SOCIAL SERVICES PROGRAM APPLICATION

Dear Parent or Community Provider:

Thank you for your interest in our Social Services Program!

Here is an overview of our services that we offer:

Respite

Our Respite Program provides care to children ages 0-22 with a diagnosis of any physical, cognitive, or language delay, autism, genetic anomaly, or special medical condition. Families are eligible to receive a **168 hours per fiscal year** of respite hours each year in their home as well as at one of our facilities in Pompano Beach and Dania Beach. We offer services 7 days a week, special events, monthly activities, and weekends! The program is FREE or subsidized depending on household income. Respite is provided by carefully screened and highly qualified childcare staff or nurses who have direct experience working with children, who have special needs. Social Services staff will work with parents to establish goals for their child, such as activities of daily living that will be applied during respite visits.

Youth Enrichment:

- Individual and group sessions to increase healthy, social interactions.
- Maximize the child's social, emotional, physical, and academic potential through fun, personalized activities.

Parent Enrichment:

- Individual sessions to increase knowledge and skills needed for parenting a child with special needs.
- Group sessions with other parents based on common experiences to gain knowledge and share experiences.

Advocacy:

The Advocacy Program at Broward Children's Center empowers and educates parents and caregivers of children with special needs on important decisions involving their children. It is our goal to partner with families to ensure they are receiving the essential tools and support to effectively advocate for their children. One of our Special Needs Advocates will work one-on-one with parents and caregivers to provide them with the support and information necessary to make the best decisions for their children, and to help give them the greatest quality of life possible.

Family Strengthening:

Broward Children's Center's Family Strengthening Program is a twelve-week program, built on an evidence-based national model known as the Nurturing Program for Parents and their Children with Special Needs and Health Challenges (NPP Special Needs.)

We will need the following information in order to begin the enrollment process for your child:

PLEASE HAVE THE FOLLOWING:

1. **Demographic Survey form in this packet completed**

2. **Documentation of child's diagnosis –** Acceptable forms of documentation include any letter or script signed by a physician that states diagnosis, copy of first page of IEP, or Statement of Good Health (if diagnosis listed on this). Please ask the Respite office staff if you are unsure what documentation is best.

3. **Verification of household income-** You may provide any one of the following: copy of recent tax return, 2 recent paystubs, or any proof of public assistance (such as, SSI approval letter, food stamps approval letter, or unemployment check)

4. **Copy of current Statement of Good Health** – (yellow form). If you do not have this, you can use the attached Medical Assessment form which must be completed by your child's physician. If you have the Statement of Good Health, please provide a copy and disregard the Medical Assessment form included in this packet.

5. **Copy of current Immunization records** – (blue form). If you do not have this and would like to provide a religious exemption form you may do so.

6. **Copy of Birth certificate**

7. **Copy of guardian(s) driver license**

8. **ONLY IF your child takes ANY medication that we will need to administer at one of our centers, will we need the following:**

Medication Orders – Provide a script or list **SIGNED BY YOU CHILD'S DOCTOR** that indicates the medications/route/dosage/frequency for each medication we will or may need to administer.

*The Medication Orders must be updated when any medications are changed, i.e. change in medication strength, change in dosage, etc., and immediately reported to the Respite Office.

You may email, or mail these documents to us as soon as they are completed (all contact info below). We suggest you send a copy and keep the original to provide during the intake. The social services coordinator will review the forms and then contact you to schedule an in-home visit to complete the remaining forms and intake process.

We look forward to hearing from you,

Julnyca Cadet, LCSW
Social Services Director
JulnycaC@bcckids.org
954-290-5810

Jessica McCook
Social Services Coordinator
JessicaM@bcckids.org
954-529-0402

Susan Katz
Assistant Director
Susank@bcckids.org
954-999-3064

Broward Children's Center
Social Services Department
Demographic Survey

Administration Division. The following survey was developed to fulfill the requirements for information stipulated by this contract. This information is for agency purposes only and is completely confidential.

☐ Advocacy ☐ Family Strengthening ☐ Respite

Primary Child's Information Date: _____

Name: _____ *Sex:* ☐ M ☐ F

_____ *DOB:* _____ *Weight:* _____

Language: _____ *Email address:* _____ _____

☐ Alaska Native ☐ White
☐ American Indian ☐ Declined
☐ Asian
☐ Black/African American
☐ Multiracial
☐ Native Hawaiian
☐ Pacific Islander

☐ No, not Spanish/Hispanic/Latino
☐ Yes, Mexican, Mexican American, Chicano
☐ Yes, Puerto Rican
☐ Yes, Cuban
☐ Yes, other Spanish/Hispanic/Latino
☐ Unknown

Diagnosis(es): _____

_____

_____

Describe briefly the child's condition and special needs that will be helpful for assistance with your child's needs:

_____

_____

_____

_____

School Name: _____ ***Grade Level:*** _____

Type: ☐ Public ☐ Private *Status:* ☐ Attending ☐ Not Attending

Insurance: ☐ Private ☐ Medicaid *Medicaid #:* _____

Pediatrician: _____ *Phone:* _____

Family Physician: _____ *Phone:* _____

Parental Information

Primary Caregiver Name(s): _____

Relationship to Child: _____

Address:	***City:***	***State:***	***Zip:***
		FL	

Phones: *Home:* _____ For whom? _____

Work: _____ For whom? _____

Mobile: _____ For whom? _____

Other (i.e. Email): _____ For whom? _____

Marital Status: ☐Cohabiting ☐Separated ☐Single ☐Married ☐Divorced ☐Widowed

Secondary Caregiver Name(s): (when applicable) _____

Relationship: _____ Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ For whom? _____

Household Members

African American/American Indian/Black Hispanic/White Hispanic/ Asian Indian/Other Asian/Haitian/Other/White

Name (List all members of household):	**Race**	**DOB:**	**Gender:**	**Relationship to Child:**
1.				***Client***
2.				
3.				
4.				
5.				
6.				
7.				

