San Gabriel/Pomona Regional Center

FAMILY RESPITE NEEDS ASSESSMENT SUMMARY

Consumers Ages 0-2

DOES CLIENT MEET PURCHASE OF SERVICE CRITERIA? IF NOT, DO NOT PROCEED

Definition of Respite: *Respite Services means intermittent or regularly scheduled temporary care and/or supervision of a child or adult with a developmental disability whose needs exceed that of an individual of the same chronological age without developmental disabilities (W&C Code 4686.5 (1)). In-Home Respite Services are provided in the family home. Out of Home Respite Services are provided in licensed residential facilities. Respite is not intended to provide for all supervised care needs of the family; it is a supplemental tot he family's responsibility for care. Respite is not daycare (W&C Code 4686.5 (4)).*

Consumer Name:		**UCI:**	
Diagnosis:		**Age:**	
Completed By:		**Date:**	

Purchase of Service Policy:

Respite care may be purchased if one or more of the following criteria are met:

1. The child or adult with a developmental disability exhibits behavioral challenges requiring specialized care. Such behaviors include aggressive acting out, assaultive or self-abusive behaviors, property destruction, hyperactivity or other behaviors which might endanger the client or others.

2. There are medical and/or physical needs requiring specialized care, including the need to be monitored for uncontrolled seizures or breathing difficulties; the need for special feeding, care of a gastrostomy, tracheostomy, or the use of special equipment.

3. The individual has significant self-care needs beyond those normally associated with his or her age. These needs include challenges in completing activities of daily living, such as feeding, toileting, dressing, bathing, or communication.

4. There are extraordinary family circumstances, which includes illness, a single-parent home, more than one family member with a developmental disability, and/or extreme financial hardship. This includes a parent who is unable to fully care for their child due to illness, age or a disability.

5. For children less than three years of age in the Early Start program, who do not have a diagnosis of a developmental disability, respite shall only be provided to enable the parent(s) to participate or receive other early intervention services (not to include Specialized Instruction, Occupational Therapy, Physical Therapy, or Speech Therapy) designated to meet specific outcomes on the child's IFSP. parent home, more than one family member with a developmental disability, and/or extreme financial hardship. This includes a parent who is unable to fully care for their child due to illness, age or a disability.

Generic Resources/Supports

IHSS	Yes/No?	IHSS Hours		Protective Supervision?	Yes/No?	NF WAIVER?	Yes/No?
Preferred Provider	Agency Worker/PC?			Nursing Assessment?	Yes/No?	Form #204 Signed?	Yes/No?
BI Workshop	Yes/No?	FCPP	Yes/No?	Medi-Cal?	Yes/No?	EPSDT	Yes/No?
						EPSDT Hrs.	

Conference Criteria

Conference: For infants and toddlers less than three years of age in the Early Start program, who do not have a diagnosis of a developmental disability, respite shall only be provided to enable the parents(s) to participate or receive other early intervention services designed to meet specific outcomes on the child's IFSP.

Is Respite Request for the purpose to attend a Training/Conference?	Yes/No?	Date	
Training/Conference Name:		Hours Needed:	

Mobility: Only applicable if infant/child is over the age of 24 months and not walking

24 months or older and not yet walking	Yes/No?	#N/A
Has a diagnosis of Cerebral Palsy, Neurological Disorder and/or displays characteristics similar to CP affecting mobility	Yes/No?	#N/A
Requires constant care due to mobility concerns	Yes/No?	#N/A
0-23 months of age	Yes/No?	#N/A

Consumer Name:	0	UCI:	0

Safety Awareness: Enter an answer for all selections		
Wanders out in the community requiring constant supervision	Yes/No?	#N/A
Does not understand commands. (ex: The meaning of No, 1-2 step commands)	Yes/No?	#N/A
Opens doors, safety locks in the home	Yes/No?	#N/A
Displays behaviors endangering self out in the community requiring constant supervision. (ex: danger to self while in a car seat)	Yes/No?	#N/A

