Channel Islands Social Services
900 Calle Plano, Suite K
Camarillo, CA 93012

Ventura County's In-Home Respite Provider
(805) 384-0983 Fax: (805) 384-0986
www.IslandSocialServices.org

Dear Foster Parent or Kinship Family:

Thank you for your interest in receiving respite support from our organization. We are looking forward to meeting you and your children! As you may know, the Foster and Kinship Respite Program is funded by First 5 and the County of Ventura. CISS began contracting with the County as of 10/1/2010 and the service is FREE to your family (there is no hourly co-pay for respite services you receive!)

Families must meet the following minimum criteria to be eligible to receive respite services:

1. Currently have a child living in your home under a court-ordered placement AND
2. Have a child living in your home who is under six (6) years old.
   (The child can be a relative or a child in placement.)

Respite care allows the primary guardians to have a short break from the care of their children by using certified, screened, and trained caregivers. Parents may go out on a date night, spend time with friends and other relatives, spend quality time with their children individually, run errands or even catch up on sleep! Respite allows you to recharge so you can continue to provide the best care possible.

Please complete and submit the following information to our office so we can get you started receiving the respite care you need. If you have ANY questions about this process, please give us a call. Once we have received all of your information, we will call you to verify the information and begin the process of matching you with a trained Respite Caregiver.

Family Intake Packet (4 pages double-sided) which includes:
- ☐ Family Preferences Form
- ☐ Respite Participation Agreement
- ☐ Intake Form – Adult Family Member (Core Participant) Information
- ☐ Consent to Participate in the Evaluation of First 5 Ventura County

Child Intake Packet:
- ☐ Child Preferences Form for ALL children who will be supervised in the CISS Respite program

Children in Placement require the Child Preferences Form PLUS:
- ☐ Authorization for Emergency Medical Treatment
- ☐ Agreement to Participate in NfL Multidisciplinary Team
- ☐ Copy of the child's Placement Agreement

Thank you again and we look forwarding to meeting you and your family soon!

Sincerely,

Sharon M. Francis

Sharon M. Francis
Chief Executive Officer
Sharon@IslandSocialServices.org

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Foster & Kinship Respite - Family Preferences Form

CISS believes in matching families and their children with qualified Respite Caregivers to enable the highest degree of compatibility and success of the in-home respite program. Please complete the following information. It will only be shared with CISS employees who are required to keep all information confidential in accordance with HIPAA-related practices.

A. Family Contact Info

Foster Parents' Names: ______________________________

☐ I/We are a Licensed Foster Home with a max. capacity of ______ children (please attach copy of license)

☐ I/We are Kinship Caregivers and we are the children's ______________________________
(Describe your relationship to the children)

Home Address: ______________________________
(Street) (City) (Zip Code)

Mailing Address (if different): ______________________________

Email: ______________________________
(Email addresses are kept completely confidential and only used for infrequent agency communication, which you can opt out of at anytime.)

Home Phone: (_____) ______________ Primary # ? ☐

Cell Phone: (_____) ______________ Primary # ? ☐

Mother's Employer: ______________________________
Company Name Work Phone

Father's Employer: ______________________________
Company Name Work Phone

Please attach a family photo to share with us or email to Sharon@IslandSocialServices.org

This is optional and is used for internal reference only

Please list an emergency contact below, other than yourselves, should you not be reachable by phone during respite care:

Emergency Contact Name: ______________________ **Relation:** ______________

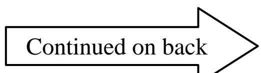
Phone 1: (_____) ______________ **Phone 2:** (_____) ______________

B. Other Relatives Living In Our Home:

Please list in order of age, youngest first, with full names. DOB's only required on children. Do not list children in placement below - list on the separate form entitled *Child Preferences Form*

1. Name: ______________________ Relationship to Parents: ____________ DOB: ________
2. Name: ______________________ Relationship to Parents: ____________ DOB: ________
3. Name: ______________________ Relationship to Parents: ____________ DOB: ________
4. Name: ______________________ Relationship to Parents: ____________ DOB: ________

Are any of the above individuals receiving services through TCRC? ☐ Yes ☐ No and/or VCBH? ☐ Yes ☐ No
If so, your family may qualify for additional respite through these organizations. CISS requires diagnostic and treatment information on any children in the home receiving supervision in the CISS respite program to share with your Respite Caregiver.


