Soaring Eagle Center

"Enabling adults with disabilities to *soar like eagles.*"

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SEC Day Program Application

Thank you for applying to SEC Day Program. This application process allows the staff, the associate and the associate's family/caregiver to determine if the SEC day program is equipped to meet the needs of the adult applying for admission. In order to determine eligibility, we have established the following requirements to complete the admissions process:

1. Completely fill out the application with all needed signatures and submit to Soaring Eagle Center. Be sure to read and sign all releases and agreement forms.

2. Interview and Half Day Visit - Once the above information is received, an interview will be scheduled with the parent(s)/caregiver and adult. The adult will spend a half day at the program including lunch time. The parents will meet with staff members and discuss their desires for their adult and The Center's procedures and expectations.

3. A committee will then meet to review the application and determine if the SEC Day Program is able serve the needs and goals of your adult.

4. Thirty Day Evaluation– If the committee determines that the SEC Day Program is able to serve the goals and needs of your adult, your adult will attend the day program one day a week for four weeks. Financial arrangements must be made before the adult can attend one day a week. At the end of the four weeks, a meeting will be scheduled with the adult, parent(s)/caregiver and staff to evaluate how the adult has done in the program. At this time, the adult, parent(s)/caregiver and staff will decide if the SEC Day Program is the right fit for the adult. If the SEC Day Program is the right fit, goals will be set for the associate by the adult, parent(s)/caregiver and staff, any additional days in the program will be added to the associate's schedule.

Soaring Eagle Center does not discriminate on the basis of race, color, ethnicity, religion, age, or gender, in its admissions policy or programs.
It is up to the discretion of the Soaring Eagle Center staff as to who is accepted for admission to the program.

For staff use only:

Application Received: _____ Insurance Card: _____ Guardianship Letter: _____

Half day visit: _____ Comments:_____

Thirty day evaluation: _____ Comments: _____

Funding: Private pay _____ HCS _____ TxHmL _____ CLASS _____

Withdrawal: _____ Reason: _____

The Soaring Eagle Center is a 501(c)3 tax-exempt charitable nonprofit organization located in Desoto, TX. Our mission is to provide life-long solutions for the social, educational, vocational, and residential needs of young adults with intellectual disabilities.

Requirements for participation

1. The adult has finished high school and lives at home.
2. The adult is able to follow directions and submit to authority.
3. The adult has no disruptive behavioral problems or mental health issues.
4. All the necessary paper work is filled out and submitted.
5. Arrangements have been made for payment for the day program. SEC accepts private pay, HCS, TxHmL, and CLASS fees.
6. The adult must intend to attend a minimum of two days a week.

Family Responsibilities

1. To provide transportation to and from The Center. To drop off/pick up their adult on time.
2. If on private pay, to pay the monthly fee by the fifteenth of each month. There is a $25.00 late fee after the fifteenth.
3. To make the necessary arrangements with your provider if you are using HCS, CLASS, or TxHmL funds to pay your fees. Attendance in the program cannot begin until a contract has been signed with the provider.
4. Meet with the SEC staff to determine your adult's progress of day program goals two months prior to your HCS/TxHmL annual meeting with your provider.
5. To notify The Center by 9:00am on the day your adult will be absent or late.
6. To communicate concerns and complaints to the staff. To follow the complaint process.
7. To update medical, provider, and guardianship information in writing at least yearly.
8. To provide written verification of any medications your adult is to take while attending the SEC Day Program.
9. To not call your adult during the program. If an emergency occurs, call The Center phone (469-730-2841) and your adult will return your call.
10. To support the policies and procedures of the SEC Day Program.

SEC Staff Responsibilities

1. To treat each associate with dignity and respect.
2. To accept each associate for whom they are right now while at the same time not limiting \ whom they can become.
3. To encourage the mental, social, and emotional growth of each associate.
4. To assign tasks which are safe and appropriate for each associate.
5. To provide an environment which is safe from any kind of abuse.
6. To communicate with the associate's parents on a regular basis.

