Parca

Serving People with
Developmental Disabilities & their Families

Raji House
1401 Palm Drive
Burlingame, CA 94010

Dear Parent /Guardian:

Thank you for your interest in Parca's Raji House Respite Care Program. Enclosed you will find the application forms needed to start your child in our out of home respite care program. Please fill out every form with as much detail as possible as it will help us care for your child more effectively. Pay special attention to all medical and emergency forms. It is very important that all forms are signed and dated by you, as you are your child's Authorized Representative and Conservator, and that certain forms are completed by your physician as well. We also ask for detailed descriptions of your child's day-to-day routines as we want to make your child's stay is as comfortable and familiar as possible. These forms provide an important reference for our staff as we get to know your son or daughter.

This packet must be filled out completely before you child is accepted into our respite program. Once we receive and review your completed application packet, we will contact you and schedule an observation of your child during regular program hours. Following the observation, we will contact you to inform you of your child's acceptance into the program and to schedule respite hours.

We look forward to finding out more about your child and what we can do to serve your family. If you have questions about this intake packet or about the program here at Raji House, please call me at (650) 376-3593.

Sincerely,

Parca Raji House
Children's Services

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ENROLLMENT PAPERWORK CHECKLIST

Parca Raji House Respite

ENROLLMENT PAPERWORK - FORM NAME	DATE RECEIVED	STAFF INITIALS
Admission Agreement:		
Raji House Policies & Procedures (p. 1-6 – please read)		
Admission Agreement (p.6 – signature needed)		
Intake Admission Packet (p. 7 to 13 – please fill out)		
Full Disclosure Statement (p. 14 – signature needed)		
Emergency Discharge Consent (p.15 – please fill out & sign)		
Medical Release for Treatment (p. 16 - signature needed)		
Postural Supports Release (p.16 – 2 signatures needed by Parent/Guardian & Physician) * if applicable *		
Photo/Video Release (p. 17 - signature needed)		
Consent to Activities Release (p. 17 - signature needed)		
Emergency Fact Sheet (p.18 – please fill out) Attach current photo on this form		
Personal Rights (signature needed)		
Notification of Parent's Rights (signature needed)		
Release of Information Form (signature needed)		
Statistical Form (please fill out)		
Child's Preadmission Health History (please fill out)		
Medical:		
Physician's Report for Community Care Facilities (completed by physician)		
Ambulatory Status Verification (on this form)		
TB Test Verification (on this form)		
Medication Authorization (2 signatures needed by Parent/Guardian & Physician)		
Immunization Record (please obtain copy from Physician)		
POS (Purchase of Service) in place		

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Serving People with
Developmental Disabilities & their Families

Admission Agreement
Raji House Respite
Policies and Procedures

Introduction

The purpose of this admission packet is to describe the procedures used by Parca and Raji House when providing respite services for the child. It is made available to children, parents, case managers at the time they sign their Admission Agreement.

Raji House Basic Services

1. Basic General Services:

    a. Lodging: double room
    b. Food Services.
        1. Three nutritious meals daily and between meals nourishment or snacks.
        2. Special diets prescribed by a doctor or as indicated by parents, i.e. allergies.
    c. Laundry service.
    d. Cleaning of child's room.
    e. Comfortable and suitable bed including fresh linen weekly or more often if required.
    f. Plan, arrange and/or provide for transportation to medical and dental appointments.
    g. A planned activity program including arrangement for utilization of available community resources.
    h. Notification to family and other appropriate person/agency of child's needs.

2. Basic Personal Services:

    a. Continuous observation, care and supervision, as required.
    b. Assistance with bathing and personal needs, as required.
    c. Assistance in meeting necessary medical and dental needs
    d. Assistance, as needed, with taking prescribed medications in accordance with physician's instructions (unless prohibited by law or regulations). Bedside care for minor temporary illness
    e. Maintenance or supervision of child cash resources or property if necessary.

Raji House will provide respite services to children with a diagnosis of a developmental disability from the ages of three through and including thirteen years. A maximum of six children may be placed at Raji House for a planned respite weekend. Children receiving out-of-home respite services must have funding through the State Department of Developmental Services in their local Regional Center. Additionally, private pay referrals will be accepted to the program. Fees charged are based on the fees provided by Regional Center for the same services. Raji House will provide weekend respite care beginning on 5 p.m. Friday and terminating on 5 p.m. Sunday. The minimum staffing ratio is three children to one staff at all times. Two staff will be on-site during the weekend respite periods. The Manager will also be available during the weekend to provide additional staff support.

Admission Procedures

Step 1: Child is referred to Parca, Raji House for respite services.

Step 2: Parca's Respite Manager, child, and parent meet for initial intake assessment and tour of the Raji House.

Step 3: An observation is done at Raji House. Based on the outcome of the observation, the Respite Manager will inform child and parents of admit or decline into program.

Step 4: Family completes necessary Admission / Intake Packet, including physician's medical evaluation which includes a T.B. (Tuberculous) test. Manager sends request to caseworker for child's I.P.P. (Individual Program Plan) and medical forms.

Step 5: Once all information has been received at Raji House, weekends will be scheduled.

Note: All applicant's paperwork will be held for one year. After one year, all information will need to be updated. Since the length of the program is only one weekend, there is no probationary period. However, should a child demonstrate such severe behavior problems that they place a staff and/or other child in immediate danger, they may be discharged at any time with notice to parents or authorized representative.

