A.F.I.R.E. of Pasco County, Inc. - 727-849-8982

REGISTRATION FORM

Legal Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Nickname:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex (M/F) Race\_\_\_\_\_ W= White, B=Black, H=Hispanic, A=Asian/ Pacific Islander

I= American Indian/ Alaskan Native, M=Multiracial

Birth Information: Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_

Name of school last attended:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Workplace/City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother's Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Workplace/City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list below any other persons that have permission to check him/her out in case of an emergency/illness, etc. (PHOTO I.D.'s will be required from person checking out a client). In order to release a client to another adult, the school MUST have written or verbal permission from the client's parent/guardian:

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relation:\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relation:\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_herby give my permission for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to be treated in a medical emergency if I cannot be contacted within a reasonable time.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of caregiver.

Sworn to and subscribed before me this \_\_\_\_\_ day of\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 2\_\_\_\_\_\_\_\_\_\_

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

Signature of Notary Public- State of Florida

Print, type or stamp Name of Notary Public

\_\_ Personally known \_\_ Produced Identification

PHYSICAL EXAMINATION

(To be completed by a Licensed Physician)

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GENERAL APPEARANCE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HEIGHT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WEIGHT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

VISION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CORRECTIVE LENSES: YES NO

HEARING: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HEARING AIDS: YES NO

BLOOD PRESSURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ LAB AND OTHER SPECIAL FINDINGS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHYSICAL DISABILITIES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MENTAL DISABILITIES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CONVULSIONS: YES NO SEIZURES: YES NO

MED ALLERGIES : YES NO (IF YES PLEASE LIST)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FOOD ALLERGIES: YES NO\_(IF YES PLEASE LIST)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ANY ACTIVITIES THAT SHOULD BE RESTRICTED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LIST OF MEDICATIONS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

MEDICAL EXAMINER NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

License or certificate #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State of License: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*A.F.I.R.E. OF PASCO COUNTY, INC. MAILING ADDRESS: PO BOX 933, ELFERS, FL 34680*

*PHONE: 727-849-8982 FAX: 727-817-1592 EMAIL:* [*afireofpaso@verizon.net*](mailto:afireofpaso@verizon.net)

*A.F.I.R.E. OF PASCO COUNTY, INC.*

PHYSICAL, BEHAVIORAL & EMOTIONAL INFORMATION FORM

(To be completed by a Caregiver)

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SEX: MALE FEMALE

LEVEL OF DEVELOPMENTAL DISABILITY: MILD MODERATE SEVERE

LIST OTHER DISABILITIES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FOOD ALLERGIES: YES NO LIST: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICINE ALLERGIES: YES NO LIST: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ASTHMA/WHEEZING: YES NO LIST MED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOSPITALIZATIONS: YES NO LIST REASON & DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HEAD INJURIES/BEEN KNOCKED OUT: YES NO SERIOUS BURNS: YES NO

BROKEN BONES: YES NO EAR INFECTIONS/DRAINING OR RUNNY EARS: YES NO

HEARING AIDS: YES NO GLASSES OR CONTACTS: YES NO

HEART MURMUR/HEART ISSUES: YES NO LIST HEART DOCTOR NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FALSE OR MISSING TEETH: YES NO “LOW BLOOD”/ANEMIA: YES NO

CONVULSIONS/ SEIZURES: YES NO

SELF CARE WITH TOILETING: YES NO SELF CARE WITH EATING: YES NO

BEHAVIORS: YES NO LIST: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*PLEASE CIRCLE ALL THAT APPLY:* COGNITIVE IMPAIRMENT MENTAL HEALTH PSYCHIATRIC DISORDER PERSONALITY DISORDER ALZHEIMERS/DEMENTIA OCD ANXIETY DEPRESSION IRRITABILITY AGRESSIVENESS BIPOLAR DISORDER

MEDICARE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MEDICAID NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BLOOD TYPE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRESCRIPTION NAMES & DOSAGES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHYSICAL LIMITS: YES NO LIST: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ANYTHING ELSE WE SHOULD BE AWARE OF: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*CLIENT OR CAREGIVER SIGNATURE*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *DATE*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**A.F.I.R.E.**

**LIST OF**

**PHONE NUMBERS**

Please list all phone numbers that we can call you in an emergency situation.

Please list numbers in order of numbers to be called (1st, 2nd, 3rd etc) Then circle if the number is HOME, CELL OR WORK and fill in the name of the contact person and relationship to the consumer for each number. (ex. Denise Haystrand/mother) Please list as many numbers as possible and list your information first then any others. Thank you!

