Thank you for your request for information and an application for our Hourly Respite Services (Afterschool, Teen and Camp Programs). Enclosed is the Hourly Respite Application that must be completed prior to consideration for service. Application must be filled out in its entirety out without any blanks; if the application is incomplete it will be sent back. We are not able to serve every individual who applies for our services. We must take into consideration the level of supervision and medical care needed as well as the safety of other individuals when determining who we can serve. There is a high demand for respite services, especially after school and summer programs. All of these services have waiting lists. Please remember that families are responsible for setting up transportation for ALL Hourly Respite Programs.

Eligibility and additional information will be required prior to starting any new service.

Please submit the applications to:

**Jennifer Shortino, Intake Coordinator**
Heritage Christian Services, Inc.
275 Kenneth Drive, Suite 100
Rochester, NY 14623
jshortino@heritagechristianservices.org
(585) 967-0178

Please check which program(s) you are applying for:

**Respite Camps:** 8:30 a.m. – 4 p.m. Campers may apply to both but can only attend one session per year due to demand
*Monday through Friday, during summer school breaks for school aged children and young adults ages 5 to 21*

- ☐ Session 1: Held at the end of June, specific dates announced in February
- ☐ Session 2: Held at the end of August, specific dates announced in February

**Afterschool Programs:**

- ☐ Respite Creek: 2:30 – 6 p.m at Creekside School, 41 O’Conner Rd, Fairport, NY 14450
  *Monday through Friday, while school is in session (program usually follow BOCES School Calendar).*
  Respite Creek is a site-based non-certified after school program located in a classroom at the Creekside School, which is part of the BOCES Foreman Center in Fairport. Respite Creek supports school aged students 5-21. They have an opportunity to spend after school hours in a safe, supportive environment and take part in a wide variety of activities including creative projects; exercise such as walking and basketball; outdoor fun on the playground; and learning opportunities on the computers and IPads. We are not able to pass any medications except an EPI PEN.

- ☐ Respite Friends: 2:30 – 6 p.m. at the Pieters Family Life Center, 1025 Commons Way, Henrietta, NY 14623
  *Monday through Friday, while school is in session (program usually follows the Holy Childhood School Calendar).*
  Respite Friends is a site-based non-certified recreation program that supports young people ages 5-21. The Pieters Family Life Center is a 21,000-square-foot, state-of-the-art health and wellness facility equipped with a gymnasium, work-out room, kitchen, café and studios for dance, music and art. Participants enjoy activities like exercising, working on a computer, reading, baking and playing games and sports. We are not able to pass any medications except an EPI PEN.

**Recreation:**

- ☐ Respite Teen: 6 – 9 pm at the Pieters Family Life Center, 1025 Commons Way, Henrietta, NY 14623
  *One time a month (usually the 3rd Friday of each month)*
  Respite Teens is a site-based non-certified recreation program that supports young people ages 13 to 21. Participants choose from a wide variety of on-site activities including cooking, watching movies, playing games and much more. Dinner is provided at this program. We are not able to pass any medications except an EPI PEN.
Hourly Respite Application

Date: ____________________________

Applicants Name: ____________________________ DOB: ____________________________

☐ Male  ☐ Female

Race: ____________________________ Ethnicity: ____________________________

1. Parent/Guardian Name: ____________________________

Relationship: ____________________________

Complete Address: Street: ____________________________ City: ____________________________

State: ____________________________ Zip Code: ____________________________ County: ____________________________

Primary Phone: ____________________________ (___) ___ - ___

Secondary Phone: ____________________________ (___) ___ - ___

Email: ____________________________

2. Parent/Guardian Name: ____________________________

Relationship: ____________________________

Complete Address: Street: ____________________________ City: ____________________________

State: ____________________________ Zip Code: ____________________________ County: ____________________________

Primary Phone: ____________________________ (___) ___ - ___

Secondary Phone: ____________________________ (___) ___ - ___

Email: ____________________________

Emergency Contact(s) Name and Number:

__________________________________________ (___) ___ - ___

__________________________________________ (___) ___ - ___

Enrolled Program/School: ____________________________ Contact Number: (___) ___ - ___

Transportation Provider(s):

