Marshfield Area Respite Care Center, Inc.
MARCC
211 S. Maple Ave.
Marshfield, Wisconsin 54449
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: ____**
Caregiver name______________________ Relationship____________________________
Telephone 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 their 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 medication, dosage, and schedule for the respite staff.

Sleeping: Participant usually gets up in the am at _____________Naps___________________________
(time) (time/frequency)

Toileting: (Please check all that apply)

- ☐ independent
- ☐ needs assistance to toilet
- ☐ lacks bowel control
- ☐ independent, uses pads
- ☐ lacks bladder control
- ☐ need 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.

Does participant have difficulty finding words to speak? ________Yes ________No

____

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 Interest/ 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

Highest educational level achieved:

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

I UNDERSTAND THIS INFORMATION WILL BE GIVING 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____