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## Respite Information Sheet

**Goal of respite care services:** The Pathways, Inc. Community Residence programs offer planned or emergency respite care to provide temporary relief to families of children with serious emotional disturbances.

**Referral Process:** Children and youth are referred for respite care services by a mental health service provider. Referrals are typically completed by Care Coordinators, Care Managers, Case Managers, DSS Case Workers and Therapists. A completed referral packet includes the Respite Care Referral Form and the following supporting documents: **General Consent Form, Informed Consent for Over the Counter Medications, immunization record**, complete and **current medication list** provided by the prescribing physician and current **safety plan**.

The complete referral packet must only be submitted once and will be kept on file. Updated medication lists will be requested for subsequent respite stays to ensure quality of youth care.

The Community Residence Program Director (or designee) will contact the referral source upon receipt and acceptance to begin planning the respite stay.

**Planning a respite stay:** After a referral has been accepted, the Referral Source can contact the Program Director to plan a respite stay. A new referral is not necessary for each subsequent respite stay; however, a stay must be confirmed by a mental health service provider to avoid any billing confusion. Once respite is confirmed by the provider, Community Residence (CR) staff can arrange arrival and departure times with the parents/guardian.

**Arrival:** Youth must arrive at the CR with a responsible adult. This adult should plan to remain at the CR for 20–30 minutes while staff complete all of the necessary steps for getting the youth settled in for respite. The adult should be prepared to count medications and sign-off that they were received by the CR staff. The adult must also remain while the youth demonstrates the ability to be self-preserving in the event of a fire. Arrival times are generally scheduled between 2:00 pm and 5:00 pm.

**Departure:** The youth must be picked up by a parent/guardian or responsible adult. If the parent/guardian is sending another adult to pick up the child, this information must be communicated prior to departure time. The parent/guardian should plan to be at the CR for approximately 10–15 minutes at pick-up in order to count and sign that s/he has received the medications. Departure is generally scheduled before 3:00 pm.

**Medications:** A current medication list must be provided with the referral packet. Medications must also be in ORIGINAL PHARMACY LABELED bottles. The youth must arrive with all of their medications as listed by the prescribing physician. If there is a difference between the list and the bottle label, the medications will be administered according to the PHYSICIAN'S INSTRUCTIONS unless a script with a new order is provided. Any medications that are not included on the medication list provided by the prescribing physician will not be administered.

An Informed Consent for Over the Counter Medications must be completed and included with the referral packet in order to maintain a high quality of care for the youth during his or her respite stay.

**Self-Preservation:** The youth must demonstrate the ability to be self-preserving in the event of a fire. Staff will give the youth a tour, pointing out the exits and the identified meeting area. Staff will then ask several standard questions to assess the youth's ability to identify the risk of a fire. The youth will then complete two timed trials to demonstrate the ability to exit the residence quickly and by way of the safest exit. In the rare case that a youth does not demonstrate the ability to be self-preserving the respite stay will be canceled.

**Supervision:** Youth are provided with “field of vision” supervision. This means that staff will be close enough to visually observe and hear the youth in order to immediately meet his or her needs. Youth that are enrolled in and referred by an OMH HCBS Waiver program will be provided 1:1 supervision. The youth will have one staff member who is assigned to his/her supervision and will remain within eye-sight.

Youth are afforded privacy in the bathroom and in their assigned bedroom; staff will conduct a verbal check with the youth at a minimum of every 15 minutes. If the youth does not respond during verbal checks two staff will enter the bathroom/bedroom to ensure safety.

If the child requires extra support to remain safe in the bathroom while showering/bathing, please ensure that that information is communicated clearly on the referral form.

**Contact with family:** Contact with parents/guardians is viewed as a right to all youth at the Community Residence programs. If a youth requests to call his/her parent(s)/guardian(s) that will be allowed and will not be limited. If a youth has a protective order or a special situation regarding contact, this should be documented on the referral form and discussed with the Program Director or designee.

**Access to electronics:** Youth may bring their electronic devices to the Community Residence during a respite stay with parent/guardian permission. Wi-Fi is not provided and staff do not monitor or “police” the use of electronics. Staff will work to help the youth develop healthy practices around the use of electronics, but will not directly monitor what the youth is doing on his/her electronic device. By allowing your child to bring an electronic device you are acknowledging that this practice is understood and that you remain solely responsible for monitoring your child’s activities on the internet.

