For Office Use Only: Individuals aged 18+, DSO eligibility confirmed database #_____

Family Registration

Parent/Caregiver Information

First Name: _____ Last Name: _____ Initial: __
Mailing Address: _____ Apt/Unit: _____
City: _____ Postal Code: _____
Nearest Major Intersection: _____
Telephone: _____ Other: _____
Fax: _____ Email: _____
Relationship to Individual: ☐ Mother ☐ Father ☐ Legal Guardian
If Other, specify _____
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: _____ Initial: __
Address: _____ Apt/Unit: _____
City: _____ Postal Code: _____
Telephone: _____ Other: _____
Fax: _____ Email: _____
Relationship to Individual: ☐ Mother ☐ Father ☐ Legal Guardian
If Other, specify _____

Individual (son/daughter) Information

First Name: _____ Last Name: _____ Initial: __
Date of Birth: _____ Male☐ Female☐

If over 18 years of age, has DSO confirmed eligibility? ☐Yes ☐ No

Check if address is same as Parent/Caregiver ☐

Address: _____ Apt/Unit: _____
City: _____ Postal Code: _____
Telephone: _____ Other: _____

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CHAP COMMUNITY HELPERS FOR ACTIVE PARTICIPATION
240 Edward St., Unit 3 Aurora, ON L3G 3S9 Phone: 1 888 695 0070 ext. 2575 Fax: 905 898 1171

Diagnoses and Support Needs

To be eligible for our services, an individual must have one of the following diagnoses:

☐ Developmental Disability
☐ Autism
☐ Asperger's Syndrome
☐ Down Syndrome
☐ Hearing Impairment (under the age of 18)
☐ Visual Impairment (under the age of 18)
☐ Physical Disability (under the age of 18)

Additional Diagnoses:

☐Dual Diagnosis (developmental disability with mental health issue) ☐ADHD/ADD
☐Medically Complex ☐Mental Health ☐Visual Impairment (over age 18)
☐ Hearing Impairment (over age 18) ☐Physical Disability (over age 18)
☐ Seizures ☐ Obsessive Compulsive Disorder

Behaviour Challenges:

☐Challenging Behaviours
☐Self-Injurious Behaviours
☐Aggression towards others
☐Other (please describe)_____
_____

Other Needs:

☐Oxygen ☐Suctioning ☐Tracheotomy ☐Ventilator ☐G/J Tube

Support Required:

☐ Experience with ABA ☐Alternative Communication Devices ☐Behavioural
☐ Medication Administration ☐ Assistive Devices (wheelchair etc.) ☐ Physical (Transfers & Lifts) ☐Sign Language ☐Speech & Language ☐ First Aid☐CPR
☐ Personal Care (i.e. toileting) ☐ CPI

Individual (son/daughter) Information

Additional Information: _____
_____
_____

Please list interests and hobbies of your son/daughter:

_____
_____
_____

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How did you hear about respiteservices.com? _____
Person filling out form: _____
Relationship to Service User/Individual: _____

Agency filling out form (if applicable): _____

Who will receive information: ☐ Parent/Caregiver ☐ Primary Contact

Support Provider Requirements

Gender: ☐ Male ☐ Female ☐ Either?

Rate of Pay: ☐ $15-18 ☐ Negotiable

For respite support require a candidate with: ☐ Driver's License? ☐ Vehicle?

Duties/Additional Comments:
Please include: any personal care necessary, support provider expectations, specific care needs etc.

_____
_____
_____
_____
_____
_____

Required Availability (other than summer months):
(Check days and times required or preferred)

Time	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Before School							
Morning							
Afternoon							
After School							
Evening							
Overnight							
Other:	Summer (months)				March Break	Holidays	Relief	
	Morn	After	Eve	Wkd				

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Classified Ad

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

Classified ads are an excellent opportunity to connect with additional support providers.

Please compose your classified advertisement for our website. By having a classified advertisement posted, CHAP respite support providers currently looking for contracts can view respite support opportunities and request their profile to be sent to families they are interested in supporting. Classified advertisements are posted for 90 days 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.

CHAP FAMILY CLASSIFIED

Description of Individual (son/daughter):

_____
_____
_____
_____

Support Provider Duties/Activities:

_____
_____
_____
_____

Additional Information

Parent/Caregiver to receive profiles by: ☐ mail ☐ fax ☐ email notice?
Primary Contact to receive profiles by: ☐ mail ☐ fax ☐ email notice?

