



Cover Sheet for Application For Enrollment

The **Application For Enrollment** must be completely filled out and renewed yearly by all participants who attend any programs at Stepping Stones Center. This document is valid for 1 year from the date of the Physician's signature. A recent picture is required each time the application is submitted. Please make sure you renew your participant's Application For Enrollment by the **expiration date (date of Physician's signature), so their services will not be interrupted.

** (The expiration date for current participants will be above their name on any mailing label we send out.)

For your convenience and assistance in completing the Application For Enrollment, please use this checklist.

_____ **Did your Doctor COMPLETELY FILL OUT, SIGN and DATE pages 6,7,8,9 of the medical section?**

_____ **If you are bringing prescription medications, are they in labeled prescription bottles with name, dosage, and time to be given?**

_____ **Did you SIGN and DATE the GENERAL RELEASE, the EMERGENCY MEDICAL RELEASE, the PHOTO RELEASE and check the photo release, either "I DO" or "I DO NOT"? (Page 4)**

_____ **If you filled out the transportation alert, did it include ONLY the names of the people you DO NOT want to pick up the participant? (Page 3)**

_____ **Did you include a recent photo of the participant with participant's name on the back? (Your application will NOT be considered complete without a RECENT picture of the participant-pictures must be mailed, NO faxes accepted.)**

_____ **If the participant intends on using a Waiver, did your Service Facilitator email a copy of the Plan to nicole.allen@steppingstonescenter.org? (Page 5)**

_____ **If you carry health insurance, did you write the company name and policy number on the bottom of Page 3?**

_____ **If participant has a written behavior support program, did you include a copy? (Page 3)**

_____ **Did you complete the payment information on page 5 and include the name and phone number of contacts? And if seeking Financial Aid, did you enclose the first two pages of your latest Federal Tax Return? (Page 5)**

_____ **Did you provide TWO emergency contacts? (Your application will NOT be considered complete without TWO emergency contacts). (Page 2)**

PLEASE DO NOT RETURN THIS PAGE.

A recent photo of participant must be paper-clipped here.
Write name on back.



APPLICATION FOR ENROLLMENT

(Must be renewed yearly)

Please fill out the application completely. Information must be complete and all parts returned in order to begin the application process. **A RECENT PHOTO MUST BE INCLUDED WITH APPLICATION. PARTIAL OR INCOMPLETE APPLICATIONS WILL BE RETURNED FOR COMPLETION. A SEPARATE REGISTRATION FORM MUST ACCOMPANY THIS APPLICATION IN ORDER TO REGISTER FOR ANY PROGRAMS.**

All registrations can be found on our website www.steppingstonescenter.org.
If you have any questions, please call Client Services @ 513-831-4660 ext 10.

(Please print clearly)

Participant

Emergency Contact Info

Last Name _____
 First Name _____ Middle Initial _____
 Street _____
 City _____
 State _____ Zip _____
 County _____
 Phone (____) _____
 Sex: Male _____ Female _____
 Social Security # _____
 Medicaid # _____
 Medicare # _____
 Ethnic Info:
 Appalachian _____ Asian _____ Black _____ Hispanic _____
 Native American _____ White _____ Other _____
 Age _____ Date of Birth ____/____/____
 Group Home Name _____
 House Manager _____
 Phone(____) _____

Mother Last Name _____
 First Name _____
 Street _____
 City _____
 State _____ Zip _____
 Phone(____) _____
 Cell Phone(____) _____
 Employer _____
 Work Phone(____) _____
 Email _____

Father Last Name _____
 First Name _____
 Street _____
 City _____
 State _____ Zip _____
 Phone(____) _____
 Cell Phone(____) _____
 Employer _____
 Work Phone(____) _____
 Email _____

Person responsible for completing paperwork
Name _____
Daytime Phone (____) _____
Evening Phone (____) _____
Cell Phone (____) _____
Email _____

Guardian Last Name _____
 First Name _____
 Street _____
 City _____
 State _____ Zip _____
 Phone(____) _____
 Cell Phone(____) _____
 Work Phone(____) _____
 Email _____



DDS



Mail Completed Application to:
 Client Services
 Stepping Stones Center
 5650 Given Road
 Cincinnati, OH 45243



Other Emergency Contacts

Please list TWO additional people who would be able and willing to respond in the case of an emergency.

