New Client Application Form

Applications are needed before attending Columbia Ability Alliance's Community Center for the first time.

Please indicate you anticipated schedule: ☐ Check here for drop-in status.

	Monday	Tuesday	Wednesday	Thursday	Friday
AM Session: 9:00 AM -12:00 PM	☐	☐	☐	☐	☐
PM Session: 12:00 PM - 3:00 PM	☐	☐	☐	☐	☐

Applicant's Information

Applicant Name: _____

Applicant's Physical Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone #: _____ **Cell Phone #:** _____

Birth Date: _____ *(Applicant must be 18 or older)* **Sex:** ☐ Male ☐ Female

E-mail: _____

Responsible Billing Party

Person Responsible for Billing: _____

Relation to Applicant: _____ **Home Phone #:** _____

Address: _____ **Cell Phone #:** _____

City: _____ **State:** _____ **Zip Code:** _____

E-mail: _____

Emergency Contact Information

Please list two emergency contacts in case one is unavailable.

1st Emergency Contact: _____ **Relation to Applicant:** _____

Home Phone #: _____ **Cell Phone #:** _____

1st Emergency Contact: _____ **Relation to Applicant:** _____

Home Phone #: _____ **Cell Phone #:** _____

Case Manager Name: _____

Home Phone #: _____ **Cell Phone #:** _____

Medical Information

Applicant's Doctor's Name: _____

☐ Please check if applicant can be taken to the nearest hospital in case of emergency.

Hospital Preference: _____

Medications: *(Please provide dosage, i.e. Vitamin C 200mg)*

_____

_____

_____

Will member be taking medications while attending the center? ☐ **Yes** ☐ **No**

If yes, do they require assistance? _____

Allergies: ☐ No Known Allergies ☐ Seasonal ☐ Bee Stings ☐ Peanuts

Other Allergies: _____

Does the applicant currently have a behavior plan in place? ☐ Yes ☐ No

If "yes" please provide a copy with your application.

Please State Primary Disability: _____

Medical Information (Continued)

Please Rate the Categories of Capabilities Below on a Scale of 1 - 5. (5 Being Most Independent)

☐ Initiate Activities	☐ Verbal Communication	☐ Uses sign/gestures
☐ Relates to Others	☐ Sexually Appropriate	☐ Eating/Drinking
☐ Clean and Orderly	☐ Needs Prompts/Reminders	☐ Aware of Personal Space
☐ Walking	☐ Controls Anger/Emotions	☐ Help with Toileting
☐ Receptive Communication	☐ Repsects Property of Others	☐ Can Follow Directions

Please check all disabilities and/or medical conditions that apply. Please explain if marked.

☐ Hearing ☐ Vision ☐ Diabetes ☐ Developmental ☐ Learning/ADD

☐ Dementia ☐ Seizures - Controlled *(Yes/No: If Yes, How?)* _____

☐ Heart Condition ☐ Fine Motor Skills ☐ Gross Motor Skills ☐ Uses Wheelchair

☐ Mental Illness ☐ Physical Limitations ☐ Medical Issues

_____

Other Pertinent Medical Information: _____

_____

_____

Racial/Ethnic Background

The Following Information is Voluntary. *(Please Check All that Apply)*

☐ Black/African American ☐ White/Caucasian ☐ Asian/Pacific Islander ☐ Hispanic

☐ American Indian ☐ Alaska Native ☐ Other: _____

Additional Questions

1. List specific favorite activities or other interests (puzzles, bowling, computers, art music, etc.).

_____

_____

2. What goals does the member have while participating in at the Community Center?

_____

_____

3. Which individuals and/or organizations have permission to provide transportation services for you?
(e.g., The Arc, public transit, Dial-a-Ride…. for individuals, please state relationship)

_____

_____

Community Center Philosophy

- **We believe that the rights and responsibilities of personal choice belong to all people with or without disabilities.**
- **We encourage those at the Center to choose and direct their own activities as much as possible.**
- **We provide staff to assist members in choosing healthy, safe, creative, and appropriate activities within the Center and our communities.**

