

Introducing Hang Time!

Hang Time is a respite program designed for families who are unable to hire traditional babysitters due to high behavioral or medical needs. This program offers a safe, supportive space for teens and young adults to socialize while giving caregivers a much-needed break.

Hang Time is open to:

- Teens and young adults ages 13 to 21
- Residents of El Paso, Park, or Teller counties
- Individuals with special health care needs, including cognitive, medical, physical, sensory, or social-emotional challenges
- Participants must have an intellectual or developmental disability, live at home with a parent or guardian, and not be enrolled in the DD waiver

Additional Details

- Siblings ages 12 and up are welcome to attend
- Volunteers will help with board games, arts & crafts, etc.
- Two staff members, a behavior specialist and a medical professional—will be on site to support the group as well

Hang Time is more than just a break—it's a chance for teens to connect and thrive in a welcoming environment.

How does it work?

- ☀ Complete this registration packet and return it to Sarah Nolan by email @ RespitePrograms@tre.org or by mail or fax (see below). Email submissions must be scanned as low resolution PDF files. Other formats are too large to send.
- ☀ We will confirm your attendance and coordinate available sessions.
- ☀ Activities will include arts and crafts, music, dancing, and lots of fun.
- ☀ A meal and snacks will be provided. Please let us know if your child has any dietary restrictions.
- ☀ Locations & times vary. Participants will be given the times and location before each session. Sessions may not be held every month.
- ☀ All participation must be confirmed prior to the sessions by the Break Time Staff. There is no capability for unscheduled drop-offs.

6385 Corporate Drive, Suite 100, Colorado Springs, CO 80919
Phone (719) 338-1718 Fax (844) 207-6957

Hang Time Enrollment Form

If any siblings will be attending, please print off and complete a sibling form for each child that will be attending. All forms must be completely filled-out for everyone before they can be registered.

Leave No Unanswered Questions or Blank Pages. Write N/A if not applicable.

Name of Individual with An Intellectual or Developmental Disability: _____

Nickname: _____ Male ☐ Female ☐ Preferred Pronouns: _____

Date of Birth: _____ Primary Language (including ASL): _____

Race: _____ Military Affiliation: _____

Name of Parent or Guardian #1: _____

Cell Phone # for Parent or Guardian #1: _____ May we text this number? ☐ No ☐ Yes

Name of Parent or Guardian #2: _____

Cell Phone # for Parent or Guardian #2: _____ May we text this number? ☐ No ☐ Yes

Is the individual their own guardian? ☐ No ☐ Yes If they are, please have them sign all spots in the application.

Home Address: _____ Zip Code: _____

Does the individual reside in the home with either their parents or guardians? ☐ No ☐ Yes

Email: _____

Emergency Contact/Name and Phone #: _____

Please list everyone who can pick up the individual: _____

How did you hear about our program? _____

What Diagnoses has been identified to meet criteria for a Intellectual or Developmental Disability over age 5? _____

Have you been determined to receive services through TRE? ☐ No ☐ Yes If yes, what services are you receiving? _____

Is the individual currently enrolled on a waiver? ☐ No ☐ Yes If so, which waiver?(Please note we can not accept anyone on the DD waiver,) _____

Are All Immunizations up to Date? ☐ No ☐ Yes (If no, which are out-of date?) _____

Name of Primary Care Physician: _____ Phone: _____

Does the individual tolerate wearing a mask well? ☐ No ☐ Yes. Please be advised masks will be worn at all sessions.

Is the individual non-verbal? ☐ No ☐ Yes. If yes, how do they communicate with others? _____

List any allergies _____

Does the individual have any dietary restrictions? _____

Describe any history or possibility of choking or aspirating while eating: _____

Does the individual have any history of seizures at any time in their life ☐ No ☐ Yes

If applicable, what will a seizure look like to a caregiver?

List & explain all special equipment used (i.e. wheelchair, oxygen, g-tube, tracheotomy, etc.):

Describe toileting needs: _____

Does the individual suffer from any of the following? (Check all that apply.)

