

## Range Respite Caregiver Program Registration

Please complete this form to the best of your ability. Shaded areas are for office use only.

|  |   |                               |                   |  |
|--|---|-------------------------------|-------------------|--|
| <b>Range Respite Caregiver Program Registration</b>  |   |                               |                   |  |
| Please complete this form to the best of your ability. Shaded areas are for office use only.   |   |                               |                   |  |
| <b>Contact Date</b><br>/ /   |   | <b>Status</b>                 |                   | <b>AAA Region</b>  |
| <b>NAPIS ID Number</b><br>- -  |   |                               |                   |  |
| <b>Caregiver :Last Name</b>  |   | <b>First Name</b>             |                   | <b>Middle Name</b>   |
|  |   |                               |                   | <b>Current Age</b>   |
|  |   |                               |                   | <b>Date of Birth</b><br>/ /  |
| <b>Gender</b><br><input type="checkbox"/> Female<br><input type="checkbox"/> Male  | <b>Race (Check one):</b> <input type="checkbox"/> White <input type="checkbox"/> American Indian/Alaskan <input type="checkbox"/> Asian<br><input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other |                               |                   | <b>Ethnicity (Check one)</b><br><input type="checkbox"/> Hispanic or Latino<br><input type="checkbox"/> Non-Hispanic |
| <b>Address</b>   |   |                               | <b>Address #2</b> |  |
|  |   |                               |                   |  |
| <b>City</b>  |   | <b>State</b>                  | <b>Zip Code</b>   | <b>County</b>  |
|  |   |                               |                   |  |
| <b>Home Phone</b><br>( )   |   | <b>Work Phone</b><br>( )      |                   | <b>Cell Phone</b><br>( )   |
|  |   |                               |                   | <b>Lives in Rural Area (Check One):</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No                  |
| <b>Emergency Contact Name</b>  |   | <b>Emergency Phone</b><br>( ) |                   | <b>Emergency Contact Relationship</b>  |
|  |   |                               |                   |  |
| <b>Marital Status (check one)</b><br><input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Unknown   |   |                               |                   | <b>Number in Caregiver Household</b>   |
|  |   |                               |                   |  |
| <b>What is your relationship to the care recipient? (Check one)</b><br><input type="checkbox"/> Husband <input type="checkbox"/> Wife <input type="checkbox"/> Son/Son-in-law <input type="checkbox"/> Daughter/Daughter-in-law <input type="checkbox"/> Other Relative<br><input type="checkbox"/> Non-Relative <input type="checkbox"/> Unknown  |   |                               |                   |  |
| <b>What is the approximate household income of the care recipient?</b><br><input type="checkbox"/> Living Alone - Under \$903 per month <input type="checkbox"/> Two Person Household - Under \$1,212 per month<br><input type="checkbox"/> Living Alone - \$903 – \$1,805 per month <input type="checkbox"/> Two Person Household - \$1,212 – \$2,428 per month<br><input type="checkbox"/> Living Alone – More than \$1,805 per month <input type="checkbox"/> Two Person Household - More than \$2,428 per month<br><input type="checkbox"/> Unknown <input type="checkbox"/> Unknown |   |                               |                   |  |
| <b>Section B Use of Information</b>  |   |                               |                   |  |
| <p>I understand that the information I am providing on this form is for registration purposes. The information will be used by the Area Agency on Aging and the Minnesota Board on Aging to create statistical reports and may be used by service providers to help identify other services from which I may benefit, such as follow up to the Nutrition Risk Assessment. This information will not be released to anyone other than the above mentioned parties in a way that will identify me as an individual unless I sign a separate consent for that purpose.</p>                  |   |                               |                   |  |
| Signature: _____ Today's Date: _____   |   |                               |                   |  |



**CONSENTS AND AUTHORIZATIONS FORM  
FOR RELEASE OF INFORMATION, MEDICATION &, TREATMENT ADMINISTRATION,  
EMERGENCY MEDICAL TREATMENT, PHOTOGRAPHING, USE OF INFORMATION**

\_\_\_\_\_ I hereby authorize Range Respite and other health care or service providers to confidentially obtain or release information regarding:

Name of Care Receiver \_\_\_\_\_  
for the purpose of arranging for and providing respite care.