Discipline Policies

Parca DOES NOT USE CORPORAL PUNISHMENT.

As part of the respite employee training, staff will be given the positive behavior techniques that will be utilized for various problem situations. Staffs employed at Raji House are trained in behavior management techniques as well as Personal Assault Response Techniques.

Following are the disciplinary steps to be taken:

1. Offering sufficient and appropriate choices
2. Modeling desired behavior
3. Reinforcing good behavior
4. Staying in close proximity
5. Redirecting behavior
6. Discussing the problem and possible solutions
7. Giving verbal reminders
8. Using of quiet time
9. Removing privileges
10. Arranging follow-through with parents
11. Developing a contract with child and program
12. Excluding child from the program (discharge)

Behavior management techniques shall be applied to children in the least restrictive manner, and shall be appropriate to the particular situation. For example, redirection could be used for a child trying to write on the wall (followed by positive reinforcement for desired behavior), quiet time could be used for a child throwing a tantrum (followed by positive reinforcement for desired behavior).

A positive approach using behavior management techniques shall be used to affect the appropriate behavior. This shall include positive reinforcement for desired behaviors; quiet time for no longer than five minutes in an unlocked living, sleeping, or play area; ignoring or redirection away from negative behaviors. During the child's quiet time staff will check on the child every two minutes to ensure safety.

Reservation and Cancellation Procedures

Reservations for respite services are made on a first come-first serve basis. For this reason, it is important to plan your respite services early and make the necessary reservations. Parca schedules staff according to the number of children who are signed up for a weekend. We, therefore, ask that you honor your reservations. **Should an unforeseen circumstances arise that necessitates a cancellation, we ask that you call the Respite Manager at least 2-days in advance so that another child may utilize the open position or Parca can make the necessary staff adjustments.**

The program itself may also have a need for cancellation. In this case, a call to all scheduled authorized representatives will be made with a 5-day advance notice.

Discharge Policy

Discharge of a child from the respite program at Raji House shall occur for any of the following stated reasons. A phone call to the authorized representative (parent or care-providers) or emergency contacts explaining the reasons for termination will be made. A follow up letter to both the authorized representative and the funding agency will be sent, explaining reason for termination. A child will be discharged from the program if any of the following circumstance occur:

1. The child engages in behavior that is harmful to self or others.
2. The child is medically fragile or has need of medical/nursing care that is unavailable from Raji House.
3. The child has insufficient medical and emergency information.
4. The child has a family who consistently fails to comply with program policies contained in the Policies and Procedures Manual.
5. The child/family no longer wishes to use or be in the program.

Termination of services shall be in effect immediately upon discharge and release of child to authorized representative. **Emergency contacts must be aware of the possibility of providing care for the child and upon acceptance of the child to their home, immediately assumes physical responsibility. All scheduled upcoming respite stays at Raji House shall be canceled, with written approval of the child's authorized representative. The Manager shall coordinate with the authorized representative, regional center, and other social service agencies to locate alternative respite care arrangements for the child whenever appropriate**.

Sickness / Injuries

The respite program will not accept a child who is sick. If the child becomes sick while at the respite program, every precaution will be made to keep the child isolated form the other children while arrangements are being made to have the child picked up. Authorized representatives will be contacted and informed of child's condition and if needed will contact child's doctor.

If there is an injury while at the respite program, staff are certified to administer first aid. If the injury requires medical assistance, the child will be taken to the nearest emergency room. The authorized representative will be contacted in both cases and informed of child's condition.

Internal Child/Family Grievance Procedure

1 . In the event that a child/family/authorized representative has a grievance with a policy, procedure, or staff member of Parca, the child/family is recommended to discuss the matter first with the person who is directly responsible (e.g. the respite staff) to see if an acceptable resolution can be made.

2. If the child/family is not satisfied with the results, they will then be referred to the Raji House Program Manager. The Manager will discuss the matter with the child/family, conduct an investigation, and make a recommendation regarding a resolution within 24 hours.

3. If the child/family is not satisfied with the resolution offered by the Program Manager, they are then referred to Parca's Director of Programs who will then investigate the matter and offer a resolution within 24 hours.

4. If the child/family is still not satisfied with the outcome, they will then be referred to the Regional Center Case Manager and/or Child Advocate as appropriate.

Visitation Policy

Authorized representatives, parents, social workers, and other authorized individuals are permitted access to the program and child on request. Appointments should be scheduled in advance to avoid disruption of the program. Individuals who are listed on court order list will not be permitted into the facility. Authorized representative will furnish the court order list.

Distribution of Medications

All medications that are distributed to the child must be approved by the child's physician. The parents/guardians must also complete an Authorization for Medication Administration record for each medication the child takes. It is the parent/guardian's responsibility to ensure that medical information is updated as needed for each visit to Raji House. Failure to do so will result in the child not being accepted into the program. Medications must be presented in their original containers with legible labels containing the name of the medication, the strength and dosage of the medications, and the name of the physician prescribing the medication.

Abandonment

Children must be picked up between the hours of 4:30 - 5:00 PM on Sunday. Children who are still at the Raji House after 5:00 PM will be considered abandoned. At that point, staff will call parents, emergency numbers, and regional center, notifying them that the child is still at the program. When all attempts have been made to contact the above individuals, the police will be called to provided emergency shelter to the child.

