Adaptive Services Information Form

TWO WAYS TO SUBMIT THIS FORM:

Fill out this form, save it, and email it to: AdaptiveServices@ScottsdaleAZ.gov	You may also print and mail this form to: Adapted Services 8102 E. Jackrabbit Rd. Scottsdale, AZ 85250

QUESTIONS? 480-312-2234 | ScottsdaleAZ.gov – Search "Adaptive Services"

Personal Information

Participant's Name: _____

Date of Birth _____/_____/_____ Age/Grade _____ Gender: Male_____Female_____

Disability:_____

Address:_____

Street City State Zip

Phone Number:_____ Email:_____

Parent or Guardian's Name(s):_____

Address:_____

Street City State Zip

Home Phone (____)_____ Cellular Phone (____)_____

Work Phone (____)_____ Pager (____)_____

Parent or Guardian's Name(s):_____

Address:_____

Street City State Zip

Home Phone (____)_____ Cellular Phone (____)_____

Work Phone (____)_____ Pager (____)_____

Emergency Contacts

1. Name_____ 2. Name_____

Relationship_____ Relationship_____

Home Phone_____ Home Phone_____

Cellular Phone_____ Cellular Phone_____

Medical/Health Information

Doctor:_____ Phone:_____

Insurance Company:_____ Policy #:_____

**Participants Insurance is sole coverage*

If the participant has allergies, please list them, the reaction, and treatment needed:

Allergy Reaction Treatment Needed

_____

_____

_____

Please list all medications that participant takes:

Name of Medication	Dosage	Dispensing Times	Will staff dispense drugs?
1.			
2.			
3.			
4.			

***Note:* All medications must be given to program supervisors in its *original container*, with instructions clearly printed on the container.**

Does the participant have a seizure history? Yes_____ No_____

If yes, what was the approximate date of the last seizure? _____

What are the warning signs for a seizure?_____

Does Participant require rest after a seizure? Yes_____ No_____

Please describe type and how staff should respond to the seizure: _____

_____

Does Participant use/wear any of the following:

☐ Glasses ☐ Contact Lenses ☐ Prosthetic devices
☐ Wheelchair ☐ Hearing Aid ☐ Orthopedic devices
☐ Dentures ☐ Crutches/Cane ☐ Communicative device

Other/Explanation:_____

_____

Activities of Daily Living/Personal Care

Please note that Adaptive Services does not provide personal care. Participants may bring their own attendant at no additional charge.

Please indicate participant's abilities by checking appropriate boxes:

Mobility

- ☐ Can walk, run without assistance
- ☐ Can walk, run without assistance on flat surfaces only
- ☐ Can walk but uses braces, crutches, cane
- ☐ Can walk with someone standing by to help (minimal assistance)
- ☐ Uses wheelchair for all mobility, transfers independently
- ☐ Uses wheelchair for all mobility, transfers with assistance
- ☐ Uses wheelchair for all mobility, does not transfer
- ☐ Requires wheelchair accessible van for transportation

Mealtimes

- ☐ Requires no assistance with meals, feeds self independently
- ☐ Requires little assistance (carrying tray, pouring liquids, cutting)
- ☐ Needs total assistance with meals
- ☐ Participant is diabetic
- ☐ Requires tube feeding
- ☐ Participant has special diet needs, they are as follows: _____

_____

Safety

- ☐ Will stay with group
- ☐ Will wander away from group but return when their name is called
- ☐ Is flight risk
- ☐ Can recognize dangerous situations
- ☐ Can manage own money
- ☐ Can swim independently
- ☐ Can cross the street independently

Toileting

- ☐ Totally independent in toileting
- ☐ Needs assistance getting on and off toilet
- ☐ Needs assistance wiping
- ☐ Needs frequent reminders to use bathroom
- ☐ Uses diapers/Depends at night only
- ☐ Uses diapers /Depends all day
- ☐ Complete transfer on and off toilet

Participant Behavior

Please describe participant's general behavior and moods (i.e. happy, shy, cautious, etc.,)_____

_____

Does the participant exhibit any of the following behaviors?