Associate's Responsibilities

1. To participate in the activities of the program.
2. Participate in the educational classes which are offered.
3. Participate in a regular work out program.
4. To respect the person and property of each individual who attends the day program.
5. Eat lunch with the other associates. Associates bring a lunch each day except for once a month on Thursdays. Each color group will eat out one Thursday a month, the associates can bring a lunch or purchase from the predetermined restaurant. A menu is provided.
6. To sign in and out each day. To check-in their phone during sign in. Associates will be able to call their parents during the program.

SEC Day Program Guidelines

Please fill out completely in blue or black ink.

Requirements for participation

1. The adult has finished high school and lives at home.
2. The adult is able to follow directions and submit to authority.
3. The adult has no major behavioral problems or mental health issues.
4. All the necessary paper work is filled out.
5. Arrangements have been made for payment for the day program. SEC accepts private pay, HCS, TxHmL, and CLASS fees.
6. The adult must intend to attend a minimum of two days a week.

Family/Caregiver Responsibilities

1. To provide transportation to and from The Center. Associates cannot be dropped off before 8:45am and must be picked up by 3:00pm. There is a $10 late fee immediately assessed for pickups after 3:00pm.
2. To pay private pay fees by the 5th of the month. Fees are late after the 15th. There is a $25.00 late fee.
3. To schedule doctor and other appointments on a day the associate is not attending the program if at all possible.
4. To notify The Center by 9:00am on the day the associate will be absent or late.
5. To contact the adult's HCS, TxHmL, or CLASS service coordinator if requested by the staff.
6. To clearly communicate any concerns with the program staff.
7. To support the decisions of the staff regarding your adult.

SEC Staff and Volunteer Responsibilities

1. To treat each associate with dignity and respect.
2. To accept each associate for whom they are right now while at the same time not limiting who they can become.
3. To encourage the mental, social, emotional, and spiritual growth of each associate.
4. To assign tasks which are safe and appropriate for each associate.
5. To provide an environment that is safe from any kind of abuse.
6. To communicate with the associate's parents on a regular basis.

Associate's Responsibilities

1. To arrive at The Center on time and stay for the entire day (9:00am-2:30pm). Staff must be notified if the associate will be arriving late or leaving early.
2. To participate in the activities of the program.
3. Participate in the educational classes which are offered.
4. Participate in a regular work out program in the exercise room.
5. Wear their SEC t-shirt every day except Monday and Birthday Friday.
6. To respect the person and property of each individual who attends the day program.
7. Eat lunch with the other associates. Associates bring a lunch each day except for once a month on Thursdays. Each color group will eat out one Thursday a month, the associates can bring a lunch or purchase from the predetermined restaurant. A menu is provided.
8. To sign in and out each day.
9. To check-in their phone during sign in. Associates will be able to call parents.

I have read the above guidelines and agree to comply with them.

Associate Signature: _____**Parent Signature:** _____

Date: _____

ASSOCIATE INFORMATION

Please fill out completely in blue or black ink.

Person filling out application: __Self __Parent/Guardian __Staff

Full Legal Name:

_____

(First) (Middle) (Last)

Preferred Name:

_____

Address:

_____

City: _____ State: _____ Zip: _____

Home Phone: _____ Associate Cell Phone: _____

Associate E-Mail: _____ T-shirt size _____

Sex: M F DOB: _____ **Disability/Diagnosis:** _____

Method of payment: HCS _____ TxHmL _____ CLASS _____ Private Pay _____

Who does he/she live with? (check one) ___Parents ___Self ___ Other_____

What kind of transportation will he/she be using to get to the Soaring Eagle Center? (check one)
___Parents ___Friend ____ Relative ___Other _____

List people who have permission to pick up your adult:

Name: _____ Phone: _____ DLN: _____

Name: _____ Phone: _____ DLN: _____

EMERGENCY CONTACT

The emergency contact should be a person other than the above stated parent/caregiver/guardian(s). This contact can be that of an additional relative, neighbor or friend who can be contacted in the event that the primary parent/caregiver/guardian(s) are unable to be reached.

