ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

RESPITE ASSESSMENT TOOL

Member's Name: _____ Date of Meeting: _____ AHCCCS ID: _____ Date of Birth: _____

1. REGULAR SCHEDULED HOURS:

Total Hours: _____ /week **Total Hours:** _____ /year

Flexible Hours: Respite that is needed and can be scheduled using one of the time frames detailed in the chart below. Flexible hours are for a set amount of time but may vary on the time of day scheduled. Write down time frames that the member needs Respite and the total hours needed for each day. *(Example: 1-3 pm or 2-4 pm, 2 hours)*

Scheduled Hours: Respite services that MUST be done at an exact time during the day and for a fixed length of time, without exceptions. Scheduled hours are times and days that cannot be changed *(Example: Every Tuesday from 9 am-1 pm, 4 hours)*

	SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY	
	Time Frame	Total Hours	Time Frame	Total Hours	Time Frame	Total Hours	Time Frame	Total Hours	Time Frame	Total Hours	Time Frame	Total Hours	Time Frame	Total Hours
SCHEDULED														
FLEXIBLE														

Is there any flexibility with these hours? ☐ Yes ☐ No Explain: _____

2. INTERMITTENT SCHEDULED HOURS *(8 hours or less, 1 week's notice)*:

Total Hours: _____ /week **Total Hours:** _____ /year

Explain: _____

3. BIG EVENT *(More than 8 hours, 30 days' notice)*:

Total Hours: _____ /year Explain: _____

4. EMERGENCY *(Use historical information and situations to predict any emergent troubles that may occur)*:

Total Hours: _____ /year Explain: _____

Total Number of Hours / Respite Benefit Year (10/1 to 9/30): _____ ***hours needed.***
(Add total yearly hours from sections 1, 2, 3 and 4)

See page 2 for EOE/ADA disclosures

VENDOR CALL NOTES

Will be copied into the Notes section of Vendor Call

1. **Specific Member Needs** ***(Please check the box if applicable and explain needs of member.)***

   ☐ G Tube Feedings: _____

   ☐ Specific Medical Needs: _____

   ☐ Prevention and Support Needed: _____

   ☐ Behavior Challenges: _____

   ☐ Vision and/or Hearing Limitations: _____

   ☐ Communication Limitations: _____

   ☐ Allergy and/or Skin Sensitivities: _____

   ☐ Incontinent and/or Level of Toileting Needs: _____

   ☐ Meal Prep and/or Feeding Needs: _____

2. **Location Preference:** ☐ In-Home ☐ Out-of-Home ☐ Combination of In-Home and Out-of-Home

3. **What are Your Preferences for the Provider?**

   1. Preferred Language: _____
   2. Will the member need transportation? ☐ Yes ☐ No If so, explain: _____
   3. Staff Preference: ☐ Smoker ☐ Non-Smoker
   4. Staff Preference: ☐ Male ☐ Female

4. **Member Information for Providers**

   1. Does anyone in the house smoke? ☐ Yes ☐ No
   2. Are there any animals and/or pets in the house? ☐ Yes ☐ No If so, explain: _____
   3. Are there siblings in the home? ☐ Yes ☐ No