Please Read This Page Carefully

Dear Family:

Franklin County Residential Services operates an In-Home and Out-Of-Home Respite Program through the Family Support & Respite Services department. If eligible, the In-Home Program can send a trained Respite Provider into your home to care for your family member with mental retardation or developmental disability. The Out-Of-Home Program can provide care for your family member at our Kimberly Woods or Palmer Donavin House locations. Please read the “In-Home Respite Fact Sheet” and the “Kimberly Woods and Palmer Donavin House Fact Sheet” for details of these services. (To access Respite Services you must complete and return the Family Support Services Eligibility and Respite Services applications).

Upon receipt of your application for respite services, a staff management person will contact you to schedule a home visit if you want to utilize In-Home respite services. The purpose of the home visit is to enable the staff person to meet your family member with a disability and to review specific procedures regarding In-Home Respite Services.

The following contains general information that applies to both the In-Home, Kimberly Woods and Palmer Donavin House out-of-home Respite Services:

- Respite care may be provided for a minimum of (2) hours up to a maximum of (14) fourteen days at a time in any forty (40) day period.
- Respite care is provided on a first-come, first-served basis.
- Respite Care on an emergency basis will be provided pending availability of space and respite staff.

To schedule Respite, call the Respite Office at 844-5847, Monday through Friday, between 8:00a.m. - 4:30p.m. Requests for Respite may be made 60 days (2 months) in advance (i.e. families wishing to request a respite stay for December 31\textsuperscript{st} may call in the request on October 31\textsuperscript{st}). You will be billed for your share of cost if any, after service has been provided. Please refer to the In-Home or Kimberly Woods fee scale.

If you need to cancel any scheduled Respite you must call the office at least 24 hours prior to the service time. If you do not cancel 24 hours in advance you will be billed the 4-hour minimum at full unit cost. The Respite Service has a management level staff person on-call 24 hours a day. The on-call number is 929-8908 for In-Home Respite and 325-6678 for Kimberly Woods and Palmer Donavin House Respite. In case of an emergency, you may call this number to request Respite or to notify staff of cancellation after office hours or on weekends. When calling please follow the directions on the prerecorded message. A staff person will return your call as soon as possible.

**KEEP THIS PAGE**
1. To schedule, please call the scheduling office at 844-5847. Families may be responsible for paying a portion of the cost for respite services (Kimberly Woods/Palmer Donavin House and/or In Home respite), depending on their income level as determined by the Respite Co-Pay Schedule submitted by the family. These services are available to families regardless of their family annual FSS allocation level. Family billing is sent once each month to families with active charges. If/when a full or partial payment has not been received for a three (3) month period for a total owed the family respite services will be denied until the family pays twenty five percent (25%) of the total owed. After this is received the family can again make respite requests.

2. The Respite Provider will prepare meals and do general pickup around the house for the family member with a disability and other siblings.

3. Adequate food should be left for all meals.

4. Families are responsible for reimbursing the Respite Provider for any purchases made that have been authorized by the family. The Respite Provider is instructed to leave receipts for any purchases made from money left by the family.

5. For extended stays, families should provide a bed and clean linen for the Respite Provider. The Respite Provider is entitled to eight continuous hours of sleep in a 24-hour period.

6. In-Home respite employees may only administer medication after all required forms are completed. Administration of medication falls under the State of Ohio Delegated Nursing laws. Foster families may not authorize administration of medication.

7. The Respite Provider can care for your other children (brothers and sisters under age 18). You will be charged $.25 per hour per sibling who is in the house while the Respite Provider is there. If you have three or more other children in your home, the maximum charge will be for three ($.75 per hour). In Home Respite Providers are not/cannot be responsible for other children who do not live in the home.

8. Make sure you are in agreement with the times on the Respite Provider’s log before you sign it.

9. We request that you leave an extra house key for the Respite Provider in case she/he would leave on an outing or an emergency.

10. If, while you are out, you realize you are going to be later than the time you told the Respite Provider you would be back, please call the Respite Provider. If you exceed the number of hours you requested, you will be billed at the full unit cost per hour (by ¼ hour).

