



# Channel Islands Social Services

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www.IslandSocialServices.org

## 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, which will only be shared with CISS employees who are required to keep all information confidential in accordance with HIPAA-related practices.

**Insert Recent Photo**  
Of Child Here  
Or email to  
Sharon@IslandSocialServices.org

### A. Contact Info

Child's Name: \_\_\_\_\_

Nickname: \_\_\_\_\_

DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Child's Current Weight \_\_\_\_\_ lbs. and Height \_\_\_\_ ft \_\_\_\_ in.

Parent's Names: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Primary # ?

Cell Phone: (\_\_\_\_) \_\_\_\_\_ Primary # ?

Other Phone: (\_\_\_\_) \_\_\_\_\_ Primary # ?

Siblings Names/Ages: \_\_\_\_\_ # of siblings also with regional center?: \_\_\_\_\_

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

Mailing Address (if different): \_\_\_\_\_

Email Address : \_\_\_\_\_

(Email addresses are also kept completely confidential and only used for infrequent agency communication such as Newsletters and Announcements of Community Events)

**B. General Respite Schedule:** (please check)  Hours are fairly consistent  Hours vary  May use \_\_\_\_x Week

Please list for each day of the week, the times in which you generally may request respite care: #

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
A							
M							
P							
M							

Will you need any overnight care?  Yes  No  Maybe, once we know & trust the person

Will there be other children in the home during respite care?  No  Yes, # \_\_\_\_\_  Maybe

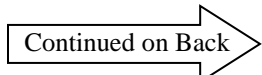
*Note: The Regional Center has authorized Channel Islands Social Services to provide respite care for your child with a disability. Parents are responsible for supervision and/or payment arrangements of the care of their other children during respite hours.*

### C. Caregiver Preferences:

Please check one or both options below that apply to your family.

We are referring \_\_\_\_\_ to be hired at this time  
(Respite Caregivers' Names)

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



**C. Caregiver Preferences Cont...**

Primary Language Preferred to be Spoken in the Home: \_\_\_\_\_

Family would prefer receiving care from:  Anyone whom s/he knows  Only Female  Only Male

**D. 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? \_\_\_\_\_

**E. General Respite Description (optional):** Please briefly describe what you typically do during respite care (where do you go? What do you do? How many hours do you use at once usually?):

\_\_\_\_\_  
\_\_\_\_\_

**F. Caregiver Expectations:** Please briefly describe what you expect the Respite Caregiver to do while providing care (eg. Play with your child? Do homework with your child? Walk to the park? Continue behavioral program in place? Bathe or change the diapers of your child? Dispense medications once trained by parent?) Feel free to attach a separate sheet.

\_\_\_\_\_  
\_\_\_\_\_

Will transportation be needed during respite?  Yes  No \***Transportation can only be provided locally for community activities which involve both the child and caregiver.**

**G. Child's Likes/Dislikes:** Please briefly describe what you would like the Respite Caregiver to know about your child's likes and dislikes, needs for routine, sensory needs, neighborhood/school friends, food/movies, etc...

\_\_\_\_\_  
\_\_\_\_\_

**H. Allergies:** Please describe any types of known allergies your child has: \_\_\_\_\_

\_\_\_\_\_

**I. Diagnoses:** Please identify your child's diagnosed conditions. CISS wants to make sure we match families with Caregivers who are comfortable and/or experienced supporting your child's specific needs. The family will ultimately be responsible for training each Caregiver on their own child's unique needs.

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Intellectual Disab. - Mild to Moderate                                    | <input type="checkbox"/> Autism                     | <input type="checkbox"/> Non-Ambulatory (wheelchair/walker)   |
| <input type="checkbox"/> Intellectual Disab. - Moderate to Severe                                  | <input type="checkbox"/> Asperger's Syndrome        | <input type="checkbox"/> Incontinence (does not wear diapers) |
| <input type="checkbox"/> Behavior Challenges - Mild to Moderate                                    | <input type="checkbox"/> Down Syndrome              | <input type="checkbox"/> Incontinence (wears diapers)         |
| <input type="checkbox"/> Behavior Challenges - Moderate to Severe                                  | <input type="checkbox"/> Cerebral Palsy             | <input type="checkbox"/> Diabetes/ Special Diets              |
| <input type="checkbox"/> Non-Verbal  | <input type="checkbox"/> Seizures (mild/infrequent) | <input type="checkbox"/> Prader Willi                         |
| <input type="checkbox"/> Medical - Minor (medication only)   | <input type="checkbox"/> Seizures (frequent)        | <input type="checkbox"/> PICA (eats inedible objects)         |
| <input type="checkbox"/> Medical - Moderate (dressing care & meds only)                            | <input type="checkbox"/> Rett Syndrome              | <input type="checkbox"/> Hearing Impaired/Deaf                |
| <input type="checkbox"/> Medical - Severe (G tube care & insulin injections – may require nursing) |   | <input type="checkbox"/> Visually Impaired/Blind              |

Other: \_\_\_\_\_

**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 internal, 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 by either myself or the funding agency to Channel Islands Social Services.

\_\_\_\_\_  
Signature AND Relationship of Parent/Primary Caregiver

*Please mail this form back to us in the envelope provided. Thank you!*

\_\_\_\_\_  
Date