Welcome to our RFENC Respite Program! We look forward to helping you meet your respite needs for your children and youth. **Our respite program is intended for you to take time for the overall health of yourself and is not intended for childcare while you are at work.**

Here at RFENC we believe it is important to provide our employees with information to meet the needs of your child, youth, or adult. Each potential employee is CPR and First Aid Certified, has a background check along with a DMV driving record background check. We meet and interview each potential applicant two times and each applicant has the option to attend a training that includes: Autism Spectrum Disorders Strategies to Improve Social – Emotional Skills and Engagement at home, Adolescence and Autism Spectrum Disorders, Mental Illness in Children and Adults, a DVD that includes, Seizure First Aid, a DVD that models proper lifting techniques and finally Mandated Reporting handouts through the State of California that includes a DVD training. If an employee completes all the above classes, they have done many hours of preparation and education to be a provider for your family.

Enclosed you will find paperwork to fill out to help us assist your child. I have enclosed a Respite Program Consumer Rights Policy, RFENC Consumer Information Form, and an Authorization to Seek Treatment form. Please read all these forms carefully sign and date them. **Please make a copy of the RFENC Consumer Information Form and the Authorization to Seek Treatment Form and keep a copy for yourself.** These forms will help our respite worker meet your child’s needs. Please send ALL papers back to FRENc after you make copies for your files. **RFENC needs to have an authorization from Far Northern Regional Center and we will need to have this paperwork sent back to us before services can begin.** Please communicate with the respite department before respite services are started to make sure we have all the needed documents.

**Respite services can be in your child, youth, or adult’s home only and not in the provider’s home. Our program reimburses each respite care provider round trip mileage from home to home.** Also, as a family, you will have the opportunity to interview with your potential respite provider. This time with the provider is taken from your total hours approved from Far Northern Regional Center and your child, youth, or adult needs need to be present. Our providers are there to provide respite to your child, youth, or adult that Far Northern Regional Center has sent to us. Please find other arrangements for your other children.

We try our best to meet your individual family needs by finding a skilled and available provider. This process takes time. We do not guarantee that we can find an appropriate provider with a last-minute request of services. Once a provider is established, families need to give at least 48 hours notice to their established provider for respite services.

Should you have any questions, please call RFENC to leave a message and we will get back to you within 48 hours. The office phone number is (530) 226-5129 x203.
Quarters are:  
January – March  
April – June  
July – September  
October – December

Dear Parents,

The respite program is designed to help you take the time you need to relax and re-energize. As a participant in the program, Far Northern Regional Center authorizes 90 respite hours and 300 miles each quarter. It is your responsibility to track these hours and miles each quarter. If you feel that you need additional hours during the quarter, you must contact your Far Northern Service Coordinator at (530) 222-4791 to request those hours. If additional hours are approved, that is when you can use them and not before.

In an effort to help you track your family’s respite hours and miles, we are attaching a tracking sheet for your use. It is also available on our website at rfenc.org under the Respite page. It is your responsibility to use this sheet to help you keep track of the hours and miles for each respite provider working for you each quarter.

Another tool we have for you to track your hours is with the time cards. Time cards are in two parts. The white copy is for your Respite Care Worker to turn in to RFENC for payment and the yellow copy is for the parents to keep for their files. Please make sure you sign the time card after each visit and verify the hours entered. The time card yellow copy is a good way to keep track of how many hours you use each quarter. These yellow copies will also be used in part of our Fraud Prevention program. We will do random audits to see if your hours used match the hours we have entered.

Any overages you incur must be reimbursed to RFENC. The rate is $15.00 - $18.50 per hour and $0.630 per mile that you go over your authorized amounts. This reimbursement rate includes a 15% administrative charge.

We are enclosing a Respite Billing Agreement form on which you can confirm your understanding of this policy; please sign it and mail it back to us as soon as possible. If you prefer, you can email the form to us at respite@rfenc.org. Please be sure to sign your name if you are emailing the forms.