11. If you ever require any information to be updated, please contact the office as soon as possible. (i.e. change of address, phone number, birth of children, change of specific needs of your son/daughter, change in income level, etc.)
12. If a parent cannot be notified by phone and we must send a substitute into your home because of an emergency, the best Respite Provider available suited to your needs will be chosen.

13. Families must complete all required medication authorization, emergency release and liability release forms before respite services can be provided.

**KEEP THIS PAGE**
Below is a guideline of your cost per hour for In-Home Respite Care Services. Families will only be charged for up to 12 hours of respite per 24-hour period.

<table>
<thead>
<tr>
<th>Income Level</th>
<th>Taxable Income</th>
<th>Cost Per Hour to Eligible Families</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>$27,258 OR LESS</td>
<td>$0.00</td>
</tr>
<tr>
<td>Level 2</td>
<td>$27,259 to $37,759</td>
<td>$0.77</td>
</tr>
<tr>
<td>Level 3</td>
<td>$37,760 to $48,260</td>
<td>$2.32</td>
</tr>
<tr>
<td>Level 4</td>
<td>$48,261 to $62,261</td>
<td>$2.87</td>
</tr>
<tr>
<td>Level 5</td>
<td>$62,262 to $79,762</td>
<td>$3.81</td>
</tr>
<tr>
<td>Level 6</td>
<td>$79,763 AND OVER</td>
<td>$4.75</td>
</tr>
</tbody>
</table>

**KEEP THIS PAGE**
1. Respite Location will be open 365 days a year, 24 hours a day.

2. Respite stays may be from a 2-hour minimum up to the 14-day maximum at a time in any forty (40) day period. Respite scheduling confirmations are based on a variety of factors and are not solely based on vacancy rate of the respite facility. On going day care is not the mission of the out of home respite service and cannot be provided.

3. The family must be registered with and have completed the Franklin County Residential Services Respite Application process to be eligible for planned service. Family Support & Respite Services telephone number is 844-5847.

4. Scheduling and payments are handled through the Family Support & Respite Services Office at 844-5847:
   Families may be responsible for paying a portion of the cost for respite services (Kimberly Woods/Palmer Donavin House and/or In Home respite), depending on their income level as determined by the Respite Co-Pay Schedule submitted by the family. These services are available to families regardless of their family annual FSS allocation level. Family billing is sent once each month to families with active charges. If/when a full or partial payment has not been received for a three (3) month period for a total owed the family respite services will be denied until the family pays twenty five percent (25%) of the total owed. After this is received the family can again make respite requests.

5. Separate facilities are maintained for adults and children. Children facilities are for children birth to age 18 and adult facilities are for individuals 18 years of age and older. Kimberly Woods Respite Facility is an 8-bed facility, 4 adult beds and 4 children’s beds. Palmer Donavin House is a 4-bed facility for children only.

6. Medication administration falls under the State of Ohio Delegated Nursing laws. The family must provide all required information in order for any/all medication to be dispensed. A current physicians order must accompany all medications and be current or medications cannot be administered. Failure to provide the needed medical information and medications at the time of the visit, prior to visits or in a timely manner may result in the denial of respite services. Medical assessments and all authorization forms and information packets are to be completed before respite services are provided. Medications are administered under Ohio Delegated Nursing Laws only.

7. Fees are based on a sliding fee scale dependent on the family’s taxable income.

8. Provisions have been made for guests in wheelchairs.

9. Trained Respite Providers will be in the Facility 24 hours a day.

10. Meals and laundry services are included in the fee.

11. Activities will be offered to the guests on an informal basis, according to their interests and abilities.
12. The facility may be available to meet emergency requests when possible. These requests must go through the Respite Office or the on call person (325-6678) after hours.

13. Each unit will provide services to both males and females. Facilities have male and female staff members.

14. FCRS, Inc. prefers and encourages families to provide transportation to and from the Respite facility for drop-offs and pick up. Special transportation requests are addressed on an individual basics at the family request.