\_\_\_\_\_ I hereby give my permission for the administration of medications and treatments according to the physician orders and my instructions. I agree to have or bring a sufficient supply of all medications and related supplies in their original, pharmacy-labeled containers.

\_\_\_\_\_ I hereby give my permission for emergency medical treatment provided by Range Respite and/or Emergency Medical Personnel. I understand I will be notified that such emergency treatment will be or has been rendered. If I am not available, the person noted on the Emergency Procedure Plan will be contacted.

\_\_\_\_\_ I hereby authorize those listed on the Emergency Procedure Plan to consent to such medical and emergency medical treatment as may be necessary to be provided to \_\_\_\_\_ . I maintain responsibility for all medical expenses for my family member.

\_\_\_\_\_ I hereby release the designated contact person, Range Respite, their agents, and employees from any liability.

\_\_\_\_\_ I hereby give permission for myself and \_\_\_\_\_ to be photographed.

The picture will be placed in his/her chart and may be used for press releases, journal articles, or other positive publicity related to our respite programs. This consent is expressly intended to release Range Respite and its employees from liability.

\_\_\_\_\_ I hereby give permission for use of our information in the collection of data for grant requests, reports, and evaluations. Your name and that of your loved one will not be associated with the information obtained..

I have fully disclosed to the Range Respite staff all pertinent facts about my family member's special needs and acknowledge full responsibility for failure to do so.

\_\_\_\_\_  
Signature of Caregiver

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Signature of Care Receiver  
If appropriate

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness/Range Respite Staff

\_\_\_\_\_  
Date

EMERGENCY PROCEDURE PLAN

CARE RECEIVER NAME: \_\_\_\_\_ DATE OF BIRTH:  
\_\_\_\_\_

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

PHONE NUMBER: \_\_\_\_\_ CLINIC:  
\_\_\_\_\_

PHYSICIAN: \_\_\_\_\_ CLINIC PHONE NUMBER:  
\_\_\_\_\_

- STAY CALM.
- Provide emergency first aid if needed.
- Call 911 for life-threatening emergency. (In the event 9-1-1 service is disrupted, dial 218-749-6010 for St. Louis County). State your name, care receiver name, address and phone number of your location, the nature of the emergency, the care you have provided, and resuscitation wishes. Stay on the line until dispatcher instructs you to hang up!
- Notify the RN on call who will provide instruction and notify the emergency contact person(s) as listed below.
- Stay with the care receiver and provide reassurance.

EMERGENCY CONTACT: I hereby authorize the following person(s) to consent to such medical and emergency medical treatment as may be necessary to be provided to \_\_\_\_\_ . I maintain responsibility for all medical expenses for my family member.

1) Family Caregiver: \_\_\_\_\_  
Address: \_\_\_\_\_

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

2) Other Contact: \_\_\_\_\_  
Address: \_\_\_\_\_

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

3) Other Contact: \_\_\_\_\_  
Address: \_\_\_\_\_

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

4) Other Contact: \_\_\_\_\_  
Address: \_\_\_\_\_

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

ADVANCE DIRECTIVE: \_\_\_ Yes \_\_\_ No If yes, location of form: \_\_\_\_\_

Check all resuscitation preferences/orders:

- \_\_\_ DO NOT RESUCITATE (DNR)
- \_\_\_ DO NOT INTUBATE
- \_\_\_ CHEMICAL CODE ONLY
- \_\_\_ FULL RESUSCITATION

DIAGNOSES: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

\_\_\_\_\_  
CAREGIVER SIGNATURE

\_\_\_\_\_  
DATE

# *Grievance Procedure for Caregiving Families: These Are Your Rights.*



## **What is a Grievance?**

A grievance is a complaint, problem, or concern of something you don't like about the program rules, services, or staff of Range Respite. A copy of this procedure is placed in the Respite Enrollment Packet and posted at the Respite House. If you have any questions, this procedure will be discussed during the enrollment

