Sovereign Care Services

Pediatric Therapy Center

Dear Parent(s),

Sovereign Care Services is a NJ DCF authorized organization that offers NJ approved respite services to children with special needs through Perform Care Family Support Services (FSS) as well as to families seeking services independently. Our services include:

- In-Home/Agency Hire Respite
- After School Respite/ESY
- Weekend Respite
- Summer Camp

We offer various extracurricular activities; all catered to the growth and development of individuals with intellectual/developmental disabilities. ***Sovereign Care Services*** is committed to providing functional and purposeful programming which are designed to increase skill acquisition at home and within the community. ***Sovereign Care Services*** prides itself in building a team that is passionate about supporting and improving the lives of individuals with disabilities and their families.

It is an honor to have the opportunity to assist you and your child. If your child is not currently enrolled in Perform Care NJ, I would be more than happy to set an appointment so that I can walk you through the application process. If you would like to register your child in one of our programs now, feel free to review the attached paperwork for instructions on how to enroll your child into Sovereign Care Services. Should you have any other questions, concerns or comments, I can be reached Monday through Friday, from 10:00AM to 5:00PM at (732) 543-0459/ (609) 883-1587.

Best Regards,

Thelma Wilson
President

2500 Brunswick Ave, Suite 101, Lawrence Township, NJ 08648
1-609-883-1587 | info@sovereigncareservices.com | https://www.sovereigncareservices.com

Sovereign Care Services
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Parent(s),

Please complete this questionnaire and return it to us with the completed documents that are included in this packet. Should you have any questions, concerns or difficulties completing the included, do not hesitate to contact us at 732-543-0459/609-883-1587 or by email at thelma@sovereigncareservices.com.

What type of Respite care are you seeking? Please check one.

In-Home/Agency Hire Respite ☐ After School Respite ☐ Weekend Respite ☐

Summer Camp ☐

Have you contacted Perform Care regarding your desired respite care?

Yes ☐ No ☐

If not, it is imperative to contact Perform Care to request the required/desired service at 1-877-652-7624. Be sure to have your child's cyber number and important demographics handy.

If you intend on obtaining services without the assistance of Perform Care are you willing to pay the out of pocket cost for care?

Yes ☐ No ☐

What hours/days are you looking to obtain respite care services? Please indicate below using a "from and until" format.

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
AM	AM	AM	AM	AM	AM	AM
PM	PM	PM	PM	PM	PM	PM

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When returning the documentation, you may do so by postal mail to:

Sovereign Care Services

2500 Brunswick Avenue, Suite 101

Lawrence Township, NJ 08648

or by email to:

info@sovereigncareservices.com

Please include copies of the following:

A) Copy of child's IEP
B) Copy of Immunization Record
C) Copy of Birth Certificate
D) Copy of your Driver's License (or State issued ID)

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Information Collection, Use, and Sharing

We are the sole owners of the information collected from you. We only have access to/collect information that you voluntarily give us via email or other direct contact from you. We will not sell or rent this information to anyone. We will not share your information with any third party outside of our organization.

Unless you ask us not to, we may contact you via email in the future to tell you about parent classes, new groups or services you may be interested in through the email address you provide us or changes to this privacy policy.

As by HIPPA law, we only disclose ANY information to a third party if you sign and date a release of information authorization form.

Security

We take precautions to protect your information. When you submit sensitive information via the website, your information is protected both online and offline.

While we use encryption to protect sensitive information transmitted online, we also protect your information offline. Only employees who need the information to perform a specific job (for example, billing or customer service) are granted access to personally identifiable information. The computers/servers in which we store personally identifiable information are kept in a secure environment.

Updates

Our Privacy Policy may change from time to time and all updates will be sent via email from Sovereign Care Services.

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Addresses and Contact Information

Mercer County

Mailing Address:

Sovereign Care Services
2500 Brunswick Ave., Suite 101
Lawrenceville, NJ 08648
609-883-1587
info@sovereigncareservices.com

Middlesex County:

Sovereign Care Services
1346 How Ln., Suite 104-106
North Brunswick NJ 08902
732-543-0459

Alternate Contact Information:

E-Mail: thelma@sovereigncareservices.com

609-450-3504

Website: www.sovereigncareservices.com

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PAYMENT POLICY

- You will be Billed for all services rendered through email by the last day (28/30/31) of each month.
- We accept credit/debit card payments or by mailing a check (be sure that the check is received before your due date.
- Payments are due by the 5th of each month.

