



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. ***

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

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

Sincerely,
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
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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)
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CHECK ALL THAT APPLY

1. SERVICE INTEREST: Daycare Mother's Day Out Weekends Overnight After School/Camp

2. TRANSPORTATION: I hereby give do not give consent for my child to be transported for emergency care

3. FIELD TRIPS: I hereby give do not give consent for my child to be transported to and participate in field trips

4. WATER ACTIVITIES: I hereby give do not give consent for my child to participate in water activities
 sprinklers. splashing/wading pools. water table play.
 Is your child able to swim without assistance? Yes No If No, what type of assistance is needed: _____

5. RECEIPT OF PARENT HANDBOOK: I acknowledge receipt of the facility's operation policies including those for discipline and guidance.

6. PUBLICITY RELEASE: I hereby give do not give consent for my child's photograph to be used for publicity.

7. THERAPIES RECEIVED: ECI Services Occupational Therapy Physical Therapy Speech Therapy Applied Behavior Analysis 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:

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 My child is not insured 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

<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 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: _____

Submitted: _____

Med: _____

Choose Program: PNO FDO MDO Daycare DRH Camps

Review Date _____ by: _____

Participant Name _____ DOB _____ Phone Number _____

Address _____ ZIP CODE _____

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:** _____

Please list any sources of household income (please provide a copy of award letter, if applicable)

X	Type of Income/Assistance/Program	Amount per month
	Employment	
	Social Security	
	Child Support	
	Government Assistance	
	Other	

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

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, 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 by the end of each week.
8. Follow the Participant Handbook that contains the quality assurance guidelines. _____ **Initials**

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**

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.

_____ 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

Operational Schedule:

Respite Care of San Antonio (RCSA) provides safe, quality, and loving care for children 6 weeks through 5 years of age. RCSA center hours of operating are from 7:30am-6:00pm, MDO hours of operating are Mondays and Wednesdays from 8:30am-4:30pm. PNO hours of operating are Fridays from 6:00pm-10:00pm. FDO hours of operating is Saturdays from 9:00am-4:00pm. We operate year-round and are closed for holidays and teacher in-service days. A list of annual centers closing dates is available from your Center Director. We will attempt to stay open during inclement weather; however, we will make announcements of school closing, late opening, or early dismissal through written correspondence. No adjustments or credits will be issued for school closings due to inclement weather.

Registration, Tuition, and Fees:

- **NO CASH:** For the safety of our employees and the children in our care, RCSA does not accept cash. Please see your Center Director or Assistance Director for payment options available at RCSA.
- **Registration Fee:** Not applicable. Registration is free for families.
- **Weekly Tuition:** \$_____. Payments can be paid any day of the week. We reserve the right to refuse service for families who have an outstanding account balance at the end of the week. Full tuition is due for holidays and in-service day closings observed by RCSA.
- **Sibling Discount:** We offer a 10% discount for the first sibling and 15% for all additional children enrolled full-time in our program for the same family. The discount will be applied to the lowest tuition rate billed for the family.
- **Late Payment Fee:** \$25.00 will be charged if payment is not received by your assigned payment due date. A \$10 fee will be added on the date after the due date assigned and everyday thereafter until payment is received.
- **Delinquent Accounts:** We reserve the right to refuse service for families who have an outstanding account balance at the end of the week. (*Delinquent accounts and all costs incurred in the collection process will be...*)
- **Non-sufficient Funds (NSF):** \$30 fee will be added to your account when we are notified of NSF for either checks or electronic withdraws. The amount of the original payment and the NSF fee MUST be paid with a money order or cashier’s check immediately upon notification of the NSF. If we receive more than two NSF notifications, your account will result in being a MONEY ORDER only basis.

- **Late Pickup Fee:** \$1.00 per minute per child.
- **Withdrawal Notification:** If you must withdraw from our center for any reason, you will be required to give notice at your earliest convenience. To re-register your child(ren), a new enrollment form must be submitted with the registration fee, provided there is an opening available. If you re-register within 30 days of the withdrawal/dis-enrolling.

Refund Policy:

- We refund tuition and fee if paid ahead and not utilized; excluding non-notification of withdraw from RCSA.
- Refunds can take up to 30 days to process.

Absentee Credit:

- Absentee credit does not apply to any of our services.

Vacation Credit:

- Every family is allowed one week vacation credit each year of service. You must submit the vacation credit form to the Director at least one week in advance of the vacation. The year of service is taken from the date of registration.

Change or Termination of Agreement:

- RCSA has the right to change their fees and/or policies with a 30-day written notice. Written notices include email correspondence.
- RCSA reserves the right to deny services without notice due to aggressive and/or unsafe behaviors of child or parent, delinquent accounts, or any behavior that we deem disruptive to our daily operation or good standing in the community.

Additional Agreement and Signature:

- I understand that it is my responsibility to keep the center advised of changes of addresses, phone numbers, and authorized pick-up information.
- I agree to abide by all the policies and procedures outlined in this tuition contract, which shall always be the official governing document, and acknowledge that I have reviewed RCSA parent handbook.
- This agreement shall be governed by and interpreted by the laws of the State of Texas, Bexar County.
- Pursuant to Company Policy and State Licensing Standards, weapons of any kind, to include but not limited to any and all firearms, knives, swords, crossbows, and tasers, are NOT permitted or allowed on the premise. See Texas Department of Family & Protective Services Minimum Standards for Child-Care Centers §746.3707(a)&(b).

My signature represents that I have the full authority to bind myself to the terms of this contract.

Parent/Guardian Signature Date

Center Director Signature Date

-----Insert Respite Care Demographic form here-----

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.

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