## **Procedure**

1. If you are having a problem, concern, or complaint that you feel is not being resolved, you should feel free to file a grievance without being afraid of criticism or losing your services. Your actions will not result in retaliation or barriers to services.
2. You may choose to represent yourself during a grievance or you may have someone else such as your legal representative, spouse, parent, sibling, adult child, friend, or outside advocate help you. The following agencies can be of assistance:

**Ombudsman Office 1-800-657-3506**

**Arc 1-800-582-5256**

At any step listed you may have assistance from the advocates listed above.

3. If you have a problem or concern, first notify and instruct the staff person involved. Do this right away if something happens that bothers or upsets you. Allow adequate time for improvement. If the problem or concern continues, notify the Respite Care Coordinator or Executive Director to discuss the problem and follow up with you within 2 business days.
4. If the problem or concern was not resolved at the step above, submit your complaint in writing by letter or use of the Grievance/Complaint Form (attached) to the Respite Care Coordinator. A telephone or in-person meeting will be arranged. The Respite Care Coordinator will gather information from all people identified with the grievance and make a decision or take action within 5 business days. You will receive written notice of the decision.
5. If you still disagree with the decision you can ask that the grievance be presented to the Executive Director. A telephone or in-person meeting will be arranged within 5 days and you will receive a response in writing within 2 weeks.
6. Copies of all grievances will be collected for all services and summarized annually to determine if there is a trend in complaints or need to change or correct internal procedures.

Grievance/Complaint Form



Your Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Care Receiver Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Person(s) Involved \_\_\_\_\_

Please describe grievance issue in detail. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature \_\_\_\_\_ Printed Name \_\_\_\_\_ Date \_\_\_\_\_

**This section to be completed by Range Respite**

Date Rec'd \_\_\_\_\_ Person/Title Receiving Report \_\_\_\_\_

Date of Telephone or In-person Meeting \_\_\_\_\_ Person Contacted \_\_\_\_\_

Action Taken

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Notification of Licensor \_\_\_ No \_\_\_ Yes Name \_\_\_\_\_

Date \_\_\_\_\_

Written Response\* Sent to \_\_\_\_\_ Date \_\_\_\_\_ (within 5 business days)

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Date Rec'd \_\_\_\_\_ Person/Title Receiving Report

\_\_\_\_\_

Date of Telephone or In-person Meeting \_\_\_\_\_ Person Contacted

\_\_\_\_\_

Action Taken

\_\_\_\_\_

Notification of Licensor \_\_\_ No \_\_\_ Yes Name \_\_\_\_\_

Date \_\_\_\_\_

Written Response\* Sent to \_\_\_\_\_ Date

\_\_\_\_\_ (within 2 weeks)

\*Attach copy

## A Home Safety Checklist for Family Caregivers of Adults



### Kitchen

- Items are kept in lower cabinets
- A sturdy step stool is available (depending on care-receiver's ability)
- There is a place to set groceries
- The stove and oven are turned off
- Enough storage is available to avoid clutter
- Towels, dishcloths, and curtains are not near the stove
- Oven mitts (not towels used as pot holders) are available
- Water temperature in the water heater is set below 120 degrees Fahrenheit
- Electric wiring is grounded where there's water
- Appliances are unplugged when not in use
- Leftover food is properly stored and eaten or disposed of before it spoils

*Does your loved one:*

- Wear appropriate clothes when cooking? (No long, billowy sleeves, for example.)
- Always remain in the kitchen when cooking?
- Wipe up spills immediately?