Would you like to receive a copy of CHAP Information Package for Parents? ☐ Yes ☐ No

Would you like to speak to the Respite Access Facilitator about Out-of-Home respite options (day programs, residential, overnight, weekends)? ☐ Yes ☐ No

Please read and sign the following:

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 respite support provider(s) with my family. I am prepared to select, interview and contract a candidate at my own discretion. I am aware for individuals aged 18+ who are applying to the CHAP Program that eligibility for developmental services must be confirmed through DSO (Developmental Services Ontario).

_____ _____
Signature Date

Please return along with signed Consent and Release Forms to: CHAP Program (see below for address and fax)

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CONSENT FORM

Collection, Use and Disclosure of the Information Provided

The information collected directly from you will be forwarded to respiteservices.com (hosted by York Support Services Network). By signing this information, you will be consenting to collection, use and disclosure of personal information contained in the form in accordance with the respiteservices.com Privacy Policy and the Terms of Use.
The information that you provide will be used for the following purposes:

- to facilitate connecting you with respite support providers seeking respite contracts in order to meet your respite needs;
- to facilitate the process of referring you to, or applying for, respite programs and option(s);
- to facilitate both processes above;
- to contact you regarding upcoming events, activities and programs that may be of interest;
- to send you information, documents or forms required to keep your information up-to-date; and
- for quality assurance purposes, including feedback on how effective and helpful our services have been, to allow us to improve our services

In cases where you would like to be connected to respite programs or options, there will be a need to disclose the information to other respite agencies/service providers. Your request implies consent to forward your information to these agencies.
Furthermore, some of the information collected will be summarized periodically to facilitate community/provincial planning activities. Such information summaries will not include personal identifiers (e.g., name, address, phone number, etc.).

Consent

I_____, have reviewed and understand the above Statement of Purpose for the Collection, Use, and Disclosure of Personal Information. I understand that I can refuse to provide my consent. I also understand that I can access and change the information I have provided or withdraw my consent by providing notice in writing to *York Support Services Network.*. I authorize the collection, use, and disclosure of my personal information for all the purposes identified above..

Parent I agree☐ Guardian I agree☐ Individual I agree☐

Withholding Consent

If there are there any restrictions regarding the collection, use, and disclosure of the information provided please provide the details below.

_____

_____

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

☐Children's Treatment Network ☐Meta Centre ☐Kinark Child and Family Services
☐City of Vaughan ☐Reena ☐Inclusive Recreation Resource service
☐Community Living York South ☐Christian Horizons ☐CommunityLivingNewmarketAurora
☐Community Living Georgina ☐Kerry's Place ☐Participation House
☐ York Region Centralized Respite Services ☐Mary Centre ☐Safehaven ☐VITA Community Living
☐Town of Newmarket Inclusion & Recreation Services ☐Town of Richmond Hill
☐Developmental Services Ontario

Date:_____**Parent Signature:**_____**Witness Signature**_____

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RELEASE and AGREEMENT REGARDING CHAP WORKER

In signing this release I understand and agree to the following:

CHAP respite support providers are not CHAP Program employees. I am paying a CHAP respite support provider and contracting with her/him directly. The CHAP Program will not assume any responsibility for disagreements over fees, payments, or services provided. Problems that arise will be resolved between the CHAP respite support provider and myself.

At the time of interview for the CHAP Program respite registry, the candidate provided an up-to-date police reference check and letters of reference. It is my responsibility, if I choose, to check these references and ensure there is a current Police Reference Check.

The CHAP worker is not a trained therapist. Her/his name is being provided as a respite support provider who has received an Orientation to the CHAP Program. The CHAP Program accepts no responsibility for the actions or conduct of the CHAP respite support provider in a respite contract.

A CHAP respite support provider who is deemed unsuitable for respite contracts will be removed from the worker database at the discretion of the CHAP Coordinators.

The CHAP respite support provider has acknowledged in writing that she/he is not an employee, agent or representative of the CHAP Program and is not authorized to make any representation for the CHAP Program or respiteservices.com.

The CHAP respite support provider has acknowledged in writing that information about the worker or family, or consequences of the contract, is not the responsibility of the CHAP Program.

The CHAP respite support provider has acknowledged in writing that she/he is solely responsible for use of any private vehicle to transport persons served by the independent contractor.

The CHAP respite support provider has acknowledged in writing that she/he is personally liable for any health or accident insurance, or any payment of taxes, or contribution to Employment Insurance or CPP or other benefits plan.

I agree that in signing this form I release the CHAP Program from any and all actions, claims and demands for damages, loss or injuries, however arising.

Dated_____

_____ _____

Parent or Guardian Signature Witness Signature

Printed Name: Printed Name:

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