My Possibilities Program Application and Waivers

Thank you for applying to My Possibilities. This application process allows the Admissions Committee, the client and the client's family to determine whether the My Possibilities program can meet the needs of the client applying for admission. In order to determine eligibility, we have established the following requirements in order to complete the admissions process:

1. Complete the Application with appropriate signatures and submit to My Possibilities with the non-refundable Application Fee of $100. *(Application fee necessary to cover additional cost of initial paperwork, intake/assessment interview and other essential documentation review required to enroll a new HIPster).*
2. Submit the following documents:
   - Most recent Full Individual Evaluation (FIE), Individual Education Plan (IEP), and/or Individual Transition Plan (ITP).
   - Agency evaluations (i.e. Lifepath, Dallas Metrocare, and/or DARS)
   - References
   - Dismissal Policy Agreement
   - Financial Agreement
   - Recent Photo
   - Guardianship paperwork
   - Consent for Services
3. Interview and Initial Visit – Once the above information is received and reviewed a decision will be made if the applicant will be invited for the next stage of the process which will include an on site interview and visit. During the interview, the applicant will tour the facility and the specifics of the program will be outlined. The application and his/her family will have an opportunity to discuss any questions or concerns they may have.
4. Upon completion of the interview process, the Admissions Committee will notify you of acceptance. At that time you will receive a Welcome Packet with the following information: program policies & procedures, ID badge information, behavioral policy, etc. If government funds are required for payment, contract and approvals must be in place prior to the commencement of enrollment.

Please mail the completed application and related documents to:

Admissions Committee
My Possibilities
1631 Dorchester Drive
Plano, TX 75075
Phone: 469-241-9100
Fax: 469-241-9020
Email: admissions@mptx.org
www.mypossibilities.org

My Possibilities does not discriminate on the basis of race, color, ethnicity, religion, age, or gender, in its admissions policy or programs. It is up to the discretion of the Admissions Committee as to who is accepted for admission to the program.

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CLIENT INFORMATION Date: ___________________

Please print legibly.

Person filling out application: ☐ Self ☐ Parent/Caregiver/Guardian ☐ Staff

Name: ______________________ Relationship: _________________

Client Legal Full Name: ____

(First) (Middle) (Last)

Preferred Name: ____

Address: ____

City: ________________________________ ST: ________ Zip: _______________________________

Home Phone: ____________________________ Client Cell Phone: ______________________________

Sex: M / F DOB: _____________ Age (as of application date): _______________

Social Security #: ______________________ TX ID/Driver's License#: _________________________

Marital Status: Single/Married/Widow/Other: __________

Ethnicity: __ Caucasian __African American __Hispanic __Asian Other:_____________________

Disability/Diagnosis: ____

Guardianship

Is the client their own legal guardian? ☐ YES ☐ NO

If **YES**, who do we have permission to talk to/consult with on your behalf?

____ (please print name and list relationship to client)

____ (please print name and list relationship to client)

____ (please print name and list relationship to client)

If **NO**, who is the Legal Guardian? (Name): ____

Legal Guardian's relationship to client: ____

Who does he/she live with? (check one) ☐ Parents ☐ Self ☐ Group Home ☐ Other _______

****PLEASE PROVIDE A COPY OF GUARDIANSHIP PAPERWORK****

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PARENT/CAREGIVER/GUARDIAN INFORMATION – please fill out completely

1. Parent/Caregiver/Guardian Name: ______________________________

Relation: ☐-Parent (Mother/Father) ☐-Caregiver ☐-Guardian ☐-Sibling ☐-Other ____________

Address: ______________________________

City: ____________________ ST: __________ ZIP: ______________

Employer: ______________________________

Home Phone: ____________________ Cell Phone: ____________________

Work Phone: ______________ Email: ____________________

(Please list email address that we can send program updates and reminders. This address will be used as a primary source of communication)

2. Parent/Caregiver/Guardian Name: ______________________________

Relation: ☐-Parent (Mother/Father) ☐-Caregiver ☐-Guardian ☐-Sibling ☐-Other ____________

Address: ______________________________

City: ____________________ ST: __________ ZIP: ______________

Employer: ______________________________

Home Phone: ____________________ Cell Phone: ____________________

Work Phone: ______________ email: ____________________

(Please list email address that we can send program updates and reminders. This address will be used as a primary source of communication.)

