

# Respite & Event Packet

## INDIVIDUAL INFORMATION:

Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_  
(Person Services Provided For)

Address: \_\_\_\_\_

Individual Weight: \_\_\_\_\_ Individual Height: \_\_\_\_\_ Sex: Male - Female

Primary Disability or Health Condition: \_\_\_\_\_

Individuals Email: \_\_\_\_\_ Individuals Phone: \_\_\_\_\_

Individual has a Behavioral Intervention Plan: Yes - No

## PARENT/GUARDIAN INFORMATION:

Parent/Guardian Names: \_\_\_\_\_

Address (if different): \_\_\_\_\_

Home Phone: \_\_\_\_\_ Parent 1 Cell: \_\_\_\_\_

Parent 2 Cell: \_\_\_\_\_

Parent 1 Email: \_\_\_\_\_

Parent 2 Email: \_\_\_\_\_

## IN CASE OF EMERGENCY (ICE):

Primary ICE Name: \_\_\_\_\_ ICE Phone: \_\_\_\_\_

ICE Relationship: \_\_\_\_\_

Secondary ICE Name: \_\_\_\_\_ ICE Phone: \_\_\_\_\_

ICE Relationship: \_\_\_\_\_

## FUNDING:

Currently Receiving: Yes - No Funding source: \_\_\_\_\_  
(Circle One)

Funding Needed: Yes - No  
(Circle One)

**MEDICAL RELEASE:**

Family Primary care Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

Individual Carries & independently uses: Inhaler EpiPen Other: \_\_\_\_\_

Date of Last Tetanus Shot: \_\_\_\_\_

Visual impairment: Yes / No Hearing impaired: Yes / No

Communication Notes: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Prompting Assistance: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Mobility Notes: \_\_\_\_\_

Current Medications and time:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Allergies:  
 food and medication  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Seizure Yes: \_\_\_\_\_ No: \_\_\_\_\_  
 Seizure Information:  
 \_\_\_\_\_  
 \_\_\_\_\_

Seizure care notes: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

I, \_\_\_\_\_ give permission for the applicant listed above to receive medical treatment in the event of an emergency, accident, injury or illness. I give authorization for treatment to all medical personnel, including licensed physicians, nurses, technicians, emergency responders, and other medical personnel. I also assume responsibility for the cost of treatment.

| Parent's or Guardian's Name | Parent's or Guardian's Signature | Date |
|-----------------------------|----------------------------------|------|
|                             |                                  |      |

**ABOUT THE INDIVIDUAL:**

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

**INDIVIDUAL ENJOYS DOING/GOING:**

*(List hobbies, interests, places the individual likes to go, to do, to eat, rewards for achievements, motivators etc.)*

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**GOALS FOR INDIVIDUAL:**

Social Skills: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Life Skills: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Education: \_\_\_\_\_  
\_\_\_\_\_

Job Skills: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Overall: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SITUATIONS/BEHAVIORS TO BE AWARE OF:**

Ex: sirens, large groups, schedule changes, elopement, undresses in public etc.

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## Permission for Obtaining or Releasing Information

I, \_\_\_\_\_, hereby give my permission to The Arc Northern Chesapeake Region to

Obtain Information from \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Disclose Information to \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Pertaining to the following:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_ I have read this form and decline to have The Arc NCR obtain/release information concerning my  Child,  Self

I understand that the information shared by The Arc Northern Chesapeake Region, Inc. shall remain confidential and may not be re-disclosed to a third party. This agreement will last for the duration of the time I receive support services from The Arc NCR. I do understand that I have the right to revoke this privilege at any time. To revoke privileges for The Arc Northern Chesapeake Region, contact the Development Department at 410-836-7177 or via email at [development@arcncr.org](mailto:development@arcncr.org).

Individuals name receiving services: \_\_\_\_\_

Signature of parent or legal guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**Consent to Interview and Permission to Release Information in Printed, Video and Photographic Form**

Name: \_\_\_\_\_

I give my permission for The Arc Northern Chesapeake Region to use information gathered during interviews, as well as my likeness in a photograph, video, sound recordings or other digital media (“photo”) in any and all of its publications, including web-based publications and social media, without payment or other consideration.

I understand and agree that all photos will become the property of The Arc Northern Chesapeake Region and will not be returned.

I hereby authorize The Arc Northern Chesapeake Region to edit, alter, copy, exhibit, publish, or distribute these photos for any lawful purpose. In addition, I waive any right to inspect or approve the finished product wherein my likeness appears. I understand that I will not be contacted each time this information is distributed as described above.