Raji House Rules

Children are to be informed of the house rules prior to coming to the respite program. These ensure safety and fun for all the children. Children will be encouraged to participate in making additional rules as they see necessary.
Please read the following house rules to your child prior to coming to the program:

1. Children will be supervised at all times, in and out of Raji House.
2. No smoking will be allowed in the facility.
3. Personal areas such as bedrooms and other common areas will be kept clean.
4. Children shall have private storage space for their personal belongings.
5. Running and rough play shall not be permitted in the facility.
6. Swearing, verbal/physical abuse and defacing of property shall not be permitted.
7. Those children using wheelchairs shall remain on the first floor of the house.
8. Bedtime hours shall be based on the individual needs of children residing at Raji House.
9. Children will have supervised access to laundry machines.
10. Children will have use of their own and Raji House's entertainment equipment.
11. Curfews, dating, dress codes, and homework assignments are not necessarily relevant during a child's short stay at Raji House, unless otherwise specified.
12. Any other rules that are deemed necessary by the Respite Manager for safety and health purposes.

If there are any other rules that you have at your home, please inform the respite program staff. We will be glad to continue your rules with your child during the respite weekend.

Emergency Procedures

In cases of emergency, such as earthquakes, fires, or natural disasters, children will be supervised at the house or one of the two emergency relocation sites. Emergency re-location sites are specified in the Emergency Care and Disaster Action Plan (LIC 610). If there is an accident or an injury, child will be given appropriate first aid and/or brought to the hospital depending upon their condition. We will make every effort to contact you.

Individual Program Plans

Parents and Regional Center Caseworkers must provide Raji House with a current Individual Program Plan for the child prior to the entry into the respite program. Respite program staff will follow goals and objectives according to the I.P.P. Staff will inform parents and caseworkers of progress by written and/or verbal procedures.

Physical Examination

Parents will provide Parca Raji House with a current physical examination of our children. The physical must include a T.B. test and authorization to administer approved medications to be taken during the respite program. The physical examination form must be signed and dated by the doctor performing the physical examination.

Conclusion

Parca continues to make every reasonable effort to meet the needs of our children. The purpose of this Admission Policy is solely to outline the general procedures on how services are provided. One copy of this agreement will be for the child and one will be in the child's file. We are committed to working with community agencies, authorized representatives, and children to provide quality programs and services and resolve any problems in the best interest of all concerned. The Department of Social Services, Community Care has the right to enter and inspect the child's records and interview child as allowed under Title 22. The following services will be provided under the provisions of the Admission Policy:

Department:	Respite Care Services
Days and Times:	Friday, 5:00 PM - Sunday, 5:00 PM
Pay Rate:	$8.98 (Subject to change if Regional Center funding changes)

Child's Name (Please print): _____

Date of Birth: _____

Authorization Signatures

My signature as child or authorized representative indicates that I have been provided the Admission Policy, understand its provisions, and enter into this agreement voluntarily.

Child Date

Authorized Representative Date

Respite Manager Date

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Intake/Admission Packet
Raji House Respite

Section I - General Information

Child's Name: _____ Social Security #:_____

Address _____
(Number and Street Name) (City) (State) (Zip)

Phone# : (____) _____

Date of Birth: _____ Age: _____ Place of Birth: _____

Sex: _____ Height: _____ Weight: _____

_____
Father's Name Mother's Name

Father's Information	Mother's Information
Name:	Name:
Address:	Address:
Home Phone#:	Home Phone#:
Work Phone#:	Work Phone#:
Employer Name:	Employer Name:
Employer Phone#:	Employer Phone#:

Conservator: _____

Emergency Contacts: To pick-up child if parents are not available	
1. Name:	
Address	
Home Phone#:	Work Phone#:
Relationship:	
2. Name:	
Address	
Home Phone#:	Work Phone#:
Relationship:	

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Section II - Medical Information

Major Disability/Diagnosis (describe) _____

Secondary Disabilities: _____

Family Physician:

_____

Name Address Phone#

Hospital Plan: _____ Medical Policy#: _____

Other Medical Specialist:

_____

Name Address Phone#

Dentist:

_____

Name Address Phone#

Psychologist/Psychiatrist:

_____

Name Address Phone#

Other Specialist:

_____

Name Address Phone#

Can the applicant walk? _____ Yes _____ Yes with walker _____ No

Has the applicant ever had a seizure?_____
If yes, when?_____ How often? _____ Length_____

Does applicant take medication now? _____
What types? _____ Dosage: _____
(If more medications are used, list on a separate sheet of paper.)

Hearing: _____No problem _____ Hearing impaired _____ Amplification device _____Deaf

Vision: _____No problem _____ Visually impaired _____ Glasses _____Legally Blind

Does applicant have any allergies? _____
If yes, describe: _____

Is applicant currently receiving therapy? _____
If yes, Name of Therapist: _____

What types of psychological testing or evaluation have been done? _____

_____

Hospitalization Plan: _____ Medical: _____

Other Health Insurance: _____ Policy: _____

Date of last physical examination: _____

Section III - Daily Routine and Personal and Important Rituals

Describe a typical day from 6:00 a.m. until 6:00 a.m. the next day:

6:00 a.m. _____

_____

8:00 a.m. _____

_____

10:00 a.m. _____

_____

12:00 noon _____

_____

2:00 p.m. _____

_____

4:00 p.m. _____

_____

6:00 p.m. _____

_____

8:00 p.m. _____

_____

10:00 p.m. _____

_____

12:00 midnight _____

_____

2:00 a.m. _____

4:00 a.m. _____

Routines/Rituals

Bedtime/Waking up routines (i.e., time to bed, time to get up, likes to lie in bed for a while, gets up immediately, etc). _____

