

Family Registration

Parent/Caregiver Information

First Name: _____ Last Name: _____

Address: _____ Apt/Unit: _____

City: _____ Postal Code: _____

Nearest Intersection: _____

Phone #: _____ Alt Phone #: _____

Fax: _____ Email: _____

Relationship to Individual: Mother Father Legal Guardian Other: _____

Language Spoken at Home: _____

Interpreter Needed: Yes No If yes, Identify Language _____

Primary Contact Information Check if same as Parent/Caregiver

First Name: _____ Last Name: _____

Address: _____ Apt/Unit: _____

City: _____ Postal Code: _____

Nearest Intersection: _____

Phone #: _____ Alt Phone #: _____

Fax: _____ Email: _____

Relationship to Individual: Mother Father Legal Guardian Other: _____

Individual (son/daughter) Information

First Name: _____ Last Name: _____

Date of Birth: _____ Male Female

Check if address is same as Parent/Caregiver If different, please provide below:

Address: _____ Apt/Unit: _____

City: _____ Postal Code: _____

Nearest Intersection: _____

Phone #: _____ Alt Phone #: _____

Please list interests and hobbies of your son/daughter:

Disability and Special Needs

Diagnosis:

- | | | |
|---|---|---|
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Allergies | <input type="checkbox"/> Autism/PDD |
| <input type="checkbox"/> Challenging Behaviours | <input type="checkbox"/> Dual Diagnosis | <input type="checkbox"/> Developmental Disabilities |
| <input type="checkbox"/> Medically Complex | <input type="checkbox"/> Mental Health | <input type="checkbox"/> Physical Disability |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> FASD | <input type="checkbox"/> Asthma |

Other Needs:

- G/J Tube Oxygen Suctioning Tracheotomy Ventilator

Support Required:

- | | | |
|--------------------------------------|---|---|
| <input type="checkbox"/> ABA | <input type="checkbox"/> Alternative Communication | <input type="checkbox"/> Sign Language |
| <input type="checkbox"/> Behavioural | <input type="checkbox"/> Assistive Devices (i.e. wheelchairs) | <input type="checkbox"/> Personal Care (i.e. toileting) |
| <input type="checkbox"/> Medical | <input type="checkbox"/> Physical (Transfers & Lifts) | <input type="checkbox"/> Speech & Language |

Additional Information: _____

How did you hear about respiteservices.com? _____

Type of respite support required:

- In-home Respite Worker Out-of-Home Both Unsure

Person filling out form: _____

Relationship to Service User/Individual: _____

Agency filling out form (if applicable): _____

Complete the following if you wish to connect with CHAP workers.

Worker Preferences



Worker gender preference: Male Female Either

Rate of Pay: \$10-12 \$12-15 \$15+ Negotiable

Do you require a worker with a driver's license: Yes No

Does a worker require the use of their own vehicle: Yes No

Worker Duties/Additional Comments: (*personal care requirements, worker expectations, specific care needs etc*)

Required Worker Availability (other than summer months): (*Check preferred days and times*)

REGULAR HOURS							
REGULAR	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Before School							
Morning							
Afternoon							
After School							
Evening							
Overnight							
OTHER HOURS							
Summer Months	Please specify:						
March Break	Please specify:						
Holidays	Please specify:						
Relief	Please specify:						

Classified Ad



Would you like to have a classified ad posted on our website: Yes No

Please compose your classified advertisement for our website. By having a classified advertisement posted, CHAP Workers currently looking for contracts can view work opportunities and request their profile to be sent to families they are interested in supporting. Classified advertisements are posted for one month and can be renewed at any time. Families' personal information is not posted in the classified. Each family is identified with an ID# assigned upon registration.

