



The Alternative Living Group, Inc.

After school Respite Program
Application



**The Alternative Living Group, Inc.
After School Respite Application**

Date Received: _____

APPLICANT DATA:

Check One

Name: _____ Birth date: _____ Gender: Male Female

Address: _____ Telephone # () _____

_____ Medicaid #: _____

_____ TABS ID #: _____

County of Residence: _____ Soc. Sec. #: _____

Email Address: _____

Is the applicant Medicaid waiver enrolled? Yes No

Is the applicant HCBS enrolled? Yes No

PARENT OR GUARDIAN:

Name: _____ Relationship: _____

Address: _____

Day Telephone # () _____ Evening Telephone # () _____

EMERGENCY CONTACT (OTHER THAN PARENT OR GUARDIAN):

Name: _____ Phone # () _____

Address: _____

Relationship of emergency contact to applicant: _____

Medicaid Service Coordinator Information (MSC):

MSC Agency: _____

MSC Person: _____

Address: _____

Phone # () _____

Education:

School: _____ Grade: _____

Teacher: _____ Other School Contact: _____

**THE ALTERNATIVE LIVING GROUP, INC. RESPITE STAFF CANNOT ADMINISTER
MEDICATIONS**

Allergies: (food, medication, other): _____

Developmental Disability/Diagnosis: _____

Medical Diagnosis: _____

Psychiatric Diagnosis: _____

History of Hospitalization _____
(*medical and/or psychiatric*)

PRIMARY PHYSICIAN:

Name: _____ Phone: () _____

Address: _____

Hospital Preferred (in case of emergency): _____

MEDICATION(s):

Name: _____ Reason for Medication: _____ Time Given: _____

Name: _____ Reason for Medication: _____ Time Given: _____

Name: _____ Reason for Medication: _____ Time Given: _____

Ongoing Medical Treatments needed: (G-Tube feeding, Chemotherapy, Kidney Dialysis, etc.)

Click on

response that best describes applicant's functioning in the following areas (indicate the one that best applies)

- | | | |
|-------------------------------------|-----|----|
| 1. Hearing deficit | Yes | No |
| 2. Visual deficit | Yes | No |
| 3. Can walk independently | Yes | No |
| 4. Can independently climb stairs? | Yes | No |
| 5. Does applicant use a wheelchair? | Yes | No |

Describe any adaptive equipment used: _____

COMMUNICATION SKILLS:

Verbal: _____ Describe level of ability: _____

Primary Language (Spoken) _____

(Understood) _____

Non-Verbal: _____ Uses Sign Language _____

Special Services received (OT,PT, Speech): _____

DAILY LIVING SKILLS:

What assistance does the applicant need in the area of **Toileting**? _____

What assistance does the applicant need for **Eating/ Drinking**? _____

What assistance does the applicant need to be safe in the **community**? _____

RECREATION / LEISURE TIME ACTIVITIES:

1. What activities does the applicant have an interest in doing or achieving? (Learning to cook, exercising, learning to read, playing outside, arts and crafts, etc.):

BEHAVIORS: For each, describe what causes the behavior, how often it happens, and how severe it is.

1. Aggressive Behaviors (verbal/physical) _____

2. Injury to self (include eating inedible objects)

3. Refuses to follow direction or accept supervision or help:

4. Sexually inappropriate behaviors:

5. Runs or Wanders Away

6. Other

What methods do you use to deal with challenging behaviors the individual presents?

Are you currently receiving services from any other agency? Yes No
(Service Coordination, Com Hab, Respite, etc.)

Agency Name: _____

Type(s) of Service: _____

Name of Contact: _____ Phone: () _____

Is there any additional information you wish to share that is not included in this application?

Agreements

I consent to the enrollment of my child listed in this recreation program and have been advised of the policies regarding administration of medications, fees, transportation, and the services provided by the facility, and the regulations under which it operates.

1. I give consent for my child to take part in neighborhood trips (i.e. library, park, and playground) away from the facility under proper supervision. **Yes** **No**
2. In case of accident or injury. I authorize any and all emergency medical, dental, and/or surgical and hospitalization advised by the physicians, surgeons or hospital necessary for the proper health and well being of my child. **Yes** **No**
3. I have provided information on my child's special needs (allergies, diet, disabilities, and/or medical information) to the provider, as may be necessary to assist the facility in properly caring for my child in case of emergency. **Yes** **No**
4. I agree to review and update this information whenever a change occurs and at least once every six months. **Yes** **No**

POLICY AND PROCEDURE

Your cooperation with these procedures will help us run a safe and enjoyable program for your child. Please call Matthew McMorris at 374-0053 ext. 314, or Sarah Slagle Family Support Services Coordinator at 374-0053, ext. 329, if you have any questions.

