Urban Farms
Food & Farms Employment Preparation Program
Application

Applicant's General Information

Name: _____Tel #_____

Address:_____ Apt #_____

City:_____ State:_____ Zip:_____

Date of Birth:__/___/____ Age:_____ Sex:_____ TabsID#: _____

Social Security Number:_____

Medicaid #:_____ Medicare #:_____

Name of Parent/Guardian:_____

Primary Language Spoken:_____

Guardianship established by Surrogate's Court : □ Yes □ No

PLEASE ATTACH ONE PHOTO HERE

(This is extremely important for the safety of the applicant).

Applicant's Residence (check only one box)

□ Home (natural family) □ State Operated IRA/ICF □ Voluntary IRA/ICF

□ Community Residence □ Other _____

Present Services

1. School Applicant Attends: _____
   Contact Name: _____
   Phone Number: _____

2. Other program (i.e. day program, after-school program): _____
   Contact Name: _____
   Phone Number: _____

3. Currently receiving any SUS services: □ Yes □ No
   If yes, which ones? _____

Service Coordination

Does applicant have a Case Manager/Service Coordinator? □ Yes □ No
If yes, please provide contact information:

Name: _____ Agency Affiliation: _____

Telephone #: _____ Fax Number: _____
Address: _____

Travel Ability

□ Travels independently
□ Can travel independently after instruction
□ Walks independently, with no assistance
□ Does **NOT** travel independently
□ Uses Wheel chair
□ Walks but requires some assistance

Other, please specify:_____

Emergency Contact

1. Emergency Contact:_____ Relationship_____

   Phone Number:_____ Cell Number:_____

   Other Number:_____ Address: _____

---

2. Emergency Contact:_____ Relationship_____

   Phone Number:_____ Cell Number:_____

   Other Number:_____ Address: _____

---

3. Emergency Contact:_____ Relationship_____

   Phone Number:_____ Cell Number:_____

   Other Number:_____ Address: _____

Medical Information

Primary Diagnosis (if known):

□ Mental Retardation
□ Autism
□ Cerebral Palsy
□ Seizure Disorder

If Mental Retardation, please check:

□ Profound □ Moderate
□ Severe □ Mild

(Note: Selected category must Match Psychological/Psychosocial report)

Secondary Diagnosis

List all other diagnosis – medical/psychological:
_____

Allergies to Medications □ Yes □ No If YES, Please List: _____
_____

Allergies to Food or Environment □ Yes □ No If YES, Please List: _____
_____

Asthma □ Yes □ No If YES, Please List: _____
_____
Nebulizer Treatment? □ Yes □ No
□ Daily □ Sometimes □ Rarely

Diabetes □ Yes □ No

Oral Medications? □ Yes □ No
Insulin Injections? □ Yes □ No

Sexuality Has sexual consent been established?
□ Yes □ No
Psychosexual completed?
□ Yes □ No
Copy of report provided?
□ Yes □ No
Is this information part of the ISP?
□ Yes □ No

Epilepsy □ Yes □ No
Date of last seizure?

Type of seizure activity? Has seizures:
□ Daily □ Weekly □ Monthly □ Other

Utilizes protective helmet?
□ Yes □ No

Medication Information

Please provide details of current medications

Medication:	Dosage/Frequency:	Reason/Diagnosis:	Time (s) Administered:

Physical Limitations? □ Yes □ No
If yes, please explain: _____

Supplemental Questions

1. What are the Individual's interest/hobbies?

   _____

2. What are the Individual's dislikes?

   _____

3. Please explain methods/ways that encourage the Individual to fully participate in an activity?

   _____

4. What works best when the Individual is upset?

   _____

5. Describe the Individual's community skills:

   _____

6. Attention span?

   _____

7. How does he/she respond to dangerous situations:

   _____

8. Favorite Foods:

   _____

9. Foods he/she should not eat?

   _____

Prosthetic Devices

□ Glasses	□ Braces (list type below)	□ Hearing Aid
□ Shoes	□ Crutches	□ Other (list below)
□ Wheelchair	□ Helmets _____	

Daily Living Skills

1 = Independent 2= Need some assistance 3= Dependent

Category	Dependency	Explanation
Drinking		
Eating		
Toileting		
Dressing		
Bathing		

Behaviors

	Behavior		Description	Frequency
☐	Physical Aggression	☐	Hitting	
		☐	Kicking	
		☐	Spitting	
		☐	Punching	
☐	Verbal Aggression	☐	Cursing	
		☐	Shrieking	
		☐	Teasing	
		☐	Interrupt	
☐	SIB	☐	Hitting	
		☐	Biting	
		☐	Slapping	
		☐	Head Banging	
		☐	Other: _____	
☐	Elopement	☐	To designated area	
		☐	To leave program	
		☐	Leaving group when in community	
☐	PICA	☐	Any objects	
		☐	Special/particular objects	
		☐	Other: _____	
☐	Destruction of Property	☐	Furniture	
		☐	Electronics	
		☐	Walls	
		☐	Other: _____	
☐	Self Mutilation	☐	Face	
		☐	Arms/Torso	
		☐	Legs/Feet	
		☐	Other: _____	

Parent/Guardian Signature_____ Date:_____

SUS Staff Reviewing Form Signature_____ Date:_____

Other Concerns:_____
_____

Primary Caregiver

Please note: This is where the participant will be dropped off after the program.