Continued on back

C. General Respite Schedule: ☐ Hours are fairly consistent ☐ Hours vary ☐ May use ____x Week

Please list below the times in which you generally may request respite care (reminder: min. 2 hours per visit)

Mon	Tues	Wed	Thurs	Fri	Sat	Sun
A M						
P M						

How many children will typically require supervision during respite care? __________

Please note! Each Respite Caregiver may have personal preferences about the number and ages of children they feel they can safely supervise. CISS allows up to six (6) children to be supervised by one Respite Caregiver at a time; however, this depends on the ages and diagnoses of the children. Any questions should be directed to the Manager of Family Services or CEO at CISS, and not the Respite Caregiver. CISS Caregivers are reimbursed an hourly wage to care for generally up to three (3) children at one time. The family and the Respite Caregiver should work out private pay arrangements for additional children, at the discretion of both parties. The CISS Respite Program does not collect any fees from the families for using the respite program.

D. Caregiver Preferences:

Please check one or both options below that apply to your family. CISS will make every effort to make the best match possible, but the family ultimately will decide when a match is made.

☐ We would prefer to have some help in recruiting a caregiver for us to interview.

☐ We are referring ____ to support our family. We have met him/her, confirmed his/her active employment status with CISS and we believe they can meet our family's needs.

Primary language spoken in the home: ______________________________________

Our family would prefer receiving care from: ☐ No Gender Preference ☐ Males ☐ Females

We would prefer the caregiver be _____ years old to _______ years old ☐ No Age Preference

We prefer to receive care from someone experienced in the following areas: ______________________________

____

E. Home Environment:

Please identify the following factors which have also been proven to be important in making a good match and protecting the health of our workers: (Check all that apply)

Does anyone in your family smoke inside the home? ☐ Yes ☐ No ☐ Outside only

Do you have any pets? ☐ Yes ☐ No If yes, how many and what type? ____________________________________

Health Information, Portability, and Accountability Act (HIPAA) and Emergency Services Authorization:

By signing this document I agree to disclose the above information to Channel Islands Social Services and their employees for the sole purpose of ensuring the quality of respite care provision, which includes recruitment of caregivers and updating of my family's confidential records. I also authorize Channel Islands Social Services to approve of emergency, life-saving medical care, which an emergency medical professional has deemed is necessary for my child, in the event that during the provision of care I am unable to be reached by phone or in person. I further understand that I may revoke this authorization in writing at any time. Additionally, such authorization shall be deemed immediately revoked upon written receipt of service cancellation.

____ ____________________

Signature of ALL Licensed Foster or Kinship Caregivers in Home Date

Please mail this form back to us in the envelope provided or fax to (805) 384-0986. Thank you!

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Foster & Kinship Family Respite Participation Agreement

Name of Primary Caregiver(s):____
Last First

Home Address: ____

Please review the following standards of participation that apply to all participants and sign below that you are in agreement and will follow these agency policies and procedures while receiving respite services from CISS.

I/We understand that:

1. CISS is the employer of record and legal supervisor for the employees performing care in my home. Only CISS can hire and fire employees, but as the foster parent or kinship caregiver I can refuse to receive care at anytime from any CISS employee. I may refer individuals to be hired by CISS to help my family and other families, and I understand that CISS makes all final decisions on an applicant's suitability for employment.
2. I agree to keep careful track of my respite hours and only schedule hours up to my family's authorized amount, with a minimum of two hours used at one time. If I direct staff to work over my authorized hours, I understand that I have acted as their employer of record for that time and that I will be liable for all related payroll, tax withholding/reporting, and worker's compensation issues. I agree to keep my own accurate records of hours and Respite Caregivers who worked each day. I further understand that frequent overages may be reason for service termination.
3. I understand that the Foster and Kinship Respite services are only available to eligible families in which there is a biological child or foster **child under age six**, due to funding requirements from First 5. I agree to notify the CISS office within twenty-four (24) hours should my foster home license change or be revoked, or if I am no longer caring for children under age six. I understand that I will be responsible to reimburse the Respite Caregiver or CISS directly should I fail to disclose these changes to CISS in a timely manner.
4. I shall sign the Respite Caregiver's timecard at the end of each shift after verifying all listed hours and miles. My signature on the timecard verifies the accuracy of the reported information. I further understand that a timecard is a legal document and that any falsifications are considered fraud and are reportable to law enforcement and the funding agency with immediate suspension of services until the issue is resolved.
5. I agree to timely communicate any concerns, complaints, and injuries directly to the CISS Family Services Manager and to keep this information confidential. I will also timely communicate any changes in my foster child's medications, behaviors, and/or behavioral plans to CISS and my Respite Caregivers.
6. I have read the job description for my Respite Caregivers and agree to only request supports that fall within the duties description. When in doubt, I will call the Family Services Manager for clarification.
7. I will not request that my biological children be supervised by the Respite Caregivers until rapport is built and a safe level of supervision for all children can be maintained. I will not request any supervision or transport for non-family members during respite care (eg. my children's friends, neighbors, etc…). I understand that CISS receives funding through a contract with the County of Ventura to compensate the Respite Caregivers for my family's respite care. I agree to negotiate a separate additional compensation arrangement with the Respite Caregivers for supervising four or more of my children at the same time. I understand that I may also request care from two Respite Caregivers at the same time should my children's needs necessitate a higher ratio of supervision.

