

## CREATIVE COMMUNITY SERVICES RESPITE CARE

### APPLICATION PROCESS

**For Emergency Respite** - The following information is required:

- 1) CALL CCS staff at (770) 469-6226 to discuss the child and specific needs.
- 2) FAX completed Respite Application and Respite Service Agreement to the CCS respite office at (770) 469-6210. Mail the original to:  
4487 Park Drive Suite A, Norcross, GA 30093.

**For Planned Respite or Adventure Weekend** - The following information is required:

- 1) CALL CCS staff at (770) 469-6226
- 2) Completed Respite care Application and Respite Service Agreement
- 3) Certified Birth Certificate
- 4) Immunization Certificate
- 5) Social Security Card
- 6) School Records
  - Current Previous IEP
  - Certificate of Eye, Ear, Dental if required by school system
  - Letter of withdrawal from previous school (if child is to be enrolled in new school)
- 7) Social History
- 8) Medical Examination: certification of general health
- 9) Psychological/Psychiatric Evaluation
- 10) Custody Papers
- 11) Court Order (if applicable)
- 12) Insurance or Medicaid card
- 13) Recent photo
- 14) Other documentation to support respite care: Copy of current ISP, Current mental status, standard assessment of child's level of functioning (i.e. CAFAS, CBCL), current problematic behaviors

When complete application materials are received at CCS, respite will be scheduled. Materials may be faxed or mailed. CCS staff and respite providers are available to meet with the child and family prior to respite.

Our Office #: 770-469-6226

Our Fax #: 770-469-6210

Our address: 4487 Park Drive Suite A, Norcross, GA 30093

**NOTE:** Your signature indicates full disclosure of all known/predicted behaviors pursuant to the Truth in Placement Act 1994 (OCGA 49-5-41)

**CREATIVE COMMUNITY SERVICES  
RESPITE APPLICATION**

Child's Name: \_\_\_\_\_ Date: \_\_\_\_\_ Type of Respite: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Race: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

County: \_\_\_\_\_ Medicaid #: \_\_\_\_\_ Language: \_\_\_\_\_ Religion: \_\_\_\_\_

Lives with (Name / Relationship)  
Home Address (including street, city, zip & county)

\_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell/Beeper: \_\_\_\_\_

Parent or Legal Guardian (if child does not reside with legal guardian)

Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell/Beeper: \_\_\_\_\_

Emergency contact when guardian cannot be reached:

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Medicaid # or Insurance Carrier & Number: \_\_\_\_\_

\_\_\_\_\_

Medication (name, dosage, & prescribing physician): \_\_\_\_\_

\_\_\_\_\_

DSM Diagnosis: \_\_\_\_\_

\_\_\_\_\_

Allergies (include foods, medications, pets, etc.): \_\_\_\_\_

\_\_\_\_\_

Physical Disabilities (any chronic health/medical concerns, treatment required, special needs):

\_\_\_\_\_

Predicted Behaviors: (please indicate with initials **C**= Current or by **H**= History)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Sexual Acting Out         | <input type="checkbox"/> Restraint Required     | <input type="checkbox"/> Lying                       |
| <input type="checkbox"/> Physical Aggression       | <input type="checkbox"/> Run Away               | <input type="checkbox"/> Seizures                    |
| <input type="checkbox"/> Hyperactivity             | <input type="checkbox"/> Tantrums               | <input type="checkbox"/> Bed Wetting                 |
| <input type="checkbox"/> Self-Injurious/Mutilation | <input type="checkbox"/> Hallucinations         | <input type="checkbox"/> Stealing                    |
| <input type="checkbox"/> Mood Swings               | <input type="checkbox"/> Hoarding               | <input type="checkbox"/> Soiling (other than toilet) |
| <input type="checkbox"/> Fire Setting              | <input type="checkbox"/> Compulsive Behavior    | <input type="checkbox"/> Defiance                    |
| <input type="checkbox"/> Suicide Attempt           | <input type="checkbox"/> Suicidal Threats       | <input type="checkbox"/> Suicidal Ideation           |
| <input type="checkbox"/> Physical Abuse (in past)  | <input type="checkbox"/> Sexual Abuse (in past) | <input type="checkbox"/> Neglect (in past)           |
| <input type="checkbox"/> Depression                | <input type="checkbox"/> Anxiety                | <input type="checkbox"/> Learning Disability         |
| <input type="checkbox"/> Inattentive               | <input type="checkbox"/> Substance Use/Abuse    | <input type="checkbox"/> Legal Involvement           |

