



Dear Parent/Guardian,

Thank you for inquiring about Respite Care of San Antonio, Inc. We are excited for you to be a part of our community and are sure you will enjoy the many services we have to offer. These include:

- a. Mother's Day Out (MDO)
- b. Family Day Out (FDO)
- c. Parent's Night Out (PNO)
- d. Respite Developmental Daycare
- e. School Age Programming (After School and Camp)
- f. Respite Weekend and Holiday Overnight Services (DRH)

Enclosed you will find a registration packet. Please complete the packet and return it in its entirety along with all required registration materials. All forms must be completed and submitted (one per household) to be considered for our programs. If an incomplete application is submitted, registrants will have 5 business days to complete their packet unless an extension is requested and approved by Respite Care Administration. We require all our families who qualify to apply for Child Care Service (CCS) assistance. Any family that does not qualify and is below the 250% of federal poverty can apply for Respite Care of San Antonio's Financial Hardship. At the end of this registration, you will find information on CCS Eligibility and our Hardship Application.

Required Registration Materials:

DRH Required Documents	Daycare Required Documents	Days Out Required Documents
Completed Registration Packet	Completed Registration Packet	Completed Registration Packet
Proof of Household Income (SNAP, SSI, TANF, etc.) Last 90 Days Paystubs (4 consecutive) Tax Return (page 1 and 2)	Proof of Household Income (SNAP, SSI, TANF, etc.) Last 90 Days Paystubs (4 consecutive) Tax Return (page 1 and 2)	Proof of Household Income (SNAP, SSI, TANF, etc.) Last 90 Days Paystubs (4 consecutive) Tax Return (page 1 and 2)
Immunization Record	Immunization Record	Immunization Record
Birth Certificate	Birth Certificate	
Social Security Card	Social Security Card	
Health Insurance	Health Insurance	
Proof of Guardianship	Proof of Guardianship, if applicable	
	CCS Application	

Please have the doctor sign the following forms:

1. **Admission and Medical Information**
2. **Parent/Practitioner Medication Authorization**

Medication orders are only necessary if your child is taking medication or receiving treatment while in care.

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

We have an on-site clinic in collaboration with UT Health Clinic, available to expedite the completion of these forms for you. For more information, please call UT Health at 210-738-1636.

If you have questions or need help completing the packet, please contact Alma Alvarado at (210) 737-1212 ext. 2015/aalvarado@respitcare.org or Nickol Gomez at ext. 2029/ngomez@respitcare.org.

We look forward to serving your loved one's needs.

The Program Team

ADMISSION & MEDICAL INFORMATION

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 the 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)		
CHECK ALL THAT APPLY				
1. SERVICE INTEREST: <input type="checkbox"/> Daycare <input type="checkbox"/> Mother's Day Out <input type="checkbox"/> Weekends <input type="checkbox"/> Overnight <input type="checkbox"/> After School/Camp				
2. TRANSPORTATION: I hereby <input type="checkbox"/> give <input type="checkbox"/> do not give consent for my child to be transported for emergency care				
3. 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				
4. 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. Is your child able to swim without assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, what type of assistance is needed: _____				
5. RECEIPT OF PARENT HANDBOOK: <input type="checkbox"/> I acknowledge receipt of the facility's operation policies including those for discipline and guidance.				
6. 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.				
7. 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 (hospital):	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