Community Center Membership Guidelines

1. **Membership Eligibility & Application:** Applications may be returned in person or by mail. Eligibility will be determined on age (High School 16+) submission of a completed application, a commitment to the center Rights and Responsibilities, and the general level of support required. A personal tour of the Center is required prior to participation to determine the appropriateness of membership, and continuing participation requires the payment of all member fees as outlined in #3.
2. **Application Review:** The Community Center Manager and Activity Supervisor will review applications as promptly as possible to determine if we can effectively support the applicant in our program. To ensure a successful, on-going relationship, the Center Manager will periodically review our ability to support each individual member. If it is determined that the Center can't support a member, that individual will not be able to continue to attend sessions at the Center.
3. **Payment of Fees:** The Center offers two half-day sessions, one morning session (9-12), and one afternoon session (12-3). If you attend for a full day, you will be billed for two sessions. Attendance fees are billed the beginning of the month for the previous month's attendance. Payment is due within 10 days of invoice date. Late payment notices are written on current invoice each month.

Community Center Membership Guidelines (Continued)

Payment should be sent or taken to Columbia Ability Alliance's main office at 900 S. Dayton St., Kennewick, WA 99336. When an invoice becomes 60 days late, a notice will be sent suspending the member's attendance until the account is paid in full. Fees are set-up in the following categories:

Number of Monthly Sessions Attended	Fees
Respite Services	$30.00 / Session
Private Pay	$20.00 / Session

4. **Member Responsibility:** Participants need to act in an appropriate manner. This includes, but is not limited to: showing respect and consideration for each participant and staff member, following staff instructions, managing anger, respecting others' personal property, etc. The Center is not equipped to resolve severe behavioral issues. Therefore, if a member has behavioral issues that are highly irritating to others or is violent towards himself/herself or others, he or she will not be allowed to continue membership with the Center. Any member can be sent home immediately if they have inappropriate behavior that cannot be managed on-site. Immediate dismissal will occur with any act of violence.
5. **Supervision:** The ratio of participants to staff can vary. We cannot provide one-on-one supervision at any time. Anyone requiring this level of supervision to maintain safe and respectful behavior will not be able to participate in our Center's program.
6. **Personal Assistance:** Columbia Ability Alliance staff will provide on-going personal assistance except for the following:
   - Administering medications.
   - Providing full toileting assistance.

   We will assist people with food prep, including cutting fruits, vegetables, sandwiches, opening snacks, dressing, and undressing (coats, hats, gloves, etc.) and other personal care routines. With minimal assistance in the rest room such as buttoning and unbuttoning pants, hand washing and hygiene. Personal assistance onto van for transportation and on community outings will be provided. Center staff will offer verbal prompts and reminders. Physical redirection will be used only to prevent immediate danger from occurring.
7. **Emergencies:** In the event of an emergency, the Center will follow standard first-aid and CPR procedures, and then contact the home-site as soon as possible. For non-911 emergencies, the home provider will be expected to pick the person up within 30 minutes, therefore, it is imperative that we have a working emergency number in each member's file.
8. **Participation:** We provide a variety of activities each day and encourage all members to participate. Those who choose not to participate will be allowed to find their own productive activities. Any activity that is limited to a certain number of people will be offered on a first come, first serve basis. Some outings may cost additional money as noted on the quarterly calendar. For members who regularly choose not to participate in Center activities, we recommend that the member's care provider have the member bring something from home that the member would enjoy doing.
9. **Transportation:** Rides to and from the Center must be arranged by the participant or provider and must coincide with session times. The official session times are 9:00 – 12:00 and 12:00 – 3:00. Arrival and departure from the Center should be within 15 minutes of noted times. Non-compliance of this will result in an additional fee of $5 per 15 minutes for any additional supervision unless non-compliance is the result of The Arc or Dial-a-Ride transportation delay.

Thank you for considering the Community Ability Alliance: Community Center!

