Night Respite Service Application Package

Introduction:

Night Respite service aims to provide caregivers of persons with dementia with Sundowning behaviour the opportunity to take time off from night-time caregiving duties. Caregivers will also be educated on and supported in managing Sundowning behaviour.

Sundowning is the worsening of behavioural difficulties towards the end of the day. Symptoms include restlessness, agitation, suspicious behaviour, disorientation, and visual and auditory hallucinations, including difficulty sleeping at night.

The service will help persons with dementia with Activities of Daily Living (ADL) and provide meaningful engagement.

Eligibility Criteria:

Caregivers applying for this service must be the long-term caregiver of a person with dementia.

Persons with Dementia eligible for admission:

- ✓ Diagnosis of dementia by a Singapore Medical Council-registered medical practitioner
- ✓ Displaying Sundowning behaviour
- ✓ Clients who are being cared for at home, and not utilising any long-term residential care services

Persons with Dementia not suitable for the programme:

- × Individuals who are bedbound and who need more than one person's assistance
- × Individuals who are currently in the active stage of infectious or contagious disease

Application Package:

Please complete and submit the following:-

PART 1: Application Details

PART 2: Health Declaration. Please complete to the best of knowledge in order for the Provider to adequately understand the needs of the person needing care.

Please also attach:

- □ Copies of identification documents (NRIC) of person needing care, and
- □ Copies of identification documents (NRIC) of main caregivers, and
- □ Dementia Diagnosis (e.g. Doctor's memo), and
- □ Latest hospital discharge summary which is dated within one year prior of this application (if available)
- □ Client's medication list from doctor if night time administration of medication is required
- □ Other documents that the Provider may require on a case-by-case basis

Note: Whilst a dementia diagnosis is required, a doctor's referral is not required for the application.

Please refer to the next page for Enquiry and Application Process.

Enquiry and Application for Night Respite Service

1. Enquiry

Via

- AIC Website (www.aic.sg) or enquiries@aic.sg or careinmind@aic.sg
- AIC Hotline 18006506060 *[Operating hours are: Mon – Fri, from 8.30am to 8.30pm, and Sat, from 8.30am to 4pm (excluding Public Holidays)]*
- AIC Link
- Your medical social worker, social worker, case manager or doctor

2. Application

All applications are to be submitted to careinmind@aic.sg and to include the following items:

a. Part 1: Application Details
b. Part 2: Health Declaration
c. Copies of client and caregiver(s) I/Cs,
d. Dementia diagnosis (e.g. doctor's memo)
e. Latest hospital discharge summary and any relevant documents pertaining to client's care (if applicable)
f. Client's medication list form doctor if night time administration of medication is required

3. Pre-Admission Assessment (Weekday)

- Upon receipt of application, the Provider will arrange to meet with both the person needing care and the applicant / caregiver. This is an important session for the Provider to better understand both caregiver's and client's needs, and for the caregiver to understand the Provider's requirements before the admission.
- The service is estimated to cost between $80 to $130 per night. The Provider will advise on the final price and subsidies available during pre-admission assessment.
- Please note that final admission will be at the discretion of Provider, subject to Provider's availability.

4. Admission

- Please arrive on time for the respite session.
- Should there be a change in admission date and time, please inform the Provider at least one working day prior to the admission date
- If the person needing care requires medication during the night, please pre-pack and bring the required medications. Please also clearly inform the Provider about the medication instructions.

