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

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: _____

_____

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: _____

_____

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.

_____
_____
_____
_____
_____
_____
_____
_____
_____

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: _____