

Recreational Respite

2008



DIRECTIONS FOR COMPLETING CYO PROGRAM REGISTRATION PACKET

CYO is pleased that you have decided to enroll an individual into one of our programs for persons with disabilities. You might also be completing this packet again to update your loved ones file. Completing this packet is a time consuming activity, and one that should be undertaken only when complete attention can be focused on the questions involved. It will probably take about 1 hour to complete the packet. In addition to information that must be provided by the legal guardian, there is a page that must be completed by the member's physician (if he/she takes medication). If you find this packet too difficult to complete alone, please call 330-762-2961 ext. 207 to schedule an appointment with us; we will assist you in any way possible.

If you are ready to begin completing this packet, get a cup of coffee or a cool drink and read the following:

1. Gather medical records such as immunization history, all meds taken, history of illness, etc.
2. Gather any records from CSBMR/DD or CSB that you may have about the member.
3. Gather most recent year's income information.
4. READ EACH QUESTION CAREFULLY.
5. Please use ink to complete the packet.
6. Please print or type on all lines except where a signature is required.
7. Be sure to initial the boxes in the corner of each page (the application will be returned to you unprocessed if this is not done.)
8. Be sure to write in name of the member being registered at the top left corner of each page (the application will be returned to you unprocessed if this is not done.)
9. Sign all waiver's, releases, and authorizations required (This includes all those in the packet with the exception of the Video/Photo Release which is at your discretion. Failure to sign in all required spaces will result in the application being returned to you unprocessed.)
11. **ATTACH A RECENT PHOTO OF MEMBER SO THAT STAFF MAY EASILY IDENTIFY HIM/HER ON HIS/HER FIRST DAY.**

Other questions? Call the CYO offices at (330) 762-2961 ext. 207 and someone there can help you. Don't delay in completing this important paperwork.

PLEASE ATTACH A RECENT PHOTO OF MEMBER TO ASSIST US IN RECOGNIZING HIM/HER



Recreational Respite

CYO & COMMUNITY SERVICES, INC.
812 BIRUTA STREET, AKRON, OHIO 44307
(330) 762-2961/ FAX (330) 762-2001
WWW.AKRONCYO.ORG
CYO PROGRAM REGISTRATION

OFFICE USE
Received:
New: YES NO
TF Family Call: YES NO
Accepted TF: YES NO

GENERAL INFORMATION

Member's name: last first middle initial Member's birth date: month/ day/ year

Member's home address: street name and number city zip code

Member's home phone: Member's home county:

Member's school or place of employment: Member's SS#:

Legal guardian's name: Relationship to member:

Legal guardian's home phone: Does member live with legal guardian? yes no

Legal guardian's cell phone & alternate phone number:

Legal guardian's place of employment: Legal guardian's work phone:

Legal guardian's or member's e-mail address:

Legal guardian's mailing address: street name and number city zip code

Legal guardian's mailing address is where all program information and correspondence will be mailed unless otherwise indicated.

Member resides with: parents foster home group home other family other

Member's social worker/ case coordinator:

Is member Medicaid eligible? yes no If yes, Medicaid number:

In the event that the legal guardian cannot be reached, the emergency contacts are:

#1 name: phone: relationship:

#2 name: phone: relationship:

Have you ever been told by transportation staff or a psychologist that your family member needs additional equipment (non release seat belt, harness, vest) in order to transport them safely? No Yes If Yes what type

legal guardian's initials: [arrow pointing to box]

SOCIAL SKILLS

Is member inclined to be outgoing? ___yes ___no Is member inclined to be shy and timid? ___yes ___no

Does member follow directions? ___yes ___no

What group experiences has member had, such as scouts, Special Olympics, social clubs, etc.? _____

What are member's hobbies/interests/favorite activities? _____

Tell us anything else about the member's home life that would help us in making him/her feel at ease and enjoy his/her experience, or that staff should be aware of in caring for member:

COMMUNICATION SKILLS

PLEASE ANSWER YES OR NO TO THE FOLLOWING QUESTIONS: Is member:

able to communicate verbally?	___yes	___no
able to use sign language?	___yes	___no
able to use a communication board?	___yes	___no
If yes, will a communication board be sent with member to the program?	___yes	___no
able to follow one-step commands?	___yes	___no
able to follow two-step commands?	___yes	___no

