



South Florida Autism Center, Inc.

AT-HOME RESPITE CARE

2022-2023

Program Handbook & Application

South Florida Autism Center, Inc. Mission Statement

It is the intention of SFA Center to provide a safe, positive and enriching experience for each child enrolled in our At-Home Respite Program.

POLICIES AND PROCEDURES

Roles and Responsibilities of each Parent:

Parents and guardians are responsible for the following:

- Timely payments of all program fees
- Signature on sign in/out form
- Complete/update the SFA Center Registration Form
- Submit the required, non-refundable registration fee of \$50

A PARTICIPANT MAY BE DISMISSED FROM THE PROGRAM IF A PARENT DOES NOT MEET THE ABOVE RESPONSIBILITIES ON A CONSISTENT BASIS!

Discipline

Behaviors will be addressed on a case-by-case basis, consistent with the methodologies utilized by SFA-Center.

Hours of Operation:

Determined on a case by case basis. Respite care will not begin until 4pm on days the School or Center are open.

Minimum of four hours.

Enrollment Requirements

The program is available to children diagnosed with autism spectrum disorder(s). Only children whose parents/guardians have completed the registration process may be considered for acceptance into the Center's At-Home Respite Program.

The following is required for registration:

- \$50 Registration Fee
- Emergency Information Form
- Payment Contract

Registration Fee: Non-refundable registration fee of \$50.00 per family.

REGULAR PROGRAM FEE:

\$20 per hour, after midnight the rate increases to \$25 per hour. Payment is due once services have been rendered.

Your credit will be charged on the following business day after services have been provided.

Cancellation:

Please provide at least 24 hour notice if you need to cancel for any reason. If less than 24 hours are given a \$25 cancellation fee will be charged to the credit card we have on file.

Allergies:

Allergies to foods, chemicals or other environmental issues (such as nuts, pollen, bee stings) must be listed in the "Allergies" section of the child's registration form. Please include any reactions and treatments.

Sick Policy:

Parents/Guardians will be called immediately if the child appears sick. Signs of illness include, but are not limited to: green mucus, fever, pink eye, diarrhea and vomiting. It is the responsibility of the Parent/Guardian to return home in a reasonable amount of time.

Medications:

If medically necessary medication will be given by staff, however, we discourage this and suggest that all medication be given prior to the start of respite care. Please provide the names of all medications that your child is currently taking.

Schedule:

Please provide staff with a schedule or routine for your child (i.e. meal time, bedtime, playtime, etc.)

Pets:

Staff is not responsible for any pets that are in the house during respite care. Please make sure you have appropriate care for your pets during that time.

Meal Prep:

Staff is able to complete simple meal preparation (microwave items and sandwich prep) during respite care.

Staff is not responsible for any other children that may be in the house during the time of respite care. If services are needed please contact us and will provide additional staff and charge for the services provided

Self-Care:

Indicate accordingly:

1. Independent 2. Needs Supervision 3. Needs Assistance 4. Completely dependent

_____ Eating _____ Dressing _____ Toileting _____ Bathing / Shower _____ Tooth
brushing
_____ Shaving _____ Menses _____ Administering medications

Please include any other special self-care information that you consider important for
the program staff to be aware of?

**If your child is not toilet trained please provide staff with the appropriate items needed
to properly care for your child’s needs. (i.e. gloves, diapers, baby wipes, etc.)**

Behavior Profile:

(Please indicate frequency)

0=Never 1=Daily 2=Weekly 3=Monthly 4=Every 3 Months 5=Every 6 Months

_____ Physically Assaultive _____ Pica _____ Self-Injurious _____ Withdrawn _____ Fire setting
_____ Sleeping Disorders _____ Eating Disorders _____ Stealing _____ Verbally Abusive
_____ Sexual Misconduct _____ Smears Feces _____ Wanders _____ Temper Tantrums
_____ Non-Compliance _____ Destroys Property _____ Elopement _____ Enuresis
_____ Impulsive _____ Mood Changes _____ Hyperactive

Please indicate other pertinent information related to unusual or maladaptive behaviors and/or psychiatric symptoms (i.e, how often do behaviors/symptoms occur?)

Please begin with morning medication and end with bedtime medication. Please check the box for medication that will be taken at the Center.

List of Medication:	Dosage/Time	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

To the best of my knowledge, the above information is correct and complete. In the event of a change of address, phone number, name, etc., I will notify the center immediately.

Parent/Guardian Signature _____ **Date**
____/____/____

Parent/Guardian Signature _____ **Date**
____/____/____

South Florida Autism Center At-Home Respite Program Payment Contract

This agreement is made on _____ (Date) between South Florida Autism Center, Inc. and the Parent/Guardian, _____, with custody of _____ who reside at the following address:

Address: _____ City: _____ Zip: _____

(H) Phone: _____ (W) Phone: _____ (C) Phone: _____

I enrolled my child(ren) for the South Florida Autism Center's At-Home Respite Program

I agree to pay \$20 per hour, after midnight the rate increases to \$25 per hour

I agree to pay a Registration Fee of \$50 per family enrolled in the program. I understand this fee is non-refundable (payment enclosed).

I agree to pay a \$25 fee if my credit card is declined more than once for any reason

I do not expect the Center's At-Home Respite Program to provide medical insurance for my child(ren) nor will I hold the South Florida Autism Center's At-Home Respite Program, Director or staff liable for injuries which may occur in the normal provision of child care. I will provide my own medical insurance.

I have read the attached policies and rules. Until these policies are changed, I accept them as they are and agree to abide by them.

Parent/Guardian Signature _____ Date: _____

Parent/Guardian Signature _____ Date: _____

**South Florida Autism Center At-Home Respite Care
Emergency Contact Information**

Child's Name: _____ Name called: _____

Date of Birth: _____ Grade: _____ Present age: _____ Sex: _____

Parent/Guardian's name: _____ Work hours: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Parent/Guardian's name: _____ Work hours: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Parent/Guardian's email: _____

Parent/Guardian's email: _____

Doctor's name & phone number: _____

Nearest relative/neighbor to contact in case emergency contacts & parents cannot be reached:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Allergies: _____

Any health problems? _____

Nearest hospital you would like us to send your child in case of an emergency:

Relate any information which you think would be of help to the staff:

Credit Card Authorization Form:

Visa: _____ MasterCard _____ Amex _____

Card Number: _____

Billing Zip Code: _____

Expiration Date: _____ Security Code: _____

Email Receipt to: _____

Parent/Guardian Signature : _____

Date: _____

Print Name: _____