### Bathroom

- Grab bars (not just a towel rack) are installed in the bathroom
- A grab bar is installed beside the toilet
- Soap is within reach when bathing
- The bathtub or shower has a bath mat
- A bath chair is in the tub/shower
- The toilet has a raised seat
- There is non-slip flooring or a rug for when the floor is wet
- There is a handheld shower head
- Water temperature in the water heater is set below 120 degrees Fahrenheit
- The door does not have a lock or else a key is readily available
- Electrical appliances are unplugged when not in use
- Electric wiring is grounded where there's water

### Bedroom

- A lamp is accessible from the bed and easy to switch on or off
- Night lights are in the bedroom, the hall, and the bathroom
- A flashlight is by the bed
- Hot pads and electric blankets are in good condition

*Does your loved one*

- Use a hot pad and/or an electric blanket in a safe manner?

### Security

- Doors, including the garage door and the door leading from the garage into the house, are locked
- Windows and sliding doors are locked
- There is a peephole in the door and a screen/security door
- An emergency alarm system is installed
- Emergency addresses and phone numbers are by the phone and written in large print
- Phone is cordless to reduce risk of falls
- Locks have dead bolts (but not a two-key system, which makes it harder to get out)
- If there are bars on the windows, they have a quick-release latch

*Does you loved one*

- Come home alone to an empty house?

### Lighting

- Lighting shines from several angles to avoid shadows
- Tops and bottoms of stairs are well lit
- A light switch is by the front door
- Daylight comes in through windows
- Correct wattage bulbs are installed in lamps and fixtures

## Stairs

- All stairs have handrails
- Handrails line the full length of the stairway
- Handrails are a different color than the wall
- Stairs are in good condition
- There are no rugs at the tops or bottoms of stairs
- There are no frayed rugs or runners on stairs
- Color-contrast paint strips are used on the edges of steps if a loved one has trouble with vision

*Does your loved one:*

- Use stairs for storage?

## Living Room and Floor Plan

- Rugs have non-slip backs
- Rugs are free of curled edges that would cause tripping
- Hallways are at least four feet wide
- Halls are free of furniture, boxes, storage, and other clutter
- Walkways from room to room, bedroom to bathroom are clear
- Cords for phones, lamps, appliances are secured and out of walkways
- Chairs have arms for support
- Furniture is sturdy
- Furniture is spaced four feet apart
- Depth of carpet nap is not a hindrance if a loved one has trouble with mobility
- No items are stacked in walkways
- Space heaters are placed at least three feet from flammable items
- Extension cords and outlets are not overloaded
- All cords, outlets, and switches are in good repair

## Fire Safety

- Smoke alarms are installed on each floor and in or by the bedroom
- Smoke alarms are tested on a regular basis and batteries are replaced as needed
- Smoke alarms are adapted if a loved one is hearing impaired
- Fire extinguisher is easily accessible
- Fire escape plan is established
- Escape routes are clear of clutter
- Fireplace has a screen
- Carbon monoxide detector is installed

*Does your loved one:*

- Smoke?
- Follow rules for safety when smoking?

## Outside

- Walks and driveway are free of wet leaves, snow, ice, and cracks in concrete
- Door has a mat for wiping wet feet
- Garden tools are put away
- Bushes are cut back from the walks and windows
- Outdoor lights have motion detectors
- Handrails are installed
- A ramp is installed, if needed
- Front door is well lit

## Special Situations

- House is child-proofed if young children are coming to visit
- Area where medication is taken is well lit
- Precautions are taken if pets are in the house
- Precautions are taken if firearms are in the house



**MEDICAL ASSESSMENT/PLAN OF CARE**  
*(To be completed by a licensed physician or designee)*

**Physicians Please Note:** The family is requesting this information so that we can provide a time of respite by caring for their family member in the home or at the Respite House.

**Please complete, sign, and return to:**  
**Range Respite 1309 20<sup>th</sup> Street South, Virginia, MN 55792-2541**  
**(or fax to 218-749-6630).**

Call Range Respite at 218-749-5051 with any questions.

