November 14, 2023

Dear Respite Families and Agency Representatives,

The purpose of our Respite Program is to provide relief for family caregivers whose daily tasks include caring for a loved one with disabilities. Our 66 acre campus and skilled staff will be utilized to provide a unique and safe respite experience. Participants may attend up to two respite weekends per year. Cradle Beach is a Home and Community Based Medicaid Waiver Program under OPWDD guidelines, therefore there is no out of pocket expense for parents/guardians.

RESPITE WEEKENDS 2024

January 26th - 28th	May 3rd - 5th	October 25th - 27th
February 9th - 11th	May 17th – 19th	November 1st - 3rd
March 22nd - 24th	September 20th - 22nd	November 15th - 17th
April 5th - 7th	September 27th - 29th	December 6th - 8th
April 19th – 21st	October 11th – 13th	

NEW FOR 2024!!!

Cradle Beach is excited to be offering two summer respite sessions for those over 18 years old.

August 26th - 28th
August 28th - 30th

Criteria for Respite Program:

- Participants must be 8 years of age or older and have a documented developmental disability.
- Participants must live at home with family or legal guardian. Individuals living in group homes or other residential facility do not qualify for this program.
- Participants must live in one of the seven counties of Western New York (Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans)
- Participants must have a physical examination, current medication orders, and prescription for and physician approved Over the Counter Medication Form (OTC Form) within a year of their Respite weekend.

OPWDD guidelines require specific documentation in order to participate in the Respite Program

If applicant is new to the Cradle Beach Respite Program they MUST have:

- **Documented negative TB test occurring within a year of their Respite weekend.**
- **Lifeplan with Cradle Beach listed as a respite provider**.
- **NOD09/Budget**
- **LCED**

****Check with your Care Coordinator about required paperwork****

Applications will be evaluated for placement on a first come, first served basis. Due to high demand, a second session will be scheduled based on availability when all applicants have received a session. If you need to cancel, PLEASE contact as soon as possible. Sessions will be rescheduled based on availability. If you have any questions, please feel free to contact us at (716) 549-6307 ext. 205 or at admissions@CradleBeach.org. Once again, we look forward to providing you with our Respite services.

Respite Themes

(Subject to Change)

Respite 1- January 26th - 28th - Winter Olympics
Respite 2- February 9th - 11th - Valentines
Respite 3- February 17th - 19th - Disney
Respite 4- March 22nd - 24th - St. Patrick's Day
Respite 5- April 5th - April 7th - Scavenger Hunt
Respite 6- April 19th - 21st - Spring
Respite 7- May 3rd - 5th - Prom
Respite 8- May 17th -19th - Camp/Adventure
Respite 9- September 20th - 22nd - Camp/Adventure
Respite 10- September 27th - 29th - Fall
Respite 11- October 11th - 13th - Harvest Fest
Respite 12- October 25th - 27th - Halloween
Respite 13- November 1st - 3rd - Scavenger Hunt
Respite 14- November 15th - 17th - Thanksgiving
Respite 15- December 6th - 8th - Holidays

Summer Respites

Respite 1- August 26th - 28th - Camp
Respite 2- August 28th - 30th - Camp
(*will be swimming, campfire, s'mores, and more)

2024 Respite Application

Mail Application to:
Cradle Beach
Attn: Respite Services
8038 Old Lakeshore Road
Angola, NY 14006

How to complete this application:
All information requested in this application is to be filled out completely even if the applicant is returning and you have submitted a completed application in the past. Completed applications are processed on a first come, first served basis. Incomplete applications will not be processed and enrollment will not be guaranteed.