(This application will NOT be accepted without 2 emergency contacts)

(Do not list names and numbers of parents and guardians)

2.

Please Print

Name _____
Relationship _____
Work Phone(_____) _____
Home Phone(_____) _____
Cell(_____) _____

Name _____
Relationship _____
Work Phone(_____) _____
Home Phone(_____) _____
Cell(_____) _____

Service Facilitator/Case Worker (if applicable)

Name _____
Phone(_____) _____
Cell(_____) _____

Participant Information

Please complete the following section as thoroughly as possible. This information enables us to plan a safe and successful experience for the participant. The information is not considered a basis for acceptance.

Disabilities (Please check any that apply and add additional under "other")

(Please print)

DOES PARTICIPANT USE WHEELCHAIR? _____ **YES** _____ **NO**

ADD _____	Autism _____	Developmental Disability _____	PDD _____	OTHER _____
ADHD _____	Bi Polar _____	Diabetes _____	Quadriplegic _____	_____
Asthma _____	Blind _____	Dual Diagnosis _____	Scoliosis _____	_____
Apraxia _____	Brain Injury _____	Down Syndrome _____	Seizure Disorder _____	_____
Arthritis _____	Cerebral Palsy _____	OCD _____	Spina Bifida _____	_____
Aspergers _____	Deaf _____	Paraplegic _____	_____	_____

SPECIFIC ASSISTANCE:

DRESSING: _____ Independent _____ Verbal Directions _____ Physical Assistance _____ Total Assistance
Other _____

TOILETING: _____ Independent _____ Verbal Directions _____ Physical Assistance _____ Total Assistance
Other _____

EATING: _____ Independent _____ Verbal Directions _____ Physical Assistance _____ Total Assistance
Other _____

COMMUNICATION: How does the participant communicate? Please note any special signs or gestures if applicable.

Does participant use a mechanical communication device? _____ Please describe it:

Will this device be brought to program? ___ Yes ___ No

(Stepping Stones Center and Camp Allyn are NOT responsible for loss or damage to mechanical devices)

Please check which over-the-counter medications are permitted to be given by our nurse, if needed.

____ IBUPROFEN (ADVIL) Dosage _____ Frequency _____ Route _____

____ ACETAMINOPHEN (TYLENOL) Dosage _____ Frequency _____ Route _____

____ BENADRYL Dosage _____ Frequency _____ Route _____

____ BENADRYL OINTMENT (HYDROCORTIZONE CREAM/TOPICAL) _____ POLYSPORIN OINTMENT TOPICAL

____ CEPACOL LOZENGES _____ SWIM EAR DROPS

____ MAALOX /PEPTO BISMOL (Per Bottle Instructions) _____ SUNSCREEN

____ MILK OF MAGNESIA (Per Bottle Instructions) _____ OTHER _____

TRANSPORTATION ALERT

(Alerts us to people you **DO NOT** want to pick up your child/adult)

As a parent or legal guardian, **I DO NOT** authorize my child/adult to be released/picked up by the following persons. I will notify, in writing, Stepping Stones or Camp Allyn of any changes in this information.

1. Name: _____ Relationship _____

2. Name _____ Relationship _____

3. Name _____ Relationship _____

OTHER INFORMATION

Please take time to carefully fill out this section. Include any information regarding family or friends and likes, special interests, dislikes or any other information that would assist us in providing the best and most complete experience for the participant.

Here is the chance to dote on your great son/daughter. Tell us the fun stuff: favorite hobbies, favorite friend, what do they do best ?

Dislikes and Fears: (i.e. loud noises, crowds, animals, change in schedule, etc.)

Aquatic Activities : Special needs that pertain to swimming. Please circle those that apply:

Swim Diaper Swim Cap Sensitivity to Chlorine Extreme Fear No Fear

Dietary Concerns: List any foods to be avoided and any behavioral or negative reaction. (i.e. red dye causes hyperactivity, caffeine causes headaches, etc.) _____

Behavioral Concerns: If there are any behavioral issues please describe what they are and how they are best handled. (Does participant have a written behavior support plan? If so, copy **MUST** be attached.)