If you do not allow your child to have or bring an electronic device during the respite stay and you have special requests regarding limits to access to electronics it should be clearly communicated on the respite referral and during conversation with the Program Director or designee.

#### **To Submit a Referral Contact:**

Lake Breeze CR  
Program Director  
(585) 394-0380

## **Frequently Asked Questions**

### **Do you provide transportation?**

Community Residence (CR) staff do not provide transportation to or from respite care, or to appointments during the respite stay.

### **How long is a typical respite stay?**

In typical situations respite is scheduled for a weekend, Friday to Sunday. Respite care is for a temporary, very short term, period of relief. Respite stays that are longer than three days will require special consideration, discussion and planning.

### **Can respite be planned on week days?**

Yes. Respite care can be planned on weekdays as long as a parent/guardian is available to transport the youth to and from school and any other activity or appointment that the youth may have.

### **What if my child is sick or becomes sick during the respite stay?**

If your child falls ill during the respite stay, the CR staff will contact you to arrange for his/her early pick-up.

### **What if I'm going out of town while my child is there for respite?**

If you will not be immediately available while your child is at the Community Residence then you must designate a person who will be available in the case of emergency, or in the rare case that respite must be ended. The designated person's name, relationship to you and contact information must be clearly communicated to the CR staff and provided in writing.

### **Can a case manager, skill-builder, or family friend drop my child off?**

Yes, with parents' permission any responsible adult can drop off and pick-up the child for respite. This person must be aware that s/he will be responsible for counting medications with staff and signing the forms, and remaining at the CR while the youth completes the Self-Preservation Test.

### **What should my child bring with them?**

Your child should minimally bring a change of clothes for each day of respite, extra undergarments and socks, pajamas, hygiene supplies (shampoo, soap, toothbrush, toothpaste, etc.), bathing suit, weather appropriate footwear and a pair of sneakers, and comfort items (if applicable).

Youth should not bring large amounts of money, items of significant value or items that s/he could easily lose and would likely miss if lost.

### **Will there be other youth there with my child?**

Quite often there will be at least one other youth at the Community Residence at the same time as your child during a respite stay. However, there are times when a respite youth is the only child at the Community Residence for the weekend. Note, if your child comes to the Community Residence during the week, there will also be several other youths at the CR during that time.

### **What happens when my child wakes up in the night?**

The Community Residence has two awake staff that work overnight. The staff provide supervision, checks at a minimum of every 15 minutes and will respond to your child's needs if he or she wakes in the night.

### **The doctor changed the dosage of my child's medications but we haven't gotten a new refill from the pharmacy yet, will you have to give the old dosage?**

Your child's medications will be given according to the medication list provided by the prescribing doctor. If there is a discrepancy between the bottle and the medication list, the Program RN will direct staff to administer the medication according to the medication list. If there is any further discrepancy, a signed order from the prescribing physician indicating the correct medication dosage will be required.



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Mental Health Residential Programs**

**Referral for Respite Care Services**

Youth's Name: \_\_\_\_\_

Youth's Date of Birth: \_\_\_\_\_

Youth's Medicaid Number: \_\_\_\_\_

Name of Youth's Parent/Guardian/Custody Agent:

\_\_\_\_\_

Address of Parent/Guardian/Custody Agent:

\_\_\_\_\_

Telephone Number(s) of Parent/Guardian/Custody Agent: \_\_\_\_\_

Person(s) to be notified in the event of an emergency, illness, or injury:

Name \_\_\_\_\_ Telephone # \_\_\_\_\_

Relationship to Child \_\_\_\_\_

Person(s) who may have contact via telephone with youth while on respite:

\_\_\_\_\_

Name of Provider & Program requesting respite:

\_\_\_\_\_

Telephone # of Provider requesting respite: \_\_\_\_\_

Name of Therapist and phone number:

\_\_\_\_\_

Name of Psychiatrist and phone number:

\_\_\_\_\_

**YOUTH'S PSYCHIATRIC DIAGNOSIS**

**DSM-V Diagnosis Code**

**Diagnosis:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Youth's Hobbies/Sports/Interests/Likes:

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

Youth's Favorite Foods: \_\_\_\_\_

Youth's Dislikes/Fears/Worries: \_\_\_\_\_

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

Are there any specific limits related to viewing and/or using electronic devices?