We appreciate your cooperation in the above matter. Please call the Respite office if you have any questions!
**Respite Hours and Miles Tracking Sheet**

Authorized for: 90 hours and 300 miles

Quarters are: Jan.-Mar./Apr.-June/July-Sept./Oct.-Dec.

<table>
<thead>
<tr>
<th>Date of Service</th>
<th>Hours Used</th>
<th>Miles Used</th>
<th>Provider's Name</th>
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**Total**
I have read the information about respite billing overages and understand that it is my responsibility to track the respite hours and miles my family uses each quarter so that my family does not exceed its authorized amount of respite hours and miles. I understand that I will be financially responsible for any billing overages that may occur as a result of my family using more than its authorized respite hours and miles.

I understand that if my family uses more hours and miles than is authorized to receive in a given quarter, I will receive a phone call and a bill.

Written Name:

Signature:

Date:
RFENC RESPITE PROGRAM CONSUMER RIGHTS POLICY

RFENC policy is;

1. Each consumer is offered individualized services based on their needs. Services shall foster the developmental potential of the child, youth, or adult. Such services shall protect the personal liberty of the individual and shall be provided under conditions that are the least restrictive environment necessary to achieve the purpose of treatment;

2. Each consumer will be treated with dignity and respect;

3. To be free from harm, including unnecessary physical restraint, or isolation, excessive medication, abuse or neglect;

4. To refer consumers for advocacy services as provided by law, to protect and assert civil, legal and services rights to which any person with a developmental disability is entitled and to assist consumers in obtaining access to legal resources as needed;

5. To offer services free from discrimination by exclusion from participation in, or denial of the benefits of, any program or activity with receives public funds solely by reason of being a person with a developmental disability;

6. To allow each client the right to withdraw from the program at any point and time without discrimination or prejudice; and

7. Each client has the right to be free from hazardous procedures and environments.

If you feel you have been denied any of the above right, please report the incident to the Respite Program Supervisor at (530) 226-5129.

I have read and/or had explained the above Rights Policy and understand what my rights are as a client of RFENC Respite Program.

Signature: __________________________ Date: __________________________
RFENC RESPITE CARE FAMILY RESPONSIBILITIES

1. The family must provide the Respite Care Provider with The Family Packet of Information including the Authorization to Seek Treatment Forms.

2. If adaptive equipment is used (i.e. braces, wheelchairs, lifts, etc.) the family is to give the Respite Care Provider complete instructions and a demonstration of how to use the equipment.

3. If special care is required to move the consumer, thorough instructions and a demonstration must be given to the Respite Care Provider.

4. Medications can be administered only if the Medication Release Form has been signed by the parent/guardian. Medication must be pre-measured and complete instructions must be written out by the parent/guardian before leaving. The parent should leave the medication out of sight and reach of the consumer and show only the Respite Care Provider the location of the medicine.

5. Families may ask the Respite Care Provider to accompany the consumer to activities outside of their home, but it is the parent’s responsibility to transport their child to and from a local community destination.

6. RFENC is only responsible for the care of the consumer. Friends, siblings, and other family members are not eligible for care.

7. Respite Care is available only when the authorized consumer is present.

8. After each service the family must sign the Respite Care Provider’s timesheet in the Parent Signature section. It is the responsibility of the family to review timesheets for accuracy.

9. It is the parent’s responsibility to track their hours and miles for each quarter. If the family goes over their allowed hours or miles, the family will need to reimburse RFENC for the overage.

10. Respite Care Providers can work no more than 40 hours per week. This includes ALL families they work with, if they care for more than one family. Our work week is from Sunday 12:00 am to Saturday 11:59 pm.

11. Families must notify their Respite Care Provider of a cancellation at least 8 hours prior to a scheduled respite appointment, unless due to illness, so the Respite Care Provider may
have adequate notice. If less than an 8-hour notice is given by the family to the Respite
Care Provider, the family may be billed 2 hours of lost work time. (See cancellation policy
on the next page.)

