



divinecare.org

14423 W McDowell RD G104
Goodyear, AZ 85395
Office: 623 547-4839 and Fax: 623 547-4567
www.divinecare.org

Member Information Packet

Date _____

Consumer Name _____

Date of Birth ____/____/____ Gender: Male _____ Female: _____

Address _____

City, State, Zip-code _____

Phone Number (____) _____

Guardianship Status (please provide copies of supporting court documents)

Parent/Guardian _____

Mailing Address _____

City, State, Zip-code _____

Home Phone (____) _____ Cell or Work Phone (____) _____

Email Address _____@_____

Name and Address of School (if applicable)

Support Coordinator:	
Office:	
Address:	
Phone:	
Fax:	
Email:	



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YMCA POLICY

Divine Care is in partnership with the Goodyear YMCA. Our members participate in multiple weekly activities at the YMCA. Before a Divine Care member is able to participate in any activities; parent or guardians are required to complete the mandatory Valley of The Sun YMCA Waiver and pay a monthly participation fee of \$10.00. Members will be unable to attend any YMCA activities until all paperwork and monthly fee is received. The fee is due on the 1st of each month.

Please check the activities that you give your member permission to participate in at the YMCA:

- Swimming
- Weight Lifting
- Yoga
- Workout Equipment
- Zumba

Member's Signature (if applicable)

Date

Responsible Person's Signature

Date

Visitor Policy

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Divine Care’s goal is to offer excellent care to our members as well as to provide transparent services. Divine Care has a standing Open Door Policy, which means a parent or guardian at any time may visit our program and have full access to their member(s). All visitors are required to check-in at our administrative front desk and sign into the visitor’s log. After the check-in process is completed parent/guardians will be escorted to visit their member(s). All visits in the community space will need to be limited to a few minutes, due to the need of protecting the privacy and rights of all our members, but if more visitation time is required member and visitor will be escorted to conference room or private space to continue visitation.

Please initial that you have read and understand this letter regarding Divine Care’s Open Door Policy.

Member’s Signature (if applicable)

Date

Responsible Person’s Signature

Date

General Agreements and Consents

I _____, certify that I am the
(Full name of the legally responsible person)
_____ of _____, who
Relationship to the individual full name of the individual
is supported by Divine Care LLC.

I consent to the following for member named above and supported by Divine Care for a period of time not to exceed 12 months from the date of the signature below.

(Check all that apply):

- Routine medical treatment.
- Emergency medical treatment.
- I request to receive a copy of Outcomes / Progress notes quarterly.
- Divine Care DOES NOT Administration over the counter medications with out physician's orders.
- Participation in routine recreational/leisure activities.
- Participation in planned and un-planned field trips.
- Release of medical records.
- Release of educational records.
- Release of psychological records.

Member's signature (if applicable)

Date

Responsible person's signature

Date

Comments or exclusions to the consents:

Divine Care

Consumer Picture Consent

Date: _____

RE: _____ (print son/daughter's name)

I _____ (parent/guardian).

Please only check 1 box.

- agree to allow the staff of Divine Care, LLC to use my son, daughter's picture(s) or reproduction in their advertising brochures, pamphlets, newspaper print ads, job fair flyers, display boards, or other print media.

OR

- agree to allow the staff of Divine Care, LLC to use my son/daughter's picture(s) or reproduction on the Divine Care, LLC annually produced calendars only.

OR

- do not wish to have my son/daughter's picture(s) or reproduction used by Divine Care, LLC for any advertising brochures, pamphlets, newspaper print ads, job fair flyers, display boards, other print media nor the annual calendar.

This agreement will be valid for the duration that I am receiving service(s) by Divine Care, LLC, although I understand that the right to discontinue it at any time. Should my services discontinue or should I choose retract this agreement, I understand that anything already in print will continue to be used.

If I decide to withdrawal my consent, I must give written notice to:

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Goodyear, AZ 85395

Signature

Date

Individual Information:

Individual's Name: _____ M or F: _____ Date of Birth: _____

Name the individual prefers to be called: _____ Grade: _____

Primary Guardian's Information:

Primary Guardian's Name: _____ Cell Phone #: _____

Physical Address: _____

Mailing Address: _____

E-mail Address: _____ Home #: _____

Employer: _____ Employer Phone #: _____

Secondary Guardian's Information:

Secondary Guardian's Name: _____ Cell Phone #: _____

Mailing Address: _____

E-mail Address: _____ Home #: _____

Employer: _____ Employer Phone #: _____

List persons who can either pick up and/or assume responsibility for your individual in the event of an emergency if parents cannot be reached. At least one non-guardian contact person must be listed with their phone number:

Non-Guardian Contact Name: _____ Cell Phone #: _____

Does your individual have any health concerns (medications, chronic conditions, behavioral or cognitive disabilities) that we should know about in order to facilitate safe and successful participation? Yes or No

If yes, please describe: _____

Known allergies and reactions: _____

Medications and frequency of use: _____

Physician: _____ Phone #: _____

Dentist: _____ Phone #: _____

Please give any additional information concerning your child, which may be helpful: _____

AUTHORIZATION FOR EMERGENCY MEDICAL CARE:

I hereby give permission to the Divine Care staff to secure emergency medical and/or surgical treatment for my individual while in their care. All expenses of such care will be accepted by the parent(s)/legal guardian, including fees for an ambulance, if deemed necessary by staff. I realize attempts to reach me prior to any decisions will be made unless a life-threatening situation is at hand or circumstances do not allow.

Signed: _____
Parent or Legal Guardian

Date: _____