**Application is complete if all documents listed below are attached.**

Family R.O.C.K. Reaching Out to Christ’s Kids

Day Activity Program for Adults with Special Needs

**Day Program Application**

|  |  |
| --- | --- |
| **COMPLETED APPLICATION** |  |
| **SIGNED FINANCIAL AGREEMENT** |  |
| **INDIVIDUAL SERVICE PLAN (ISP) ATTACHED –** **If Applicable** |  |
| **RISK MANAGEMENT OR BEHAVIOR PLAN (BSP) ATTACHED – If Applicable** |  |
| **COPY OF CURRENT PHYSICAL EXAM/MEDICAL RELEASE****(must be within 1 year of application date)** |  |
| **RECENT PHOTO OF CLIENT** |  |

**We will only process applications with all documentation attached.**

**Please include all current plans for us to consider the client for acceptance. We understand that a new physical exam may be needed before the clients’ session, but a copy of the most recent one is required for processing the application.**

Individuals are not enrolled until they receive confirmation of acceptance. Please make sure **all information** is complete including mailing address, email addresses and phone numbers.

#

#

# mailing address: Family R.O.C.K.

# P.O. Box 507

# Kennedale, TX 76060

www.family-rock.org

**DAY PREFERENCE**

|  |  |
| --- | --- |
|  | **Please check the days attending** |
|  | Monday  |
|  | Tuesday |
|  | Wednesday |
|  | Thursday |
|  | Friday |

**CLIENT PERSONAL INFORMATION**

**Client’s Name**: Phone Number:

Address (*street/city/state/zip*):

Age: \_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: [ ]  M [ ]  F T-Shirt size: \_\_\_\_\_\_\_\_

Client Lives at: [ ]  Group Home [ ]  Home [ ]  Independent Living LOC/LON: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PERSON COMPLETING APPLICATION**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to client:

Address ([ ]  same as client):

Phone Number ([ ]  same as client): Alt. Phone Number:

Email: Fax Number:

Caregiver Name (if different from above): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number (if different from client):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alt. Phone Number:

**EXPERIENCE**

Is this the client’s first time attending a day center? [ ]  YES [ ]  NO Years of attendance:

If no, did the client enjoy the experience(s) and adjust well at previous centers? [ ]  YES [ ]  NO

Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Why did the client leave the previous day center? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has the client ever been asked to leave a day center? If so, why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Does the client have strong fears (e.g. darkness, water, thunder, bugs, animals, large crowds)?

[ ]  YES [ ]  NO Details:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_

What methods should be used to address these fears?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What level of supervision does the client need while in a center or community environment (lots of people, open spaces)?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there any additional assistance the client may require?

**INSURANCE INFORMATION**

Does this client currently receive Medicaid? [ ]  YES [ ]  NO Medicaid #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Service Coordinator: Agency providing service: \_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: Email:

Other insurance plan : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Account #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ACTIVITIES OF DAILY LIVING**

Review all the activities of daily living listed below and provide details regarding required assistance.

| **ADL** | **Independent** | **Verbal Reminders** | **Physical Assistance** | **Total Support** | **Details including any adaptive equipment needed** |
| --- | --- | --- | --- | --- | --- |
| Dressing | [ ]  | [ ]  | [ ]  | [ ]  |  |
| Grooming | [ ]  | [ ]  | [ ]  | [ ]  |  |
| Toileting | [ ]  | [ ]  | [ ]  | [ ]  | Toilet arms [ ]  YES [ ]  NO  |
| How does the client indicate they need to use the bathroom?  |
| Is the client incontinent during the day? [ ]  YES [ ]  NO Details:  |
| Is there a schedule for using the toilet? [ ]  YES [ ]  NO Schedule:  |
| Wears incontinence product (Attends)? [ ]  YES [ ]  NO |
| Females: Help with menstruation cycle? [ ]  YES [ ]  NO Help required:  |

**COMMUNICATION** (check all that apply)

|  |  |
| --- | --- |
| [ ]  Verbal and can be clearly understood by others[ ]  Verbal but may be difficult to understand  [ ]  Uses communication board/device  [ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | [ ]  Non-verbal[ ]  Gestures[ ]  Uses sign language |

