SOUTHEAST KANSAS RESPITE SERVICES, INC.
PO Box 936, PARSONS, KS 67357
1-800-362-0390 OR 620-421-6550 EXT. 1642 OR EXT. 1899

Application for Respite Services

Information (for person to be served)

Last name ____ First ____ Middle ____

Street/Mailing Address ____ City ____ State ____ Zip ____

Gender ____ Birth Date ____ Age ____

Family/ Caregiver Information

Last name ____ First ____ Middle ____

Daytime Phone ____ Cell phone ____ Evening Phone ____

Doctor

Name ____ Phone ____

Hospital

Name ____ Phone ____

Emergency Contact

Name ____ Phone ____ Relationship ____

Special Care Requirements

Disability/Special Needs ____

Special Physical Considerations ____

Chronic Conditions (such as seizures, asthma, allergies or other on-going conditions) ____

Memory problems ❑ Y ❑ N If yes, describe ____

Height ____ Weight ____

Daily Living

Abilities Sit up alone? ❑ Y ❑ N Stand? ❑ Y ❑ N Walk? ❑ Y ❑ N
Climb Stairs ❑ Y ❑ N

Transfer Assistance Needed? ❑ Y ❑ N If yes, describe ____________________

____

Dressing Assistance Needed? ❑ Y ❑ N If yes, describe ____________________

____

Toileting Assistance Needed? ❑ Y ❑ N If yes, describe ____________________

____

Other (Special assistance or attention required in daily life. Include any special likes or dislikes.)

____

____

____

Communications

Speech Difficulties? ❑Y ❑N If yes, describe ____________________

____

Language Difficulties? ❑Y ❑N If yes, describe ____________________

____

Augmentation Needed? ❑Y ❑N If yes, describe any equipment used ____________________

____

Medical Equipment

Equipment Required ____________________

____

Equipment Use Notes ____________________

____

Form completed by: ____________________ Date: ____________________

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Enrollment - Medication Release Form

Person Served (One person per form) ______________________________

Date of Birth ____________________ Gender

Insurance Company Name ______________________________

Policy Holder Name ______________________________

Policy Number Group Number ______________________________

Billing Address ______________________________

____

Medical Alerts (drug allergies, diabetes, food allergies) ______________________________

____

____

____

Over the Counter Medications (non-prescription medications such as Tylenol, aspirin, cough syrup, eye drops, nasal spray, skin ointment, etc.)

Non-Prescription medication	Dosage	Time

Prescription Medications (also list any potential side effects)

Medication	Purpose	Dosage	Time

I understand that no medications can be given by the SEKRS provider unless I have specified in writing the exact drugs, dosages, and times the medication is to be given and signed this consent form.

In case emergency treatment is required and I am not readily available, I authorize the SEKRS provider to obtain any emergency procedures that may be necessary to insure the health and well-being of the above named person.

I give permission to the SEKRS provider to transport the above named person as necessary.

Signature ____ Date ______________________________

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Release of Information Consent

I ______________________________________ as an individual, or

I ____ as Parent/Guardian/Spouse (please circle one)

do hereby authorize Southeast Kansas Respite Services, Inc. (SEKRS), and/or the attending SEKRS Provider to share necessary information with and receive necessary information from the following agencies (please check the box next to each relevant agency):

☐ Hospice (name): ____

☐ DCF (Department for Children and Families)

☐ Area Agency on Aging

☐ School (list name): ____

☐ Community Service Provider (list name): ____________________________

☐ Hospital (list name): ____

☐ Mental Health Center (name) ____________________________________

☐ Community Developmental Disability Organization (name) ________________

☐ Other (please list): ____

☐ ____

☐ ____

Check one box below:

☐ I authorize information to be shared indefinitely.

☐ I authorize information to be shared between the dates of ______________ and ______________.

______________________________ Individual Signature

______________________________ Date

______________________________ Parent/Guardian Signature

______________________________ Date

______________________________ Witness Signature

______________________________ Date

(Send forms via U.S. Mail. Do not email.)