DEVELOPMENTAL CENTER OF THE OZARKS
ENROLLMENT
ADULT SERVICES

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 #:**	
Height:	**Weight:**	**Identifying Marks:**	**Hair Color:**	**Eye Color:**
School District: ☐ Springfield R-12 ☐ Other:		**Education:**	**City of Birth:**	
Language Understood:		**Language at home:**		
Mo Health Net #:	**Medicare #:**		**Social Security #:**	
Culture/Ethnicity:	**Race:**		**Religion:**	

Service Coordinator	**VR Counselor**
Name:	**Name:**
Phone:	**Phone:**
Email:	**Email:**

Parent/Guardian/Information

RELATIONSHIP TO INDIVIDUAL	**RELATIONSHIP TO INDIVIDUAL**
☐ **Mother** ☐ **Guardian** ☐ **Father** ☐ **Other:**_____	☐ **Father** ☐ **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 (required):	**E-Mail Address (required):**
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.

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** ☐ **Glasses** ☐ **Hearing Aids** ☐ **Communication Device** ☐ **Other**		

HOSPITAL PREFERENCE (Check Only One)

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

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
ADULT SERVICES AGREEMENT

☐ **Technology & Learning Center** ☐ **Adult Day Center** ☐ **Community Based Learning** ☐ **Employment**

Individual's Name:	**Birthdate:**

REQUESTED SCHEDULE			**REQUESTED CARE**
Monday	**From:**	**To:**	☐ Partial Week
Tuesday	**From:**	**To:**	☐ Full Week
Wednesday	**From:**	**To:**	
Thursday	**From:**	**To:**	
Friday	**From:**	**To:**	

☐ **Initial Agreement**	☐ **Amended Agreement**
Payment Source:	**Rate: $**

AGREEMENTS

1. I understand that the above schedule must be maintained in order to continue services.
2. I understand that the Program Supervisor will schedule a meeting to discuss continued enrollment if the schedule is not maintained. This includes more than 1 occurrence of late pick-ups.
3. I understand that all individuals are enrolled on "trial basis" and that if an individual's needs are greater than the Program can provide. I will be notified of a discharge date.
4. I understand that I am responsible for any charges not covered by MO Health Net (Medicaid) **including Medicaid Spend down.**
5. If Medicaid status is inactive, I understand my services will be suspended until resolved.
6. If I have made Private Pay arrangements, I understand that I am responsible for all charges.
7. I understand I will be billed monthly with any charges for which I am responsible. The due date is upon receipt of bill. If not paid a discharge notice will be issued.

Conditions of Continued Enrollment:	
Transportation has been arranged: ☐ **Yes Source:**	
Start Date:	**Effective Date of Change:**

Individual or Guardian's Signature:	**Date:**
Finance Department's Signature:	**Date:**

DEVELOPMENTAL CENTER OF THE OZARKS
APPLICATION and CONSENT for ADULT SERVICES

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

Name of Individual to Receive Services

☐ **Technology & Learning Center**
- ☐ Day Habilitation (Classroom activities with skills practiced during community activities/trips)
  - ☐ Medical or Behavior Exception (Active and approved Behavior Support Plan)
  - ☐ Group Services

☐ **Community Based Learning**
- ☐ Community Integration (Inclusive activities taking place fully in the Community)
  - ☐ Individual Services
  - ☐ Group Services

☐ **Adult Day Center**
- ☐ Adult Care (Nurse oversight with Dept. of Health Authorization)
  - ☐ Day Habilitation- Medical or Behavior Exception
  - ☐ Group Services

☐ **Employment Services**
- ☐ Community Employment (Vocational Rehabilitation authorization)
- ☐ Supported Employment
  - ☐ (Vocational Rehabilitation authorization)
  - ☐ (Regional Office/Support Coordinator Authorization)
- ☐ ESP-ASD (VR Authorization)
- ☐ Prevocational Volunteer Services (SRO/SC Authorization
- ☐ Benefits Planning

ACKNOWLEDGEMENTS

The Program Handbook and Rights Handout is included in the enrollment information. It includes the Notices of Privacy Practices several Consent and Releases, Grievance Procedure, Rights, etc. 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.

