DEVELOPMENTAL CENTER OF THE OZARKS
ENROLLMENT/ RE-ENROLLMENT
THERAPY & CHILDCARE

Instructions
All blanks **MUST** be filled in. Please write "NA" (Not Applicable) if appropriate. Attach pages for comments or additional information.

General Information

Individual's Name:			**Date of Birth:**	
Address:			**Gender:** ☐ **Male** ☐ **Female** ☐ **Other**	
City: **State:** **Zip:**			**Phone #:**	
School District: ☐ Springfield R-12 ☐ Other:			**City of Birth:**	
Height:	**Weight:**	**Identifying Marks:**	**Hair Color:**	**Eye Color:**
Language Understood:			**Language at home:**	
Mo Health Net #:			**Medicare #:**	
Culture/Ethnicity:	**Race:**		**Religion:**	

Service Coordinator	**DFS Case Worker**
Name:	**Name:**
Phone:	**Phone:**

Parent/Guardian Information

RELATIONSHIP TO INDIVIDUAL	**RELATIONSHIP TO INDIVIDUAL**
☐ **Mother** ☐ **Foster Parent** ☐ **Guardian** ☐ **Father** ☐ **Other:**________________	☐ **Father** ☐ **Foster Parent** ☐ **Guardian** ☐ **Mother** ☐ **Other:**_________________
Name:	**Name:**
☐ Same as above. If different, please complete:	☐ Same as above. If different, please complete:
Home Address:	**Home Address:**
City/State/Zip:	**City/State/Zip:**
Primary Phone: ☐ Cell ☐ Home ☐ Message **Alternate Phone:** ☐ Cell ☐ Home ☐ Message	**Primary Phone:** ☐ Cell ☐ Home ☐ Message **Alternate Phone:** ☐ Cell ☐ Home ☐ Message
E-Mail Address:	**E-Mail Address:**
Employer or School Attending:	**Employer or School Attending:**
Address:	**Address:**
City/State/Zip:	**City/State/Zip:**
Work/School Phone #:	**Work/School Phone #:**
Work E-Mail Address:	**Work/School E-Mail Address:**
Work/School Hours:	**Work/School Hours:**

Legal Documentation (Required)

☐ Check this box if a Court Order or other legal document is attached naming any person not allowed visitation or custody.
☐ Check this box if a document is attached showing legal guardianship of the individual named above.
☐ Check this box if a document is attached limiting contact or visitation.

EMERGENCY INFORMATION

Emergency Contact(s), other than parent(s) or doctor, TWO required.
*** If in Foster Care, the Children's Division assigned Case Worker or Court Appointed person and their title MUST be listed.**

Emergency Contact #1	Emergency Contact #2
Name:	**Name:**
Address:	**Address:**
City/State/Zip:	**City/State/Zip:**
Home Phone:	**Home Phone:**
Cell Phone:	**Cell Phone:**
Relationship to Individual:	**Relationship to Individual:**

Medical Information

Physician:	Address:	Telephone:
Current Immunizations: ☐ Yes ☐ No	Date of Last Examination:	Date of last TB testing:
Specialist:	Address:	Telephone:
Reason for care:		
Therapists:	Address:	Telephone:
Reason for care:		
Assistive Devices: ☐ Braces (AFO/SMO) ☐ Wheelchair ☐ Walker ☐ Other		
Supportive Devices: ☐ Glasses ☐ Hearing Aids ☐ Communication Device ☐ Other		

HOSPITAL PREFERENCE (Check Only One)

	Comments
☐ Cox South, 3801 S. National Ave., Spfld, MO (417) 269-6000 ☐ Mercy, 1235 E. Cherokee, Spfld, MO (417) 820-2000 ☐ Other:	

INDIVIDUAL'S DAYCARE INFORMATION (THERAPY ONLY)

Daycare:	Contact Person:
Address:	Phone #:

Signature:	Date:

I authorize DCO staff to be able to communicate using any contact information given in the Parent/Guardian and/or Daycare sections via phone/fax/voicemail/text/email/public facing media platform. (i.e. Zoom) I understand that these forms of communication will result in the information being insecure. Documents can be picked up by Parent/Guardian. I understand that this means that person(s) not authorized to view it could access my Protected Health information.

**I understand that this Release of information will automatically expire in one (1) year or if the individual receiving services
is discharged, whichever occurs first.**

I understand that I can revoke this authorization at any time with a written request to DCO at 1545 E. Pythian, Springfield, MO 65802 or by giving the written request directly to a staff person.

____ **Relationship**: ________________ **Date**: ________
Parent, Guardian, Legally Responsible Person

Signature of Case Worker if Foster Care: _____________________________ **Date**: ______________

Privacy Officer Approval: ______________________________ **Date**: ________________

DEVELOPMENTAL CENTER OF THE OZARKS

APPLICATION and CONSENT for SERVICES

I am requesting the Developmental Center of the Ozarks to provide the following services for:

Name of Individual to Receive Services

THERAPY SERVICES

☐ First Steps (birth to 3) ☐ Private (Non First Steps) ☐ Contract

REQUESTED THERAPY	**REQUESTED LOCATION**
☐ ABA/Behavioral ☐ Occupational Therapy ☐ Physical Therapy ☐ Special Instruction ☐ Speech Therapy	☐ In Home ☐ In Center ☐ Other, please specify:

CHILDREN'S SERVICES

☐ Child Care Services ☐ Other: ______________________________

ACKNOWLEDGEMENTS

The Program Handbook and Parental Rights Handout is included in the enrollment information. It includes the Notices of Privacy Practices, several Consent and Releases, Grievance Procedure, Rights, etc. It is important that you review the Handbook and keep it for future reference. By signing below, I acknowledge I have been given the opportunity to review this information, have had adequate explanation given and have had my questions answered.