_____

Does child take naps? _____ What time? _____

Bathing, dressing, toileting, grooming, tooth brushing, etc.: _____

_____

_____

Eating and feeding routines/rituals (i.e., favorite foods, dislikes, does the child eat snacks? what time etc.): _____

_____

Comforting/calming routines/rituals: _____

_____

Section IV - Recreational Activities:

List all recreational activities the child enjoys:

Outdoor: _____

_____

_____

Indoor: _____

_____

_____

Group Activities _____

_____

_____

Individual Activities: _____

_____

Favorite Sports: _____

_____

_____

What are applicant's dislikes? _____

_____

_____

List favorite places to go: _____

_____

_____

Swimming:

_____ Enjoys a lot _____ Likes it _____OK _____Doesn't Like _____Is afraid of water

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Section V - Program Information

Source of Referral

Agency Position

Address Phone#

Source of Funding for Respite: _____

Reason for application to Raji House Respite Program: _____

Is applicant a client of Regional Center? _____ Yes _____ No

If yes: _____
Name of Regional Center Address Phone#

Name of Case Worker: _____

Section VI - Program Specifics

Does applicant require medical care? _____ Yes _____ No

If yes, what type of care: _____

_____

Does applicant have a Behavior Plan? _____ Yes _____ No

If yes, describe the plan(s): _____

_____

Does applicant require a special diet? _____ Yes _____ No

If yes, describe the diet: _____

_____

Is applicant injurious to self or others? _____ Yes _____ No

If yes, explain: _____

Will this be the first time away from parents? _____ Yes _____ No

Is applicant able to feed self? _____ Yes _____ No

Is applicant able to toilet self? _____ Yes _____ No

What time does applicant usually go to bed? _____ o'clock

Does applicant snore? _____ Yes _____ No

Does applicant have any run-away tendencies? _____ Yes _____ No

If yes, how do you deal with this? _____

Does applicant have chores? _____ Yes _____ No

If yes, list type of chores: _____

_____

For safety purposes please list all individuals who are not allowed to visit applicant, i.e., by court order etc.:

1. _____
   Name

2. _____
   Name

3. _____
   Name

4. _____
   Name

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Full Disclosure Statement

I, the undersigned, agree that the information I have given Parca Respite Program on this application and during the assessment interview, is to the best of my knowledge accurate and complete. I understand that admission to the Respite Care Program is contingent upon the fact that the person named in the application is not physically aggressive or abusive, nor requires any type of skilled nursing care. I have presented all information concerning health problems or behaviors, which may possibly endanger the person named in this application, staff, participants or others while attending Parca, Raji House. I understand that failure to provide true and accurate information may result in discharge from the Respite Care Program under the terms of the Admission Policy; Discharge.

Applicant or Representative's Signature Date

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Emergency Discharge Consent

In case of emergency, I authorize the following two emergency contacts to pick up and assume physical responsibility for my child. I have been informed of the Discharge Policy (page 3), and understand that emergency contacts are to be notified of the potential responsibility they may have. The two Emergency Contacts I authorize are:

First Emergency Contact:

Name Area Code and Phone #

Address City State Zip

Second Emergency Contact:

Name Area Code and Phone #

Address City State Zip

Applicant or Representative's Signature Date

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Medical Release for Treatment

In case of accident or injury where medical treatment such as first aid is needed, I hereby give permission to Parca to act on my behalf for the "IMMEDIATE" medical treatment of my child while at the respite program. I have given two emergency contacts and a physician's name to Parca to contact if I cannot be reached. I have enclosed the "Medical Policy Number" and the Hospital Plan for my child.

Applicant or Representative's Signature Date

Postural Supports Release

In order for child to use braces, spring release trays, soft ties or other items for mobility or independent functioning while attending respite program, child needs to have a written release from appropriate authorities; Child's Representative, Community Care Licensing, and Child's Physician.

As cited in General Regulation 80072(8)(B): All requests to use postural supports shall be in writing and include a written order of a physician indicating the need for such support.

I, the undersigned, give permission to Parca staff to use the below prescribed device on _____ for the purpose of mobility or independent
(Child Name)
functioning. I understand that advance approval from the Child's Representative, Community Care Licensing Representative and the Child's Physicians, be given before Parca can utilize these support devices. The Child's representative will train the respite staff on how the device is attached and detached. Approved postural supports shall be fastened or tied in a manner, which permits quick release by the child.

Device: _____

Applicant or Representative's Signature Date

Community Care License Representative Signature Date

Physician's Signature Date

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Authorization Signatures

Child's Name Date

Photo/Video Release

During the Raji House Respite Program, there may be photo and video opportunities for our program participants.

I _____permit _____do not permit photographs or videotaping of my child while at Raji House.

Applicant or Representative's Signature Date

Consent to Activities

I, the undersigned, hereby give permission for _____ to participate in supervised and recreational activities, including field trips, transportation and day trips with Parca staff members.

I hereby release, for myself and the child named above, Parca and any of their staff from liability in any way connected with the above activities.