It is important that you review the Handbook and keep it for future reference. 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:

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
COMMUNITY FOOD AND NUTRITION ASSISTANCE (CFNA)
CHILD AND ADULT CARE FOOD PROGRAM (CACFP)

INCOME ELIGIBILITY FORM FOR CHILD CARE CENTERS

To apply for free or reduced-price meal eligibility benefits for your child(ren), please fill out this form and return it to the child care center.

PART 1: CHILDREN ENROLLED AT THE CHILD CARE CENTER

Complete information below for children enrolled at the center. If child(ren) are receiving Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamp) or Temporary Assistance (formerly AFDC, now funded by TANF), complete Parts 1, 3, and 4 only. Complete Parts 1, 2, 3, and 4 if you did not provide a SNAP case number or Temporary Assistance case number **for all of the children listed in Part 1.**

NAME (first and last)	FOSTER CHILD	BIRTH DATE	SNAP CASE NUMBER	TEMPORARY ASSISTANCE CASE NUMBER
		/ /		
		/ /		
		/ /		
		/ /		

PART 2: HOUSEHOLD AND INCOME INFORMATION

List all members of the household not including the children listed in Part 1. Indicate source and amount of current monthly gross income for all members of the household before deductions, such as taxes and social security. Where there are wage earners and self-employed adults, the income of the wage earner cannot be offset by the business losses of the self-employed adult. If last month's income does not accurately reflect your circumstances, you may provide a projection of your current annual income. Irregular self-employed income may be averaged over the prior 12 months. Foster children may be eligible regardless of household income. Contact the center for more information.

INCOME BASED ON (CHECK ONE) ☐ YEARLY ☐ MONTHLY ☐ 2 X A MONTH ☐ EVERY 2 WEEKS ☐ WEEKLY

HOUSEHOLD MEMBERS	GROSS WAGES	WELFARE, CHILD SUPPORT, ALIMONY	PENSIONS, RETIREMENT, SOCIAL SECURITY	OTHER

PART 3: RACIAL ETHNIC INFORMATION (You are not required to answer this section)

Are you of Hispanic or Latino origin? ☐ **YES** ☐ **NO**

What is your race? (Select one or more)

AMERICAN INDIAN OR ALASKA NATIVE	ASIAN	BLACK OR AFRICAN AMERICAN	NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	WHITE
☐	☐	☐	☐	☐

PART 4: SIGNATURE

I hereby certify that all information provided is correct. I understand that this information is being given in connection with the receipt of federal funds, that institution officials may verify information, and that deliberate misrepresentation may subject me to prosecution under applicable state and federal laws.

SIGNATURE OF ADULT FAMILY MEMBER	SOCIAL SECURITY NUMBER (LAST 4 DIGITS ONLY) XXX-XX-	DATE / /
PRINTED NAME OF ADULT	ADDRESS	PHONE NUMBER ( ) -

Section 9 of the National School Lunch Act requires that, unless your children's SNAP or Temporary Assistance case number is provided, you must include the last four digits of a social security number of the adult household member signing the application or indicate that the household member signing the application does not possess a social security number. Provision of the last four digits of a social security number is not mandatory, but if the last four digits of a social security number are not provided or an indication is not made that the signer has none, the application cannot be approved. The social security number may be used to identify the household member in carrying out efforts to verify the accuracy of information stated on the application. These verification efforts may be carried out through program reviews and investigations, and may include contacting employers to determine income, contacting a SNAP or welfare office to determine current certification for receipt of SNAP or Temporary Assistance benefits, contacting the State employment security office to determine the amount of benefits received and checking the documentation produced by the household member to provide the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal actions if incorrect information is reported.

