After School Respite Program Application 2015-2016 School Year

Section 1: Personal Information

Site: ___Wauwatosa Center (7111 W. Center St.) ___Waukesha Center (201 W. Wisconsin Ave.)

Name: _____Home Phone: _____ Cell Phone: _____

Mailing Address: _____
Street City Zip Code

Email Address: _____

Birthdate: _____/_____/_____ SSN#_____-_____-_____ _____Male _____Female

Days of attendance: (please circle a minimum of 2 days) M T W Th F

School/Workplace

School Name and Address: _____
Name Street City Zip Code

Teacher's Name: _____ Phone Number: _____

Student Workplace/Day Program Name and Address:

_____
Name Street City Zip Code

Program Staff Contact: _____Phone Number: _____

Participant Heritage: __African American __Asia __Caucasian __Hispanic __Native American __Other

Household Income: (*Please check appropriate family annual income. This will assist our agency in providing feedback to our funding sources)* __$0-$11,999 __$12,000-$14,999 __$15,000-$24,999 __$25,000-49,999 __$50,000-$74,999 __More than $75,000

Is there a member of your immediate family who serves/ed in the military? Yes__ No__
Is this person on Active Duty__ or a Veteran__ Branch of Military Service? _____
Does this person participate in the National Guard? Yes__ No__

Parent/Guardian Information.

Parent(s)/Guardian(s):_____
First Last

Parent/Guardian Work Phone or Program Time Phone: _____

Transportation Services- Please include for school bus service, and transit service

Transportation Service: _____Phone Number: _____

Bus Service and Route Number: _____ Phone Number: _____

Section 2: Emergency Information

Emergency Contact Person: _____

Phone: _____ Relationship: _____

Medication: _____yes _____no If yes, please specify: _____

(If medication is to be administered during program, the medication administration form must be completed by participant doctor, no exceptions. A form is included with this application.)

Allergies: _____yes _____no If yes, please specify: _____

_____

Physician's Name: _____Phone:_____

Insurance Provider: _____Insurance Number: _____

Disability: (please list actual diagnoses to ensure we are better able to serve individuals)

_____

Please list any additional special needs we should be aware of (example: vision, hearing, mobility, behavior, eating, dressing, toileting, communication, etc.):

_____

_____

_____

_____

Section 3: Personal Information

Does the participant need mobility assistance? ___yes ___ no

If yes, please explain: _____

Does he/she use a wheelchair? ___ yes ___ no

Does participant need help transferring? ___ yes ___ no

If yes, please explain: _____

Does participant indicate when he/she needs to go to the bathroom? ___ yes ___ no

If yes, please explain: _____

Does participant need assistance in the bathroom? ___ yes ___ no

If yes, please explain: _____

Does applicant require diapers? ___ yes ___ no

Please list any dietary restrictions: _____

Please circle which form (s) of communication the participant uses:

__Sounds __Gestures __Verbal Language __Sign Language ___Communication Board

__Other: _____

**If participant uses sign language, please enclose a list of signs the participant uses.*

Section 4: Behavior/Personality

If a formal plan is in place, please include a copy*

Describe the participant on his or her best day.

_____
_____
_____

Describe the best way to get the participant involved in an activity.

_____
_____
_____

Does the participant have any phobias/fear, i.e., fear of dogs, heights, etc.?
□ yes □ no If yes, please explain: _____
_____

Are there any settings or activities that may cause behavior difficulties, i.e., noisy surroundings, flashing lights, etc.? □ yes □ no If yes, please explain

_____
_____

Please describe the best way to introduce or explain new tasks or transitions:

_____
_____

Please indicate what types of things frustrate or anger the participant:

_____
_____

Please indicate the best way to redirect or engage the participant's attention:

_____
_____

Is the participant using a specific plan for behavior? ___yes ___no
If yes, please explain:

_____
_____

What type of behavior management or reinforcement works best?