☐ School District: ____________________________ Contact Number: (___) ___ - ___

☐ Family Will Provide All transportation

☐ Other: ____________________________

Funding Source:

☐ HCBS Waiver

☐ Children’s Comprehensive Waiver
Level of Supervision

☐ ONE STAFF ASSIGNED Range of Scan: Requires assigned staff to maintain the person in visual scanning field at ALL times – by turning head left or right, staff is able to see the person. The person cannot be behind the staff. The staff person will ONLY be assigned to support this person and will not be responsible for any other duties. If the person could work with at least one other peer this is not the appropriate supervision. PLEASE EXPLAIN: ____________________________

Or

☐ Range of Scan: Requires assigned staff to maintain the person in visual scanning field at all times – by turning head left or right, staff is able to see the person. The person cannot be behind the staff. The staff person will be assigned to support 1-2 other people. Reason: (History of running away, inappropriate interactions with others, etc.)

Or

☐ Periodic Observation Every ☐5 ☐15 ☐30 Minutes: (staff member completes a visual check at that interval).

Emergency Evacuation

☐Independent (requires no assistance from another) ☐Touch Prompts (hand holding, guiding)
☐Verbal Prompts ☐Total Support

Supervision Required at the Meeting Point

(supervision needed once the person has safely evacuated the program and is outside at the designated safe area.)

☐ Range of Scan with ONE STAFF ASSIGNED ☐ Range of Scan
☐ Periodic Observation if yes, for how long? ☐ Independent
☐5 minutes ☐10 minutes ☐15 minutes

Medical Information

Diagnosis- Check If Applicable:
☐ Intellectual Disability
☐ Mild ☐ ADD/ADHD ☐ Hearing Impaired ☐ Cerebral Palsy ☐ Autism
☐ Moderate ☐ Fragile X Syndrome ☐ Down Syndrome ☐ Visually Impaired ☐ Epilepsy
☐ Profound ☐ Please list other medical conditions: ____________________________

Medication(s): ☐ YES ☐ NO Please List All: _____________________________________________

Allergies (food, insects, medications, etc.) ☐ YES ☐ NO Please List All: _____________________________

Reaction and response/treatment needed:

Seizure Activity ☐ YES ☐ NO Please describe time, length, type, duration, treatment: _____________________________

Primary Doctors Name: ______________________________

Practice Name: ______________________________

Address: ______________________________

Phone: (____) ____- ____ Fax: (____) ____- ____
Dietary Needs

Likes: _____________________________________________________________

Dislikes: ____________________________________________________________

Foods (select one diet):

☐ Whole Diet with whole hot dogs/sausages: (This is a regular diet with no restrictions, but the individual may need food cut up before consuming.)

☐ Ground Diet (rice size pieces, moistened)

☐ Pureed Diet (yogurt/applesauce consistency)

☐ NPO-NOTHING BY MOUTH

Additional Notes:

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Liquids (select one diet):

☐ Thin liquids (Regular)

☐ Nectar thick liquids

☐ Honey thick liquids

☐ Pudding thick liquids

Additional Supports

Adaptive Equipment:

____________________________________________________________________

Wheelchair Use:

☐ Not applicable

☐ Maneuvers chair independently

☐ Maneuvers with assistance

☐ Transfers independently

☐ Transfers with assistance (when describe): ______________________________

Transfers (Check all that apply):

☐ Not applicable

☐ Independent (requires no assistance from another)

☐ Stand Pivot

☐ One-person Transfer

☐ Two-person Transfer

Bathroom Needs (Check only ONE):

☐ Independent

☐ Bladder control only

☐ Bowel control only

☐ Wears Attends/diapers at all times (Staff check for freshening every 2 hours unless needed based on observation)

Specific supports: ______________________________________________________

____________________________________________________________________
Social/Recreational Activities

Describe interactions/relationships with others (peers, younger children, authority figures - list any significant patterns or concerns ex. gets along better with younger children):

___________________________________________________________

What types of activities are enjoyed/preferred? (i.e., arts/crafts, computers, movies, music, animals, playground, and sports):

___________________________________________________________

Any activities to avoid? (i.e., noisy activities, animals, mascots):

___________________________________________________________

Any specific cultural or religious traditions or preferences? If yes, please describe:

___________________________________________________________

Behavior Notations:

Please describe specific behavior challenges (i.e. hitting, kicking, spitting, biting, pulling hair, self-injurious behavior, property destruction, running, wandering, pica, others...) how often they occur and how they are addressed:

___________________________________________________________

Sexuality:

If 18 or older, has a sexual consent evaluation been completed? □ YES □ NO
If yes, what was the determination? □ Consenting □ Non-Consenting
Please describe any sexuality issues/concerns and how they are addressed:

___________________________________________________________

Care Coordinator Information:

Name: ____________________________________________________________
Agency Name: ______________________________________________________
Agency Address: _____________________________________________________
Email: _____________________________________________________________
Phone: (____) ____- ____ext. ____
Fax: (____) ____- ____ext. ____

Swimming Supervision: Rotary Camp Only
*SHALLOW END ONLY*

Rotary provides 2 trained Life Guards on duty at all times, 3:1 Supervision in the pool at all times.
□ Eyes on supervision
□ Staff in the pool
□ Staff is in the pool within in close proximity: only assigned with one person. Person is not safe being in the pool without hands on support.
Reasons: __________________________________________________________

□ Needs floatation device: Specify
SERVICE AGREEMENT

☐ I, the undersigned, understand and acknowledge that information on the application form is absolutely necessary for the proper and competent delivery of Respite Services by the Respite Staff at Heritage Christian Services. I warrant that I have fully disclosed all the pertinent facts about the individual applying.

☐ I understand that the Respite staff, while providing care, are acting in full reliance upon the completeness of the information given. Failure to provide complete and accurate information regarding the person applying for services may result in future denial of service. I give my permission for the Respite staff to have access to this information and, upon the decision of the Program Manager, for any other individuals needing access to this information for in-service training.

ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

☐ I hereby acknowledge that I have received a copy of Heritage Christian Services, Inc. Notice of Privacy Practices, Individual Rights, Individual Right to Object, Service Agreement, Notification of Incident Information, and Liability Notice.

PARENT/GUARDIAN/INDIVIDUAL ACKNOWLEDGEMENT AND AGREEMENT

☐ I, the undersigned, give permission to Heritage Christian Services hereby to the use of my child’s/myself, likeness, features, voice, identity or resemblance in photographs, pictures, recordings and all other forms of print, audio and visual media for advertising, promotional display, commercial and other general purposes by and on behalf of Heritage Christian Services, their affiliates, successors and assigns. I am aware that Heritage Christian Services will use their discretion for this purpose. This agreement is in effect until canceled by the undersigned.

MODEL RELEASE

☐ I, the undersigned, give permission to Heritage Christian Services hereby to the use of my child’s/myself, likeness, features, voice, identity or resemblance in photographs, pictures, recordings and all other forms of print, audio and visual media for advertising, promotional display, commercial and other general purposes by and on behalf of Heritage Christian Services, their affiliates, successors and assigns. I am aware that Heritage Christian Services will use their discretion for this purpose. This agreement is in effect until canceled by the undersigned.

MEDICAL RELEASE

☐ I give Heritage Christian Services permission to seek any emergency medical or surgical treatment necessary for my child/myself in the event that I am unable to provide this or if my surrogate decision maker cannot be reached.

-- If the person is unable to provide consent on his/her own behalf and s/he is not acutely ill or injured, such that a delay to secure consent would incur the risk to the person’s life or health, every attempt shall be made to contact the surrogate decision maker.

-- If the surrogate decision maker cannot be contacted, dependent on the medical condition of the individual, the hospital or physician will indicate what procedure/treatment should be done/provided to protect the health and life of the person.

-- Please also be aware that hospitals are prepared to handle emergency treatment and also have very stringent guidelines for proceeding with emergency treatment—as stated in the first paragraph—Heritage Christian Services shall make every possible effort to obtain appropriate informed consent before proceeding with medical/surgical treatment.

This form is considered valid unless revoked by the person or his/her surrogate decision maker who authorized the medical release form.

☐ I authorize program staff or individual to apply Sunscreen as needed

☐ I authorize program staff or individual to apply bug spray as needed

Applicant Signature or circle UNABLE TO SIGN  Date

Parent/Guardian Signature  Date