ADMISSION & MEDICAL INFORMATION

Child's Name	Date of Birth	Child's Diagnosis
ADMISSION REQUIREMENT		
<input type="checkbox"/> My child does not attend a pre-kindergarten or school away from Respite Care of San Antonio, Inc. <i>Children not in school need this form signed by both a health care professional and the parent.</i> Check one of the following boxes: <input type="checkbox"/> HEALTH CARE PROFESSIONAL'S STATEMENT: See Parent/ Practitioner's Authorization <input type="checkbox"/> 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.		
<input type="checkbox"/> My child is school age and attends a pre-kindergarten or school away from Respite Care of San Antonio, Inc. Provide all of the following boxes: <input type="checkbox"/> My child has been examined within the past year by a health care professional and is able to participate in the day care program. <input type="checkbox"/> My child has received both a vision and hearing screening in the past year. (Required if 4 y/o and older) <input type="checkbox"/> Current Well Child Summary		
ALLERGY INFORMATION		
<input type="checkbox"/> My child has no known allergies <input type="checkbox"/> Environmental allergies. <input type="checkbox"/> My child is allergic to the following (provide action plans for all that apply): _____ Medication: _____ Reaction: _____ Response: _____ Medication: _____ Reaction: _____ Response: _____ Food: _____ Reaction: _____ Response: _____ Other: _____ Reaction: _____ Response: _____		
Height: _____ Weight: _____		
MEDICAL INTERVENTIONS / SPECIAL DIET REQUIREMENTS/CHILDS SPECIAL CARE NEEDS		
Any interventions to be administered at RCSA programs must be accompanied by a Parent / Practitioner Authorization form . <input type="checkbox"/> My child has NO special diet requirements <input type="checkbox"/> My child has NO special medical intervention requirements. <input type="checkbox"/> My child has a SPECIAL DIET (provide special diet order) <input type="checkbox"/> Food intolerances <input type="checkbox"/> Existing Illness <input type="checkbox"/> Previous Serious Illness <input type="checkbox"/> Limitations/Restrictions on Childs Activities <input type="checkbox"/> Reasonable Accommodations/Modifications <input type="checkbox"/> Symptoms/Indications of Complications <input type="checkbox"/> A FEEDING TUBE <input type="checkbox"/> NEBULIZER <input type="checkbox"/> CATHETER <input type="checkbox"/> DIAPERS <input type="checkbox"/> ADAPTIVE EQUIPMENT (list below) <input type="checkbox"/> STOMA BAG Explain: _____ Other: _____ Special Equipment List: _____		
MEDICATIONS		
Any medications to be administered at RCSA programs must be accompanied by a Parent / Practitioner Authorization form . <input type="checkbox"/> My child takes NO medication. <input type="checkbox"/> My child takes the following medications <input type="checkbox"/> Medications prescribed for continuous long-term use. Medication: _____ Dosage: _____ Frequency: _____ Reason: _____ Medication: _____ Dosage: _____ Frequency: _____ Reason: _____ Medication: _____ Dosage: _____ Frequency: _____ Reason: _____		
HOSPITALIZATION / SURGICAL HISTORY		
<input type="checkbox"/> My child has NOT been hospitalized in the past 12 months. <input type="checkbox"/> My child HAS been hospitalized in the past 12 months. <input type="checkbox"/> My child has NOT had surgery in the past 12 months <input type="checkbox"/> 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 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 for a 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 found 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

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

RCSA Staff Submitted: _____

Choose Program: PNO FDO MDO Daycare DRH Camps

Review Date _____ by: _____

Child's Name: _____ Child's D.O.B: _____ Phone Number: _____

Address: _____ Zip Code: _____

CODE: _____ HOH Email: _____

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.			Head of Household
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
Head of Household		\$	Hr./ Mo./Yr.		
		\$	Hr./ Mo./Yr.		
		\$	Hr./ Mo./Yr.		
		\$	Hr./ Mo./Yr.		
		\$	Hr./ Mo./Yr.		

For each individual listed above, please provide the 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 the household receive SSI or Social Security Benefits? Yes No

List Household Member	Amount per month

Please provide a 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

Child (participant) Name: _____ DOB: _____

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 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. I hereby authorize and give my consent for the release of information pertaining to my record. This authorization grants permission for RCSA to disclose the requested information to abide by city, state and federal guidelines.

I understand and acknowledge that the released information may contain sensitive and confidential data. I hereby release RCSA, its employees, agents, and affiliated parties from any liability that may arise from the disclosure and use of the authorized information, provided such disclosure is made in good faith and in accordance with applicable laws and regulations.

