CAREGIVER RESPITE APPLICATION

Molly's House offers Caregivers the opportunity to take a respite at our facility while your loved one is being cared for by a professional caregiver at your home. Active Caregivers can apply for a one, two or three night stay at Molly's House. Through grants from The William and Helen Thomas Charitable Trust, The Women In Philanthropy and Loblolly Foundation, this program is provided at no cost to you and your family.

Complete this application and mail to Molly's House, 430 SE Osceola Street, Stuart, Florida 34994 or fax to 772.223.9990. Your application will be reviewed and you will be notified of your acceptance for a "Respite at Molly's House".

Name____Phone____________________________

Address ____

City__________________________________ State_________________Zip________________________

Email Address ____

Emergency Contact_____________________________________Phone____________________________

Who referred you to Molly's House? ____

How long have you been caring for your loved one?____

Type of care required____________________________________ Is it 24/7 care? YES_______ NO_______

Please select the month you would like to attend "Molly's House Caregiver Respite Program". (No Holidays)

January	February	March	April
May	June	July	August
September	October	November	December

Please select the day(s) of the week you would like to stay at Molly's House. (No Holidays)

Tuesday	Wednesday	Thursday	Friday

Please select activity you would like to participate in, if available at little or no costs.

Facial/Massage	Manicure/Pedicure	Hair Salon	Gym
Museum	Live Theater	Movie Theater	Restaurant Certificate
	Walking Tour	Outdoor/Water Activity	

Patient Name ____Phone____________________________

Address ____

City__________________________________State_________________Zip________________________

Family Private Care is the agency that will be caring for your loved one while you are at Molly's House Caregiver Respite. You agree to allow Family Private Care to provide services to your loved one while you are staying at Molly's House. You agree to hold harmless Molly's House and Family Private Care.

Signature____Date_______________________________

CLIENT INTAKE RECORD

Client's Name____ Companion HHA/CNA SN

Client's Address ____

Community Name ____Gated?_______ Gate Code ___________

Home Phone ______________________________ 2nd Contact Phone _________________________________

Directions to Home: ____

____

Sex______ Date of Birth__________________________SS#________________________ Ht.______ Wt._____

Diagnosis/History:____

Hospice Involved? Yes_____ No_____ DNR in place? Yes_____ No_____ Allergies________________________

Does patient use a pill box? Yes_____ No_____ Does patient sleep through the night? Yes_____ No_____

Can the patient be left alone for a few hours? Yes_____ No_____ Smoking Status ________________________

Ambulatory Yes _____ No_____ Walker Yes _____ No_____ Wheelchair Yes _____ No_____

Lifting/Transfers Yes_____ No _____ Pets? ____

Caregiver Responsibilities ____

Transportation Needed Yes_____No_____ Client or Caregiver Car (Circle One)

Care Begins __________________________________Frequency of care needed _________________________

Hurricane/Disaster Plan _______________________________CG Needed Yes_____No_____ Priority #_______

Main Contact_____________________________________Relationship______________Phone_____________

Address ____Cell #_______________________

2nd Contact ______________________________________ Relationship______________Phone_____________

Address ____Cell #_______________________

Person Responsible for Payment____

Address ____

Person Responsible for Signing SOC paperwork ____

Physician Name____Phone ___________________________

Medicare Involved____

Referal Source____Date___________________________

Person Giving Information _____________________________________Phone _________________________

FPC Information will be sent by: Fax______________________________Email___________________________

Mailing Address ____