Dear Applicant,

Thank you for your request for information and an application for our hourly respite services. The enclosed materials must be completed in order to be considered for admittance. It is our goal to serve as many people as possible, while taking into consideration the level of supervision and medical care needed. Our Club Adventure and Afterschool Adventures may, at times, have a waiting list, which you or your loved one may be placed on should space not be immediately available.

RESPITE PROGRAM THAT YOU ARE APPLYING FOR (CHECK ALL THAT APPLY):

☐ **Club Adventure**: A weekend respite program operating out of 1000 Ellicott Creek Road, Tonawanda, NY 14150. This program offers events on Friday nights (6–9 p.m.), Saturdays (9 a.m.–12 p.m., 1–4 p.m., or 10 a.m.–4 p.m.), and Sundays (1–4 p.m.) most weekends. Club Adventure is a site-based, non-certified respite program that supports children and young adults ages 5 to 30. Each event is planned around a central theme and held either at the site or in the community. Participants are welcome to choose from a variety of activities including crafts, playing games, watching movies, and much more. This program is not able to pass any medications except an EPI PEN in the event of an emergency. ***Please note: Friday events are designated for our Young Adults (13–30) and Saturdays/Sundays are designated as either Kiddos (5–13) or All Ages (5–30).***

Please submit the following. *Please note that incomplete applications cannot be processed.* Please contact our team should you have any questions or concerns about the application process:

☐ Completed Application
Note: An updated application is required every two years from the start of services.
☐ Current Life Plan
☐ Recent Photo of applicant
☐ Notice of Decision Letter
Note: The person MUST be enrolled in the Home and Community Based Services (HCBS) Waiver to be eligible for this service.
☐ Current Psychological Evaluation or Triennial Evaluation
☐ LCED
☐ DDP2
☐ Copy of Medicaid Card and Insurance Card
☐ Request for Service Amendment (RSA) or Service Authorization Request Form (SARF)
☐ Approval Letter with the authorized units from the Office for People With Developmental Disabilities (OPWDD)
Note: If a SARF has not been submitted, please contact our team regarding the number of units to request based on the person's needs.
☐ Signed Releases: HCS Consent to Obtain Information / Photo Release / Email Release

Please have applicant's primary care physician complete and submit the following:
☐ Physical Exam completed within the past year

We appreciate you taking the time to fully and complete the application so that we can ensure the highest level of care for our guests. Should you be interested in scheduling a tour of any of our programs prior to completing the application or if you have any questions, please reach out to (716) 743-2020 or clubadventure@heritagechristianservices.org.

Please return the completed Application Packet to:
Heritage Christian Services, Inc.
Attn: Jessica Spence
130 John Muir Drive, Suite 106
Amherst, NY 14228

Sincerely,
WNY Respite Team

Date of Application: _____ **Check One:** ☐ **New Intake** ☐ **Update**

Name: _____

Date of Birth: _____ Ethnicity: _____

ATTACH PHOTO HERE

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ - _____ ext. _____

Cell Phone: (_____) _____ - _____ ext. _____

Sex: ☐ Male ☐ Female

Religious Preference: _____

Social Security Number: _____ - _____ - _____

Medicaid Number: _____ TABS ID: _____

PLEASE INCLUDE A CURRENT COPY OF THE PERSON'S MEDICAID CARD

Funding Source: ☐ HCBS Waiver ☐ Care at Home Waiver ☐ Children's Waiver

Person must be Waiver enrolled to be eligible to receive respite services.

Are you currently receiving any Respite services? ☐ YES ☐ NO

If yes, what service and where? _____

Are you currently receiving any other Waiver services? ☐ YES ☐ NO

If yes, what service and where? _____

Do you have a Self-Directed Plan or anticipate starting a Self-Directed Plan within the year of this application?