This agreement will last for the duration of the time I receive support services from The Arc NCR. I do understand that I have the right to revoke this privilege at any time. To revoke privileges for The Arc Northern Chesapeake Region, contact the Development Department at 410-836-7177 or via email at [development@arcncr.org](mailto:development@arcncr.org).

**I UNDERSTAND AND AGREE TO THE CONDITIONS OUTLINED IN THIS PHOTOGRAPH, VIDEO AND SOUND RECORDING RELEASE AND CONSENT FORM.**

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

**BILLING AGREEMENT:**

I, \_\_\_\_\_ understand that The Arc NCR is providing respite care for Applicant: (print name): \_\_\_\_\_.

I agree to the rate for respite care listed below and the rate of each event I participate in and/or send my child to.

*\*\*Please note financial aid opportunities are available, through outside sources. We are NOT responsible for filling out paper work, that is to be done individually.*

Furthermore, I understand that I am responsible for providing money for activities upfront unless noted on the event and it will be added to your bill. (Examples are dinner, movie ticket, entrance fee etc.) Funding sources will not cover any activity cost from the given establishment ex: cost of dinner, entrance fee etc. I agree to not ask the respite provider/staff person to pay out of pocket for food, clothes, tickets or anything else necessary while receiving respite or at an event.

I agree to send a check to The Arc NCR at 4513 Philadelphia Rd Aberdeen, MD 21001 upon receiving an invoice/bill weekly. Failing to make the required payment within 30 days will result in a late fee per week as well as a suspension of services until full balance is paid. Using a funding source to pay is exempt from late fee, as we know funding sources are slow to pay at times. We encourage you keep track of when The Arc NCR employees are providing respite care and/or when your child attends an event. Please note group activity/event rates will vary. Please check each event cost before registering for any individual events.

I, (Printed Parent/Guardian name:) \_\_\_\_\_ understand and agree to the terms stated above.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Fees and Rates**

Fees are as of 7/1/18  
Fees are subject to change.

Fee adjustments will be communicated 30 days in advance of their effective date.

|                                         |                                   |
|-----------------------------------------|-----------------------------------|
| Respite Care                            | \$20.83 per hour (2-hour minimum) |
| Group Events                            | \$15 per hour or set price listed |
| Transportation to/from recurring events | \$10.00 (one way or both ways)    |
| School closed program                   | \$150 (8:00a-4:00p)               |
| Late Fee to pick up                     | \$1.00 per minute after 5 min     |
| Late fee for payment                    | \$20 per week after 30 days       |
| Event admission fee                     | Very per event                    |

**RELEASE OF LIABILITY**

I, \_\_\_\_\_ give permission for The Arc NCR and Employees of The Arc NCR to transport my child to and from; events, camp, community involvement activities, and for any other reason my child needs to be transported.

I, \_\_\_\_\_ understand that The Arc NCR is not liable for any injury, accidents, and or anything that may occur to my child while in the vehicle of the employee transporting them. I acknowledge that driving will be handled in a safe/secure manner, however accidents may occur.

I, \_\_\_\_\_ understand that The Arc NCR is not liable for any personal items that are lost, broken, misplaced or stolen caring for my child. We will do everything in our power to keep track of personal items but cannot guarantee they won't be misplaced.

I, \_\_\_\_\_ understand that I am responsible for any items that are damaged or broken due to my child's actions.

I, \_\_\_\_\_ understand that The Arc NCR is not liable for any personal injury that my child inflicts on his or herself. I furthermore understand that The Arc NCR is a HANDS-OFF organization however in a life threatening situation can and will restrain my child only when he or she is in a crisis life or death situation and harming his/herself and or others. If a crisis situation takes place a team meeting will be held within five days of the incident and parents will be notified immediately. If necessary 911 will be called.

I, (Printed parent/Guardian name:) \_\_\_\_\_ understand and agree to the terms stated above.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**SCHEDULING RESPITE SERVICES**

When scheduling respite services for yourself or your child you need to call The Arc NCR and inform them of the time and date that you are requesting services if time/date is not listed on the respite request form. Also, once a time and date has been selected for services, then you will be billed for those times, unless your child is ill, or other serious circumstance has arisen. If a group event does not meet the minimum required participants, you will be notified if the scheduled event is canceled and/or the fee changes 24 hours prior to the event.

When picking a time and date for services the start time and end time determines the billing amount. If you arrive home early the end time originally chosen for services will be billed to your account. The same applies for events, if you pick your child up early the event cost will be billed to your account. If you arrive late to your home or to pick up your child from an event there is a late fee as listed in the fee/rate schedule.

I, (Printed Parent/Guardian name:) \_\_\_\_\_ understand and agree to the terms stated above.

Parent/ Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_









