Respite Care
of San Antonio
Caring for children with special needs.

Dear Parent/Guardian,

Thank you for inquiring about Respite Care of San Antonio, Inc.

Enclosed you will find a registration packet. Please complete the packet and return it in its entirety. All forms must be completed to be considered for registration.

Please include copies of the following documents:

- 4 consecutive pay check stubs OR most recent tax return (pages 1 and 2)
- If anyone is receiving SSI, Food Stamps, TANF or child support
  - must include copies of award letters
- Immunization Records

If child will be using Davidson Respite House we will also need a copy of:

- Birth Certificate
- Health Insurance Card
- Social Security Card

Please <u>have the doctor sign</u> the following forms:

- ***Admission and Medical Information***
- ***Parent/Practitioner Medication Authorization***
  If child is taking medication, please attach prescription to application.
  Medication orders are only necessary if your child will be taking medication or receiving treatment while in care.

  ****NO MEDICATIONS WILL BE GIVEN WITHOUT DOCTORS ORDERS.****

If you have questions or need help completing the packet, please contact Nickol Gomez at (210) 737-1212 ext. 2015. We look forward to serving your loved one's needs.

Sincerely,
The Program Team

ADMISSION & MEDICAL INFORMATION

Child's Name	Date of Birth	Gender ☐Male ☐Female	Home Telephone Number

Child's Diagnosis	☐ nonverbal ☐limited speech ☐ verbal

Child's Home Address	City, State and Zip Code
Name of School (if applicable)	School District
Mother / Guardian Name	Address (if different from child's address)
Father / Guardian Name	Address (if different from child's address)

List telephone numbers where parent's guardian may be reached while child will be in care	Mother' / Guardian Telephone	Father / Guardian Telephone	e-mail address

Give the name, address and phone number of person to call **in case of emergency** if parents/guardian cannot be reached

Name	Address	Phone	Relationship

I hereby authorize the childcare operation to allow my child to leave the childcare operation ONLY with the following persons. Please list name and telephone number for each. Children will only be released to a parent or a person designated by the parent/guardian after verification of ID.

1)	2)	3)

Family: Tell us about your family_____

CHECK ALL THAT APPLY

1. TRANSPORTATION: I hereby ☐ give ☐ do not give consent for my child to be transported for emergency care

2. FIELD TRIPS: I hereby ☐ give ☐ do not give consent for my child to be transported to and participate in field trips

3. WATER ACTIVITIES: I hereby ☐ give ☐ do not give consent for my child to participate in water activities
☐ sprinklers ☐ splashing/wading pools ☐ water table play

4. RECEIPT OF PARENT HANDBOOK: ☐ I acknowledge receipt of the facility's operation policies including those for discipline and guidance.

5. PUBLICITY RELEASE: I hereby ☐ give ☐ do not give consent for my child's photograph to be used for publicity.

6. THERAPIES RECEIVED: ☐ECI Services ☐Occupational Therapy ☐Physical Therapy ☐Speech Therapy ☐Applied Behavior Analysis ☐None

Child daycare operations are public accommodations under the Americans with Disabilities Act (ADA), Title III. If you believe that such an operation may be practicing discrimination in violation of Title III, you may call the ADA Information Line at (800) 514-0301 (voice) or (800)-514-0383 (TTY).

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION:

In the event I cannot be reached to make arrangements for emergency medical care, I authorize the person in charge to take my child to:

Name of Primary Care Physician:	Address:	Phone Number:
Name of Emergency Medical Facility:	Address:	Phone Number:

☐ I give consent for the facility to secure any and all necessary emergency medical care for my child.

Please list any specialists that may provide us with information important to the care of your child

Name of Physician:	Specialty:	Address:	Phone Number:

MEDICAL INSURANCE INFORMATION ☐ My child is not insured ☐ My child is insured by: _____

Please list any behavioral information that may be important to the care of your child

Behavior:	Antecedent:	Plan of correction:	Reward/ Consequence

How did you hear about us? _____ **Referred by:** _____

ADMISSION & MEDICAL INFORMATION

Child's Name	Date of Birth	Child's Diagnosis

ADMISSION REQUIREMENT

☐ My child **does not attend** a pre-kindergarten or school away from Respite Care of San Antonio, Inc.

Children who are not in school will need this form signed by both a health care professional and the parent.