**BEHAVIORAL PROFILE**

In order to best prepare for and meet the needs of the client, please provide accurate and detailed information as well as a current behavior plan, if available. Include behaviors displayed at home, at school/program, and in the community.

| **Behavior** | **Never** | **Seldom** | **Often** | **Explain/Details** |
| --- | --- | --- | --- | --- |
| Enjoys social gatherings | [ ]  | [ ]  | [ ]  |  |
| Interacts with peers | [ ]  | [ ]  | [ ]  |  |
| Follows directions | [ ]  | [ ]  | [ ]  |  |
| Destructive | [ ]  | [ ]  | [ ]  |  |
| Emotional outbreaks | [ ]  | [ ]  | [ ]  |  |
| Lying  | [ ]  | [ ]  | [ ]  |  |
| Stealing | [ ]  | [ ]  | [ ]  |  |
| Physically aggressive | [ ]  | [ ]  | [ ]  |  |
| Sexually aggressive | [ ]  | [ ]  | [ ]  |  |
| PICA | [ ]  | [ ]  | [ ]  |  |
| Scratches, hits or grabs | [ ]  | [ ]  | [ ]  |  |
| Self-abuse | [ ]  | [ ]  | [ ]  |  |
| Self-stimulating behaviors | [ ]  | [ ]  | [ ]  |  |
| Sensitive to touch | [ ]  | [ ]  | [ ]  |  |
| Temper tantrums | [ ]  | [ ]  | [ ]  |  |
| Uses inappropriate language | [ ]  | [ ]  | [ ]  |  |
| Wanders or runs away intentionally | [ ]  | [ ]  | [ ]  |  |
| Wanders unintentionally due to distractions | [ ]  | [ ]  | [ ]  |  |
| What approaches are most effective to help client de-escalate or calm?  |

**MOBILITY**

Check one:

[ ]  The individual is independent with all ambulation and mobility.

[ ]  The individual requires assistance with transfers and/or mobility.

**AMBULATION – LEVEL OF ASSISTANCE**

***[ ]*** Independent with all ambulation [ ] Walks with direct staff support

[ ]  Requires ASSISTIVE DEVICE for ambulation (cane, crutches, walker, etc.)

LIST DEVICE, BRACES, SPLINTS, & ADAPTIVE EQUIPMENT (*MUST BRING IF ACCEPTED):*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**WHEELCHAIR MOBILITY – LEVEL OF ASSISTANCE**

**PLEASE NOTE: Many areas have uneven surfaces and there is a distance between activities. If the client uses a wheelchair in these situations, please send the chair with them**

*[ ]  Uses a WHEELCHAIR* *[ ]  Manual* *[ ]  Power*

*When?* *[ ]  For long distances* *[ ]  At all times Can the client self-propel? [ ]  YES [ ]  NO*

Comments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**DINING NEEDS**

**LEVEL OF DINING ASSISTANCE REQUIRED**

[ ]  **High Need** Requires ongoing assessment/monitoring due to health concerns and swallowing disorder or requires specific training of techniques

[ ]  **Consistent** Ranges from providing minimal prompts to needing direct assistance to dine.

[ ]  **Supervised** May require assistance with set-up, cut-up and/or clean-up.

[ ]  **Independent** Requires no supervision during dining/training protocol

Comments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**HEALTH / MEDICAL INFORMATION**

Primary Diagnosis:

Secondary Diagnosis:

Primary Physician: Phone Number:

Address:

**Person to contact for Medical Consent**

Name: Relationship to Client:

Phone Number: Alternate Phone Number:

**Alternate contacts in the event of an emergency, illness or injury**

List individuals granted permission to pick up the client at any time during the client’s session. Please inform the individual(s) prior to starting at the day center that they have been listed as a contact. Family R.O.C.K. management will release the client only to individuals listed below.