_____ Initials

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

Parent/Guardian Signature

Date

RCSA Staff Member

Date

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. If any changes occur in household income, it should be reported to registration immediately.

Signature of Parent or Guardian

Date

Print Name & Relationship to Participant

Phone Number

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

Demographic Information

Head of Household: _____



For *reporting purposes only*

Gender: Gender identity of the clients served by the program

- Female
 Male
 Other
 Gender Unknown

Age Grouping: Age ranges based on the ages of the clients served by the program.

- | | | |
|--|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Unborn Children | <input type="checkbox"/> 20-24 Years | <input type="checkbox"/> 75-84 Years |
| <input type="checkbox"/> 0-2 Years | <input type="checkbox"/> 25-34 Years | <input type="checkbox"/> 85-Over |
| <input type="checkbox"/> 3-4 Years | <input type="checkbox"/> 35-44 Years | <input type="checkbox"/> Age Unknown |
| <input type="checkbox"/> 5-9 Years | <input type="checkbox"/> 45-54 Years | |
| <input type="checkbox"/> 10-14 Years | <input type="checkbox"/> 55-64 Years | |
| <input type="checkbox"/> 15-19 Years | <input type="checkbox"/> 65-74 Years | |

Race and Ethnicity:

- American Indian or Alaska Native
 Asian
 Black or African American
 Hispanic or Latino
 Native Hawaiian or Other Pacific Islander
 White
 Some Other Race
 Two or More Races
 Race/Ethnicity Unknown

Hispanic or Latino Origin:

- Hispanic or Latino
 Not Hispanic or Latino
 Hispanic or Latino Origin Unknown

Education Level: Highest (or current level of education) achieved by the clients served by the program.

Measured at the client level as a count of the clients.

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Less than Kindergarten | <input type="checkbox"/> 5 th Grade | <input type="checkbox"/> 11 th Grade | <input type="checkbox"/> Associates |
| <input type="checkbox"/> Kindergarten | <input type="checkbox"/> 6 th Grade | <input type="checkbox"/> 12 th Grade | <input type="checkbox"/> Bachelors |
| <input type="checkbox"/> 1 st Grade | <input type="checkbox"/> 7 th Grade | <input type="checkbox"/> HS Diploma | <input type="checkbox"/> Grad or Prof. Degree |
| <input type="checkbox"/> 2 nd Grade | <input type="checkbox"/> 8 th Grade | <input type="checkbox"/> GED or Equivalent | <input type="checkbox"/> Ed. Level Unknown |
| <input type="checkbox"/> 3 rd Grade | <input type="checkbox"/> 9 th Grade | <input type="checkbox"/> Post HS or Equivalent | |
| <input type="checkbox"/> 4 th Grade | <input type="checkbox"/> 10 th Grade | <input type="checkbox"/> Some College (No Degree) | |

Household Composition: Type of household the client(s) served in the program are members of.

Measured at the client level as a count of household/families.

- | | |
|--|---|
| <input type="checkbox"/> Single Parent/ Caregiver Family Household with children (no grandparent(s) present) | <input type="checkbox"/> Single Person Non-Family Household |
| <input type="checkbox"/> Two-Parent/Caregiver Family Household with children (no grandparent(s) present) | <input type="checkbox"/> Household Type Unknown |
| <input type="checkbox"/> Family Household with grandparent(s) responsible for grandchild(ren) present | |
| <input type="checkbox"/> Other Family Household | |
| <input type="checkbox"/> Other Non-Family Household (other than single person) | |

Military Service: Military services status of the clients served by the program. Measured at the client level as a count of clients.