Continued on next page

8. I will timely communicate with my Respite Caregivers to ensure my scheduling needs are met. Scheduling requests shall be made directly with my Respite Caregivers with preferably seventy-two (72) hours notice. I understand that I should contact CISS when my scheduling needs cannot be met with my existing Respite Caregivers so that a back-up person may be recruited, or when I wish to request a change in support staff. I further understand that frequent and/or last minute cancellations on my part may be grounds for service termination.

9. I agree to always be available by phone when I have left my children alone in the care of the Respite Caregiver should the caregiver need advice or an emergency arises. I also agree to notify CISS immediately should any accidents or injuries to my children or Respite Caregivers occur during care.

10. Requests for transportation of my children into the community by my Respite Caregivers shall not be a frequent occurrence. It is up to each Respite Caregiver to determine if (s)he believes that my children can be safely transported to local outings. Additionally, it is my responsibility to judge the safety of the vehicle and ability of the Respite Caregiver to safely transport my loved one prior to each request. When child safety seats are required by law, I will ensure that they have been properly installed prior to any transportation occurring.

    All transportation shall be made in accordance with the Travel Authorization form. Only CISS employees on the approved driver's list who are over age twenty-one (21) may be allowed to transport children in their care in the local community (within five miles from home) for recreational purposes only.

11. All CISS Respite Caregivers and Administration staff are mandated reporters of suspected abuse and neglect and as such, may need to contact protective service agencies (CPS or APS) to file reports without notifying me, in accordance with state law. As a matter of policy, CISS employees are not allowed to verify or deny any requests for confirmation of such reporting to protect the reporter(s).

12. If my family also receives respite care or daycare funding from another County or State program, I understand that care can only be funded by one program at a time (i.e. no "double-dipping" for same hours of care). These programs include but are not limited to: Regional Center, County of Ventura, First 5, Child Development Resources (CDR), In-Home Supportive Services (IHSS), Ventura County Behavioral Health Respite (VCBH) or Medi-Cal funded respite/childcare.

13. I will participate in all requested family respite meetings or home visits at a time that is mutually convenient for my family and CISS. I agree to participate in a semi-annual satisfaction survey required by First 5 and to notify CISS immediately in writing of any concerns with my home respite services.

14. I will keep all emergency contact information updated and immediately accessible in my home by all Respite Caregivers. I will orient all caregivers to the location of this information, as well as all First Aid supplies prior to any care being provided.

15. I shall keep all confidential written respite program materials in a safe, designated area accessible only by CISS Respite Caregivers, myself and my spouse (or other primary caregivers in our home.) I will keep the documents from being easily accessed by children and by unauthorized others.

____ ____________________

Signature of Foster Parent or Kinship Caregiver Date

Please make a copy of this agreement and return the original to CISS so that your respite services may begin. If you have any questions, please call us! (805) 384-0983

INTAKE FORM - ADULT FAMILY MEMBER (CORE PARTICIPANT) INFORMATION

Agency Name: CHANNEL ISLANDS SOCIAL SERVICES	Program Name: FOSTER CARE & KINSHIP RESPITE
FAMILY INFORMATION	
GEMS Defined Family ID:	Alternate Program Defined Family ID:
Family Last Name:	Phone Number:
Family Street Address:	City:
Zip:	State:
We don't need to know exactly, but which of the following categories best describes your total family income in the last 12 months? ☐ Less than $10,000 ☐ $10,000 – less than $20,000 ☐ $20,000 – less than $30,000 ☐ $30,000 – less than $40,000 ☐ $40,000 – less than $50,000 ☐ $50,000 – less than $75,000 ☐ More than $75,000 ☐ No answer/prefer not to say	Is there an expectant mother in the family? ☐ Yes ☐ No ☐ No answer/prefer not to say How many children are there in your household between the ages of 0-5 years old (up to 6th birthday)? ___ ___ How many family members are there in your household, including you? ___ ____