If you have any questions or need further assistance with this application, please contact us at 509.582.4142 extension 1201. Please return this application to:

Columbia Ability Alliance: Community Center
900 S. Dayton St.
Kennewick, WA 99336

Fax: 509.586.3825

To the best of my knowledge, I affirm the above is true. I have read, understood, and agree to the Community Center's Membership Guidelines in this document and the Rights and Responsibilities attached to this application. I accept full responsibility for my participation on any equipment, or as a passenger in any vehicle, operated by Columbia Ability Alliance or its staff. I accept full responsibility for payment of Columbia Ability Alliance: Community Center fees.

If any of the information required in this application changes, I will notify Columbia Ability Alliance: Community Center staff as soon as possible at 509.582.4142. If I fail to do so, I understand that it may affect the Community Center's ability to safely serve me.

Applicant Signature: _____ Date: _____

Home Provider/Guardian/Parent Signature: _____ Date: _____

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Rights and Responsibilities

I have the **RIGHT** to make my own choices.
I have the **RESPONSIBILITY** to make choices that will not hurt me, others, or property that does not belong to me.

I have the **RIGHT** to participate in the activities I choose.
I have the **RESPONSIBILITY** to choose activities that are not already filled and are currently being offered.

I have the **RIGHT** to express my feelings.
I have the **RESPONSIBILTY** to express myself in a way that does not harm anyone or anything.

I have the **RIGHT** to be angry.
I have the **RESPONSIBILITY** to express my anger in a calm voice, or to go away from others until I can do this.

I have the **RIGHT** to interact (do things) with other people.
I have the **RESPONSIBILITY** to treat them with respect, and to make sure they want to do things with me.

I have the **RIGHT** to do things when I want.
I have the **RESPONSIBILTY** to make sure I am ready to go when the activity starts, or when my ride comes to pick me up.

I have the **RIGHT** to bring things to the center with me.
I have the **RESPONSIBILTY** to keep track of these things and to keep them out of the way of other people.

I have the **RIGHT** to use any and public rooms in the Center.
I have the **RESPONSIBILTY** to ask before using any offices, storerooms, or locked places.

I have the **RIGHT** to use anything that belongs to the Center members.
I have the **RESPONSIBILITY** to keep these things in good shape, to put them away when I am finished, and to share them with anyone else who wants to use them.

I have the **RIGHT** to ask Center staff for help and attention.
I have the **RESPONSIBILTY** to ask in a nice way, and to let them help others as well.

I agree that these are my rights and responsibilities and that I will follow them to the best of my ability at all times.

Name: _____ Date: _____

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PERSONAL/EMERGENCY INFORMATION

Participant: _____ **DOB:** _____ **DDA Case Manager:** _____

Address: _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Emergency Contact: _____ **Legal Guardian:** _____ Yes _____ No

Emergency Contact Address: _____ **Emergency Contact Email:** _____

Transportation: _____ **Phone:** _____

Physician: _____ **Phone:** _____

Disability/Limitation: _____

Preferred Activities: _____

Behavioral Concerns: _____

Medications: _____

Allergies: _____

Hours Allotted Per Month: _____

Referral Source: _____

Service (Funding): ☐ DDA ☐ DVR ☐ IL ☐ Recreational ☐ Private Pay

Media Release: I, the undersigned, give permission to Columbia Ability Alliance to use photographs, videos, and/or audio recordings of me/the participant for promotional purposes. This may include but is not limited to, social media, newsletters, brochures, website content, and other marketing or public relations materials.

☐ Yes, I consent to media use as described above. ☐ No, I do not consent to media use.

Name of Participant: _____ **Name of Legal Guardian (if applicable):** _____

Signature: _____ **Date:** _____

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MEDIA RELEASE FORM

I, _____ , hereby consent to the photographing of myself and to the recording of my voice by Columbia Ability Alliance. I understand that the organization may use or cause to be used said still photographs or motion picture footage, recordings of my voice for advertising, publicity, commercial, or other business purposes, including but not limited to social media. Said photographs and/or recordings may be used singularly or in conjunction with other photographs and/or recordings.

