Enrollment Application

Name:______________________________ Date:____________________

Address:____________________________ Telephone:________________

____________________________ Alternate Phone:____________

Date of Birth:________________________ Gender:__________________

Current Living Arrangement: ☐ Family's House/Apartment ☐ Own House/Apartment, ☐ Group Home ☐ Other;____________

Parent/Guardian (if applicable):____

Parent/Guardian Address: ____

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Parent/Guardian Telephone: (Home):____________________ (Work/Cell):____________________

Residential Service Provider (if applicable):____________________________________

Contact Staff:________________________________ Telephone:____________________

Please check all CCC programs the individual would like to participate in:

☐ Day Habilition – Creative X-pressions Group
☐ Day Habilition – Getting Out Group
☐ Spare Time Choices (Recreation Program)
☐ First Class Opportunities

Is the individual currently enrolled on a HCBS Waiver? ☐ No , ☐ Level I Waiver , ☐ IO Waiver
Is the individual currently residing in an ICF/MR facility? ☐ Yes, ☐ No
Name of the individual's Service & Support Administrator:______________________________

Supervision for Spare Time Choices & First Class Opportunities will be provided by:

☐ Individual does not need supervision
☐ Parent, Guardian, or family member
☐ Residential Provider (listed above)
☐ Requesting CCC staff to supervise. Please indicate funding: ☐ Waiver or ☐ Private Pay

Transportation will be provided by:

☐ Individual ☐ Parent, Guardian, or family member ☐ Residential Provider,
☐ Public Transportation ☐ Other ________________________________
☐ Requesting CCC to transport to/from activities. Please indicate funding: ☐ Waiver or ☐ Private Pay

Emergency Contact Information: In the event of a medical emergency, 911 will be called immediately, to assess/treat the individual. Please identify who should be notified of any emergency.

Name:______________________________ Phone Number(s):______________________

List anyone who is authorized to pick-up the individual:

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Releases

Participant's Name:____

Participant, Parent, or Guardian Release

As a participant or as a parent/guardian of the participant, I recognize that there are certain risks of physical injury and I agree to assume the full risk of any injuries, damages, or loss resulting from participation in any and all activities connected with or associated with the CCC Program. I agree to waive and relinquish all claims I may have, as a result of my or my son'/daughter's participation in the program, against Toward Independence, Inc. and their agents employees, staff and/or volunteers. I do hereby fully release and discharge Toward Independence Inc and their agents, employees, staff and/or volunteers for any and all claims from injuries, damage or loss which I have or which may accrue to me on account of my son's/daughter's participation in the program. I further agree to protect, defend and hold harmless Toward Independence Inc. and their agents, employee's, staff and/or volunteers from any and all claims resulting from injuries, damage, or losses sustained by myself, or my son/daughter or arising out of, connected with, or in any way associated with the activities or the CCC program. I have read and fully understand this release. **Before enrollment in this program is valid, this release must be signed by the participant or the participant's parent or legal guardian.**

Signature of Participant / Parent / Guardian:________________________________ Date_________

Multi-Media Release

I, the undersigned, hereby authorize Toward Independence, Inc. to utilize photographs of the participant to be used exclusively for the promotion, advertising and marketing of Toward Independence, Inc. and/or the CCC program.

Signature of Participant / Parent / Guardian:________________________________ Date_________

Participant Needs Assessment

Name:______________________________________ Date:________________

Assessment Source:____

Primary Disabling Condition:_____________________________________

Secondary Diagnosis:____

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Communication Skills: *(Please check all that describe the individual's abilities/needs)*

What best describes the individidiuals hearing: ☐ normal, ☐ hard of hearing, or ☐ deaf.
Does individual wear hearing aids. ☐ yes, ☐ no
How does the individual typically communicate: ☐ Speaks (☐ easy or ☐ hard to understand)
☐ Gestures, ☐ Sign Language, ☐ Pictures, ☐ Electronic Talker, or Other_____________

Mobility: (*Please check all that describe the individual's mobility abilities/needs:*)

- ☐ Walks independently, with no difficulty & no adaptive equipment
- ☐ Walks independently with some difficulty (unsteady gait)
- ☐ Needs physical support for stairs or uneven surface heights
- ☐ Ambulates independently with a ☐ walker or ☐ cane
- ☐ Ambulates independently with a wheelchair (indicate primary type ☐ Manual or ☐ Motorized)
- ☐ Ambulates with physical assistance using a ☐ wheelchair, ☐ walker or ☐ gait belt
- ☐ Requires physical assistance with transfers
- ☐ Other (describe)____

Behavioral Needs: *(Check all behaviors that are exhibited then check average frequency of those behaviors)*

- ☐ Wanders away from home/location (☐daily, ☐weekly, ☐,monthly, ☐ within the last year)
- ☐ Physically aggressive to others (☐daily, ☐weekly, ☐,monthly, ☐ within the last year)
- ☐ Verbally aggressive to others (☐daily, ☐weekly, ☐,monthly, ☐ within the last year)
- ☐ Self injurious (☐daily, ☐weekly, ☐,monthly, ☐ within the last year)
- ☐ Refuses to follow directions (☐daily, ☐weekly, ☐,monthly, ☐ within the last year)
- ☐ Other:____________________(☐daily, ☐weekly, ☐,monthly, ☐ within the last year)

Comments regarding behaviors:____

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Meal Time Skills/Needs: *(Please check all that describe the individaul's abilities/needs)*

- ☐ Eats and drinks independently
- ☐ Needs assistance to serve self lunch/food (type of assistance need ☐ verbal or ☐ physical)
- ☐ Needs assistance to put food/drink into mouth (type of assistance need ☐ verbal or ☐ physical)
- ☐ Needs assistance to clean up (dispose of trash) (type of assistance need ☐ verbal or ☐ physical)
- ☐ Other:____

 Name: ____________________

List any dietary restrictions or food allergies: ____________________

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Bathroom Skills: *(Please check all that describe the individual's abilities/needs)*

- ☐ Uses toilet independently
- ☐ Requires verbal reminders to toilet
- ☐ Requires physical assistance with ☐ lowering pants, ☐ wiping, or ☐ pulling up/adjusting clothing
- ☐ Wears and changes undergarment protection ☐ independently or ☐ with physical assistance
- ☐ Requires ☐ physical or ☐ verbal assistance during mensus (changing femine hygiene pads)
- ☐ Other (describe) ____________________

Medical Needs Summary:

Does the individual have seizures? ☐ Yes ☐ No If yes how often: ____________________
If yes, type of seizures: ☐ Grand Mal, ☐ Petit Mal, ☐ Focal Seizure, ☐ Other: ____________________

Will the individual need to take any medication(s) during CCC programming? ☐ Yes ☐ No
List only medication that need to be taken during CCC programming (including inhalers or epi pens).
CCC staff can only administer medication if an order is received from the prescribing physician.

Medication	dose	Time	Prescribed for	Who will administer medication

Please check all medical conditions that apply to the individual:

☐ Allegies (specify below)	☐ Diabetes	☐ Hemophilia
☐ Arthritis	☐ Ear Tubes	☐ High Blood Pressure
☐ Asthma	☐ Heart Condition	☐ Other (specify below)

Comments ____________________

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Does the individual have any activity restrictions? ____________________

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