ADULT PARTICIPANT INFORMATION		
Participant's First Name:	Participant's Last Name:	Middle Initial
Participant's date of birth: (mm/dd/yyyy) ____ / ____ /_______	Participant gender: ☐ Male ☐ Female	
What is your current employment status? ☐ Unemployed ☐ Employed part-time ☐ Employed full-time ☐ Seasonal worker ☐ Temporary employment ☐ Stay at home parent ☐ No answer/prefer not to say	What is your marital status? ☐ Now Married ☐ Domestic partner ☐ Never married ☐ Separated ☐ Divorced ☐ Widowed ☐ No answer/prefer not to say	
Family Member type: ☐ Biological parent ☐ Adoptive parent ☐ Foster parent ☐ Domestic partner ☐ Grandparent ☐ Other relative of child 0-5 ☐ Expecting Parent	Do you have a high school diploma or a GED? ☐ Yes ☐ No ☐ No answer/prefer not to say	
How did you hear about this program: ☐ Friend ☐ Radio or TV ☐ School or childcare ☐ Neighborhood for Learning (NfL) ☐ Flyer or Written Material ☐ Doctor or Nurse	☐ Other: _________________________ ☐ No Answer	
Participant ethnicity (check all that apply) ☐ Alaska Native/American Indian ☐ Asian ☐ White ☐ Pacific Islander ☐ Black/African-American ☐ Hispanic/Latino Mexican, Mexican-American, ☐ Unknown ☐ Other	***For Office Use Only:*** Program Intake Date: (mm/dd/yyyy) ____ / ____ / ____ Consent form signed? ☐ Yes ☐ No Date consent form signed: ____ / ___ / ____ (mm/dd/yyyy)	

What language is spoken most often in your home?

- ☐ Mostly or all English
- ☐ English and another language equally (indicate other language)
- ☐ Mostly another language (indicate language)
- ☐ Unknown

(Indicate language here)

- ☐ Korean
- ☐ Spanish
- ☐ Cantonese
- ☐ Tagalog (Filipino)
- ☐ Vietnamese
- ☐ Mandarin
- ☐ Mixteco
- ☐ Some other language/unknown
- ☐ Not Applicable

Consent to Participate in the Evaluation of First 5 Ventura County and First 5 California Authorization to Share Confidential Information

Adult Participant

I agree to allow **Channel Islands Social Services** to share information about me with First 5 Ventura County and the First 5 California evaluator (SRI International). This information will help First 5 learn how programs can help me prepare children to be ready to learn and do well in school. I understand that:

- Program staff will ask me questions at the start and end of this program, or every six months. Program staff also will record the program activities I participate in.
- Program staff will ask me for my name, birth date, birth place, gender, current address, ethnicity (race/ethnic group), language spoken, and other information about your participation in First 5 services.
- I will **not** be asked about drug or alcohol use, or any criminal arrests or convictions I might have. This program is not allowed to share this information unless I sign a different consent form.
- Only certain program staff and First 5 evaluation staff will be able to see my personal information (such as names, address, phone number, or place of birth). People who can see my personal information **cannot** share it with anyone else, unless program staff believes I may be in danger of being hurt or be a danger to someone else.
- Reports will **never** have information in them (such as a name or address) that might identify me.
- It is very important to First 5 that my private information is safe. That is why my information will be protected with the utmost advanced and secure methods.
- State and federal laws protect the personal health information I share even if the Federal Privacy Rule does not do so.
- Taking part in this evaluation involves very little risk to me.
- Program staff will use my information to provide better services to me. First 5 evaluators and staff will use my information, **without** names or other identifying information, to learn what activities and programs are most useful for children and families.
- This Authorization is voluntary; I can choose not to sign it and I still will receive the services from the contractor.
- I can always change my mind and ask that my information no longer be shared or that it be erased. I can do this by sending a form (that can be obtained from this organization) to: First 5 Ventura County, 2580 East Main Street, Suite 203, Ventura, CA 93003
- My approval to use my information will end ten (10) years from the date on this form.
- If you have any questions about this form or your rights, please call (805) 648-9990.

____ ________________

Signature of Adult Participant **Date**

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Foster & Kinship Respite - Child Preferences Form

CISS believes in matching families and their children with qualified Respite Caregivers to enable the highest degree of compatibility and success of the in-home respite program. Please complete the following information. It will only be shared with CISS employees who are required to keep all information confidential in accordance with HIPAA-related practices.