Child or Representative's Signature Date

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Emergency Fact Sheet

Name:

Date of Birth:

Place of Birth: City: **State**

Address

City **State, Zip**

Phone:

Payee/Guardian/Conservator:

Address:

City **State, Zip**

Placement Agency: **Date Placed:**

Counselor Name:
Counselor's Phone #:

Social Security #:
Medical Insurance Name and #:

Other Insurance

ATTACH PHOTO

Emergency Contacts (Parent/Guardian, Relative):
Name: **Phone #:**

Name: **Phone #:**

General Physical Characteristics:
Sex: **Weight:** **Build:** **Hair Color:** **Eye Color:**

Other Characteristics:

General

PERSONAL RIGHTS
Children's Residential Facilities

EXPLANATION: The California Code of Regulations, Title 22 requires that any child admitted to a home/facility must be advised of his/her personal rights. Homes/Facilities are also required to post these rights in areas accessible to the public. Consequently, this form is designed to meet both the needs of children admitted to homes/facilities and the home/facility owners who are required to post these rights.

This form describes the personal rights to be afforded each child admitted to a home/facility. This form also provides the complaint procedures for the child and authorized representative.

This form is to be reviewed, completed and signed by each child and/or each authorized representative upon admission to the home/facility. The child and/or authorized representative also has the right to receive a completed copy of the originally signed form. The original signed copy shall be retained in the child's file which is maintained by the home/facility.

TO: CHILD OR AUTHORIZED REPRESENTATIVE:

Upon satisfactory and full disclosure of the personal rights as explained, complete the following acknowledgment:

ACKNOWLEDGMENT: I/We have been personally advised of, and have received a copy of the personal rights contained in the California Code of Regulations, Title 22, at the time of admission to

(PRINT THE NAME OF THE HOME/FACILITY)	(PRINT THE ADDRESS OF THE HOME/FACILITY)
Parca Raji House	1401 Palm Dr. Burlingame, CA 94010

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE CHILD) (DATE)

(SIGNATURE OF THE AUTHORIZED REPRESENTATIVE)

(TITLE OF THE AUTHORIZED REPRESENTATIVE) (DATE)

THE CHILD AND/OR THE AUTHORIZED REPRESENTATIVE HAS THE RIGHT TO BE INFORMED OF THE APPROPRIATE LICENSING AGENCY TO CONTACT REGARDING COMPLAINTS, WHICH IS:

NAME

Community Care Licensing

ADDRESS

801 Traeger Ave.

CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER
San Bruno, CA	94066	(650) 266-8800

PERSONAL RIGHTS
Children's Residential Facilities

YOU HAVE THE RIGHT:

- To live in a safe, healthy, and comfortable home and to be treated with respect.
- To be free from physical, sexual, emotional or other abuse, or corporal punishment.
- To be free from discrimination, intimidation, or harassment based on sex, race, color, religion, ancestry, national origin, disability, medical condition or sexual orientation or perception of having one or more of those characteristics.
- To receive adequate and healthy food and adequate clothing.
- To wear your own clothing.
- To possess and use personal possessions, including toilet articles.
- To receive medical, dental, vision, and mental health services.
- To be free of the administration of medication or chemical substances, unless authorized by a physician.
- To contact family members (unless prohibited by court order) and social workers, attorneys, foster youth advocates and supporters, Court Appointed Special Advocates (CASA), and probation officers.
- To visit and contact brothers and sisters, unless prohibited by court order.
- To contact Community Care Licensing Division of the State Department of Social Services or the State Foster Care Ombudsperson regarding violations of rights, to speak to representatives of these offices confidentially and to be free from threats or punishments for making complaints.
- To be informed by the caregiver of the provisions of the law regarding complaints.
- To make and receive confidential telephone calls and send and receive unopened mail (unless prohibited by court order).
- To attend religious services and activities of your choice.
- To maintain emancipation bank account and manage personal income, consistent with your age and developmental level, unless prohibited by the case plan.
- To not be locked in any room, building, or facility premises, unless placed in a community treatment facility.
- To not be placed in any restraining device, unless placed in a postural support and if approved in advance by the licensing agency or placement agency.
- To attend school and participate in extracurricular, cultural, and personal enrichment activities, consistent with your age and developmental level.
- To work and develop job skills at an age appropriate level that is consistent with state law.
- To have social contacts with people outside of the foster care system, such as teachers, church members, mentors, and friends.
- To attend Independent Living Program classes and activities if you are 16 or older.
- To attend court hearings and speak to the judge.
- To have storage space for private use.
- To review your own case plan if you are over 12 years of age and to receive information regarding out-of-home placement and case plan, including being told of changes to the plan.
- To be free from unreasonable searches of personal belongings.
- To have all your juvenile court records be confidential (consistent with existing law).

Reference: California Code of Regulations - Foster Family Homes Regulations, Section 89372; Group Homes Regulations, Section 84072; Small Family Homes Regulations, Section 83072.

CHILD CARE CENTER
NOTIFICATION OF PARENTS' RIGHTS

PARENTS' RIGHTS

As a Parent/Authorized Representative, you have the right to:

1. Enter and inspect the child care center without advance notice whenever children are in care.

2. File a complaint against the licensee with the licensing office and review the licensee's public file kept by the licensing office.

3. Review, at the child care center, reports of licensing visits and substantiated complaints against the licensee made during the last three years.

4. Complain to the licensing office and inspect the child care center without discrimination or retaliation against you or your child.

5. Request in writing that a parent not be allowed to visit your child or take your child from the child care center, provided you have shown a certified copy of a court order.

6. Receive from the licensee the name, address and telephone number of the local licensing office.

   Licensing Office Name: Community Care Licensing

   Licensing Office Address: 801 Traeger Ave.