Total Number of persons living in Household:

Animals living inside household: ☐**Cat(s):** *How Many?*

☐**Dog(s):** *How many of each size?* _____ *Small* _____ *Medium* _____ *Large*

Emergency Contacts

Name:		Phone:		Relationship:	
Name:		Phone:		Relationship:	
Name:		Phone:		Relationship:	

Referred to Broward Children's Center by: _____

Have you utilized any other Respite Program in the past twelve months? ☐**Yes** ☐**No**

If yes, which program? _____

Last approx. date of utilization: _____

Is your child receiving any mental health services/ has a mental health diagnosis? ☐**Yes** ☐**No**

If yes, diagnosis? _____

BCC
MEDICAL ASSESSMENT
To be completed by a physician

Statement of Good Health** (yellow form) can be provided in lieu of this form only if child has a non-medical condition

Child's Name: _____ **DOB:** _____

Diagnosis: _____

Parent / Guardian: _____

Pertinent Medical History: _____

_____

VITAL INFORMATION:

Temperature	Pulse (Reg./Irreg.)	Respiratory Rate	Blood Pressure

Birth Weight	Height/Length	Current Weight	Head Circumference	Abdominal Girth

Immunizations up to date? ☐Yes ☐No **If no, check which?** ☐DPT ☐MMR ☐Polio ☐HIB ☐Hep B (7th grade)

List Allergies: _____

CURRENT MEDICATIONS: Name, Dosage, Route, Frequency

1.
2.
3.
4.
5.
6.
7.

GENERAL APPEARANCE:

Abrasions/Bruises *

Burns "

Birthmarks X

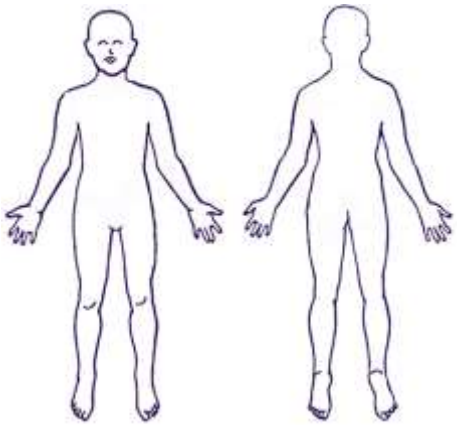
Laceration / Scars - -

Pressure Sores 0

Moles =

Reddened areas ~

Other _____



Front Back

SYSTEMS ASSESSMENT

Level of consciousness

___Alert/Responsive _____

___Alert/Attentive _____

___Sleeping _____

___Lethargic _____

___Unresponsive _____

Head and Neck

___Fontanels: ___N/A ___Depressed

___Flat ___Bulging

___Nucchal Rigidity _____

___VP Shunt _____

Eyes, Ears, Nose, Throat

___Normal _____

___Eye Swelling _____

___Eye Glasses _____

___Ear Tubes _____

___Drainage _____

Location: _____

Mucous Membranes

___Pink ___Moist _____

___Pale ___Dry _____

___Cyanotic _____

Skin

___Warm ___Dry ___Cool ___Diaphoretic

___Rash ___Acne _____

Musculoskeletal

___Weak ___Spastic _____

___Flaccid ___Rigid _____

___Limited ROM _____

___Gait: ___Steady ___Unsteady

___Normal motor strength

Genitourinary

___Normal ___Anomaly ____Discharge

Menses: ___Yes ___No

Last Menstrual Period:_____

Respiratory

Breath sounds: Indicate type of sound on illustration

R= Rales
RH= Rhonchi
C= Clear
W= Wheeze
A= Absent
E= Expiratory
I= Inspiratory

Anterior Posterior

Secretions: Color _____ Type _____ Amount _____
Cough: ☐Non-Productive ☐Productive
Tracheostomy: ☐Yes ☐No Size & Type: _____

Circulatory

___Pink ___Mottled ___Pallor

___Flushed ___Cyanotic

___Capillary Refill: ___<3 seconds ___>3 seconds

___Radial Pulse: ___R ___L

___Pedal Pulse: ___R ___L

___Brachial Pulse ___R ___L

___Femoral Pulse ___R ___L

___Murmur ___Edema

Gastrointestinal

Abdomen: ___Soft ___Distention

___Flat ___Tenderness

Bowel Sounds: ___Active ___Diminished

___G-Tube Size _____

Neurological

___PERRLA _____

___Hyperactivity _____

___Seizure _____

___Gag reflex ___Present

___Hand grasps: ___Equal bilaterally ___Absent

Growth & Development

Size: ___ Age appropriate ___SFA ___LFA

Fine Motor: ___Age appropriate ___Delayed

Gross Motor: ___age appropriate ___Delayed

Social: ___Age appropriate ___Delayed

Physician's Signature: _____

Physician's stamp: _____

Date of Assessment: _____