CONSUMER’S NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. HOME/CELL/WORK\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_NAME/RELATIONSHIP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. HOME/CELL/WORK\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_NAME/RELATIONSHIP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. HOME/CELL/WORK\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_NAME/RELATIONSHIP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. HOME/CELL/WORK\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_NAME/RELATIONSHIP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. HOME/CELL/WORK\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_NAME/RELATIONSHIP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. HOME/CELL/WORK\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_NAME/RELATIONSHIP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. HOME/CELL/WORK\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_NAME/RELATIONSHIP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**MEDICAID WAIVER INFORMATION**

AFIRE of Pasco County, Inc. is an approved Medicaid Waiver Provider for ADT (Adult Day Training). Please supply the following information:

NAME OF MEDWAIVER CLIENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME OF SUPPORT COORDINATOR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME AND ADDRESS OF AGENCY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

AGENCY PHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IF ACCEPTED INTO OUR ADT PROGRAM, CLIENT'S SUPPORT COORDINATOR WILL HAVE TO SUBMIT PROOF OF APPROVAL IN THE FORM OF A SERVICE AUTHORIZATION FOR "ADULT DAY TRAINING", AS WELL AS "TRANSPORTATION" IF IT APPLIES.

WE WILL ALSO NEED TO RECEIVE A COPY OF THE CLIENT'S SUPPORT PLAN INDICATING THE GOALS CLIENT HAS CHOSEN TO WORK ON WHILE ATTENDING OUR ADULT DAY TRAINING PROGRAM.









9. At least annually, AFIRE staff will conduct a workshop informing consumers of their right to seek employment, if they so choose.

10. At least annually, AFIRE staff will conduct a workshop and inform consumers about types of abuse, and how to report any such abuse.

11. Annually, AFIRE will send each Consumer a Satisfaction Survey. The Consumer can choose to complete it and return it with or without a signature if they desire. AFIRE will then supply an aggregated assessment of the results, which will be included in AFIRE's Self-Assessment.

12. In addition, AFIRE will annually conduct face-to-face interviews with each Consumer regarding their satisfaction with our services. Again, AFIRE will use this information gathered to compile an aggregated assessment and include it in the Annual Self-Assessment.

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

Consumer Signature Date

A copy of this document has been provided to the individual named herein and a copy sent home with the individual to their legal representative (if applicable) as required by APD. A.F.I.R.E. of Pasco County, Inc. does not sell and/or rent any personal identifiable information about the individuals we serve. All such information is considered strictly confidential and always protected.

EMPLOYEE SIGNATURE: I HAVE BEEN PROVIDED WITH A COPY OF THIS POLICY. I AGREE TO ABIDE BY THIS POLICY.

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

Employee Signature Date

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

Trainer Signature Date



##### ADDENDUM TO GRIEVANCE PROCEDURE

**AFIRE of Pasco County, Inc.**

The following is the procedure that shall be used by consumers of AFIRE of Pasco County, Inc. with regards to grievance/problems that may arise while riding one of our vehicles.

1. All attempts shall be first made to resolve any grievance/problems with the consumer by scheduling an informal meeting between the consumer and his/her guardian and AFIRE Administrator and appropriate staff of AFIRE of Pasco County. The AFIRE telephone number (727-849-8982) is posted in our vehicles.
2. If the consumer still feels that he/she has a legitimate complaint after the informal meeting, then the consumer may contact the Community Transportation Coordinator (CTC) at 727-834-3200. A sign is posted in our vehicles with this phone number.
3. As an option after these two steps have been taken, if consumers still feel that problem has not been resolved to their satisfaction, they may call the Transportation Disadvantaged Ombudsman Program at 1-800-983-2435.

I have been provided with this Grievance Procedure upon admission to the AFIRE program.

Signature of Consumer Date

##### EMPLOYEE SIGNATURE: I HAVE BEEN PROVIDED WITH A COPY OF THIS POLICY.

Employee Signature Date

Trainer Signature Date

**AFIRE of Pasco County, Inc.**

###### GRIEVANCE FORM

AFIRE of Pasco County, Inc. seeks to resolve any grievances/problems that a consumer of AFIRE may encounter while attending our adult day training program. Please complete the following form and present it to the AFIRE Administrator. You will be contacted to schedule a meeting.

NAME: DATE:

ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

###### PLEASE DESCRIBE THE PROBLEM YOU ARE ENCOUNTERING:

**(FOR OFFICE USE ONLY)**

DATE OF REVIEW: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FINDINGS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

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

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

SIGNATURE DATE

**AFIRE of Pasco County, Inc.**

###### POLICIES AND PROCEDURES WITH REGARD TO

***65G-3.005 RULES FOR TERMINATION OF SERVICES BY THE PROVIDER***

1. AFIRE will give every new consumer that indicates they meet our criteria, a 30-day trial period, as per our enrollment packet. AFIRE has the option to extend this 30-day period for further evaluation of the consumer.
2. AFIRE will make every effort to assist consumers with meeting our criteria. If it is determined that the consumer does not meet our criteria, written notice of termination of the individual will be sent to the individual and/or guardian by Certified Mail, within 15 days prior to the effective date of termination. A copy of this letter will then be sent to the individual's WSC for their files.
3. AFIRE will also abide by these above terms for consumers that have already been enrolled, if the need arises.

*Consumer Signature Date*

*Employee Signature Date*

*Administrator Signature Date*

A.F.I.R.E. OF PASCO COUNTY, INC.

