

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. 6-27-2019

Application for Personal Care 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 _____

Case Manager's Name: _____ Phone: _____

Community Service Provider: _____ Phone: _____

Emergency Contact: _____ Phone: _____ Relationship _____

Special Care Requirements

Disability/Special Needs: _____

Special Physical Considerations: _____

PLAN OF CARE: YES _____ NO _____

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Release of Information Consent
PERSONAL CARE SERVICES

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 _____

Individual Signature Date: _____

Parent/Guardian Signature Date: _____

Witness Signature Date: _____

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