E-mail: nextstepfarms19@gmail.com
Web site: **https://nextstepfarm.org**

Mission ~ Our mission is to provide a safe and nurturing day program for individuals with intellectual and developmental disabilities who seek to participate in a homestead type environment.

Vision~ The Vision of Next Step Farms is to provide a hands on program for special needs adults through the production of farm fresh protein, produce, and products generated through the homestead environment.

Culture Statement~

At Next Step Farms, our goal is to create a day care program with a homestead feel for individuals ages 18 and up who have special needs. Areas of daily routine involvement and opportunity at Next Step Farms include but are not limited to:

- Animal Husbandry
- Horticulture/Landscaping
- Mechanical Maintenance
- Culinary Techniques
- Data Entry
- Basic Finance
- Daily Living Skills/Healthy Living
- Crafts

Requirements

Candidates will complete an application that will be reviewed by designated personnel. To qualify for consideration, applicants must meet the following criteria:

- Display a cognitive or developmental IQ below 70
- Age 18 or older
- Independently mobile ...use of assistive devices is considered mobile
- Able to convey personal and/or medicinal needs independently
- Able to complete tasks in a supervised environment
- Able to accept each other understanding that we have our own abilities and limitations.
- Able to encourage one another in positive ways.
- Able to fully participate in teaching, learning, work and social activities.
- Aim to work as a team until the task at hand has been completed.
- Create a culture free of abuse, harassment and unfair criticism.

Applicants and their support networks would meet with personnel to ease the transition and determine a start date. Once accepted, attendees can choose the program that best suits their personal goals and abilities. These fees will help meet the obligations of day to day operations.

Daily Program	Select Day Program
● Currently open two days per week	● Attends 1 or 2 scheduled days ● Fee $85 per day

<u>Transportation</u>~ Families must arrange for all participants' transportation.
<u>Location of Services~</u> Services are provided only at 1355 Douglass Road
<u>Hours of Services</u>~9:00- 2:00 Tuesday and Thursday. **Please see attached late pick up fee and policy. Holiday closings will be denoted on the yearly calendar.**
Inclement weather policy: **Next Step Farms will be closed when Madison County schools are closed due to weather conditions.**

Please note, if Next Step Farms schedules a week to be closed, no fees are due for that week. If you opt to be gone for a week you are still obligated to pay for that week, however we will attempt to make up that time with you when we have spots available during that month.

<u>Health-related Medical Support Services</u>~ This facility does not provide any type of medical treatment. We are happy to provide personal medication reminders as needed. Participants should be able to operate, maintain and administer life saving devices /medications. Caregivers may schedule any specialist onsite visit to benefit the good health of the participant. A first aid/sick room is available to isolate a participant who becomes ill during their scheduled time at the Farm until a responsible guardian arrives. EMS will be called if necessary.

Criteria and Agreement Contract for participants of Next Step Farms

- Participants must display a cognitive or developmental IQ below 70
- Participants must be age 18 or older
- Participants must be independently mobile …use of assistive devices is considered mobile
- Participants must be able to understand and follow simple directions and remain with a group without the use of additional staff members.
- Participants must not present a significant threat to themselves or others.
- Participants should be able to communicate needs and thoughts for sufficient benefit.
- Participants must be either on the conscious of bowel and bladder or be able to attend to bathroom needs independently of staff supervision. Reminders will be given if needed..
- Participants who require medication during the day must bring medication in a duplicate prescription bottle with dosages and schedule indicated. Staff does not administer medication but will provide reminders and supervision
- Participants must not require nursing care or attend with a fever or serious illness.
- Family members /responsible guardians must provide or arrange all transportation for participants.
- Participants may be suspended or terminated from the program for: behavior which is severe, cannot be managed at the center; communicable diseases; when participant no longer meets criteria; failure of responsible party or caregiver to adhere to center policies; and failure to pays fees prior to service.
- Participants and Staff with infectious disease or illness such as vomiting, or diarrhea are not allowed to attend the center. This is a non-medical facility therefore any participant who becomes ill or injured at the center must be picked up by a caregiver or designated driver, within one hour of notification by staff.
- Center closing dates will be published in the newsletter. Center may close for inclement weather conditions. If Madison Schools are closed for inclement weather this adult day center will be closed.
- A late fee will be charged for any fees, which are not paid in 30 days.
- If a 30 day mark is reached for non payment of late pick up fees or three late pick ups within a 6 month period, there is an automatic suspension from the program. The spot will be held for one month pending payment of accrued late fees. The first time late after suspension within that same time frame will result in expulsion from the program and a new application will be required to return.
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- If a participant becomes anxious and asks to leave before the scheduled pickup caregiver will be called.

Signature ______________________________ Date ___________________

Witness ______________________________ Date __________________

A copy of this form will be made for your records

Next Step Farms Participant Information

Client Information

Name ______________________________ D O B ___/___/___

Address ____

How long have you lived at this address?__________________________________

Age _________ Sex________ Race _________Ethnicity _________________

Primary Caregiver _____________________ Phone___________ Email____________

Power of Attorney y or n Name _______________ Ph # ___________ (provide copy)

Emergency Contact #1 ____

Phones: Home _____________ Work _____________ Cell ____________

Emergency Contact #2 ____

Phones: Home _____________ Work _____________ Cell ___________

Disability areas____

____

Who is authorized to transport the participant? If needed use the back of this page to list all who may transport participant.

