South Florida Autism Center, Inc.

AT-HOME RESPITE CARE

2024-2025

Program Handbook & Application

Mission Statement:
SFAC intends to provide a safe, positive, and enriching experience for each child enrolled in our Before Care Program. Our program is designed to give the parents flexibility regarding drop-off and pick-up times for their children. A student-to-teacher ratio of 3:1 is maintained at all times.

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 $100

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

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 5 pm on days the School or Center is 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:
[ ] $100 Registration Fee
[ ] Emergency Information Form
[ ] Payment Contract

REGULAR PROGRAM FEE:
$25 per hour, after midnight the rate increases to $30 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 $50 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, and 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 before 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 can 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) in 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 that may occur in the normal provision of child care. I will provide my 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: _____