12. Families are not allowed to give Respite Care Provider’s keys to their homes or any other
property.

13. The family will be occasionally asked to verify hours and services provided as part of our
fraud prevention policy.

14. Please report any problems or concerns to the RFENC Respite Office immediately at
(530) 226-5129.
RFENC POLICY ON SCHEDULING RESPITE

In order to maintain accurate records of the hours respite care families use, provider’s time cards need to be submitted every two weeks with parent signatures on the time cards in the parent signature box.

BILLING OVERAGES

It is the parent’s responsibility to track their hours and miles. If an overage takes place, it is the family’s responsibility to pay RFENC. The process will be as follows:

1. A phone call will be made to the family to inform them of their overage.
2. RFENC will send a bill to the family for the overage of hours and/or miles. This bill will include an extra administrative fee of 15%.
3. If we do not receive the reimbursed payment from the family. Respite services will be suspended until RFENC is paid back from this overage.

CANCELLED OR NO-SHOW RESPITE APPOINTMENTS

An 8-hour notice must be given to cancel respite by the parent or provider, unless due to illness. If less than an 8-hour notice is given by the parent, the Respite Care Provider has the option to turn in a cancellation notice for reimbursement of lost wages. If the Respite Care Provider turns in a cancellation notice for reimbursement, the Respite Department will contact the family to see why the respite appointment was cancelled. From the conversations with the family and the Respite Care Provider, the Respite Department will determine if the family will be charged a cancellation fee or if the fee will be waived. If the Respite Department determines that the family will be charged a cancellation fee, a bill will be sent to the family in the amount of $30.

If the Respite Care Provider shows up to the family’s home and the family is not there. This will be classified as a No-Show appointment. The same procedure outlined above will be followed and the family could be charged the $30 cancellation fee.
If less than an 8-hour notice is given by the Respite Care Provider, the family needs to call RFENC and we will do our best to find another provider to cover the appointment.

**MEDICAL TASKS**

Respite providers are not medically trained to perform tasks such as tube feeding, urinary catheter procedures, shunt procedures, diabetes checks, or oxygen support procedures. If the consumer requires one of these tasks, please call the Respite Department right away to discuss other respite options.

**RFENC HEALTH AND ILLNESS POLICY**

In general, Respite Care should be provided by healthy workers to healthy families. RFENC Respite Care Providers should not be expected to provide care for clients who are actively ill with communicable conditions: colds, flu, sore throats, diarrhea, etc. If a child is ill at the time of a respite appointment the family should inform the Respite Care Provider, as soon as possible, to make other arrangements. It is advisable to reschedule the respite care to a time when the child is well. A respite care provider who is actively ill with a possible communicable condition should inform any families he/she has agreed to provide respite for, giving them a chance to make other arrangements. Any of the following are signs of active illness if occurring within 24 hours of a respite appointment:

- Fever of 100+ degrees
- Vomiting
- Diarrhea (unusually loose or frequent, unnaturally strong odor, unusual color or frothy appearance)
- Discharge from the nose or eyes that is anything but clear
- Sore throat or swollen glands
- Conjunctivitis (pink eye)
- Head or Body lice
- Childhood illness such as: chicken pox, measles, mumps
- Other communicable illness: strep throat, mononucleosis, hepatitis
HOSPITALIZATION AND APPOINTMENTS

If the child, youth, or adult is hospitalized for any reason please give your Far Northern Service Coordinator a call to let them know. Your Respite Care Provider cannot provide respite to your child, youth, or adult while they are in the hospital or in an out-of-home placement facility. It is also outside the scope of respite, and not permitted, for your Respite Care Provider to attend doctor and/or therapy appointments with the consumer.

RFENC CARE TO NEURO-TYPICAL SIBLING POLICY

RFENC only provides care to FNRC consumer(s).

