



Adventure Program Application

Please return application and attachments to:

Living Resources

300 Washington Ave Extension

Albany, NY 12203-7303

Attn: Jacqueline M. Calder

<https://www.livingresources.org/>

518-218-0000

Dear Families,

Project Adventure is a respite funded by Office for People with Developmental Disabilities (OPWDD) Family Support Services (FSS) focusing on community inclusions, recreation and social goals, while giving family care takers a chance to work or have time to themselves.

The Adventure Program is open individuals with developmental disabilities who are 11 years of age or older and who live at home with family. The program serves individuals meeting OPWDD's eligibility criteria who live in the Capital Region. Participation in any given activity depends on the abilities of each individual and the nature of the activity.

Program operates for one week in February during the school break, two weeks in June between school ending and beginning of the extended school year, along with various weekend dates throughout the year. Project Adventure activities range from water park visits, gyms, museums, trips to NYC or Boston, holiday themed, movies and much more.

Program dates include the winter break in February and the last two weeks in June.

Thank you for applying to Living Resources Corporation for Adventure Program. Please contact Jacqueline Calder, After School Program and Adventure Program Manager, using the contact information provided below with any questions or assistance needed in completing the application.

Best Regards,

Jacqueline M. Calder
Community Living Coordinator
P: 518-218-0000x5414
C: 518-209-8595
E: jcalder@livingresources.org



Adventure 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 #: _____

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: _____

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 1-2 step instructions? _____

How well does the applicant manage in public? _____

Documents needed:

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

Life Plan/Individualized Support Plan (ISP)

Self Directed Budget (if applicable)

OPWDD Letter of Eligibility

How would you like to be notified about upcoming Adventure Program dates and activities?

- Mail
- Email to _____

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: _____