Classified Ad
<p>Description of Individual: _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p>Workers Duties/Activities: _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>

Additional Information
<p>Who do you want information to be sent to? <input type="checkbox"/> Parent/Caregiver <input type="checkbox"/> Primary Contact</p>

<p>Please read and sign the following:</p> <p><i>I am interested in being registered with the CHAP Program. I understand that the information provided will be used to facilitate the process of matching a worker(s) with my family. I am prepared to select, interview and contract a worker at my own discretion.</i></p>
<p>_____</p> <p>Signature Date</p>



CONSENT FORM

Collection, Use and Disclosure of the Information Provided

The information collected directly from you will be forwarded to the respiteservices.com staff (hosted by Northumberland Family Respite Services) and will be used for the following purposes:

- to facilitate the process of matching a worker with your respite needs,
- to facilitate the process of applying for an out-of-home respite option(s)
- to facilitate both processes named above.

In order to assist you in the best possible manner, there will be a need to share (as appropriate) the information provided with other respite agencies / service providers, including other respiteservices.com host agencies.

Furthermore, some of the information collected will be summarized periodically to facilitate community planning activities. Such information summaries will not include personal identifiers (e.g., name, address, phone number, etc).

Consent

I _____, have reviewed the statement concerning the collection, use, and disclosure of personal information with regards to _____ (name). I understand that I can refuse to provide consent. I also understand that I can withdraw my consent any time.

I hereby authorize the collection, use, and disclosure of my personal information for all the purposes identified above.

- | | |
|------------|----------------------------------|
| Parent | I agree <input type="checkbox"/> |
| Guardian | I agree <input type="checkbox"/> |
| Individual | I agree <input type="checkbox"/> |

Withholding Consent

Are there any restrictions regarding the collection, use, and disclosure of the information provided?

If you do not authorize the disclosure of your information to other respite agencies, please name the agencies:



CHAP PROGRAM FAMILY AGREEMENT and RELEASE

By signing this Agreement and Release I acknowledge and agree that:

CHAP workers are not CHAP Program employees. The CHAP Program has provided me a list of names of available CHAP workers and I am responsible for my selection of a CHAP worker. I will pay the CHAP worker I hire directly. The CHAP Program is not responsible for disagreements I may have with the CHAP worker. I will resolve my problems directly with the CHAP worker. The CHAP Program is not responsible for the actions or conduct of any CHAP worker I hire.

The CHAP worker provided an up-to-date Police Reference Check and letters of reference to the CHAP Program at the time of their interview for the CHAP Program worker database and has confirmed the accuracy and completeness of those references. The CHAP Program has made no representations about the references and is not responsible for checking those references. It is my responsibility to check references and to ensure there is a current Police Reference Check on the CHAP worker.

A CHAP worker is not a trained therapist. Her/his name is being provided to me as a possible respite worker who has received a full day orientation to the CHAP Program, including an introduction to autism. A CHAP worker may be removed from the CHAP worker database at any time, in the sole discretion of the CHAP Coordinators.

The CHAP worker has acknowledged in writing that:

1. She/he is an independent contractor and is not an employee, agent or representative of the CHAP Program and is not authorized to represent or speak for the CHAP Program or respiteservices.com;
2. Except where my employer consents, I will keep information about my employer and her/his family or my contract with my employer confidential;
3. She/he is solely responsible for any private vehicle she/he uses to transport persons served by the CHAP worker; and
4. She/he is solely responsible for her/his own health or accident insurance, or payment of taxes, or contribution to Employment Insurance or CPP or other benefits plan.

In consideration of my being given access to the names of CHAP workers, I release the CHAP Program and respiteservices.com (which terms in this Agreement and Release includes all parties legally responsible for the CHAP Program and respiteservices.com in particular, the local sponsoring agency(ies), Geneva Centre for Autism, and their employees, officers and directors) from all actions, causes of action, proceedings, claims, demands, losses, damages and liabilities of every nature and kind arising from my dealings with the CHAP Program, respiteservices.com and any CHAP worker. I agree to indemnify the CHAP Program and respiteservices.com from all claims made against them as a result of my conduct. I will make no claim against any party that may claim contribution or indemnity from the CHAP Program and respiteservices.com.

Date: _____

Parent or Guardian (please print)

Witness (please print)

Parent or Guardian (signature)

Witness (signature)

