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Prov. ID# \_\_\_\_\_

## Lifespan Respite Care Provider Intake Form

415 Main Street  
Klamath Falls, OR 97601  
541-850-5200

Welcome to Lifespan Respite Care! We are please that you are interested in becoming a Respite Care Provider enrolled with this referral agency.

Lifespan maintains a current listing of *registered self-employed* Respite Care Providers and centers that are available to provide respite care related services to families and individuals in the community.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Phone: \_\_\_\_\_

The following information is used to better tailor a match between providers and families seeking help, and for statistical reporting purposes.

Age: \_\_\_\_\_

Marital Statues:  Single  Married  Separated  Divorced  Widowed

Race/Ethnicity:  Alaskan Native  American Indian  Asian, Pacific Islander  
 Black  Hispanic  Hispanic (other)  Southeast Asian  
 White  Other

### Your Respite Care Services:

Where are you willing to provide care?

Provider's home (yours)  Family's home (live-out)  Family's home (live-in)  
 Foster Care/Group Home  Center-based  Camp/Recreation

Available Days;

S  M  T  W  TH  F  S

Available Hours:

From: \_\_\_\_\_ am/pm To: \_\_\_\_\_ am/pm Are these hours flexible? \_\_\_\_\_

Type of Schedule:  Full time  Part time

Special Schedule:  Drop in  Hourly  Temp/Emergency  Sick Care  24 Hour

Day Schedule:  All Day  Evening  Overnight  Morning  Afternoon  
 Weekend  Vacation/Holidays

Care Category:  Children 0-18  Adults 18-55  Elderly 56-110

Care Level: (refer to Care Chart)  Level I (Basic)  Level II (Moderate)  Level III (Intense)

Care Group:  Medically Fragile  Mental Emotional Disability  
 Physical Disability  Developmental Disability  
 Speech/Lang Impairment  Hearing Impairment  
 Visual Impairment  Seizure Disorder  
 Alzheimer's  Health Related  
 At Risk Abuse/Neglect  Hospice/Terminally Ill  
 Other

Care Needs:  Female needing care  Male needing care  Assist w/meds  
 Adaptive equipment  Toileting assist.  Special feeding  
 Heavy lifting  Constant supervision  No pets  
 Verbally aggressive  Bilingual  Sign language  
 Physically aggressive  Non smoking  Immobile

Affiliation:  Private Business  State Agency (HSD)  Religious  
 County Agency (MH-DD)  Non-profit (Hospice/Senior Center)  Schools

Transportation: Will you help with transportation needs?  Yes  No

Do you have:  Valid Drivers Lic  Auto Insurance  Seatbelts

Other Transportation:  BTS Stop near  School Bus Stop  School w/in walking

How far are you willing to travel to provide care?  Less than 10 miles round trip  
 Less than 30 miles round trip  Less than 50 miles round trip  
 More than 50 miles round trip

**Fees:**

Level I (Basic)  Hour  Day  Overnight  Weekend  
Level II (moderate)  Hour  Day  Overnight  Weekend  
Level III (Intense)  Hour  Day  Overnight  Weekend

**Certification Licenses:** Are you a certified provider for any of the following agencies?

Klamath County Mental Health  Developmental Disabilities Office  
 Services to Children & Families  Senior & People with Disability Services  
 Self Sufficiency Services  Klamath Hospice

Are you a registered:  CEP  CNA  LPN  RN  PCA

Permission to Release Information

I understand that Lifespan Respite Care only makes referrals, not recommendations to families. I agree to assist Lifespan in maintaining current information regarding the respite care services I offer by reporting changes as they occur. I give Lifespan permission to release the information on this to those seeking respite care services. In addition, Lifespan has permission to release this information to carefully screened respite care related agencies and organizations unless otherwise indicated.

I hereby certify that I have read and understand the above statement and that all the information I have provided on this form is accurate and true.