_____
_____

Section 5: Activities

Please list activities participant enjoys:

_____
_____

Please list activities participant does not enjoy:

_____

_____

Please list activities participant should be restricted from:

_____

_____

Section 6: Consents

I hereby give consent to Easter Seals Southeast Wisconsin to:

- Obtain emergency medical care or treatment, to be used only if I cannot be reached immediately __yes __no
- Take and show films, videotapes, or photographs of the student named above which may be used for publicity, educational purposes or professional training __yes __no
- Use cleansing tissues and/or powder or lotion when changing diapers __yes __no
- Administer medications **according to physician's directions**
- *(authorized form must be completed by doctor)* __yes __no
- Perform special medical care (i.e. G-tube feeding, diabetic testing, etc., as instructed __yes __no
- Release or obtain written/verbal reports (educational, therapy, medical and/or psychological) containing information about my child __yes __no
- Take my child/ward on off-site community outings either in an agency vehicle or by foot __yes__no

_____

Signature (parent/guardian) Date

Section 7: Payment Agreement

- I agree to enroll my child two or more days per week
- **I understand the days that I will not be reimbursed if my child is absent**
- I understand I am responsible for payment of contracted fees and payment agreements, and my child will be suspended from the program if fees are not received according to such agreements *(any unforeseen causes for outstanding payments require that all payments are attempted electronically, however, should payment drop off be arranged prior, payment will only be accepted at Easter Seals Administration Office located in West Allis)*
- I understand, if private paying, the first payment will be withdrawn on the 10th of each month via automatic withdrawal
- I understand I must provide care manager contact information, as well as contact my care manager to initiate a prior authorization upon enrollment
- I understand if I choose to change my payment plan I must notify the Business Office one month in advance *(Payment arrangements will then be changed the first of the following month)*
- I will give two weeks notice of withdrawal from the program.
- I understand that there is a late fee for your child being picked up after 6:00 pm

_____

Signature (parent/guardian) Date

Section 8: Registration
****Enrollment is based on a first come first serve basis. Please complete and return your application as soon as possible.*

PLEASE NOTE: Registration Fee of $25.00 will be automatically withdrawn upon receipt of payment agreement and enrollment application. If using a managed care organization please send a separate $25.00 check, or have your managed care organization authorize payment for $25.00.

You will receive more information will be sent out confirming application, and start dates over the summer of 2015. If you have any questions or concerns regarding after school program please contact Bridget Mangan.

Section 9: Payment Plan ***(Applicable to Private Pay Only, Please complete Automatic Payment Agreement. Application will not be processed unless completed)***
Monthly Payment: Due the 10th of each of the month **via automatic withdrawal**
Full-time: (5 days) = $413.00
Part-time: (4 days) = $343.00
(3 days) = $260.00
(2 days) =$180.00 ******Prices subject to minor change***

_____ Interested in scholarship options. (Based on total family income)

****Cost of the program is averaged out for the entire school year. Each month will be billed at the above costs. If the program is open on additional days that we would normally not operate (exam days, holidays, teacher conference days, etc.) there will be a separate sign up and additional cost for those days.***

Section 10: Care Management Organization (CMO) Billing
(If this portion is not completed, your application will not be processed as Business Office must work with CMO to obtain prior authorization)

Care Management Organization (funding stream): _____
(Care Wisconsin, Children's Service Society, IRIS, St. Francis CLTS, Milwaukee County Department of Family Care, Community Care, Wraparound)
Care Management Unit: _____
(Goodwill, MCFI, ARC, Curative, St. Francis Children's Center, Easter Seals Southeast Wisconsin, etc.)
Care Manager Name: _____
Address: _____
Phone: _____
Email: _____

Please return application, payment agreement and/or authorization to:

Easter Seals Southeast Wisconsin
2222 S. 114th Street
West Allis, WI 53227
Program Related Questions:
Bridget Mangan- Respite Supervisor
Office- 414-963-5938
Cell- 414-286-1844
Email- bridgetm@eastersealswise.com