If yes, please include the Fiscal Intermediary information below:

FI Name: _____ Agency Name: _____

Email Address: _____ Phone: (_____) _____ - _____ ext. _____

Broker Name: _____ Agency Name: _____

Email Address: _____ Phone: (_____) _____ - _____ ext. _____

Level of Supervision (Choose ONE for each location)

Within the Program:

☐ **1 Staff Assigned with Range of Scan Supervision:** Requires assigned staff to maintain the person within their field of vision at all times. Staff must be in the same area and remain in close proximity to the person to ensure overall well-being.
Reason: _____

☐ **Range of Scan Supervision:** Requires assigned staff to maintain the person in visual scanning field at all times – by turning head left or right, staff is able to see the person to ensure overall well-being. The person cannot be behind the staff.
Reason: _____

☐ **Periodic Checks:** Requires assigned staff to observe the person on a periodic basis every **5, 15, or 30 minutes** either visually, audibly or otherwise have a clear awareness of the person. Staff will ensure the person's overall well-being.
Reason: _____

☐ **Independent with Staff Present:** Requires assigned staff to be aware of the location of the person and is within a planned vicinity to assist the person if needed and ensure overall well-being. There is no schedule of checks.
Reason: _____

☐ **Independent:** Person does not required a specified Level of Supervision. Staff will assist as needed to ensure the person's overall well-being.
Reason: _____

In the Community: (Outside the program site)

☐ **1 Staff Assigned with Range of Scan Supervision:** Requires assigned staff to maintain the person within their field of vision at all times. Staff must be in the same area and remain in close proximity to the person to ensure overall well-being.
Reason: _____

☐ **Range of Scan Supervision:** Requires assigned staff to maintain the person in visual scanning field at all times – by turning head left or right, staff is able to see the person to ensure overall well-being. The person cannot be behind the staff.
Reason: _____

☐ **Periodic Checks:** Requires assigned staff to observe the person on a periodic basis every **5, 15, or 30 minutes** either visually, audibly or otherwise have a clear awareness of the person. Staff will ensure the person's overall well-being.
Reason: _____

☐ **Independent with Staff Present:** Requires assigned staff to be aware of the location of the person and is within a planned vicinity to assist the person if needed and ensure overall well-being. There is no schedule of checks.
Reason: _____

☐ **Independent:** Person does not required a specified Level of Supervision. Staff will assist as needed to ensure the person's overall well-being.
Reason: _____

Swimming Safeguard:

_____

Any Special Travel Needs: (*Car seat, booster seat, harness, seatbelt cover, specific supervision, etc.*)

_____

Emergency Evacuation: *Please describe assistance needed to exit during a fire drill or other emergency (independent, touch prompts, verbal prompts, total assistance, etc.)*

_____

Parent/Guardian Information:

1. Name: _____

Relationship: _____

Complete Address: _____

Home Phone: (_____) _____ - _____ ext. _____

Cell Phone: (_____) _____ - _____ ext. _____

Work Phone: (_____) _____ - _____ ext. _____

Email: _____

2. Name: _____

Relationship: _____

Complete Address: _____

Home Phone: (_____) _____ - _____ ext. _____

Cell Phone: (_____) _____ - _____ ext. _____

Work Phone: (_____) _____ - _____ ext. _____

Email: _____

Emergency Contacts/Alternate Placement:

Please list ONE person. This must be someone who could take responsibility for making decisions for your family member when you are unavailable. If, in the judgement of the director of community services, the person is unable to remain within the Heritage Christian Services respite program, and you are unavailable, the alternate placement/emergency contact listed below agrees to be responsible for the person's welfare while the parent/guardian is absent (including providing a residential alternative if necessary). If the director of community services or respite coordinator contacts the alternate placement provider, he/she will provide transportation, as soon as possible for the person to the alternate placement provider's location.

Please be sure to discuss this with the person who will be an emergency backup for you. Explain the exact nature of his/her responsibilities.