Name: _____Relationship to client: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Name: _____ Relationship to client: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

FUNCTIONAL SKILLS
Please print legibly

Communication: ___Verbal (Talk/Speak) ___Non-verbal
If non-verbal, what method of communication does he/she use?
___Sign Language ___Symbols ___Other _____
___Communication Device (Dynavox, IPad, etc.)
Please describe device: _____

Ambulatory: Can the client walk unaided? ____Yes ____No

Does client require adaptive equipment? ____Yes ____No
(i.e. walker, wheelchair, crutches, etc.)
If yes please explain: _____
Does client require special assistance for long distances or if attending outings?

___Yes___No If yes, please Explain: _____

Toileting: ___Requires **no** assistance with toileting (can wipe, pull pants up, etc. independently)
___Requires **minimal** assistance (needs verbal reminder to wipe, wash hands, etc.)
___Requires **total** assistance (needs help with wiping, changing diaper/pad, etc.)
___Wears adult diapers.
___Other: _____

Female Associates: ___Requires **no** assistance, is able to self-manage during menstruation.
___ Requires **minimal** assistance during menstruation.
(Verbal reminder to check/change feminine products, etc.)
___Requires **total** assistance during menstruation.
(Take to bathroom, physical check/change feminine products, etc.)

Feeding: ___ Able to feed himself/herself independently.
___ Requires minimal assistance (help with warming up food, cutting up food, etc.)
___ Total assistance (feeding tube, puree food, etc.)

Dressing: ___Is able to dress himself/herself independently.
___Requires minimal assistance in dressing himself/herself.
___Total assistance.
Note: (Please list what assistance is required) _____

_____

_____

Behaviors (Please check all that apply)

__Tantrums __Screams __Bites __Hits __Spits

__Scratches __Pulls Hair __Kicks __Head Bangs __Slaps

_Steals __Withdrawn __Moody __Self Abusive __Destructive

__Hyperactive __Runs Away __Pinches __Aggressive __Depressed

__Fantasizes __Talks to Self __Uses Inappropriate Language __Lies

Explanation of the above checked items:

_____
_____
_____

Are there things that bother him/her? (loud noises, change of routine, large crowds, etc.)

_____
_____

How would you describe his/her day-to-day behavior? (quiet, hyperactive, social, aggressive, etc.)

_____
_____

Please include any other vital information about him/her that would be helpful to us:

_____
_____
_____

PERSONAL INFORMATION

Reading: (Please check where he/she performs currently.)

__Cannot read __He/She can read simple words __Read independently

Writing: (Please check where he/she performs currently)

__Cannot write __He/She can write simple words __Write independently

Check any/all of the extracurricular activities that he/she enjoys doing:

__Board games __Crafts __Art __Sports __Reading __Computer

__Drama __Fitness __Cooking __Music __Video Games __Other

Other:_____
_____
_____

Does he/she have any dietary restrictions? ___YES ___NO

If YES, please list: _____

Please check YES/NO if he/she has any of the following:

	YES	NO		YES	NO		YES	NO
Asthma/Bronchitis	__	__	Emotional Problems	__	__	Cerebral Palsy	__	__
Heart Condition	__	__	Contact Lenses	__	__	Hepatitis	__	__
Seizure Disorder	__	__	Learning Disabled	__	__	Ear Aches	__	__
Visual Disorders	__	__	Blind	__	__	Skin Rashes	__	__
Artificial Limb	__	__	Glasses	__	__	Dyslexia	__	__
Limb Pain	__	__	Diarrhea	__	__	Chewing/Swallowing	__	__
Behavior	__	__	ADD/ADHD	__	__	Hearing Impairment	__	__

Other:

_____

If you checked YES above, please explain:_____

_____

MEDICATION SELF-ADMINISTRATION WAVIER

Please fill out completely in blue or black ink.