Name: \_\_\_\_\_\_\_\_ Relationship to Client: \_\_\_\_

Phone Number: Alternate Phone Number:

Name: \_\_\_\_\_\_\_\_ Relationship to Client: \_\_\_\_\_

Phone Number: Alternate Phone Number:

**DIAGNOSES:** (check all that apply)

|  |  |  |
| --- | --- | --- |
| [ ]  ADD/ADHD[ ]  Alzheimer’s / Dementia[ ]  Audio Processing Disorder[ ]  Autism Spectrum Disorder[ ]  COPD[ ]  Behavior Disorders[ ]  Cerebral Palsy | [ ]  Colostomy[ ]  Developmental Disability[ ]  Diabetes [ ]  Down Syndrome[ ]  Hearing Impaired[ ]  Epilepsy[ ]  Intellectual Disability | [ ]  Learning Disability[ ]  Muscular Dystrophy[ ]  Sensory Processing [ ]  Visual Impaired |
| Specify Other:  |

**TEMPERATURE RESTRICTIONS:** [ ]  YES [ ]  NO

 If yes, limit outdoors if below/above: \_\_\_\_\_\_\_\_\_ degrees

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATION RECORD**

**Note: We cannot administer any Medications. If client needs medication, you need to speak with the administration for options available to you while the client is at the day center.**

[ ]  This individual will not take any routine medications while attending.

[ ]  This individual will take routine medications while attending and can self-administer.

**CONSENT**

[ ]  **CONSENT TO TREAT**

In the event of an emergency wherein any of the documented physicians are not available, I give my consent to provide treatment and to conduct any tests by appropriate medical staff on duty that are required to intervene and obtain necessary medical care.

[ ]  **CONSENT TO ATTEND AND PARTICIPATE**

I hereby request and give permission for the named client to attend Family R.O.C.K. and participate in all activities. I also agree not to send this individual if exposed to a contagious disease within 21 days of the date the applicant is to report, and I will notify the Director immediately.

**PERMISSION TO APPLY SUNSCREEN AND BUG SPRAY**

I give the staff at Family R.O.C.K. permission to apply the following to the below named client.

[ ]  Sunscreen [ ]  Bug Repellent

**PHOTO RELEASE** (check one)

[ ]  Permission is given to Family R.O.C.K. to use any photograph, digital or video taping of the client and the client’s name for television news stories, newspaper articles, news releases, publications (brochures, newsletters, website, etc.) and community awareness programs.

[ ]  No photos

**PARENT/GUARDIAN CONSENT**

All the information provided is accurate and complete to the best of my knowledge. If any information is found to be false or incomplete, I understand the client may be asked to withdraw immediately.

As the Parent/Guardian/Advocate of \_\_\_\_\_\_\_\_\_\_\_\_\_, I have read and understand the above.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent/Guardian/Advocate Signature** **Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to individual**

|  |  |
| --- | --- |
|  |  |

**SWIMMING PERMISSION**

Swim assessments will be done by our Red Cross certified life guards. Assessments will be sent home with the client at the end of the session.

Will the client swim while at Family R.O.C.K. Days? [ ]  YES [ ]  NO

Does the client enjoy swimming? [ ]  YES [ ]  NO

If the client does not enjoy swimming, will he or she want to be at the pool during swim time?

 [ ]  YES [ ]  NO

Will the client enjoy dipping his or her feet in the water? [ ]  YES [ ]  NO

What level swimmer is the client? Check the appropriate box.

[ ]  **No Previous Swimming Experience** – client has never swam before/unknown

[ ]  **One-on-One Support** – client requires constant hands-on support at all times

[ ]  **Non-Swimmer** – will enter water with assistance

[ ]  **Beginner** – has swam before; limited swimming ability

[ ]  **Advanced Beginner** – can move through the water using a floatation device or mild physical

 assistance

 [ ]  **Intermediate** – can support self in water, go under water

[ ]  **Advanced** – can independently swim

Does the client wear ear plugs when in the pool? [ ]  YES [ ]  NO

Are there any swimming restrictions? [ ]  YES [ ]  NO Details:

As the Parent/Guardian/Advocate of , I have read and understand the above.  *Client Name*

**Parent/Guardian/Advocate Signature Date**