GENESEO | CENTER FOR COMMUNITY
Home Away From Home Respite Center

Client Application and Intake Form

Thank you for your interest in the Home Away from Home Respite Center. We want to make sure that everyone in our care is safe and secure including clients, students, and staff. This application will provide us with necessary information and will help guide us in planning activities as well as give us clear information in case of an emergency. Thank you for taking the time to fill out the form completely. Please let us know if you have questions.

General Information

Name of Care Receiver: _____
First: Middle: Last:

Preferred Name: _____

Home Address: _____

_____

Date of Birth: _____ Current age: _____

The Care Receiver lives: ◯ Alone ◯ With a Spouse ◯ With a family member ◯ Other

****

Name of Primary Caregiver: _____
First: Middle: Last:

Preferred Name: _____

Home Address: _____

_____

Email address: _____

Phone number: _____

Date of Birth: _____

Relationship to Care Receiver: _____

GENESEO | CENTER FOR COMMUNITY
Home Away From Home Respite Center

Emergency Contacts

In an emergency, we will call the Primary Caregiver first.
If we are unable to reach the Primary Caregiver, the following people will be contacted:

Name: _____ Relationship to client: _____

Home #: _____ Cell #: _____

Name: _____ Relationship to client: _____

Home #: _____ Cell #: _____

Preferred Hospital: _____

Primary Health Care Provider: _____

Health Care Provider address: _____

Health Care Provider Phone #: _____

Does the Care Receiver have a Power of Attorney (POA): ◯ Yes ◯ No

- If YES, please provide a copy of the POA
- Power of Attorney Name: _____

Does the Care Receiver have a Do Not Resuscitate (DNR) Request: ◯ Yes ◯ No

- If YES, please provide a copy of the DNR

Does the Care Receiver have a Healthcare Proxy: ◯ Yes ◯ No

- If YES, please provide a copy of the Healthcare Proxy

Does the Care Receiver have a Medical Order for Life-Sustaining Treatments (MOLST) Form:

◯ Yes ◯ No

- If YES, please provide a copy of the MOLST Form

Health Insurance Information

Primary Health Insurance: _____

Primary Insured: _____ ID/Group #: _____

Public Aid Case #: _____ Recipient #: _____

Medicare #: _____

Medication List:

Name of Medication:	Dosage:

Allergies (both food/drink and medications):

Name of Allergen:	Reaction:

GENESEO | CENTER FOR COMMUNITY
Home Away From Home Respite Center

Medical/Health History

Chronic Illnesses. Please check all that apply:

- ☐ Acid Reflux
- ☐ Alcoholism
- ☐ Allergies
- ☐ Alzheimer's
- ☐ Anemia
- ☐ Anorexia
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Problems
- ☐ Cancer
- ☐ Cellulitis
- ☐ Chronic Constipation
- ☐ Chronic Diarrhea
- ☐ COPD
- ☐ Chronic Pain
- ☐ Colitis
- ☐ Colostomy
- ☐ Congestive Heart Failure
- ☐ Decubitus Ulcers
- ☐ Dehydration
- ☐ Dementia
- ☐ Dental Problems
- ☐ Developmental Disabilities
- ☐ Diabetes
- ☐ Dialysis
- ☐ Diarrhea
- ☐ Digestive Problems
- ☐ Diverticulitis
- ☐ Emphysema
- ☐ Fractures (recent)
- ☐ Frequent falls
- ☐ Gallbladder Disease
- ☐ Glaucoma
- ☐ Hearing Impairment
- ☐ Heart Disease
- ☐ Hiatal Hernia
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hyperglycemia
- ☐ Hypoglycemia
- ☐ Incontinence
- ☐ Legally Blind
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Multiple Sclerosis
- ☐ Muscular Degeneration
- ☐ Osteoporosis
- ☐ Oxygen Dependent
- ☐ Paralysis
- ☐ Parkinson's
- ☐ Pernicious anemia
- ☐ Renal Disease
- ☐ Respiratory Problems
- ☐ Shingles
- ☐ Smelling Impairment
- ☐ Speech Problems
- ☐ Stroke
- ☐ Swallowing Difficulties
- ☐ Taste Impairment
- ☐ Thyroid
- ☐ Traumatic Brain Injury
- ☐ Tremors
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Urinary Tract Infection
- ☐ Visual Impairment

Please elaborate on any of the above and/or list other important Diagnoses:

Fall Risk Factors:

Has the care recipient has fallen within the past year: ◯ Yes ◯ No

If Yes, did it result in injury requiring medical care? Please elaborate.

