**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**<br>☐ **Father** ☐ **Other:**_____ | ☐ **Father** ☐ **Guardian**<br>☐ **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**<br>**Alternate Phone:** ☐ **Cell** ☐ **Home** ☐ **Message** | **Primary Phone:** ☐ **Cell** ☐ **Home** ☐ **Message**<br>**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<br>☐ Mercy, 1235 E. Cherokee, Spfld, MO (417) 820-2000<br>☐ Other: | **Comments** |

**I authorize DCO staff to be able to communicate using any contact information given in the <u>Parent/Guardian</u> and/or <u>Daycare</u> 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 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:** |

**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
# 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<br>TB Testing (Reading **MUST** be marked.) | | | |
|---|---|---|---|
| Date Given: | Date Read: | ☐ Negative | ☐ Positive |
| Results of others as recommended by physician: | | | |

| IMMUNIZATION RECORD<br>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**
**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: _____

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**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: _____

**DEVELOPMENTAL CENTER OF THE OZARKS**
**SUPPORTED EMPLOYMENT**
**INITIAL ASSESSMENT INTERVIEW**

Name: _____ Date: _____ Birthdate: _____

**Are the following available?**

SS Card: ☐ Yes ☐ No Missouri ID Card: ☐ Yes ☐ No Drivers License: ☐ Yes ☐ No

Why do you want to get a job at this time?

Do you have any experience? What past jobs/volunteer have you had? Why did those jobs end?

What are your interests in terms of a job? (Reading Free Interest Inventory used if individual cannot read or express interests clearly.) What is your dream job? Are there any jobs you don't want to do?

How are you planning to get to your job (transportation)? Do you have a back up plan? (If so, what is your back up plan?

Who provides support to you (family, group home, staff, neighbors, church etc.)?

How much Social Security do you receive each month? Who is the payee? What other income/benefits (food stamps, rent assistance, etc.) do you receive?



SE 1 12/89, 5/90, 11/90, 1/94, 10/96, 10/00, 9/01, 10/02, 2/08, 1/09, 1/10, 1/12, 1/13, 1/14**,** 1/15, 2/18, **1/19**

What is the highest level of education you have reached? What was your best subject in school?

How many hours a week are you wanting to work? At what hours during the day are you at your best? Are there any days or hours you cannot work?

Do you have any adaptive equipment needs, environmental accommodation needs, or health needs which would impact your availability for work? Are you able to lift? If so, please describe them.

Can you do simple math? Give me an example.

Are you comfortable working with money? Give me an example.

What do you like to read?

What computer skills do you have?

What do you do on an average day?

What time do you get up in the AM and go to sleep?

What office equipment can you use (fax, copier, calculator, etc)

Do you prefer working indoor or outdoors? Explain why.

Signature Title Date



SE 1 12/89, 5/90, 11/90, 1/94, 10/96, 10/00, 9/01, 10/02, 2/08, 1/09, 1/10, 1/12, 1/13, 1/14**,** 1/15, 2/18, **1/19**