Applicant's Full Name:_____

Caregiver's Name:_____

Telephone Number:_____ Other Telephone Number:_____

Address: _____ Apt:_____

City:_____ State:_____ Zip:_____

Note: As you review each section and agree please initial the box on the left hand side. Completely fill out all necessary information and remember to sign and date on the bottom.

Alternate Placement Agreement

If the Primary Caregiver of the applicant is unavailable before, during, or immediately following Services for the Underserved activity, it is advised the Services for the Underserved contact the "Alternate Placement Person" listed below, who agrees to be responsible for the participant's welfare while the Primary Caregiver is unavailable. If a Day Hab Specialist, Recreational Aide or appointed staff person deems it necessary to contact the "Alternate Placement Person" for pick-up, that placement person will provide transportation as soon as possible, or be available to receive that Individual when transported. In addition, in case the Primary Caregiver is not home when a transportation company arrives, Service for the Underserved will call the "Alternate Placement Person" and transport the Individual to the listed address.

Parent/Guardian's Name:_____

Parent/Guardian's Signature:_____ Date: _____

Alternate Placement Person

Name:_____

Relationship:_____

Telephone Number:_____

Other Telephone Number:_____

Address:_____

City:_____ State:_____ Zip:_____

Photo/Video Release

☐ I hereby give my consent for the above-named Individual's name, photograph and video to be used by Services for the Underserved in conjunction with agency press releases, newspaper and or other publications. I give authorization without incurring any financial or moral obligation to either myself or the Individual.

☐ opting out of Photo/Video Release

Emergency Medical Treatment

☐ In case of emergency, I understand every effort will be made to contact the parent, guardian or alternative emergency contact person of the Individual. However, in the event that I can not be reached, I hereby give permission to the physician selected by the SUS administration to hospitalize, secure proper treatment, order injection, anesthesia, or surgery for my son/daughter as named above.

☐ opting out of Emergency Medical Treatment

Consent for Release of Information

☐ I hereby authorize the release of medical/clinical/fiscal information to/from the records of _____.These records can also be released to/from: _____ for the purpose of arranging needed medical/clinical/fiscal service, and that the receiving agency will maintain the confidentiality of the information and use only for this purpose. Access to this information will be limited to only those persons involved in arranging this service, in accordance with HIPAA Privacy Regulations. I also understand that this consent can be withdrawn at anytime.

☐ opting out of Consent for Release of Information

Consent for Placement

☐ I agree to the placement of the above named individual for services at Services for the Underserved within the site listed above.

Trip Release

☐ I give permission for the above named Individual to attend all trips arranged by the SUS Urban Farms

program. I recognize that walking, the use of Services for the Underserved van service and/or public transportation will be the modes of transportation and/or use of contracted transportation services. I release Services for the Underserved from any claim/liability in connection with these trips.

Acknowledgement of receipt of - Notice of privacy practices

☐ I acknowledge that I have been provided a copy of the Notice of Privacy Practices of Services for the Underserved-MR Programs, Inc. and have therefore been advised of how medical information about me may be used and disclosed by Services for the Underserved and how I may obtain access to this information.

Emergency Release Form

In the event of a medical emergency or an emergency closing of the program, you will be notified by telephone. However, in the event that you are unavailable the program will contact an alternative person, who will act on your behalf. Please provide the information requested below, which will provide the program with an alternate to contact, should you be unavailable.

Name:_____ Relationship: _____Phone Number: _____

Address: _____

Individual Rights & Jonathan's Law

☐ I have read (or have been informed of) and reviewed the Statement of Individual Rights and understand and agree to the services, rights, responsibilities as so stated for the program. I have similarly been informed of my right to:

- Register complaints, concerns, or suggestions
- Object to and appeal any plan or services or part thereof, other care or treatment, or plans of placement
- Object to and appeal the application, adaptation for denial of any right stated herein

Grievance Procedures

☐ I have read (or have been informed of), reviewed the attached Grievance Procedures.

Liability Declaration

☐ I have read (or have been informed of), reviewed the attached Liability Declaration.

The signatures below signify understanding and agreement to comply with the above conditions and a witnessing of same.

I guardian/advocate of _____ understand and in agreement with the above conditions.

_____ _____
Guardian/Witness/Advocate Date

_____ _____
Program Participant Date

_____ _____
Program Representative Date