Late Payments:

- You will be charged a $75 late fee if payment is not received on time.
- Services will be terminated after a balance is 10 days late/overdue or the amount owed totals $500 or above.
- If you are late more than 3 times in a 12-month period, services will be terminated without the necessity of prior notification on our part.

Cancellation Notice:

- Cancellation of services must be given in writing and no later than 2 weeks prior to the cancellation of the service.
- If proper in writing notification is not provided you may be charges full price.
- You may be charged full price after a cancellation notification has been give whether or not services have been rendered.

Terminating Services for Programs containing 5 or more hours per week:

- You must give a 2-week notice before terminating services. If not, you will be billed for those hours.

Termination of Services on our behalf:

- We reserve the right to terminate services rendered at any time, at our discretion.
- We reserve the right to terminate services if we feel that company protocol and/or regulations have been infringed upon or broken.
- We reserve the right to terminate services if we feel that the client is not a good fit for what services our organization can provide.
- We reserve the right to terminate services at any time for any reason we find viable.

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Agreement

Please initial beside each that you have read and agree to each statement. Confidentiality & Privacy Notice. All information exchanged between client and Instructional Counselor is kept confidential except for when the Instructional Counselor has reasonable cause to suspect your child or adult child has been harmed or is a risk to bring harm to another: we are bound by the law to report immediately.

The documents included in this packet are to be filled out and turned into Sovereign Care Services by your first appointment, prior to services being rendered. Services cannot be started until this is completed. These forms can be filled out online and emailed to Sovereign Care Services with your consent to submit sensitive information online.

☐ I give my consent to email this new client packet to Sovereign Care Services.

Initials here: ____________

Date: __________________

☐ I have been given and understand the privacy notice located in this packet. I read and understand Sovereign Care Services payment policy listed on this page.

Initials here: ____________

Date: __________________

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Photographs/Videos taken

Respite Techs and/or Respite Coordinators will ask you before any photograph or video is taken; you have the right to decline. These images will not be stored or shared once session is complete or for any purpose other than company and client relations demonstrations, social media postings and website/company advertisement. You have the right to ask to see or for a copy of any photo or video taken at any time.

Photographs may be taken during company special events, lessons, arts & crafts, field trips and the like.

Please take a moment to fill out the bottom of this form.

I understand the photos and videos of my child as well as other children in this program may be taken as part of events and lessons.

☐ Yes. I approve that photos and/or videos be taken of my child while in the care of Sovereign Care Services programs and events.

☐ No. I do not approve that photos and/or videos be taken of my child while in the care of Sovereign Care Services programs and events.

I have read and understood that I have the right to accept or decline photo/video footage be taken of my child while in the care of Sovereign Care Services programs.

______________________________ ______________________

Signed Name Date

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Enrollment Form

Child Name: __________________________________ Date of Birth: _____________________

Social Security Number: ____

Home Address: ____

Primary Phone: _________________________ Secondary Phone: ______________________

School Name and Grade: ____

What is your child's official diagnosis? ____

____

Does your child have any allergies to foods, medications, pathogens, toiletries and the like?
Please be specific: ____

____

____

Does your child take any medication? Please list the names, dosage and what they are for:

____

____

____

____

BEHAVIORS

Please check all behaviors below that your child exhibits. Where applicable indicate frequency.

Behavioral Issue	Yes/No	Frequency
Aggression to self or others		
Verbal aggression to self or others		
Self-Injury/harm		
Violence		
Tantrums		

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Situational anxiety		
Generalized anxiety disorder, depression or bipolar disorder		
Biting		
Scratching/hitting self or others		
Elopement, roaming or wandering		
PICA, eating disorders or inability to tolerate certain textures		
Stimming or stereotypical behaviors		
Separation anxiety		
Inappropriate self-stimulation		

PERSONAL CONTACT AND EMERGENCY INFORMATION

Mother's Name/Legal Guardian: ____

Home address: ____

Primary Phone: ________________________ Secondary Phone: _________________

Email Address: ____

Employer: ____

Employer Address: ____

Employer Telephone Number: ____

Father's Name/Legal Guardian: ____

Home address: ____

Primary Phone: ________________________ Secondary Phone: _________________

Email Address: ____

Employer: ____

Employer Address: ____

Employer Telephone Number: ____

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Emergency Contact(s):

	Full Name	Relationship to Child	Phone Number
1			
2			
3			

Person(s) to whom Child May be Released:

	Full Name	Relationship to Child	Phone Number
1			
2			
3			

PARENT'S SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT

Please check all that you approve to:	✔
Obtaining Emergency Medical Assistance	
Administration of Minor First Aid Procedures	
Administration of CPR	
Emergency Restraints for safety during outdoor activities	
Transporting to nearest hospital Emergency Room in case of major accident	

I hereby understand and give permission for Sovereign Care Services to implement any of the aforementioned and checked emergency protocols should my child require the assistance. By signing below, I give consent.

