



Family Support Services
APPLICATION

Dear _____:
(Please insert applicant's name)

Date: _____

Thank you for your interest in HeartShare's Respite/Recreation programs!

In order to properly provide the quality HeartShare care to our individuals and families, we are asking you to share as much information as possible about your family member. We understand that our application asks many detailed questions and we keep all information confidential.

In order for your family member to receive respite/recreation services, he/she must meet the following criteria:

- Be a Brooklyn or Queens resident
- Minimum age of 6 years
- Be currently eligible for Medicaid Waiver Services
- Be able to safely participate in community activities with a staffing ratio of 1:4

The following documents must be returned with this application:

- Psychological Evaluation (within three years)
- Psycho-Social Evaluation (within one year)
- Medical Evaluation (within one year)
- ISP (within one year + semi-annual)

If available, please provide the following as well:

- Individualized Education Plan (IEP)
- Day Habilitation Plan

Please understand that current psychological, psycho-social, physical exam, and ISP reports are essential for the processing of your application. If you do not have these documents on hand, please contact your Medicaid Service Coordinator, Day Program or school, so that you can obtain them before returning this application to HeartShare. *Only completed applications with all required documents will be considered.*

All of HeartShare's Respite/Recreation programs give individuals an opportunity to engage in recreational and socialization activities mostly in the community. Families are given much-needed respite during the time their loved ones are engaged in a recreational activity. Please note family support services are available *only* to people who live at home with their natural or adoptive family. We cannot provide service to those currently residing in residential facilities or in foster care or family care settings.

For more information call:

Coordinator **Yolanda Deceus** at 718-422-3257
Assistant Coordinator **Benita Ramsaroop** at 718-422-3292
Assistant Coordinator **Elmise Bonhomme** at 718-422-3276

There are a total of 16 programs within the following 10 program types.

Please refer to the program grid below and check all the programs you might be interested in:

	Program	Borough	Time Frame	Ages	Level	Transportation	Session Fees
	Club HeartShare Wednesday	Brooklyn Queens	1-2 times a month 4 hour sessions October - June	Children Adults	Varying	Door-to-door	\$20 per session
	Club HeartShare Saturday	Brooklyn Queens	1-2 times a month 4 hour sessions October - June	Children Adults	Varying	Door-to-door	\$20 per session
	Club HeartShare Sunday	Queens	Weekly (except for holidays)	Older teens Adults	Mild Moderate	Door-to-door	Variable cost of trip \$20-\$40
	Aiello Saturday Recreation	Brooklyn	Every other Saturday (except for holidays)	Adults	Moderate Profound	Door-to-door	\$10 per session
	Heels and Wheels	Brooklyn Queens	Monthly September - June	Adults	Mild Moderate Severe Profound	Door-to-Door	\$10 per session
	Holiday Overnight	Brooklyn	Overnight weekend trips <i>(previous overnight experience preferred)</i>	Adults	Mild Moderate	Door-to-door	\$85 per trip
	Home Away From Home	Brooklyn	Overnight weekend with a local family	Children Adults	Autism Varying	N/A	N/A
	In-Home Respite	Brooklyn	4 hour sessions 13 sessions total In individual's home	Children Adults	Varying	N/A	N/A
	School Holiday	Brooklyn	4-hour sessions school holidays	Teens (Ages 13-21)	Autism Mild Moderate	Door-to-Door	\$10 per session
	TGIS-Thank God It's Saturday	Brooklyn	Weekly	Adults	Travel Trained	Public Transport	\$10 per session

Please mail your application to:

HeartShare Family Support Services, Attn: Yolanda Deceus
12 Metro Tech Center 29th Floor
Brooklyn, New York 11201



Family Support Services
APPLICATION

Name of Individual (First, Last)		Today's Date		Please attach a photo of the individual				
Date of Birth/Age	Physical Traits	Gender						
Date of Birth	Height	<input type="checkbox"/> Male <input type="checkbox"/> Female						
Current Age	Weight							
Race	Hair Color	Ethnicity						
	Eye Color							
Address								
Street		Apt #	City	State	Zip Code			
Social Security #		Medicaid #		TABS ID #				
Applicant's Diagnosis				Other Conditions				
Primary:		Secondary:						
(Mental Retardation, Autism, Cerebral Palsy, other, etc.)								
FAMILY INFORMATION								
Parent/Guardian 1			Phone Number(s)/Email Address					
Name			Home () -					
			Relationship			Work () -		
						Cell () -		
			Email			@ .		
Street Address (if different from above)		Apt #	City	State	Zip Code			
Parent/Guardian 2			Phone Number(s)/Email Address					
Name			Home () -					
			Relationship			Work () -		
						Cell () -		
			Email			@ .		
Street Address (if different from above)		Apt #	City	State	Zip Code			

OTHER SERVICE PROVIDERS				
Service Coordinator		Phone Number(s)/ Address		
Name of Contact Person		Home () -		
Agency		Work () -		
		Cell () -		
		Email _____ @ _____ .		
Street Address	Apt #	City	State	Zip Code
School/ Day Program/ Workshop		Phone Number(s)/ Address		
Name of Contact Person		Home () -		
Agency		Work () -		
		Cell () -		
		Email _____ @ _____ .		
Street Address	Apt #	City	State	Zip Code
Emergency Contact - other than parent				
Name		Home () -		
Relationship		Work () -		
		Cell () -		
		Email _____ @ _____ .		
Street Address	Apt #	City	State	Zip Code
Who were you referred to this program by?				
Please indicate if individual is enrolled and/or actively receiving services from any other programs, including overnight respite or sleepaway camps:				
INDIVIDUAL'S SPECIFIC NEEDS				
Ambulation		Communication		Languages Spoken
<input type="checkbox"/> Able to walk on own <input type="checkbox"/> Requires mobility device (please specify):		<input type="checkbox"/> Verbal <input type="checkbox"/> Non-Verbal <input type="checkbox"/> Uses ASL		
				Languages Understood
How does the individual express needs, wants or feelings?				

