Career and Technical Education Program Participant Application

Office Use Only	
RECEIVED	START
_____	_____

Applicant's Name: _____

The Arc of the Capital Area Career and Technical Education Program (9:00 am – 2:00 pm) –The Arc of the Capital Area offers a wide variety of post-secondary education options to ensure the continued career growth and independence with individuals in the ID/D community. Students will register for 8 week modules of their choosing.

Class hours will be Thursday & Friday 9:00 am – 2:00 pm
Arrival time is between 8:30 am- 9:00 am
Pick up time is between 2:00 pm- 2:30 pm

Please select the course in which you are applying to:

☐ Food Services Assistant - March 19th - May 8th
- Application Due March 1st

☐ Horticulturist - May 20th - July 10th
- Application Due May 1st

☐ Child Care Assistant - - July 22nd - September 18th
- Application Due July 1st

☐ TBD - September 30th - November 20th
- Application Due September 11th

If you have filled out the application for another course during a calendar year update the course you would like to take and any information below that has changed.

☐ I have applied for another course this calendar year

CLIENT INFORMATION * Please print clearly

Client Full Name:

First Middle Last Nickname

Client Address:

Street Address Unit # City State Zip Code

Client Email Address:

Email Address

Phone #'s:

Cell # Home #

Appearance:

Height Weight

Hair Color Eye Color Ethnicity

PARENT/GUARDIAN/HOUSE STAFF INFORMATION

Parent/Guardian/House Staff Name:

Relationship:

Address:

Street Address Unit #

City State Zip Code

Phone #'s:

Cell

Home

Email:

Employer:

Name

Parent/Guardian/House Staff Name:

Relationship:

Address:

Street Address Unit #

City State Zip Code

Phone #'s:

Cell

Home

Email:

Employer:

Name

Is applicant own guardian? Yes ☐ No ☐

Documentation will be required upon acceptance

Financially Responsible Party

(Who is responsible for financial plans for applicant)

Name:

Address:

Phone Number:

Email Address:

1.17.19

EMERGENCY CONTACT INFORMATION (OTHER THAN GAURDIAN/PARENT/HOUSE STAFF)

When no one can be reached at the above numbers, who should staff contact in case of emergency ? This person must be willing to help if guardian is not accessible.

Full Name: _____
First Middle Last Nickname

Address: _____
Street Address Unit # City State Zip Code

Phone #'s: _____
Cell Work Home

Direct Service Agency

Direct Service Agency_____

Case Manager: _____
Name Phone # Email

Mailing Address _____
Street Address Unit #

_____
City State Zip Code

Integral Care

Service Coordinator: _____
Name Phone # Email

SERVICE CARE PROVIDER INFORMATION

Name of Group Home/ Facility_____

House Manager: _____
Name Phone # Email

Mailing Address _____
Street Address Unit #

_____
City State Zip Code

MEDICAL INFORMATION

Medical Diagnosis: ***Including Disability*** _____

_____

_____

_____

Level of Need (LON) :_____

Physician: _____
Name Phone #

Psychologist/ Counselor: _____
Name Phone #

Medication:

Name of Medication	Dose	Time Taken

Are any medication that will need to be taken while at Art class? **Yes** ☐ **No** ☐
Please note that we will not be able to administer any medications. All medications must be self administered or administered by Guardian.

Are you allergic to any food, drugs, or anything else? Yes ☐ **No** ☐
If yes, list all allergies:

Food allergy: _____

Drug allergy: _____

Latex allergy: _____

Other allergy: _____

Has the participant ever had seizures? Yes ☐ **No** ☐

If yes, click the statement that applies:

Seizures stopped long ago and participant is OFF medication
Seizures are totally controlled but still on medication. (no seizures in over a year)
Seizures are partially controlled on medication.
Seizures happen often

Type of seizure, *check all that apply*:

- ☐ Gran mal (falls down and moves around)
- ☐ Petit mal (staring spells)
- ☐ Other

Does client have a documented Service plan in the event a seizure occurs?