EMERGENCY CONTACT

The emergency contact should be a person other than the above stated parent/caregiver/guardian(s). This contact can be that of an additional relative, neighbor or friend who can be contacted in the event that the primary parent/caregiver/guardian(s) are unable to be reached.

REQUIRED:

Name: ______________________________

Relationship to client: ______________________________

Home Phone: ____________________ Cell Phone: ____________________

Work Phone: ____________________

OPTIONAL:

Name: ______________________________

Relationship to client: ______________________________

Home Phone: ____________________ Cell Phone: ____________________

Work Phone: ____________________

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FUNCTIONAL SKILLS
Please print legibly

Communication: ☐ Verbal (Talk/Speak) ☐ Non-verbal
If non-verbal, what method of communication does he/she use?
☐ Sign Language ☐ Symbols ☐ Other ______________________________
☐ Communication Device (Dynavox, IPad, etc.)
Please describe device: ______________________________

Ambulatory: Is the client ambulatory? ☐ YES ☐ NO
Does client require adaptive equipment? ☐ YES ☐ NO
(ie. walker, wheelchair, crutches, etc.)
If yes please explain: ______________________________
Does client requires special assistance for long distances or if attending outings?
☐ YES ☐ NO
If yes, please Explain: ______________________________
____

Toileting: ☐ Requires **no** assistance with toileting (can wipe, pull pants up, etc. independently)
☐ Requires **minimal** assistance (needs verbal reminder to wipe, wash hands, etc.)
☐ Requires **total** assistance (needs help with wiping, changing diaper/pad, etc.)
☐ Wears adult diapers
☐ Other: ______________________________

Female HIPsters: ☐ Requires **no** assistance, is able to self manage during menstruation.
☐ Requires **minimal** assistance during menstruation.
(Verbal reminder to check/change feminine products.)
☐ Requires **total** assistance during menstruation.
(Take to bathroom, physically check/change feminine products, etc.)

Feeding: ☐ Is able to feed themselves independently
☐ Requires minimal assistance (help with warming up food, cutting up food, etc.)
☐ Total assistance (feeding tube, puree food, etc.)

Dressing: ☐ Is able to dress themselves independently
☐ Requires minimal assistance in dressing themselves
☐ Total assistance
Note: (Please list what assistance is required)______________________________
____

Behaviors (please check all that apply)

___ Tantrums ___ Screams ___ Bites ___ Hits ___ Spits
___ Scratches ___ Pulls Hair ___ Kicks ___ Head Bangs ___ Slaps
___ Steals ___ Withdrawn ___ Moody ___ Self Abusive ___ Destructive
___ Hyperactive ___ Runs Away ___ Pinches ___ Aggressive ___ Depressed
___ Fantasizes ___ Talks to self ___ Uses Bad Language

Explanation of the above checked items: ____

____

____

Are there things that bother him/her? (loud noises, change of routine, large crowds, etc.)

____

____

How would you describe his/her day-to-day behavior? (quiet, hyperactive, social, aggressive)

____

____

Please include any other vital information about him/her that would be helpful to us: ____________

____

____

PERSONAL INFORMATION

Reading: (Please check where he/she performs currently)

☐ Cannot read ☐ He/She can read simple words ☐ Read independently

Writing: (Please check where he/she performs currently)

☐ Cannot write ☐ He/She can write simple words ☐ Write independently

Check any/all of the extracurricular activities that he/she enjoys doing:

___ Board games ___ Crafts ___ Art ___ Sports ___ Reading ___ Computer
___ Drama ___ Fitness ___ Cooking ___ Music ___ Video games ___ Other

Other: ____

____

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MEDICAL INFORMATION
Please print legibly

Client's Primary Care Physician: ____
(First) (Last)

Address: ____
(City) (ZIP)