Check one of the following boxes:

1. ☐ **HEALTH CARE PROFESSIONAL'S STATEMENT:** **See Parent/ Practitioner's Authorization**
2. ☐ I have attached a signed and dated copy of a health care professional's statement.
3. ☐ Medical diagnosis and treatment conflict with the tenets and practices of a recognized religious organization, which I adhere to or am a member of; I have attached a signed and dated affidavit stating this.

☐ My child **is school age** and attends a pre-kindergarten or school away from Respite Care of San Antonio, Inc.

☐ My child has been examined within the past year by a health care professional and is able to participate in the day care program.

☐ My child has received both a vision and hearing screening in the past year.

☐ Current Well Child Summary

ALLERGY INFORMATION

☐ My child has no known allergies ☐ My child is allergic to the following: _____

Medication:_____ Reaction: _____Response:_____
Medication:_____ Reaction: _____Response:_____
Food:_____Reaction: _____Response:_____
Other:_____Reaction: _____Response:_____

Height:_____ Weight: _____

MEDICAL / INTERVENTIONS / SPECIAL DIET REQUIREMENTS

Any interventions to be administered at RCSA programs must be accompanied by a **Parent / Practitioner Authorization** form.

☐ My child has no SPECIAL DIET requirements ☐ My child has no special MEDICAL INTERVENTION requirements

☐ My child has a special diet (explain):_____

☐ My child has: ☐ A FEEDING TUBE ☐ NEBULIZER ☐ CATHETER ☐ STOMA / BAG: _____ ☐ DIAPERS

Explain:_____

Other: _____

Special Equipment: (list)_____

MEDICATIONS

Any medications to be administered at RCSA programs must be accompanied by a **Parent / Practitioner Authorization** form.

☐ My child takes NO medication ☐ My child takes the following medications

Medication:_____ Dosage: _____ Frequency:_____ Reason:_____

Medication:_____ Dosage: _____ Frequency:_____ Reason:_____

Medication:_____ Dosage: _____ Frequency:_____ Reason:_____

HOSPITALIZATION / SURGICAL HISTORY

☐ My child **HAS NOT** been hospitalized in the past 12 months ☐ My child **HAS** been hospitalized in the past 12 months

☐ My child **HAS NOT** had surgery in the past 12 months ☐ My child **HAS** had surgery in the past 12 months

If Yes, please list (date & reason): _____

_____ _____ _____ _____
Health Care Professional's Signature Date Parent/Guardian's Signature Date

_____ _____
Health Care Professional's Printed Name or Stamp Parent/Guardian's Printed Name

Parent/ Practitioner's Authorization

Medication Administration, TB Questionnaire, Immunization, Examination & Orders

Child (participant's) Name:_____DOB:_____
Allergies:_____
Medications: _____

For allergy and/or emergency purposes, please provide a list of ALL medications/supplements your child is currently taking.

Medication Authorization

If your child will need medication administered or any other type of nursing care while he/she is in the care of Respite Care of San Antonio a **doctor's order is required** before any medication or treatment can be administered. The order must state the name of the patient and medication, the dosage, time, frequency and route of administration. A start and end date (or "ongoing") should be indicated. It must be signed and dated and must match the orders on the prescription bottle provided. We cannot provide care for your child unless ordered medications are provided. Any PRN or "as needed" medication must list the indicators of the need. If any changes are made, to include discontinuing a medication, the updated order must be provided prior to administration.

Tuberculosis (TB) Screening

Place a mark in the appropriate box:	Yes	No	Unknown
TB can cause fever of long duration, unexplained weight loss, a bad cough (lasting over two weeks), or coughing up blood. As far as you know, has the above named individual: -been anyone around with these symptoms or problems? OR -been anyone around diagnosed with TB? OR -had any of these symptoms?			
Was the above named individual born in Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia?			
Has the above named individual traveled in the past year to Mexico, or any other country in Latin America, the Caribbean, Africa, Eastern Europe, or Asia for longer than 3 weeks? If so, specify the country/countries: _____			
To your knowledge has the above named individual spent time (longer than 3 weeks) with anyone who is/has been an intravenous (IV) drug user, HIV–infected, in jail or prison or recently came to the United States from another country?			

Has the above named individual been tested for TB? YES NO If yes, specify date: _____
Has the above named individual ever had a positive TB skin test? YES NO If yes, specify date: _____

Immunization Record

☐ I have provided a copy of my child's most recent and up to date immunization record.

☐ I am excluding my child from the immunization requirements for reasons of conscience, including a religious belief. I have attached an official notarized affidavit form developed and issued by the Department of State Health Services. I understand this affidavit is valid for 2 years.