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Active Duty | <input type="checkbox"/> Military Dependent | <input type="checkbox"/> Active Reserve | <input type="checkbox"/> Inactive Reserve |
| <input type="checkbox"/> Veteran (not dishonorable discharge) | <input type="checkbox"/> Discharged- dishonorable | <input type="checkbox"/> National Guard | |
| <input type="checkbox"/> Retired Military | <input type="checkbox"/> Never Served in the Military | <input type="checkbox"/> Military Status Unknown | |

Total number of clients: _____

If more than one client, please write in page _____ of page _____

Demographic Information

Domestic/Partner: _____



For *reporting purposes only*

Gender: Gender identity of the clients served by the program

- Female
 Male
 Other
 Gender Unknown

Age Grouping: Age ranges based on the ages of the clients served by the program.

- | | | |
|--|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Unborn Children | <input type="checkbox"/> 20-24 Years | <input type="checkbox"/> 75-84 Years |
| <input type="checkbox"/> 0-2 Years | <input type="checkbox"/> 25-34 Years | <input type="checkbox"/> 85-Over |
| <input type="checkbox"/> 3-4 Years | <input type="checkbox"/> 35-44 Years | <input type="checkbox"/> Age Unknown |
| <input type="checkbox"/> 5-9 Years | <input type="checkbox"/> 45-54 Years | |
| <input type="checkbox"/> 10-14 Years | <input type="checkbox"/> 55-64 Years | |
| <input type="checkbox"/> 15-19 Years | <input type="checkbox"/> 65-74 Years | |

Race and Ethnicity:

- American Indian or Alaska Native
 Asian
 Black or African American
 Hispanic or Latino
 Native Hawaiian or Other Pacific Islander
 White
 Some Other Race
 Two or More Races
 Race/Ethnicity Unknown

Hispanic or Latino Origin:

- Hispanic or Latino
 Not Hispanic or Latino
 Hispanic or Latino Origin Unknown

Education Level: Highest (or current level of education) achieved by the clients served by the program.

Measured at the client level as a count of the clients.

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Less than Kindergarten | <input type="checkbox"/> 5 th Grade | <input type="checkbox"/> 11 th Grade | <input type="checkbox"/> Associates |
| <input type="checkbox"/> Kindergarten | <input type="checkbox"/> 6 th Grade | <input type="checkbox"/> 12 th Grade | <input type="checkbox"/> Bachelors |
| <input type="checkbox"/> 1 st Grade | <input type="checkbox"/> 7 th Grade | <input type="checkbox"/> HS Diploma | <input type="checkbox"/> Grad or Prof. Degree |
| <input type="checkbox"/> 2 nd Grade | <input type="checkbox"/> 8 th Grade | <input type="checkbox"/> GED or Equivalent | <input type="checkbox"/> Ed. Level Unknown |
| <input type="checkbox"/> 3 rd Grade | <input type="checkbox"/> 9 th Grade | <input type="checkbox"/> Post HS or Equivalent | |
| <input type="checkbox"/> 4 th Grade | <input type="checkbox"/> 10 th Grade | <input type="checkbox"/> Some College (No Degree) | |

Household Composition: Type of household the client(s) served in the program are members of.

Measured at the client level as a count of household/families.

- | | |
|--|---|
| <input type="checkbox"/> Single Parent/ Caregiver Family Household with children (no grandparent(s) present) | <input type="checkbox"/> Single Person Non-Family Household |
| <input type="checkbox"/> Two-Parent/Caregiver Family Household with children (no grandparent(s) present) | <input type="checkbox"/> Household Type Unknown |
| <input type="checkbox"/> Family Household with grandparent(s) responsible for grandchild(ren) present | |
| <input type="checkbox"/> Other Family Household | |
| <input type="checkbox"/> Other Non-Family Household (other than single person) | |

Military Service: Military services status of the clients served by the program. Measured at the client level as a count of clients.