1. Name: _____

Relationship: _____

Complete Address: _____

Home Phone: (_____) _____ - _____ ext. _____

Cell Phone: (_____) _____ - _____ ext. _____

Work Phone: (_____) _____ - _____ ext. _____

Release List:

The following people (in ADDITION to parents/guardian) may pick up_____from the Respite Program:

1. _____

2. _____

3. _____

Picture identification will be required at the time of pick up, and the personl will not be released to anyone under the age of 18.

Guardianship Information:

If the applicant is over the age of 18 years old and not their own guardian, please select one of the following:

☐ **Guardian of the Person –** A guardian of the person can make life decisions for the person like health care, education and welfare decisions.

☐ **Guardian of the Property** – A guardian of the property handles decisions about the person's money, investments and savings as directed by a Judge. A guardian of the property must file an annual report about the property.

☐ **Guardian of the Person and Property**. This kind of guardian has responsibility of both the person's life decision and the person's property.

Name of Primary Guardian(s):

_____

Name of Standby Guardian(s):

_____

Care Coordinator/Manager Information:

Name: _____

Agency Name: _____

Email: _____

Phone: **(_____)** _____ - _____ ext. _____

School/Program Information:

Highest Level of Education:

☐ None ☐ High School

☐ Ungraded ☐ Vocational

☐ Preschool ☐ Some College

☐ Elementary ☐ College

Please detail school/program, diploma/certificate obtained and completion date (*if applicable*):

_____

Current Enrollment:

School/Program Name: _____

Address: _____

Phone Number: **(_____)** _____ - _____ ext. _____

Contact Person: _____

School/Program Hours: (***Please indicate if hours change in the summer or on specific weekdays***)

_____ ☐ am ☐ pm **to** _____ ☐ am ☐ pm

_____

Note: Respite services cannot be provided during the hours when students should be receiving educational services in a school setting. Every district varies regarding the times students are required to be in school. This policy also includes people who are home schooled or have other educational accommodations.

Physician Information:

Primary Physician: _____

Address: _____

Phone Number: (_____) _____ - _____ ext. _____

Fax Number: (_____) _____ - _____ ext. _____

Hospital Affiliated With: _____

Dentist: _____

Address: _____

Phone Number: (_____) _____ - _____ ext. _____

Fax Number: (_____) _____ - _____ ext. _____

Other Insurance:

Insurance Carrier: _____ Subscriber's Name: _____

Contract Number: _____ Group Number: _____

PLEASE INCLUDE A CURRENT COPY OF THE PERSON'S INSURANCE CARD

Medical Information:

Primary Diagnosis: *(Check if Applicable)*

- ☐ Intellectual Disability
  - ☐ Mild
  - ☐ Moderate
  - ☐ Severe
  - ☐ Profound
- ☐ Autism
- ☐ ADD/ADHD
- ☐ Fragile X Syndrome
- ☐ Epilepsy
- ☐ Cerebral Palsy
- ☐ Down Syndrome
- ☐ Hearing Impaired
- ☐ Visually Impaired
- ☐ Other (*Please Specify*) _____

Secondary Diagnosis: (*Please Specify*)

_____

Other Medical Conditions:

_____

Does this person have a **DNR order or MOLST**? ☐ YES ☐ NO ***If YES, please attach a copy.***

☐ Please check if you are currently receiving nursing services in your home, or you feel your family member requires something **other than routine first aid/medical care**.

If checked, please detail:

_____

Medications: ☐ YES ☐ NO ***If YES, please list.***

_____

_____

Is the person able to administer medication independently? ☐ YES ☐ NO

Does the person require medications during respite hours? ☐ YES ☐ NO

Note: Staff are unable to administer medications (including over-the-counter) to people during respite hours.

Medical History:

Check if the person had **ANY** history of the following?

