HERITAGE
CHRISTIAN SERVICES
Empowering people. Enriching lives.

275 Kenneth Drive● SUITE 100● ROCHESTER, NY 14623
(585) 340-2000
● WWW.HERITAGECHRISTIANSERVICES.ORG

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 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 afterschool 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:

Respite Intake
Heritage Christian Services, Inc.
275 Kenneth Drive, Suite 100
Rochester, NY 14623
respiteintake@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 – 6pm 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 afterschool program that supports school aged students 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:_____

Must attach current photo

Applicants Name:_____ **DOB:**_____

☐**Male** ☐**Female**

1. **Parent/Guardian Name:**_____

Relationship: _____

Address:_____

Primary Phone:_____ **(_____) _____- _____**

Secondary Phone:_____ **(_____) _____- _____**

Email: _____

2. **Parent/Guardian Name:** _____

Relationship: _____

Address: _____

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**
  - ☐ **Self-Directed Plan**

Fiscal Intermediary information

Name: _____

Agency Name: _____

Agency Address: _____

Email: _____

Phone: (_____) _____- _____ ext. ____

- ☐ **Children's Comprehensive Waiver**

Level of Supervision

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

(One staff assigned to be completed by Respite Staff after evaluation)
☐ **REQUIRES ONE STAFF ASSIGNED** The staff person will be assigned to support only this person and will not be responsible for any other duties.
Reason: _____

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.)

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

Medical Information

Diagnosis- Check If Applicable:

☐ Intellectual Disability
- ☐ Mild
- ☐ Moderate
- ☐ Severe
- ☐ Profound

☐ Autism
☐ ADD/ADHD
☐ Fragile X Syndrome
☐ Epilepsy
☐ Cerebral palsy

☐ Down Syndrome
☐ Hearing Impaired
☐ Hearing Impaired

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.) _____
- ☐ **Whole Diet** (In this diet, hotdogs/ sausages are sliced lengthwise) _____
- ☐ **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** ☐**N/A under 18**

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.

ACKNOWLEGE 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 acknowledge that I have read and understand the items below which describe the inherent risks of using e-mail to communicate personally identifiable information. You have chosen to communicate personally identifiable information concerning your son/daughter's/your own services by e-mail with any Heritage employee whose email address ends with ***@heritagechristianservices.org*** without the use of encryption. Sending personally identifiable information by e-mail has a number of risks that you should be aware of prior to giving your permission. These risks include, but are not limited to, the following:

- E-mail can be forwarded and stored in electronic and paper format easily without prior knowledge of the parent/guardian.
- E-mail senders can misaddress an e-mail and personally identifiable information can be sent to incorrect recipients by mistake.
- E-mail sent over the Internet without encryption is not secure and can be intercepted by unknown third parties.
- E-mail content can be changed without the knowledge of the sender or receiver.
- Backup copies of e-mail may still exist even after the sender and receiver have deleted the messages.
- Employers and online service providers have a right to check e-mail sent through their systems.
- E-mail can contain harmful viruses and other programs.

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*