



Dear Parent,

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 completely filled out.

Don't forget to include copies of the following documents:

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

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

- Birth Certificate
- Health Insurance Card
- Social Security Card

Don't forget to have the doctor sign the following forms:

- *Admission and Medical Information*
- *Parent/Practitioner Medication Authorization*

If child is taking meds, attach prescription to application.

Medication orders only necessary if your child will be taking medication or receiving treatment while in care. ***NO MEDS WILL BE GIVEN WITHOUT DOCTORS ORDERS.***

Please contact the office with questions or help completing the packet at (210) 737-1212 ext. 2015. We look forward to serving your loved one's needs.

Sincerely,
The Program Team

Child's Name		Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Home Telephone Number
Child's Diagnosis				<input type="checkbox"/> nonverbal <input type="checkbox"/> limited speech <input type="checkbox"/> 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 <input type="checkbox"/> give <input type="checkbox"/> do not give consent for my child to be transported for emergency care	
2. FIELD TRIPS: I hereby <input type="checkbox"/> give <input type="checkbox"/> do not give consent for my child to be transported to and participate in field trips	
3. WATER ACTIVITIES: I hereby <input type="checkbox"/> give <input type="checkbox"/> do not give consent for my child to participate in water activities <input type="checkbox"/> sprinklers <input type="checkbox"/> splashing/wading pools <input type="checkbox"/> water table play	
4. RECEIPT OF PARENT HANDBOOK: <input type="checkbox"/> I acknowledge receipt of the facility's operation policies including those for discipline and guidance.	
5. PUBLICITY RELEASE: I hereby <input type="checkbox"/> give <input type="checkbox"/> do not give consent for my child's photograph to be used for publicity.	
6. THERAPIES RECEIVED: <input type="checkbox"/> ECI Services <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Speech Therapy <input type="checkbox"/> Applied Behavior Analysis <input type="checkbox"/> 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:
<input type="checkbox"/> 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 <input type="checkbox"/> My child is not insured <input type="checkbox"/> 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 Cont.

Child's Name (cont)	Date of Birth (cont)	Child's Diagnosis (cont)
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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 (client'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

<input type="checkbox"/> I have provided a copy of my child's most recent and up to date immunization record.
<input type="checkbox"/> 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, Inc.
Family Financial Information
 Page 1 of 2

For Office Use Only:	
Name: _____	
Rate DC: _____	DRH: _____
THI: _____	HUD: _____

Please complete the information requested regarding your family's income to assist RCSA in determining your eligibility for financial assistance for Respite fees.

Participant Name _____ DOB _____ Phone Number: _____

Residence 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**

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 Housing Assistance? **Yes No**
 Do you receive TANF? **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 _____

Family Financial Information, pg 2 of 2

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 **Ethnicity:** Hispanic
 American Indian/ Alaska Native Non-Hispanic
 Native Hawaiian or Other Pacific Islander
 Other (Indicate) _____

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

Daytime Phone Number

Respite Care Accounting Office Use Only

	Rec'd documentation	Totals from above
Employment Income		
Social Security Income		
Child Support Income		
Government Assistance		
Other		
Total		

- How many persons in the household? _____
- What is the gross annual income for the household? _____
- Please check the line below corresponding to the household size and gross annual income. Only one line should be checked.

FY 2015 INCOME LIMITS – CITY OF SAN ANTONIO (effective March 2015)

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 \$21,800	_____ \$21,801 to \$34,850
2	_____ \$15,930 or lower	_____ \$15,931 to \$24,900	_____ \$24,932 to \$39,800
3	_____ \$20,090 or lower	_____ \$20,091 to \$28,000	_____ \$28,001 to \$44,800
4	_____ \$24,250 or lower	_____ \$24,251 to \$31,100	_____ \$31,101 to \$49,750
5	_____ \$28,410 or lower	_____ \$28,411 to \$33,600	_____ \$33,601 to \$53,750
6	_____ \$32,570 or lower	_____ \$32,571 to \$36,100	_____ \$36,101 to \$57,750
7	_____ \$36,730 or lower	_____ \$36,731 to \$38,600	_____ \$38,601 to \$61,700
8	_____ \$40,890 or lower	_____ \$40,891 to \$41,100	_____ \$41,101 to \$65,700



Release & Agreement

Child (client's) 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 hereby 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 and 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.
8. Follow the Participant Handbook that contains the quality assurance guidelines. _____ Initials

<input type="checkbox"/> Email	Rate	Service	Rate	Service	Rate	Service	Rate	Service	Rate	Service	Rate	Service	Rate	Service
Admin Initial/Date	\$	Daycare	\$ 10	Extended Care	\$50.00	After School	\$5.00	Mother's Day Out	\$	Davidson Respite House	\$10.00	Family Day Out	\$5.00	Parent's Night Out
<input type="checkbox"/> Called	week		week	4-6pm	week	3:30-6p	day		night		day		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.

<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Cognitive / Mental Health reports	<input type="checkbox"/> Medical testing / records
<input type="checkbox"/> Diagnosis	<input type="checkbox"/> Advanced Directives	<input type="checkbox"/> ECI/ Therapy / Education reports /plan
<input type="checkbox"/> Immunization Record	<input type="checkbox"/> Practitioner / Physician's Order	<input type="checkbox"/> 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