- ☐ Bleeding problems
- ☐ Bone or Joint problems (Osteoporosis, etc.) _____
- ☐ Breathing problems (Asthma, Sleep Apnea, etc.) _____
- ☐ Chronic Skin Conditions (Eczema, Psoriasis, Dermatitis, etc.) _____
- ☐ Dentures / False Teeth
- ☐ Dizziness/Frequent Falls
- ☐ Fainting Spells
- ☐ Heart / Blood Pressure problems
- ☐ History of MRSA/ORSA (Methicillin/Oxacillin Resistant Staphylococcus Aureus)
- ☐ Hepatitis *Type:* _____
- ☐ Other:

_____

If you answered YES to any of the above, please explain.

_____

Vision:

- ☐ No problem
- ☐ Wears glasses
- ☐ Partial sight
- ☐ Blind

Hearing:

- ☐ No problem
- ☐ Wears hearing aid(s)
- ☐ Hard of hearing
- ☐ Deaf

☐ **Allergies:** (Food, Insects, Medications, etc.)

_____

Describe typical reaction: _____

Response needed for reaction: _____

☐ **History of Seizures:** (*Please describe Time, Length, Type, Duration*)

_____

☐ **Current Seizure Activity:** (*Please Describe*):

_____

Response Instructions: _____

Any special medical equipment needed: ☐ YES ☐ NO ***If YES, please list.***

_____

Wearing Schedule:

_____

Daily Living Skills Information:

(*Please check all that apply and, where specified, please include detailed information*)

Ambulation:

- ☐ Walks freely
- ☐ Uses walker
- ☐ Walks with assistance *(when ✓ describe)*: _____
- ☐ Non-ambulatory

Wheelchair Use:

- ☐ Not applicable
- ☐ Maneuvers chair independently
- ☐ Maneuvers with assistance
- ☐ Transfers independently
- ☐ Transfers with assistance (*when ✓ describe*): _____

Transfers: (*Check only ONE*)

- ☐ Independent (*Requires No Assistance from Staff*)
- ☐ Stand pivot
- ☐ One-person transfer
- ☐ Two – person transfer
- ☐ Mechanical device

Note: Two staff must be present at ALL TIMES when using a Hoyer lift or other mechanical device to transfer.

Speech:

- ☐ Sentences: _____
- ☐ Occasional words only (list some words): _____
- ☐ Speaks with difficulty
- ☐ Non-verbal
- ☐ Uses sign (specify signs used): _____
- ☐ Uses communication board/device (specify signs or symbols used): _____

Comprehension:

- ☐ No problem
- ☐ Understands simple directions
- ☐ Does not understand
- ☐ Understands sign (specify signs understood): _____

Daily Living Skills Information (Cont.):

(*Please check all that apply and, where specified, please include detailed information*)

Bathroom Needs: (*Check only ONE*)

- ☐ Independent
- ☐ Independent days only
- ☐ Bladder control only
- ☐ Bowel control only
- ☐ Wears Attends/diapers at all times
- ☐ Wears Attends/ diapers only at times specified: (*Please List Times*)**:** _____
  ***Specify assistance needed and usual schedule if applicable*:** _____

Dressing:

- ☐ Independent
- ☐ Needs help with selection (specify assistance needed): _____
- ☐ Needs help with dressing (specify assistance needed): _____

Additional Comments:

_____

Nutrition Information:

Please check all that apply to this person:

- ☐ Diabetes: ☐ Type 1 ☐ Type 2
- ☐ NPO (Nothing by mouth) ☐ G-tube ☐ J-tube
- ☐ Some food taken by mouth with feeding tube
- ☐ Gluten free diet (Family to provide)
- ☐ Casein free diet (Family to provide)

Food Preferences:

Likes: _____

Dislikes: _____

Adaptive Equipment:

☐ Plate ☐ Cup ☐ Straw ☐ Utensils ☐ Shirt Protector ☐ Other

Please Describe: _____

Additional Information Regarding Diet:

_____

Food and Drink Consistencies:

Food Consistency:

- ☐ Regular: no restrictions
- ☐ Soft: fork mashed foods
- ☐ Ground: appearance of size of relish (ground up in a food processor)
- ☐ Pureed: made to a yogurt consistency in the food processor

Food Size:

The following are cut up sizes of foods (if now ground or pureed). Choose the size ONLY IF NEEDED:

☐ Cheez-it size (1" x 1") ☐ Cheerio size (½" x ½") ☐ Pea Size (¼" x ¼")



Drink Consistency:

☐ No Restriction ☐ Nectar ☐ Pudding Thickened

☐ Liquids must be thickened for safety ☐ Honey Thickened

Food Intolerances:

☐ History of **acid reflux** (GERD-Gastro-Esophageal Reflux Disorder)

☐ Needs to remain upright after meals due to acid reflux? If yes, for how long? _____

*Please check any of the foods listed here that are **NOT** tolerated due to acid reflux:*

☐ Raw tomato	☐ Chocolate
☐ Tomato based red sauces	☐ Tomato based red foods
☐ Spearmint	☐ Peppermint
☐ Pineapple	☐ Cucumber

☐ Spicy Foods: _____

☐ Citrus foods: ☐ Lemon ☐ Lime ☐ Orange ☐ Grapefruit

☐ Other foods(s) not tolerated related to acid reflux:_____

☐ Lactose intolerant: Please check for foods tolerated or not ***due to lactose intolerance***:

Food	Tolerated	Not Tolerated
Milk	☐	☐
Yogurt	☐	☐
Pudding	☐	☐
Cottage Cheese	☐	☐
Cheese Cubed or sliced	☐	☐
Ice Cream	☐	☐

Any other food/drink **NOT** tolerated and **Reason**:

_____

_____

Social/Recreational Activities:

Does guest interact appropriately with peers, younger children, and authority figures*?* (*Describe any significant comments/concerns.*)

_____

What types of activities does the person like to do (*i.e., toys, games, hobbies, movies, community activities, group vs. individual activities*)*?*

_____

Any activities to avoid (*i.e., crowds, shopping, noisy activities, pets*)?

_____

Any behavioral concerns in public? If yes, please describe problems and strategies for management.

_____

Behavior Notations:

Does the person have a behavior support plan or guideline at school or program?

☐ Yes ☐ No ***If YES, please provide a current copy of the plan.***

Please describe specific behavior problems (i.e. hitting, kicking, spitting, biting, pulling hair, self-injurious behavior, property destruction, running, wandering, pica, etc.) and how they are handled:

_____

_____

How often do the behaviors listed above occur?

_____

Has the person ever been involved with crisis intervention and/or had mental health arrest?: ☐ YES ☐ NO

If YES, when?

_____

What were the issues?

_____

Note: If the person has been involved with crisis intervention or has been placed under mental health arrest, we require a minimum period of six months and a physician's note stating that the person is behaviorally stable prior to utilizing respite services.

CONSENT TO OBTAIN INFORMATION:

I, the undersigned, understand and acknowledge that information on the application form is absolutely necessary for the proper and competent delivery of respite services by the respite staff at Heritage Christian Services. I warrant that I have **fully disclosed all the pertinent facts** about _____ (*Name of Person*).

If **any** changes occur, I shall notify the customized support soordinator as soon as possible. By signing below, I attest that I have reviewed the Notice of Privacy Practices, Individual Rights, Individual Right to Object, Service Agreement, Notification of Incident Information, and Liability Notice. **Copies provided upon request.**

I understand that the respite staff, in performing their care, are acting in full reliance upon the completeness of the information given by me. Failure to provide complete and accurate information regarding the person applying for services may result in future denial of service. I give my permission for the respite staff to have access to this information and, upon the decision of the respite coordinator, for any other personnel needing access to this information for in-service training.