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Active Duty | <input type="checkbox"/> Military Dependent | <input type="checkbox"/> Active Reserve | <input type="checkbox"/> Inactive Reserve |
| <input type="checkbox"/> Veteran (not dishonorable discharge) | <input type="checkbox"/> Discharged- dishonorable | <input type="checkbox"/> National Guard | |
| <input type="checkbox"/> Retired Military | <input type="checkbox"/> Never Served in the Military | <input type="checkbox"/> Military Status Unknown | |

Total number of clients: _____

If more than one client, please write in page _____ of page _____

Demographic Information

Client/Child: _____



For *reporting purposes only*

Gender: Gender identity of the clients served by the program

- Female
 Male
 Other
 Gender Unknown

Age Grouping: Age ranges based on the ages of the clients served by the program.

- | | | |
|--|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Unborn Children | <input type="checkbox"/> 20-24 Years | <input type="checkbox"/> 75-84 Years |
| <input type="checkbox"/> 0-2 Years | <input type="checkbox"/> 25-34 Years | <input type="checkbox"/> 85-Over |
| <input type="checkbox"/> 3-4 Years | <input type="checkbox"/> 35-44 Years | <input type="checkbox"/> Age Unknown |
| <input type="checkbox"/> 5-9 Years | <input type="checkbox"/> 45-54 Years | |
| <input type="checkbox"/> 10-14 Years | <input type="checkbox"/> 55-64 Years | |
| <input type="checkbox"/> 15-19 Years | <input type="checkbox"/> 65-74 Years | |

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- American Indian or Alaska Native
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 Black or African American
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 Two or More Races
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Hispanic or Latino Origin:

- Hispanic or Latino
 Not Hispanic or Latino
 Hispanic or Latino Origin Unknown

Education Level: Highest (or current level of education) achieved by the clients served by the program.

Measured at the client level as a count of the clients.

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Less than Kindergarten | <input type="checkbox"/> 5 th Grade | <input type="checkbox"/> 11 th Grade | <input type="checkbox"/> Associates |
| <input type="checkbox"/> Kindergarten | <input type="checkbox"/> 6 th Grade | <input type="checkbox"/> 12 th Grade | <input type="checkbox"/> Bachelors |
| <input type="checkbox"/> 1 st Grade | <input type="checkbox"/> 7 th Grade | <input type="checkbox"/> HS Diploma | <input type="checkbox"/> Grad or Prof. Degree |
| <input type="checkbox"/> 2 nd Grade | <input type="checkbox"/> 8 th Grade | <input type="checkbox"/> GED or Equivalent | <input type="checkbox"/> Ed. Level Unknown |
| <input type="checkbox"/> 3 rd Grade | <input type="checkbox"/> 9 th Grade | <input type="checkbox"/> Post HS or Equivalent | |
| <input type="checkbox"/> 4 th Grade | <input type="checkbox"/> 10 th Grade | <input type="checkbox"/> Some College (No Degree) | |

Household Composition: Type of household the client(s) served in the program are members of.

Measured at the client level as a count of household/families.

- | | |
|--|---|
| <input type="checkbox"/> Single Parent/ Caregiver Family Household with children (no grandparent(s) present) | <input type="checkbox"/> Single Person Non-Family Household |
| <input type="checkbox"/> Two-Parent/Caregiver Family Household with children (no grandparent(s) present) | <input type="checkbox"/> Household Type Unknown |
| <input type="checkbox"/> Family Household with grandparent(s) responsible for grandchild(ren) present | |
| <input type="checkbox"/> Other Family Household | |
| <input type="checkbox"/> Other Non-Family Household (other than single person) | |

Military Service: Military services status of the clients served by the program. Measured at the client level as a count of clients.

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Active Duty | <input type="checkbox"/> Military Dependent | <input type="checkbox"/> Active Reserve | <input type="checkbox"/> Inactive Reserve |
| <input type="checkbox"/> Veteran (not dishonorable discharge) | <input type="checkbox"/> Discharged- dishonorable | <input type="checkbox"/> National Guard | |
| <input type="checkbox"/> Retired Military | <input type="checkbox"/> Never Served in the Military | <input type="checkbox"/> Military Status Unknown | |

Total number of clients: _____

If more than one client, please write in page _____ of page _____

Demographic Information

Client/Child: _____



For *reporting purposes only*

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- Female
 Male
 Other
 Gender Unknown

Age Grouping: Age ranges based on the ages of the clients served by the program.