Name of Patient \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Date of Last Physical Examination: \_\_\_\_\_

Diagnosis/Conditions/Physical Limitations (List all applicable): \_\_\_\_\_

\_\_\_\_\_

**I. Medical History:**

1. Past History \_\_\_\_\_

2. Social History \_\_\_\_\_

3. Alcohol \_\_\_\_\_ Smoking \_\_\_\_\_ Other \_\_\_\_\_

4. **Allergies** - Medications \_\_\_\_\_  
Environment \_\_\_\_\_  
Foods \_\_\_\_\_

II. Free of reportable communicable diseases (as specified by the MN Department of Health in MN Rules, Part S4605.7000 to 4605.7800)? Yes \_\_\_\_\_ No \_\_\_\_\_

III. **ADULT:**

Date of last Mantoux \_\_\_\_\_ Mantoux must be current (within 1 year).

Result of Mantoux \_\_\_\_\_

OR result of Chest x-ray within last 12 months \_\_\_\_\_

**CHILD:**

Are immunizations current? Yes \_\_\_\_\_ No \_\_\_\_\_

If not, reason: \_\_\_\_\_

Please attach copy of current Immunization Schedule.

IV. **Assessment/Discussion:**

1. Physical Examination: Height \_\_\_\_\_ Weight \_\_\_\_\_  
Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Respirations \_\_\_\_\_ BP \_\_\_\_\_

Observations (appearance/behavior) \_\_\_\_\_

\_\_\_\_\_

Head & Neck \_\_\_\_\_

Mouth & Throat \_\_\_\_\_

Heart \_\_\_\_\_

Lungs \_\_\_\_\_

Abdomen \_\_\_\_\_

GI \_\_\_\_\_  
GU \_\_\_\_\_  
Musculoskeletal \_\_\_\_\_  
Neurological \_\_\_\_\_  
Mental/Orientation \_\_\_\_\_

III. Physician's Treatment Recommendations

**Diet:** \_\_\_\_\_

Food consistency \_\_\_\_\_

\_\_\_\_\_ Tube Feedings: Type of tube \_\_\_\_\_ Size \_\_\_\_\_

Formula (include name, amount, frequency)  
\_\_\_\_\_

Breathing

\_\_\_\_\_ Oxygen: Litres/min \_\_\_\_\_ via \_\_\_\_\_

\_\_\_\_\_ CPAP: Settings: \_\_\_\_\_

Via: \_\_\_\_\_ Oxygen \_\_\_ Litres/min \_\_\_\_\_

\_\_\_\_\_ Nebulizer How often \_\_\_\_\_

\_\_\_\_\_ Tracheostomy Type \_\_\_\_\_ Size \_\_\_\_\_

Activity Level or Restrictions to Activities:  
\_\_\_\_\_  
\_\_\_\_\_

Resuscitation Status:

\_\_\_ DNR\* (Do Not Resuscitate) \_\_\_ DNI\* (Do Not Intubate)

\_\_\_ Chemical Code Only \_\_\_ Full Resuscitation

\*A DNR Form is required and will be sent to you for your signature.

**MEDICATIONS & TREATMENTS**

**Is your patient capable of administering his/her own medications without assistance? \_\_\_ Yes \_\_\_ No**

**Instructions if medication is not taken as directed: (eg. refusal, error)**

\_\_\_ RN discretion \_\_\_ Notify physician

**Admit for Respite Care.**

**Personal care assistance as needed.**

Please list **all PRESCRIPTION OVER-THE-COUNTER medications and treatments or attach a copy.**

The respite care staff will use these orders to administer or assist with medications and treatments.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Examining Physician

\_\_\_\_\_  
Date

Please *Print* Physician's Name: \_\_\_\_\_

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

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

**CONSENT TO RELEASE INFORMATION**  
I hereby authorize the provider to release the information contained in this Medical Assessment/Plan of Care regarding (name of care receiver) \_\_\_\_\_ to Range Respite for the purposes of providing respite care services.

\_\_\_\_\_  
Signature of Care Receiver (if required)

\_\_\_\_\_  
Date

Signature of Caregiver

Date

**CARE RECEIVER'S RIGHTS  
FOR  
ADULT FOSTER CARE PROGRAMS**



Range Respite provides respite care through licensure as both an Adult and Child Foster Care Provider. Adult rules require that you be given this information when respite is provided at the Respite House.

