San Gabriel/Pomona Regional Center

FAMILY RESPITE NEEDS ASSESSMENT SUMMARY

Consumers Ages 3 to 17

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.

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.	Yes/No		

Daily Life: Enter Values According to CDER		
Safety Awareness	Select an option	0
Using Hands	Select an option	0
Walking	Select an option	0
Using a Wheelchair	Select an option	0
Taking Prescribed Meds	Select an option	0
Eating	Select an option	0
Toileting	Select an option	0
Bladder and Bowel Control	Select an option	0
Personal Care	Select an option	0
Dressing	Select an option	0

Challenging Behaviors: Enter Values According to CDER		
Disruptive Social Behavior	Select an option	0
Physical Aggressive Behavior	Select an option	0
Self Injurious Behavior	Select an option	0
Destruction of Property	Select an option	0
Running or Wandering Away	Select an option	0
Emotional Outbursts	Select an option	0

Consumer Name:	0	**UCI:**	0

Other Care Needs:		
Age	Select an option	0
Family Situation	Select an option	0
Medical	Select an option	0
Day Program Attendance	Select an option	0

If Medically Involved List Conditions and Medications:

Daily Life Total:	0	Behaviors Total:	0	Other Care Needs Total	0	Total Points	0

IN HOME RESPITE		OUT OF HOME RESPITE
1-16	Up to 12 hours per month (36 hrs/quarter)	Up to 1 day per month/ not to exceed 12 days per year.
17-32	Up to 16 hours per month (48 hrs/quarter)	
33-48	Up to 20 hours per month (60 hrs/quarter)	
49-64	Up to 24 hours per month (72 hrs/quarter)	Up to 2 days per month/ not to exceed 21 days per year.
65-78	Up to 32 hours per month (96 hrs/quarter)	
79+	Up to 36 hours per month (108 hrs/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:

* 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.

Please provide a narrative in boxes below with details supporting your request:

Indicate number of hours requested?	Who currently assists with the care and supervision of the consumer?
How is the family going to use respite?	**How long will extraordinary respite be needed?**

Total Hours/ Days Requested		

Signature of Manager, Client Services

San Gabriel/Pomona Regional Center

FAMILY RESPITE NEEDS ASSESSMENT SUMMARY

Consumers Ages 18 +

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.

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.	Yes/No

Daily Life: Enter Values According to CDER		
Safety Awareness	Select an option	0
Using Hands	Select an option	0
Walking	Select an option	0
Using a Wheelchair	Select an option	0
Taking Prescribed Meds	Select an option	0
Eating	Select an option	0
Toileting	Select an option	0
Bladder and Bowel Control	Select an option	0
Personal Care	Select an option	0
Dressing	Select an option	0

Challenging Behaviors: Enter Values According to CDER		
Disruptive Social Behavior	Select an option	0
Physical Aggressive Behavior	Select an option	0
Self Injurious Behavior	Select an option	0
Destruction of Property	Select an option	0
Running or Wandering Away	Select an option	0
Emotional Outbursts	Select an option	0

Consumer Name:	0	UCI:	0

Other Care Needs:		
Age	Select an option	0
Family Situation	Select an option	0
Medical	Select an option	0
Day Program Attendance	Select an option	0

If Medically Involved List Conditions and Medications:

Daily Life Total:	0	Behaviors Total:	0	Other Care Needs Total	0	Total Points	0

IN HOME RESPITE		OUT OF HOME RESPITE
1-16	Up to 12 hours per month (36 hrs/quarter)	Up to 1 day per month/ not to exceed 12 days per year.
17-32	Up to 16 hours per month (48 hrs/quarter)	
33-48	Up to 20 hours per month (60 hrs/quarter)	
49-64	Up to 24 hours per month (72 hrs/quarter)	Up to 2 days per month/ not to exceed 21 days per year.
65-78	Up to 32 hours per month (96 hrs/quarter)	
79+	Up to 36 hours per month (108 hrs/quarter)	

Expanded Review Process:

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* 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.

Please provide a narrative in boxes below with details supporting your request:

Indicate number of hours requested?	Who curerntly assists with the care and supervision of the consumer?
How is the family going to use respite?	How long will extraordinary respite be needed?

Total Hours/ Days Requested		

Signature of Manager, Client Services

CDER OPTIONS	Value
Rows 3-8 for Safety Awareness	0
Select an option	0
Does not require supervision to prevent injury/harm	0
Requires someone nearby to avoid injury/harm in unfamiliar settings only	1
Constant supervision to prevent injury/harm in unfamiliar settings	2
Someone nearby during waking hours to prevent injury/harm in all settings	3
Constant supervision during waking hours to prevent injury/harm in all settings	4
Rows 11-17 for Using Hands	
Select an option	0
Uses fingers of both hands to manipulate objects	1
Uses fingers of one hand to manipulate objects	2
Grasps objects with both hands	3
Grasps objects with one hand	4
Does not use either hand	5
Rows 20-25 for Walking	
Select an option	0
Walks alone at least 20 ft with good balance	1
Walks alone at least 20 ft but unsteady	2
Walks alone at least 10 ft but unsteady	3
Walks with support	4
Cannot Walk	5
Rows 28-34 for Using Wheelchair	
Select an option	0
Question does not apply	0
Independently and smoothly in nearly all situations	1
Independently in some situations	2
Independently but difficult to steer in some situations	3
But needs assistance	4
Sits in a wheelchair, but cannot move it	5
Rows 36-42 for Taking Prescribed Meds	
Select an option	0
Question does not apply	0
Always takes medications without reminders	1
Usually takes medications without reminders	2
Takes medication when reminded	3
Takes medication with supervision	4
Requires assistance to take medications	5
Rows 44-49 for Eating	
Select an option	0
Eats with at least one utensil, without spillage	0
Eats with at least one utensil, with spillage	2