- | | | |
|--|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Unborn Children | <input type="checkbox"/> 20-24 Years | <input type="checkbox"/> 75-84 Years |
| <input type="checkbox"/> 0-2 Years | <input type="checkbox"/> 25-34 Years | <input type="checkbox"/> 85-Over |
| <input type="checkbox"/> 3-4 Years | <input type="checkbox"/> 35-44 Years | <input type="checkbox"/> Age Unknown |
| <input type="checkbox"/> 5-9 Years | <input type="checkbox"/> 45-54 Years | |
| <input type="checkbox"/> 10-14 Years | <input type="checkbox"/> 55-64 Years | |
| <input type="checkbox"/> 15-19 Years | <input type="checkbox"/> 65-74 Years | |

Race and Ethnicity:

- American Indian or Alaska Native
 Asian
 Black or African American
 Hispanic or Latino
 Native Hawaiian or Other Pacific Islander
 White
 Some Other Race
 Two or More Races
 Race/Ethnicity Unknown

Hispanic or Latino Origin:

- Hispanic or Latino
 Not Hispanic or Latino
 Hispanic or Latino Origin Unknown

Education Level: Highest (or current level of education) achieved by the clients served by the program.

Measured at the client level as a count of the clients.

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Less than Kindergarten | <input type="checkbox"/> 5 th Grade | <input type="checkbox"/> 11 th Grade | <input type="checkbox"/> Associates |
| <input type="checkbox"/> Kindergarten | <input type="checkbox"/> 6 th Grade | <input type="checkbox"/> 12 th Grade | <input type="checkbox"/> Bachelors |
| <input type="checkbox"/> 1 st Grade | <input type="checkbox"/> 7 th Grade | <input type="checkbox"/> HS Diploma | <input type="checkbox"/> Grad or Prof. Degree |
| <input type="checkbox"/> 2 nd Grade | <input type="checkbox"/> 8 th Grade | <input type="checkbox"/> GED or Equivalent | <input type="checkbox"/> Ed. Level Unknown |
| <input type="checkbox"/> 3 rd Grade | <input type="checkbox"/> 9 th Grade | <input type="checkbox"/> Post HS or Equivalent | |
| <input type="checkbox"/> 4 th Grade | <input type="checkbox"/> 10 th Grade | <input type="checkbox"/> Some College (No Degree) | |

Household Composition: Type of household the client(s) served in the program are members of.

Measured at the client level as a count of household/families.

- | | |
|--|---|
| <input type="checkbox"/> Single Parent/ Caregiver Family Household with children (no grandparent(s) present) | <input type="checkbox"/> Single Person Non-Family Household |
| <input type="checkbox"/> Two-Parent/Caregiver Family Household with children (no grandparent(s) present) | <input type="checkbox"/> Household Type Unknown |
| <input type="checkbox"/> Family Household with grandparent(s) responsible for grandchild(ren) present | |
| <input type="checkbox"/> Other Family Household | |
| <input type="checkbox"/> Other Non-Family Household (other than single person) | |

Military Service: Military services status of the clients served by the program. Measured at the client level as a count of clients.

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Active Duty | <input type="checkbox"/> Military Dependent | <input type="checkbox"/> Active Reserve | <input type="checkbox"/> Inactive Reserve |
| <input type="checkbox"/> Veteran (not dishonorable discharge) | <input type="checkbox"/> Discharged- dishonorable | <input type="checkbox"/> National Guard | |
| <input type="checkbox"/> Retired Military | <input type="checkbox"/> Never Served in the Military | <input type="checkbox"/> Military Status Unknown | |

Total number of clients: _____

If more than one client, please write in page _____ of page _____

Child (participant) Name: _____ DOB: _____

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

Income Type	Documentation Received	Totals from above
Employment		\$
Social Security		\$
Child Support		\$
Government Assistance		\$
Other		\$
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.