Pursuant to Minnesota Rules, part 9555.6255, upon admission to an adult foster care program, a license holder must give a care receiver and his/her legal representative information about the care receiver's rights including:

- A. an explanation and copy of the care receiver's rights specified in Minnesota Rules, part 9555.6255, subparts 2 to 7;
- B. a written summary of the Vulnerable Adults Act prepared by the department; and
- C. the name, address, and telephone number of the local agency to which a resident or a care receiver's legal representative may submit an oral or written complaint.

**Each care receiver has the right to use a telephone.** A care receiver has the right to daily, private access to, and use of a non-coin operated telephone for local calls. Long distance calls may also be made collect or paid for by the care receiver.

**Each care receiver has the right to receive and send uncensored, unopened mail.**

**Each care receiver has the right to privacy.** A care receiver has the right to personal privacy and privacy for visits from others, and the respect of individuality and cultural identity. Privacy must be respected by operators, caregivers, household members, and volunteers by knocking on the door of a care receiver's bedroom and seeking consent before entering, except in an emergency, and during toileting, bathing, and other activities of personal hygiene, except as needed for care receiver safety or assistance as noted in the care receiver's individual record.

**Each care receiver has the right to use personal property.** A care receiver has the right to keep and use personal clothing and possessions as space permits, unless to do so would infringe on the health, safety, or rights of other care receivers or household members.

**Each care receiver has the right to associate.** A care receiver has the right to meet with or refuse to meet with visitors and participate in activities of commercial, religious, political, and community groups without interference if the activities do not infringe on the rights of other care receivers and household members.

**Married care receivers have the right to privacy.** Including, privacy for visits by their spouses, and, if both spouses are care receivers at the Respite House, they have the right to share a bedroom and bed.

**RESPIRE CARE SERVICE AGREEMENT**  
**DATE \_\_\_\_\_**

The following agreement for the provision of respite services has been mutually agreed upon between \_\_\_\_\_ and Range Respite.

\_\_\_\_\_  
(Print Caregiver/Guardian/Legal Representative Name)

The caregiver/guardian/legal representative of \_\_\_\_\_ (Date of Birth \_\_\_\_\_) has been authorized respite services as described in the caregiver handbook.  
(Print Care Receiver Name)

Range Respite agrees to:

- Keep information about the care receiver and his/her family confidential and discussed only with the appropriate agency staff persons or other professional.
- Provide respite care for your loved one, including personal care assistance and administration of medications and treatments as written in the medical plan of care and instructed by the physician or caregiver.
- Notify the family or emergency contact and/or obtain authorized emergency medical treatment if needed by your loved one while receiving respite services.
- Provide service at the pre-arranged time only. Range Respite will not be responsible for transporting the respite guest and/or caregiver/guardian.
- Provide supervision for Respite Aides in the form of routine telephone calls and visits when indicated or requested.

The Caregiver/Guardian agrees to:

- Provide accurate information concerning the needs of the respite guest.
- Provide a written description of the daily routine and activities for care.
- Provide necessary personal care items, equipment, and supplies and assure that all medications, prescribed and over-the-counter, have current physician orders and are properly labeled and in sufficient quantity.
- Follow appropriate procedures for scheduling and utilizing respite services.
- Notify Range Respite of cancellation of services 24 hours in advance. You may be charged for respite time scheduled if respite has not been cancelled.
- Arrange for and give Range Respite all relevant information needed to contact the primary caregiver or a responsible party to come home, or pick up your loved one from the Respite House, should he/she become ill or need urgent medical services.
- Provision of emergency care by Range Respite staff and/or Emergency Medical Personnel when necessary.
- Not be away for more than the agreed upon scheduled times.
- Not hold Range Respite responsible for any damaged or missing personal property.
- Notify Range Respite when they feel a supervisory visit is indicated.
- Pay for services at rate specified in this agreement.
- Sign the respite guest in and out legibly (Respite House).