I hereby **__give permission/ __do not give permission to** Soaring Eagle Center personnel to oversee the self- administration of medication by my son/daughter _____(*name)* according to the instructions below. I understand that Soaring Eagle Center personnel are not certified as a registered nurse: however, I consent to allowing their oversight of medical administration to my son/daughter. I acknowledge that Soaring Eagle Center is to incur no liability, except for willful and wanton conduct, arising from the self – administration of medication or use of an epinephrine auto–injector by my son/daughter. I further waive any claims against Soaring Eagle Center, members of the Board of Directors, its employees and agents arising out of the self-administration of said medication or use of an epinephrine auto–injector. I agree to hold harmless and indemnify Soaring Eagle Center, the members of the Board of Directors, its employees and agents, either jointly or severally, from and against any and all liability, claims demands, damages, or causes of action or injuries, costs and expenses, including attorneys' fees, resulting from or arising out of the self-administration of asthma medication or use of an epinephrine auto-injector, this waiver and indemnification are not applicable to willful and wanton acts to the extent required by law .

Medication for self-administration while at the Soaring Eagle Center:

RX Name:_____Dosage:_____Time:_____

Reason for Medication: _____Side affects_____

RX Name: _____Dosage:_____Time:_____

Reason for Medication: _____Side affects_____

Signature: _____ Phone#: _____Date: _____

PARENT/CAREGIVER/GUARDIAN INFORMATION

Please fill out completely in blue or black ink.

Parent/Caregiver/Guardian Name: _____

Relation: ___Parent (Mother /Father) ___Caregiver ___Guardian ___Sibling ___Other

Address: _____

City: _____ State: _____ Zip: _____

Employer: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Parent/Caregiver/ Guardian Name: _____

Relation: ___Parent (Mother /Father) ___Caregiver ___Guardian___Sibling ___Other

Address: _____

City: _____ ST:_____ Zip: _____

Employer: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

(Please list email address to which we can send program updates and reminders. This address will be used as a primary source of communication.)

REFERENCES

Name: _____ Relation: _____

Phone#: _____ Email:_____

Name: _____ Relation: _____

Phone#: _____ Email: _____

I give permission for Soaring Eagle Center Committee to contact the above references.

_____ _____

Parent/Guardian Signature **Date**

Soaring Eagle Parent Questionnaire

Please fill out completely in blue or black ink.

1. What do you as a parent desire for your son or daughter?

2. What are three or four things you would like for your son or daughter to gain from his/her participation in the Soaring Eagle Center Day Program?

3. What would you consider your son or daughter's gifts and talents to be?

4. What are your son or daughter's interests?

5. What are your son or daughter’s likes and dislikes?

ASSOCIATE EMERGENCY RESPONSE INFORMATION

If otherwise instructed, 911 will be called if your child is experiencing a seizure.

.

Full Legal Name: _____

Preferred Name: _____ Sex: M F DOB:_____

Disability/Diagnosis: _____

Current Medications: _____

Medication Allergies: _____

Does he/she have seizures? ___Yes ___No Frequency: _____ Length: _____ Helmet? _____

Characteristics of seizures: _____

Communication: ___Verbal (Talk/Speak) ___Non-verbal

Hearing Loss: ____None ____Mild ____ Moderate ____Severe

Possible source of agitation in an emergency: _____

_____

Please include any other vital information that would be helpful to medical personnel:_____

_____

ASSOCIATE MEDICAL INFORMATION

Primary Care Physician: _____Phone: _____

Primary Insurance Company: _____

Insurance Phone: _____

ID#: _____Group #: _____

Primary Insured Name: _____

Secondary Insurance Company: _____

Insurance Phone: _____

ID#: _____ Group #: _____

Primary Insured Name: _____

Medicaid#: _____

Legal Guardian: _____

In case of emergency transport to (*name of hospital*):_____

PARTICIPANT RELEASE FORM

Please fill out completely in blue or black ink.