   Licensing Office Telephone #: 650-266-8800

7. Be informed by the licensee, upon request, of the name and type of association to the child care center for any adult who has been granted a criminal record exemption, and that the name of the person may also be obtained by contacting the local licensing office.

8. Receive, from the licensee, the Caregiver Background Check Process form.

NOTE: ***CALIFORNIA STATE LAW PROVIDES THAT THE LICENSEE MAY DENY ACCESS TO THE CHILD CARE CENTER TO A PARENT/AUTHORIZED REPRESENTATIVE IF THE BEHAVIOR OF THE PARENT/AUTHORIZED REPRESENTATIVE POSES A RISK TO CHILDREN IN CARE.***

For the Department of Justice "Registered Sex Offender"database, go to www.meganslaw.ca.gov

LIC 995 (9/08) (Detach Here - Give Upper Portion to Parents)

ACKNOWLEDGEMENT OF NOTIFICATION OF PARENTS' RIGHTS

(Parent/Authorized Representative Signature Required)

I, the parent/authorized representative of _____, have received a copy of the "CHILD CARE CENTER NOTIFICATION OF PARENTS' RIGHTS" and the CAREGIVER BACKGROUND CHECK PROCESS form from the licensee.

Parca Raji House Program
Name of Child Care Center

_____ _____
Signature (Parent/Authorized Representative) Date

NOTE: ***This Acknowledgement must be kept in child's file and a copy of the Notification given to parent/authorized representative.***

For the Department of Justice "Registered Sex Offender"database go to www.meganslaw.ca.gov

Serving People with
Developmental Disabilities & their Families

Release of Information Form

This authorizes exchange of information between:

Parca Raji House
Name of Facility

AND

Name of Agency and/or Individual

Address

City State Zip code

For the purpose of maintaining the highest level of care and training for the following individual:

Consumer Name Date of Birth

Regarding the following (check all that apply):

___ MEDICAL SUMMARY (including history, examination and appropriate lab work)
___ PSYCHOLOGICAL REPORT
___ EDUCATIONAL EVALUATION
___ SOCIAL EVALUATION
___ WORK EVALUATION
___ OTHER (as specified) _____

Signature and Date Relationship Witness Date

*If individual is 18 years and older and does not have court-appointed legal conservator, he/she must sign this release with an "X" witnessed by yourself/neighbor/friend.

Parca

Serving People with
Developmental Disabilities & their Families

Parca Client Demographic Information Form

In order to keep the fees for Children's Services at affordable levels and obtain grant funding for all Parca programs, we must collect client information on as regular basis to present to current and prospective funders. The following information will be used for statistical purposes only and will be kept confidential. Thank you for your compliance.

Name: _____

City of Residence:_____

Head of Household (please check one):

____Male ____Elderly (over age 62)
____Female ____Disabled Head of Household

Ethnicity Informaiton:

If you **ARE NOT** Hispanic/Latino please check one of the following:

____American Indian/Alaska Native
____American Indian/Alaska Native & Black /African American
____Asian
____Asian & white
____Black/African American
____Black African American & White
____Native Hawaiian/Other Pacific Islander
____White
____Other _____

If you **ARE** Hispanic/Latino please check one of the following:

____Hispanic/Latino American Indian/Alaska Native
____Hispanic Latino American Indian/Alaska Native & Black African American
____Hispanic/Latino Am Indian/Alaska Native & White
____Hispanic/Latino Asian
____Hispanic/Latino Asian & White
____Hispanic/Latino Black/African American **or**
____Hispanic/Latino Black/African American &White
____Hispanic/Latino Native Hawaiian/Other Pacific Islander
____Hispanic/Latino White
____Hispanic/Latino Other

Income Data:

Number of people in your household_____
Your annual combined household income: $_____

CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT

CHILD'S NAME	SEX	BIRTH DATE
FATHER'S/FATHER'S DOMESTIC PARTNER'S NAME		DOES FATHER/FATHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD?
MOTHER'S/MOTHER'S DOMESTIC PARTNER'S NAME		DOES MOTHER/MOTHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD?
IS /HAS CHILD BEEN UNDER REGULAR SUPERVISION OF PHYSICIAN?		DATE OF LAST PHYSICAL/MEDICAL EXAMINATION

DEVELOPMENTAL HISTORY (*For infants and preschool-age children only)

WALKED AT*	BEGAN TALKING AT*	TOILET TRAINING STARTED AT*
MONTHS	MONTHS	MONTHS

PAST ILLNESSES — Check illnesses that child has had and specify approximate dates of illnesses:

	DATES		DATES		DATES
☐ Chicken Pox		☐ Diabetes		☐ Poliomyelitis	
☐ Asthma		☐ Epilepsy		☐ Ten-Day Measles (Rubeola)	
☐ Rheumatic Fever		☐ Whooping cough		☐ Three-Day Measles (Rubella)	
☐ Hay Fever		☐ Mumps			

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

DOES CHILD HAVE FREQUENT COLDS? ☐ YES ☐ NO	HOW MANY IN LAST YEAR?	LIST ANY ALLERGIES STAFF SHOULD BE AWARE OF

DAILY ROUTINES (*For infants and preschool-age children only)

WHAT TIME DOES CHILD GET UP?*	WHAT TIME DOES CHILD GO TO BED?*	DOES CHILD SLEEP WELL?*
DOES CHILD SLEEP DURING THE DAY?*	WHEN?*	HOW LONG?*

DIET PATTERN:
(What does child usually eat for these meals?)