Name ____

Phone #: Home _____________________ Work#: ______________________

Any repetitive behaviors? ____

Medical Information

Personal Physician _________________________ Phone # ______________

List of prescription and non-prescription drugs the participant currently takes: __

____

Complete form titled: **Current Prescription Medication Form**.

List known allergies of the participant: __________________________________

____

Is participant on a special diet? ____ If yes explain _____________________

____

Special Instructions for Emergency Care: ________________________________

Notice: Our office must be notified in writing of any changes in the information provided concerning the care of the participant listed above to assure information and records are current and accurate in case Emergency Medical Services (EMS) is needed.

Activities of Daily Living

Please help us to know your family member better….
Communication Needs Yes or No
Explain ____
Vision/Hearing Needs Yes or No
Hearing aid Yes or No
Vision problems, glasses, or other? ______________________________
Toileting Needs Yes or No
Explain if yes ____
____
Instructional Needs Yes or No
Explain if yes ____
____
Follows simple instruction? _____ Comments ________________
Other special needs or concerns? ______________________________
____

Does participant wander or try to leave primacies? _____ If yes, explain. ____________
____
Medication Needs while at the Farm Yes or No
If yes, specify____

Publication Release Form

Participant Name: ______________________________

I give permission for the day center staff or designated volunteer to (check all that you agree to):

- ☐ Take a photograph or video tape of my family member
- ☐ Record my family member's voice
- ☐ Use my family member's art work or a reproduction thereof
- ☐ Arrange for publication of my family member's photo for local newspaper(s) and/ or social media (Facebook, website)

Furthermore, I authorize the use and reproduction of these for publicity or education and informational purposes without compensation to my family member or me. All copies and negatives shall constitute the property of Next Step Farms. I understand that only first names will be used for identification purposes. I understand that I will be given advance notice of any photo sessions which will be published in a newspaper. I can refuse individual photo sessions at any time. **Caregiver Initials ________ Date _____________**

Please Note: Failure to agree to any of the items on this release form **will not** affect your family member's eligibility for the program.

Contract for Attendance

Next Step Farms has been explained to me and I have been given a copy of the policy statement.

I am enrolling: ____

For: Tuesday Thursday (circle days that apply)

I agree to pay monthly for care at the rate of $ ___85___ per day and I understand that this amount is due prior to the service.

Next Step Farms staff agrees to accept this participant for enrollment under the following conditions.

Full time(M-F) ________ Effective date _____________ Signature ___________________

Part time: ___ days a week Effective date __________ Signature ___________________

Monday Tuesday Wednesday Thursday Friday

If emergency medical care becomes necessary, I give permission for any treatment the staff deems necessary. I understand any charges are the responsibility of the participant or caregiver.

I, ________________________________, have read and understand the current Policies and Admissions Agreement, the rules and criteria of the adult center and agree to abide by them.

Date __________________ Signature _____________________________

(Parent/Guardian)

Date _________________ Signature _____________________________

(Client)

Date _________________ Witness __________________________

Waiver of Liability

Participant's Name ____

I hereby give permission for my family member to participate in the adult center activities describe below.
I will not hold any of the Next Step Farms staff, volunteers, or board members responsible for any injury to the above-named participant which occurs during any of the activities listed below.

❑ Daily activities at Next Step Farms. To include but not limited to: baking or cooking activities, gardening activities, animal care, business skills, sales, personal daily living and hygiene
❑ Monitor prescription medications, as prescribed by physician. Staff will give reminders when medication is to be taken.
□ Monitor nonprescription medications as requested by the caregiver. Caregiver is responsible for bringing the medication to the NSF in its original container.
□ Utilize exercise equipment or daily required tasks activities that are provided
□Without restrictions □ With restrictions as listed below.

____

____

If there is an item or items, you **Do Not Approve** please indicate below the activity or activities to omit.

____

____

Caregiver ________________________________ Date _____________________

Witness _________________________________ Date _____________________

Medication Assistance Form

I request staff of Next Step Farms assist and monitor medications for ___________________________ as ordered by Dr. ____________________. I have read the policies concerning medications and will inform the staff of any changes made in the medication.

Caregiver ________________________________ Date ____________________________

Witness _________________________________ Date ____________________________

Current Prescription Medication Form

Date: __________________ Review Date: ___________________

Participant's Name: ____

Allergies: ____

Note: Please, fill out this form or have your pharmacist fill it out. The caregiver is responsible for notifying our office in writing of any change in medication. Each medication must be brought in a prescription bottle/container. No medication will be stored overnight at the center.

Name of Responsible Party ___________________ Signature ________________

Physician ____

Medication	Dosage	Time	Start Date	Purpose	Side Effects

Note: This form will be updated as medications are changed by the participant's physician.