Dear Parent or Guardian,

Thank you for your interest in the Community Care Family Respite Program. This program is funded by the Maine Department of Health & Human Services (DHHS) and is designed to give planned breaks to families of children with special needs. Upon completion of the application process, your family may be allotted up to 24 hours per month of planned respite services, as long as funding remains available.

To be approved for respite services, child(ren) must be in the custody of, and live in the same household as, the adult applicant. **This program is not open to children in foster care.** If you are in the process of adopting, the adoption needs to be finalized prior to applying for respite services.

It is extremely important that you submit a complete application as we are not able to process incomplete applications. Incomplete applications will be discarded after 30 days.

The following information must be received for your application to be considered complete.

1. Family Information Section - this needs to be filled out once for each family
2. Child Application Section - this must be completed for each child you are adding to the respite program for approval
3. Policies, Notices and Releases - must be initialed and signed where indicated
4. Diagnostic Evaluation(s) - a diagnostic evaluation is required for each child you are adding for approval (see next page for details)
5. Signature Page - this page must be completed and returned with your application

The complete Family Application Packet can also be found at https://comcareme.org/respite/
If you have any further questions, please feel free to email CCRespite@comcareme.org .

Please submit this completed application to CCRespite@comcareme.org

P.O. Box 936 Bangor ME 04402
Phone: (207)945-4240 Fax: (207)990-3660 website: www.comcareme.org

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Respite Needs and Application Assistance

Family Name: _____

Respite Needs:

1) When would you like to start receiving respite services?

2) Do you have specific scheduling needs?

3) How many hours of respite do you think your family would use each month?

4) What is the best way to contact you to discuss your respite needs? (Phone? Email? Both?)

Application Assistance:

If you need help understanding or filling out any sections of this application, please email CCRespite@comcareme.org

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FAMILY RESPITE PROGRAM FAMILY APPLICATION

Families must meet the following eligibility criteria:

- The child(ren) must be no older than 17 years ***and***
- The child(ren) must have a documented emotional or behavioral diagnosis ***or*** two or more developmental delays ***and***
- The child(ren) must be living with and in the custody of the adult applicant.
- All sections of the application must be filled out and signed before the application will be considered complete.

FAMILY INFORMATION SECTION
Incomplete applications will be discarded after thirty (30) days.

☐ Parent ☐ Guardian Name(s): _____

Email Address: _____

Phone Number: _____ Alternate Phone Number: _____

Physical Address : _____

Street: _____

City/Town and Zip Code: _____

Mailing Address if different than Physical Address: _____

Street: _____

City/Town and Zip Code: _____

Diagnostic Evaluation

We need an evaluation *for each child* you are requesting respite for. Please send in one of the following *for each child* along with this completed application:

1. An assessment or evaluation signed and dated within the past year by one of the following:

    - Advanced Practice Registered Nurse (APRN)
    - Board Certified Behavior Analyst (BCBA)
    - Licensed Clinical Professional Counselor (LCPC)
    - Licensed Clinical Professional Counselor-Conditional Clinical (LCPC-CC)
    - Family Nurse Practitioner (FNP)
    - Licensed Clinical Social Worker (LCSW)
    - Licensed Masters Social Worker (LMSW)
    - Licensed Masters Social Worker Conditional (LMSW-C)
    - Psychiatric Mental Health Nurse Practitioner (PMHNP)
    - Medical Doctor (MD)
    - Doctor of Osteopathic Medicine (DO)
    - Psychologist (PsyD)
    - Doctor of Philosophy (PhD)
    - Licensed Marriage and Family Therapist (LMFT)
    - Psychological Examiner

OR

2. An older assessment or evaluation ***and*** an updated letter providing current diagnoses from one of the above mentioned healthcare providers. The letter must be signed and dated within the past year.

Family Information Section

We would like to know a little more about you and your environment, please complete the survey below to the best of your knowledge. This survey is solely to gather information about the families served by the respite program and will not affect your eligibility for the program.

1. How many people live in your household?
2. How many members of your household people are under 18?
3. How many of the children have special needs requiring daily care? Please include those you are requesting respite for.

List all household members and relationship:

_____

_____

_____

_____

_____

_____

Child Information Section

If you are applying for respite for more than one child, please fill this section out separately for each child.

Child's Name: _____

DOB: _____ **Gender:** ☐ Female ☐ Male ☐ Other: _____

Please complete the following questions about your child. We use this information to assess the level of needed provider for the child and to help us to find the best provider available for your family. Please answer the questions honestly and completely.

1. Can your child use the toilet on their own? ☐ No ☐ Yes

2. How well does your child follow verbal commands?

___ They can follow commands easily

___ They struggle to understand or comply sometimes, but eventually follow instruction

___ They often refuse to do what they are asked

3. When was the last time your child hit, bit, or showed physical aggression toward non- family members?

___ Never

___ More than 6 months

___ More than a month, less than 6 months

___ More than a week, less than a month

___ Less than a week

4. How well is your child able to communicate their needs?

___ Easily

___ They can communicate what they need, but sometimes it might take some work for us to understand one another

___ They cannot communicate their needs; it is a guessing game trying to figure out when they want something

5. Does your child have medical condition(s) that requires intervention every 4-8 hours?
☐ No ☐ Yes

6. About how many times does your child wander/disappear in a week (sometimes referred to as "bolting")?

7. About how many times in a week does your child get overwhelmed and have a meltdown that requires them to be moved to a quiet place?