Phone: ______________________ Fax: ______________________

Does he/she take any medications? If so, what kind(s) of medications and what are the administration times? (*If you need additional space, please use a separate sheet of paper.)*

1. RX Name: __________ Dosage: __________ Time: __________

Reason for Medication: ____

2. RX Name: __________ Dosage: __________ Time: __________

Reason for Medication: ____

3. RX Name: __________ Dosage: __________ Time: __________

Reason for Medication: ____

4. RX Name: __________ Dosage: __________ Time: __________

Reason for Medication: ____

****We prefer you provide a full week's worth of medication(s) in the original marked prescription bottle(s) with clear instructions. A written waiver signed by the parent/caregiver is required for staff to oversee the self-administration of medication. See waiver for details****

Does he/she have seizures? ☐ YES ☐ NO

If YES, how often and length? ____

Has he/she ever stopped breathing during a seizure? ______________________

Does he/she wear a helmet or head protection? ______________________

If otherwise instructed, 911 will be called if he/she is experiencing a seizure.

____

____

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Does he/she have any dietary restrictions? ☐ YES ☐ NO
If YES, please list:

____

____

Does he/she have any allergies to food, animals, medication, etc? If yes, please list and describe reaction:
Example: Food allergy – Diary products (all). Reaction - Will break out in hives, rash, etc.

____

____

____

____

____

Please check **YES/NO** if he/she has any of the following:

	YES	NO		YES	NO		YES	NO
Asthma/Bronchitis	___	___	Emotional Problems	___	___	Cerebral Palsy	___	___
Heart Condition	___	___	Contact Lenses	___	___	Hepatitis	___	___
Seizure Disorder	___	___	Learning Disabled	___	___	Ear Aches	___	___
Visual Disorders	___	___	Blind	___	___	Skin Rashes	___	___
Artificial Limb	___	___	Glasses	___	___	Dyslexia	___	___
Limb Pain	___	___	Diarrhea	___	___	Chewing/Swallowing	___	___
Behavior	___	___	ADD/ADHD	___	___	Hearing Impairment	___	___

Other: ____

If you checked **YES** above, please explain: ______________________________

____

____

____

____

____

____

____

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MEDICATION SELF-ADMINISTRATION WAVIER
Please print legibly

I hereby ☐ **give permission** / ☐ **do not give permission to** My Possibilities personnel to oversee the self-administration of medication by my son/daughter/HIPster ________________________________ *(name)* according to the instructions below. I understand that My Possibilities personnel may/may not be certified as a registered nurse; however, I consent to allowing their oversight of medical administration to my son/daughter/HIPster. I acknowledge that My Possibilities is to incur no liability, except for willful and wanton conduct, arising from the self-administration of medication or use of an epinephrine auto-injector by my son/daughter/HIPster. I further waive any claims against My Possibilities, members of the Board of directors, its employees and agents arising out of the self-administration of said medication or use of an epinephrine auto-injector. I agree to hold harmless and indemnify My Possibilities, the members of the Board of directors, its employees and agents, either jointly or severally, from and against any and all liability, claims, demands, damages or causes of action or injuries, costs and expenses, including attorneys' fees, resulting from or arising out of the self-administration of medication or use of such epinephrine auto-injector. With respect to client's self-administration of asthma medication or use of an epinephrine auto-injector, this waiver and indemnification are not applicable to willful and wanton acts to the extent required by law.

Medication for self-administration while at My Possibilities:

1. RX Name: ____________________ Dosage: ____________________ Time: __________

Reason for Medication: ____

2. RX Name: ____________________ Dosage: ____________________ Time: __________

Reason for Medication: ____

3. RX Name: ____________________ Dosage: ____________________ Time: __________

Reason for Medication: ____

For asthma medication or epinephrine auto-injector only
I consent to my child's possession and unsupervised self-administration of asthma medication:

☐ YES ☐ NO

I consent to my child's possession and unsupervised use of his/her epinephrine auto-injector:

☐ YES ☐ NO

Printed Name: ____

Guardian Signature:____________________Phone #:______________ Date:__________

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Please print legibly

I hereby ☐ **authorize** / ☐ **do not authorize** My Possibilities staff and agents permission to transfer my son/daughter/HIPster to any reasonably accessible hospital should a situation occur that is deems this action be necessary. I give permission to those administering emergency treatment to do so using measures deemed necessary. I absolve My Possibilities from liability in acting on my son/daughter/HIPster's behalf in this regard.