Information Requested:

- ☐ **Most Recent** Life Plan
- ☐ **Most Recent** Medicaid Card and Insurance Card
- ☐ **Most Recent** Psychological Evaluations or Triennial Evaluations
- ☐ **Most Recent** Physical Examination
- ☐ **Most Recent** Notice of Decision Letter (NOD)
- ☐ **Most Recent** LCED/ DDP-2/ RSA or SARF
- ☐ **Most Recent** Guardianship Paperword (*if applicable*)
- ☐ **Most Recent** Other (*Specify*): _____

_____ _____

Parent/Guardian Signature *Date*

Authorization for the Disclosure of Protected Health Information: Photo Use

Heritage Christian Services, Inc.
275 Kenneth Drive, Suite 100
Rochester, NY 14623

As required by the Health Insurance Portability and Accountability Act of 1996, Heritage Christian Services, Inc. may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning to this office.

AUTHORIZATION SECTION

I, _____(print name) hereby authorize the program staff of Heritage Christian Services, Inc. to display photos of me in hallways, program areas and other public areas within Heritage Christian Services, Inc. The photos may be used so that Heritage Christian Services, Inc. staff may identify me and/or to show my participation and involvement in program activities.

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and will no longer be protected.

I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to Heritage Christian Services, Inc. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.

I understand that this authorization will automatically expire if and when I no longer receive services from Heritage Christian Services, Inc.

I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain services will not depend in any way on whether I sign this authorization or not. I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.

Print Name: _____

_____ _____
Signature Date

If not signed by the Person receiving services, please indicate:

Relationship:

- ☐ Parent, guardian or personal representative of person
- ☐ Other (specify) _____

Name of Person receiving services: _____

Authorization for the Disclosure of Protected Health Information: Photo Use

REVOCATION SECTION

I hereby revoke this authorization.

Print Name:_____

_____ _____
Signature Date

If not signed by the Person receiving services, please indicate:

Relationship:

- ☐ Parent, guardian or personal representative of person
- ☐ Other (specify) _____

Name of Person: _____

Parental/Individual Consent to Use E-mail to Exchange Personally Identifiable Information

Parent/Guardian/Individual Name:_____
Individual's Name:_____D.O.B.: _____

At your request, you have chosen to communicate personally identifiable information concerning your son/daughter's/your own services by e-mail without the use of encryption. Sending personally identifiable information by e-mail has a number of risks that you should be aware of prior to giving your permission. These risks include, but are not limited to, the following:

- E-mail can be forwarded and stored in electronic and paper format easily without prior knowledge of the parent/guardian.
- E-mail senders can misaddress an e-mail and personally identifiable information can be sent to incorrect recipients by mistake.
- E-mail sent over the Internet without encryption is not secure and can be intercepted by unknown third parties.
- E-mail content can be changed without the knowledge of the sender or receiver.
- Backup copies of e-mail may still exist even after the sender and receiver have deleted the messages.
- Employers and online service providers have a right to check e-mail sent through their systems.
- E-mail can contain harmful viruses and other programs.

Parent/Guardian/Individual Acknowledgement and Agreement

I acknowledge that I have read and understand the items above which describe the inherent risks of using e-mail to communicate personally identifiable information.

Nevertheless (choose one or both options):

- I, _____, authorize the following individual Heritage employees Club Adventure whose e-mail address is clubadventure@heritagechristianservices.org and Afterschool Adventures whose email address is afterschooladventures@heritagechristianservices.org.
  AND/OR
- I, _____, authorize any Heritage employee whose email address ends with @heritagechristianservices.org to communicate with me at my e-mail address, _____, concerning my son/daughter's/my own respite services, including but not limited to communication regarding service delivery, his/her progress, and any other related matters. I understand that use of e-mail without encryption presents the risks noted above and may result in an unintended disclosure of such information.

(Optional) In addition, I give permission for the employees identified above to communicate personally identifiable information concerning my son/daughter/myself with individuals that work outside of Heritage Christian Services using unencrypted e-mail. The outside individuals who I give permission for the above parties to use unencrypted e-mail to communicate with back and forth about treatment include:

(1) _____ with the e-mail address _____
(2) _____ with the e-mail address _____
(3) _____ with the e-mail address _____

_____ _____
Signature Date

Club Adventure Participant Agreement

Dear Club Adventure Participants and Families,

In order to ensure the continued safety for every person who attends Club Adventure as well as the continued success of the program, we ask that you please take the time to review the Club Adventure Participant Agreement. If you have any questions on these policies or if you have any additional concerns, please feel free to let us know.

