Nassau Suffolk Services for Autism
The Martin C. Barell School

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

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. 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 Nassau Suffolk Services for Autism (NSSA) at 80 Hauppauge Road, Commack NY 11725. Be sure to complete all required information accurately and make sure all signatures have been provided.

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.

Once your application and documents are received, they will be processed and your son or daughter will be included in our database for consideration for future openings. Applications are accepted throughout the year. Application reviews are conducted during December of each year, in preparation for January enrollment which runs through December 31st of that year. 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 Rodriguez, Coordinator of Adult Day & Family Support Services.

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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 the general principles of Applied Behavior Analysis as well as a mandatory Corporate Compliance training for all Respite Specialists that we hire. All candidates are also finger printed 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 $13.35 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.

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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 a bath.
- Provide respite overnight. (No respite hours will be provided between the hours of 2 am – 5 am)

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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: ___________________________

DATE OF BIRTH: ___ / __ / _____ AGE: ______ MALE: ________ FEMALE: _______

MOTHER'S NAME: ____________________________ FATHER'S NAME: __________________________

GUARDIAN'S NAME (IF APPLICABLE):____

HOME ADDRESS: ____

CITY: ________________________________ STATE: _________ ZIP: ___________

CONTACT INFORMATION

HOME PHONE: ______________________________

CELL PHONE (M): ____________________________ CELL PHONE (F):________________________

WORK PHONE (M): __________________________ WORK PHONE (F):_______________________

EMAIL (M):____

EMAIL (F): ____

EMERGENCY CONTACT INFORMATION

NAME: ____ RELATIONSHIP: __________________________

HOME PHONE: ________________________________ CELL PHONE: _____________________________

PHYSICIAN NAME: ________________________________ PHONE: ___________________________

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

HAS YOUR SON/DAUGHTER GONE THROUGH THE OPWDD FRONT DOOR ☐YES ☐NO
(*if yes please attach copy of letter supporting services)*

DOES YOUR SON/DAUGHTER HAVE MEDICAID? ☐YES ☐ NO
(*if yes please provide Medicaid number)* MEDICAID #________________

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

DO YOU CURRENTLY HAVE SELF DIRECTION? ☐ YES ☐ NO

SIGNATURE: ____ DATE: ______________________

RELATIONSHIP TO APPLICANT: ____

PARENT QUESTIONNAIRE:

What types of challenging behavior does your son/daughter exhibit?

____
____
____
____

Under what situations do they occur?

____
____
____
____

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What are your son/daughter's strengths and assets?

____

____

____

What are your son/daughter's greatest challenges?

____

____

____

____

What strategies, materials, techniques have proven to be effective for your son/daughter?

____

____

____

____

What would you say is your son/daughter's primary mode of communication? How does your son/daughter make his/her wants and needs known?

____

____

____

____

Describe your son/daughter's recreation/leisure skills.

____

____

____

____

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List your son/daughter's preferred activities and foods.

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Additional information that you would like us to know about your son/daughter:

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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 Respite Specialist.

______________________________________ ______________________

Signature of Parent/Guardian Date

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EMERGENCY MEDICAL INFORMATION AND RELEASE FORM

CHILD'S LAST NAME: ______________________________ FIRST NAME: ______________________________

MOTHER'S NAME: ______________________________ CELL PHONE: ______________________________

WORK PHONE: ______________________________ HOME PHONE: ______________________________

FATHER'S NAME: ______________________________ CELL PHONE: ______________________________

WORK PHONE: ______________________________ HOME PHONE: ______________________________

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

NAME: ______________________________ PHONE: ______________________________

ADDRESS: ____

RELATIONSHIP: ____

NAME: ______________________________ PHONE: ______________________________

ADDRESS: ____

RELATIONSHIP: ____

PRIMARY PHYSICIAN: ______________________________ PHONE: ____________________

ADDRESS: ____

DENTIST: ______________________________ PHONE: ______________________________

ADDRESS: ____

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

ALLERGIES:____
____
____

SEIZURE CONDITIONS: ____
____
____

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 Date