I authorize Columbia Ability Alliance to reproduce or cause to be reproduced and used such photographs and voice recordings. I understand that these materials may be exhibited in all domestic and foreign markets. I acknowledge that others may use and/or reproduce said photographs and/or recordings with or without Columbia Ability Alliance's consent.

By signing this release, I hereby release Columbia Ability Alliance, its associated or affiliated companies, their directors, officers, agents, employees, customers, and any appointed advertising agencies, officers, directors, agents, and employees, from all claims of any kind on account of such use.

_____ I grant permission for Columbia Ability Alliance to use my picture and/or voice in any form of media as described above.

_____ I do not grant permission for Columbia Ability Alliance to use my picture and/or voice in any form of media.

I understand that this release will supersede any previous releases on file.

_____ _____

Participant's Signature Date

_____ _____

Parent or Guardian's Signature Date

_____ _____

Columbia Ability Alliance Staff Date

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CONSENT FOR MUTUAL EXCHANGE OF INFORMATION

Participant Name: _____

I authorize Columbia Ability Alliance to obtain from or release to the below-identified agencies information concerning:

- Budgeting and financial records
- Medical diagnostic and treatment records
- Psychiatric diagnostic and treatment records
- Counseling and treatment records
- Employment history, job application, resumes and work restrictions
- Rehabilitation plan and treatment records

I understand this form will be valid for 1 year after signing.

I also understand that I have a right to review and receive a copy of any records shared by Columbia Ability Alliance with another agency and that I may revoke this release through written notification to Columbia Ability Alliance, however, any information released before that revocation cannot be retrieved.

List of Agencies I authorize Columbia Ability Alliance to share information/records:

_____ ARC of Tri-Cities (transportation)

_____ Ben Franklin Transit (transportation)

_____ B/F Dept. of Human Services (County)

_____ Developmental Disabilities Administration (DDA)

_____ Division of Vocation Rehabilitation (DVR)

_____ Mental Health Provider

_____ Residential Provider

_____ Substance Abuse Provider

_____ Department of Services for the Blind (DSB)

_____ Parents/Family

_____ School District

_____ Background Check

_____ Other: CARF

_____ Other: NISH

_____ Other: _____

Comments: _____

_____ _____

Participant's Signature Date

_____ _____

Parent or Guardian's Signature Date

_____ _____

Columbia Ability Alliance Staff Date

CI SUPPORT, LLC, PARENT COMPANY CI SUPPORT, LLC

Disclosure and Authorization Regarding Procurement of Background Reports

In connection with employment (including contract for services), I understand that investigative background inquiries are to be made which include the (WSP), Washington State Patrol Background Check, DSHS Background Check, and Background Source International. I understand that you will be requesting information regarding any criminal background and/or any criminal convictions I may have. I am being allowed to disclose any information and authorize the (WSP), Washington State Patrol Background Check, DSHS Background Check, and Background Source International Check to be run by CI Support, LLC, parent company Columbia Industries as per yearly (WSP) and every three-year, (DSHS Background Check) contract requirements. In addition, background checks may be conducted on prospective employees, volunteers, or adoptive parents who will be or may have unsupervised access to children less than 16 years of age, developmentally disabled persons, or vulnerable adults. The (WSP) Washington State Patrol Background check, DSHS Background Checks, and Background Source International Checks are used for initial employment decisions and are done regularly per contract. The revised code of Washington (RCW) 43.43.830-43.43.845 gives complete information as to the law. Child/Adult Abuse Information Act background checks may be conducted by Washington State businesses or organizations.

1. I have been convicted of a crime: _____ Yes _____ No
   Please explain what crime and the circumstances:

2. I have had findings made against me for a civil adjudicative proceeding: _____ Yes _____ No
   Please explain:

3. I have had both a conviction and findings made against me: _____ Yes _____ No

You will be notified of the findings of the Washington State Patrol Background results within 10 days of their return.

Please print and then sign your full name with the middle initial below:

_____	_____	_____	_____
First name	Middle Initial	Last Name	Date

_____ _____

Full Name Including Middle Initial Signature Date of Birth

_____ _____

Parent or Guardian's Signature Date