Parent Signature: ____________________________________________________________

Parent Name: ___________________________________________ Date: ________________

QUARTER BREAKDOWN

The following represents the breakdown of RFENC Respite Care Program quarters:

January 1 – March 31
April 1 – June 30
July 1 – September 30
October 1 – December 31

As of ________________________, your family is authorized for a total of

____________ hours per quarter and ________________ miles per quarter.
RFENC CONSUMER INFORMATION FORM

Family Name(s) _______________________________ Date __________________

Address ___________________________________ City ___________________________

Zip _______________ Child/Youth Ethnicity _________________ Parent Ethnicity ____________

Phone ______________________________________

E-mail Address ____________________________________________

Child/Youth/Adult Name _______________________________ Date of Birth ______________

Diagnosis ___________________________________________ Age of Diagnosis__________

Age of Child/Youth/Adult ________ School of Attendance _______________________________

Sibling’s Names and Ages _______________________________________________________

Grade ______ Check your child’s educational setting:
   Special Day Class __________
   Full inclusion with one-on-one aide _____________
   Full inclusion without an aide _____________
   Other ______(describe) ____________________________________________

Please check if: ______ under 18 years old, _______ Conserved, ________ Not Conserved

Does your child have a social program as part of an IEP at school? ________________

If so, please describe ______________________________________________________________________

List your child/youth/adult’s top 3 greatest needs/challenges at this time:

1. _____________________________________________________________

2. _____________________________________________________________

3. _____________________________________________________________

List your top 3 greatest parenting challenges/needs at this time:

1. _____________________________________________________________

2. _____________________________________________________________

3. _____________________________________________________________
Self-Care (Please check and explain below)
Consumer needs assistance with:

Dressing  Toileting  Bathing  Eating  Special Nutrition

Explain the above:

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Does the child/youth/adult have sensory issues (Please explain)?
____________________________________________________________________________________
____________________________________________________________________________________
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Does the child/youth/adult have any motor issues (Please explain)?
____________________________________________________________________________________
____________________________________________________________________________________
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Communication:

Does child/youth/adult have limitations in communication?

__________________________________________________________________________

__________________________________________________________________________

Does the child/youth/adult use speech, gestures, sign language, or picture boards?

__________________________________________________________________________

__________________________________________________________________________

Does the child/youth/adult respond to speech?

__________________________________________________________________________

__________________________________________________________________________

Does the child/youth/adult have any special health care considerations?

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Does the child/youth/adult have any allergies?

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Does the child/youth/adult have seizures? Yes _________ No _________

Does the child/youth/adult take any medications?

__________________________________________________________________________

__________________________________________________________________________
Behavioral Information

Does the child/youth/adult have special behavioral needs or concerns?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

How does the child/youth/adult handle or express frustration/anger/distress?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

What are the triggers that cause the child/youth/adult to become frustrated?
(Example: being told no, denial of wants, etc.)

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

What works to de-stress the child/youth/adult or calms him/her down?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

If there is anything else that you want RFENC to know please write it below.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
AUTHORIZATION TO SEEK TREATMENT

I, the parent/guardian/conservator of ____________________________, (date of birth) _____________, hereby authorize the staff of RFENC respite care program to seek emergency treatment in my absence, in the event of an illness or injury to my child/dependent.

Signed ____________________________________________________________

Relationship ___________________________ Date __________________________

Emergency Contact ___________________________ Phone _____________________

2nd Emergency Contact ___________________________ Phone _____________________

Physician ___________________________ Phone _____________________

If the child/youth/adult has to go to the hospital which one would you prefer?