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

Youth's swimming ability: \_\_\_\_\_

**YOUTH'S MEDICAL INFORMATION**

Physician: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

Date of last physical exam: \_\_\_\_\_

Does this youth have allergies? If yes, specify: \_\_\_\_\_

Describe any ongoing medical needs/concerns (ie. Asthma, seizures, diabetes, acne, etc.):

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

Has the youth received the COVID-19 Vaccine? If yes, specify:

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Is the youth prescribed any NON-psychotropic medications? If yes, specify:

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Does the youth struggle with enuresis (bedwetting) and/or encopresis (soiling)? If yes, specify and include frequency (if child uses Pull-Ups please specify and provide):

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Does the youth require assistance with hygiene routines or have any particular routines we should be aware of? If yes, describe:

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**YOUTH BEHAVIORS**

**COMMENTS**

Fire Setting	___yes ___no	_____
Sexual Perpetration	___yes ___no	_____
Sexual Victimization	___yes ___no	_____
Sexualized Behavior	___yes ___no	_____
Verbal Aggression	___yes ___no	_____
Suicidal Ideation	___yes ___no	_____
Suicidal Gestures	___yes ___no	_____
Suicide Attempts	___yes ___no	_____
Other Self-Harm	___yes ___no	_____
Homicidal Threats	___yes ___no	_____
Homicidal Gestures	___yes ___no	_____
Substance Use (including Nicotine)	___yes ___no	_____
Criminal Activities	___yes ___no	_____
Legal Adjudication(s)	___yes ___no	_____
Property Destruction	___yes ___no	_____

Compulsive Behavior \_\_\_yes \_\_\_no \_\_\_\_\_

Eating Disorder \_\_\_yes \_\_\_no \_\_\_\_\_

Sleep Disturbance \_\_\_yes \_\_\_no \_\_\_\_\_

Hyperactivity/  
Impulsivity \_\_\_yes \_\_\_no \_\_\_\_\_

Rule Challenging \_\_\_yes \_\_\_no \_\_\_\_\_

Running-Away \_\_\_yes \_\_\_no \_\_\_\_\_

**FOR CR STAFF**

Date Written Request for Respite & Required Information Received: \_\_\_\_\_



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Mental Health Community Residence Programs

CONSENT FOR RESPITE CARE SERVICES

As the parent/guardian of \_\_\_\_\_, I understand that my child has been referred for respite care services at Lake Breeze Community Residence Program for Youth. While my child receives respite care services at Lake Breeze Community Residence located at 3101 NYS Rte 21, Canandaigua, NY 14424, telephone (585) 394-0380, I give permission to Lake Breeze Community Residence Program staff to:

- administer my child's medications, as prescribed and provided.
- transport my child to and from activities and outings.
- seek treatment for my child at the nearest hospital emergency department in the event of an injury/ medical emergency (staff will contact me immediately if this occurs).

This consent will remain in effect until my child no longer receives/ participates in respite care services at Lake Breeze Community Residence Program. I have been provided the telephone number for Lake Breeze Community Residence (585) 394-0380.

\_\_\_\_\_  
Parent / Legal Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Parent / Legal Guardian

\_\_\_\_\_  
Staff Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date



COMMUNITY RESIDENCE PROGRAMS
Respite Care
INFORMED CONSENT FOR MEDICATION (OVER THE COUNTER)

YOUTH: \_\_\_\_\_ DOB: \_\_\_\_\_ EFFECTIVE DATE: \_\_\_\_\_

Please initial medications for which consent is to be provided:

MEDICATION:

DIRECTIONS FOR USE:

- Regular Strength Tylenol 325mg.
Anti-Itch Lotion (Caladryl Lotion)
Medicated Body Powder (Gold Bond)
Sunscreen
Insect Repellant (Deet)
Triple Antibiotic Ointment (Neosporin)

Other (specify):
Other (specify):
Other (specify):

I hereby consent to the administration of the above medications for my minor child. I have been informed of the desired effects of the Medication and have received written information regarding the above medications if requested. I am in agreement with this plan.

Parent/Guardian/Custody Agent Date

Responsible Agency Representative Date

Physician Date