columbia ABILITY ALLIANCE | Nexus Youth Club

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
Afternoon Session:	☐	☐	☐	☐	☐

Location: ☐ Kennewick ☐ Pasco

APPLICANT INFORMATION

Applicant Name: _____

Full Physical Address: _____

Phone #: _____ **Email:** _____

Birth Date: _____ **Sex:** ☐ Male ☐ Female

Applicant's School: _____

How do you plan to have your child transported to Nexus Youth Club? _____

Shirt Size: _____ **How did you hear about us?** _____

RESPONSIBLE BILLING PARTY

How do you plan to pay? ☐ DDA Respite Funds ☐ Private Pay

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.*

- ☐ Hearing
- ☐ Vision
- ☐ Diabetes
- ☐ Developmental Disability
- ☐ Learning Disability
- ☐ ADD/ADHD
- ☐ Dementia
- ☐ Seizures
- ☐ Heart Condition
- ☐ Fine Motor Skills
- ☐ Gross Motor Skills
- ☐ Uses Wheelchair
- ☐ Mental Illness
- ☐ Physical Limitations
- ☐ Medical Issues

Explain above disabilites 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)

- ☐ Verbal Communication
- ☐ Uses Sign/Gestures
- ☐ Toileting Assistance Needed
- ☐ Initiate Activites
- ☐ Can Regulate Vocal Volume
- ☐ Aware of Personal Space
- ☐ Aware of Personal Space
- ☐ Eat and Drink Independently
- ☐ Ability to Follow Directions
- ☐ Maintain Personal Cleanliness and Organization
- ☐ 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 after school. 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. 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:** _____