If you ever have any questions, please call 417-829-0896 (Executive Director), 417-829-0898 (Assistant Executive Director)

Emergency Medical Treatment is given for emergency treatment/first aid and notification of the physician on record if needed or for specific orders. Ambulance/paramedics will be called as determined by treating staff when parent or guardian is not present.

Legally Responsible Person:
Relationship:
Date:

DEVELOPMENTAL CENTER OF THE OZARKS
AUTHORIZATION for LIMITED RELEASE/EXCHANGE OF INFORMATION

I, ______________________________________, give my informed consent for information regarding:
☐ Parent ☐ Guardian ☐ Legal Representative ☐ Foster Parent (Please check the appropriate box)

Child's Name: ______________________ Date of Birth: _______________

THE PURPOSE OF THIS DISCLOSURE IS: First Steps Therapy – Exchange of Information

☐ Request that information disclosed is exchanged between the following two entities: **Developmental Center of the Ozarks Therapist and (check only what applies)**

☐ Childcare Provider Name: ____

☐ Family Member Name: ____

☐ Other __________________ Name: __________________________ Relationship: _______________

Specific Information to be Disclosed/Released:
☐ Verbal Only ☐ Written as specifically requested by Parent/guardian
If Written, please indicate what is approved to disclose: ____

1. **Read Carefully:** I understand that the information for the above-named child's record is confidential. I understand that by signing this authorization, I am allowing the release of this information.

2. The authorization includes both information presently compiled and information to be compiled during the enrollment at the Developmental Center of the Ozarks for the specified time frame.

3. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so **in writing** and present my written revocation to the Privacy Officer. I further understand that actions already taken based on this authorization, prior to revocation will **not** be affected.

4. I understand that I have the right to receive a copy of this authorization. A photographic copy of this authorization is as valid as the original.

5. I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure services. I understand that I may request to inspect or request a copy of information to be used or disclosed. If I have questions about disclosure of my medical/health information, I can contact the Privacy Officer, or designee, at the Developmental Center of the Ozarks.

6. This authorization becomes effective on ______________ and will expire on ________________. (Cannot be more than 1 year.)

7. If I fail to list an expiration date, this authorization will **automatically expire 1 year from my dated signature**.

My signature below acknowledges that I have read (or have had read to me), understand, and authorize the release of my child's therapy information.

Signature of Person Completing this Release: ____________________ Relationship: ____________ Date: _________

Signature of Witness (Case Worker if Foster Care): ___________________________ Date: ___________

Privacy Officer Approval: ____________________________ Date: _________________

DEVELOPMENTAL CENTER OF THE OZARKS
FAMILY HOME VISIT AGREEMENT

THE FOLLOWING ARE AGREED TO BY THE FAMILY OF _____________________________:
(CHILD'S NAME)

1. I have received a copy of the First Steps Overview handout outlining the Program and services based on my child's IFSP. I understand the concept of First Steps is for my Therapist to teach me ways to incorporate my child's therapy into our regular schedule and activities. I will actively participate in my child's therapy session.

2. I agree to be home at the designated time as scheduled with my Therapist, **or call at least 24-hours prior to the appointment** if I need to cancel it. I understand that if I fail to cancel my appointment with at least 24-hours notice or if I have 2 or more absences in a month, I may lose my standing appointment. I also understand that if I do not reply to a reminder text or message from my therapist reminding me of my next appointment, my lack of response will be considered a cancellation of that appointment.

3. I understand that if my child is sick or has any type of contagious condition, I will need to obtain a Physician's statement indicating the child is no longer contagious or under what conditions my child can continue receiving therapy services. This include symptoms that relate to COVID-19.

4. I agree to notify my Therapist directly or the Therapy office, 417-829-0820, if my child or anyone in my home is ill to decide if Therapy will be held.

5. I agree to keep any distractions to a minimum including phone, television, music, computers, pets, etc.

6. I agree that I and anyone in my home will refrain from smoking during Therapy visits. If not in agreement, I understand that I need to identify an alternate location for Therapy that is smoke free. I understand that if a solution is not found, my Therapist may be unable to provide services.

7. I have received a copy of the Handbook and have read or reviewed the general procedures and information about the Program. The process for the development of the Individual Plan, progress, goals, and objectives has been explained to me. I understand the meaning and content of the Handbook and agree to abide by the general policies and procedures as outlined. I understand who to contact with questions or concerns.

8. The "Rights and Privileges of Those We Serve" is included in the Program Handbook. The Handbook information includes the grievance procedure as well as contact if there is a complaint of physical or verbal abuse, or a violation of any posted rights.

9. I understand that any audio, video or other electronic production of the therapy session is prohibited, unless approved by the Therapist, Parent/Guardian and DCO Privacy Officer who will require an Authorization to Release Protected Health Information form completed and signed, if an outside entity other than the parent. No taping or filming will be permitted in environments where there are unrelated children in attendance.

I understand that failure to comply with any of the above agreement may result in the loss of my scheduled therapy time, being placed on a waiting list, or the requirement to select another provider.

______________________________________ ______________
Parent/Family Signature Date

THE FOLLOWING ARE AGREED TO BY ALL THERAPISTS WORKING WITH THE CHILD NAMED ABOVE:

1. Appointments will be kept as scheduled or you will be notified as soon as possible prior to the appointment about any changes.
2. Direct therapy, screening, or evaluations are based on the IFSP, IEP, or Treatment Plan recommendations.
3. Will wait 10 minutes after the scheduled appointment time, then leave for their next appointment.