_____

_____

Describe symptoms of seizure:

_____

_____

Who is the student's neurologist? _____Dr.'s Phone_____

Does the participant have a shunt? Yes ☐ **No** ☐ If yes, where is it located? _____

Has the participant ever had surgery? Yes ☐ **No** ☐

If yes, please list including date and type of surgery:

Additional Comments:_____

_____

Surgery	**Date**

_____

_____

_____

_____

Please disclose all known medical history and concerns. In this section, check all the problems that apply to the participant with explanation or any comments in the right column.

Problem	Comments
☐ Asthma	
☐ Breathing Problems	
☐ Nebulizer or Mist Machine	
☐ Heart Problem	
☐ Kidney or Bladder Problem	
☐ Stomach or Intestinal Problem	
☐ Muscles	
☐ Bones/ Joints	
☐ Skin (e.g. rashes, eczema, sunburn easily)	
☐ Raynaud's phenomenon	
☐ Dehydrates easily	
☐ Diabetes	
☐ Frequently constipated	
☐ Frequent loose stool or diarrhea	
☐ Eczema	
☐ Frequent Skin Rashes	
☐ No Concerns	
Toileting	**Comments**
☐ Needs some help (describe)	
☐ Needs total assistance	
☐ Partially-trained (describe)	
☐ Help with transfer (describe)	
☐ Wears diapers	
☐ Has a catheter	
☐ Trouble with bowel movements	
☐ On a toileting schedule. Please describe.	
☐ Other. Please describe	
☐ Needs no help	

Dieting/Eating	Comments
☐ Needs total assistance	
☐ Assist with cutting	
☐ Uses a straw	
☐ Difficulty swallowing liquids	
☐ Difficulty swallowing solids	
☐ Has a tongue thrust	
☐ Needs special utensils	
☐ No Assistance Needed	

Walking and Equipment	Comments
☐ Walks alone but not well	
☐ Walks with assistance from: ☐ An assistant ☐ Hand held walker ☐ Crutches or cane	
☐ Uses wheelchair and will bring to class ☐ Power ☐ Manual	
☐ Can transfer alone	
☐ Needs help to transfer. Type of transfer?	
☐ Cannot transfer at all	
☐ Pressure Ulcers/Sores	
☐ Braces ☐ AFO's ☐ SMO's Other braces (list) _____ Hand splints_____	
☐ Will wear braces or splints. If yes, what is his/her wearing schedule?	
☐ Contractures/Spasticity	
☐ Chronic Pain	
☐ Other equipment needed	
☐ Walks well alone	

Vision and Hearing	Comments
☐ Wears Glasses	
☐ Wears Contacts	
☐ Has partial vision	
☐ Is totally blind	
☐ Uses hearing aid	
☐ Has hearing impairment	
☐ Totally deaf	
☐ Wears hearing aid	
☐ Other	
☐ No assistance needed	

Communication	Comments
☐ Talks, but it is hard to understand	
☐ Understands, but cannot speak	
☐ Does not understand at age level	
☐ Uses sign language	
☐ Speaks only a few words	
☐ Has almost no communication	
☐ Writes notes to communicate	
☐ Uses other communication tools	
☐ No concerns	

Please describe special communication techniques/devices:

_____

_____

_____

Behavioral Concerns	Comments
☐ Hitting	
☐ Biting	
☐ Hallucinations	
☐ Obsessions/perseverations	
☐ Elopement risk	
☐ Overwhelmed frequently	
☐ Uses abusive language	
☐ Does not taking responsibility when he/she has made a mistake	
☐ Oppositional behavior	
☐ Does not respond well to redirection and consequences	
☐ Requires one to one supervision at all times	
☐ Likes to be alone	
☐ Over stimulated on community outings	
☐ Does not interact well with others	
☐ No behavioral concerns	

Describe any successful behavioral interventions used for behavioral problems:

_____

_____

PERSONAL DATA (applicant directed questions)

1. Do you have a job? ☐ Yes ☐ No If yes, where?

_____

2. Do you attend school? ☐ Yes ☐ No If yes, where?

_____

3. What type of hobbies do you have? (Please list)

_____

4. Please list any fears, concerns or problems the you might have while at class.

_____

5. What things interest you?

_____

6. When you get upset what type of help do you want?

_____

7. Are there specific things that trigger you to be upset?

_____

8. How would you describe your day to day behavior or attitude?

9. Does you require a personal attendant? ☐ Yes ☐ No If yes, please describe.

10. Please list what activities you should not participate in by doctor or parent/guardian request:

_____

Name of additional support personnel who will be coming to visit or assist client (counselors, therapist, occupational supports)

1. _____
Name Phone # Email

2. _____
Name Phone # Email

3. _____
Name Phone # Email

Employment Information

Eligibility documentation needed for intake

1. Authorized to work in the US
   - ☐ Social Security card
   - ☐ Texas issued Identification Card or Passport
2. Meets Military Selective Service Registration requirements **(males only)**
   - ☐ Confirmation of Military Selective Service Registration (https://www.sss.gov/Home/Verification)
3. Participant has documented intellectual or developmental disability
   - ☐ Documentation of intellectual or developmental disability
     - Acceptable documentation:
       - Physician's documentation of disability
       - Individualized Education Plan (current or previous)
       - Guardianship paperwork stating individual's disability
       - TWC Individualized Plan for Employment (IPE)
       - Self-attestation form

Please check each program/benefit that participant receives (if applicable)

*Documentation will be required during intake interview

Program	Acceptable Documentation
☐ Temporary Assistance for Needy Families (TANF)	☐ Crossmatch with TWIST TANF screens ☐ Copy of HHSC records ☐ Copy of out-of-state HHSC/public assistance documentation
☐ Supplemental Nutrition Assistance Program (SNAP)	☐ Telephone/written verification ☐ Public assistance record ☐ TWIST legacy search ☐ Letter from SNAP dispersing agency
☐ Supplemental Security Income (SSI or SSDI)	☐ Copy of authorization to receive cash public assistance ☐ Public assistance record ☐ Social Security benefits ☐ Telephone verification
☐ Other Public Assistance	☐ Authorization to receive cash public assistance ☐ Public assistance check ☐ Medical card showing cash grant status ☐ Refugee assistance records ☐ Local cash assistance program

The Arc
Capital Area

The Arc of the Capital Area
Emergency Medical Authorization

I hereby authorize The Arc of the Capital Area and give my consent for said provider and The Arc of the Capital Area Providers to seek emergency medical including hospitalization or surgical procedures as may be necessary on behalf of Participant_____ D.O.B. _____.

I further authorize the medical provider to bill me for the cost of such care.

Parent/Guardian Name: _____
First Middle Last

Phone #'s: _____
Cell Work Home

Insurance Company: _____

Policy Number:_____ **Medicaid Number:**_____

Name of Doctor:_____ **Phone Number:**_____

Emergency Contacts ***(all three lines need to be filled out)***

Name	Relationship	Phone Number

Allergies:

_____

_____

Current Medications:

Name	Dosage	Frequency

Special circumstances for participant, which require a call to 911 and immediate notification to family?

_____

_____

This authorization is valid unless revoked in writing by:

_____
Client / Participant / Parent / Legal Guardian's Printed Name

_____
Client / Participant / Parent / Legal Guardian's Signature Date

The Arc
Capital Area

Release of Liability

Name of Participant: _____

Name of Parent/Guardian: _____

I authorize The Arc of the Capital Area to request, approve, or administer any medical attention needed by the Participant.

I confirm that I have fully disclosed to The Arc of the Capital Area all pertinent facts about Participant's needs and disability and acknowledge full liability and responsibility for any failure to do so. I affirm that I do not believe that the Participant has any medical, psychological, or emotional conditions that in any way could result in harm to the Participant or others attending with or supervising the Participant at The Arc of the Capital Area.