NIGHT RESPITE CARE APPLICATION

Part 1: Application Details

1. CAREGIVER & CLIENT INFORMATION					
A. DETAILS OF PERSON NEEDING CARE					
Name:		**NRIC/ Passport/ FIN/ UIN No:**		**Citizenship:** ***(please delete accordingly)***	Singaporean / PR / Others: _____
Date of Birth: (dd/mm/yyyy)		**Gender:**		**Religion:**	
Residential Address:	S( ) ☐ Living with family ☐ Living with Foreign Domestic Worker	**Languages / Dialects Spoken:**		**Household Means Testing (HHMT)**	☐ Client has conducted HHMT ☐ Client does not want to conduct HHMT
Eligibility (please tick)	☐ Client has a diagnosis of dementia by a Singapore Medical Council-registered medical practitioner ☐ Client has symptoms of Sundowning behaviour ☐ Client not utilising any long-term residential care services ☐ Client is not bedbound and does not need more than one person's assistance ☐ Client is not in the active stage of infectious or contagious disease				
Existing client of any community services(please tick)	☐ Day Rehabilitation Services ☐ Dementia Day Care Services ☐ Senior Activity Centres	☐ Community Wellness Programme/Club ☐ Home-based Services (e.g. home medical, home nursing, etc.) ☐ CREST / COMIT	☐ Others: _____		
B. CAREGIVER'S INFORMATION					
Name:		**NRIC/ Passport/ FIN/ UIN No:**		**Date of Birth: (dd/mm/yyyy)**	
Relationship to person needing care:		**Contact no:**	(HOME) (MOBILE)		
Email:		**Address:**	☐ Same as client		
C. ALTERNATIVE CONTACT PERSON'S INFORMATION (IF AVAILABLE)					
Name:		**NRIC/ Passport/ FIN/ UIN No:**		**Date of Birth: (dd/mm/yyyy)**	
Relationship to person needing care:		**Contact no:**	(HOME) (MOBILE)		
Email:		**Address:**	☐ Same as client		

2. REASON(S) FOR APPLICATION

Please share with us some of your reasons for using Night Respite Service to help us understand your needs better.

_____

_____

_____

How did you hear of this service?

☐ AIC: _____ ☐ Community Partner: _____

☐ General Practitioner:_____ ☐ Hospital: _____

☐ Others: _____

3. REQUESTED ADMISSION DETAILS (Please fill in this section to the best of your abilities. Applicants will be able to discuss further with Service Providers during the pre-admission assessment.)

Admission Date Requested (dd/mm/yy)		**Frequency**	☐ Weekly / regular ☐ Ad hoc	
Required nights	☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday			☐ Transport required
Dietary Preference	☐ No preference ☐ Halal ☐ Vegetarian ☐ Others (please specify):_____			

NIGHT RESPITE CARE APPLICATION

Part 2: Health Status Declaration Form (To be completed by Applicant)

Current Functional Status
How competent is the client in the following areas?

Communication

Able to understand others:
☐ All the time ☐ Often times
☐ Sometimes ☐ Not at all

Able to make himself understood by others (can express):
☐ All the time ☐ Often times
☐ Sometimes ☐ Not at all

Cognition & Memory

Making safe and reasonable decisions:
☐ Independent ☐ Occasionally unsafe
☐ Always unsafe ☐ Unable to make safe & reasonable decisions

Short Term Memory:
☐ Good ☐ Fair ☐ Poor

Recognising people and places:
☐ Good ☐ Fair ☐ Poor

Vision

☐ Can see well
☐ Can see with difficulty
☐ Impaired

Hearing
☐ Can hear well
☐ Can hear with difficulty
☐ Impaired
☐ Using hearing aid

Dentures
☐ Yes ☐ No

Mobility Status
☐ Walks independently
☐ Walks using walking aid
☐ Wheelchair Bound

Assistance level:
☐ Independent ☐ Requires assistance

Transfer (wheelchair to toilet)
☐ Independent
☐ Requires assistance?