Applicant Information: (Please print all information clearly)

Last Name: _____ First Name: _____Middle Initial: ___

Preferred Name: _____ Date of Birth: _____/_____/_____ Age: _____

Pronouns: _____ Gender: ☐ Female ☐ Male ☐ Prefer not to respond

Race (Optional): ☐ African American ☐ American Indian ☐ Caucasian/White
☐ Middle Eastern ☐ Native Hawaiian/Pacific Islander ☐ Asian

Ethnicity (Optional): ☐ Hispanic ☐ Non-Hispanic

Address: _____ City: _____ State: _____ Zip Code: _____

County: _____ Telephone: (_____)_____-_____

Have you attended Respite previously at Cradle Beach (circle one): YES or NO If so, Last year attended: _____

Parent/Guardian Information: (Please print all information clearly)

Parent/Guardian 1:
Name: _____

Cell Phone: (_____)_____-_____

E-mail Address: _____

Employer: _____

Work Phone: (_____)_____-_____

Parent/Guardian 2:
Name: _____

Cell Phone: (_____)_____-_____

E-mail Address: _____

Employer: _____

Work Phone: (_____)_____-_____

Respite Date Preferences: Please place a #1, #2, #3 in front of dates for your first respite weekend preference and #1, #2, #3 behind dates for your second respite weekend preference. Please note the summer dates are only for individuals over the age of 18.

1st	Date	2nd		1st	Date	2nd		1st	Date	2nd
	January 26th – 28th				May 17th – 19th				October 11th - 13th	
	February 9th – 11th				August 26th – 28th				October 25th – 27th	
	March 22nd – 24th				August 28th – 30th				November 1st – 3rd	
	April 5th – 7th				September 20th – 22nd				November 15th – 17th	
	April 19th – 21st				September 27th – 29th				December 6th – 8th	
	May 3rd – 5th									

Participant Name: _____ DOB: _____

Interests:

What does the participant like to do?

_____

_____

What strategies are used to manage the participant's challenging behaviors?

_____

_____

What promotes good behavior while at Respite?

_____

_____

What does the partipant dislike to do?

_____

_____

What things upset the participant?

_____

_____

How to they (the participant) express anger or frustration?

_____

_____

Behavioral Issues: (Please check all that apply) **These behaviors will not exclude partipants from Cradle Beach.** (Information provided allows for a safe and enjoyable experience for all.)

☐ Wanders/Runs away ☐ Inappropriate Language ☐ Self Injurious Behavior ☐ Destroys Property

☐ Bites others/self ☐ Inappropriate sexual behaviors: ☐ To self ☐ To others

☐ Non-Compliant ☐ Eats Inedible Objects ☐ Collects items that do not belong to them

☐ Physically aggressive (ex: hits, kicks) ☐ Self Harm

Does the participant have a Behavior Intervention Plan at his/her school or agency? ☐ Yes ☐ No
If yes, please provide a copy.

Does the participant have a Safety Plan? ☐ Yes ☐ No **If yes, please provide a copy.**

Participant Name: _____ DOB: _____

Do you or anyone in the household receive any of the following services:

☐ Family Assistance Benefits ☐ Supplemental Nutrition Assistance Program (SNAP) ☐ Child Welfare Services

Has the participant experienced:

☐ Foster Care ☐ Kinship Care ☐ Adoption

School/Program Information:

School/Program: _____ Grade: _____

Household Information:

Total number of people living in the household including participant: _____

Are ther any custody issues? ☐ Yes ☐ No

Who has custody or legal guardianship of the participant? _____

Please list ALL members livinng in the household, age, and their relationship to the participant

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Emergency Contact Information

In case of emergency Cradle Beach staff will contact parents/guardians **FIRST.** If you cannot be reached, the Emergency Contacts listed below will be contacted. Please complete the entire section. Provide two (2) contact names (relatives, friends, etc.) **other than yourself** to contact in case of an emergency. Please include their phone number and relationship. All emergency contacts must be over the age of 18.