- You must contact your child's Site Coordinator in the instance your child will be absent from, late to, or picked up early from program.
- Attendance at the Respite Program is **very** important. Children who are consistently absent may be in danger of losing their placement in the program, as there are many children on a waiting list each year.
- The Schenectady Respite Programs operate according to the Schenectady City School District calendar for the Schenectady sites. The programs operate from 3:00 p.m. to 6:00 p.m., on regular school days. On half days **only**, the programs start at 11:30 am, (11:00 am Mt. Pleasant only) and dismiss at 6:00pm. The programs do **not** meet on holidays, school vacations, or snow days. * If your child needs to be picked up early, please contact the site coordinator to ensure that your child is on site.
- The Hoosick Falls Respite Program site operates according to the Hoosick Falls School District calendar for that year. The program will begin directly after school ends and will dismiss at 5:30 p.m. On half days **only**, the program will begin at the end of the half day and continue until 5:30 p.m. These programs do **not** meet on holidays, school vacations, or snow days. * If your child needs to be picked up early, please contact the site coordinator to ensure that your child is on site.
- In the event that school is dismissed early, due to inclement weather or other unforeseen circumstances, the Respite Program will be cancelled and **your child will be transported directly home from school**. It is **the parent's responsibility** to watch for school closings throughout the day and arrange for someone to be home to meet your child after school.
- Parents/guardians need to ensure that their children are properly attired for the weather as many activities take place outdoors.
- Parents/guardians need to be home to receive their children each day at the end of the program. They will also need to provide ALG with the names of alternate individuals who can receive the child in the absence of the parent/guardian. The designated alternates must be an individual who is at least 18 years of age. The agency cannot release a child to anyone other than the parent/guardian or designated alternates.

- Parents/guardians need to notify the Family Services Coordinator of any pertinent changes including: change of address, phone number, emergency contact, changes in school placement, intent to withdraw, changes in medical/health status, or any change which may affect the child’s respite placement. This information will also be documented on the Child Release Form and submitted to the site coordinator. Staff is not authorized to accept verbal changes to the Child Release Form.
- ALG does offer 2 snacks while your child attends the after school respite program. ALG does provide lunches and 2 snacks during half days of programing. During our GAP program, ALG offers am snack, lunch, and a pm snack. We do provide healthy snack options and 100% juice.
- Parents are permitted to visit the Respite Sites. When possible, parents will be offered the option of attending field trips. Any parent willing to participate would have to provide for their own expenses and transportation.
- Parents/guardians will complete the Child Sign In/Sign Out Sheet each time they pick their child up from program.

I hereby verify that all of the above information is correct and accurate to the best of my knowledge. I have read and understand the procedures I am expected to follow as a parent/guardian. I authorize the Alternative Living Group, Inc. to verify any and all information provided in this application and its attachments.

Parent/ Guardian_____ **Date:**_____

Applicant:_____ **Date:**_____

(If able to sign)

Person completing application:_____

PLEASE RETAIN THIS INFORMATIONAL SHEET FOR YOUR RECORDS

IMPORTANT PHONE NUMBERS

The Alternative Living Group, Inc. Office: 374-0053, fax 374-4811

Sarah Slagle, Family Services Coordinator: 374-0053, ext. 329, cell 469-7303

Matthew McMorris, Family Services Coordinator: 374-0053, ext. 314, cell 469-7412

Mont. Pleasant Coordinator: cell 925-5815

M.L. King Coordinator: cell 469-6856

Woodlawn Coordinator: 641-9908

Elmer Coordinator: 461-4613

Hoosick Falls Coordinator: 686-7321 ext. 1109

ALG Emergency On-Call Cell Number: 229-8828

The Administrator On Call (AOC) – is utilized during non-business hours, before 9am,
and after pm, and on weekends and holidays.

PHOTOGRAPH RELEASE

I hereby authorize The Alternative Living Group, Inc. to obtain and use photographs of my child and/or myself for the purpose of publication.

Individual's Name: _____ Date of Birth: _____
(Print Name)

Address: _____
(Street) (City) (State) (Zip)

Phone Number(s): _____
(Home) (Work/Other)

Signature: _____ Date: _____

Permission Slips

I give _____ permission to attend off-site activities and field
(Name of Child)

trips with The Alternative Living Group, Inc.'s Respite Program.

Signature of Parent or Guardian Date

Permission Slips

I give _____ permission to participate in closely supervised
(Name of Child)

water activities, swimming, etc. with The Alternative Living Group, Inc.'s Respite Program.

Signature of Parent or Guardian Date

Permission Slip

I understand that it is necessary for my child to wear sunscreen on all outdoors activities,

so I hereby give The Alternative Living Group staff to apply sunscreen to my child,

_____ when necessary.

Parent/Guardian Signature

Date

Some important information you should know about my child in regards to swimming

Capabilities:_____

Information Release

I hereby authorize _____

to release the following records/information: _____

to: _____

I understand the all information requested in this release will be kept confidential and will only be used in best interests.

I authorize a copy of this same signed authorization to be executed with the same authority as the original.

Signed: _____ Date: _____

Name: _____ Date: _____

Address: _____ SS#: _____

_____ I.D.: _____

If signed by a mark, two witnesses must sign below:

Witnessed: _____ Date: _____

Witnessed: _____ Date: _____

Child Release Form

The Alternative Living Group, Inc.
After School Respite Program

I give permission for the staff at the After School Respite Program to release my child to the following persons:

Name: _____
Address: _____
Phone No.: _____
Relationship to Child: _____

Name: _____
Address: _____
Phone No.: _____
Relationship to Child: _____

Name: _____
Address: _____
Phone No.: _____
Relationship to Child: _____

Please Note: It is your responsibility that all persons listed above be made aware of their responsibility to pick up a child by the end of program at 6:00p.m. on any given day. Also, any person asking for the release of any child in the respite program will be required to show picture identification to be identified as a person listed above.

Please also note: It is ALG's policy to take students to the Schenectady Police station if no adult listed on this Child Release Form is available at dismissal time.

If you have any questions regarding this information, please call
Matthew McMorris at, 374-0053 x 314 or Sarah Slagle at, 374-0053 ext. 329.

Child's Name: _____ **Date:** _____

Parent/Guardian Signature: _____