I understand that this authorization is given to provide authority and power on the part of My Possibilities employees or representatives to give specific consent to any diagnosis, treatment or hospital care, which, in the judgment of a licensed physician is deemed advisable.

Insurance Information

Primary Insurance:
Company: ________________________ Insurance Phone: ________________

ID #: ________________________ Group #: ________________

Primary Insured Name: ________________________________

Physician's Name: ________________________ Phone: ________________

Secondary Insurance:
Company: ________________________ Insurance Phone: ________________

ID #: ________________________ Group #: ________________

Primary Insured Name: ________________________________

HIPster Name**:** ________________________ DOB: ____________

Guardian Signature ________________________ Date ____________

DISMISSAL POLICY

It is the policy of My Possibilities to dismiss a HIPster in the following circumstances:

- Upon direct orders of a physician
- Upon the repeated violation of circumstances stated in the behavioral policy
- As deemed necessary by the Executive Director:
- If services and activities beyond those normally provided are needed.
- If the client becomes a threat to the health and safety of herself/himself or others; including but not limited to:
    - Wandering or running away
    - Consistent non-compliant behavior
    - Throwing objects
    - Biting, scratching, kicking, fighting
    - Refusal to take prescribed medications
    - Inappropriate sexual behavior
    - Verbal abuse
    - Destruction of property
    - Persistent aggression (verbal and/or physical)
    - As per conditions outlined in the My Possibilities behavior policy

- Requested voluntary discharge by the client, family or legal guardian.

HIPSter Name:____

HIPster Signature: ______________________________________ Date:___________________

Guardian Signature: ______________________________________ Date: ___________________

HIPster Name: ______________________________

Consent to Release Information

If the HIPster is **his or her own legal guardian**, please have them complete the following information below.

I authorize My Possibilities to disclose any information to the individuals listed below:

Name: ______________________________ Relationship: _________________________

Name: ______________________________ Relationship: _________________________

This authorization for release of information will remain in effect until such time as I no longer attend My Possibilities or I inform My Possibilities of a new Caregiver and sign a new form.

I understand that I have the right to revoke this authorization at any time.

HIPster First Name: _____________________ HIPster Last Name: ________________________

Signature of HIPster: ____

Printed name of caregiver: ____

Relationship to HIPster: ____

If the HIPster is NOT his or her own legal guardian, My Possibilities will need a current copy of the Guardianship paperwork to place in their file. This will need to be submitted each year at the time of the HIPster's birthday. Please send all guardianship paperwork to the attention of Lez Meggersee. If you have any questions or concerns, please contact Lez at (469)241-9100 or at contracts@mptx.org.

Consent to Receive Services

__ Yes __NO I give My Possibilities permission to contact the Hipster's Medicaid Provider to obtain benefit information as it pertains to services provided by My Possibilities.

__Yes __NO I give consent to receive day habilitation and social/recreational services provided by My Possibilities, with exception to the following activities/services:

____

____

____________________________________ ____________
HIPster or Guardian Signature Date

____
HIPster or Guardian Printed Name

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REFRENCES

Please print legibly

Please list all that apply:

Personal

Name: ____

Relation: ____

Phone #: ____________________ Email: ____________________

School

Name: ____

Relation: ____

Phone #: ____________________ Email: ____________________

Job Site

Name: ____

Relation: ____

Phone #: ____________________ Email: ____________________

Social/Therapeutic Activities

Name: ____

Relation: ____

Phone #: ____________________ Email: ____________________

Special Olympics

Name: ____

Relation: ____

Phone #: ____________________ Email: ____________________

I give permission for My Possibilities Admissions Committee to contact any and/or all of the above references.