Eats with fingers without assistance	3
Eats with fingers with assistance	4
Does not feed self, must be fed completely	5
Rows 51-56 for Toileting	
Select an option	0
Toilets independently, does not require assistance	0
Toilets without prompting, but needs assistance	1
Toilets when prompted	2
Habit trained only	3
Not habit trained	4
	5
Rows 59-64 for Bladder and Bowel Control	
Select an option	0
Complete control of bladder and bowel	0
Wetting and/or soiling no more than 1x a month	1
Wetting and/or soiling at least 1x a week at night	2
Wetting and/or soiling at least 1x a week during waking hours	3
No control of either bladder or bowel	4
Rows 66-71 for Personal Care	
Select an option	0
Performs personal care activities independently w/o reminders	0
Performs personal care activities independently when reminded	1
Performs personal care activities, but needs assistance	2
Assists with personal care activities, but needs assistance	3
Does not perform or assist with personal care activities	4
Rows 74-79 for Dressing	
Select an option	0
Dresses self independently without reminders	0
Dresses self independently, but needs reminders to complete	1
Dresses self, but needs assistance	2
Assists with dressing by performing helpful movements	3
Does not dress self	4
Rows 82-87 for Disruptive Social	
Select an option	0
Disruptive behavior never occurs	0
Interferes w/social participation less than 1x a month	1
Interferes w/social participation at least 1x a month, not every week	2
Interferes w/social participation at least 1x a week, not every day	3
Interferes w/social participation almost every day	4
Rows 90-95 for Physical Aggressive Behavior	
Select an option	0
Physical aggression behavior never occurs	0
Occurs less than 1x a mo but not caused injury in past 12 mo	1

Occurs at least 1x a mo but not caused injury in past 12 mo	2
Resulting in injury occurred 1x in past 12 mo	3
Resulting in injury occurred more than 1x in past 12 mo	4
Rows 98-103 for Self Injurious behavior	
Select an option	0
Self injurious behavior never occurs	0
Self injurious behavior occurs, but no apparent injury occurs	1
Causes injury. First aid/medical care needed at least 1x a month, not every week	2
Causes injury. First aid/medical care needed at least 1x a week, not every day	3
Causes injury. First aid/medical care needed almost every day	4
Rows 106-111 for Destruction of Property	
Select an option	0
Intentional destruction of property never occurs	0
Caused minor damage (little or no repair of object) 1x in past 12 months	1
Caused minor damage (little or no repair of object) more than 1x in past 12 mo.	2
Caused major damage (require replacement/substantial repair) 1x in past 12 mo.	3
Caused major damage (require replacement/substantial repair) more than 1x in past 12 mo.	4
Rows 114-119 for Running or Wandering Away….	
Select an option	0
Running or wandering away never occurs	0
Occurs or is attempted less than once a month	1
Occurs or is attempted at least once a month, but not every week	2
Occurs or is attempted at least once a week, but not every day	3
Occurs or is attempted almost every day	4
Rows 122-127 for Emotional Outbursts	
Select an option	0
Emotional outbursts never occur	0
Occur less than 1x a week, but do not typically require intervention	1
Occur less than 1x a week and usually require intervention	2
Occur at least 1x a week, but do not typically require intervention	3
Occur at least 1x a week and usually require intervention	4
3-17 Age Row 130-134 for 3-17 Respite Tool	
Select an option	0
3 to 5 years old	1
6 to 9 years old	2
10 to 13 years old	3
14 to 17 years old	4
Rows 137-141 for 18+ Respite Tool	
Select an option	0
18 to 25 years old	1
26 to 35 years old	2

36 to 49 years old	3
50 years and older	4
Rows 144-151 for Family Situation	
Select an option	0
Two parent family/ only 1 client with DD in home	1
Two parent family- one parent w/ disability & only 1 client with DD in home	2
Single parent family/ only 1 client with DD in home	2
More than one DD consumer in home	3
Primary caregiver(s) over age 60	3
Primary caregiver has chronic condition/disability. Impairs ability to meet consumer's daily care needs	4
Primary caregiver in treatment for acute condition. Impairs ability to meet consumer's daily care needs	4
Rows 154-158 for Medical	
Select an option	0
No health problems, only routine care needed	0
Minimal Health (reg med schedule, adaptive diet, seizure disorder requiring little/no care giver support)	1
Chronic medical condition requiring treatment periodic treatment.	2
Acute/Chronic med condition constant monitoring (apnea episodes, suctioning, RHCP nurse eval)	5
Rows 161-166 for Day Program Attendance	
Select an option	0
Attends program over 20 hours/week or refuses available program options	0
Goes to program 10-20 hours per week	1
Individual is chronically suspended due to behaviors	3
Individual is chronically unable to attend due to health reasons	3
Program n/a to meet clients needs due to behavioral/medical need	5
Yes/No	
No	0
Yes	2
Preferred Provider	
Agency Worker/PC	
Agency Worker	
PC	