BREAKFAST

LUNCH

DINNER

WHAT ARE USUAL EATING HOURS?
BREAKFAST _____
LUNCH_____
DINNER

ANY FOOD DISLIKES?	ANY EATING PROBLEMS?

IS CHILD TOILET TRAINED?* ☐ YES ☐ NO	IF YES, AT WHAT STAGE:*	ARE BOWEL MOVEMENTS REGULAR?* ☐ YES ☐ NO	WHAT IS USUAL TIME?*
WORD USED FOR "BOWEL MOVEMENT"*		WORD USED FOR URINATION*	

PARENT'S EVALUATION OF CHILD'S HEALTH

IS CHILD PRESENTLY UNDER A DOCTOR'S CARE? ☐ YES ☐ NO	IF YES, NAME OF DOCTOR:	DOES CHILD TAKE PRESCRIBED MEDICATION(S)? ☐ YES ☐ NO	IF YES, WHAT KIND AND ANY SIDE EFFECTS:
DOES CHILD USE ANY SPECIAL DEVICE(S): ☐ YES ☐ NO	IF YES, WHAT KIND:	DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME? ☐ YES ☐ NO	IF YES, WHAT KIND:

PARENT'S EVALUATION OF CHILD'S PERSONALITY

HOW DOES CHILD GET ALONG WITH PARENTS, BROTHERS, SISTERS AND OTHER CHILDREN?

HAS THE CHILD HAD GROUP PLAY EXPERIENCES?

DOES THE CHILD HAVE ANY SPECIAL PROBLEMS/FEARS/NEEDS? (EXPLAIN.)

WHAT IS THE PLAN FOR CARE WHEN THE CHILD IS ILL?

REASON FOR REQUESTING DAY CARE PLACEMENT

PARENT'S SIGNATURE	DATE

PHYSICIAN'S REPORT FOR COMMUNITY CARE FACILITIES

For Resident/Client Of, Or Applicants For Admission To, Community Care Facilities (CCF).

NOTE TO PHYSICIAN:
The person specified below is a resident/client of or an applicant for admission to a licensed Community Care Facility. These types of facilities are currently responsible for providing the level of care and supervision, primarily nonmedical care, necessary to meet the needs of the individual residents/clients.

THESE FACILITIES DO NOT PROVIDE PROFESSIONAL NURSING CARE.
The information that you complete on this person is required by law to assist in determining whether he/she is appropriate for admission to or continued care in a facility.

FACILITY INFORMATION (To be completed by the licensee/designee)

NAME OF FACILITY:		TELEPHONE:
Parca Raji House Program		650-376-3593
ADDRESS: NUMBER	STREET	CITY
1401 Palm Dr.		
LICENSEE'S NAME:	TELEPHONE:	FACILITY LICENSE NUMBER:
Parca Raji House	650-376-3593	411408919

RESIDENT/CLIENT INFORMATION (To be completed by the resident/authorized representative/licensee)

NAME:		TELEPHONE:
ADDRESS: NUMBER	STREET / CITY	SOCIAL SECURITY NUMBER:
NEXT OF KIN:	PERSON RESPONSIBLE FOR THIS PERSON'S FINANCES:	

PATIENT'S DIAGNOSIS (To be completed by the physician)

PRIMARY DIAGNOSIS:

SECONDARY DIAGNOSIS: | LENGTH OF TIME UNDER YOUR CARE:

AGE:	HEIGHT:	SEX:	WEIGHT:	IN YOUR OPINION DOES THIS PERSON REQUIRE SKILLED NURSING CARE?
				☐ YES ☐ NO

TUBERCULOSIS EXAMINATION RESULTS: ☐ ACTIVE ☐ INACTIVE ☐ NONE | DATE OF LAST TB TEST:

TYPE OF TB TEST USED: | TREATMENT/MEDICATION: ☐ YES ☐ NO If YES, list below:

OTHER CONTAGIOUS/INFECTIOUS DISEASES:
A) ☐ YES ☐ NO If YES, list below:

TREATMENT/MEDICATION:
B) ☐ YES ☐ NO If YES, list below:

ALLERGIES
C) ☐ YES ☐ NO If YES, list below:

TREATMENT/MEDICATION:
D) ☐ YES ☐ NO If YES, list below:

Ambulatory status of client/resident: ☐ Ambulatory ☐ Nonambulatory

Health and Safety Code Section 13131 provides: "Nonambulatory persons" means persons unable to leave a building unassisted under emergency conditions. It includes any person who is unable, or likely to be unable, to physically and mentally respond to a sensory signal approved by the State Fire Marshal, or an oral instruction relating to fire danger, and persons who depend upon mechanical aids such as crutches, walkers, and wheelchairs. The determination of ambulatory or nonambulatory status of persons with developmental disabilities shall be made by the Director of Social Services or his or her designated representative, in consultation with the Director of Developmental Services or his or her designated representative. The determination of ambulatory or nonambulatory status of all other disabled persons placed after January 1, 1984, who are not developmentally disabled shall be made by the Director of Social Services, or his or her designated representative.