Student Dress Code Policy

Effective July 1, 2024

**TOPS:** The following style of tops are **approved**: Button-up shirts, blouses, sweaters, pullovers, and t-shirts. Colors, prints, and slogans are welcomed as long as they are in good taste. Tank-top style shirts are **approved**; however, spaghetti strap style tops are **NOT APPROVED** At no time should your midriff show nor should your back. You are expected to move freely in your shirt without revealing any additional part of your body.

**BOTTOMS:** The following styles of pants are **approved:** chinos, slacks, Khakis, and jeans. All pants should be worn in the appropriate size and not fall off of your body. Shorts and skirts are **approved** as long as they are mid-thigh or longer. At no time should your bottoms be see-through.

**DRESSES:** Similar to skirts, dresses are **approved** as long as they are mid-thigh or longer. Open-back dresses or dresses that are above themed-thigh are **NOT APPROVED.**

*Please note that at any time that a student’s outfit is deemed inappropriate, a staff member will offer the student a change of clothes from our donation bin, or a call home will be made so that appropriate clothing may be brought for them to change into.*

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

Student Signature Date

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

Guardian Signature Date

Logo

Description automatically generated

A.F.I.R.E.  
of

Pasco County, Inc.

7540 Ridge Road

Port Richey, FL 34668

Mailing address:

P.O. Box 933

Elfers, FL 34680-0933

Phone: (727) 849-8982

Fax: (727) 817-1592

**Email:** [**afireofpasco@verizon.net**](mailto:afireofpasco@verizon.net)

**Website: afireofpascocounty.com**

WELCOME

**Welcome to A.F.I.R.E. of Pasco County, Inc.**

A.F.I.R.E. is a non-profit, non-denominational Adult Day Training program dedicated to enhancing the quality of life of the developmentally disabled in West Pasco County. The goal of this program is to concentrate on emotional, social, safety, and academic skills producing a well-rounded individual. Daily tasks are taught in addition to social interaction in the form of small-group outings, large group outings and activities, and other events in the community. The program is run by an Administrator and overseen by the A.F.I.R.E. Board of Directors.

**ELIGIBILITY**

Our classes have an achievement expectation of increased independent functioning in both residential and classroom settings. This expectation of client progress requires certain eligibility criteria, which all potential participants must meet. These criteria are:

1. *Participants must be 18 years of age.*
2. *He or she must be able to function semi-independently in an individual and small group setting.* ***IF*** *the participant cannot function semi-independently and needs assistance with any ADL’s such as toileting or feeding, a meeting will be held by office personnel to ensure that the needs of the potential client can be met.*
3. *If the potential participant needs behavior services, a meeting with office personnel will be held to ensure that there is current or pending behavior services prior to starting.*
4. *All participants will be on a* ***thirty (30) day trial period****; however, he/she may be removed from the program any time during the evaluation process if the evaluations deem it appropriate.*

These criteria ensure that the participants are functioning at an appropriate level to benefit from the classroom training and that the safety and success of each participant in the program can be maintained.

Final determination on the enrollment application will be made after the thirty (30) day trial period.

An interview with the appropriate Admissions Officer and pertinent paperwork **MUST** be completed before attending class, **no exceptions.** This includes a written physical filled out by their attending physician, PCM paperwork, (if applicable) and Medication Administration paperwork, (if applicable).

\*All of these papers are included in this enrollment packet

In addition, the required approval **must** be obtained through your Med waiver Support Coordinator, (if applicable) and all necessary documentation completed to attend A.F.I.R.E. Adult Day Training program.

**CLASS SCHEDULE**

Classes are held Monday through Friday from 8:30am to 2:30pm., except for posted closings, holidays, scheduled outings, or in the event of a school closure due to unforeseen circumstances. A goal-based curriculum is followed on a daily basis consisting of many different activities such as academic based learning, computer training, independent life skills training, daily exercise, basic American Sign Language, reading and reading comprehension, BINGO, interactive social lessons, crafts, and more. Prior to admittance, a support plan containing both long and short-term goals will be created with input from the client, family members, and the clients WSC.

**TRANSPORTATION**

Transportation is provided for those living within the designated travel area provided space is available on the vans.

**FUNDRAISING**

Fundraising is an important part of our program. Parents and/or guardians are strongly encouraged to participate in fundraising events to benefit our program.

**FILED TRIPS/MONTHLY ACTIVITES**

The group participates in many different types of field trips and activities during the year. Release forms are required (monthly permission slips) prior to participating. In most instances, the trip/activity will require a fee to be paid in order to participate.

**ABSENTEEISM**

Participants who will not be attending our program or riding the van will contact the appropriate van driver the night before. In addition, please notify the office personnel. Clients who are absent 5 consecutive days without notification to the office will be sent a letter of inquiry. If a response is not received within 10 days, the client will be removed from the rolls.

**MISCELLANEOUS**

All visitors to the A.F.I.R.E. program during our program hours must report and sign in at the front desk. Please either call or send a written note if you will be picking up your student earlier in the day or bringing them in after the beginning of the scheduled start time.

*\*If a client is accepted into the program after the 30-day trial period, a red A.F.I.R.E. shirt may be purchased from the school.*