Adult Services Programs Annual Application Update

This form to be updated annually during ISP/IP meeting

NAME (Last, First, Middle)____

ADDRESS (Street, City, State, Zip Code) ______________________________________

Primary Phone # __________________ D.O.B. ___________ Email ________________________

S.S. # ________________ Medicare # ________________ Medicaid #____________________

What is your payment source? (Please check one) ◯Unknown ◯TDD Waiver ◯ICF/IID ◯ IO Waiver ◯SELF ◯Level 1 Waiver ◯OOD Funding ◯Local Funding ◯Private Pay

What is your level of acuity? *(Please select one)* ◯**Level A** ◯**Level B** ◯**Level C** ◯**Unknown** (need an assessment done)

Do you have an SSA through your local County Board of Dev. Disabilities? (Please circle one) Yes or No

SSA Contact Name ________________________ SSA's Office # __________________ ex. ________

SSA's Cell # ____________________ SSA's Email ________________________________

What is your living situation? (Please check the one that applies)

◯ I live alone ◯ I live with my Parents and/ or Guardian ◯ I live with my spouse ◯ I live in a group home

◯ I live in an Intermediate Care Facility (ICF) ◯ Other ______________________________________

If you live in a Group Home and/or an ICF, Please list your Provider Name and Address____

____

How many days a week do you plan to attend our program? _________ All day or half a day? ______________

If you will be attending less than 5 days a week please indicate the days that you plan to attend: (Please check all that apply)

◯ ***Monday*** ◯ ***Tuesday*** ◯ ***Wednesday*** ◯ ***Thursday*** ◯ ***Friday***

Who were you referred By? ____

Are you your own Guardian? (Please circle one) Yes or No : If the Answer is No, Please list below who the responsible party is:

Name:		**Relationship**
Address:		
Phone:	**Email:**	**Employer/Phone:**

Name:		**Relationship**
Address:		
Phone:	**Email:**	**Employer/Phone:**

****EMERGENCY BACKUPS*:** Please identify two neighbors or relatives with a local telephone and available transportation who have agreed to relay a message and/or pick up the individual in an emergency:

Name **Address** **Phone** **Relationship**

1) ____

2) ____

Adult Services Programs Annual Application Update

This form to be updated annually during ISP/IP meeting

INDIVIDUAL'S HEALTH INFORMATION

Age:________ Height: __________ Weight: ___________ Date of Last Physical Exam: ____________________________

Last Vision Exam: ___________________ Last Dental Exam: __________________ Last Tetanus: ___________________

Immunizations Last Year: ____

Primary Diagnosis:____

Seizure Information:

Does the individual have seizures? (*Please circle one*) Yes or No If yes, date of last seizure:_____________________

How long does a seizure last? ________________ How often do they occur? _________________________________

BEFORE, DURING OR AFTER A SEIZURE, DO ANY OF THE FOLLOWING OCCUR? (*please check all that apply*

__________ Body Jerks __________ Urinates __________ Stares Off __________ Becomes Rigid

__________ Cries Out __________ Eyes Roll __________ Twitching __________ Becomes Confused

__________ Falls Down __________ Vomits __________ Skin Color Changes __________ Becomes Unconscious

Additional Health Information:

(Physical Limitations, Food Restrictions, Chronic Conditions such as Asthma, Infections, Illnesses, etc.)

Health/Medical Issues	Treatment	Things to avoid	How often does this occur

Allergies: (Food and Medication)

Allergy	Allergic Reactions/Side effects	Treatment

Adult Services Programs Annual Application Update

This form to be updated annually during ISP/IP meeting

Medication List: Please list current prescribed medications as well as over-the-counter medications (i.e. Vitamins, Tylenol, Ibuprofen, Robitussin, Claritin, Benadryl, etc.) The individual takes daily or 'as needed', whether at home, school, day program, etc. IF NO MEDICATION IS TAKEN, WRITE NONE.

Medication Name	Diagnosed Condition	Dosage/Times a day	Side Effects

NOTE: YOU ARE REQUIRED TO NOTIFY US IN WRITING OF ANY CHANGE(S) REGARDING ROUTINE MEDICATION AND PRN MEDICATION. SERVICES MAY BE INTERRUPTED IF CURRENT EMERGENCY INFORMATION IS NOT PROVIDED. IT IS THE RESPONSIBILITY OF THE PARENT AND/OR GUARDIAN TO INFORM THE PROGRAM DIRECTOR/CAMPUS DIRECTOR/OR DESIGNEE IMMEDIATELY OF CHANGES IN THIS INFORMATION.

Any additional notes regarding health and/or medication:

____
____
____
____
____
____
____
____

Adult Services Programs Annual Application Update

This form to be updated annually during ISP/IP meeting

Insurance Info/ Consent to Release Update

Name of Individual enrolled in our program. Please print clearly. **Date:** ________________________

Legal Name ____

First **M.I.** **Last**

This pertains to court appointed guardians. If the address and phone number are the same as the individual, you may put SAME.

Family/ Guardian Name: ____

Address: ____

Street **Apt#**

__________________________________ ________________________ _______________________

City **State** **Zip**

Phone Number: ____

Medical& Hospitalization Insurance Coverage : If you have a family health care pan that covers an individual, please complete this section. The name of insured refers to the person who the policy is under. If there is no health care coverage on the individual, please put N/A.

List all health care insurance companies which provide coverage to the individual. Include health care maintenance organizations (HMO's) , BCMH, Medicare, if appropriate.

