

# DOWN HOME RANCH

ESTD ★ 1989

## RESPITE APPLICATION

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DOWN HOME RANCH DOES NOT ACCEPT E-MAILED APPLICATIONS.

Please mail application:

Down Home Ranch  
c/o Residential Respite  
20250 FM 619  
Elgin, TX 78621

Fax application:

512-856-0256

EMAIL PROGRAM@DOWNHOMERANCH.ORG WITH QUESTIONS

## BEHAVIORAL QUESTIONNAIRE

Please answer the following questions fully and explain anything you believe will help us ensure that respite participant will enjoy a safe and fun respite stay. Use space provided to add information, explain or indicate current status. Please note that these questions are for evaluation to help assess general ability to adapt to ranch life and will not exclusively bar the participant from consideration. Answers will be used to provide the applicant with the best supports possible.

1. Has the applicant ever deliberately run or wandered away from a group he or she was supposed to stay with?  
\_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_
2. Has the applicant ever experienced a significant eating disorder, such as refusal or inability to eat, bulimia (induced vomiting after bingeing) or foraging for or stealing food?  
\_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_
3. Has the applicant indulged in emotional outbursts, rages, temper tantrums, willful destruction of property, etc. in the past five years?  
\_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_
4. Has the applicant ever exhibited aggressive behavior toward another person, such as shoving, fighting, hitting, scratching or biting?  
\_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_
5. Has the applicant ever exhibited self-injurious behavior, such as biting self, hitting self, head-banging, skin picking to injury or anal picking?  
\_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_
6. Has the applicant ever gone through periods when he or she was unable to sleep through the night?  
\_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_
7. Has the applicant ever walked in his/her sleep?  
\_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_
8. Does the applicant mostly sleep all day and stay up all night?  
\_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_
9. Does the applicant exhibit foul language and cursing more than occasionally?  
\_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_
10. Has the applicant ever exhibited extreme hypochondria to attract attention?  
\_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_

11. Is the applicant incontinent for bowel or bladder?

\_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_

12. Has the applicant ever been sent home from a camp or similar situation for reasons of behavior or general inability to adapt to new environment?

\_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_

14. Does the applicant currently use tobacco products?

\_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_

15. Has the applicant ever been hospitalized, arrested or detained in a mental health facility because of concern for injury toward self or others?

\_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_

The terrain at Down Home Ranch is rough and primitive, and the Ranch is located a minimum of 45 minutes from emergency medical care. *Down Home Ranch* **cannot** accept applicants who are medically fragile, use G-tubes, feeding pumps or baclofen pumps. *Down Home Ranch* **can** accept applicants who use wheelchairs, with the understanding that a few activities might not be available to them.

***Down Home Ranch*** is set up for applicants whose behavior is within acceptable guidelines. If applicant has exhibited any of the behaviors listed below, please ensure that explanations are included in your answers above:

Wandering, running away  
Refusal/inability to eat  
Throwing objects  
Emotional outbursts  
Biting, scratching, kicking

Fighting  
Self-injurious behavior  
Refusal/inability to sleep  
Tantrums  
General inability to adjust to life

Foul language, cursing  
Extreme hypochondria  
Incontinence of bowel/bladder  
Willful destruction of property

## **RESPITE AGREEMENT**

I understand that if my child/ward engages in behavior during their stay that negatively impact or endanger other people, I will be asked to pick up my child/ward within the hour.

I agree to make arrangements to pick up my child/ward within the hour, if so requested by a member of the Down Home Ranch staff.

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Date

## DEMOGRAPHIC INFORMATION

Date: \_\_\_\_\_

### APPLICANT INFORMATION

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

County: \_\_\_\_\_

Phone: \_\_\_\_\_

Primary Diagnosis/Disability: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Gender: ☐ Male ☐ Female ☐ Other

Ethnicity: ☐ American Indian or Alaska Native ☐ Black or African American ☐ Hispanic or Latino  
☐ Native Hawaiian or Other Pacific Islander ☐ White or Caucasian

### PARENT/GUARDIAN INFORMATION

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

Day Phone: \_\_\_\_\_ Night Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

### EMERGENCY CONTACT PERSON #1 (THIS PERSON MUST BE REACHABLE DURING STAY)

Same as Parent/Guardian Information? ☐ Yes ☐ No (If no, please complete below)

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

Day Phone: \_\_\_\_\_ Night Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

### EMERGENCY CONTACT PERSON #2 (THIS PERSON MUST BE REACHABLE DURING STAY)

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

Day Phone: \_\_\_\_\_ Night Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Attach  
Photo  
Here  
(Required)

