CLUBHOUSE For Special Needs, Inc.

Fun & Fellowship

For the mild to moderate mentally/ physically challenged teenagers and young adults.

Application Date

Office Use:

New Member Application

EMAIL: _____

YOUNG PERSON'S NAME: **PHONE:**

ADDRESS:

CITY: STATE: ZIP CODE:

AGE:_____ SEX: _____ DATE OF BIRTH:_____ SS #: __ __ __ __ (first 4 digits)

Diagnosis _____ MILD ___ MODERATE ___ SEVERE ___ PROFOUND ___

Allergies/Medications _____

MEDICATIONS TAKEN, WHEN and FOR WHAT: _____

Seizures ____YES ____ NO Need Assistance with: _____

Preferred doctor: Name _____ Phone:_____

Hospital preferred _____ Location _____ Phone _____

Medicaid Waiver: __ HCS __TxHmL __CLASS ___ DBMD ___STAR+PLUS ___MDCP ___ YES

Agency: _____Phone:_____

Service Coordinator_____Email:_____

NAME OF SCHOOL: CITY: Grade:

SERVICES REQUESTED:

_____ After-School Program _____ Spring/Winter Break _____ Summer Program
_____ All-Day Program _____ Other _____

PARENT/GUARDIAN NAME:

ADDRESS: CITY: ZIP:

PHONE:

NAME OF PERSONS TO CALL IN CASE YOU CANNOT BE REACHED IN AN EMERGENCY:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

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AUTHORIZED TO PICK UP MEMBER

(Please Note: If the person is not on this list, the staff cannot release your member to them. This is for your Young Person's protection)

Please note that if you do not pick your member up by the time allotted and we are unable to reach any of the three names below, our staff is instructed to call the local police department.

PLEASE PRINT

Name	Phone:	Driver's License #:
Name	Phone:	Driver's License #:

Name	Phone:	Driver's License #:
Name	Phone:	Driver's License #:

HEALTH HIS TORY

Has Child Had	Yes	No	Date
Measles			
Mumps			
Chicken Pox			
Frequent Bed Wetting			
Urinary Tract Infections			
Rheumatic Fever			
Hospitalization			
Frequent Colds			
Hepatitis			
Frequent earaches or infection			

All Shots Are Current:

____ YES

____ NO

PERMSISION TO CONTACT PREVIOUS PROVIDERS

I, _____ give "**The Clubhouse for Special Needs, Inc.**" permission to contact my young person's previous providers/ case managers/ caregiver/ group homes etc. to gain insight to behaviors and needs. I understand that precautions will be taken to ensure the confidentiality of my child/adult personal information.

_____ _____ _____

Young Person's name Parent/Guardian signature Date

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SERVICES HISTORY

Provider Name		**Date Started**	
Address		**Date Left**	
Company Phone		**Coordinator/ Contact**	
Ext.		**Email**	
Service Provided		**Cell Phone**	
Reason for Leaving			

Provider Name		**Date Started**	
Address		**Date Left**	
Company Phone		**Coordinator/ Contact**	
Ext.		**Email**	
Service Provided		**Cell Phone**	
Reason for Leaving			

Provider Name		**Date Started**	
Address		**Date Left**	
Company Phone		**Coordinator/ Contact**	
Ext.		**Email**	
Service Provided		**Cell Phone**	
Reason for Leaving			

Provider Name		**Date Started**	
Address		**Date Left**	
Company Phone		**Coordinator/ Contact**	
Ext.		**Email**	
Service Provided		**Cell Phone**	
Reason for Leaving			

Provider Name		**Date Started**	
Address		**Date Left**	
Company Phone		**Coordinator/ Contact**	
Ext.		**Email**	
Service Provided		**Cell Phone**	
Reason for Leaving			

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PHOTO/NAME PERMISSION SLIP

I, _____ give "**The Clubhouse for Special Needs, Inc.**" permission to use my Young Person's name/photo in their brochure, mailings or other advertisements for The Clubhouse.

_____ _____ _____

Young Person's name Parent/Guardian signature Date

TRANSPORT PERMSISION SLIP

I, _____ give "**The Clubhouse for Special Needs, Inc.**" permission to transport my young person on excursions, errands, or other planned field trips to off campus activities. I understand that precautions will be taken to ensure the safety and health of my child/adult.

_____ _____ _____

Young Person's name Parent/Guardian signature Date

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Notice of HIPAA Privacy

By signing below I acknowledge that _____'s records are protected, whether oral or written – according to HIPPA Privacy rules. All information is private and confidential and The Clubhouse for Special Needs, Inc. is obligated to safeguard all consumer related information according to the Health Insurance Portability and Accountability Act of 1996.

_____ _____
Signature Date

_____ _____
Witness Date

LIABILITY DISCLAIMER

The Clubhouse for Special Needs, Inc. performs background checks on ALL staff and volunteers. While your young person is in our care, whether in our facility or on field trips, **The Clubhouse for Special Needs** is dedicated to provide a safe place. When the director is not present, there is always two staff assigned. This helps in eliminating any misconduct or abuse.

We realize that relationships are formed between staff, clients and families and often these relationships are not limited to within The Clubhouse and its activities.