   Mercy __________
   SRMC __________
   Other __________ Specify ____________________________________________

MEDICAL INFORMATION

Allergies:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Medications:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Pre-existing Medical Conditions:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Signature ___________________________________________ Date __________________
MEDICATION RELEASE FORM AND POLICY

I, the parent/guardian/conservator of ____________________________,
(Date of Birth) ______________, hereby authorize the staff of RFENC respite program
to supervise the distribution of medication to the consumer as indicated below. I agree
to give detailed, written instructions and to pre-measure all medications. A separate
form is required for each consumer in need of medication disbursement. If instructions
are not provided and medications are not pre-measured a Respite Care Provider cannot
dispense medications. The Respite Care Provider will confirm that the medication
amount and the time it is to be given match the prescription information on the
medication package. If the Respite Care Provider cannot verify the prescription
information on the package then he or she cannot dispense the medication. This
procedure is followed to prevent overdose. Over the Counter (OTC) medication can be
given to the consumer if an OTC form is completed. This form must be completed by the
care provider and will list the OTC medications that can be given if requested. If these
medications are given they will be listed on the OTC form along with the dosage and time
given. It is the care provider’s responsibility to check the form upon arrival to prevent
giving excess medications.

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<tr>
<th>MEDICATION NAME</th>
<th>DOSAGE</th>
<th>TIME TO ADMINISTER</th>
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Further instructions regarding medication disbursement (i.e. with food, on empty stomach, side
effects, etc.):

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Signature ___________________________ Date ___________________
OVER THE COUNTER MEDICATION (OTC) FORM

Please list the over the counter medications that can be given to the consumer.

**NOTE:** The Respite Care Worker has to follow the directions on the package exactly as written.

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<th>Amount</th>
<th>How Often</th>
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Family’s Signature ____________________________ Date __________________

During my shift, I gave the parent pre-dispensed medication(s) to the consumer:

<table>
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<tr>
<th>Medication</th>
<th>Amount</th>
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Care Provider’s Signature ____________________________ Date __________________
RFENC RESPITE AGREEMENT

RFENC is hereby given permission to refer Respite Care Providers to my home. I agree to fully discuss all facts pertinent to my child/children’s or adult’s needs and care and acknowledge full responsibility to do so. I will provide information such as diet, discipline, behavior, medications, and personal habits, and will ensure current medical emergency information is available to the worker during each respite appointment. I agree to update this information each year and to inform RFENC respite office of any changes in the status of my dependent. RFENC is not responsible for any incident which arises due to my failure to provide the Respite Care Provider with all relevant information.

As of ______________________ I am authorized for a total of _________ hours per quarter and _________ miles per quarter.

I have been provided with copies of the RFENC respite policies regarding in-home respite, and I agree to read and follow them to the best of my ability. If I have any questions or concerns I will call the Respite Coordinator at (530) 226-5129.

Family/Guardian Signature ____________________________________________

Respite Coordinator Signature ____________________________________________

Date ____________________________
IMPORTANT RESPITE REMINDERS

- Our respite program is designed to bring respite to your child, youth, or adult who is a Far Northern Regional Center consumer only. Other arrangements will need to be made to care for your other children.

- Our providers are not lifeguard certified. Our providers are prohibited to provide respite in any body of water which includes: a backyard pool, a community pool, a lake, or on a boat.

- Parents must transport their child, youth, or adult to any community outings. Respite Providers are prohibited from transporting clients. Our providers can meet parents at local community destinations.

Parent Signature: ____________________________________________________________

Parent Name: ________________________________________________________________

Date: ____________________

*Please return this form to RFENC*
AUTHORIZATION FOR RELEASE OF INFORMATION & RECORDS
(Please Print)

Parent/Legal Guardian: ____________________________________________

Phone Number: __________________________________________________

Street Address: __________________________________________________

City, State, Zip: ________________________________________________

Consumer’s Full Name: __________________________________________

Consumer’s Date of Birth: ________________________________________

I, ____________________________________________________________, as legal guardian of the child, youth, or adult named above, hereby give permission to RFENC’s Respite Program Coordinator, to discuss and share information regarding my child, youth, or adult for the purpose of finding the most qualified Respite Care Provider to meet my family’s needs.

Parent/Legal Guardian: _______________________________ Date: __________

Witness: ________________________________ Date: __________

This authorization is valid for one year from date signed.