I hereby release and discharge The Arc of the Capital Area and its agents, servants, and employees from all claims, causes of action, and liability arising out of or related in any way to the above-named individual's participation in The Arc of the Capital Area's program activities whether on-site or during the course of a field trip. I expressly release, on behalf of myself and/or the Participant, The Arc of the Capital Area and its agents, servants, and employees from liability for any act or omission, including negligence, which results in injuries or damages to the Participant whether on-site or during the court of a field trip. I further indemnify The Arc of the Capital Area for any losses, damages, costs, claims or attorneys' fees associated with any injury sustained or caused by the Participant.

X _____ _____

Signature of Client or Gaurdian

Date

The Arc
Capital Area

Consent to Use Photographs, Video Images, Spoken and Written Comments

The Arc of the Capital Area (the Arc) is always pleased when a client is willing to communicate the stories, experiences, and information about his or her services at the Arc. The Arc respects the privacy of our clients, visitors and staff. Ensuring that health information is kept confidential is among our highest priorities.

The Arc seeks your consent to allow us to take and use audio/video/photographic material of you in our internal and external communications, including social media such as Facebook, twitter, Instagram, and google+, general interest and to distribute such materials online, in print and in news media (such as TV, radio, newspapers and magazines).

We will keep a copy of your written permission on file. If not revoked/withdrawn by me, this authorization expires ten (10) years from the date that I sign it. I understand that I may revoke this Authorization at any time by providing The Arc with written notice stating that the Authorization is cancelled. However, I understand that the revocation will not affect uses or disclosures that occurred prior to the date that The Arc received the revocation. If I decide to sign this form, I have the right to request that audio/video recording, filming, or photographing cease at any time. I am aware that my personal information will exist forever in either a recorded, printed, and/or electronic version or other version as may develop over time and that once it is published or disclosed in any form it will continue to be used.

Once my personal information is disclosed to the persons or organizations authorized by this form, my personal information have the potential to be further disclosed by these parties and would no longer be protected by the HIPAA Privacy Rule. The Arc is not responsible for any such subsequent disclosures.

I acknowledge that I have read and understand this form, and have been provided a copy of this form for my records. I understand that I may access and copy the information described on this form. I acknowledge that I do not have to sign this authorization form in order to receive any services from The Arc or in order to receive any other health care treatment, payment, enrollment in a health plan, or eligibility for benefits.

I do give permission for the Arc of the Capital Area to use my name and written comments and consent to take and make use of my audio/video/photographic images in publications produced by or on behalf of the Arc and on social media. This permission extends to both electronic versions on the Arc's website and other internet/electronic applications as well as to printed, filmed and taped versions.

Printed Name of Client:_____ Date: _____

Signature of Client (or Personal Representative*): _____

*Name of Personal Representative (if applicable): _____

*Relationship to the Client and Authority to Act: _____

Client Use of Technology Agreement and Release of Liability Form

The Arc of the Capital Area authorizes students to use technology owned or otherwise provided by The Arc of the Capital Area as necessary for instructional purposes. The use of the companies technology is a privilege permitted at the companies discretion and is subject to the conditions and restrictions set forth in applicable policies, administrative regulations, and this Acceptable Use Agreement. The company reserves the right to suspend access at any time, without notice, for any reason.

The company expects all students to use technology responsibly in order to avoid potential problems and liability. The company may place reasonable restrictions on the sites, material, and/or information that students may access through the system.

Each student who is authorized to use companies technology and his/her parent/guardian shall sign this Acceptable Use Agreement as an indication that they have read and understand the agreement.

Definitions

The Arc of the Capital Area's technology includes, but is not limited to, computers, the companies computer network including servers and wireless computer networking technology (Wi-Fi), the Internet, email, USB drives, wireless access points (routers), tablet computers, smartphones and smart devices, telephones, cellular telephones, personal digital assistants, pagers, MP3 players, wearable technology, any wireless communication device including emergency radios, software, third-party applications and/or future technological innovations, whether accessed on or off site or through company-owned or personally owned equipment or devices.