I. PHYSICAL HEALTH STATUS: ☐ GOOD ☐ FAIR ☐ POOR	COMMENTS:			
	YES (Check One)	NO (Check One)	ASSISTIVE DEVICE	COMMENTS:
1. Auditory impairment				
2. Visual impairment				
3. Wears dentures				
4. Special diet				
5. Substance abuse problem				
6. Bowel impairment				
7. Bladder impairment				
8. Motor impairment				
9. Requires continuous bed care				

II. MENTAL HEALTH STATUS: ☐ GOOD ☐ FAIR ☐ POOR	COMMENTS:			
	NO PROBLEM	OCCASIONAL	FREQUENT	IF PROBLEM EXISTS, PROVIDE COMMENT BELOW:
1. Confused				
2. Able to follow instructions				
3. Depressed				
4. Able to communicate				

III. CAPACITY FOR SELF CARE: ☐ YES ☐ NO	COMMENTS:		
	YES (Check One)	NO (Check One)	COMMENTS:
1. Able to care for all personal needs			
2. Can administer and store own medications			
3. Needs constant medical supervision			
4. Currently taking prescribed medications			
5. Bathes self		✔	
6. Dresses self			
7. Feeds self			
8. Cares for his/her own toilet needs			
9. Able to leave facility unassisted			
10. Able to ambulate without assistance			
11. Able to manage own cash resources			

PLEASE LIST OVER-THE-COUNTER MEDICATION THAT CAN BE GIVEN TO THE CLIENT/RESIDENT, AS NEEDED, FOR THE FOLLOWING CONDITIONS:

CONDITIONS	OVER-THE-COUNTER MEDICATION(S)
1. Headache	
2. Constipation	
3. Diarrhea	
4. Indigestion	
5. Others *(specify condition)*	

PLEASE LIST CURRENT PRESCRIBED MEDICATIONS THAT ARE BEING TAKEN BY CLIENT/RESIDENT:

1.	4.	7.
2.	5.	8.
3.	6.	9.

PHYSICIAN'S NAME AND ADDRESS:	TELEPHONE:	DATE:

PHYSICIAN'S SIGNATURE

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION (TO BE COMPLETED BY PERSON'S AUTHORIZED REPRESENTATIVE)
I hereby authorize the release of medical information contained in this report regarding the physical examination of:

PATIENT'S NAME:

TO (NAME AND ADDRESS OF LICENSING AGENCY):

SIGNATURE OF RESIDENT/POTENTIAL RESIDENT AND/OR HIS/HER AUTHORIZED REPRESENTATIVE	ADDRESS:	DATE:

Parca

Serving People with
Developmental Disabilities & their Families

Authorization for Medication Administration

I, _____ give permission for Parca employees to administer to my child,

_____, the medication indicated below in the designated amount at the designated time.

Medication Name:
Dosage:
Time Given:

Medication Name:
Dosage:
Time Given:

Medication Name:
Dosage:
Time Given:

I hereby authorize Parca, to give above prescribed medications to _____ _____. I understand that all medication will be provided in its original bottles with legible labels on them. Medication not in accordance will be returned to authorized representative for proper presentation. I understand that leftover medications will be returned to authorized representative in their original container.

Authorized Representative's Signature Date

Physician's Signature Date

PLEASE NOTE: STAFF CANNOT ADMINISTER MEDICATIONS THAT ARE DESIGNATED TO BE GIVEN "AS NEEDED". ON THE PERMISSION SLIP, IT NEEDS TO BE SPECIFIC IN DETAIL WHEN THE MEDICATION NEEDS TO BE ADMINISTERED.

PRN AUTHORIZATION LETTER
Community Care Licensing
California Department of Social Services

Dear Dr._____

Re: Your Patient_____
A client of: Parca Raji House

To receive nonprespcription and prescription PRN medications, State Licensing requires that either:

1) your patient be capable of determining his/her own need for the medication,
2) or nonprescription medications only, be able to clearly communicate his/her symptoms.

If your patient cannot determine his/her need for a medication, or clearly communicate the symptoms for a nonprescription medications then you, the physician, must be contacted before PRN medication can be give. Your completion of this form will serve to document your patient's current ability to determine his/her own need for these medications.

As a licensed care provider, it is my responsibility to monitor your patient's continued ability to determine his/her own need for PRN medications and inform you of any changes which indicate he/she can no longer make these decisions.

Thank you for your assistance:

Sincerely,
Signature_____ Title_____

Telephone Number_____ Date_____

Please check which circumstances describe your patient:

____My patient **CAN** determine and clearly communicate his/her need for prescription and nonprescription medication on a PRN basis.

____My patient **CANNOT** determine his/her own need for nonprescription PRN medication, but **CAN** clearly communicate his/her symptoms indicating a need for a nonprescription medication.

_____My patient **CANNOT** determine his/her need for prescription and/or nonprescription PRN medication and **CANNOT** clearly communicate his/her symptoms indicating a need for a nonprescription PRN medication and **Staff of Licensee must contact physician before each dose.**

My patient can take the following prescription and nonprescription on a PRN basis:

___cough drops	___ibuprofen	___metamucil
___non-aspirin	___pepto-bismol	___cold medication tablets
___lip balm/chapstick	___acetaminophen	___chlorpheniramine maleate tablets
___hydrocortisone cream	___cough syrup (alcohol free)	___chloraseptic
___clotimazole cream	___antacid tablets	

___allergy medication (such as benadryl/Sudafed)

___able to take all over the counter medications listed above

Physician's Signature_____ Date_____

Request Copy of Immunization Records

As a licensed children's care facility, Raji House is required to keep a copy of your child's immunization records on file with his/her medical documents. Please include your child's immunization records with this preadmission packet. These records may need to be obtained from your child's physician.

Physician's Signature _____