In consideration of participating in the activities of the **Soaring Eagle Center**, I _____ (parent/legal guardian of _____), understand the nature of such activities and that my adult, _____, is in adequate health and in proper physical condition to participate in such activities. Since there are inherent risks associated with any activity, I, the arent/guardian of the above-named adult, state that I have considered the risks and hereby give my permission for my adult to attend and participate in such activities, including transportation in the private vehicles of program volunteers to any associated activities.

Parent/Guardian Signature: _____ Date: _____

AUTHORIZATION FOR TRANSPORTATION

I, _____ (parent/legal guardian of _____),

___authorize ___do not authorize

Soaring Eagle Center staff or representatives my permission to transport my son/daughter to Soaring Eagle Center authorized activities. I understand that the Soaring Eagle Center staff or representatives are required to have a minimum amount of drivers insurance in order to transport and this insurance shall be used first should a situation arise.

AUTHORIZATION FOR PHOTO/MEDIA RELEASE

By singing below, I, _____ (parent/legal guardian) of _____,

___CONSENT ___DO NOT CONSENT

that the Soaring Eagle Center has permission to take and use the above stated associate's photographs, digital images and video images for official Soaring Eagle Center purposes, such as, but not limited to media press releases, brochures, posters, flyers, newsletters, internet publication, etc.

WAIVER OF LIABILITY

By signing below, I, _____ (parent/legal guardian) of _____, release, indemnify, covenant not to sue, and hold harmless the **Soaring Eagle Center**, its administrators, directors, agents, officers, volunteers, employees, and (if applicable) any owners and lessors of premises on which any activity takes place, from all liability, losses, claims, demands, costs, or damages that my adult may incur as a result of participation in **Soaring Eagle Center** programs or activities.

I have fully read and considered all of the terms and statements contained in this release before affixing my signature.

This Release is intended to be as broad and inclusive as permitted by the laws of the State of Texas, and in the event that any clause or provision of this Release shall by held to be invalid by any court of competent jurisdiction, the invalidity of such clause or provision shall not otherwise affect the remaining provisions of this Release which shall continue to be enforceable.

Parent/Guardian Printed Name: _____

Signature: _____ Date: _____

FINANCIAL AGREEMENT

CHOOSE ONE OPTION:

Private Pay _____ HCS _____ TxHmL _____ CLASS _____

PRIVATE PAY FEE SCHEDULE

Number of Days per Week	Monthly Fee
One	$100.00
Two	$200.00
Three	$300.00
Four	$400.00
Five	$500.00

1. Fees are due by the 5th of the month. After the fifteenth of the month, there is a $25.00 late fee.
2. Failure to pay the program fee and late fee by the end of the month will result in the associate losing their place in the program.
3. The Soaring Eagle Center has the right to raise the fees if necessary.
4. There is no refund for absences.

HCS, TxHmL, AND CLASS DAY HAB FEES

The HCS, TxHmL, and CLASS programs will pay for day programs. It is your responsibility to contact your provider to make arrangements for this. For HCS and TxHmL providers, our fee is $25.00 a day.

We must receive a signed contract from your provider before your adult can begin attending the program. This process can take up to a month. If you wish for your adult to begin attending immediately, but do not yet have a signed contract with your provider, you may pay the private pay fees for the day program until provider funds become available.

I accept financial responsibility for the fees associated with _____ attending the SEC Day Program.

Name _____ Date _____

PROVIDER INFORMATION

Provider's Name _____ Phone _____

Address _____ State _____ ZIP _____

Email _____ Fax _____

Case Manager's Name _____

Phone _____ Email _____

Local Authority Information

Name _____ Phone _____

Address _____ State _____ ZIP _____

Email _____ Fax _____

Service Coordinator's Name _____

Phone _____ Email _____

I understand that it is my responsibility to contact my service coordinator and provider when changes are made to the number of days my adult attends the SEC Day Program. I understand that it is my responsibility to inform the SEC staff 2 months prior to my annual renewal date, so they can be involved in setting goals for my adult at the day hab.