*****Quality Assurance Check: Final Review/Approval ADMIN*****

Reviewed On: _____

Approved By (Print): _____

Approval Signature: _____

-----Insert CCS Eligibility Criteria, Hardship Application, State Median Income and Federal Poverty form here-----



DATE: _____

RESPIRE CARE OF SAN ANTONIO (RCSA) ASSESSMENT

Which RCSA programs have you and your family used? (Select all that apply)

Daycare Parent's Night Out Virtual Mother's Day Out Family Day Out

How many children in each of the age groups below have participated in RCSA programs?

0-2 _____ 3-4 _____ 5-8 _____ 15-17 _____

How many times have you used the services you circled above?

Daycare _____ Parent's Night Out _____ Mother's Day Out _____ Family Day Out _____

Relationship of Person Completing Form?

Parent Guardian Foster Parent Other _____

Instructions: For each statement, please place a CHECK on the response that best described how the statement applies to you.					
<ul style="list-style-type: none"> • Parent Stress Index (PSI) • Adult Adolescent Parent Index (AAPI) • Family Empowerment Scale (FES) 	Never	Almost Never	Occasionally	Almost All the Time	All the Time
1. I feel that I cannot handle things	5	4	3	2	1
2. My children do things that cause me to react negatively	5	4	3	2	1
3. I feel trapped by my parenting responsibilities	5	4	3	2	1
4. I'm never able to do things that I like to do	5	4	3	2	1
5. My children do things that are bothersome to me.	5	4	3	2	1
6. My efforts for my child are never enough	5	4	3	2	1
7. I feel confident in my ability to help my child grow and develop.	1	2	3	4	5
8. I am able to work with agencies and professionals to decide what services my child needs.	1	2	3	4	5
9. I feel I am a good parent.	1	2	3	4	5
10. Praising children is a good way to build their self-esteem	1	2	3	4	5
11. Children who learn to recognize feelings in others are more successful in life.	1	2	3	4	5
12. Parents expectations of their children should be high, but appropriate	1	2	3	4	5

<ul style="list-style-type: none"> • Parent Stress Index (PSI) • Adult Adolescent Parent Index (AAPI) • Family Empowerment Scale (FES) 	Never	Almost Never	Occasionally	Almost All the Time	All the Time
13. Rewarding children's appropriate behavior is a good form of discipline	1	2	3	4	5
14. My opinion is just as important as professionals' opinions in deciding what services my child needs	1	2	3	4	5
15. I know what services my children/child needs	1	2	3	4	5
16. Children who bite others need to be bitten to teach them what it feels like	1	2	3	4	5
17. Children should never be hit	1	2	3	4	5
18. When I need help with problems in my family, I am able to ask for help from others	1	2	3	4	5
19. I make efforts to learn new ways to help my child grow and develop	1	2	3	4	5
20. Children learn violence through exposure.	1	2	3	4	5
21. I have a good understanding of my child's disorders.	1	2	3	4	5
22. Children who are spanked behave better than children who are not.	1	2	3	4	5
23. My stress and anxiety are reduced because Respite Care is available to my child.	No, I am still stressed 1	Yes, I am a little less stressed. 2	My stress is the same. 3	Yes, I am less stressed. 4	Yes, I am a lot less stressed. 5

Are you currently working: YES NO

Are you currently attending school: YES NO

How did you hear about RSCA? Internet Attended Event Advertising

Referred by another agency, (which agency) _____

Other (please provide source) _____

To obtain scores, follow the instructions below

PSI – (1+2+3+4+5+6)/6 = Average Score = _____

- The PSI is a self-report screening tool that helps providers and families identify the level of stress a person feels in their role as a parent. Higher scores generally indicate higher levels of stress.

AAPI – (10+11+12+13+16+17+20+22)/8 = Average Score _____

- The AAPI- has been useful in identifying parents who were unlikely to abuse or neglect their children. Higher scores generally represent the least likely candidates to abuse or neglect their children.