Medical Needs: Enter an answer for all selections		
Has moderate illnesses or a condition requiring monthly medical appointments to medical visits (high risk clinics, specialty follow up, laboratory work, CCS MTU) specialist or routine	Yes/No?	#N/A
Has hearing/ vision loss. Requires continual monitoring/immediate caregiver involvement.	Yes/No?	#N/A
Has medical conditions that are extreme and not typical for an infant under age 3; such as infants on g-tubes, oxygen, palliative care, or hospice care etc.., or facing life threatening conditions	Yes/No?	#N/A
Has unusual genetic disorder that cause un-expected medical conditions and require care that would not be typical to that of an infant (0-3)	Yes/No?	#N/A
Requires specialized feeding accommodations; has significant allergies impacting daily living function	Yes/No?	#N/A

Behavioral Concerns: Enter an answer for all selections		
Displays significant behaviors resulting in interruption of therapies on a daily/weekly basis	Yes/No?	#N/A
Displays severe behaviors (hitting, kicking, throwing self on floor, self-injurious behaviors) through the day resulting in supervision at all times.	Yes/No?	#N/A
Displays significant behaviors resulting in constant redirection prompting from parent through the day	Yes/No?	#N/A
Displays significant behaviors interfering with their ability to participate in family/social activities/outings (such as frequent tantrums, biting, screaming, etc…)	Yes/No?	#N/A

Family Situation: Enter an answer for all selections		
Member of a single parent or two parent family and has a sibling who is a client of Regional Center with a developmental disability residing in the home	Yes/No?	#N/A
Has a parent or primary caregiver that has a disability or permanently disabled and unable to work or is in treatment for chronic medical problem which directly interferes with their ability to meet the individual's daily care needs	Yes/No?	#N/A
Member of a single parent; father/mother is not available to provide relief because he/she is the sole support; extended family are not available; friends as well; other siblings that may be clients or have mental health needs	Yes/No?	#N/A
Parent(s) have a mental health disorder, postpartum depression, facing significant circumstances in the home causing related health concerns to caregiver, etc.	Yes/No?	#N/A
Parent is participating in more than 10 hours per week of Mandated Parent Participation Early Intervention Therapies	Yes/No?	#N/A

Mobility	#N/A	Safety	#N/A	Medical	#N/A	Behaviors	#N/A	Family	#N/A	Total	#N/A

Developmental Levels: Enter child's present developmental levels.							
Cognition		Receptive		Fine Motor		Social/Emotional	
Adaptive		Gross Motor		Expressive			

Consumer Name:	0	**UCI:**	0

Enter additional comments below, about child/family situation related to respite need request: (Extraordinary circumstances, unexpected family emergencies, etc…)

Points	Hours
0-5 Points	Routine Supervision
5-16 Points	Up to 12 hours per month (36hrs/quarter)
16-19 Points	Up to 16 hours per month (48hrs/quarter)
20-25 Points	Up to 20 hours per month (60hrs/quarter)
26-31 Points	Up to 24 hours per month (72hrs/quarter)
32-36 Points	Up to 30 hours per month (90hrs/quarter)
37-42 Points	Up to 36 hours per month (108hrs/quarter)

Expanded Review Process

Requests over 36 hours per month or 108 hours per quarter of respite must undergo an expanded review process. The Service Coordinator must first review the exceptional request with their manager, then proceed to Exceptional Service Review Committee if the request meets one of the two following considerations.

* It is demonstrated that the intensity of the person's care and supervision needs are such that additional respite is necessary to maintain him/her in the family home, or

* There is an extraordinary event that impacts the family member's ability to meet the care and supervision needs of the person.

Indicate Number or Hours Requested			
How is the Family going to use the Respite?			
Total Hours Approved		Hours to be reviewed by (Date)	

Signature of Manager, Client Services

Signature of Associate Director, Client Services