Respite Care Needs Assessment

This assessment will be used to determine eligibility for Respite Care. A complete evaluation with specific details, frequency of care, and supporting documentation by your Physician/Provider is necessary to determine eligibility and level of need. A separate form is required for each enrolled Exceptional Family Member applying for Respite Care.

Patient Name: _____ Patient Age: _____

Patient Diagnosis/Diagnoses (including severity): _____

Provider Name and Specialty:_____ Date:_____

Provider Instructions: Please complete all applicable sections for your patient.

DETAILS	PHYSICIAN/PROVIDER INPUT*
1. Medical or Adaptive Equipment needed- Specify type(s)	
2. Surgical intervention to sustain life in last 12 months OR surgical intervention for limbs, eyes, hearing within last 6 months	
3. Skilled care intervention and frequency	
4. Visual or hearing impairment-specify complete or partial impairment	
5. Requires assistance with ADLs for prescribed medical needs- specify complete or moderate	
6. Therapy frequency (daily, weekly, monthly)-specify type (ST, OT, PT, Mental Health, etc)	
7. Medications- include route and frequency	
8. Special dietary needs and delivery systems (IV/TPN/tube feeding)	
9. IQ	
10. Verbal Status/Adaptive Equipment for communication	
11. Safety concerns (elopement behavior, risk to others, etc.) and/or self-injurious behavior in past year	
12. Special Education Requirements (IEP, 504, behavior plan, alternate school placement) and/or ABA services	

PRIVACY ACT STATEMENT AUTHORITY: 10 U.S.C. 136; 20 U.S.C. 927; DoDI 1315.19: DoDI 1342.12. PRINCIPAL PURPOSE(S): Information will be used by DoD personnel to evaluate and document the special medical needs of family members.

13. Immunocompromised-indicate if moderate or severe	
14. Number of ER, Urgent Care, or hospitalizations in past year	
15. Potential to require rapid emergency care	
16. Other conditions/concerns that can adversely affect life	

***PHYSICIAN/PROVIDER INPUT AND/OR JUSTIFICATION**

Provider Signature:_____ Date:_____

PRIVACY ACT STATEMENT AUTHORITY: 10 U.S.C. 136; 20 U.S.C. 927; DoDI 1315.19: DoDI 1342.12. PRINCIPAL PURPOSE(S): Information will be used by DoD personnel to evaluate and document the special medical needs of family members.