After School Program Application

Please return application and attachments to:

Living Resources After School Program

300 Washington Ave Extension

Albany, NY 12203-7303

Attn: Jacqueline M. Calder

https://www.livingresources.org/

518-218-0000

After School Program Application

Date: ________________

Name of Applicant: ____

Street Address: ____

City: ______________________________ State: __________ Zip Code: _______________

Age: ______ D.O.B. ___/____/_____ Male / Female / Other (please circle one)

SSN: _____-____-______ TABS ID: _____________ Medicaid #: ____________________

School Attending: ____

Home School District: _______________________________ Classroom Ratio: __________

Grade: ____________ Special Services Received (OT/PT/Speech): _____________________

Transportation Services for School: ____

Parent/ Guardian Information:

Name (First/Last): ____

Relationship to applicant: ________________________Home Phone: __________________

Work Phone: ___________________ Cell Phone: __________________

Email Address: ____

Address (if different then applicant) ____

City: _______________________ State: ___________________ Zip Code: _____________

Name (First/Last): ____

Relationship to applicant: ________________________Home Phone: __________________

Work Phone: ___________________ Cell Phone: __________________

Email Address: ____

Address (if different then applicant) ____

City: _______________________ State: ___________________ Zip Code: _____________

Emergency Contact Information (other than parents):

Name (First/Last): ____

Relationship to applicant: ________________________Home Phone: __________________

Work Phone: ___________________ Cell Phone: __________________

Email Address: ____

(Please note that emergency contact must be available when parent/guardian is not available)

Care Coordinator Information (best completed with or by coordinator):

Care Coordinator Name: ____

Corporate Name: _______________________ Phone #: ______________________________

Street Address: ____

City: ___________________________ State: ________________ Zip Code: ____________

Email Address: ____

Is the applicant waiver approved? __________________ Amount of units allocated: _________

Enrolled in Self Direction? Yes / No Broker Contact Information: _______________________

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Medical Information:

Physician's Name: ________________________________ Phone #: ____________________

Address: ____

Hospital Preferred (in case of emergency) ____

Dates of last medical exam: _________________________ Dental: _____________________

Allergies: ____

Height: __________ Weight: ____________ Are they up to date on immunizations? Yes / No

Insurance Company name: _______________________ Policy #: _______________________

Disability Information (please check all that apply)

Intellectual Disability ______ Cerebral Palsy ______ Epilepsy ______ Autism ______ TBI ____

Down Syndrome _____ Visually Impaired ______ Hearing Impaired _____ Spinal Bifida _____

Other: ____

Any other medical concerns: ____

Medications taken and what it controls: ____

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Getting to know the applicant:

Is the applicant on a special diet?

Does the applicant need assistance when eating?

Is the applicant physically aggressive?

Is the applicant aggressive towards self?

How well does the applicant interact with others?

Is the applicant verbal or non-verbal? If non-verbal how do they communicate?

If verbal, does the applicant use obscene language?

How does the applicant react when frustrated?

What coping methods does the applicant utilize?

Does the applicant need help when utilizing the bathroom?

Can the applicant walk independently?

How well does the applicant follow instructions?

How well does the applicant manage in public?

Please take this page to let us know anything you feel is important for us to know about the applicant and how would the After School Program would benefit the applicant and their family.

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Documents needed:

With this application, please send in the following most recent documents needed.

Immunization records

Individualized Support Plan (ISP)

Individual Educational Plan (IEP)

Psychological Evaluation

By signing below, I hereby certify that the above information given are true and correct as to the best of my knowledge. I authorize Living Resources Corporation to verify any and all information given in this application and attachments.

Signature of applicant: ____
Date: _____________

Signature of Parent/Guardian: ____
Date: _____________