Name: _____ Phone # (_____)_____ Relationship: _____

Name: _____ Phone # (_____)_____ Relationship: _____

Agency Services:

Agency: ☐ Person Centered Services ☐ Prime Care **Self Directed Services:** ☐ Yes ☐ No **Tabs #: _____**

Care Coordinator/Manager: _____ Telephone: (_____)_____

Care Coordinator/Manager's Email: _____

If Self Directed:

Fiscal Intermediary Agency: _____

Fincal Intermediary Contact Name: _____ Telephone (_____)_____

Fiscal Intermediary Email: _____

Participant Name: _____ DOB: _____

Authorize to release medical information:

As the parent/guardian of _____, I authorize the
(participant's name)
participant's medical information and prescriptions to be released to Cradle Beach during the time the participant attends Respite.

_____
(Physician's Office)

At (_____) _____, (_____)_____
Phone Numer Fax Number

_____
(Pharmacy with address)

At (_____) _____
Phone Numer

I give the physician (listed above) and/or pharmacy permission to fax the participant's physical and/or prescriptions to Cradle Beach at (716) 549-6825. I authorize any physician nurse or health care provider, to communicate with the medical staff and Director of Campus Based Services at Cradle Beach about the participant's medical condition, treatment, and/or prognosis. I further authorize the medical staff at Cradle Beach to discuss any medical conditions with the Director of Campus Based Services, his/her designee, or the participant's counselor when the medical staff, believes such communication will be in the best interest of the participant.

Parent/Guardian Signature: _____

Print Name: _____ Date: _____

Parent/Guardian Medical Disclaimer Agreement
Must be signed for participant to attend respite

The nurses at Respite may give the participant routine medications and over the counter medications as approved by participant's physician, monitor health status and provide first aid and routine care. If there is any change in the participant care or their medical status, I wish to be notified.

If emergency treatment is necessary, **I give permission for the participant to be brought to the nearest emergency room** by ambulance or staff transport for treatment. I authorize staff to release all records necessary for insurance purposes so that my insurance company can be billed for the visit, lab tests, and/or x-rays if necessary.

If time and circumstances permit, I would prefer that the participant be taken to:

☐ John R. Oishei Children's Hospital ☐ ECMC ☐ Mercy Hospital ☐ Buffalo General ☐Sisters of Charity Hospital

I will provide all necessary medications and supplies needed by the participant for three (3) days. However, if the participant requires any additional prescription medication, I give the medical staff at Cradle Beach permission to obtain and bill me for this medication/supply after my notification. Cradle Beach will bill you directly if there is no medical insurance. In consideration of admission of this participant to Cradle Beach, the undersigned hereby releases any and all claims for injuries sustained by the participant in going to or coming from Cradle Beach, or while at Cradle Beach and consents to hospital or medical care if needed.

Parent/Guardian Signature: _____

Print Name: _____ Date: _____

Participant Name: _____ DOB: _____

Health Insurance Information:

Please Note: ALL insurance information is requested below is **required**, as well as a copy of the participant's current insurance card. If this section is not completed, it will be returned to you causing delays in processing your application.

Insurance Provider: _____ Insurance Provider Phone: _____
Insurance Group Number: _____ Insurance Policy Number: _____
Insurance Subscriber Name: _____ Subscriber Date of Birth: _____

Physical/Medical Information:

Please Note: Every applicant must have completed a physical dated within at least one (1) year prior to the date they plan to attend a Respite Weekend. Please have your physician fill out the provided physical and over the counter form. Until we receive proof of physical and over the counter form, applicant will be placed on a pending list. **ANY MEDICATION CHANGES AFTER PHYSICAL EXAM DATE MUST BE ACCOMPANIED BY A CURRENT WRITTEN PRESCRIPTION FROM THE APPLICANT'S PHYSICIAN OR PHARMACY.**

Physician's Name: _____
Telephone #: (_____)_____ Fax #: (_____)_____
Most recent or pending date of physical: _____
Pharmacy's Name: _____
Telephone #: _____

Has the participant been hospitalized within the past three (3) years? ☐ Yes ☐ No
If yes, please explain in detail with date(s):

_____

Current Medications: Must match physician orders for medication(s).

