Marshfield Area Respite Care Center, Inc.
MARCC
P.O. Box 485
Marshfield, Wisconsin 54449-0485
715-384-8478

APPLICATION FOR ENROLLMENT

1. **Participant Information**
Participant's Name_____ Enrollment #_____
Marshfield Clinic #_____
Phone: ____-_____-_____ Birthdate: Month_____ Day_____ Year_____
Address_____
City_____ State_____ Zip Code_____

Type of housing: (Please check all that apply.)
□ home/apartment □ nursing home/foster □ retirement housing □ care/assisted living facility
□ other (please specify)_____

Living situation: (Please check all that apply.)
□ living alone □ with adult child □ with non-relative
□ with other relative(s) □ with hired caregiver □ with spouse

2. **Caregiver Information** email address:_____
Caregiver name_____ Relationship_____
Phone number (daytime) _____ (evenings) _____
Address_____
City_____ State_____ Zip Code_____
Birthday Month___ Day___ Year___ How many years of caregiving?_____

3. **Billing Information**
Person to receive bill_____ Relationship_____
Address (if different from caregiver above)_____
City_____ State_____ Zip Code_____ Phone_____
Does the Participant have a **court-appointed** Legal Guardian? □ No □ Yes If yes, what is the name?_____ Phone_____
Address (if different from above)_____

4. **Emergency Information***
1.Emergency Contact_____ Relationship_____
Daytime Phone: _____ Evening Phone:_____
2. Emergency Contact_____ Relationship_____
Daytime Phone: _____ Evening Phone: _____

***NOTE: 911 will be called in case of a medical emergency**

5. Participating Health Information

Current medical history/diagnosis:_____

_____

_____

Primary Health Care Provider: (Physician, Physician Assistant, or Nurse Practitioner)

Name_____ Phone_____

Address (if not Marshfield Clinic) _____

City_____ State_____ Zip Code_____

Additional care providers: Name_____ Phone_____

Address_____

City_____ State_____ Zip Code_____

Names individual prefers to be called_____

Special health conditions: (Please check all that apply.)

- ☐ seizures
- ☐ dizziness/fainting
- ☐ falling
- ☐ heart problems
- ☐ high/low blood pressure
- ☐ diabetes
- ☐ swallowing/choking
- ☐ heat/cold sensitivity
- ☐ other
- ☐ asthma/breathing

Please explain_____

Hand dominance: ☐ Right ☐ Left

Dietary restrictions: (Please check all that apply.)

☐ low sodium ☐ low fat ☐ diabetic ☐ needs assistance eating ☐ other

Please explain_____

Special Equipment used? (Please check all that apply.)

- ☐ hearing aid
- ☐ walker
- ☐ cane
- ☐ glasses/contacts
- ☐ prosthesis
- ☐ other
- ☐ dentures
- ☐ wheelchair

Needs assistance with standing? ☐ **Yes** ☐ **No** **With walking?** ☐ **Yes** ☐ **No**

Please explain_____

Allergic reactions? (Please check all that apply.)

☐ smoking ☐ foods ☐ medicines ☐ animals ☐ insects ☐ plants

☐ other, please explain_____

Will participant need to take any medications while using the respite service?

☐ Yes ☐ No ☐ Do not know

Please complete the list of those medications, dosages, and schedule for the respite staff.

Sleeping: Participant usually gets up in the a.m. at _____(time) Naps_____(time/frequency)

Toileting: (Please check all that apply.)

- ☐ independent
- ☐ needs assistance to toilet
- ☐ lacks bowel control
- ☐ independent, uses pads
- ☐ lacks bladder control
- ☐ needs reminding to toilet
- ☐ behavioral problems relating to toileting

Please describe routine for toileting (i.e. how often, times of day, what type of assistance needed)

_____

Behaviors: (Please check all that apply.)

□ sociable	□ agitation	□ confusion
□ cooperative	□ pacing	□ wandering
□ talkative	□ verbally aggressive	□ hallucinations
□ anxious	□ physically aggressive	□ unaware of surroundings
□ helpful	□ agitation increases in evening	□ unaware of physical limitations
□ socially withdrawn	□ unable to recognize familiar people	□ other

What methods work best to handle behaviors? _____
_____
What methods/approaches do **not** work? _____
_____
Are there helpful phrases to communicate? _____
_____

6. Participant Social Information

The following information will help to increase his or her abilities, self-esteem, and social contact.

Languages spoken (past or present) _____
If unable to speak, describe how participant communicates_____
Marital Status: (Please check all that apply.)

□ Married □ Widowed □ Divorced □ Separated □ Single □ Unknown

Years Married_____ Number of children_____

Former occupation(s)_____
Favorite conversational topic_____

Special Interests/Hobbies: (Please check all that apply.)

□ reading	□ radio	□ music	□ singing	□ dancing
□ games	□ sports	□ lectures	□ exercise	□ plays instrument
□ crafts	□ movies/T.V.	□ sewing	□ handiwork	□ gardening
□ church	□ concerts	□ cooking	□ prayer/spiritual reading	
□ outings	□ travel	□ woodworking	□ walking	
□ collector	□ grooming	□ pets	□ conversation	

Additional comments_____

6. Participant Demographic Information

The following section is optional to complete. It will provide helpful information about the participant for purposes of research and securing future funding for the program.

Highest educational level achieved:

□ grammar school	□ GED	□ college
□ high school	□ post high school, vocational	□ graduate school

Ethnicity:

□ Asian or Pacific Islander	□ Hispanic	□ Other
□ American Indian or Alaskan Native	□ Black, non-Hispanic	□ Decline to respond
□ Caucasian, non-Hispanic		

Religion: _____

I UNDERSTAND THIS INFORMATION WILL BE GIVEN TO THE RESPITE STAFF AND WILL BE KEPT ON FILE IN THE RESPITE OFFICE. THIS INFORMATION IS CONFIDENTIAL AND WILL NOT BE RELEASED TO ANY OTHER PERSON WITHOUT MY WRITTEN PERMISSION.

Signature of Caregiver_____Date_____

Signature of Staff Member_____