happens immediately after the behavior?)
❑ Physical aggression (e.g., SIB, hitting) ❑ Property destruction ❑ Verbal aggression ❑ Tantrum ❑ Repetitive stimming ❑ Other	Example: SIB — hitting self on head with closed fist	❑ Constant ❑ 2-3 times a day ☑ 1time a day ❑ 1-2 times a week ❑ 1-2 times a month	❑Denied access to item ❑Asked to complete work/no preferred task ❑ Bored/without attention ❑Going to certain places ❑Other__________	❑ Behavior is ignored ❑ Child is put in time out ❑ Child gets preferred item ❑ Childreceives reprimand ❑ Child is blocked from behavior/redirected ❑ Other
❑ Physical aggression (e.g., SIB, hitting) ❑ Property destruction ❑ Verbal aggression ❑ Tantrum ❑ Repetitive stimming ❑ Other		❑ Constant ❑ 2-3 times a day ❑ 1 time a day ❑ 1-2 times a week ❑ 1-2 times a month	❑Denied access to item ❑Asked to complete work/no preferred task ❑ Bored/without attention ❑Going to certain places ❑Other	❑ Behavior is ignored ❑ Child is put in time out ❑ Child gets preferred item ❑ Childreceives reprimand ❑ Child is blocked from behavior/redirected ❑ Other
❑ Physical aggression (e.g., SIB, hitting) ❑ Property destruction ❑ Verbal aggression ❑ Tantrum ❑ Repetitive stimming ❑ Other		❑ Constant ❑ 2-3 times a day ❑ 1 time a day ❑ 1-2 times a week ❑ 1-2 times a month	❑Denied access to item ❑Asked to complete work/no preferred task ❑ Bored/without attention ❑Going to certain places ❑Other__________	❑ Behavior is ignored ❑ Child is put in time out ❑ Child gets preferred item ❑ Childreceives reprimand ❑ Child is blocked from behavior/redirected ❑ Other
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Prescription Medication Authorization

Person Served: ____ Case #: __________________

Date: ____

Is the person served currently taking prescribe medication? ❑ Yes ❑ No

The above medication will be given during respite services: ❑ Yes ❑ No

MEDICATIONS:

Name of Medication	Dose	Frequency	# Pills	Reason

Prescribed by: ____

Doctor's Name Phone Number

Administered: ❑ Orally ❑ Topically ❑ Other

____

Your signature below constitutes your acknowledgement that (1) you have read and agree to the foregoing; (2) that the medication and treatment set forth above have been adequately explained and/or discussed with you by your supervising physician and that you have received all the information you desire concerning such medication and treatment; and (3) that you authorize and consent to the administration of such medications and treatment.

_____________________________ _________________________________ ________

Parent or Legal Guardian Name Parent or Legal Guardian Signature Date

Respite Program

Discharge Summary

Person Served: ____ Case #: __________________________

Date of Birth: ____

Intake Date: ___________________Time:_____________ Discharge Date: _____________ Time: ______

Discharge Recommendations and notes:

____

____

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