SELF-HELP SKILLS

PLEASE ANSWER YES OR NO TO THE FOLLOWING QUESTIONS: Does member:

dress him/herself?	___yes	___no
need assistance with buttons?	___yes	___no
About how long does it take member to dress? _____		
feed him/herself?	___yes	___no
need straws, special spoons, etc?	___yes	___no
Approximately how long does it take member to eat a meal? _____		
go to the bathroom alone?	___yes	___no
tell someone he/she needs to use the restroom?	___yes	___no
need to be lifted on/off the toilet?	___yes	___no
use toilet paper?	___yes	___no
use diapers?	___yes	___no
adjust clothing before and after toileting?	___yes	___no
have accidents with bladder and bowel control?	___yes	___no
if female, experience menstrual periods?	___yes	___no
If yes, does she know how to use feminine protection products?	___yes	___no
know how to put on/tie shoes?	___yes	___no

 legal guardian's initials:

BEHAVIOR

PLEASE ANSWER YES OR NO TO THE FOLLOWING QUESTIONS: Does member:

- hit others? yes no
- bite others? yes no
- pull hair on self or others? yes no
- fight? yes no
- swear? yes no
- demonstrate non-compliance (refusal to follow directions)? yes no
- spit? yes no
- scream? yes no
- throw things? yes no
- become easily agitated? yes no
- fear water/swimming? yes no
- wander? yes no
- eat non-food items? yes no
- have a history of sexually inappropriate or aggressive behavior? yes no

If yes, please explain: _____

(If you are unable to explain in this small space, please add an additional page with complete information.)

- have a history of arrest or police involvement? yes no

If yes, please explain: _____

(If you are unable to explain in this small space, please add an additional page with complete information.)

Please feel free to include any behavior management suggestions that you believe would enhance your member's experience with us. Although we cannot promise absolute compliance, we can use reasonable efforts to compliment your existing system.

DISABILITY

Member's disability: visual hearing orthopedic learning SBH autism
(please check all that apply) other: _____

Level of mental retardation: mild moderate severe profound

Please describe the type of/ name of disability the member has: _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING QUESTIONS: Does member:

- take medication at program? yes no
- walk independently? yes no
- need assistance walking? yes no
- use crutches? yes no
- have a shunt? yes no
- use a wheelchair? yes no
- electric chair manual chair
- assist in transfer from chair? yes no
- wear eyeglasses? yes no
- use a walker? yes no
- wear a helmet? yes no
- eat through a g tube? yes no
- use mechanical aids? yes no
- have a tracheotomy? yes no
- need suctioning? yes no
- wear braces? yes no
- Can braces be removed during the day? yes no
- wear a hearing aid? yes no

Have other equipment/aids that he/she will use at program? _____

(please explain)

If member uses a wheelchair, can he/she be removed throughout the day to sit on a blanket, towel, bean bag chair etc.? yes no



 legal guardian's initials:

MEDICAL HISTORY AND INFORMATION


Member's age: _____

Member's weight: _____

Member's height: _____

IMMUNIZATION HISTORY (please give dates)		
DTP series:	Booster:	Tetanus Booster:
Polio OPB (Sabin):	date of Booster:	
Tuberculin Test:		
German Measles (Rubella):		
other:		

MEDICAL HISTORY (Please include dates of illness where they apply and other details that may help us to care for the member.)		
ear infection:	insect stings:	ringworm:
Rheumatic Fever:	chicken pox:	tires easily/needs rest during the day:
convulsions:	measles:	sun sensitive (Does child wear sunscreen?):
mumps:	German Measles:	difficulty swallowing (Please offer details.):
hay fever:	anemia:	any physical restrictions?
ivy poisoning:	Sickle Cell Anemia:	other:

SPECIAL HEALTH CONSIDERATIONS	
Does member have allergies? <input type="checkbox"/> yes <input type="checkbox"/> no What is member allergic to (please include food/drug reactions/ etc.)? In case of allergic reaction, what action should be taken?	Is Member allergic to Sunscreen? <input type="checkbox"/> yes <input type="checkbox"/> no Do you give permission for staff to apply sunscreen to your member? <input type="checkbox"/> yes <input type="checkbox"/> no Legal Guardian's Initials: _____
Does member have a seizure disorder? <input type="checkbox"/> yes <input type="checkbox"/> no How often does member seizure? Date of last seizure: If member has a seizure disorder, do you believe it is safe for him/her to go swimming? <input type="checkbox"/> yes <input type="checkbox"/> no If member seizures during programming, what action should be taken?	
Is member Diabetic? <input type="checkbox"/> yes <input type="checkbox"/> no What method of control is utilized? <input type="checkbox"/> diet <input type="checkbox"/> medication other: _____ How often is blood sugar checked?	
Does member have a heart or respiratory problem? <input type="checkbox"/> yes <input type="checkbox"/> no Please explain and include action to be taken in case of incident at program:	
Does member have asthma? <input type="checkbox"/> yes <input type="checkbox"/> no What method is utilized to control asthma? <input type="checkbox"/> inhaler <input type="checkbox"/> other medication <input type="checkbox"/> breathing treatment other _____	
Other health problems:	



 legal guardian's initials:

MEDICATION AUTHORIZATION

PLEASE NOTE THE FOLLOWING INFORMATION:

1. Instructions given by physician, guardian and prescription bottle **MUST MATCH IDENTICALLY**.
2. This form must be completed each time any medication is added, changed or deleted.
3. Medication Authorization must be renewed every six months.
4. CYO & Community Services, Inc. has no responsibility for the contents of medications nor for the filling of prescriptions.
5. **If no meds are taken at all please write NO MEDS on the form, sign the form and initial the box in the corner of the page.**

TO BE COMPLETED BY PHYSICIAN

DRUG NAME	STRENGTH	DOSAGE	FREQUENCY & TIME OF DAY

Name of patient: _____ Patient's birth date: _____

Date prescribed: _____ Discontinuation date: _____

List reactions/side effects to be reported to physician: _____

Special instructions for administering medication (e.g.: with lunch, in food, dissolved in water, etc.):

Date: _____ Physician's signature: _____


Physician's name (typed or printed): _____ Physician's phone: _____


Physician's address: _____

TO BE COMPLETED BY LEGAL GUARDIAN

My signature below indicates that I give permission to CYO & Community Services to facilitate the delivery of medication as indicated by this doctor's order.

Legal Guardian's signature: _____ Date: _____



 legal guardian's initials:

AUTHORIZATION FOR MEDICAL TREATMENT AND RELEASE

I hereby give permission and authorize CYO & Community Services (hereinafter "CYO") and Catholic Charities Health & Human Services (hereinafter "CCHHS"), their agents, employees, successors and assigns to provide medical care including but not limited to the administration of prescribed medications and the delivery of first aid care to me or to the program member for whom I am parent or legal guardian (hereinafter "the program member"). I hereby give permission and authorize CYO and CCHHS, their agents, employees, successors and assigns to act on my behalf or on the behalf of the program member to seek medical treatment in the case of illness or accident from a medical practitioner or hospital and to arrange necessary related medical transportation. Should medical attention be required to care for me or for the program member, I agree to pay any expenses incurred.

In consideration of my participation or the participation of the program member in a CYO and/or CCHHS program, and wishing to promote and benefit this non-profit cause, I hereby release and hold harmless CYO and CCHHS, any of their related corporate entities, the Bishop of the Roman Catholic Diocese of Cleveland, the Roman Catholic Diocese of Cleveland, their representatives, licensees, agents, employees, successors and assigns, from any and all liability for claims and demands arising out my medical care or the medical care of the program member. I specifically waive any rights and claims that I may have as well as any other claims for damages in law or equity.

I have read and fully understand the contents of this Authorization For Medical Treatment and Release, and agree to the provisions contained herein. IN WITNESS WHEREOF, I set my hands hereto as of the date set forth below:

X _____
Signature of Program Member or Parent/Legal Guardian of Program Member Date

AUTHORIZATION TO PARTICIPATE IN FIELD TRIPS AND RELEASE

I hereby give permission and authorize CYO & Community Services (hereinafter "CYO") and Catholic Charities Health & Human Services (hereinafter "CCHHS"), their agents, employees, successors and assigns to include me or the program member for whom I am parent or legal guardian (hereinafter "the program member") in any and all travel and/or field trips offered by CYO and/or CCHHS throughout the term of the program. I am aware that travel of any kind, whether by vehicle, foot, or any other means, constitutes a field trip. I understand that it is my responsibility to ascertain my physical fitness or the physical fitness of the program member to participate in any and all field trips of the program.

