



## NEXUS YOUTH CLUB APPLICATION

This application must be completed prior to participating in our program.

Please indicate you anticipated schedule:

	Monday	Tuesday	Wednesday	Thursday	Friday
<b>Afternoon Session:</b> 3:00 PM - 6:00 PM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Nexus Attendance Policy:** In the event that you are unable to attend on one of your scheduled days you must give staff a 24-hour notice. If you miss three (3) days without giving a 24-hour notice your position will be reassigned to another person on the wait list and you will be returned to the bottom of the wait list.

I acknowledge that I have read and understand the Nexus Attendance Policy.

### APPLICANT INFORMATION

Applicant Name: \_\_\_\_\_

Full Physical Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Email: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Sex:  Male  Female

Shirt Size: \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

### RESPONSIBLE BILLING PARTY

Person Responsible for Billing: \_\_\_\_\_

Relation to Applicant: \_\_\_\_\_ Phone #: \_\_\_\_\_

Full Address: \_\_\_\_\_

E-mail: \_\_\_\_\_

### DEMOGRAPHIC INFORMATION

The following question is voluntary and is used to help us better understand and serve our community.

Please select all that apply.

White   
  Black or African American   
  Hispanic or Latino/a/e   
  Asian  
 Native Hawaiian or Other Pacific Islander   
  American Indian or Alaska Native  
 Prefer to Self-Describe: \_\_\_\_\_

## EMERGENCY CONTACT INFORMATION

Please list two emergency contacts in case one is unavailable.

1st Emergency Contact: \_\_\_\_\_

Relation to Applicant: \_\_\_\_\_ Phone #: \_\_\_\_\_

2nd Emergency Contact: \_\_\_\_\_

Relation to Applicant: \_\_\_\_\_ Phone #: \_\_\_\_\_

Case Manager Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

## MEDICAL INFORMATION

Please State Primary Disability: \_\_\_\_\_

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

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Hearing             | <input type="checkbox"/> Vision               | <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Developmental Disability |
| <input type="checkbox"/> Learning Disability | <input type="checkbox"/> ADD/ADHD             | <input type="checkbox"/> Dementia           | <input type="checkbox"/> Seizures                 |
| <input type="checkbox"/> Heart Condition     | <input type="checkbox"/> Fine Motor Skills    | <input type="checkbox"/> Gross Motor Skills | <input type="checkbox"/> Uses Wheelchair          |
| <input type="checkbox"/> Mental Illness      | <input type="checkbox"/> Physical Limitations | <input type="checkbox"/> Medical Issues     |   |

Explain above disabilities and/or medical conditions marked. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Applicant's Doctor's Name & Location: \_\_\_\_\_

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 the applicant be taking medications while attending our program?  Yes  No

If yes, do they require assistance?  Yes  No

Allergies:  No Known Allergies  Seasonal  Bee Stings  Peanuts

Other Allergies: \_\_\_\_\_

Dietary Needs: \_\_\_\_\_

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

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

## MEDICAL INFORMATION (CONTINUED)

Please Rate the Categories of Capabilities Below on a Scale of 1 - 5.

(1 Being Requires Support, 5 Being Fully Independent)

<input type="checkbox"/> Verbal Communication	<input type="checkbox"/> Uses Sign/Gestures	<input type="checkbox"/> Toileting Assistance Needed
<input type="checkbox"/> Initiate Activities	<input type="checkbox"/> Can Regulate Vocal Volume	<input type="checkbox"/> Aware of Personal Space
<input type="checkbox"/> Aware of Personal Space	<input type="checkbox"/> Eat and Drink Independently	<input type="checkbox"/> Ability to Follow Directions
<input type="checkbox"/> Maintain Personal Cleanliness and Organization	<input type="checkbox"/> Independent Mobility (walk/move safely)	

## ADDITIONAL QUESTIONS

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

---

---

2. What goals would you like the participant to focus on while attending this program?

---

---

3. Which individuals and/or organizations have permission to provide transportation services for you?

(The Arc, public transit, Dial-a-Ride. For individuals, please state relationship)

---

---

## COLUMBIA ABILITY ALLIANCE MEMBERSHIP GUIDELINES

- 1. Eligibility & Application:** Eligibility is determined after we receive a completed application, confirm a commitment to the program's Rights and Responsibilities, and review the general level of support needed. A personal tour may be required prior to participation to confirm the program is a good fit. Continued participation requires payment of applicable fees as outlined below.
- 2. Application Review:** The 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, ongoing relationship, the Manager will periodically review our ability to support each individual participant. If it is determined that the program cannot safely support a participant, that individual will not be able to continue to attend sessions.
- 3. Payment of Fees:** Nexus offers one session from 3:00 PM-6:00 PM. Attendance fees are billed at the beginning of each month for the previous month's attendance. Payment is due within 10 days of invoice date. Late payment notices will be included on the current invoice each month. 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 participant's attendance until the account is paid in full. Fees are setup in the following categories:

Service Type	Rate	Notes
Respite Services	6 Units / Session	Billed based on sessions attended
Private Pay	\$35.00 / Session	Billed based on sessions attended

4. **Participant Responsibility & Behavior:** Participants are expected to behave appropriately. This includes, but is not limited to, showing respect and consideration for other participants and staff, following staff instructions, managing anger/emotions, and respecting personal space and property. The program is not equipped to resolve severe behavioral challenges. If a participant’s behavior becomes disruptive, unsafe, or violent toward themselves or others, they may be sent home immediately and may not be allowed to continue participating in the program. **Any act of violence will result in immediate dismissal.**
5. **Supervision:** Participant-to-staff ratios may vary. We cannot provide one-on-one supervision. Anyone who requires one-on-one supervision to maintain safe and respectful behavior may not be able to participate unless one-on-one support is provided by family/guardian/provider.
6. **Personal Assistance:** Staff may provide ongoing assistance with daily routines, except for **administering medications** or **providing toileting assistance** that requires chair-to-toilet transfers. Staff can assist with basic food preparation (e.g., cutting food, opening snacks), dressing/undressing outerwear (coats, hats, gloves), and hygiene routines with minimal to moderate assistance (such as buttoning/unbuttoning pants, handwashing, and general hygiene reminders). Staff can also assist with boarding program transportation and support participants on community outings. Verbal prompts and reminders will be provided. Physical redirection will only be used to prevent immediate danger.
7. **Emergencies:** In the event of an emergency, staff will follow standard first-aid and CPR procedures and contact the designated emergency contact as soon as possible. For non-911 situations, the parent/guardian/provider may be expected to pick the participant up within **30 minutes**. It is essential that we have a current, working emergency phone number on file.
8. **Participation:** We provide a variety of activities each day and encourage all to participate. Participants who choose not to join an activity may select another appropriate, productive activity. 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 individuals who regularly choose not to participate in activities, we recommend that the participant’s care provider have them bring something from home that they would enjoy doing.
9. **Transportation & Pick-Up/Drop-Off:** Transportation to and from the program must be arranged by the participant or provider and must align with program hours (3:00 PM-6:00 PM). Arrival and departure should occur within **15 minutes** of scheduled times. Late pick-up or early drop-off outside the allowed window may result in an additional fee of **\$5 per 15 minutes** for extra supervision, unless the delay is due to The Arc or Dial-a-Ride transportation delays.

## AGREEMENT

To the best of my knowledge, I affirm the above is true. I have read, understood, and agree to the Columbia Ability Alliance’s Membership Guidelines. 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 fees.

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

**Applicant Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Home Provider/Guardian/Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_