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:	

Emergency Contact Information

In case of an emergency and you are unable to be reached, who we should contact:

Name: _____ Relation _____

Address _____ Phone ( ) _____

Name: _____ Relation _____

Address _____ Phone ( ) _____

Member's Doctor's Name _____

Doctor's Phone _____

Hospital Preference _____

Hospital Address _____

Hospital Phone _____

Name of Health Plan/Medical Insurance _____

Group Number/ Policy Number _____

Primary Name on Insurance _____

Please list the name and relationship of any persons NOT authorized to pick up or interact with the consumer:

Name	**Relation**
_____	_____
_____	_____

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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 activates; 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**

Personal Items

Divine Care

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Dear Parents:

Divine Care is not responsible for personal items brought to the program or the replacement of those items. For example: toys, electronics, money, jewelry, or anything else of a personal nature. If your child/adult brings personal items from home and it is broken, lost or stolen; Divine Care will not reimburse you for the replacement.

Thank you,
Divine Care Staff

Please initial that you have read and understand this letter regarding the issue that Divine Care will not be held responsible for any personal items your child/adult brings to the program.

_____ _____

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:

14423 W McDowell RD G104
Goodyear, AZ 85395

_____ _____

Signature **Date**

Allergies

Does the member have any allergies? Yes ____No____**If yes**, please list the substance the consumer is allergic to and describe the reaction: _____
_____
_____

Seizures

Does the member have seizures? Yes____No_____
How often do the seizures usually occur? _____

How long do the seizures usually last? _____
Does the member sleep after the seizure occurs? Yes_____No_____

Please describe the type of seizures, any triggers to the seizures, and how you and the member normally respond before and during and after the seizure: _____
_____
_____

Special Considerations

Does the member take the medication for his/her blood pressure? Yes_____No_____ If yes, what monitoring techniques are to be used and what procedures should be followed if the blood pressure is out of established ranges? _____
_____
_____

Does the member take medication for bowel movements? Yes_____ No_____ if yes, what type of monitoring is required? _____

Does the member have diabetes? Yes_____ No_____ If yes, what are the instructions for blood sugar monitoring?
_____
_____

Does the member take any thinning medications? Yes_____ No_____ If yes, please specify:_____
_____
_____

Does the member require any special lab work on a regular basis Lithium, Dilantin, Thyroid levels, etc?) ? Yes_____ No_____ If yes please specifies what is required and at what frequency:

_____
_____
_____

List any medical restrictions to activities:
_____
_____
_____

Please describe any special techniques for handling medical concerns:
_____
_____
_____

Activities of Daily Living

Please briefly describe your typical daily routine:
_____
_____
_____

Is there a need for adaptive equipment? Yes_____No_____ If yes, please describe the type of equipment and when it should be used: _____
_____
_____

Is there a need for protective devices? Yes_____No_____ if yes, please describe the type of equipment and when it should be used:
_____
_____

Please identify any special instructions for lifting, carrying, and positioning:_____
_____
_____

Please identify any gender preferences for personal care:

Male_____Female_____No preference_____

Personal Care

Please check only those that best apply to current activity of daily living needs.

TOILETING **PLEASE DESCRIBE:**

_____Uses the toilet independently _____
_____Needs some assistance with toileting _____
_____Needs reminders to use the toilet _____
_____In diapers or Attends _____

BATHING

_____Bathes independently _____
_____Needs some assistance with bathing _____
_____ Needs reminders to bathe _____

HYGIENE (teeth brushing, hair brushing, hand wash, etc.)

_____Completes hygiene routine independently _____

_____Needs some assistance with hygiene _____
_____Needs reminders to complete hygiene _____

DRESSING

_____Dresses himself/herself independently _____
_____Needs some assistance with dressing _____
_____Needs reminders to dress _____

FEEDING

_____Feeds himself/herself independently _____
_____Needs some assistance with feeding _____
_____Has a feeding tube _____
_____Is on a special diet _____

Nutritional Needs

Please provide the consumers need for food preparation:

Regular____ Bite-sized_____ Puree_____ Other____ If other pleases describe:

Please indicate any special diet or nutritional supplements: _____

_____
_____

Are there any concerns regarding choking or gag reflex? Yes_____No_____If yes, please describe:
_____
_____

Fluid Needs

Can the obtain/request fluids? Yes_____No____If no, please specify the fluid recommendations and how to ensure that adequate fluids are provided: _____
_____
_____

Communication

What languages are spoken? _____

What languages are understood? _____

Are there any communication deficits? Yes ____ No ____ If yes, please describe:
_____
_____
_____

Please explain any words or sounds the consumer uses regularly that can help us to understand and communicate with that him/her: _____
_____
_____

Please describe any special communication techniques used (Sign language, visual chart, communication board, etc.): _____
_____
_____

Auditory, Tactile, and Visual Skills

Are there any auditory (hearing) issues? Yes _____ No _____ If yes, please describe:
_____
_____

Are there any tactile (touch) issues? Yes _____ No _____ If yes, please describe:
_____
_____

Are there any visual issues? Yes _____ No _____ If yes, please describe: _____
_____
_____

Motor Skills

Does the consumer have any limitations in physical functioning? Yes ____ No ____
If yes, please describe: _____
_____

Supervision Needs

What is the length of time and the places that the member can safety be unsupervised (consider time in the bathroom, at any programs, in the consumer's own home/bedroom, etc.): _____
_____
_____

Please describe any possible risks (does he/she is he/she attracted to unsafe items or situations) if the person is unsupervised or missing: _____
_____
_____

Like / Dislikes

What activities does the consumer like to participate in? _____
_____
_____

What activities does the consumer not like to participate in? _____
_____
_____

Please list names of family members, friends, or pets that live at home or that the member frequently socializes with and or talks about.

Name	**Relation in the member**
_____	_____
_____	_____
_____	_____

What motivates the member? _____
_____

What things does the member like? _____
_____
_____

What things does the member not like? _____
_____
_____

What triggers these behaviors? _____
_____

What warning sign are there for these behaviors? _____
_____
_____

Is there a current behavior program and or discipline technique for the member?
Yes _____ No _____ If yes, please describe: _____
_____
_____

Parent / guardian suggestions: _____
_____
_____

Parent / guardian requests (please note, we will make every attempt to comply with your request within the boundaries of the law and current best known practices):
_____
_____

_____ _____
Signature of person completing the form **Relation to the member**

*** PLEASE NOTE, THIS FORM WILL NEED TO BE UPDATED ANNUALLY AT THE INDIVIDUAL'S ISP DATE OR ANY TIME THERE ARE CHANGES.**

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: _____ Date: _____

Parent or Legal Guardian