Please submit one form for each child who will be receiving care during respite. For children in placement, the following additional forms are also required before respite services can begin: ☐Placement Agreement ☐ Authorization for Emergency Medical Treatment ☐Consent to Participate in NfL Multidisciplinary Team

Foster Parents' Names: ____

I/We have ____ children in placement with us, and ____ other children in our home as of ____________ (date).

The information below is ☐New ☐An Update *(Report all placement changes by phone to CISS within 24 hours!)*

Child's Full Name: ________________________________ **DOB:**__________ Age: ____**Gender:** M F

1. Things that our child would like the Respite Caregiver to know about them (likes, dislikes, hobbies, sensitivities):

____

____

____

2. Things we would like the Respite Caregiver to know about our child (safety considerations, routines, historical info)

____

____

____

3. ☐Foster ☐Kinship ☐Other___________ This child has ___ siblings and ___ are in our home (list names on back)

This child has lived in our home since:___________ They are expected to stay in our home until: ___________

4. Child's Primary Language: ☐English ☐Spanish ☐Non-verbal ☐Other: _______________

5. Name of Child's School and Grade Level: ____

6. Child requires assistance with (check all that apply) ☐Hygiene ☐Bathing ☐Toileting ☐Diapers ☐Uses Wheelchair

7. Child has been diagnosed with the following conditions: ____

____

8. Allergies and/or Current Medications: ____

____

Will the CISS Respite Caregiver be expected to dispense medication after you have provided training? ☐Yes ☐No

9. List any special dietary or food preferences: ____

10. Child's Physician (Name/Phone) ____ Medi-Cal#___________

Child's Dentist (Name/Phone) ____

____ ____________________

Signature of Licensed Foster or Kinship Caregiver Date

Please mail this form back to us or fax to (805) 384-0986. Please keep a copy in your home for the Respite Caregivers. 10-1-2010

county of ventura

Human Services Agency

Authorization for Emergency Medical Treatment

RE: Channel Islands Social Services Contracted Respite Care

RE: ____ (Child) DOB: ______________

COURT AUTHORIZATION:

The County of Ventura Superior Court ORDER FOR RELEASE OF PRIVILEGED INFORMATION AND AUTHORIZATION FOR TREATMENT authorizes foster or relative caregivers to secure medical, surgical or dental care for the above foster child that is of a routine nature or requires immediate (emergency) attention.

CHILDREN & FAMILY SERVICES CONTACTS:

It is understood that a conscientious effort must be made to notify the Human Services Agency children and Family Services before such an action is taken. However, the child's immediate emergency medical needs are the priority. The 24 hour contact phone for Children and Family Services is **(805) 654-3200**.

The child's Children and Family Services social worker is ______________________________.

The social worker's phone is: ___________________.

CHILD'S HEALTH CONDITIONS / NEEDS (PLEASE PRINT)**:**

List known allergies, medical conditions and needs:

____
____
____

List medications, dosage and frequency given:

____
____
____

Names and phone numbers of the child's physicians:

____
____

____ _______________

(Foster/Relative Caregiver - Printed Name & Signature) Date

In an emergency, I can be reached at: _________________________________

Phone

Foster Kinship Respite Program
Agreement to Participate in [NfL] Multidisciplinary Team

Authorization to Share Information

In order to provide the best services possible for families and children birth to five, FIRST 5 Ventura County funds services from a number of agencies as part of the NfL Multidisciplinary Team. We ask for your agreement to participate in order to provide collaborative services to you and your family.

I. Child/Family Information		
Child's Name:	Birth Date:	Gender: M / F (circle)
Primary Family Language:	Child's Language:	
Parent/Guardian Name(s):		
Child's Address:		
Phone Number:	Child's School:	

II. Authorized Agencies (please check all the authorized NfLs/service agencies/school districts):

- ❑ Neighborhood for Learning (NfL)
- ❑ Ventura County Public Health
- ❑ Ventura County Behavioral Health
- ❑ Ventura County Office of Education, Special Education Department
- ❑ School District
- ☒ Channel Islands Social Services (Respite)

III. Agreement and Authorization to Release Information: I hereby agree to participate in the multidisciplinary services at the NfL and authorize the sharing of the following information as necessary for the benefit of referral, service coordination and/or observation.

- ❑ First 5 Intake Form
- ❑ Treatment Plan
- ❑ Screenings
- ❑ Assessments
- ❑ Case Management Notes
- ❑ ______________________________

IV. Authorization Signature: This authorization expires one year from the date it is signed, or on the date specified below.

____
Parent/Guardian Signature

____
Date

____
Parent/Guardian Name – PLEASE PRINT

Expires one year from date signed, or on: _______________