Student Obligations and Responsibilities

Students are expected to use the companies technology safely, responsibly, and for educational purposes, accessing personal email, social media accounts only. The student in whose name companies technology is issued is responsible for its proper use at all times. Students shall not share their assigned online services account information, passwords, or other information used for identification and authorization purposes, and shall use the system only under the account to which they have been assigned.

Students are prohibited from using The Arc of the Capital Area's technology for improper purposes, including, but not limited to, use of companies technology to:

1. Access, post, display, or otherwise use material that is discriminatory, libelous, defamatory, obscene, sexually explicit, or disruptive.
2. Bully, harass, intimidate, or threaten other students, staff, or other individuals ("cyberbullying").
3. Disclose, use, or disseminate personal identification information (such as name, address, telephone number, Social Security number, or other personal information) of another student, staff member, or other person with the intent to threaten, intimidate, harass, or ridicule that person.
4. Infringe on copyright, license, trademark, patent, or other intellectual property rights.
5. Intentionally disrupt or harm company technology or other district operations (such as destroying district equipment, placing a virus on district computers, adding or removing a computer program without permission from a teacher or other company personnel, changing settings on shared computers).

6. Install unauthorized software.
7. "Hack" into the system to manipulate data of the company or other users.
8. Engage in or promote any practice that is unethical or violates any law or policy, administrative regulation, or companies practice.

Privacy

Since the use of companies technology is intended for educational purposes, students shall not have any expectation of privacy in any use of companies technology.

The Arc of the Capital Area reserves the right to monitor and record all use of company technology, including, but not limited to, access to the Internet or social media, communications sent or received from company technology, or other uses. Such monitoring/recording may occur at any time without prior notice for any legal purposes including, but not limited to, record retention and distribution and/or investigation of improper, illegal, or prohibited activity.
Students should be aware that, in most instances, their use of companies technology (such as web searches and emails) cannot be erased or deleted.

All passwords created for or used on any companies technology are the sole property of the companies. The creation or use of a password by a student on companies technology does not create a reasonable expectation of privacy.

Personally Owned Devices

If a student uses a personally owned device to access The Arc of the Capital Area's technology, he/she shall abide by all applicable policies, administrative regulations, and this Acceptable Use Agreement. Any such use of a personally owned device may subject the contents of the device and any communications sent or received on the device to disclosure pursuant to a lawful subpoena or public records request.

Reporting

If a student becomes aware of any security problem (such as any compromise of the confidentiality of any login or account information) or misuse of the company's technology, he/she shall immediately report such information to the teacher or other personnel.

Consequences for Violation

Violations of the law, policy, or this agreement may result in revocation of a student's access to companies technology and/or discipline, up to and including suspension or expulsion. In addition, violations of the law, policy, or this agreement may be reported to law enforcement agencies as appropriate.

Student Acknowledgment

I have received, read, understand, and agree to abide by this Acceptable Use Agreement and other applicable laws and policies and regulations governing the use of technology. I understand that there is no expectation of privacy when using the companies technology. I further understand that any violation may result in loss of user privileges, disciplinary action, and/or appropriate legal action.

Student Name:_____ Student Signature: _____

Parent or Legal Guardian Acknowledgment

As the parent/guardian of the above-named student, I have read, understand, and agree that above-named student shall comply with the terms of the Acceptable Use Agreement. By signing this Agreement, I give permission for my child to use The Arc of the Capital Area technology and/or to access the companies computer network and the Internet. I understand that, despite the companies best efforts, it is impossible for the company to restrict access to all offensive and controversial materials. I agree to release from liability, indemnify, and hold harmless The Arc of the Capital Area and its company personnel against all claims, damages, and costs that may result from my student's use of the company technology or the failure of any technology protection measures used by the company. Further, I accept full responsibility for supervision of my students use of his/her access account if and when such access is not in the company's setting.