______________________________ ____________________
Client Signature Date

______________________________ ____________________
Guardian Signature Date

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HCS/CLASS PROVIDER INFORMATION

CURRENT:

Date services began:____________________ Date services were terminated: ________________

Provider Name: ____

Case Manager: ____

Phone Number: ____

Other (please explain): ____

____

UPDATED:

Date services began:____________________ Date services were terminated: ________________

Provider Name: ____

Case Manager: ____

Phone Number: ____

Other (please explain): ____

____

UPDATED:

Date services began:____________________ Date services were terminated: ________________

Provider Name: ____

Case Manager: ____

Phone Number: ____

Other (please explain): ____

____

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Getting to know your HIPster

We would like to get to know your adult child better, so please answer the following questions. Please print legibly.

1. What is his/her favorite activity, games, or hobby? ____

____

2. What is his/her favorite thing to talk about? ____

____

3. What are his/her favorite foods? ____

____

4. What is his/her least favorite foods? ____

____

5. Who are his/her favorite people? ____

____

6. When is he/she most cooperative? ____

____

7. When is he/she least cooperative? ____

____

8. What frightens him/her? ____

____

9. What calms him/her? ____

____

10. What personal goals would you like to have him/her work on?
    1. ____
    2. ____
    3. ____

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FEE EXPLANATION AND AGREEMENT FORM

The ***My Possibilities*** organization is funded through fundraising and program fees. The day program structure is based upon a fixed number of HIPsters attending per day. To continue the current level and quality of services currently provided by *MP*, it is important we ensure that we are operating as close to our maximum capacity as possible. Therefore, we have implemented a fee structure to ensure that all enrolled HIPsters and their families being provided with the maximum amount of time necessary to progress, grow and learn. This agreement exists solely between ***My Possibilities*** and the family/guardian of the HIPster privately and does **not** reflect any sort of Medicaid waiver program, including HCS funding or general revenue. The different fees and penalties are thus explained:

- <u>**GOOD STANDING FEE**</u> – The foundation of the program cost off of a full ***MP Achieve*** Day Habilitation program and a full continued ***MP Explore*** continued growth program. Fees have been assigned to absences in both programs and are explained as the amount of money necessary to ensure your HIPster's place within the program remains in good standing. As issues are sure to arise in a family's weekly schedule, these fees are both easy to comprehend and very affordable.

  - ***MP ACHIEVE*** - *Day Habilitation Absence Fee*: To secure your HIPster's place within the ***MP Achieve*** program, a fee is applied to any day of services missed by the family. This fee results from enrolling for a set number of days per week and failing to meet this agreement. Partial days are also included in the structure.
    - *****It should be noted that a FULL day of Day Habilitation is defined as a minimum 5 hours of service. To avoid any absence fees, it is important to arrive at the MP program no later than 9:00am, as the *MP Achieve day habilitation program* ends promptly at 2:00pm*****
    - Full day missed - $10.00
    - Quarter and half days missed will be accumulated on a weekly basis to determine weekly fee.
    - ***If you are private pay in MP Achieve and are paid by the first of the month, no late fees will be applied to your account for missing a day. Make-up days are available upon space in program and lead instructor approval.*

  - ***MP EXPLORE*** - *Continued Growth Program Fee:* To secure your HIPster's place within the ***MP Explore*** program, a fee is applied to any day of services missed by the family. This fee results from enrolling for a set number of days and failing to meet this agreement.
    - Day missed - $10.00
    - Quarter and half days missed will be accumulated on a weekly basis to determine weekly fee.
    - ***If you are private pay in MP Achieve and are paid by the first of the month, no late fees will be applied to your account for missing a day. Make-up days are available upon space in program and lead instructor approval.*