Behavior	Yes/No	Comments
Withdrawn/Shy	_____	_____
Easily Discouraged	_____	_____
Hyperactive	_____	_____

Short Attention Span _____ _____

Easily Distracted _____ _____

Bites _____ _____

Physically Harms self/others _____ _____

Manipulative _____ _____

Other _____ _____

Is participant currently using behavior plan at home/school? Yes_____ No_____

If yes, please explain and/or attach a copy: _____

_____

_____

Please list activities or items the participant especially enjoys that are used to reinforce positive behavior: _____

_____

_____

Please describe any disruptive behaviors and effective ways to reduce them:

_____

_____

Does the participant have any fears or phobias (i.e. fear of dogs, heights, etc)? Yes_____ No_____

If yes, please expalain:_____

Please indicate the best way to introduce new tasks or transitions:_____

Please indicate what types of things frustrate the participant:_____

_____

Please list participant's leisure interests, hobbies, etc._____

_____

Are there any settings or activities that might cause behavior difficulties (i.e. noisy surroundings, airplanes, escalator, flashing lights, etc.)?_____

_____

Is there any additional information you would like to share with us?

_____

_____

Socialization

(Please check al that apply)

Interacts well with peers: Yes_____ No_____ Prefers to be alone: Yes_____ No_____

Interacts well with adults: Yes_____ No_____ Prefers large groups Yes_____ No_____

Prefers small groups (10 or less) Yes___No___ Enjoys group outings Yes___ No___

Comments:_____

_____

Publicity Release

I do___ do not ___ grant permission to the City of Scottsdale's Parks & Recreation Division to use the likeness, voice, or words of (participant's name) _____ on television, newspaper, film and/or other media for educational purposes and/or the purpose of promoting Adaptive Services and their activities, programs & events.

_____ ☐ _____

Participant's Signature (if over 18) Date
(check box if submitting electronically)

_____ ☐ _____

Parent/Guardian Signature (if applicable) Date
(check box if submitting electronically)

Release of Liability for Transportation in a City Vehicle

Transportation for Adaptive Services activities will be by vans owned by or leased to the City of Scottsdale. The drivers of these vans will be City of Scottsdale Recreation Leaders. These Recreation Leaders are not professional drivers. They are part-time or full time employees or volunteers. The drivers will participate in an eight-hour classroom and driving course, as well as an hour orientation on driving a van.

I hereby give permission for to be transported by a van owned or leased by the City of Scottsdale and driven by a full time City of Scottsdale employee or a part time Recreation Leader to and from sites for all Adaptive Services activities.

I understand that physical injury may occur during participation in this program.

I have read and understand that Recreation Leaders, who are not professional drivers, will drive City or Rental vans.

I understand that transportation by these vans involves all the risks associated with car or vehicle travel, including collision, rollover, and vehicle-pedestrian accidents. I also understand that transportation in a City van could result in physical injury or death. The undersigned acknowledges and expressly agrees to hold harmless and indemnify the City of Scottsdale and its representatives, to the maximum extent allowed by law, for any and all damages claims or expenses that arise from being transported in a City van.

_____ ☐ _____

Participant's Signature (if own guardian) Date
(check box if submitting electronically)

_____ ☐ _____

Parent/Legal Guardian Signature (if applicable) Date
(check box if submitting electronically)

Authorization to Dispense Medication

The undersigned acknowledges that any and all medications are given to City of Scottsdale staff in their original container and that instructions on the pharmaceutical container are accurate.

Furthermore, the undersigned agrees to allow the City of Scottsdale Adaptive Services staff to present medication to their son or daughter or legal charge and waive any claims against the City of Scottsdale and/or its staff.

☐ _____ _____
Participant's Signature (if over 18) Date
(check box if submitting electronically)

☐ _____ _____
Parent/Guardian Signature (if applicable) Date
(check box if submitting electronically)

Rideshare Release

I authorize Adaptive Services staff to release participant's name and telephone number to other Adaptive Services participants or volunteers for the purpose of making ridesharing arrangements.