Insurance Company Name: ____

Address: ____

Policy Number: ____

Name(s) of Insured: ____

Insurance Company Name: ____

Address: ____

Policy Number: ____

Name(s) of Insured: ____

PLEASE BE SURE TO COMPLETE THE CONSENT FORM

CONSENT TO RELEASE INFORMATION: This form must be signed by the individual or legal guardian. **It is extremely important that this release is signed.** Thank you

CONSENT TO RELEASE INFORMATION

I certify that the information given is correct to the best of my knowledge.

I will notify Cater to You within fourteen (14) calendar days should any information change.

I also understand that Cater to You will use this information to hill appropriate sources for reimbursement for costs and services provided.

I authorize Cater to You to release or obtain to/from any company, organization, health benefit plan, or third party payor, or government body (for example: Social Security Administration for the purpose of obtaining information concerning financial income, eligibility for coverage under an insurance policy, and eligibility for programs and services provided by Cater to You or to anyone assisting Cater to You in obtaining payment for services rendered to me, including in billing , coding and collection agents.

I also hereby authorize and give permission to Cater to You to discuss my medical or other relevant information with their legal counsel, accountant, medical malpractice carrier, and other health professionals as may be deemed necessary by Cater to You.

I understand and consent to the release of my medical information to the above entities and individuals including any information pertaining to alcohol abuse, drug abuse, and psychiatric condition any condition related to sexually transmitted disease and or/ HIV (Human Immunodeficiency Virus and AIDS (Acquired Immune Deficiency Syndrome).

I understand that this release will cover a period of one year from the date of signature below and a copy of this authorization shall be considered as valid as the original.

AUTHORIZED SIGNATURE: ____ Date: __________________________________

You have the right to revoke your consent to have information regarding yourself, or persons for whom you are legally responsibly, released at any time, any further release of information shall cease immediately, Revocation of consent may be made at any time and only requires a signed and dated statement to that affect.

EMERGENCY MEDICAL AUTHORIZATION

PURPOSE- To enable parents and guardians to authorize the provision of emergency treatment for individuals who become ill or injured while under Cater to You authority, when parents or guardians cannot be reached. This information may be shared with the Cater to You team members to best meet the individual's needs.

Individuals Name____ **Phone #**____

Address____ **Program attending**____

____

Address Change (Circle one) Y / N **Sex: M F**

Birth Date ____

Seizure Information:

Does the individual have seizures? (*Please circle one*) Yes or No If yes, date of last seizure:____________________

How long does a seizure last? ________________ How often do they occur? ______________________________

BEFORE, DURING OR AFTER A SEIZURE, DO ANY OF THE FOLLOWING OCCUR? (*please check all that apply*

__________ Body Jerks __________ Urinates __________ Stares Off __________ Becomes Rigid
__________ Cries Out __________ Eyes Roll __________ Twitching __________ Becomes Confused
__________ Falls Down __________ Vomits __________ Skin Color Changes __________ Becomes Unconscious

When the individual is dropped off at home from out transportation, does there need to be someone at home to meet the individual?
__________ Yes __________ No If yes, please identify the person to be present at Home______________________________

First Aid

Do you consent to the program staff administering first aid in the case of illness or injury to the individual while under Cater to You authority?
__________ Yes __________ No

If yes, I agree to hold harmless Cater to You and its employees for any injury for any injury resulting from administration of such first aid.

______________________________ __________ ______________________________ __________
Individuals Signature **Date** **Parent/ Guardian Signature** **Date**

IMPORTANT – YOU MUST COMPLETE AND SIGN EITHER PART I OR PART III BELOW- IMPORTANT

GRANT OF CONSENT

Part I

In the event reasonable attempts to contact me at (phone number) ____________________ or to contact (other parent/guardian) ____________________ at (phone number) ____________________ have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by ______________________________or to Dental______________________________ or in the event these are not available, any other licensed physician or dentist, and (2) the transfer of the individual to ______________________________ or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two (2) other licensed physicians or dentists, concurring in the necessity for surgery, are obtained prior to the performance of such surgery.

______________________________ __________ ______________________________ __________
Individual's Signature **Date** **Parent/ Guardian Signature** **Date**

-OR-

REFUSE TO CONSENT

Part II

I DON NOT give my consent for emergency medical treatment of this individual. In the event of illness or injury requiring treatment, I wish program authorities to TAKE NO ACTION or to:

____

____

______________________________ __________ ______________________________ __________
Individual's Signature **Date** **Parent/ Guardian Signature** **Date**

MEDIA RELEASE FORM

Cater to You must obtain permission from both client and guardian for the use of media, voice, and/or name for educational and community activities and events. Please read the following disclosure then sign and date where indicated. Thank you

- **YES – I CONSENT.** I grant permission for the client listed to participate in both audio and video recordings, films, photographs, written articles, and on websites or social media projects completed by Cater to You. This consent includes the use and editing of photographs, voice, and name for various media projects by Cater to You. In consideration to the opportunity of participation, I release Cater to You, including its employees and contractors, from all claims resulting from the use and editing of (named) client's photo, voice, and/or name.
- **NO – I DO NOT CONSENT** to the non- Cater to You use of (named) client's photo, voice, and/or name for various media projects.

Your selection remains valid for all media projects performed within one calendar year of the date this consent was signed. You may change your selection at any time by completing a new form obtained by the staff at Cater to You.

Date (month/day/year) - ______________________________

Participant name - ______________________________

Participant signature - ______________________________

Guardian signature - ______________________________

Legal Guardian signature is required for all participants at Cater to You.