- NYS law requires **all medications including Over the Counter Medications** to be dispensed only by physician's orders.
- Please include all medications, inhalers with frequency and/or nebulizer treatments.
- Any changes prior to arrival must be accompanied with current prescription.

Medication	Dosage	Times Given	Route	Reason	PLEASE LIST ANY SPECIAL WAYS TO ADMINISTER THE MEDICATION

New York State public law has been amended to require that the following information be included on this application:
1. Cradle Beach is required to be licensed by the New York State Dept. of Health. 2. Cradle Beach is required to be inspected twice yearly. 3. Inspection reports concerning camp are on file at the Erie County Dept. of Health, Rath Building , Buffalo, NY

Participant Name: _____ DOB: _____

Allergy Infromation: ☐ Does Not Apply

General Allergies:

☐ Dust (Please specify): _____

Reaction: _____ Treatment: _____

☐ Mold (Please specify): _____

Reaction: _____ Treatment: _____

☐ Insect (Please specify): _____

Reaction: _____ Treatment: _____

☐ Animal (Please specify): _____

Reaction: _____ Treatment: _____

☐ Seasonal (Please specify): _____

Reaction: _____ Treatment: _____

☐ Other (Please specify): _____

Reaction: _____ Treatment: _____

Allergies to Medications and Medical-Related Allergies:

☐ **Allergies to Medciations (Please list all below):**

Medication: _____ Reaction: _____ Treatment: _____

Medication: _____ Reaction: _____ Treatment: _____

Medication: _____ Reaction: _____ Treatment: _____

Medication: _____ Reaction: _____ Treatment: _____

Medication: _____ Reaction: _____ Treatment: _____

Medication: _____ Reaction: _____ Treatment: _____

☐ **Latex Allergy**

Reaction: _____ Treatment: _____

☐ **Sunscreen or PABA Allergy**

Reaction: _____ Treatment: _____

☐ **Allergies to Food: (**For example: lactose, dye allergy, specific food)

Food: _____ Reaction: _____ Treatment: _____

Food: _____ Reaction: _____ Treatment: _____

Food: _____ Reaction: _____ Treatment: _____

Participant Name: _____ DOB: _____

Disability/Diagnosis: (Check all that apply) ☐ Does Not Apply

☐ **Epilepsy/Seizure – Type of Seizure: _____ Date of Last Seizure: _____**
Frequency: _____ Emergency Medications: _____
*****Please forward seizure plan for review by our medical staff*****

☐ Apraxia of _____

☐ ADHD – Attention Deficit Hyperactive Disorder

☐ APD – Auditory Processing Disorder

☐ Asthma - ☐ Allergic Rhinitis ☐ Exercise Induced ☐ Other: _____

☐ Autism - ☐ Level 1 ☐ Level 2 ☐ Level 3

☐ Celiac Disease

☐ CP – Cerebral Palsy

☐ Diabetes ☐ Type 1 ☐ Type 2 ☐ Pre-diabetic
*****Please forward diabetic plan for reveiew by our medical staff*****
Managed by: ☐ Diet ☐ Medication ☐ Insulin Pump

☐ Down Syndrome

☐ Microcephaly

☐ Muscular Dystrophy

☐ Genetic Condition – Specify: _____

☐ GERD – Gastroesophageal Reflux Disease

☐ Hearing Disability: ☐ Partial Hearing Loss ☐ Total Hearing Loss **Use of:** ☐ Hearing Aids ☐ Cochlear Implant

☐ Heart Condition: ☐ Heart Defect ☐ Murmur ☐ Hypertension ☐ Other: _____

☐ Hydrocephalus

☐ Intellectual Disabilities

☐ Learning Disabilities – Types: _____

☐ Mental Health Concerns - ☐ Adjustment Disorder ☐ Anxiety ☐ Bipolar Disorder ☐ Depression
☐ Mood Disorder ☐ OCD – Obsessive Compulsive Disorder ☐ ODD – Oppositional Defiant Disorder
☐ Phobia - _____ ☐ PTSD – Post Traumatic Stress Disorder ☐ RAD – Reactive Attachment Disorder