☐ _____ _____
Participant's Signature (if over 18) Date
(check box if submitting electronically)

☐ _____ _____
Parent/Guardian Signature (if applicable) Date
(check box if submitting electronically)

Release of Information

Request to:_____ Date:_____
Name of Agency

Name of Participant:_____

Check here, if over 18 years & own guardian ☐

I consent to the release of the most recent records concerning the above named participant to <u>Scottsdale Adaptive Services staff,</u> including the following:

Please check the boxes as they may apply:

☐ *Individual Education Plan/Share Information with School*
School:_____
Teacher contact:_____
☐ *Discharge Plan*
☐ *Individual Program Plan (DES/DDD)*
☐ *Psychological Evaluation*
☐ *Therapeutic Recreation Assessment*
☐ *Other:*_____
☐ *I consent to information being provided verbally via telephone.*

I understand the released information will be maintained in confidence by the Adapted Services staff, and will be utilized in the interest of providing quality and appropriate recreation services to the above named participant.

☐

Participant/Legal Guardian's Signature *(check box if submitting electronically)*

Date

Requesting Agency:	Adaptive Services Center, City of Scottsdale	
Agency Contact:	Stacy Yoder Recreation Leader Senior	Phone: 480-312-2214
Office Location:	Adaptive Services Center 8102 E. Jackrabbit Rd. Scottsdale, AZ 85250	**Mailing Address:** 8102 E. Jackrabbit Rd Scottsdale, AZ 85250

If you are filling this out on your computer, remember to SAVE and email it to: AdaptiveServices@ScottsdaleAZ.gov

ADAPTIVE SERVICES CENTER
CLIENT INTAKE FORM

In order to be considered complete, this form must include client's name, race, ethnicity, address, phone numbers, specify at least one qualifying characteristic from the list below, and include a dated signature.

Client Name:	Date of Birth:
THE FOLLOWING INFORMATION IS GATHERED TO COMPLY WITH FEDERAL CDBG PROGRAM REQUIREMENTS:	
Race: ☐ White ☐ Black/African-American ☐ Asian ☐ Am. Indian/Native Alaskan ☐ Pacific Islander/ Hawaiian ☐ Asian & White ☐ Am. Indian/Native Alaskan & White ☐ Black/African-American & White ☐ Am. Indian/Native Alaskan & Black/African-American ☐ Other Multi-Racial	Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino
Address: (Number) (Street)	(City) (State) (Zip)
Phone Number:	Alternate Phone Number:

Please select one to qualify as severely disabled:

☐ **I have used a wheelchair or another special aid for 6 months or longer**

☐ **I am unable to perform one or more of the following functional activities:**
- **seeing**
- **hearing**
- **having ones speech understood**
- **lifting and carrying**
- **walking up a flight of stairs**
- **walking**

☐ **I need assistance with activities of daily living; such as:**
- **getting around inside the home**
- **getting in or out of bed or a chair**
- **bathing**
- **dressing**
- **eating**
- **toileting**

☐ **I need assistance with instrumental activities of daily living:**
- **going outside the home**
- **keeping track of money or bills**
- **preparing meals**
- **doing light housework**
- **using the telephone**

☐ **I am prevented from working at a job or doing housework**

☐ **I have one of the following selected conditions:**
- **autism**
- **cerebral palsy**
- **Alzheimer's disease**
- **senility**
- **dementia**
- **intellectual disability**

☐ **I am under the age of 65 and am covered by Medicare or receive Supplemental Security Income (SSI).**

I certify that all the information I have given and will give in connection with this application, either in writing or orally is true and correct. I understand that false, fictitious or fraudulent statements, or representations to defraud the United States Government of funds voids my application for assistance, and is punishable by fines not to exceed $10,000 or imprisonment for not more than five years, or both under U.S.C. Title 18, Sec. 1001. I understand that it is the obligation of the City of Scottsdale to prosecute violations.

Participant/Parent/Guardian Signature (please indicate which):_____

(check box if submitting electronically to certify that said client named above is authorizing and signing the form) ☐ Date

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