FOR CENTER USE ONLY

TOTAL HOUSEHOLD SIZE:	INCOME:	INCOME BASED ON (CHECK ONE): YEAR ❑	MONTH ❑	2 X A MONTH ❑	EVERY 2 WEEKS ❑	WEEKLY ❑	SNAP (Food Stamp) ❑	TEMPORARY ASSISTANCE ❑

Eligibility Determination: ❑ Free ❑ Reduced ❑ Paid

SIGNATURE OF CENTER REPRESENTATIVE	DATE

DEVELOPMENTAL CENTER OF THE OZARKS
HISTORY AND INDIVIDUAL INFORMATION

(Adult Services)

Name of Individual to Receive Services:
Residence: ☐ Own home ☐ With Parent/guardian ☐ Residential (ISL) ☐ Other:

Culture/Ethnicity:(family culture, beliefs, ethnic, important to you and/or individual to receive service)

Immediate Family

Name	**Relationship**	**Age**

Medical & Health Information

Yes	No		Yes	No	
☐	☐	Exposure to Tobacco/secondhand smoke	☐	☐	Concerns with Hearing: _____
☐	☐	History of use of tobacco/tobacco products	☐	☐	Uses a Walker
☐	☐	History of use of alcohol	☐	☐	Recent Falls/Injuries: _____
☐	☐	History of use of drugs	☐	☐	Uses a Wheel Chair
☐	☐	Seizures/Epilepsy	☐	☐	Heart Disease or Condition: _____
☐	☐	Assistive/Protective Devices: _____	☐	☐	Medication Reactions: _____
☐	☐	Concerns with vision:_____	☐	☐	Diabetes Treatment: _____
☐	☐	Allergies: _____			

EDUCATION/VOCATIONAL TRAINING HISTORY

Level of Education	☐ Elementary School ☐ High School ☐ GED ☐ College

PREVIOUS PROGRAM/SERVICE EXPERIENCES

What type Program:	
Still Attending? ☐ Yes ☐ No	If not, Why?

Any other information which would help us understand the person to receive services:

_____ Date: _____

Signature of Person completing form

DEVELOPMENTAL CENTER OF THE OZARKS
ADULT PHYSICAL EXAMINATION

Individual's Name:		Date of Birth:
Address:		
Medical/Physical/Psychological Diagnosis:		
Physical Findings:	Height:	Weight:

	Normal	Abnormal	Comments
Head/Eyes			
Impression of Vision			
Ears			
Impression of Hearing			
Nose			
Throat			
Lungs			
Heart			
Breasts			
Abdomen			

NEUROLOGICAL	
MOTOR:	Tone
	Gait
	Strength
	Reflexes

LABORATORY RESULTS TB Testing (Reading **MUST** be marked.)			
Date Given:	Date Read:	☐ Negative	☐ Positive
Results of others as recommended by physician:			

IMMUNIZATION RECORD Booster	Date	Date	Date	Booster
DT/DTaP				
HEPATITIS A				
HEPATITIS B				
HPV				
INFLUENZA				
MMR				
PNEUMOCCAL				
SHINGLES				
VARICELLA				
MENINGOCOCCAL CONJUGATE				
Covid Vaccine				

PHYSICAL EXAMINATION
Page 2

Individual's Name:	Date of Birth:

RECOMMENDATION(S)	**SPECIFIC ORDERS**
☐ Assistive/Supportive Equipment	
☐ Special/Restricted Diet Orders	
☐ Food Allergies	
☐ Medication Allergies	
☐ Other Allergies	
Specialized Treatments *(Please describe & attach a protocol if appropriate.)*	

NOTE: The following information MUST be completed for enrollment.
(This sections does not act as an exemption for TB test)

The above named individual is free from communicable disease/condition: ☐ Yes ☐ No
If "Not Free of Communicable Conditions", please indicate the circumstances under which the individual would be considered "Free of Communicable Conditions" and could attend program activities.