## PERMISSIONS

Notice: Down Home Ranch uses standard horses, miniature horses and miniature donkeys in its equine program, which is limited to non-riding activities. Texas law limits the liability of equine professionals under Statute 87. Please initial your agreement or disagreement with the following items:

| YES   | NO    |   |
|-------|-------|---|
| _____ | _____ | Barn program, includes interacting and working with Ranch livestock such as horses, miniature horses, goats, pigs, chickens, etc. It does not include horseback riding, but might include ground training for horses and donkeys, grooming, etc. All animals, stock and domesticated, are vaccinated. Initial NO if you do not wish to interact with Ranch animals.                   |
| _____ | _____ | The medical or designated staff at Down Home Ranch may give routine medications and over-the-counter medications, monitor health status and provide first aid and routine care.   |
| _____ | _____ | For non-emergency purposes, applicant may ride in a properly insured Ranch or privately owned vehicle with medical staff to the hospital for lab tests, x-rays or treatment. All drivers will have undergone appropriate screenings for background and driving record.  |
| _____ | _____ | I authorize Down Home Ranch staff and volunteers to share, without restriction, health information and medical records with any person (whether or not affiliated with Down Home Ranch) as may be reasonably necessary in order to facilitate the applicant's care.   |
| _____ | _____ | If emergency treatment is deemed necessary, I give permission for applicant to be brought to the nearest emergency room by ambulance, helicopter or other means.  |
| _____ | _____ | I authorize staff to release all records necessary for insurance purposes so that my insurance company can be billed for the visits, lab tests, and/or x-rays if necessary. I accept personal responsibility for payment for anything not covered by insurance.   |
| _____ | _____ | I give Down Home Ranch permission to use the applicant's name, photograph or video image for publicity purposes.  |
| _____ | _____ | I agree to not hold Down Home Ranch responsible, financially or otherwise, for the theft, loss or damage of any item brought to Down Home Ranch. I further agree to not hold Down Home Ranch responsible for items left behind.   |
| _____ |       | I affirm that the information on this application is accurate and hereby release and forever discharge Down Home Ranch, its members, employees, and volunteers from any liability, suit, claim, or demand, whether for personal injury to myself or members of my family including minor children, or for property damage resulting from participation in respite at Down Home Ranch. |

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

# SUPPORT INFO SHEET

Name of Applicant: \_\_\_\_\_

## AGE

Chronological: \_\_\_\_\_

Developmental (approximate): \_\_\_\_\_

**DIABETIC** ☐ Yes (see eating/ diet section) ☐ No ☐

Insulin dependent

## EATING/ DIET

☐ Diabetic Diet ☐ Special Diet ☐ Gluten Free

*If you checked one of the above diets, you must enclose a Doctor's order with your application.*

☐ No help needed at meals

☐ Needs help only with \_\_\_\_\_

☐ Retainer ☐ Braces ☐ Dentures

☐ I will send special food with applicant (Dr's order required at check-in)

## DIAGNOSIS

Please list all conditions, e.g. Down syndrome, Autism, asthma, diabetes, general IDD, ASD, etc.

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

## ALLERGIES

☐ None ☐ Yes (list below)

Food: \_\_\_\_\_

Medication: \_\_\_\_\_

Other: \_\_\_\_\_

## SEIZURES

☐ None ☐ Regularly ☐ One or two as a Child

Type: \_\_\_\_\_ Date of last seizure: \_\_\_\_\_

Usual Frequency: \_\_\_\_\_ Duration: \_\_\_\_\_

Triggers: \_\_\_\_\_

## AMBULATION

☐ Walks unassisted

Walks using: ☐ walker ☐ crutches ☐ braces/cane

Wheelchair: ☐ manual ☐ electric- (bring charger)

Transfers: ☐ alone ☐ needs assistance

## COMMUNICATION

☐ No Problems

☐ Limited abilities but can communicate daily needs

☐ Non Verbal ☐ Sign Language

## VISION

☐ Normal ☐ Limited ☐ Glasses ☐ Blind

## HEARING

☐ Normal ☐ Hearing Impaired ☐ Hearing Aids

## SLEEP

☐ No Problems Usual bed time: \_\_\_\_\_

☐ Walks in Sleep ☐ Awakes at: \_\_\_\_\_

☐ Apnea, uses CPAP or similar

## TOILETING

☐ Self-toileting ☐ Needs reminding to go

☐ Needs help: \_\_\_\_\_

## SELF CARE (EX: BRUSH TEETH, BATHE)

☐ Handles on own

☐ Needs help

☐ Must be performed for him/her

## MEDICATIONS

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Attach sheet for additional medications/comments

## BEHAVIOR PROBLEMS

☐ No ☐ Yes If Yes please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## ACTIVITY RESTRICTIONS

☐ Yes ☐ No

Explain: \_\_\_\_\_

## HEAT TOLERANCE

☐ Good ☐ Fair ☐ Poor ☐ Dehydrates easily

## SWIMMING

Knows how? ☐ Yes ☐ No

Ear plugs when swimming ☐ Yes ☐ No

## WANDERS

☐ Yes ☐ No ☐ Occasionally

## ADDITIONAL INFORMATION

\_\_\_\_\_

\_\_\_\_\_

Please add additional pages if necessary

## RESPIRE INFORMATION

Please indicate the dates you would like respite at Down Home Ranch:

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Please indicate how you wish to pay for respite services:

☐ Private Pay      ☐ Texas IDD waiver services      ☐ Contract General Revenue  
(HCS, TxHml, CLASS)      (local IDD authority Bluebonnet Trails, Integral Care, etc.)