Vision:

Normal:	◯ Yes	◯ No	
Wears Glasses	◯ Yes	◯ No	
Wears Contact Lenses	◯ Yes	◯ No	
Legally Blind:	☐ Left Eye	☐ Right Eye	☐ Both Eyes

Hearing:

Normal:	◯ Yes	◯ No	
Hearing Impaired in:	☐ Left Ear	☐ Right Ear	☐ Both Ears
Uses Hearing Aids:	☐ Left Ear	☐ Right Ear	☐ Both Ears
Legally Deaf:	☐ Left Ear	☐ Right Ear	☐ Both Ears

Cognitive/Emotional Status

Please check all that apply:

☐ Accepts Help	☐ Agitation	☐ Alert
☐ Anxiety	☐ Articulates Needs	☐ Assertive
☐ Cares for Others/Things	☐ Confusion	☐ Cooperative
☐ Critical Life Change	☐ Depression	☐ Diagnosed MH Disorder
☐ Disruptive Socially	☐ Friendly	☐ Hallucinations
☐ Healthy Family Attachments	☐ History of MH Treatment	☐ Hoarding
☐ Impaired Decision Making	☐ Lonely	☐ Member of Community Orgs
☐ Memory Deficit	☐ Oriented	☐ Physical/Sexual Aggression
☐ Problem Behavior	☐ Recent Losses	☐ Self-neglect
☐ Sense of Humor	☐ Shows Initiative	☐ Sleep problems
☐ Substance abuse	☐ Suicidal behavior	☐ Suicidal Thoughts
☐ Verbal Disruption	☐ Other	

Please elaborate on any of the above and/or list other important cognitive or emotional issues:

Speech and Communication Abilities

Language(s) spoken: ☐ English ☐ Other- Please Specify

Speech Abilities:

	Most of the Time	Occasionally	Never
Talks Voluntarily			
Answers when spoken to			
Occasional “words search”			
Difficulty finding the right words			
Can’t communicate with words			
Expresses needs with body language			
Repetitive words/phrases			
Talks to Self			

Comments:

Situational Orientation

	Most of the Time	Occasionally	Never
Knows own name			
Knows date and year			
Knows environment			
Can identify objects			
Knows family members names			
Knows Personal information (i.e. address, phone number)			
Knows how to work familiar machines around the house			
Remembers conversations from the last few days			
Can handle own financial matters			
Can conduct their own food shopping			
Can follow a story or TV show			
Speaks appropriately (i.e. at the right time, says the appropriate material)			

Daily Routine

Please describe what the care recipient can and cannot do in the course of a “typical” day.
(Include dressing, eating, exercise, toileting, medication, and rest periods)

Before Breakfast:

Breakfast:

Before Lunch:

Lunch:

Afternoon:

Before Dinner:

Does the care recipient usually nap during the day? ◯ Yes ◯ No

GENESEO | CENTER FOR COMMUNITY
Home Away From Home Respite Center

Activities of Daily Living

Eating:

Activity Status:
- ☐ Person does not participate; another person performs all aspects of this task
- ☐ Requires continual help with all of most of this task
- ☐ Requires intermittent supervision and/or Minimal assistance
- ☐ Totally able

Transfer:

Activity Status:
- ☐ Person does not participate; another person performs all aspects of this task
- ☐ Requires continual help with all of most of this task
- ☐ Requires intermittent supervision and/or Minimal assistance
- ☐ Totally able

Mobility:

Activity Status:
- ☐ Person does not participate; another person performs all aspects of this task
- ☐ Requires continual help with all of most of this task
- ☐ Requires intermittent supervision and/or Minimal assistance
- ☐ Totally able

Toileting:

Activity Status:
- ☐ Person does not participate; another person performs all aspects of this task
- ☐ Requires continual help with all of most of this task
- ☐ Requires intermittent supervision and/or Minimal assistance
- ☐ Totally able

Personal Hygiene:

Activity Status:
- ☐ Person does not participate; another person performs all aspects of this task
- ☐ Requires continual help with all of most of this task
- ☐ Requires intermittent supervision and/or Minimal assistance
- ☐ Totally able

Self-Administration of Medications:

Activity Status:
- ☐ Person does not participate; another person performs all aspects of this task
- ☐ Requires continual help with all of most of this task
- ☐ Requires intermittent supervision and/or Minimal assistance
- ☐ Totally able

Bathing/Dressing:

Activity Status:
- ☐ Person does not participate; another person performs all aspects of this task
- ☐ Requires continual help with all of most of this task
- ☐ Requires intermittent supervision and/or Minimal assistance
- ☐ Totally able

GENESEO | CENTER FOR COMMUNITY
Home Away From Home Respite Center

Social Profile of Care Recipient

Occupation(s): _____

Education: _____

Care Recipient's Identified Strengths:

_____

_____

_____

Hobbies/leisure activities:

_____

_____

_____

Coping Styles (lifetime patterns for dealing with things such as anger, stress, etc.):

_____

_____

_____

Care Recipient's Problem Behaviors - including but not limited to any heightened violent or sexual aggressions:

_____

_____

_____

Care Recipient's Fears:

_____

_____

Names of significant relatives/friends (for example, children, grandchildren) and their whereabouts:

_____

_____

_____

GENESEO | CENTER FOR COMMUNITY
Home Away From Home Respite Center

Community Support Status

Does the care recipient have a family, friends, and/or neighbors who helps with care? ◯ Yes ◯ No

Degree of involvement (Type of help/frequency):

Does the care recipient appear to have a good relationship with this individual? ◯ Yes ◯ No

Describe:

Any additional information which you feel we should know about the care recipient?

****

Thank you for taking the time to fill out this form.

When you are finished, please return this form to:

The Home Away from Home Respite Center
Center for Community
MacVittie Union 353
1 College Circle
Geneseo, NY 14454

Phone: 585-245-6057