☐ Auto Immune Disease ☐ Asthma ☐ Diabetes ☐ High Blood Pressure

Please list any other medical conditions we should be aware of?

Hang Time Behavioral Questionnaire

Please answer all questions as honestly as possible. Please explain all Yes answers. Please note at this time we can not accept high behavior needs

Does the individual suffer from any of the following? (Check all that apply.)

<input type="checkbox"/> Mood swings (i.e. goes from great sadness to happiness)	<input type="checkbox"/> Very upset when left by parents	<input type="checkbox"/> Sexual Inappropriate Behavior	<input type="checkbox"/> An elopement risk
<input type="checkbox"/> Compulsions	<input type="checkbox"/> Homicidal Ideation	<input type="checkbox"/> Obsessions	<input type="checkbox"/> Developmental Delays
<input type="checkbox"/> Eating problems	<input type="checkbox"/> Suicidal Ideation	<input type="checkbox"/> Substance Abuse	<input type="checkbox"/>

Describe any legal charges or convictions? ☐ No ☐ Yes, please explain _____

How do you handle behavioral issues? _____

How does the individual respond to your intervention? _____

Please list at least 5 things the individual/enjoys doing: _____

Hang Time Medication Form

Make copies of this blank if there are more than 2 medications to be administered.

Fill out this form completely and accurately. If your child is on medications, but will not be receiving them during Hang Time, please just attached a copy of all current medications they are on.

Bring a sufficient amount of medication, in a current, prescription container. Over-the-counter medications, ointments and sunscreens must be delivered in original containers with instructions and warnings clearly visible. Medications that are brought to sessions in any other manner cannot be administered during Break Time or even left at the facility. You will have to choose between coming back at medication time or skipping a dose. The Registered Nurse must approve those options and may decide to reschedule your child. ****Caregivers do not administer or accept possession of any medications.****

Today's Date _____ Participants Name _____

Name of Medicine #1: _____ Dosage: _____

Reason the child needs the medication: _____

Method of Administration: _____

Any difficulties giving? (suggestions for nurse) _____

Times(s) to be given: _____

Side effects to watch for: _____

Does this medication need to be refrigerated? (please circle) Yes No

Name of Medicine #2: _____ Dosage: _____

Reason the child needs the medication: _____

Method of Administration: _____

Any difficulties giving? (suggestions for nurse) _____

Times(s) to be given: _____

Side effects to watch for: _____

Does this medication need to be refrigerated? (please circle) Yes No

Parent's Signature _____

CONSENT TO RELEASE INFORMATION/PHOTOS, VIDEOS, STATEMENTS.

Please list ALL individuals that will be attending.

Participant's Names:	Birth Dates:	
I hereby authorize: The Resource Exchange		To release information to: The Resource Exchange

1. Authorization: Initial ONE OF THE FOLLOWING CHOICES BELOW:

- A. ____ I authorize The Resource Exchange to photograph
B. ____ I do not authorize The Resource Exchange to photograph
(name)_____ or use likeness to promote The Resource Exchange.

2. Information Request: Initial ALL THAT APPLY or mark "N/A" if not applicable to this consent.

The following information is requested:

	Photos, Videos, Statements, printed material. These may be used with or without my name and for any lawful purpose for TRE Marketing and promotions both internally with staff and externally with the community via TRE's website and social media.
	____ (please initial) I understand that photos, videos, statements and printed materials released between the effective date of this authorization and the date of revocation may still be used in the public domain.
	Other: (please specify)

3. Identification Authorization: Initial your preference.

	TRE may use my full name on marketing and promotions materials.
	TRE may only use my first name on marketing and promotions materials.
	I wish to remain anonymous.

4. Information Usage: The above information may be utilized for: (please specify):

5. Consent Term: This consent will remain in effect until (not to exceed one year: __ (Date of Expiration)

5. Signatures: I/We do understand that I may revoke this authorization at any time, provided that I/we do so in writing to The Resource Exchange.