**KEEP THIS PAGE**
Below is a guideline of your cost per hour for Kimberly Woods and Palmer Donavin House locations Respite Care Services. This fee includes meals and laundry services. Families will only be charged for up to 12 hours of respite per 24-hour period.

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<td>$1.60</td>
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<tr>
<td>Level 4</td>
<td>$48,261 to $62,261</td>
<td>$1.91</td>
</tr>
<tr>
<td>Level 5</td>
<td>$62,262 to $79,762</td>
<td>$2.50</td>
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<td>Level 6</td>
<td>$79,763 AND OVER</td>
<td>$3.33</td>
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**KEEP THIS PAGE**
PROCEDURES FOR FAMILIES

1. To schedule, please call the Respite Scheduling Office at 844-5847. Families may be responsible for paying a portion of the cost for respite services (Kimberly Woods/Palmer Donavin and/or In Home respite), depending on their income level as determined by the Respite Co-Pay Schedules submitted by the family. These services are available to families regardless of their family annual FSS allocation level. Family billing is sent once each month to families with active charges. If/when a full or partial payment has not been received for a three (3) month period for a total owed the family respite services will be denied until the family pays twenty five percent (25%) of the total owed. After this is received the family can again make respite requests.

1. The first time you schedule for the Respite location, we request that arrangements be made for a Pre-Visit so that you and your family member with special needs may tour the facility and exchange information. Bring your completed fact packet. If your family member is on prescription medication, a medical assessment must also be scheduled with the facility nurse before respite care can be provided.

2. For every visit: (Overnight respite check-in times are between 4:00pm and 7:00pm only)

   a. Your FACT PACKET must be completed and up-to-date. This packet must be at the facility during your family member’s stay. Service will have to be denied if the FACT PACKET is not completed and available.

   b. Releases will need to be signed. An Authorization to Dispense Medication Form and the current medication required will need to be completed each time you use the Respite Facility. Medical assessment by the facility RN is required if any medications are to be administered.

   c. All medication should be labeled to include guest’s name, name of medication, dosage, times given, physician’s name and pharmacy, and purpose of medication. The medication must be in a bottle labeled by your pharmacy. We will dispense the medication according to the pharmacist’s label and written directions from the physician. Service will have to be denied if these procedures are not followed.

   d. Please label all clothing with family member’s full name.
e. Families need to furnish all toilet articles including: toothbrush, toothpaste, deodorant, shampoo, diapers etc.

f. Guests may feel free to bring their personal belongings such as special toys, games or books. These items must be labeled.

g. Families are responsible to bring any adaptive equipment, wheelchairs, care chair, bath chair etc. that their son/daughter requires.

h. If your son or daughter attends a day program, please inform that program/programs and transportation of your son’s/daughter’s stay at Kimberly Woods or Palmer Donavin House. Since the Respite Facility’s van transports guests anywhere in Franklin County, the guests may be late arriving and/or may need to leave their day program early.

3. Upon arrival:

a. Sign the log to indicate date and time that service begins.

b. Leave FACT PACKET, signed releases, current emergency parent contact numbers and labeled medication/special diet supplements if applicable. If the guest becomes ill, emergency contact will be notified immediately and arrangements made for pick-up.

c. Please complete a Clothing and Personal Inventory.

d. The Respite Facility cannot accept guests who are ill. If a guest becomes ill while at the facility, the family or emergency contact (if the parent cannot be reached) will be contacted to take the guest home.

4. Upon departure:

a. Sign log to indicate date and time service ends.

b. Check your family member’s clothing/personal items and sign the Inventory form.

c. Pick up FACT PACKET.

d. Exchange of information.

e. Please complete an Evaluation Form as soon as possible and return to the Respite Facility Manager.

5. The first time your family member is a guest at Kimberly Woods or Palmer Donavin House, a Polaroid picture will be taken for his/her file. The Franklin County Board of DD operation rules require that a photograph is available in the guest’s permanent file.

6. Please feel free to call the Manager anytime you have questions/concerns or suggestions.

**KEEP THIS PAGE**
The following information must be provided for **IN-HOME** and/or **FACILITY BASED RESPITE SERVICES**.