_________________________________ _________________________________

Signature of Parent/Guardian Date

CHILD BACKGROUND AND HISTORY

School Name: _______________________________________ Grade: ___________

School District: ___________________________ Type of Classroom: ______________

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Does your child have an IEP and/or Behavioral Plan?

☐ Yes ☐ No

If so, please be sure to provide a copy of the IEP and/or Behavioral Plan.

COMMUNICATION

Please indicate how your child communicates by checking all that apply:

Verbal	
American Sign Language	
Device	

If your child uses a device, please explain what type of device and how it is being used.

____
____
____

Is your child toilet trained?

☐ Yes ☐ No

PLEASE ANSWER EVERY QUESTION THOROUGHLY

Please list and describe your child's likes and motivators:

____
____
____

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Please list and describe your child's dislikes and triggers:

____
____
____

Please provide a brief narrative of your child's strengths:

____
____
____

Please provide a brief narrative of your child's areas of need:

____
____
____

Please provide any other important information you would like to share about your child:

____
____
____

Please list your child's likes and dislikes:

LIKES:

____
____
____

DISLIKES:

____
____
____

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In-Home Respite Intake

Child Full Name: ______________________________________ DOB: _____________

Nickname: ____ Grade: ____________

Child's Official Diagnosis: ____

Level of Functionality: Low ☐ Moderate ☐ High ☐

What days and times would you need Respite services? Please be as specific as possible.

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
AM	AM	AM	AM	AM	AM	AM
PM	PM	PM	PM	PM	PM	PM

What types of activities does your child enjoy? Please be as specific as possible.

____
____
____
____

Does your child like going out? Yes ☐ No ☐

Would you allow your Respite Tech to take your child out of the house on outings/field trips?

Yes ☐ No ☐

What are some preferred activities or objectives that you would like your Respite Tech to focus on while with your child? (For Example: homework, social skills, self-care skills, etc.) Please be as specific as possible.

____
____
____
____

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Does your child have aggression issues? Yes ☐ No ☐

If so, please explain:

____
____
____
____

What are some triggers which will cause your child to become upset, emotional or have a tantrum?

____
____
____
____

What are some of the things you do when your child is having a melt-down that helps ease him/her?

____
____
____
____

Does your child have a restrictive diet? If so, please explain the restrictions. Please be as specific as possible.

____
____
____
____

Does your child have any food, environmental of product allergies? If so, please explain.

____
____
____
____

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Are there any things that you prefer your child not to engage in while being looked after by your Respite Tech? Please be specific.

____
____
____
____

Do you have specific instructions for your Respite Tech? If so, please do elaborate.

____
____
____
____

Who do we contact in case of an emergency?

Name: _______________________________________ Relationship to Child: __________________

Home Phone: ______________________________ Cellphone: ______________________________

Is there anything you'd like to add? Please use the back of the page if necessary.

____
____
____

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Payment Agreement Form

I understand the Payment Policy as shown in the "*Information Collection, Use, and Sharing*" from included in this packet. I understand that I am responsible for paying any fees pertaining to respite services for my child. Below I have selected my preferred method of payment and have signed my agreement.

Please check all that apply, then sign and date below.

☐ I am paying by check* (Please make checks out to Sovereign Care Services) *There will be a $35 fee for returned checks

☐ I am paying by cash (Must be received prior to camp start date)

☐ Other funding source

☐ Credit Card Payments: Visa/MasterCard/American Express

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Please enter name on the Card: ____

Please enter Credit Card number: ____

Expiration Date: ___________________________ CCV Code: ___________________

Please enter total amount to be paid by card: ___________________________________

__________________________________ __________________________

Printed Name Date

____

Signed Name

2500 Brunswick Ave, Suite 101, Lawrence Township, NJ 08648
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*** FOR OFFICE USE ONLY ***

Assigned Respite Tech: ____

Start Date: ______________________________ Contact Phone: __________________________

_________________________________ _____________________________

Respite Tech Printed Name Date

____

Respite Tech Signature

_________________________________ _____________________________

SCS Supervisor Printed Name Date

____

SCS Supervisor Signed Name