☐ I have read and understand the above information and attest that all information I have provided is accurate. I authorize any medication and/or treatment to be administered per doctor's orders.

☐ I have read and understand the above questions on TB and attest that all information I have provided is accurate.

_____ _____ _____
Parent/Guardian Signature Date Parent/Guardian's Printed Name

For completion by Health Care Provider:

Based on the information provided above, does the above named individual require a PPD? _____YES ____NO

If yes, date administered _____ Date read _____ Results? _____

☐ I have examined the above named child within the past year and find that he/she is able to take part in the day care program.

☐ I have provided a copy of the child's most recent and up to date immunization record.

☐ I have provided a copy of the child's most recent medical orders (medication and medical intervention i.e. g-tube, nebulizer,etc.).

_____ _____ _____
Health Care Professional's Signature Date Health Care Professional's Printed Name or Stamp

Respite Care of San Antonio
Caring for children with special needs.

Submitted: _____

Respite Care of San Antonio, Inc.
Family Financial Information

Office Use Only:
Name: _____
Rate DC: _____DRH:_____
THI: _____ HUD: _____

Name: _____
Rate DC: _____DRH:_____
THI: _____ HUD: _____

Review Date _____ by: _____

Participant Name _____ DOB_____ Phone Number_____
Address _____
Number in Household _____ Number claimed on last tax return _____ Single Parent Family? **Yes** **No**

	Names of Household Members	Date of Birth	Relationship to Participant
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Please list employment information for all adults in household:

Household Member	Place of Employment	Rate of Pay	Per: (circle one)	If paid per hour, # Hrs. per week	Avg # Overtime Hrs./week
		$	Hr./ Mo./Yr.		
		$	Hr./ Mo./Yr.		
		$	Hr./ Mo./Yr.		

For each individual listed above, please provide most recent Federal tax return OR 4 consecutive payroll check stubs.

Do parents within the household attend school? **Yes** **No** If yes, is parent attending school: **Full time** **Part time**
School attending: _____

Do any members of household receive SSI or Social Security Benefits? **Yes** **No**

List Household Member	Amount per month

Please provide copy of Social Security Award letters for each listed person.

Do you receive child support for children in your household? **Yes** **No** Amount per Month $_____

Do you receive Food Stamps? **Yes** **No**
Do you receive TANF? **Yes** **No**
Do you receive Housing Assistance? **Yes** **No**
Do you receive any other government assistance? **Yes** **No**

Type of Assistance/Program	Amount per month
	$

Please provide copies of all award letters.

Participant Name _____

Please list any other source of household income:

Type of income	Amount per month

For *reporting purposes only*, please provide participant's ethnicity:

Race: ☐ Anglo ☐ Asian ☐ African American/Black ☐ American Indian/ Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Other (Indicate)_____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

I certify that the above information is true and correct to the best of my knowledge. I understand the above information may be used to determine eligibility for financial assistance from Federal, State and/or local government agencies for respite care/ daycare services and is subject to verification by authorized government agency officials. Should any undisclosed information or incorrect information result in funding sources disallowing my bill, I understand I will be responsible for those fees.

_____ _____

Signature of Parent or Guardian Date

_____ _____

Print Name & Relationship to Participant Phone Number

************Respite Care Accounting Office Use Only************

Income Type	Documentation Received	Totals from above
Employment		$
Social Security		$
Child Support		$
Government Assistance		$
Other / SNAP		$
Total		$

1. # persons in the household: _____
2. Gross annual income for the household: _____
3. Select the line below that corresponds to the household size and gross annual income.

FY 2016 INCOME LIMITS – CITY OF SAN ANTONIO (effective March 6, 2016)

Household Size	Extremely Low Income (30% of Median)	Very Low Income (50% of Median)	Low Income (80% of Median)
1	_____$13,100 or lower	_____ $13,101 to $21,750	_____ $21,751 to $34,800
2	_____$16,020 or lower	_____ $16,021 to $24,850	_____ $24,850to $39,800
3	_____$20,160 or lower	_____ $20,161 to $27,950	_____ $27,951 to $44,750
4	_____$24,300 or lower	_____ $24,301 to $31,050	_____ $31,051 to $49,700
5	_____$28,440 or lower	_____ $28,441 to $33,550	_____ $33,551 to $53,700
6	_____$32,580 or lower	_____ $32,581 to $36,050	_____ $36,051 to $57,700
7	_____$36,730 or lower	_____ $36,731 to $38,550	_____ $38,550 to $61,650
8	_____$40,890 or lower	_____ $40,891 to $41,000	_____ $41,001 to $65,650

Respite Care of San Antonio
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Child (participant) Name: _____ DOB: _____

Release of Liability

I, the parent/guardian of_____understand that any respite worker of Respite Care of San Antonio, Inc., (RCSA) has been screened and has received special training and orientation by RCSA. I agree that Respite Care of San Antonio, Inc., shall not, under any circumstances be liable under or by reason of this agreement, directly or indirectly, for accident or injury to any person or persons during the course of providing and receiving respite services.