Skill or Activity That We Should Focus On Specifically:

(If the participant has an IEP, IPP, or IFSP, copy **MUST** be attached.)

FINANCE PAGE

Please Print

For office use only

ADHP
ADTRIP
AIS
DCCA
DCSS
EE CA
RCA
RCY
RESA
RESY
SKC
SU

RENEWAL

Participant Name _____
First Middle Initial Last

Contact Name _____ Daytime Phone Number (_____) _____

Contact Email _____

You will be billed for services. Please check your form of payment.:

SELF PAY:

- Requesting Financial Aid (see below)
- Cash
- Check (There is a \$20 charge for all returned checks) (Make check out to Stepping Stones Center)
- Money Order (Make check out to Stepping Stones Center)
- Credit Card (MasterCard, Visa, Discover, American Express)
(Please call our billing dept. @ 513-831-4660 ext 17 to pay by credit card)

 Family Resources Voucher (Please include voucher if you have it)
Contact _____ Phone (_____) _____

Job & Family Service Child Care Voucher (Please include voucher if you have it)
Contact _____ Phone (_____) _____

Third Party Funding (Grant, Scholarship, etc)
Name of Organization _____
Contact _____ Phone (_____) _____

County Contract/Independent Budget
County _____
Contact _____ Phone (_____) _____

* Waiver (check one) Independent Options _____ Level One _____ Ohio Homecare (for overnight stays only) _____
County _____
Service Facilitator _____ Phone (_____) _____
Email _____

Local School District Funding
School District _____
Contact _____ Phone (_____) _____

***Copy of CURRENT plan MUST be emailed by your SSA, Service Facilitator or Case Manager to nicole.allen@steppingstonescenter.org (unless already on file with Stepping Stones)**

Financial Aid

If you are a private payer, you may be eligible for financial assistance.
Please see the box on the right to determine eligibility.

If you believe you are eligible, please submit the first two pages of your latest IRS Federal Tax Return and someone will get back to you to discuss your eligibility.

Please Note: Financial aid will be granted on a first come basis, and limits exist as to the amount available per program.

Family Size	Annual Income**
1	20,500
2	27,400
3	34,400
4	41,300
5	48,300
6	55,200
7	62,200
8	69,200

** Adjusted Gross Income from IRS Form 1040EZ, 1040A, or 1040

Parent/Guardian and Physician Please Read

To protect the health and safety of all participants, we require a Physician to complete, sign and date pages 6 through 9 of the Application For Enrollment. All sections must either be completely filled out or checked “Not-Applicable”.

Failure to fill out any section will result in the application being returned to the parent or guardian.

Returning pages for parent’s or Physician’s completion could cause a delay that might result in a missed deadline and an inability for participant to attend desired program.

This page is for Physician’s and Parent’s reference only.
Please do not return with Application For Enrollment.

Stepping Stones Center Master Medical Form

Stepping Stones Nurse Phone 513-831-4660 ext 25 Fax 513-831-5918 Camp Allyn Nurse Phone 513-732-0240 ext 14 Fax 513-735-1461

Please be aware that the information requested from your physician by the Master Medical Form is to be used solely in our efforts to provide as safe and healthy an environment as we reasonably can. Neither the absence or nature of any response given on the form will determine your acceptance into the program. We are not seeking the disclosure of any information the confidentiality of which is protected by law except in accordance with that law.

