



Dear Family:

Thank you for your interest in NSSA's Family Support Services. These programs include In-Home Respite, Saturday Recreation, and a one week Summer Camp. Enclosed you will find a copy of our application as per your request. You will also find additional information about Nassau Suffolk Services for Autism.

Please read all information regarding your specific program of interest. Upon completing the application, please return to NSSA at the address above. Be sure to complete all required information accurately; make sure all signatures have been provided, and that the application is notarized in the designated area. Also, please include a copy of your son or daughter's most recent psychological evaluation stating the diagnosis of Autism Spectrum Disorder. The psychological evaluation must have been conducted no longer than 3 years from the date of applying.

We also require a copy of your son or daughter's eligibility letter from OPWDD. If your child has a Medicaid waiver please include a copy of his/her notice of decision (NOD). Failure to provide all necessary information as outlined above will disqualify your son or daughter from consideration for services. If you have not secured eligibility please follow up with the Long Island Developmental Disabilities Regional Office "Front Door" at (631) 434-6000 or online at OPWDD_DDRO5FrontDoor@OPWDD.ny.org.

Once your application and documents are received, they will be processed and your son or daughter will be included on the waiting list for consideration for future openings. Please be aware that there is no specific time frame for the waiting list. Applications are accepted throughout the year. After the initial review, application reviews for enrollment are conducted during December of each year, in preparation for January enrollment which runs through December 31st of that year. After available slots have been determined, a case by case assessment and lottery will be conducted to enroll families into those slots. Families will be notified by NSSA if they are chosen.

NSSA's Family Support programs currently support the needs of many families throughout Long Island. We understand the great need for services in caring for a family member with autism and we strive to support as many families as possible. If you have any questions or concerns please contact Christine MacPherson, Administrative Assistant for OPWDD Programs and Services.

Sincerely,

A handwritten signature in black ink, appearing to read 'Jason Watson', is written over the word 'Sincerely,'.

Jason Watson, BCaBA
Coordinator of OPWDD Programs



KEEP FOR YOUR RECORDS

DEFINITION OF IN-HOME RESPITE SERVICES

In-Home respite is designed to relieve a family of the responsibility for the supervision of a family member with autism (consumer) for brief periods of time. The role of the Respite Specialist is to provide supervision for and ensure the safety of the consumer.

The program is funded by a grant from OPWDD, Office for People with Developmental Disabilities, Medicaid (if applicable), and private contributions. Based on the provider agreement, each family is allotted a predetermined number of hours for one year (January through December) to be used as needed. We serve families in Nassau and Suffolk counties. The consumers must be at least 3 years of age and diagnosed with autism or on the autism spectrum.

Our agency interviews potential providers, conducts a training session on Autism and general principles of Applied Behavior Analysis as well as a mandatory Corporate Compliance training for all Respite Specialist that we hire. All candidates are also fingerprinted through OPWDD's Criminal Background Unit. We do not pay for training or time being fingerprinted. However, the cost of the finger printing is covered by New York State. We currently pay \$12 per hour once the individual begins working with a family. The hours vary, based on the need of the family. Respite Staff must be at least 16 years of age and be able to get to and from the consumers homes on their own.

Respite Specialist's are required to fill out time sheets and case notes for any hours provided to the families. The time sheets are signed by the consumer's family member or guardian. The case notes are used to give a brief summary of events and to write about any concerns the Specialist might have. Families are also required to keep track of all hours used. Use of hours may be randomly verified by NSSA's Coordinator of Quality Management.

Activities engaged in during the respite hours will be structured, appropriate and safe. The activities and the involvement of the Respite Specialist will vary depending on the level of need of the consumer. These activities will not duplicate or supplement the activities performed by a teacher or tutor, but may be something the consumer considers entertaining or enjoyable.



DEFINITION OF IN-HOME RESPITE SERVICES

It is strongly recommended that during the first few scheduled sessions, the family be home. This affords the opportunity for the Respite Specialist to become familiar with the consumer as well as the family to become familiar with the Specialist.

During ongoing respite, the Respite Specialist may NOT:

- Transport the consumer or family member of the consumer in his/her personal vehicle. They may, however, accompany the family out into the community either on foot or in transportation provided by the family.
- Administer any medical attention of any kind to any family member, including the consumer, prescriptive or over the counter medications, or monitor any vital signs or implement any medical procedure, such as taking a temperature or pulse, etc.
- Accept the responsibility for any family member, other than the consumer.
- Provide respite in the Respite Specialist's home or any other home than that of the family.
- Accept responsibility for any family member, including the consumer, in any setting that involves water, including a pool, a beach or bath.
- Provide respite overnight. (No respite hours will be provided between hours of 2am-5am)



FAMILY SUPPORT SERVICES APPLICATION

PLEASE CHECK ALL FAMILY SUPPORT SERVICES THAT YOU ARE INTERESTED IN:

- IN- HOME RESPITE SATURDAY RECREATION PROGRAM
 WEEK- LONG SUMMER DAY CAMP

CHILD'S LAST NAME : _____ FIRST NAME: _____

SOC SEC # _____ - _____ - _____ DATE OF BIRTH ____ / ____ / ____ AGE _____

MALE _____ FEMALE _____ MEDICAID # (if applicable) _____

HAS YOUR CHILD BEEN DEEMED ELIGIBLE BY OPWDD? YES NO
(if yes please attach copy of letter of determination)

HAS YOUR CHILD GONE THROUGH THE OPWDD FRONT DOOR? YES NO
(if yes please attach copy of letter supporting services)

HOME ADDRESS: _____ CITY _____

STATE _____ ZIP _____ HOME PHONE: _____

MOTHER/GUARDIAN NAME: _____ CELL PHONE: _____

WORK PHONE _____ EMAIL: _____

FATHER'S NAME: _____ CELL PHONE: _____

WORK PHONE _____ EMAIL: _____

DO YOU CURRENTLY RECEIVE RESPITE SERVICES OR REIMBURSEMENT FROM ANY OTHER AGENCY? YES _____ NO _____



80 Hauppauge Road, Commack, NY 11725
631-462-0386 fax: 631462-4201

FAMILY SUPPORT SERVICES APPLICATION

I CURRENTLY OR WILL USE THE RESPITE SERVICE FOR THE FOLLOWING PURPOSE(S)

SPECIAL NOTES:

****PLEASE ATTACH A COPY OF YOUR CHILDS OPWDD LETTER OF ELIGIBILITY AND THE MOST RECENT PSYCHOLOGICAL EVALUATION.****

SIGNATURE _____ DATE: _____

RELATIONSHIP TO APPLICANT: _____



GENERAL RELEASE FORM

I, _____, understand that NASSAU SUFFOLK SERVICES FOR AUTISM (NSSA) is a not for profit corporation organized under the laws of New York State, funded in part by a grant from the New York State Office of People with Developmental Disabilities, Medicaid (if applicable), and in part by private contributions. Under the terms of its grants and provider agreement, NSSA recruits and trains respite specialists to deliver respite services to families that have a family member with Autism. While such Respite Specialists are screened and trained by qualified personnel under contract to NSSA, and every effort is made to insure the competence and dependability of such staff, I understand that NSSA makes no warranty and assumes no responsibility for the actions of its Respite Specialists. If problems arise or if the quality of service provided is deemed unsatisfactory, every effort will be made to ameliorate the situation, but NSSA hereby disclaims any liability for damage, loss or injury due to the activities of its Respite Specialists.

I also agree to the release and/or gathering of necessary medical, psychological, and any other information and records which may be necessary for the provision of respite care services.

I acknowledge that I have read and understand this release agreement and have provided full and complete information to the Respite Coordinator and the Respite Specialist.

Signature of Parent/Guardian

Date



EMERGENCY MEDICAL INFORMATION AND RELEASE FORM

CHILD'S LAST NAME : _____ FIRST NAME: _____

MOTHER/GUARDIAN NAME: _____ CELL PHONE: _____

WORK PHONE _____ HOME: _____

FATHER'S NAME: _____ CELL PHONE: _____

WORK PHONE _____ HOME: _____

NAME OF PERSONS TO CONTACT IN CASE PARENTS CAN NOT BE REACHED:

NAME: _____ PHONE: _____

ADDRESS: _____

RELATIONSHIP TO CHILD: _____

NAME: _____ PHONE: _____

ADDRESS: _____

RELATIONSHIP TO CHILD: _____

PRIMARY PHYSICIAN: _____ PHONE: _____

ADDRESS: _____

DENTIST: _____ PHONE: _____

ADDRESS: _____



EMERGENCY MEDICAL INFORMATION AND RELEASE FORM

PLEASE COMPLETE THE FOLLOWING INFORMATION. DO NOT LEAVE ANY QUESTIONS BLANK; INDICATE NONE BY WRITING "NONE".

ALLERGIES: _____

SEIZURE CONDITIONS: _____

SPECIAL DIETS: _____

SPECIAL AIDS OR EQUIPMENT: _____

MEDICATIONS / SIDE EFFECTS: _____

OTHER ALERTS: _____



EMERGENCY MEDICAL INFORMATION AND RELEASE FORM

I, the parent /guardian of _____ do hereby give permission to Nassau Suffolk Services for Autism to seek treatment or diagnosis for my family member in case of an emergency. I have reviewed and approved the emergency procedure guidelines for In-Home Respite. I understand that should an emergency occur, the Respite Specialist will seek qualified medical help to treat my family member, and I will not hold them responsible for any untoward results.

SIGNATURE OF PARENT /GUARDIAN: _____

NOTARY PUBLIC

Sworn to before me this

_____ day of _____ 20 _____

NOTARY PUBLIC

ADDRESS

TOWN