In consideration of my participation or the participation of the program member in a CYO and/or CCHHS program, and wishing to promote and benefit this non-profit cause, I hereby indemnify, release and hold harmless CYO and CCHHS, any of their related corporate entities, the Bishop of the Roman Catholic Diocese of Cleveland, the Roman Catholic Diocese of Cleveland, their representatives, licensees, agents, employees, successors and assigns, from any and all liability for claims and demands arising out of my participation or the participation of the program member in any field trips. I specifically waive any rights and claims for damages in law or equity.

I have read and fully understand the contents of this Authorization to Participate in Field Trips, and agree to the provisions contained herein. IN WITNESS WHEREOF, I set my hands hereto as of the date set forth below:

X _____
Signature of Program Member or Parent/Legal Guardian of Program Member Date

AUTHORIZATION TO PHOTOGRAPH & RELEASE

I hereby give permission and authorize CYO & Community Services (hereinafter "CYO") and Catholic Charities Health & Human Services (hereinafter "CCHHS"), their agents, employees, successors and assigns to photograph, or otherwise electronically or digitally record my image or the image of the program member for whom I am parent or legal guardian (hereinafter "the program member") for publication in printed or electronic form, and for my image or that of the program member to be seen and disseminated to the general public in any media form, including, but not limited to CYO and/or CCHHS newsletters, posters, displays, films, videos or websites.

In consideration of my participation or the participation of the program member in a CYO and/or CCHHS program, and wishing to promote and benefit this non-profit cause, I hereby indemnify, release and hold harmless CYO and CCHHS, any of their related corporate entities, the Bishop of the Roman Catholic Diocese of Cleveland, the Roman Catholic Diocese of Cleveland, their representatives, licensees, agents, employees, successors and assigns, from any and all liability for claims and demands arising out of the use of my image or the image of the program member in any aforementioned media. I specifically waive any rights and claims that I may have or claim for privacy, invasion of privacy, libel, payment or royalties for use of the above-described photograph, as well as any other claims for damages in law or equity.

I have read and fully understand the contents of this Authorization to Photograph and Release, and agree to the provisions contained herein. IN WITNESS WHEREOF, I set my hands hereto as of the date set forth below:

X _____
Signature of Program Member or Parent/Legal Guardian of Program Member Date

WAIVER OF LIABILITY AND RELEASE

I pledge that all of the information contained in this application is accurate, complete and true. This application has my approval, and I agree to abide by the rules and decisions of CYO & Community Services (hereinafter "CYO") and Catholic Charities Health & Human Services (hereinafter "CCHHS"). I understand that all activities have certain risks and could result in injury. I specifically waive and relinquish all claims that I or the program member for whom I am parent or legal guardian (hereinafter "the program member") might have, fully release and discharge and agree to indemnify and hold harmless and defend CYO and CCHHS, any of their related corporate entities, the Bishop of the Roman Catholic Diocese of Cleveland, the Roman Catholic Diocese of Cleveland, their representatives, licensees, agents, employees, successors and assigns from any and all liability for claims and demands resulting from harms or injuries, including but not limited to loss of life, damages and losses sustained by me or by the program member arising out of, connected with or in any way associated with activities of CYO and/or CCHHS.

I have read and fully understand the contents of this Authorization to Photograph and Release, and agree to the provisions contained herein. IN WITNESS WHEREOF, I set my hands hereto as of the date set forth below:

X _____
Signature of Program Member or Parent/Legal Guardian of Program Member Date

NAME OF MEMBER: _____

CONSENT FOR APPLICATION OF STRATEGIES AND PROCEDURES TO PRODUCE APPROPRIATE BEHAVIOR

I have read and understand the **CYO Strategies and Procedures for Producing Appropriate Behavior**. I agree to cooperate with the CYO personnel in implementing these activities. I understand that these structures are in place to allow all members to have a fun and safe recreational experience.

I understand that positive techniques will be used regularly so all members will be learning to behave and interact with other persons in a healthy way. I feel that CYO programs offer experiences such as field trips and overnight experiences that the member I am enrolling will enjoy. I feel these opportunities are appealing and may be used effectively to bring about appropriate behavior.

I am aware of the process that CYO personnel will follow in the case that they judge the behavior of the member I am enrolling to be inappropriate. I know that the CYO Program Manager may need to consult with CSMBR/DD professionals that oversee the program in the event that the member I am enrolling is:

1. endangering himself/herself
2. endangering others
3. or destroying property.