Please List All Charges (both current and by history): \_\_\_\_\_

Mental Health Worker: \_\_\_\_\_

Mental Health Emergency Number: \_\_\_\_\_

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Does your child require assistance with personal care chores? \_\_\_\_\_

\_\_\_\_\_ Toileting    \_\_\_\_\_ Bathing    \_\_\_\_\_ Grooming    \_\_\_\_\_ Dressing

Please indicate frequency and time for baths and shampoo

\_\_\_\_\_

Please describe any assistance needed:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Bed-Wetting: if yes, how often, how to respond, suggestions?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does your child have a history of seizures? \_\_\_\_\_

If yes, how often, how to respond, suggestions?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does your child require specific dietary restrictions? \_\_\_\_\_

Any foods that the parent would prefer the child not be given? \_\_\_\_\_

Please specify: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does your child require a specific behavior plan? \_\_\_\_\_

What interventions are used in the home? (Time out, extra chores, etc) \_\_\_\_\_

What rewards are given in the home? \_\_\_\_\_

Are there rewards the parent would prefer the child not be given? \_\_\_\_\_

Does your child require a specific daily routine? \_\_\_\_\_

If yes, please describe or attach specific instructions to this application

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please describe all significant behavioral/ treatment concerns and provide information regarding Substance Use or Abuse

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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**CREATIVE COMMUNITY SERVICES  
RESPIRE CARE AGREEMENT**

**Creative Community Services (CCS)** provides respite services for severely emotionally disturbed and/or developmentally disabled youth. This involved the child's being in the home of a trained respite care giver for weekend and/or overnight stays.

Being the parent(s) of \_\_\_\_\_ and believing the best interest of the child will be served, I/We \_\_\_\_\_ enter into this agreement with CCS.

**Creative Community Services'** part in this agreement is as follows:

CCS will temporarily provide care for the child for the period that the child is in placement. Care includes placement in a home where the parents are specifically trained to handle the problems of an emotionally disturbed child; 24-hour crisis intervention, and necessary medical care (reimbursed by the parent/guardian or covered by Medicaid).

I/We, \_\_\_\_\_ agree that our part in this program is as follows:

1. I/We agree to pay the daily respite rate of \$ \_\_\_\_\_.
2. I/We will continue to assume legal and financial responsibility for the child, including the cost of the child's support care (including medical) and education.
3. I/We will cooperate fully with the visit plan worked out and be willing to work to provide transportation when necessary.
4. I/We confer on CCS and the respite providers the right to act on our behalf for arranging medical care as deemed necessary or appropriate by licensed health care professionals. We understand that we continue to be financially responsible for such medical care.
5. I/We will not be responsible to pay for actual respite services. This is approved under a contract between \_\_\_\_\_ and CCS.
6. I/We agree that information concerning the child and us may be disclosed to respite providers, when in the judgment of CCS such disclosure is indicated, subject in all cases to the obligation of respite providers to treat such information as confidential as required by CCS policies and applicable to Federal and State laws.
7. I/We release CCS, its officers and employees, and the respite provider with whom the child is placed, from any liability for injuries to the child sustained while the child is in placement, to the full extent permitted by law, so long as the released parties have acted in good faith.

**Both Parties** agree that:

1. The parent or guardian may terminate this agreement at any time by giving appropriate notice to CCS. However, the parent or guardian may not remove a child from the respite care home, any schools or otherwise take physical custody of the child except through CCS at the time and place arranged by CCS upon receipt of the notice.
2. CCS may terminate this agreement for cause upon notice of (a) loss of program funding or the inability to place the child with care givers; (b) the failure of the child's parent or guardian to comply with this agreement.
3. CCS may terminate this agreement without cause upon 48-hour prior to notice.

Signatures:

Parent or Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Mental Health Staff: \_\_\_\_\_ Date: \_\_\_\_\_

CCS staff: \_\_\_\_\_ Date: \_\_\_\_\_

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