South East Consortium for Special Services, Inc.

740 West Boston Post Road, Suite 316 | Mamaroneck, NY 10543

Program Admission Application

Please complete this application accurately and completely to ensure safety and program effectiveness

This application is valid for three years

Name of Participant: _____ DOB: _____/____/_____ Sex: M F (circle one)

Participant's Social Security # (required): _____ Participant's Medicaid Waiver # (if applicable): _____

Parent/Guardian's Name: _____

Address: _____, _____, _____, _____
Street Municipality State Zip Code

Home Phone: _____ Cell Phone: _____ Email: _____

Emergency Contacts: (if parent(s)/guardian(s) are unavailable:

Primary Person: _____ Best Phone #: _____

Secondary Person: _____ Best Phone #: _____

Relationship to Participant: Primary_____ Secondary _____

Parent/Guardian's Release Statement

I am the parent/guardian of _____ (Participant) on whose behalf I have submitted this Admission Application for his/her participation in the programs and activities of the South East Consortium (SEC). I represent and warrant that, to the best of my knowledge and belief, the Participant is physically and mentally able to participate in SEC's programs and activities.

The SEC has my permission to use (both during and after a program or activity) the likeness, name, voice or words of the Participant in television, radio, film, newspaper, magazine and other media or formats, for the purpose of advertising or communicating about the SEC's programs and activities and/or for the purpose of applying for or raising funds to support these programs and activities.

I hereby release and discharge the SEC, and its officers, directors, employees, supervisors and volunteers from any and all claims for damage, personal injury and other liability in connection with events occurring while the Participant is involved in the SEC's programs and activities.

If, during the Participant's involvement in the SEC's programs and activities, he/she were to need emergency medical treatment, I hereby authorize the SEC to take such measures as it may deem necessary for the benefit of the Participant's health and well-being (including, if necessary, hospitalization).

Do you carry health/medical insurance for the Participant? Yes No. If "No" – I will be responsible for payment of all medical services rendered.
Name of Insurance Company: _____ Policy #: _____
_____

Release of Test Score Information Required by New York State OPWDD

In order to ensure the Participant's eligibility to receive the important funding which is provided to the SEC by the New York State Office for People with Developmental Disabilities (OPWDD), the SEC is required to provide to said Office the individual I.Q. scores, Vineland Adaptive Behavior Scale Scores or other recognized assessment instruments in connection with the Participant. By submitting this application to SEC, you are confirming that the SEC may release this required information to the New York State OPWDD. Your cooperation is appreciated.

Delivery of the Participant

The South East Consortium may release the Participant only to the persons named below:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I give my permission for the Participant to arrive and depart the SEC's programs on his/her own. Y N . Circle one

Signature: _____ Date: _____

Parent/Guardian and also by the Participant (if 18 years or older). Must be signed to participate.

Participant Information

Participant's School or Workplace: _____

Brief description of family and living situation: _____

_____

What does the Participant enjoy during free time? _____

_____

What outcomes would you like the Participant to achieve? _____

_____

Daily Living Activities		**Comments**
Assistance eating/drinking	☐ Yes ☐ No	
Assistance with toileting	☐ Yes ☐ No	
Assistance with dressing	☐ Yes ☐ No	
Other thinks we should know		
Social Ability		
Interacts with others	☐ Yes ☐ No	
Unusual fears or concerns	☐ Yes ☐ No	
Aggressive behavior/outbursts	☐ Yes ☐ No	
Leaves or wanders from groups	☐ Yes ☐ No	
Other things we should know	☐ Yes ☐ No	
Cognitive/Communication Ability		
Verbal/Non-verbal	☐ Yes ☐ No	
Hearing speech/hearing impairments	☐ Yes ☐ No	
Other things we should know		
Physical Ability		
Ambulatory	☐ Yes ☐ No	
Gross/fine motor ability	☐ Yes	
	☐ No	
Over/under active	☐ Yes ☐ No	
Likes physical activity	☐ Yes ☐ No	
Other things we should know		