TO BE COMPLETED , SIGNED AND DATED ONLY BY PHYSICIAN

(PLEASE PRINT)

Participant's Name _____ Age _____
 Physician Name _____ Phone _____ Birthdate ____/____/____
 Diagnosis _____ Sex _____ Weight _____
 _____ Height _____
 _____ Blood Pressure _____
 _____ Temperature _____

PAST MEDICAL AND PHYSICAL HISTORY

All items must be checked "yes" or "no"

		Y	N	If yes, describe				Y	N	If yes, describe	
Auditory Needs				Hearing Aid L R	P.E. Tubes L R					Muscular	
				Cochlear Implant L R	Earplugs L R					Range of Motion Every Two Hours	
Learning Disability										Contractures	
Developmental Disability										Weakness	
Psychological Needs										Degeneration	
Speech Needs										Chair repositioning every _____ hours.	
Visual Needs				Glasses yes ____ no ____	Contacts yes ____ no ____					In chair 2 hours, out of chair 2 hours	
Cardiac Problems										Skeletal	
Circulatory										Spinal Column Injury	
PVD										Subluxing Joints	
Diabetes										Dislocating Joints	
Sensory Loss										Laminectomy/Fusion	
Respiratory										Scoliosis-Degree Type	
Asthma/COPD				Inhaler yes ____ no ____	Nebulizer yes ____ no ____					Brace/Last x ray	
Tracheostomy										Kyphosis/Lordosis Degree/Type	
Neurological										Spondylolisthesis	
Seizures/Type										Spinal Abnormality	
Protective Headgear										Osteoporosis	
Controlled										Heterotrophis Ossification	
Date of Last Seizure										Joint Disease	
Hydrocephalus										Cranial Defects	
Microcephalus										Fractures: Location Healed	
Shunt - Type										Menstrual History	
										Dermatological Condition	

Physician Signature _____ **Date** ____ / ____ / ____

Participant Name _____ Date of Birth ___/___/___

AUTHORIZATION FOR ADMINISTRATION OF PRESCRIPTION MEDICATION(S)

Will we be administering medications during program hours? YES _____ NO _____

If YES, please fill in boxes below and sign & date bottom of page,
or attach a signed & dated computerized printout of medications to be administered.

If NO, please attach a signed & dated computerized printout of medications the participant is currently taking.
(for informational purposes only)

If participant takes no prescription medications, please check here

N/A

Medication _____
Dosage _____
Time(s) to be given _____

Route _____
Side Effects _____

Medication _____
Dosage _____
Time(s) to be given _____

Route _____
Side Effects _____

Medication _____
Dosage _____
Time(s) to be given _____

Route _____
Side Effects _____

Medication _____
Dosage _____
Time(s) to be given _____

Route _____
Side Effects _____

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Route _____
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Medication _____
Dosage _____
Time(s) to be given _____

Route _____
Side Effects _____

Medication _____
Dosage _____
Time(s) to be given _____

Route _____
Side Effects _____

Medication _____
Dosage _____
Time(s) to be given _____

Route _____
Side Effects _____

Physician Signature _____ Date ___/___/___

THIS PAGE MUST BE COMPLETELY FILLED OUT.
IF ITEM IS NOT APPLICABLE, N/A BOX MUST BE CHECKED

DIASTAT AcuDial (diazepam rectal gel)
Treatment: Order and Emergency Seizure Plan

Treatment Order Date ___/___/___ Age _____ Weight _____

Treatment:

Diastat (diazepam rectal gel) _____ mg rectally prn for:
 Seizure > _____ minutes OR for _____
 Use VNS (vagal nerve stimulator) magnet _____
 Other _____

If Diastat is administered, 911 will always be called

N/A

TOILETING INSTRUCTIONS

Colostomy Yes _____ No _____
 Ileostomy Yes _____ No _____
 Collection Bag Yes _____ No _____ Type _____
 Catheter Yes _____ No _____ Type _____
 How Often _____
 Enema Yes _____ No _____ Type _____
 How Often _____
 Protocol For Administration _____

N/A

DIABETES NEEDS

Special Diet _____ **Insulin Sliding Scale**
 Oral Hypoglycemics _____
 Insulin yes _____ no _____
 Glucagon yes _____ no _____
 Treatment for Hypoglycemia _____

N/A

ALLERGIES (food, environmental, seasonal, medications, insects, other)

<u>Allergy</u>	<u>Signs & Symptoms</u>	<u>Treatment</u>

N/A

EPI-PEN (MUST BE PROVIDED BY PARENT/GUARDIAN)

Administered for severe allergic reactions to _____
 No _____ Yes _____ Dosage _____

If Epi-Pen is administered, 911 will always be called

N/A