I agree to be available for communication about the positive and negative progress of the member who I am enrolling. I understand that I may be called at any time for cooperation, advice and intervention for a behavior problem.

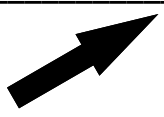
I understand that at any time I am welcome to visit and observe any CYO program of which the member I am enrolling is a participant. I am also welcome to speak to the CYO employees, Site Director and Program Director about any concerns I have about the member I am enrolling in the program.

I am aware of the needs of, _____,
(your member's name here)

and believe his/her participation in these Strategies and Procedures to Produce Appropriate Behavior will serve his/her best interest. It is with the above understandings that I give permission for CYO to utilize these Strategies and Procedures mentioned above during the provision of service to the member I am enrolling.

Legal Guardian's Signature

Date



PLEASE RETURN

NAME OF MEMBER: _____

CONFIDENTIAL STATISTICAL FORM

All information contained in this form is for statistical analysis only. The analysis will assist CYO & Community Services, Inc. to maintain current funding levels and to obtain grants from government agencies, foundations, corporations, and private individuals for the SumFun Program, Recreational Respite Program, and other programs offered by the agency. These grants are used to keep fees at a minimum and to improve and expand program opportunities for all members.

This page will NOT be seen or available to activity staff and is for office use only.

Member name: _____ male _____ female _____ age

Address of member: _____
street name and number city zip code county

Please check if member is:

_____ in foster care

_____ county ward

Please check member's race:

_____ Native American Indian

_____ Hispanic American

_____ Asian American

_____ Caucasian

_____ African American

Other: _____

Total number of people living in the home

(circle one)

more than 11

10

9

8

7

6

5

4

3

2

1

Check ALL sources of income received by ALL members of household

_____wages/salary

_____ADC

_____SCDCFS

_____unemployment

_____Social Security

_____child support/alimony

_____SSI

_____pension/retirement

_____other

Total annual household income (from ALL sources, before taxes)

\$

Number of dependant children under 18 years old living in home

Number of people 18 years or older living in home

legal guardian's initials:



**Family Resource Services
Sliding Fee Scale
(January 1, 2008 – December 31, 2008)**

The Family Support program is based on a sliding fee scale. *The co-payment schedule for a family shall be based on the family's taxable income as certified by their signature. Income shall be based on the Federal taxable income (after applicable deductions). The family shall be responsible for reporting any changes in income.* Family taxable income means the sum total of all individual's income, **EXCLUSIVE OF THE INDIVIDUAL WITH THE DELAY OR DISABILITY**, in the household. The taxable income to report should be from the last Federal income tax reporting period.

Families who elect not to certify their income by signature may access Family Support Services, however the family shall to be charged 100% of the cost of service.

NAME OF PERSON TO BE SERVED

I certify that the yearly family taxable income for 2007 was \$_____.

Or

I am not required to file federal taxes.

SIGNATURE OF THE PRIMARY CARE GIVER

DATE

FAMILY RESOURCE SERVICES FEE SCALE AND AGENCY FEES FOR SERVICE

CHECK IN-COME	FAMILY INCOME	CO-PAY	C.Y.O.		
			Regular Session	12 Hr. Session	3 day overnights
	\$27,258 OR LESS	0%	\$0.00	\$0.00	\$0.00
	\$27,259 - \$37,759	10%	\$5.94	\$9.51	\$23.76
	\$37,760 - \$48,260	30%	\$17.82	\$28.52	\$71.28
	\$48,261 - \$62,261	50%	\$29.70	\$47.54	\$118.80
	\$62,262 - \$79,762	75%	\$44.55	\$71.30	\$178.20
	\$79,763 & OVER	100%	\$59.40	\$95.07	\$237.60

In order to comply with the CSBMRDD Family Support Services Plan for 2007, please attach a copy of your most current year's (2007) 1040 document



Recreational Respite

Please make sure all information is fully completed so your application will not be returned.

DID YOU:

- ✓ Sign or initial all pages at the appropriate arrows?
- ✓ Complete all the forms?
- ✓ Did you include a recent photo?

If you have any questions or need any help filling out these forms please call CYO Rec Respite at [330-762-2961](tel:330-762-2961) ext. 207

Please mail completed forms to:

**Rec Respite—Registration
CYO & Community Services
812 Biruta Street
Akron, OH 44307**