FES – (7+ 8+ 9+ 14+15+18+19+21)/8 = Average Score _____

- The FES assesses the effectiveness of interventions or programs designed to increase the empowerment of parents or other family caregivers. Higher scores indicate an increased sense of empowerment.



PARENT/CAREGIVER NAME: _____

DATE: _____

Resilience, Self Esteem, and Relevance Survey

Instructions: For each statement, please place a CHECK on the response that best described how the statement applies to you.

<ul style="list-style-type: none"> Brief Resilience Scale (BRS): Relevance Scale (RS) Quality of Life Enjoyment & Satisfaction Questionnaire (QLESQ) 	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. I tend to bounce back quickly after hard times	1	2	3	4	5
2. I have a hard time making it through stressful events	5	4	3	2	1
3. It does not take me long to recover from a stressful event	1	2	3	4	5
4. It is hard for me to snap back when something bad happens	5	4	3	2	1
5. I usually come through difficult times with little trouble	1	2	3	4	5
6. I tend to take a long time to get over setbacks in my life	5	4	3	2	1
7. The content provided by Respite Care was relevant to your needs as a parent/caregiver	1	2	3	4	5
8. The content provided improved your confidence as a parent/caregiver	1	2	3	4	5
9. You found the content was relevant and useful	1	2	3	4	5
General Activities	Overall Level of Satisfaction				
Taking everything into consideration, during the past week how satisfied have you been with your...	Very Poor	Poor	Fair	Good	Very Good
10. ...physical health?	1	2	3	4	5
11. ...mood?	1	2	3	4	5
12. ...work?	1	2	3	4	5
13. ...household activities?	1	2	3	4	5
14. ...social relationships?	1	2	3	4	5
15. ...family relationships?	1	2	3	4	5
16. ...leisure time activities?	1	2	3	4	5

17. ...ability to function in daily life?	1	2	3	4	5
18. ...sexual drive, interest and/or performance?	1	2	3	4	5
19. economic status?	1	2	3	4	5
20. living/household situation?	1	2	3	4	5
21. ability to get around physically without feeling dizzy or unsteady or falling?	1	2	3	4	5
22. your vision in terms of ability to do work or hobbies?	1	2	3	4	5
23. overall sense of well-being?	1	2	3	4	5
24. medication? (if not taking any, check here _____ and leave item blank)	1	2	3	4	5
25. How would you rate your overall life satisfaction and contentment during the past week?	1	2	3	4	5

To obtain scores, follow the instructions below

Brief Resilience Scale (BRS): $(1+2+3+4+5+6)/6 = \text{Average Score} = \underline{\hspace{2cm}}$

The BRS is an evidence-based survey tool that helps providers and families identify the level of resiliency a person feels in their role as a parent/caregiver.

BRS Score	Interpretation
1.00 - 2.99	Low resilience
3.00 - 4.30	Normal resilience
4.31 - 5.00	High resilience

Smith, B.W., Dalen, J., Wiggins, K., Tooley, E., Christopher, P. and Bernard, J. (2008). The Brief Resilience Scale: Assessing the Ability to Bounce Back. International Journal of Behavioral Medicine, 15, 194-200.

Relevance Scale (RS): $(7+8+9) / 3 = \text{Average Score} \underline{\hspace{2cm}}$

The relevance scale is a survey tool that helps providers and families identify the level of relevance a person feels the content, or services administered by the provider was.

Quality of Life Enjoyment & Satisfaction Questionnaire (QLESQ)

This QLESQ is an evidence-based survey tool designed to help assess the degree of enjoyment and satisfaction experienced during the past week.

(Raw score minus the minimum possible raw score (16) divided by the maximum possible raw score (80) minus the minimum possible raw score).

If items are left blank the maximum and minimum scores must be modified to reflect the number of items scored.

The 1/3 rule is usually used for excluding subjects who have no scores for 1/3 of the items. At times some investigators may apply more stringent or less stringent rules.