I hereby certify that I have signed all necessary consents for providing respite care.

I understand the stated policies and practices and agree to carry out my responsibilities. I have fully disclosed to Range Respite all pertinent facts about my family member's special needs and acknowledge full responsibility for failure to do so.

POLICIES FOR FEES FOR SERVICES

1. We strongly recommend and may require contact of St. Louis County Social Services (749-7128) For a Long Term Care Consultation to determine care receiver needs and eligibility for a waiver.
2. A fee for the provision of respite care will be determined according to a sliding fee scale.
  - a. Annual gross income of care receiver \$ \_\_\_\_\_
  - b. Annual gross income of caregiver \$ \_\_\_\_\_ Number in
  - c. Annual gross income of all members in household \$ \_\_\_\_\_ Household \_\_\_\_
3. A periodic review of the charges will be made by Range Respite to determine if changes in the family's economic status or changes in frequency of use of respite services requires an adjustment.
4. This agreement will be renewed annually and revised as necessary.
5. Services will be invoiced monthly. Payment in full is due within 30 days of the statement date unless other arrangements are made.
  - a. Send bill to \_\_\_\_\_.
  - b. Address \_\_\_\_\_.
6. Please make your check or money order payable to Range Respite.
7. The amount of respite cost-sharing dollars available to each caregiving family depends upon the number of families receiving respite care and the amount of money designated for that purpose.
8. No set amount is guaranteed. After the cost-sharing money is used, the charge will be the full \$23.50 per hour.

**THIS SECTION TO BE COMPLETED BY RANGE RESPITE RN AT TIME OF ENROLLMENT & ANNUALLY**

- None – reimbursement through St. Louis County Social Services.
  - o Case Manager \_\_\_\_\_ Type of SLCSS Waiver \_\_\_\_\_
- Long Term Care Insurance - .Copy of policy required to determine billing arrangements.
- Respite Options - \$500 grant for *initial* respite services (no copayment).
- Respite Scholarship – Initial award of \$500 to subsidize your copayment of \$\_\_\_\_\_/hour. The respite subsidy will continue as long as funds are available. If funding is no longer available, you will be notified one month prior to any change in your copayment.
- Actual cost per hour of \$23.50.
- Other \_\_\_\_\_

I, \_\_\_\_\_, caregiver/guardian of \_\_\_\_\_, agree to the terms stated and pay the amount designated to Range Respite for respite care services. I understand that my rate per hour is based on a sliding fee schedule determined with the financial information that I have provided. I hereby certify that all of the information contained is true and correct to the best of my knowledge.

\_\_\_\_\_  
Caregiver/Guardian/Legal Representative

\_\_\_\_\_  
Range Respite Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

**This form must be received in the Range Respite office before respite is provided.**

Receipt of Information



I have received information on, discussed,  
and understand the following: (please initial each subject)

- \_\_\_\_\_ Respite Care Handbook
- \_\_\_\_\_ Vulnerable Adult Act
- \_\_\_\_\_ Care Receiver's Rights for Adult Foster Care
- \_\_\_\_\_ Grievance Procedure
- \_\_\_\_\_ Access of Health Records Notice of Rights
- \_\_\_\_\_ Home Safety Checklist
- \_\_\_\_\_ Fall Prevention
- \_\_\_\_\_ Medication Safety
- \_\_\_\_\_ *Grievance Procedure*
- \_\_\_\_\_ End of Life Choices: DNR & CPR

*If I have questions regarding the laws or if I wish to submit an oral or written complaint regarding my  
respite care, I may contact:*

- *the Respite Care Coordinator or Executive Director at Range Respite at 749-5051 (per  
Grievance Procedure) or*
- *my social worker, \_\_\_\_\_ at \_\_\_\_\_ or*  
Name Telephone
- *my case manager, \_\_\_\_\_ at \_\_\_\_\_*  
Name Telephone

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

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

\_\_\_\_\_  
Care Receiver Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Range Respite Representative Signature

\_\_\_\_\_  
Date