Toilet Use
☐ Independent
☐ Requires assistance?
☐ Urinary catheter

Diapers
☐ Yes ☐ No

Oral Feeding
☐ Independent
☐ Need help
☐ Tube feeding

Falls

Any falls recently?
☐ None in the last 90 days
☐ One or more in last 90 days

Activity Tolerance

Any shortness of breath?
☐ None
☐ When doing exercise
☐ At rest

Behaviour

Difficulty sleeping at night	☐ Frequently	☐ Sometimes	☐ Not at all
Daytime napping	☐ Frequently	☐ Sometimes	☐ Not at all
Increased behaviours of concern* towards night time	☐ Frequently	☐ Sometimes	☐ Not at all
Wandering	☐ Frequently	☐ Sometimes	☐ Not at all
Shouting/screaming	☐ Frequently	☐ Sometimes	☐ Not at all
Hits/shoves/pinches	☐ Frequently	☐ Sometimes	☐ Not at all
Hoarding/rummaging	☐ Frequently	☐ Sometimes	☐ Not at all
Disrobing/inappropriate behaviour	☐ Frequently	☐ Sometimes	☐ Not at all
Resists care (feeding, taking medication, toileting)	☐ Frequently	☐ Sometimes	☐ Not at all

**Symptoms include restlessness, agitation, suspicious behaviour, disorientation, visual and auditory hallucination.*

The above declaration will be taken into consideration together with the Provider's pre-admission, to assess the total care needs of person needing care. Please note that final admission will be at the discretion of Provider.

Please list allergies (food, drug, bee stings etc.), symptoms and treatment if known:

Please tell us any other information you would like us to know about the client, if any:

I hereby make an application for admission into the Night Respite Care service and agree to the terms and conditions as listed.

I declare that the person needing care applying for admission to the program is free from infectious or contagious diseases to the best of my knowledge and belief, and that I have not wilfully suppressed any material fact.

I declare that the particulars stated in Parts 1 and 2 and the documents submitted together with this application are true and correct to the best of my knowledge and understanding, and that I have not wilfully suppressed any material fact.

I hereby give my consent for your organisation and the referral source(s) (if applicable) to collect the information provided by me in this application (including in the supporting documents submitted), and disclose it to any relevant person or organisation for the purpose of assessment and processing of this application, including verification of the information provided by me. The information provided by me will be kept confidential.

I also hereby give my consent for your organisation to disclose the information (including in the supporting documents submitted) provided by me in this application, and any information about me or the person needing care in relation to the enrolment and participation of the person needing care in the program, to the Ministry of Health to facilitate the administration of Night Respite Care service (including funding for such services) and to evaluate, analyse and review such services.

If there are any changes to the client's medical condition while he/she is enrolled in the service, I will notify the centre manager at that time.

_____	_____	_____
Name of Applicant & NRIC	Signature or Right Thumb Impression of Applicant	Date (dd/mm/yyyy)

FOR OFFICIAL USE (FOR SERVICE PROVIDER)

Respite Care Reference No: _____

Date application was received: _____

Staff in-charge: _____ Provider: _____

Staff contact No./ email: _____

Has household means testing been conducted for client?

☐ **Yes**

Funding Level: _____% (For Non-Residential Funding)

Date of Expiry: ____(dd)____(mm)____(yyyy)

☐ **No**

(Note: Please complete the Means-Test Declaration Form available on AIC website www.aic.sg/resources/means%20testing. ***Please indicate the scheme, 'Non-Residential MOH ILTC').***

After completion, please submit the form and required documents to your Provider who will assist with the means-test procedure.

Application Status:

☐ Approved

☐ Rejected. Reason: _____

☐ Withdrawn. Reason: _____

☐ Transferred to: _____ (centre name)

Status Date: _____ (dd/mm/yyyy)

Commencement of Service Date (if known): _____ (dd/mm/yy)

Remarks (if any):

List of Providers by Region for Night Respite Care Service

S/N	Region	Centre	Address	Operation Day/Time (except PHs)	Contact Number
1	West	St Joseph's Home	36 Jurong West St 24 Singapore 648141	Monday – Saturday 7pm – 7am	Tel: 6268 0482 Fax: 6268 4787
2	East	The Salvation Army Peacehaven Nursing Home	9 Upper Changi Road North Singapore 507706	Monday – Saturday 7pm – 7am	Tel: 6546 5674 Fax: 6546 1831

Accurate as of 9 December 2019