Allergies	Dietary Restrictions	Medical Alerts
Can Self-Medicate	Seizures	Adaptive Equipment
<input type="checkbox"/> Yes <input type="checkbox"/> No Please describe need:	<input type="checkbox"/> Yes <input type="checkbox"/> No Please describe need:	
Name of Medication	Reason for Taking	Dosage/Frequency

CAN INDIVIDUAL INDEPENDENTLY: _____ **EXPLAIN WHEN NECESSARY** _____

- TOILET _____ YES _____ NO _____
- BATHE _____ YES _____ NO _____
- DRESS _____ YES _____ NO _____
- EAT/DRINK _____ YES _____ NO _____
- COMPLETE ORAL HYGIENE _____ YES _____ NO _____
- USE MONEY _____ YES _____ NO _____
- TRAVEL (PUBLIC TRANSPORTATION) _____ YES _____ NO _____
- INITIATE PLAY/REC _____ YES _____ NO _____
- PREPARE SIMPLE MEAL _____ YES _____ NO _____

BEHAVIOR

HISTORY OF/ CURRENTLY PRESENT SELF-INJURIOUS BEHAVIOR? _____YES _____NO (IF YES EXPLAIN)

HISTORY OF / CURRENTLY PRESENT AGGRESSIVE BEHAVIOR? _____YES _____NO (IF YES EXPLAIN)

IS THERE A CURRENT BEHAVIOR MANAGEMENT PLAN? _____YES _____NO (IF YES EXPLAIN)

ARE THERE TRIGGERS OR SIGNS THAT WOULD ALERT US OF UPCOMING OUTBURSTS OR OTHER BEHAVIORS?

WHAT ARE THE APPLICANT'S RECREATION/SOCIAL INTERESTS? _____

Caregiver Signature _____ Date _____

COMMUNITY OUTING RELEASE AND WAIVER OF LIABILITY

(General Consent)

I hereby give permission for _____ (the "Consumer") to participate in community outings arranged by HeartShare Human Services of New York ("HeartShare").

These community outings may include trips to shops, restaurants, local businesses, malls, parks and cultural institutions, as well as other destinations.

I understand that walking/wheeling, use of HeartShare vans, use of arranged van or bus services, and/or public transportation may be among the modes of transportation utilized.

I voluntarily give permission for the Consumer to participate in these community outings and voluntarily release HeartShare from any claim of liability in connection with these outings or the mode of transportation employed.

Name _____

Relationship to Consumer _____

Signature _____

Date _____



SCHOOL/PROGRAM INFORMATION RELEASE FORM

I hereby give permission for the release of a complete packet of information to HeartShare Human Services. That packet may include but not limited to the following: ISP, IEP, Psychological evaluation, Psychosocial evaluation, Level of Care (LOC/LCED), Medical reports including seizure activity charts and other reports, evaluations and paperwork deemed necessary by HeartShare Human Services. I also give my permission for a representative of HeartShare Human Services to speak with the teacher/supervisor and counselor of my son or daughter's full time program regarding information relevant to the provision of services requested by the parent/guardian.

Individual's Name: _____

Parent/Guardian Signature: _____

Date: _____

TRAVEL ARRANGEMENTS

PLEASE FILL IN THE GROUP MEMBER'S NAME WHERE APPROPRIATE:

_____ Has my permission to be picked up and dropped off independently – he/she may wait for van unaccompanied and be dropped off in front of address unaccompanied.

_____ Can be dropped off and watched until someone answers door or buzzes him/her into the lobby

_____ May only be dropped off if escorted to the door and left in the care of myself or:

Signed: _____

Relationship: _____

PLEASE INDICATE IF YOU HAVE A BUILDING # OR BELL # _____

Time group member usually arrives home from school / program / work: _____



Communications Department
12 MetroTech Center, 29th Fl.
Brooklyn, NY 11201
www.heartshare.org

MEDIA CONSENT FORM

I/We _____, residing at _____
_____, am/are the parent(s)/guardian(s) of:
_____ (referred to as “my child”). We participate in programs and
activities with HeartShare Human Services of New York, through
_____ (enter program name).

I/We hereby consent that photographs and video taken of my child, on behalf of HeartShare Human Services of New York, may be used for the following purposes: *(select all that you grant permission for)*

- HeartShare Annual Report
- HeartShare newsletters, including InSights and Heart to Heart
- HeartShare website
- Social media websites including, but not limited to, Facebook, Twitter and YouTube.
- Press releases from HeartShare for print or broadcast media. These may include newspaper or magazine articles, radio and television interviews and/or features, publications
- Advertisements for HeartShare
- Information materials such as, but not limited to, agency brochures, videos, and photo and audiovisual information displays
- Everyday Heroes Program

or

- Only internal program use (i.e. classrooms, hallways); do not use externally

I/We consent to use of our names and association with HeartShare for the foregoing purposes. I/We give this authorization without incurring any financial or moral obligations to my child or myself/ourselves and without any remuneration to my child or myself/ourselves.

Signature(s): _____ Date: _____

Witness: _____ Date: _____