THE ALS RESPITE CARE APPLICATION

Name _____

Address _____

_____

Phone _____

Contact Person _____

Relationship _____

Phone _____

County _____ Date of Birth _____

Emergency contact person while primary caregiver is on respite:

Name _____

Telephone Number (____) _____ Relationship _____

I am currently receiving help at home from the following agencies:

☐ County Office of Aging or Waiver Programs ☐ Hospice

☐ VA (Veterans' Administration) ☐ Insurance funded RN/PT/OT

☐ Private Caregiver/Agency ☐ LTC Policy (Long Term Care) ☐ None

Agency	Contact Person	Phone	How often?

I have applied to the following programs:

☐ VA ☐ LTC Policy

Agency	Contact Person	Phone

REQUESTED DATES OF SERVICE

	Day	Dates	Time	# of Hours
1st Choice:	_____	_____	_____	_____
2nd Choice:	_____	_____	_____	_____

Describe current physical condition:

Weight: _____ Height: _____

Pets in home: ☐Yes ☐No If yes, type of Pet? _____ Smoking in home? ☐Yes ☐No

(continued on back of page)

Please check equipment you utilize: ☐ Manual wheelchair ☐ Power wheelchair ☐ Walker

Do you use a communication device? ☐ Yes ☐ No If yes, what type? _____

Are you utilizing any equipment to help with your breathing? (Check all that apply)

☐ BiPap ☐ Trilogy ☐ Ventilator with tracheotomy

If yes, how many hours do you use the machine?

☐ 2-4 hours ☐ 6-8 hours ☐ 8-10 hours ☐ Overnight ☐ 24 hours ☐ Other _____

Are you currently using any of the following equipment?

☐ Suction Machine ☐ Cough Assist ☐ Nebulizer

If yes, how often do you use the equipment? _____

I need help with the following: (Check all that apply)

☐ Bathing ☐ Meal Preparation ☐ Transfers (do you have a hoyer lift? Y / N) ☐ Dressing

☐ Light Housekeeping ☐ Range of Motion Exercises ☐ Feeding (Do you have a feeding tube? Y / N)

☐ Suction ☐ Cough Assist ☐ BiPAP ☐ Trilogy ☐ Nebulizer

Other (explain) _____

By agreement with the ALS Association, I understand that if approved for The ALS Respite Care Program, services will be provided by a preferred provider of the ALS Association. I understand that services will be provided on a limited basis. I authorize the Chapter's Social Worker to release and obtain any information necessary to complete this referral.

Patient's Signature _____ Date _____

Return form to:

The ALS Respite Care Program
Wendy Barnes, LSW
ALS Association, Greater Philadelphia Chapter
321 Norristown Rd. Suite 260
Ambler, PA 19002
610-797-2102 phone
610-791-1283 fax
wendy@alsphiladelphia.org

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