☐ Schizoaffective Disorder

☐ Neurological - ☐ Tourette's Syndrome ☐ Tics ☐ Migraines ☐ Other: _____

☐ PICA

☐ Prader-Willi Syndrome

☐ Rett Syndrome

☐ Scoliosis

☐ Shunt – Type: _____ Restrictions: _____

☐ Spina Bifida

☐ TBI – Tramautic Brain Injury

☐ William Syndrome

☐ Vision - ☐ Legally Blind ☐ Nystagmus ☐ Visually Impaired **Use of:** ☐ Glasses ☐ Contacts ☐ Mobility Aid

Comments:

_____

Participant Name: _____ DOB: _____

Ambulatory Abilities/Aids: ☐ Does Not Apply

☐ Walks with assistance ☐ Walker ☐ SMOS ☐ Manual wheelchair ☐ Medical Stroller

☐ Awkward Gait ☐ Crutches ☐ AFOS ☐ Electric wheelchair

Communication:

☐ Developmentally appropriate communication skills ☐ Expressive Language Delays ☐ Receptive Language Delays

☐ Limited Verbal

☐ Articulation Delay ☐ Speech is easily understood

☐ Responds to own name

☐ Respods to directions - ☐ One-step directions ☐ Multi-step Directions

☐ Can communicate daily needs

☐ Uses Gestures

☐ Uses Sign Language - ☐ ASL ☐ Signed English ☐ Home signs

☐ Uses Communication Device (Please send device with participant) – Type: _____

☐ Uses communication board or picture symbols

☐ Other: _____

Activities of Daily Living Skills:

	Independent	**Needs Prompts**	**Needs Partial Assistance**	**Needs Total Assistance**
Showering				
Washing hands				
Drying Hands				
Brushing Teeth				
Dressing				
Hair Care				
Menstruation Care ☐ N/A				
Toileting				

Sleeping Needs/Information:

☐ Walks in sleep ☐ Awakens during the night ☐ Utilizes CPAP ☐ Sleeps through the night

☐ Requires respite bed (Cradle Beach utilizes a bed with built up sides in place of bed rails) ☐ Repositioning

Strategies to help at bedtime: (please be specific) _____

_____

Medications for sleep, such as Melatonin, cannot be given without a prescription from the physician.

Toileting Issues/Information:

Bring to the bathroom _____ times a day. ☐ Wake participant up at night. How often? _____

☐ Wets bed. How often? _____ Wears: ☐ Briefs ☐ Pull-ups (☐ At night ☐ All Day)

☐ Needs supervision in the bathroom

☐ Requires catherization – every _____ hours or other: _____

(PARENTS/GUARDIANS MUST SUPPLY BRIEFS/PULL-UPS FOR THE DURATION OF THE WEEKEND SESSION)

Participant Name: _____ DOB: _____

Mealtimes:

	Independent	Needs Prompts	Needs Partial Assistance	Needs Total Assistance
Finger Foods				
Uses Spoon				
Uses Fork				
Uses Knife				
Drinks				
Cleans Self				

Diet Level:

☐ Regular ☐ Soft and Bite sized ☐ Minced and Moist ☐ Pureed

Liquid Level:

☐ Thin liquids ☐ Slightly thick/nectar ☐ Mildly thick/honey ☐ Moderately thick/pudding

☐ **Uses adaptive Equipment (Please list) (All adaptive equipment should be labeled):**

_____

Eating Difficulties:

☐ Bite reflex ☐ Chewing ☐ Unable to close mouth ☐ Eats slowly ☐ Eats to fast ☐ Choking