I assume the risk of all damage, loss, costs and expenses and agree to indemnify and hold harmless Respite Care of San Antonio, Inc., its officers, agents, and employees, from and against any and all claims, losses, damages, cause of action, suits and liability of every kind including all expenses of litigation, court costs, and attorney's fees for injury to any person or persons caused by the negligence of Respite Care of San Antonio, Inc. or the joint negligence of Respite Care of San Antonio, Inc. and any other person or entity.

Furthermore, I will indemnify the respite worker from and against any and all losses or damages which may sustain by reason of injury to any person or persons or damage to property while the respite worker is engaged in performing the services arising out of and within the scope of performance of this agreement, other than those which may arise in part out of the contributory negligence of the respite worker.

In addition, I herby agree to indemnify Respite Care of San Antonio, its agents, employees and servants from all liability or claims, demands, damages and costs for or arising out of any of the services provided by RCSA during any respite provided at a facility base. ☐_____**Initials**

Individual Service Plan/ Rates Agreement

This mutual agreement year begins_____and ends_____. Respite Care of San Antonio, Inc, agrees to:

1. Provide specially trained respite workers who will care for your child during the absence of the parent/guardian, including assistance with medication.
2. Notify the parent/guardian or emergency contact and/or obtain authorized emergency services, in case of an emergency while respite is being conducted.

The Parent/Guardian agrees to:

1. Provide accurate information on the needs of the child including any dangerous or potentially dangerous conditions or tendencies.
2. Follow appropriate procedures for scheduling and utilizing respite services: (**A**) call RCSA in advance (**B**) make all respite arrangements through the office, including change of time and cancellation at (210) 737-1212.
3. Assure that all medications, prescribed and non-prescribed, have current practitioner's orders, are properly labeled and in sufficient quantity.
4. Give RCSA all relevant information needed to contact you or a responsible party to obtain medical services in an emergency situation.
5. Furnish enough clean clothes, foods, diapers, supplies, and necessary adaptive equipment for your child.
6. Provide a description of your child's daily routine and activities of care.
7. Pay for services at the negotiated rate by the end of each week.
8. Follow the Participant Handbook that contains the quality assurance guidelines. ☐_____**Initials**

Email	Service	Rate	Service	Rate	Service	Rate	Service	Rate	Service	Rate	Service	Rate	Service	Rate
Adm Initial Date Called	Daycare	$	Extended Care	$10	After School	$50.00	Davidson Respite House	$	Mother's Day Out	$5.00	Family Day Out	$10.00	Parent's Night Out	$5.00
		per wk	4-6pm	per wk	3:30-6pm	per wk		per night		per day		per day		per night

Rates are determined by RCSA staff upon review of supportive financial information.

Release of Information

I authorize Respite Care of San Antonio, Inc. and its administrative and clinical team to obtain the following information. Check all that apply.

☐ Discharge Summary	☐ Cognitive / Mental Health reports	☐ Medical testing / records
☐ Diagnosis	☐ Advanced Directives	☐ ECI/ Therapy / Education reports /plan
☐ Immunization Record	☐ Practitioner / Physician's Order	☐ Family financial information

This information will be used to provide care for your child utilizing services with Respite Care of San Antonio, Inc.(RCSA) All information is regarded as confidential to outside entities. I understand that all information regarding my child, his / her care, their history, health, medical and behavioral information as well as family information pertinent to receiving services will be shared within RCSA agency. All information will be maintained in my child's file. I understand information may be shared with funding entities outside of RCSA in order to ensure compliance with funding, licensing or contractual agreements. This Authorization is in effect for the time that my child is registered to utilize services from RCSA. I understand that I have the right to revoke this authorization.

☐_____**Initials**

I have provided RCSA all necessary personal, medical, financial and behavioral information needed for the proper care and protection of my child.

_____ _____ _____ _____

Parent/Guardian Date RCSA Staff Member Date