  - *FULL DAY MISSED:* If enrolled separately in **both** the ***MP Achieve*** Day Habilitation program and the ***MP Explore*** continued growth program and a full day is missed resulting in an absence in both, a penalty of $10.00 is applied for both programs independently, resulting in a $20.00 total fee for both programs missed.
  - *MP Closures:* During the cold weather season, My Possibilities will keep in accordance with the Plano Independent School District regarding building closures. Should the district be not in session, families are to check the MP Email list-serve as well as the website for updates.
    - *Families are still responsible for the monthly portion of their program fees. Day habilitation days missed due to inclement weather will not be charged to the provider or family. HIPsters enrolled in the afternoon program will not receive a refund for days missed; however, My Possibilities will be flexible with allowing the rescheduling of days in the following weeks to make up for these missed days.*

- **<u>AFTER HOURS CARE</u>** – The ***MP Achieve*** Day Habilitation program concludes at **2:00pm** each day. We provide families, guardians and group homes a 30 minute window leading up until 2:30pm. (This only applies to those not enrolled in the ***MP Explore*** program). The fees associated with after hours care are as follows:

  - Minimum $15.00 charge after 30 minutes. *This fee is applied beginning after the 30 minute window, promptly at 2:30pm.*
  - Continued rate: $15.00 per hour. *Rates will be rounded up to the nearest ½ hour.*

- **<u>EXTENDED LEAVE FEES</u> –** In an effort to accommodate any circumstance that may constitute an extended leave of absence but to allow a HIPster/Family to secure a place within our program, an extended leave fee structure has been established. This is to ensure that families are given the opportunity to miss up to a maximum 3 months time for any reason without losing their place within the program and only accrue the penalties listed below. *HIPsters who are forced to leave the program temporarily due to illness will be given additional consideration upon re-entry to the program.*

  - Week 1: Regular absence rates will apply as described in the MP Achieve & Explore sections above
  - Week 2: Regular absence rates will apply as described in the MP Achieve & Explore sections above
  - Week 3 – Week 12: Beginning Week 3 a $50 fee will be assessed each week your HIPster is absent and will apply throughout the 3 month limit. This fee is to ensure that your HIPster's spot in the program will be secured. *HIPsters enrolled in both the **MP Achieve** and **MP Explore** programs will have a slightly larger fee for weeks 1 and 2; however, this rate will be the same in week 3 and beyond regardless of program involvement.*
    - Example: Should a family decide to take an extended leave of absence for 6 weeks and their HIPster is enrolled in both the ***MP Achieve*** program and ***MP Explore*** program for 3 days per week, they would owe the following:
      - Week 1: $20 per day x 3 days per week = $60
      - Week 2: $20 per day x 3 days per week = $60
      - Weeks 3-6 = $50 per week. $50 x 4 = $200.
      - Total amount necessary to miss 6 weeks and reserve a spot in the full MP program = $320.00. *(Math based upon being enrolled 3 days a week in both programs. Different rates will apply for different scenarios).*

  - These fees are to be paid at the beginning of each month. A minimum 30 days notice must be provided to ensure the arrangements can be made for the extended leave.
  - At the 90 day mark, the HIPster operating within the extended leave structure will be removed from the program and will have to re-apply to the program. Application will include a new $25.00 application fee.

I understand the My Possibilities Fee and Explanation policies and adhere to pay my part in full at the beginning of the month after receiving my billing statement. I understand that these fees are in place to ensure my HIPster's spot in the program is kept in good standing. I understand that these fees are not in addition to any Medicaid waiver funds, such as HCS or general revenue funds, and rest solely upon me as a private payer.

____ ____________________________
Signature of Payer Date:

____
Printed Name

____ ____________________________
Signature of Legal Guardian

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Program Payment Details & Agreement

☐ **– My Possibilities: Achieve (8:00am – 2:00pm) –** The MP Achieve program promotes training in social skills, independent living skills & pre-vocational skills training skills in order to better equip our HIPsters with the skills necessary to live independently, obtain gainful employment and become productive and integrated members of our community.

