SOUTHEAST KANSAS RESPITE SERVICES, INC.

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

Rev. 10-2018

Application for Respite Services

Information (for person to be served)

Name (Last, First and Middle): _____

Street/Mailing Address: _____

City, State, Zip: _____

Gender: _____ Birth Date: _____ Age: _____

Family/Caregiver Information

Name (Last, First and Middle): _____

Phone: Daytime _____ Cell _____ Evening _____

Doctor's Name: _____ Phone: _____

Name of Hospital: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Special Care Requirements

Disability/Special Needs: _____

_____

Special Physical Considerations: _____

_____

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

_____

Memory Problems? Yes No

If yes, describe: _____

Height: _____ Weight: _____

Daily Living

ABILITIES Sit upalone? 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:_____

_____

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:_____

_____

_____

Medical Equipment

Equipment Required:_____

_____

_____

Equipment Use Notes:_____

_____

_____

_____

_____

_____

_____

_____

Form completed by: _____

Date:_____

SOUTHEAST KANSAS RESPITE SERVICES, INC.

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

Rev. 10-2018

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

SOUTHEAST KANSAS RESPITE SERVICES, INC.

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

Rev. 10-2018

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:_____

SOUTHEAST KANSAS RESPITE SERVICES, INC.

PO Box 936, PARSONS, KS 67357

1-800-362-0390 OR 620-421-6550 EXT. 1642 OR EXT. 1899

Rev. 10-2018

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:

___Authorize information to be shared indefinitely.

___Authorize information to be shared between the dates of_____and_____

_____Date:_____
Individual Signature

_____Date:_____
Parent/Guardian Signature

_____Date:_____
Witness Signature

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