Client Name ____________________________________________________________

Parent/Guardian Name ___________________________________________________

Address ________________________________ Phone __________________________

Physician Name & Address ________________________________ Phone __________

Pharmacy Name & Address ________________________________ Phone __________

Dentist Name & Address ________________________________ Phone __________

Insurance type & number ________________________________________________

**Physical Information**  Weight ______ Height ______ Is lifting required? ________

Describe any current health concerns (i.e. allergies, Diabetes, shunt) ________________

Check the following that best describe the individual:  (Please check **ALL** answers that apply)

____ Down syndrome  ____ Multi-handicapped  ____ Mentally Retarded

____ Hydrocephalis  ____ Cerebral Palsy  ____ Hyperactive

____ Physically handicapped  ____ Autistic  ____ Behavior disorder

____ Epilepsy  ____ Spina Bifida  ____ Other ______________________

____ Developmentally Delayed

**Medication Schedule:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Color/Shape</th>
<th>Dosage</th>
<th>Time</th>
<th>Purpose</th>
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**Please complete the BACK of this page and send to FAMILY SUPPORT SERVICES**

OVER
If individual has **seizures**, please complete the following:

- [ ] Controlled seizures
- [ ] Uncontrolled seizures

**Type:**

- [ ] Petit mal
- [ ] Grand Mal
- [ ] Psychomotor

**Frequency** ______________________  **Duration** ________________________________

**Behavior after seizure** ______________________________________________________

**Type of Adaptive Equipment used** ____________________________________________

**Behavior Requiring Intervention**

- [ ] No behavior problems
- [ ] Less than once per month
- [ ] More than once per month
- [ ] More than once per week

**Any behaviors we should be aware of** _________________________________________

**Communication**

- [ ] Communicates with speech
- [ ] Functional with other modes
- [ ] No functional communication

If no speech, how wants are made known

**Vision**

- [ ] No vision problems
- [ ] Wears glasses
- [ ] Visually impaired
- [ ] Legally blind

**Hearing**

- [ ] No hearing loss
- [ ] Wears hearing aid(s)
- [ ] Complete loss

**Ambulation**

- [ ] Walks independently
- [ ] Walks independ. with difficulty
- [ ] Walks independ. with device
- [ ] Walks only with assistance
- [ ] Cannot walk

**Devices**

- [ ] Leg braces
- [ ] Cane
- [ ] Walker
- [ ] Wheelchair
- [ ] Other ________________________

**Wheelchair Mobility**

- [ ] Uses/transfers independently
- [ ] Requires assistance in transfer/moving
- [ ] No mobility
- [ ] Not applicable

**Toileting**

- [ ] Independent
- [ ] Not toilet trained
- [ ] Wears diapers (day/night)

**Vision**

- [ ] No vision problems
- [ ] Wears glasses
- [ ] Visually impaired
- [ ] Legally blind

**Hearing**

- [ ] No hearing loss
- [ ] Wears hearing aid(s)
- [ ] Complete loss

**Ambulation**

- [ ] Walks independently
- [ ] Walks independ. with difficulty
- [ ] Walks independ. with device
- [ ] Walks only with assistance
- [ ] Cannot walk

**Devices**

- [ ] Leg braces
- [ ] Cane
- [ ] Walker
- [ ] Wheelchair
- [ ] Other ________________________

**Wheelchair Mobility**

- [ ] Uses/transfers independently
- [ ] Requires assistance in transfer/moving
- [ ] No mobility
- [ ] Not applicable

If assistance with toileting is needed, describe routine ____________________________

**Please complete the next page and send this application to**

FAMILY SUPPORT SERVICES**
Eating Habits
Feeds self _____ Needs some help _____ Needs to be fed _____ G-tube ______
Drinks from cup independently _____ Needs help _____ Other method (bottle) _____
Special positions while eating _____________________________________________
Food Allergies __________________________________________________________
Special food preparation (i.e. strained, mashed) ____________________________
Special diet (i.e. reducing, Diabetic, salt-free) ______________________________
Special Feeding Instructions ________________________________________________

