The Sally Panfel In-Home Care & Respite Program

Application-Part I

Name:		Date of Birth:			
Address:		County:			
Phone:		Email:			
Insurance(s):					
Contact Person:		Relationship:		Phone:	

I am currently receiving help at home from the following agencies:

County Office of Aging/Senior Services ☐
Insurance Funded RN/PT/OT ☐
VA (Veterans' Administration) ☐
LTC Policy (Long Term Care) ☐
Private Caregiver/Agency ☐
Palliative Care ☐
Hospice ☐
Medicaid Waiver/Home Care Programs ☐
None (No Services at this time) ☐

Agency: ________________________ Contact Person and Phone number: ______________________________

This program has limited funds, therefore, in general, The Sally Panfel In-Home Care and Respite Program Funds are not to be used to provide in-home care services where this service is adequately covered through a LTC policy, community agency, or hospice.

I am requesting_______hours per day, _________days per week. Preferred time of day is____________
(Hours can range from minimum of 2 to 12 maximum hours weekly depending upon circumstances)

What types of care does the person living with ALS currently require? (Check all that apply)

☐ Bathing
☐ Dressing
☐ Range/Motion Exercises
☐ Meal Preparation
☐ Feeding (feeding tube? Y/N)
☐ Other(explain)
☐ Transfers (Hoyer lift? Y/N)
☐ Light Housekeeping

Are you currently using any of the following equipment?
☐ BiPap ☐ Tracheotomy(Ventilator) ☐ Suction Machine ☐ Cough Assist

If yes, how often do you use the equipment? ____

If yes, how many hours do you use the machine?

☐ 2-4 hours ☐ 6-8 hours ☐ 8-10 hours ☐ Overnight ☐ 24 hours ☐ Other

ALS ASSOCIATION
Georgia Chapter

Current physical condition: Weight: ________________ Height: ___________________

Please check equipment you utilize: ☐ Transport Wheelchair ☐ Power Wheelchair ☐ Walker/Rollator

Do you use a communication device? ☐ Yes ☐ No If yes, what type? ______________________

Pet in the home? ☐ Yes ☐ No If yes, what type of pet? _____________________

Smoking in home? ☐ Yes ☐ No

Section must be completed

- **Based on understanding of program guidelines and limitations; what is the current plan of care to address patient needs beyond the Panfel opportunity?**

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By agreement with the ALS Association of Georgia, Inc., I understand that if approved for The Sally Panfel In-Home Care and Respite Program, services will be provided by a preferred provider of ALS Association of Georgia, Inc. I authorize the In-Home Care Coordinator to release and obtain any information necessary to complete this referral.

I have read The Sally Panfel In-Home Care and Respite Program guidelines and I understand that services will be provided on a limited basis.

By signing below, I also acknowledge that the ALS Association of Georgia, Inc., is not a provider of medical services, and is only arranging for Respite Care treatment by a third-party provider. The ALS Association of Georgia, Inc. will not be providing medical services of any kind. As such, by signing below you hereby agree to release the ALS Association of Georgia, Inc. from any legal claims you, or any party related to you, may have arising out of the negligence or other actions of the third-party Respite Care provider.

Person living with ALS or Caregiver Signature: ________________________ Date: ____________________

Return Form To:
The ALS Association of Georgia, Inc.
ATTN: Care Services Team
5881 Glenridge Drive, Suite 200 Atlanta, GA 30328
Fax: 404-636-9949 or Email: careservices@alsaga.org