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

REFERENCES CHECK PERMISSION FORM

Name: \_\_\_\_\_

I give permission to the following individuals/organizations to release information regarding my past employment history, work ethic and character.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Present Employer (or most recent)

Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Supervisor's Name and Title: \_\_\_\_\_

Dates of employment: From: \_\_\_\_\_ To: \_\_\_\_\_

Responsibilities: \_\_\_\_\_

Reason for wanting to leave: \_\_\_\_\_

Additional References (need not be past employer)

Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

How long have you known this person? \_\_\_\_\_

What is/was your relationship with this person? (family, friend, past employer, etc.): \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

How long have you known this person? \_\_\_\_\_

What is/was your relationship with this person? (family, friend, past employer, etc.): \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

How long have you known this person? \_\_\_\_\_

What is/was your relationship with this person? (family, friend, past employer, etc.): \_\_\_\_\_

# *Lifespan Respite Care*

## CONFIDENTIALITY POLICY STATEMENT

All families have the right to have all of their records and activities remain confidential. This extends to discussions with other staff, providers, volunteers, and their immediate families. Breach of confidentiality is a violation of the law. Written permission must be obtained to discuss, photograph or write about any individual or family, except in the case of abuse and neglect in the protection of the individual being cared for. The confidentiality of information given to Lifespan will be respected and maintained to the extent the law allows.

I have read and understand the above Confidentiality Policy statement and agree to abide by it.

\_\_\_\_\_  
*Signature of Respite Provider*

\_\_\_\_\_  
*Date*

## ABUSE REPORTING POLICY STATEMENT

Lifespan Respite Care providers, volunteers and staff are required by law to report any suspected cases of abuse or neglect of any individual under the age of 18 to the Services for children and Families Division (SCF) and any individual 18 and older to the Senior and Disabled Services Division (SDSD). If the individual is developmentally disabled or has a mental illness, the report should be made to the Klamath County Mental Health Department (KCMH). The report should be made immediately. All reports are kept confidential. Anyone acting in good faith will have immunity from liability. Failure to report is a Class 1 misdemeanor.

I have read and understand the above Abuse Reporting Policy and agree to abide by it.

\_\_\_\_\_  
*Signature of Respite Provider*

\_\_\_\_\_  
*Date*

Return to:  
*SPOKES Unlimited*  
415 Main Street  
Klamath Falls, OR 97601

**CRIMINAL RECORD AUTHORIZATION  
FOR  
LIFESPAN RESPITE CARE PROGRAM**

I authorize the Senior and People with Disabilities Program to obtain information about me from the Oregon Policy and other law enforcement agencies and the courts. I further understand that SPOKES Unlimited may choose to complete internal checks with other agencies such as:  
Klamath County Mental Health, Developmental Disabilities Services, DHS, etc. as well as conduct checks on the personal references I have provided.

**FULL LEGAL NAME:** \_\_\_\_\_

**BIRTH NAME:** \_\_\_\_\_

**OTHER NAMES USED:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_ **SOCIAL SECURITY #:** \_\_\_\_\_

**DRIVER'S LICENSE #:** \_\_\_\_\_

I \_\_\_ Have \_\_\_ Have not resided in Oregon for the last 6 months.

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

For SCF use only  
Approved: \_\_\_\_\_  
Not Approved: \_\_\_\_\_

# Lifespan Respite Care

## LIABILITY AGREEMENT

As a condition of my participation in the SPOKES Unlimited/Lifespan Respite Care training, I waive all claim of liability against SPOKES Unlimited/Lifespan Respite Care, and their respective officers, employees, agents, and volunteers and agree to hold same harmless for injury or damage to person or property which might arise in conjunction with any services I might perform as a Lifespan Respite Care Provider.

I acknowledge that this educational program is intended only to train me in basic non-medical skills which should benefit me as a Respite provider in a home or group setting.

I further acknowledge that this educational program does not qualify me as a home health aide or as a practical, professional, or licensed nurse, or as any type of medical practitioner nor will I hold myself out to the public as such a medical professional or para-professional.

I also acknowledge that I have been advised to consult my own legal and liability insurance counsel, realizing that the above mentioned parties are not, either individually or collectively, culpable or responsible in any way for my proper or improper use of misuse of any idea, concept, technique, or method which is taught, shown, explained, demonstrated, or otherwise presented in the training program.

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Printed Name*

Revised 08/2007