8. How active is your child?

___ They prefer not to be very active (or are not able to)

___ They are active and energetic, but they also have quieter activities they enjoy

___ They run around all the time, trying to keep up with them to supervise is exhausting

Please use this space to provide explanations or further information about the areas of need identified above:

<u>Parental Responsibilities</u> (Please review the following policies, fill in information, and initial where indicated)

1. **Choice of provider** – Community Care believes families should choose the respite provider most appropriate to the needs of their family and will do all it can to help to certify and employ respite care providers that are referred to us by families.
2. **Inform and train the provider about your child(ren)'s special needs** - Parents know their children best and are the most able to inform a provider what their child(ren) requires. It is the parent who must fully inform the provider of the child(ren)'s every need, including programs and treatments.
3. **Respite Care Plans** - Each family will be asked to complete a respite care plan that documents the expectations of the family, the understanding of the respite provider, and outcomes expected from the provision of respite care. Respite services are to be delivered to address the health, social, behavioral, and daily living needs of children who are receiving care.
4. **Instruct the provider regarding medications** – Parents are responsible for informing their providers about their child(ren)'s medications and dosages. A Signed permission form must be in effect each time respite takes place in order for a provider to give medications or supervise the taking of medications. Families must clearly separate and label each prescription with the preference being that medication is within its original prescription bottle. Failure to complete and submit the medications permission form will result in delays in payment to the provider. Repeated instances of non-compliance may result in termination of services.
5. **Changes in special needs** - Parents are responsible for reporting any changes in their child(ren)'s special needs, in the families' needs, residence, or telephone number. Eligibility is based on need, and may be reassessed at a maximum of three year intervals which require new documentation of disability. These reviews may be required more frequently based on the child(ren)'s diagnosis or as requested by DHHS.

☐ I have read the *Parental Responsibilities*, understand, and agree. ***Please initial here:*** _____

NOTICE OF CONFIDENTIALITY

Community Care complies with state and federal confidentiality laws that govern the release of information about medical and behavioral health. Our records consist only of the information you have shared with us as part of the application process. In this regard, Community Care staff and respite care workers will maintain the privacy of your respite records with the following exceptions:

- There are concerns about or allegations of abuse or neglect of a child or a dependent adult;
- There are allegations or concern about the safety of a child or dependent adult;
- There are allegations or concerns about self-harm or harm to a child or dependent adult;
- There are other health or safety concerns that lead Community Care to believe that the child or family is at risk because of an inability to care for the child or to care for themselves.

In all instances where a Community Care staff person has any of the concerns listed above they will discuss them with a supervisor and if warranted, make a report to the DHHS abuse and neglect help line and/or to law enforcement authorities.

I have read the *Notice of Confidentiality*, understand, and agree. ***Please initial here:*** _____

INFORMED CONSENT

I understand that Community Care will do all it can to certify, orient, train, and supervise the respite care providers that assist my family. I understand that Community Care will check the criminal, child protective, and driving histories of all respite care providers before they perform service.

I understand that I will be asked to (1) approve of the respite care provider that I choose to provide respite care to me and my family, (2) design an action plan with the respite care provider that outlines my goals for the respite care services I receive, and (3) that I will be required to provide direction to the provider delivering care based upon the needs of my child(ren), their specific treatment needs, and my knowledge of how that care needs to be provided.

I understand that respite care is neither a clinical service nor a medical or treatment service, and is a program that I have voluntarily chosen to utilize in order to receive planned breaks from caring for my child(ren) with special needs.

I understand the inherent risks associated with participation in respite care services and in asking another person to provide care to my child/children outside of my supervision. I knowingly and voluntarily accept these risks and agree to provide Community Care with a satisfaction survey before respite care begins and at least quarterly thereafter.

I acknowledge that I am solely responsible for medical or other costs arising out of any injury, illness, or property damage or loss sustained through my voluntary participation in this program. I also agree to provide necessary funds, fees & travel costs ($.45 per mile) for any activity in which I have asked the respite care provider to bring my child(ren).

My initials next to the following denote my permission for any respite provider providing respite care for my child(ren) to:

(initial all that apply):

_____Transport my child(ren) in their personal vehicle

_____Dispense medications while providing respite care

_____Escort my child(ren) to activities I have approved (examples include horseback riding, swimming, playgrounds, parks or other similar activities)

_____Perform the necessary care my child(ren) require such as feeding, toileting, bathing, special medical care (G-tube, colostomy bag, catheterization, diapering, etc.).

_____Other (please specify)

Please complete the following if your child(ren) receives Case Management Services

First Child
Print Child's Name: _____

Name of Case Manager: _____

Case Management Agency: _____

Case Manager's Email: _____

Case Manager's Phone Number: _____

Second Child
Print Child's Name: _____

Name of Case Manager: _____

Case Management Agency: _____

Case Manager's Email: _____

Case Manager's Phone Number: _____

Third Child
Print Child's Name: _____

Name of Case Manager: _____

Case Management Agency: _____

Case Manager's Email: _____

Case Manager's Phone Number: _____

Fourth Child
Print Child's Name: _____

Name of Case Manager: _____

Case Management Agency: _____

Case Manager's Email: _____

Case Manager's Phone Number: _____

Family Respite Program Application Signature Page

- *I understand that the information provided on this application will be used to determine my child(ren)'s eligibility for the Family Respite Program.*
- *I give my consent to Community Care to verify the information included in this application.*
- *I understand I am required to give complete and truthful information.*
- *I have read and reviewed each of the preceding policies, understand and agree to each.*

Print Name: _____

Date: _____

Parent/Guardian Signature: _____

Date: _____

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