By signing below I [parent/guardian] fully understand that:

1. The Clubhouse for Special Needs is NOT responsible or liable for any agreements between staff/ young person /parent, i.e. Picking up to bring to The Clubhouse or to take home. The only exception to this is if and only if it was made through the Director.
2. The Clubhouse for Special Needs is NOT responsible or liable for any agreements between staff/ young person /parent that is not a part of The Clubhouse activities.
3. When a parent/guardian is present, liability is upon that parent/guardian and not upon The Clubhouse.

Young Person's name _____

Parent/Guardian Signature_____ Date: _____

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ORIENTATION GUIDELINES

Mission Statement: to provide a safe and fun place for teens and young adults with intellectual / physical challenges – an opportunity for education, socialization and independence in a recreational atmosphere.

Medicine - Because of liability issues, we **DO NOT** dispense any medications. If your young person needs medications during his/her stay here, you must come and dispense them. - The young person is **never** to have medications (over the counter or otherwise) on them or in their backpack.

Personal Hygiene: Client must be able to handle their bathroom needs 100%. Any exception will need to be in writing and special rules may apply. Clubhouse **Does Not Assist** clients with their bathroom needs. Client or Parent/ Guardian is responsible for client hygiene issues. Non-compliance may result in client dismissal.

Behavior: Client should not to display aggression to themselves, others or property nor have behavior that is distressing to existing population. Non-compliance may result in Client dismissal.

Drop-off and pickup: It is your responsibility to make drop-off and pickup arrangements of your young person. This is not our responsibility. **Please** never leave without making sure they inside the building. If your young person is able to sign themselves in then you do not need to come in. **PICKUP** You do need to come in so we see who is picking them up also we may have information to give you or need to discuss something with you.
Doors open at 8:00 am (not 7:59 am). Please be aware that staff may be here early to get ready for the day. Please don't ask to be let in early.
Day ends at 6:00 pm (not 6:01 pm). If you are going to be later than 6:00 pm **please** have a plan B in place. Some of our staff are here for 8-10 hours and would like to go home. We understand circumstances may cause you to be late. PLEASE call to let us know are running late or someone else is picking up your young person. Continued tardiness may result in client dismissal.
NOTE: If you pick-up your young person immediately at the time school bus drops them off, Be sure to sign them in and then immediately sign them out. We must have a record of the school dropping them off.

Personal Items - Any items brought to The Clubhouse should have your young person's name on it. That includes clothing, video games, DVDs, VHSs, books, toys of any kind, etc. Clubhouse is not responsible for lost or stolen items. Guardian needs to provide a change of clothing in case of an accident. It is Clubhouse preference that client leave all devices at home, if possible.

Discipline First offense [depending on severity] the young person is reminded that "we do not do that here." Second offense [depending on severity] the young person is sent to office and privileges taken away. Third offense [depending on severity] the young person is put on probations and subject to discharge from our program. Continued issues may result in client dismissal.

Tuition Payments - Payments are due on the 1st of the month. However, if this is not possible for whatever reason, you will need to make arrangements with the office and have exception in writing. There is $25 late fee if payment is not receive by 7th of the month. Failure to pay tuition may result in client dismissal.

The Clubhouse for Special Needs is a nonprofit and we hope you will participate in our fundraiser opportunities (which so we can stay open for your young person). We are here for you and your young person. These guidelines are designed to keep your young person safe as well as for the safety of everyone else.

The Clubhouse reserves to right to refuse service for unforeseen reasons not listed above. These guidelines are subject to change without notice.

I have read and agree to follow these guideline and that my young person fits the above criteria.

_____ _____

Name ***Date***

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NAME _____

Observation: [Physical, mental, social, independence levels]

Goals

Observations/Goals performed by: _____ Date _____

Clubhouse for Special Needs, Inc. ♦ *1390 N. Main, #2912* ♦ *Euless, Texas 76039* ♦ *817-835-0446*

"... exceedingly, abundantly above all we ask or think."

The Clubhouse admits anyone regardless of race, color, and national or ethnic origin. ***A MHMRTC Contracted Provider***

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AUTHORIZATION FOR MEDICAL TREATMENT

Young Person's name DOB Allergies/Special Conditions

_____ _____ _____

_____ _____ _____

I, being the parent or legal guardian of the above named student of The Clubhouse for Special Needs do hereby appoint the staff of The Clubhouse for Special Needs to act in my behalf in authorizing unexpected medical care and hospitalization for the above named Young Person during the period of my absence.

This document shall be presented to the physician or appropriate hospital representative at such time as unexpected medical or surgical care or hospitalization may be required.

_____

Parent/Guardian Signature

HOSPITALIZATION COVERAGE FOR THE ABOVE NAMED INSURED YOUNG PERSON

_____ _____

INSURANCE COMPANY/ GOV'T PROGRAM I.D. OR CONTRACT #

_____ _____

FAMILY PHYSICIAN PHONE#

This document must be notarized

STATE OF TEXAS
COUNTY OF DALLAS

SUBSCRIBED AND SWORN TO BEFORE ME, A NOTARY PUBLIC IN AND FOR TARRANT COUNTY, TEXAS, THIS THE _____ DAY OF _____ 20____.

MY COMMISSION EXPIRES

_____ _____

Date Witness