☐ Gagging ☐ Swallowing ☐ Drooling ☐ Overstuffs mouth

☐ Needs help with positioning during meals (be specific): _____

☐ Likes: _____

☐ Dislikes: _____

Additional information on how to best assist the participant during meals & snack time: _____

_____

_____

Dietary Needs:

☐ Does Not Apply

PLEASE NOTE: CRADLE BEACH IS A PEANUT/TREENUT FREE FACILITY
(THIS INCLUDES NUT MILKS SUCH AS ALMOND OR CASHEW MILK)

Please give details for any dietary needs/restrictions

☐ Gluten

☐ Casein

While Cradle Beach carries gluten and casein free meals and products, we ask that any special brands or unique items that the participant prefers be provided. All items will be labeled and checked in with the kitchen staff.

☐ Lactose Intolerant

☐ Vegetarian

☐ Food restrictions/ARFID Please list food preferences:

_____

_____

(We will try our best to have preferred foods on hand however families may bring foods they know their participant will like.)

☐ Diabetic Diet (Parents/Guardians **MUST** provide suggested carb counting/substitutions provided by your physician/practitioner or dietary specialist)

☐ Ketogenic Diet (Must provide physician/practitioner or dietary specialist plan)

☐ Low Calorie _____

Is Portion Control needed? ☐ Yes ☐ No

Participant Name: _____ DOB: _____

*****The following documentation MUST be sent in with application*****

- A completed physical dated within one (1) year prior to the date they plan to attend Respite.
- Lifeplan submitted with application. Following documents needed before the participant attends – NOD09/Budget, LCED, and Lifeplan with Cradle Beach as a respite provider for new applicants to Respite.
- New applicants to Respite must be tested for TB, within at least one (1) year prior to the Respite Weeekend they plan to attend, ad results proven to be negative must be forwarded to Cradle Beach for our records.

Program information:

I grant to Cradle Beach, Inc. , its representatives and employees the right to take photographs and/or video of the participant and their property in connection with the above-identified subject. I authorize Cradle Beach, Inc., its assigness and transferees to copyright, use and publish the same in print and/or electronically. I agree that Cradle Beach, Inc., may use such photographs and/or video of the participant with or without my name and for any lawful purpose, including, for example, such purposes as publicity, illustration, advertising and web content.

☐ **Yes** ☐ **No Signature: _____Print Name: _____**

I grant to Cradle Beach, Inc., to post the participant's photograph and/or video on our parent blog/newsletter? (Access to the blog is only granted to parents/guardians whose individual is attending the respite weekend and to staff)

☐ **Yes** ☐ **No Signature: _____Print Name: _____**

Parent/Guardian Commitment:

(Please check all the boxes on the left to show that you have read and agreed to each statement.)

☐ I give permission for the participant to attend Cradle Beach.

☐ He/she can participate in all recreational and educational activities except those noted as restrictions.

☐ I give Cradle Beach permission to contact my participant's school or agency personnel to release information (i.e. Counseling Services, Individualized Education Plan, Behavioral Intervention Plans, Safety Plan and Individualized Service Plan.)

☐ I will not hold Cradle Beach accountable for any items my participant might bring to camp. (For example: clothing, money, valuables or electronic items.)

☐ Cradle Beach reserves the right to send a participant home. This could be for behavioral, medical or mental health reasons. If we cannot guarantee the safety of your participant or others (including staff) your participant will be sent home. If your participant is being sent home; they MUST be picked up within two (2) hours.

☐ I give permission for the Respite Nurse to administer prescription medications, which I will send in the original container with the original label.

☐ I give permission for the Respite Nurse to carry out the medical protocol of Cradle Beach's standing orders on the participant, as it pertains to non-emergencies and over the counter medicaitons.

☐ I release any and all claims for injuries suffered or sustained by the participant in going to or coming from Respite or while at respite and consent to hospital or medical care as needed.

- **Completed by (print name): _____**
- **Signature: _____ Date: _____**
- **Relationship to applicant: _____**