Private Pay Cost

Days per week	Cost (Per month)
1	$150
2	$250
3	$350
4	$400
5	$450

HCS / CLASS / General Revenue

Days per week	Cost (Per month)
1	To be discussed with Provider
2	To be discussed with Provider
3	To be discussed with Provider
4	To be discussed with Provider
5	To be discussed with Provider

NUMBER OF DAYS DESIRED IN PROGRAM: _____

DESIRED DAYS: *(Circle all that apply)* **MONDAY TUESDAY WEDNESDAY THURSDAY FRIDAY**

Payment Requirements:

My Possibilities strives to keep all cost to our clients as low as feasibly possible. My Possibilities will also conscientiously pay its vendors, local, state and federal agencies, employees, and staff in a prompt and timely manner. In order to do this My Possibilities requires all payments to be made in full and at the beginning of the month. Non-payment may result in removal from the program.

Payment Provided by:

______ Self, Parent or Guardian

______ HCS Provider

Provider Name: ____

Case Manager: ____

Phone Number: ____

Other (please explain): ______________________________________

____

Individual(s) Responsible for Payment:

I understand and agree to the payment terms as stated above.

Signature: ______________________________________ Date: _______

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Program Payment Details & Agreement

☐ – **My Possibilities: Explore (2:00pm – 6:00pm) –** The MP Explore program provides our HIPsters with the opportunity to continue development on a personal level. This includes creative expression, personal wellness, continued mathematics and reading skills, independent goals and continued socialization and community interaction.

Private Pay Cost

Days per week	Cost (Per month)
1	$150
2	$250
3	$350
4	$400
5	$450

HCS / CLASS / General Revenue / Respite

Days per week	Cost (Per month)
1	To be discussed with Provider
2	To be discussed with Provider
3	To be discussed with Provider
4	To be discussed with Provider
5	To be discussed with Provider

NUMBER OF DAYS DESIRED IN PROGRAM: _____

DESIRED DAYS: *(Circle all that apply)* **MONDAY TUESDAY WEDNESDAY THURSDAY FRIDAY**

Payment Requirements:

My Possibilities strives to keep all cost to our clients as low as feasibly possible. My Possibilities will also conscientiously pay its vendors, local, state and federal agencies, employees, and staff in a prompt and timely manner. In order to do this My Possibilities requires all payments to be made in full and at the beginning of the month. Non-payment may result in removal from the program.

Payment Provided by:

______ Self, Parent or Guardian

______ HCS Provider

Provider Name: ______________________________

Case Manager: ______________________________

Phone Number: ______________________________

Other (please explain): ______________________________

____

Individual(s) Responsible for Payment:

I understand and agree to the payment terms as stated above.

Signature: ______________________________ Date: _______

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Program Payment Details & Agreement

☐ **– My Possibilities: University (2:00pm – 6:00pm) –** The MP University program is a series of 6 – 8 week training programs focusing on extensive job training in 6 different professional industries. Though these job fields may change, some listed are kitchen/restaurant services, document destruction and recycling, custodial services, pet/animal services and office administration**. *Acceptance to this program is based on a completion of an individual assessment by the HIPster, parent/guardian and evaluation by members of the program team.***

Private Pay Cost

Days per week	Cost (Per month)
1	$150
2	$250
3	$350
4	$400
5	$450

HCS / CLASS / General Revenue / Respite

Days per week	Cost (Per month)
1	To be discussed with Provider
2	To be discussed with Provider
3	To be discussed with Provider
4	To be discussed with Provider
5	To be discussed with Provider

NUMBER OF DAYS DESIRED IN PROGRAM: _____

DESIRED DAYS: *(Circle all that apply)* **MONDAY TUESDAY WEDNESDAY THURSDAY FRIDAY**

Payment Requirements:

My Possibilities strives to keep all cost to our clients as low as feasibly possible. My Possibilities will also conscientiously pay its vendors, local, state and federal agencies, employees, and staff in a prompt and timely manner. In order to do this My Possibilities requires all payments to be made in full and at the beginning of the month. Non-payment may result in removal from the program.

Payment Provided by:

______ Self, Parent or Guardian

______ HCS Provider

Provider Name: ____

Case Manager: ____

Phone Number: ____

Other (please explain): ____

____

Individual(s) Responsible for Payment:

I understand and agree to the payment terms as stated above.

Signature: ____ Date: _______