Jackson Services
1175 E Main St. Medford, OR 97504
(541) 772-0127 Office Fax (541) 772-0966

KAIROS

The moment when change is possible

INTERVAL RESPITE REFERRAL

Member Information:

Youth Name: ______________________________________ DOB: __________ OHP#:___________________

Eligibility: ☐ JCC ☐ AllCare ☐ Other ______________________

***Note that only Jackson Care Connect Members are eligible for Interval Respite without prior authorization from Kairos.**

Provider Information:

Referring Agency:_______________________________________ Referral Contact: ______________________

Phone:____ Fax:_________________________________

Reason for Respite/Recent Events:

____

____

____

DROP-OFF DATE: __________________ (After 3pm) **DROP-OFF PERSON**:_________________________

PICK-UP DATE:____________________ (Prior to 1pm) **PICK-UP PERSON**:_________________________

BACK-UP TRANSPORTATION: ____

***Note that if transportation person is different from guardian, paperwork must be signed completely by guardian prior to drop-off and arrangements confirmed with authorized representative prior to transport.**

Diagnosis:____

Comments for Respite Providers:____

____

____

***Note: Please contact respite providers directly in the case of a cancellation or reschedule at (541) 494-0837**

Placement Criteria:

☐ Individual between ages 4-17
☐ Individual must be able to manage hygiene/toileting needs independently
☐ Evidence of an acute behavioral, emotional or situational crisis that is likely to resolve with a temporary change in placement (criteria for crisis placement only)
☐ Evidence that the individual does not require acute psychiatric services
☐ Evidence that the individual does not require medical stabilization
☐ No evidence of acute alcohol or substance intoxication, no substance use in the last 48 hours
☐ Evidence that the behavior would not be better managed in a juvenile detention facility
☐ Evidence that the individual does not present immediate risk of harm to self or others (willingness to sign "no harm" contract)
☐ **Evidence that a discharge destination is available:** ______________________________________

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Interval House – Crisis Respite Treatment Foster Home

Youth Name: ____ DOB: _________________________
Primary Diagnosis:___________________________________ Gender:______________ Age:__________________

Legal Guardian: __________________________________ Relationship to youth: _________________________
Address: ____
Home Phone: ___________________ Work Phone: ____________________ Cell Phone: ____________________
After-Hours Phone:____

Primary Caregiver: ___________________________________ Relationship to youth: _______________________
Address: ____
Home Phone: ___________________ Work Phone: ____________________ Cell Phone: ____________________

Emergency Contact: __________________________________ Relationship to youth:_______________________
Address: ____
Home Phone: ___________________ Work Phone: ____________________ Cell Phone: ____________________

Primary Care Physician: __________________________________ Phone: ________________________________

Safety Planning:

- Recent Behavioral Concerns:____
  ____
- Precautions/Supervision requirements:____
  ____
- Triggers:____
  ____
- Identified Coping/Self-Soothing Strategies:____
  ____

  It helps when others…____
  ____
- Crisis Plan:
  - Use coping skill:____
  - Call Guardian or __________________ (circle one)
  - Call Kairos therapist/provider or Crisis Therapist (during business hours)
  - Call Jackson County Mental Health
  - Call Police, 911 in emergency situations

☐ Behavioral Support Plan/Safety Plan dated in the last 90 days attached (or hospital discharge records)

School Youth Attends:____
☐ May Attend School ☐ May Not Attend School (Check One)
Transportation:____

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Physical Health Concerns: (Check yes to any that apply)

- Allergies ☐ no ☐ yes
- Seizures ☐ no ☐ yes Headache/Migraine ☐ no ☐ yes
- Enuresis ☐ no ☐ yes Food Allergies ☐ no ☐ yes
- Other ☐ no ☐ yes List:____

If yes to any of the above, please describe the situation/condition, plan, needs, and ability for self-care: __
____
____
____

Current Medications:

Name of Medication	Dosage	Time of Administration

Note: All medications must be in their original bottles and youth must arrive with enough medications to cover the dates of the respite stay.

Mental Health Treatment Team:
Therapist: ____ Phone: _________________________
Care Manager/WRAP coordinator: _________________________________ Phone: _________________________
Skills Coach:____ Phone: _________________________
☐ Sessions are approved at the home.
☐ I consent to communication between respite providers and the above team.__________________________(sig)

Phone Calls:
☐ Place ☐ Receive: Name/#______________________________Time Limit_________________☐Supervision
☐ Place ☐ Receive: Name/#______________________________Time Limit_________________☐Supervision
☐ Place ☐ Receive: Name/#______________________________Time Limit_________________☐Supervision

Visits:
☐ On-Site ☐ Off-Site: Name:________________________ Time Limit______________________☐Supervision
☐ On-Site ☐ Off-Site: Name:________________________ Time Limit______________________☐Supervision

Required Supervision: (check one or more)
☐ Same room with adult during waking hours.
☐ May have time alone in room – amount of time: ☐ Routine ☐ Other: _______________________________

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Individual Skills Training/Treatment Outcome of Respite:____

____

____

____

Acknowledgement of the Plan as described above
The undersigned agree to the plan as it is written above. Legal Guardian/Primary Caregiver agrees to be accessible at all times during placement, at least by phone. An Emergency Contact must be available and contact information must be provided. In an emergency, youth will be taken either to the PCP or RRMC Emergency Department, as appropriate.

Youth	Date	Therapist	Date
Legal Guardian	Date	Respite Foster Parent	Date
Primary Caregiver	Date	Skills Coach	Date
Case Manager/WRAP Coordinator	Date	Transportation/Other	Date