Parent Name:_____ Parent/Guardian Signature: _____

Date: _____

Authorization to Use or Disclose Health Information

Participants of the Career and Technical Education program agree that in working with The Arc of the Capital Area (The "Arc") to support their employment goals, they may be associated with The Arc's mission:

The Arc of the Capital Area, a non-profit organization, is committed to empowering Central Texans with intellectual and developmental disabilities and their families through compassionate case management and innovative programs.

Potential reasons for program to use or disclose health information include, but are not limited to:

- Assisting participant in applying for jobs
- Advocating for reasonable accommodations with employer
- Assisting participant in completing new hire paperwork

You may revoke this Authorization at any time by providing The Arc with written notice stating that the Authorization is cancelled. However, I understand that the revocation will not affect uses or disclosures that occurred prior to the date that The Arc received the revocation.

Today's Date: _____

Name: _____
First Middle Last

Address: _____
Street City State Zip Code

Telephone Number: _____

Date of Birth: _____Social Security Number _____

This disclosure is limited to (check all that apply):

☐No limitation – all records may be disclosed
☐Evaluations/Psychiatric Report/Diagnosis and Evaluation
☐Medical Information
☐Background Information and Current Status
☐Other:_____

The Arc is authorized to release this information to:

☐Physician/clinic
☐Therapist/counselor
☐I.S.D.
☐ATCIC
☐DSHS
☐HHSC (DADS)
☐Texas Workforce (DARS)
☐Social Security
☐Bank/Savings and loan
☐Employer
☐Medicaid
☐Family member. Please specify _____
☐Personal Advocate. Please specify:_____
☐Other:_____

The purpose of this disclosure is:

☐At my request
☐Determination of Eligibility for other services/providers
☐Consultation/Program Planning/Coordination of Services
☐Other:_____

This authorization will expire one year from signature date unless otherwise specified:
_____

INFORMATION RELEASE

I acknowledge that I have read and understand this form, and have been provided a copy of this form for my records.

I may access and copy the information described on this form.

I do not have to sign this authorization form in order to receive any health care treatment, payment, enrollment in the health plan, or to be eligible for benefits.

Once my health information is disclosed to the persons or organizations authorized by this form, my health information has the potential to be further disclosed by these parties and would no longer be protected by the HIPAA Privacy Rule. The Arc is not responsible for any such subsequent disclosures by Recipient(s).

Signature of Participant (or Personal Representative*) Date:

X_____ ____/____/____

*If you are a personal Representative of the Participant, please provide the following information:

Name: _____
First Middle Last

Address: _____
Street City State Zip Code

Relationship to the Participant and Authority to Act: _____

Phone Number: (H) _____(W)_____

Verification of Identity of Requestor:

- ☐Photo ID
- ☐Identifying Information
- ☐Matching Signature
- ☐Other_____

ACKNOWLEDGEMENT FORM

This form acts as a comprehensive signature acknowledgement indicating you have received the information where to find the Participation Handbook (www.arcaustin.org) with our agency policy, procedures and guidelines of the daytime arts education program with The Arc of the Capital Area.

Initial next to each area below to indicate the understanding and acceptance of these policy, procedures and guidelines.

I Accept:	Title
	Divine Canines Pet Therapy
	Admission Guidelines
	Attendance Policy
	Payment Policy
	Discharge Policy
	Consumer Rights and Responsibilities
	Code of Ethics
	Confidentiality
	Grievance Procedures
Client Signature:	
Parent or Guardian of Client:	
The Arc of the Capital Area Staff Member Signature:	

By signing above, you acknowledge receipt of the information and policies as listed above. You further acknowledge that you have read, understand, and accept each policy in its entirety, and have indicated so by initialing above. You acknowledge that you have retained the policies in your possession for your records. This Signature Authorization form will become part of your record.