Name _____ Date _____

INFORMATION RELEASE

I give ____ or do not give _____ permission for the SEC Day Program to give my family's name, address, phone number, and email to other parent(s)/caregivers in the SEC Day Program.

I agree to not use this information for any solicitation or business' purposes. This information is intended to be used by associates, parent(s), and caregivers for personal reasons only (arranging transportation, planning parties, developing relationships with other families, etc.)

Name _____ Date _____

VACATION AND SICK DAYS

In order to encourage consistent attendance of the associates and to maintain a low staff/associate ratio, our policy regarding absences and late arrivals is to allow each associate a certain number of days off each session. If the associate exceeds the allotted number of days off, the Executive Director and SEC Day Program staff will meet with the adult and parents to determine the reason for the absences. If there are no extenuating circumstances, the number of days the associate attends will be reduced. This policy does not apply to associates who are private pay.

Fourteen days off are built into the schedule for holidays and staff development days. In addition to the fourteen days, each associate has five weeks of allowed days off based on how many days a week they attend. The following chart shows the number of days off allowed:

Associates Attending Both School and Summer Sessions

Five days a week	25 days
Four days a week	20 days
Three days a week	15 days
Two days a week	10 days
One day a week	5 days

Associates Attending the School Year Session Only

Five days a week	20 days
Four days a week	16 days
Three days a week	12 days
Two days a week	8 days
One day a week	4 days

We understand that there are extenuating circumstances due to severe illness, a death in the family, etc. If these occur, please contact the SEC Day Program staff.

If an associate attends less than three hours of the program, the day will be counted as an absence.

If the associate does not attend five days a week, we ask that you try to schedule appointments for the days they do not attend. If your associate attends five days a week, we ask that you try to schedule appointments before or after the day program hours.

BEHAVIOR POLICY

Adults in the SEC Day Program are expected to maintain a level of consistent behavior while attending The Center. This behavior includes but is not limited to:

1. Active participation in all parts of the program.
2. Compliance with the rules and procedures of the program and instructions of the staff.
3. Responding respectfully to the staff, volunteers, and other associates.
4. Speaking appropriately to staff, volunteers, and associates (ie: no profanity, no sexual comments, no making fun of, no bullying, etc.)

The following behavior will not be allowed (including but not limited to) during the program:

1. Wandering or running away.
2. Non-compliance to staff's instructions.
3. Non-compliance to the rules and procedures of the program as outlined in the associate handbook.
4. Throwing objects.
5. Biting, scratching, kicking and fighting.
6. Refusal to take prescribed medication.
7. Inappropriate sexual behavior, words or touching.
8. Verbal, physical, and social (ie: bullying, excluding others, etc.) abuse.
9. Destruction of property.
10. Stealing
11. Pursuit of a boyfriend/girlfriend relationship (ie: no exclusive relationship, no holding hands, no close dancing, etc.)

Parents will be contacted when there is a consistent violation of the behavior policy. A meeting will occur with SEC Day Program staff, Executive Director, adult and the parents to discuss the behavior and develop solutions for changing the behavior. Continued violation of the behavior policy will result in a review of the associate's place in the program.

DISMISSAL POLICY

It is the policy of the Soaring Eagle Center to dismiss an associate in the following circumstances:

- Upon direct orders of a physician.
- If services and activities beyond those normally provided are needed.
- If the associate becomes a threat to the health and safety of herself/himself or others.
- Repeated violation of the program's behavior policy.
- Requested voluntary discharge by the associate, family or legal guardian.
- Failure to pay the program fee with the late fee by the end of the month.
- Excessive absences and tardies and failure to call when absent or tardy.

I have read the above dismissal policy and agree to comply with its guidelines.

Associate Name: _____Associate Signature:_____

Parent/Guardian Signature: _____ Date: _____