ANY PROGRAM OR ACTIVITY LIMITATIONS/RESTRICTIONS *(Please be aware that the individual may be participating in a group setting.)*

Additional Comments:

Physician's Signature:	**Physician's Stamp:**	**Date:**
MO HealthNet Provider Number:		

PLEASE ATTACH CURRENT SIGNED PHYSICIAN'S ORDERS

DCO Adult Services Fax: (417) 831-0901

DEVELOPMENTAL CENTER OF THE OZARKS

AUTHORIZATION TO PICK UP INDIVIDUALS

NAME: _____BIRTHDATE: _____

ADDITIONAL PERSONS AUTHORIZED TO PICK UP:

1. _____ 3. _____

2. _____ 4. _____

5. _____ 6. _____

The following individuals **DO NOT**** have authorization to pick up the above-named person:
Legal documentation must be attached if restricting biological parents or parent of record.

1. _____

2. _____

3. _____

****NOTE:** If the above individual(s) is one of the parents or legal guardian, we must have appropriate documentation, such as a court approved visiting restriction, restraining order, or other legal document, to prevent contact or picking up. If the individual(s) does indicate the desire to leave, DCO staff will attempt to prevent them from leaving while another staff calls you and/or 911.

Unless notified otherwise, our staff will allow the above named individual(s) to leave with and/or have contact with their Service/Support Coordinator, Case Worker, Residential Staff (if applicable), and immediate family members.

_____	_____	_____
Relationship	Legally Responsible Person	Date

_____	_____
Caseworker	Service/Support Coordinator

NOTE: No individual will be voluntarily released to an authorized person who is obviously incapacitated due to alcohol, substance abuse, or mental condition. If the authorized person insists on picking up the individual served, staff will immediately contact 911 to report the incident.

DEVELOPMENTAL CENTER OF THE OZARKS
MEDIA and INFORMATION RELEASE – AUTHORIZATION

DCO has several media events each year in which we highlight individuals attending our Programs. If you authorize the use of pictures or video, you have the right to revoke the authorization at any time by completing the bottom portion of this form and sending it to the Privacy Officer at the above address. We are also expanding our services to conduct them virtually. This release will also give permission for our individuals to participate in those activities depending on program**.** Actions already taken based on this authorization, prior to revocation will **not** be affected. Services are in no way affected by the authorization of this release.

MEDIA RELEASE

Events where pictures/photographs/video may include:

1. Annual Report – published one (1) time annually to individuals, families, and donors.
2. Brochures – used to highlight the Agency services and/or specific Programs. Distributed to those having an interest, touring the Program, or inquiring about services.
3. Annual Campaign Letter – annual letter announcing the new year for contributions to donors, foundations and other contributors.
4. Pictures taken for the above reasons may be used on the DCO website/social media depicting the appropriate Program.
5. Numerous marketing and fundraising efforts take place annually which support all DCO Programs.
6. Public Service Announcements and video for news reports/articles may include videotaping of you, son, daughter, or ward interactions in a specific Program and/or activity. It may be used in conjunction with a special event or to provide information about the Developmental Center and its Programs.
7. Virtual services conducted via Zoom or another platform. These will not be recorded and will offer live interaction.

☐ Yes, you have permission to send me information through email, text, video, voice mail, fax and phone.
☐ No, you do not have permission to send me information through email, text, video, voice mail, fax and phone.

☐ Yes, you have permission to take and use pictures for the specific purposes listed above including DCO's social media accounts.
☐ No, you do not have permission to take or use pictures.

This Authorization is good for one (1) year from the date signed below unless revoked by the legally responsible party. Please indicate below and return this release if we have permission to include pictures. If you do not return this release, we will **not include** yourself, son, daughter, or ward in the event.

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.

Name of Individual: _____

Signature of Legal Representative: _____ Date: _____

Privacy Officer: _____ Date: _____

NOTICE OF REVOCATION

I, _____ (Individual or Legal Representative) hereby revoke my authorization of this disclosure of information. This revocation effectively makes null and void any permission for disclosure of information expressly given by the above authorization. I understand that any actions based on this authorization, prior to revocation, will not be affected. I also understand that I can revoke my approval at any time in the future if I communicate in writing to the Program Coordinator or Secretary.

Signature of Legal Representative: _____ Date: _____

Signature of Privacy Officer (acknowledging revocation): _____ Date: _____