Attendance
Programs like Club Adventure are funded by Medicaid with oversight from the Office for People with Developmental Disabilities (OPWDD). Heritage Christian Services bills Medicaid for these services in quarter hour increments called units (1 unit = 15 minutes). If your loved one arrives late or leaves early, Club Adventure is unable to bill for those units. Ultimately, this will have an impact on the financial health of the program.

We are asking that all families please be mindful of arrival and pick up times. Club Adventure bills for services between 5 p.m. and 9 p.m. on Fridays and between 10 a.m. and 3 p.m. on Saturdays. It is the expectation that your loved ones are signed in before and signed out after these set times. If there is a scheduling conflict, please contact the respite coordinator and we will record this into our database. If tardiness or early departures become routine, the Club Adventure coordinator may call a meeting to discuss.

Cancellations
Club Adventure staff work very hard to ensure the highest quality of supports are provided to the people we serve. There are many people enrolled in this program and even more who are eager to join our family. We understand that sometimes situations such as illness, vacations, and emergencies do occur. Please communicate any changes regarding attendance to Club Adventure as early as possible. This provides the opportunity for us to make schedule adjustments so another person can attend in your loved one's place.

In the event that a person is absent two times without notice, the person and his/her family will need to arrange a meeting with the Club Adventure coordinator before attending another event. Upon the third absence without notice, the person will be discharged from the program. The person may re-apply for services at a later date; all applications are processed in order of submission.*

Allergy Awareness
In addition to Club Adventure, the day habilitation program which is hosted at the same site serves people with severe peanut, tree nut and other nut allergies. **Please do not send peanuts or any other nuts or nut products (peanut butter, almond butter, etc.) to Club Adventure as a snack or packed meal.** Sunbutter (sunflower-based) is okay to bring. **Should your loved one require a specific allergy accommodation, please let us know.**

Continued on next page

Medications/Over-the-Counter Items
Club Adventure is a non-certified site which means our staff are not trained to administer medications, even over-the-counter items. Any medications need to be taken before or after the Club Adventure session. Please do not send your loved one to Club Adventure with medications (pocket, bag, etc.) as this can become a safety concern for other people who attend. In the event your loved one becomes sick or needs significant medical attention, we will contact the participant's parent/guardian who will be responsible for arranging medical care.

Personal Care Items
Providing individualized, personal care is of the utmost importance to us at Club Adventure. Should the person attending Club Adventure need support in the bathroom, please be sure to bring items that are needed for personal care. This includes any specific products the person may need, such as hypoallergenic wipes, undergarments, etc. This allows us to continue to provide the best level of support and care possible. Please also send an extra set of clothing, in case a change is needed during the Club Adventure session.

Labeling Peronsal Items
Club Adventure serves up to twelve people per event and we want to ensure all items return home with the person who brought them. While providing services, staff need to be able to quickly identify a person's belongings. **Please be sure to label all bags, lunches/dinners, coats, and any other personal item before bringing them to Club Adventure. We are not responsible for items that are lost during Club Adventure sessions.**

Supervision for Siblings and Guests
Club Adventure requests that parents/guardians provide the necessary supervision for any siblings and/or guests who are present during the drop off and pick up times. When participants arrive and leave Club Adventure, this becomes a very busy time for staff regarding meals, personal belongings, and any updates from parents/guardians. Staff are responsible for the supervision of Club Adventure participants and we cannot extend this supervision to siblings and/or guests. Please help our staff ensure the safety of everyone involved.

Your compliance with these policies ensures that we can provide an exceptional experience for all Club Adventure participants. Again, please feel free to contact us at any time with questions or concerns. Thank you for your continued support of Club Adventure!

Person Receiving Services: _____

Parent/Guardian Signature: _____ Date: _____