Miscellaneous
Describe any important bedtime routine _______________________________________
Describe bathing routine __________________________________________________
Special restraint or attention when riding in a car? ___________________________
Please use this space to include information that will make the individual’s stay with the Respite Provider a pleasant one. Indicate special habits, favorite games, etc.___________

Describe any unusual habits or other risk situations that need special attention for this individual _____________________________________________________________
Any restrictions for medical/physical reasons? __________ yes __________ no
If yes, please specify restrictions and reason __________________________________
How did you hear of this service? __________________________________________

*Signature of individual completing form ____________________________________
Relationship to person with DD ____________________________________________

**Please send this completed application to FAMILY SUPPORT SERVICES**
1021 Checkrein Avenue
Columbus, Ohio 43229-1106
614-844-5847
FAX – 614-844-5916
FRANKLIN COUNTY RESIDENTIAL SERVICES, INC
ALTERNATE FUNDING IDENTIFICATION FORM

Franklin County Residential Services, Inc. (FCRS, Inc.) provides In-Home and Out of Home direct Respite Services in Franklin County. Alternate funding options (Including Individual Options Waiver (I.O Waiver), Level One Waiver) that are available to enrolled families for Respite Services are to be identified before direct respite services are provided and/or upon enrollment in the FCRS, Inc. respite program. Families receiving respite services are to complete this form and provide all needed information. Incomplete or missing forms may result in the denial of respite services. The individual/guardian/parent of the individual with DD must complete and sign the items below.

Consumer Name: (Please Print) ____________________________________

Check all that apply, complete all items:

A. __________ Our family is receiving the Individual Options Waiver (I.O Waiver) through the Franklin County Board DD, or other Ohio County Board. FCRS, Inc. is/will be identified as a respite service provider in the annual Individual Service Plan (ISP) for the eligible family member residing in our home. Provider authorization forms for billing and a copy of the ISP will be sent to FCRS, Inc.

B. __________ Our family is not receiving Individual Options Waiver through the Franklin County Board DD, or other County Board at this time.

C. __________ Our family is receiving the Level One Waiver through the Franklin County Board DD, or other County Board. FCRS, Inc. is/will be identified as a respite service provider in the Annual Individual Service Plan for the eligible family member residing in our home. Provider authorization forms for billing and a copy of the ISP will be sent to FCRS, Inc.

D. __________ Our family is not receiving the Level One Waiver through the Franklin County Board DD, or other County Board at this time.

E. The assigned Franklin County Board of DD Service Coordinator for my family is __________________________, and his/her phone number is _________.

In signing this I/we are aware that FCRS, Inc. will be identified as a waiver provider for my family, and FCRS, Inc. will bill for all respite services provided under the above-identified waiver if applicable. FCRS, Inc. also may contact my assigned Service Coordinator in regards to the information provided above. If there are any status changes to the above I/we will make FCRS, Inc. aware of these changes immediately.

Signed: Individual/Guardian/Parent ___________________________ Date: __________

“Please complete this page and send to FAMILY SUPPORT & RESPITE SERVICES”
Franklin County Residential Services, Inc.
Respite Care Services

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

In case of an emergency, or if emergency treatment is necessary and I am not readily available, I authorize the Respite Provider referred by Franklin County Residential Services, Inc. to obtain any emergency procedures or medical assistance that may be necessary to protect the health and well-being of ________________________________
Ind. with DD and sibling(s)

except as otherwise noted here ________________________________________________________________

Date __________________________ Signature of Parent/Guardian __________________________

Client (if own legal guardian) ______________________________________________________________

AUTHORIZATION TO ADMINISTER SPECIFIED MEDICATION

I hereby authorize the Respite Provider referred by Franklin County Residential Services, Inc. to administer the below listed medication prescribed by his/her physician to

______________________________
Name of Individual

Name Dosage How often Time Color

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

Date __________________________ Signature of Parent/Guardian __________________________

Client (if own legal guardian) ______________________________________________________________

**Please Send this Form to FAMILY SUPPORT SERVICES**
WITH YOUR COMPLETED APPLICATION