### APPLICANT INFORMATION (CONTINUED)

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Date Last Physical: \_\_\_\_\_  
Insurance Carrier: \_\_\_\_\_ Group Number: \_\_\_\_\_  
Member Name & Relationship: \_\_\_\_\_

☐ APPLICANT DOES NOT HAVE INSURANCE COVERAGE

If Down syndrome, is he/she stable for Atlanto-Axial Subluxation (AAS)? ☐ Yes ☐ No

Date last cervical spine X-ray for AAS: \_\_\_\_\_ (Verification may be requested)

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

### IMMUNIZATIONS

Dates of illness or immunization:

|                         |                     |                          |
|-------------------------|---------------------|--------------------------|
| _____ Polio, type _____ | _____ Measles (red) | _____ Measles ("German") |
| _____ Diphtheria        | _____ HIB           | _____ Chicken Pox        |
| _____ Whooping cough    | _____ Mumps         | _____ COVID-19           |
| _____ Other: _____      |                     |                          |

### PERMISSION TO GIVE OVER-THE-COUNTER MEDICATIONS ON AS-NEEDED BASIS

Initial each medication or its generic equivalent that may be administered under direction of the nurse. Write "NO" beside any medications you do not wish administered. **NOTE:** You must have a doctor's written orders for any OTC medications to be administered on a regular, scheduled basis.

|                                       |                          |                                |                  |
|---------------------------------------|--------------------------|--------------------------------|------------------|
| _____ Tylenol                         | _____ Ibuprofen          | _____ Chlorpen (antihistamine) | _____ Robitussin |
| _____ Lanacane /Solarcaine            | _____ Cortaid            | _____ Maalox/Pepto Bismol      |                  |
| _____ Benadryl (tabs, cream or spray) | _____ Sudafed            | _____ Tylenol PM               |                  |
| _____ Laxative                        | _____ Immodium           | _____ Chloraseptic Spray       |                  |
| _____ Calamine Lotion                 | _____ Neosporin Ointment | _____ Anbesol (tooth,gum pain) |                  |

## **PRESCRIPTION MEDICATION POLICY**

Prescription medication must be brought, and will be dispensed from the original container in which it was prescribed. The medication, purpose for which it was prescribed, date of prescription, prescribing physician, dosage, route and frequency of administration must be listed on the original container. Administration of the medication will be exactly as prescribed and no exceptions will be made.

### **PLEASE READ AND SIGN**

**Prescription Medication Policy Agreement.** By signature below, I affirm that I have read the policy concerning prescription medication and will deliver medications in their original containers. I understand that requests to administer dosages of medication different than that prescribed cannot be honored.

**Permission to Obtain Medical Treatment.** I give my consent by signature below for medical treatment to be obtained by a representative of Down Home Ranch in the event I or my designee cannot be reached.

**Agreement to Pay for Medical Treatment.** I understand that in the event of a medical emergency, EMS may be called and the applicant may undergo hospitalization and/or treatment. By signature below, I agree to assume all costs associated with such summoning of emergency medical care, hospitalization and treatment, and I hold Down Home Ranch, its staff, Board of Directors and volunteers harmless for any liability, medical or financial, arising from such.

**Photo agreement.** By my signature below, I give my consent for Down Home Ranch to publish images of the applicant within any Down Home Ranch publication.

Parent/Legal Guardian Signature\_\_\_\_\_ Date\_\_\_\_\_

**Please verify that you have completed and signed the application in full. Upon completion, please mail your application to:**

**Down Home Ranch  
c/o Residential Respite  
20250 FM 619  
Elgin, TX 78621**

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### **OFFICE USE ONLY**

Date Application Received:

Notes:



Participant's Name : \_\_\_\_\_ Date of Birth: \_\_\_\_\_

\*Please fill out complete script information and under **\*\*"Times"**, circle when to administer the med.

| *Medication | **Times   | Sunday | Mon | Tues | Wed | Thurs | Friday |
|-------------|-----------|--------|-----|------|-----|-------|--------|
|             | Breakfast |        |     |      |     |       |        |
|             | Lunch     |        |     |      |     |       |        |
|             | Dinner    |        |     |      |     |       |        |
|             | Bed       |        |     |      |     |       |        |
| *Medication | **Times   | Sunday | Mon | Tues | Wed | Thurs | Friday |
|             | Breakfast |        |     |      |     |       |        |
|             | Lunch     |        |     |      |     |       |        |
|             | Dinner    |        |     |      |     |       |        |
|             | Bed       |        |     |      |     |       |        |
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|             | Dinner    |        |     |      |     |       |        |
|             | Bed       |        |     |      |     |       |        |
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|             | Lunch     |        |     |      |     |       |        |
|             | Dinner    |        |     |      |     |       |        |
|             | Bed       |        |     |      |     |       |        |
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|             | Bed       |        |     |      |     |       |        |