Date

Signature of Parent/Guardian

Parent Permission Slips

Break Time staff will call 911 to obtain emergency services for your child in any situation that is perceived to be life threatening. Please attach copies of all applicable insurance cards to avoid treatment delays.

The granted permissions and signed authorizations below are for my children: (name)

Contact parent/guardian: Name _____

Phone number(s) where you can be reached: _____

Other desired

action: _____

Please read and sign the following authorizations (Write “Not Approved” in the date for any denied permissions).

In case of a non-life threatening emergency, illness, or accident, the staff of Break Time is authorized to provide transportation, including ambulance service deemed necessary by the Break Time staff which includes a registered nurse.

Parent/Guardian _____ Date _____

I authorize and consent to any medical diagnostic tests, procedures and treatment to be performed by an appropriate physician, relating to or arising out of any accident, illness, or injury occurring at, or in conjunction with, any Break Time activity.

Parent/Guardian _____ Date _____

Required for attendance if applicable: My child _____ uses a wheelchair, and I give my permission for caregivers and professional staff to push/operate his/her wheelchair under the supervision of the BreakTime staff.

Parent/Guardian _____ Date _____

Your child is receiving these services in cooperation with our local colleges. Details of his/her behavior, medical condition, or other provided information could be studied, evaluated, or written about by faculty or students.

Your child's and family's identity will remain confidential and any copies of enrollment forms will have all names obscured.

I give my permission for college faculty and students to have access to my child's _____ name-obscured enrollment form copies and know that they may be used for classroom case studies.

Parent/Guardian _____ Date _____

I am willing to discuss more details about my child _____ with faculty and students. Confidentiality will be maintained for my entire family.

Parent/Guardian _____ Date _____

Per TRE policy, any granted permission can be immediately revoked by a parent, guardian or participant by any means of communication. This includes a verbal, written or digital notice to TRE.

Are any Sibling(s) attending Hang Time? Yes / No

If Yes, please print and fill out the form below for every child that will be attending. We MUST have a completed section for ALL children that will be attending. Please do not list them all on one. If the sibling has a diagnosed or undiagnosed intellectual or developmental disability please contact us to get a custom application.

Name of Child: _____ **Nickname:** _____ **Male** ☐ **Female** ☐

Pronouns: _____

Date of Birth: _____ **Name of Parent(s) or Guardian(s);**

If any medications could be given at Break Time, fill out the Medication Form for this child.

Does your child have any allergies? ☐ No ☐ Yes (If yes, please list) _____

Please answer all questions as honestly as possible. Behavioral issues will not exclude your child from attending Hang Time. Please explain all Yes answers.

Does your child suffer from any of the following? (Check all that apply.)

☐ Auto Immune Disease ☐ Asthma ☐ Diabetes ☐ High Blood Pressure

Please list any other medical conditions we should be aware

of? _____

Does your child suffer from any of the following? (Check all that apply.)

☐ Mood swings (i.e. goes from great sadness to happiness) ☐ Very upset when left by parents ☐ Sexual Inappropriate Behavior ☐ An elopement risk

☐ Compulsions ☐ Homicidal Ideation ☐ Obsessions ☐ Developmental Delays

☐ Eating problems ☐ Suicidal Ideation ☐ Substance Abuse ☐

Does your child have any legal charges or convictions? ☐ No ☐ Yes, please explain

How do you handle your child's behavioral issues?

How does your child respond to your intervention? _____

Please list at least 5 things your child likes/enjoys doing:

All information will be kept confidential and for the exclusive use of The Resource Exchange-Respite Programs staff only.

Your signature signifies that the information you have or will provide is, to the best of your knowledge, true and accurate.

(Signature of Parent or Guardian)

(Date)

Please provide us with any information that you would like us to know about your children. Finish incomplete answers to previous questions below as well. If there is not enough space, please attach your narrative of important medical, behavioral, or any information that we may need to care for your child.

[illegible]

Do you have any questions at this time?

Do you know of another family that might benefit from our program? Please include their name, phone number, and email address: