

# GENERAL PROGRAM APPLICATION

(rev. 6/2016)

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**What**            **Work and Activity Program**

**Who**             Adults 18 years old and older with intellectual disabilities

**Where**          Fellowship Hall, 14015 San Pedro, San Antonio, TX 78232

**Costs**           Participates with agency support will be billed to their appropriate Provider with no min. production required. New members *who are not agency sponsored* will be charged **\$400/MONTH or \$25/day service fee**, billed at the end of the month, due 10 days after receipt of invoice.

**Start Time:**    **Monday through Friday - 9:00 AM (open at 8:00am)**

**End Time:**     **Monday through Friday - 4:00 PM (close at 5:00pm)**

**Application:**    **Please fill out the attached forms. Only completed forms will be considered. A processing fee of \$50 is required with each application prior to consideration.**

The Texas Foundation of Hope (TXFH) Activity Program is designed for persons 18 years of age & older who:

- 1) have intellectual disabilities,
- 2) are emotionally and physically well, and
- 3) shows behavior within acceptable guidelines.

## **Please note:**

- 1) TXFH **does not** accept participants requiring one-on-one supervision and participants requiring such supervision will be withdrawn.
- 2) Participants with controlled seizure disorders, cerebral palsy, autism spectrum disorders and other physical disabilities will be individually evaluated for admission.
- 3) Medical conditions and equipment which TXFH cannot accommodate include G-tubes, feeding pumps, baclofen pumps & toileting assistance. **There is no on-site nurse.**
- 4) Smoking (tobacco, smoke-less, and e-cigarette type) is not allowed at Texas Foundation of Hope (TXFH) and no accommodations are made for smokers. If a prospective participant cannot comfortably go without smoking, then he or she *should not apply*.

**Please mail application with a \$50 fee to:  
Texas Foundation of Hope  
ATTN: BEATRICE STEPHENS  
14015 San Pedro Ave., Fellowship Hall  
San Antonio, TX 78232**

# TXFH GENERAL PROGRAM APPLICATION

I affirm by signature below that my participant for whom this application is made meets the health and behavior guidelines described on the cover page. If misrepresentation is made regarding my participant's health or behavior, or if my participant becomes ill enough, or engages in behavior deemed serious enough to warrant dismissal, he or she may be dismissed from the Program. I understand that if my participant is dismissed due to health or behavior considerations, it is my sole responsibility to pick up my participant on the day I am notified and that no refund will be made for the session from which my participant attends.



Parent/Legal Guardian \_\_\_\_\_

Application Date \_\_\_\_\_

Start Date (TXFH staff complete) \_\_\_\_\_

## Participant Information

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_

Participant's Phone \_\_\_\_\_ Primary Diagnosis/Disability \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age at Program \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Gender:  Male  Female:

Social Security Number \_\_\_\_\_ Date of Last Physical Exam \_\_\_\_\_

Insurance Carrier \_\_\_\_\_ Group Number \_\_\_\_\_ Member Name \_\_\_\_\_

Primary Physician \_\_\_\_\_ Phone \_\_\_\_\_

My Participant does **NOT** have insurance \_\_\_\_\_ Medicaid No. \_\_\_\_\_

Limitations of Participants' Disability: \_\_\_\_\_

If Down Syndrome, stable for atlanto-axial subluxation (AAS)? Yes No

Most recent cervical x-ray for AAS (date) \_\_\_\_\_ (city) \_\_\_\_\_

Physician \_\_\_\_\_ Phone \_\_\_\_\_

**SCHEDULE REQUEST:** Will the Applicant be **full-time** or **part-time**? Yes \_\_\_\_\_ No \_\_\_\_\_

If part-time, no. of days per week (min. 3 days) \_\_\_\_\_.

Please be aware this may impact the applicant's approval or disapproval, depending on vacancies.

## Previous Day Habs and Previous Employment

Name \_\_\_\_\_ Date \_\_\_\_\_ Reason for Leaving \_\_\_\_\_

Name \_\_\_\_\_ Date \_\_\_\_\_ Reason for Leaving \_\_\_\_\_

Name \_\_\_\_\_ Date \_\_\_\_\_ Reason for Leaving \_\_\_\_\_

Name \_\_\_\_\_ Date \_\_\_\_\_ Reason for Leaving \_\_\_\_\_

Name \_\_\_\_\_ Date \_\_\_\_\_ Reason for Leaving \_\_\_\_\_

Name \_\_\_\_\_ Date \_\_\_\_\_ Reason for Leaving \_\_\_\_\_

**Service Provider**

*(If applicable)*

Name of Service Provider (Agency/Company): \_\_\_\_\_

Address: \_\_\_\_\_

Business Phone #: \_\_\_\_\_ Contact Person: \_\_\_\_\_

Case Manager / QMRP: \_\_\_\_\_ Office Phone #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Name of Group Home / Facility: \_\_\_\_\_

Address: \_\_\_\_\_

Residence Manager: \_\_\_\_\_ Phone #: \_\_\_\_\_

Nurse / LVN: \_\_\_\_\_ Office Phone #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Social Worker: \_\_\_\_\_ Office Phone #: \_\_\_\_\_ Cell #: \_\_\_\_\_

**Payroll:** Where will payroll checks be sent? \_\_\_\_\_

If given on-site, may we give the check directly to the applicant? \_\_\_\_\_

**Parent/Guardian Information**

Name \_\_\_\_\_ Relation to Participant \_\_\_\_\_

Who is the Applicant's LEGAL Guardian? \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_

Day Phone \_\_\_\_\_ Night Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

**Emergency Contact Person (This person MUST be available during the Program hours)**

Same as Parent/Guardian Information? Yes \_\_\_\_\_ No \_\_\_\_\_ (If no, please complete the information below)

Name \_\_\_\_\_ Relation to Participant \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_

Day Phone \_\_\_\_\_ Night Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

**Guardian/Family Contact Information (if different):**

Legal Guardian's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Type of Guardianship: \_\_\_\_\_

Contact in case of emergencies: Yes \_\_\_\_\_ No \_\_\_\_\_

Is the consumer his or her own guardian? Yes \_\_\_\_\_ No \_\_\_\_\_ **(If yes, continue)**

I, (consumer) \_\_\_\_\_ give permission for The Texas of Hope, aka TXFH, to contact My Case Manager or Direct Care Staff about programmatic issues while attending TXFH.

\_\_\_\_\_  
Consumer Signature

## Transportation

Will this applicant use *VIA Trans* for transport? YES NO ID No. \_\_\_\_\_

If not who will transport them to the TXFH site? \_\_\_\_\_

(May change method of transportation after becoming a member if needed)

## Immunization

Proof of immunizations required for Participant 16 and under. Dates of Illness or Immunization:

Polio \_\_\_\_\_ type: \_\_\_\_\_ Measles-Red \_\_\_\_\_ Rubella-German \_\_\_\_\_

Diphtheria/Pertussis \_\_\_\_\_ Tetanus \_\_\_\_\_ HIV Virus \_\_\_\_\_ Chicken Pox \_\_\_\_\_

Shingles \_\_\_\_\_ Influenza \_\_\_\_\_

Other(specify): \_\_\_\_\_

## Current Medication Regimen

(Please list **all medications** taken on routine basis, **DAY OR NIGHT**; prescription and over-the-counter)

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Time of Day: \_\_\_\_\_

Reason Taken: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Time of Day: \_\_\_\_\_

Reason Taken: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Time of Day: \_\_\_\_\_

Reason Taken: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Time of Day: \_\_\_\_\_

Reason Taken: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Time of Day: \_\_\_\_\_

Reason Taken: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Time of Day: \_\_\_\_\_

Reason Taken: \_\_\_\_\_

## Permission to give over-the-counter medications (OTC) on as needed basis:

Please initial each medication or its generic equivalent that may be administered to your Participant. Please check "No" or "YES" beside each medication AND initial. **NOTE:** TXFH does not have a nurse on duty/staff. Any medication needed during the program hours will need to be brought by the member and taken by the member on their own. TXFH Staff is not responsible for the medication nor the administration of the medication in any form.

\_\_\_\_\_ (initials) YES NO - Tylenol \_\_\_\_\_ (initials) YES NO - Motrin/Ibuprofen \_\_\_\_\_ (initials) Yes No - Benedryl

\_\_\_\_\_ (initials) YES NO - Other: \_\_\_\_\_

## Allergies:

My Participant is allergic to: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

How is the reaction recognized? \_\_\_\_\_

Does your Participant carry a required Epi-Pen? \_\_\_\_\_

Special Dietary Concerns: \_\_\_\_\_

# TXFH Permissions

**THIS APPLICATION CANNOT BE PROCESSED UNLESS ALL QUESTIONS HAVE BEEN INITIALED**

Under Texas law (Chapter 87, Civil Practice and Remedies Code), an equine professional is not liable for an injury to or the death of a participant in equine activities resulting from the inherent risks of equine activities.

Please initial as recognition of this equine statement. \_\_\_\_\_

**Yes**      **No**

\_\_\_      \_\_\_      I give my Participant permission to attend the TXFH Program. He/she may participate in all activities. **ANY EXCEPTIONS ARE:** \_\_\_\_\_

\_\_\_      \_\_\_      I understand that opportunities may be available for participants to interact with live vaccinated animals. I give my Participant permission to participate in those activities.

\_\_\_      \_\_\_      I authorize TXFH staff and volunteers to share, without restriction, my participant's health information and medical records with any person (whether or not affiliated with Texas Foundation of Hope) as may be reasonably necessary in order to facilitate the care of my participant.

\_\_\_      \_\_\_      If emergency treatment is necessary, I give permission for my participant to be brought to the nearest emergency room by ambulance or helicopter for treatment. I authorize TXFH to release all records necessary for insurance purposes so that my insurance company can be billed for the visits, lab tests, and/or x-rays if necessary.

\_\_\_      \_\_\_      In the event that participant has no insurance, I will be responsible for his/her medical bills.

\_\_\_      \_\_\_      I understand TXFH allows parents/guardians to call and check the health status of their participant or speak with a staff in regards to their participant's well being.

\_\_\_      \_\_\_      I give TXFH permission to use my participant's name, photograph, or video image for publicity purposes.

\_\_\_      \_\_\_      I understand that TXFH has a designated Lost and Found. However, if I or my participant leaves my participant's items anywhere, I will not hold TXFH responsible for them. **THIS INCLUDES ALL ELECTRONIC DEVICES, INCLUDING CELL PHONES, GAME, IPODS, ETC. Members are encouraged to leave these at home.**

## Equipment Use

\_\_\_      \_\_\_      My participant may use the laminating machine after being trained by TXFH.

\_\_\_      \_\_\_      My participant may use the paper cutter after being trained by TXFH.

\_\_\_      \_\_\_      My participant may use box cutters (Utility Knife) after being trained by TXFH.

I, \_\_\_\_\_, guarantee that the information on this application is accurate and hereby release and forever discharge TXFH, its members, employees, and volunteers from any liability, suit, claim, or demand, whether for personal injury to myself or members of my family including minor children, or for property damage which result from any participation in the work program.

Participant Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

**TEXAS FOUNDATION OF HOPE**  
***Behavior Checklist for New Applicants***

Each person will be evaluated on a one-to-one basis. Behaviors listed below that occur with enough frequency to disrupt normal program operations may result in a member’s admission denial or future dismissal.

	<b>Yes</b>	<b>No</b>
1. Wanders off or runs away	_____	_____
2. Oppositional toward staff	_____	_____
3. Throws objects, bites or scratches	_____	_____
4. Displays emotional outbursts	_____	_____
5. Tantrums when angry or frustrated	_____	_____
6. Physically fights with others	_____	_____
7. Injures self	_____	_____
8. Steals or destroys property	_____	_____
9. Uses electronics inappropriately	_____	_____
10. Uses foul or inappropriate language or talks constantly	_____	_____
11. Continually complains of unfounded illness	_____	_____
12. Hallucinates to the point of dysfunction	_____	_____
13. Needs assistance for toileting needs	_____	_____
14. Does not respond to authority	_____	_____
15. Difficulty adjusting to new environment	_____	_____
16. Difficulty working with peers	_____	_____
17. Needs one-on-one supervision	_____	_____
18. Demonstrates sexual advances toward others	_____	_____
19. Taunts or bullies others	_____	_____
20. Requires medication to control behavior	_____	_____

Explanation for any of the above that were answered “yes”: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**\*I/we have read these behaviors and understand that such behaviors will not be tolerated at TXFH.**

\_\_\_\_\_  
 Applicant’s Signature

\_\_\_\_\_  
 Parent/Guardian’s Signature

\_\_\_\_\_  
 Date Signed

## Likes / Dislikes

Please identify specific likes / dislikes the applicant may have (i.e. dislikes loud noises; likes painting)

LIKES

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DISLIKES

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## CONSENT / RELEASE FORM

REVIEW THE FOLLOWING FORM TAKING INTO CONSIDERATION THE PARTICIPANT MAY BE INVOLVED IN ONE OR MORE OF THE ACTIVITIES LISTED BELOW. WE ASK THAT YOU AS THE PARTICIPANT, LEGAL GUARDIAN OR PARENT OF A MINOR MAKE A DETERMINATION ON EACH OF THESE ISSUES AND INDICATE YOUR RESPONSE APPROPRIATELY. THIS FORM SHOULD BE COMPLETED AT THE TIME OF ADMISSION AND AT LEAST ANNUALLY THERAFTER..

I, \_\_\_\_\_ give or do not give (circle one) my consent/permission for  
(Legal Guardian/Parent/Adult Participant)

\_\_\_\_\_ on each of the following issues:

(Participant)

### PHOTOGRAPHS / VIDEOS

       YES           NO (initial one)

- 1) Consent/permission for photographs to be used for programming purposes in the classroom, on posters or in other participant's communication books.
- 2) Consent/permission for photographs or videos to be used by the Texas Foundation of Hope to portray or promote TXFH activities.
- 3) Consent/permission for photographs to be used on the Texas Foundation of Hope publications and brochures.
- 4) Consent/permission for photographs to be used on the Texas Foundation of Hope Website.
- 5) If consent/permission for photographs or videos is given, I also give my consent/permission for the participant's first name to accompany the photograph or videos.
- 6) If consent/permission for photographs or videos is given, I also give my consent/permission for the participant's first and last name to accompany the photograph of videos.

### PARTICIPATION IN OUTINGS / FIELDTRIPS and EMERGENCY TRANSPORT

       YES           NO (initial one)

- 1) Consent/permission to participate in community outings and fieldtrips (i.e. shopping, movies, parks, bowling, etc.) after given trip details and confirmation of attendance
- 2) If consent/permission to participate in community outings and fieldtrips is given, I also give my consent/permission for TXFH staff to transport the participant.
- 3) In the event of a medical, facility, environmental or natural disaster emergency, I also give my consent/permission for TXFH staff to transport the participant.

### RELEASE OF CONFIDENTIAL INFORMATION

       YES           NO (initial one)

- 1) Consent/permission for the participant's confidential information to only be shared with TXFH staff for programming purposes.
- 2) 2) Consent/permission for the participant's confidential information to be shared with the participant's Service Coordinator, Case Manager, QMRP or Provider.
- 3) 3) Consent/permission for the participant's confidential information to be shared with (Please Indicate Who):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

## MEMBER AGREEMENT TO PARTICIPATE

**Parent or Guardian: Please read carefully and initial by each Agreement:**

1. New Member agrees to follow rules as specified during orientation. \_\_\_\_\_
2. Member will be respectful to staff and other Members. \_\_\_\_\_
3. Member will not use foul language while at the Foundation or during transportation or community activities. \_\_\_\_\_
4. Member will not use tobacco products, smokeless tobacco products , e-cigarette type products, illegal or non-prescribed drugs or alcohol during program hours & sponsored activities. \_\_\_\_\_
5. Member will remain on the premises until parent or guardian arrives for pickup or VIA-transportation. \_\_\_\_\_
6. Member will not exhibit nudity, exposure, or demonstrate sexual acts at any time, nor via their cell phone, laptop or electronic device, nor when possessing written materials. \_\_\_\_\_
7. Member will not physically harm, tease, or intimidate another Member or staff at any time. \_\_\_\_\_
8. Member will engage in meaningful work or activity while at TXFH, or as directed by staff. \_\_\_\_\_
9. Member are asked to inform staff IMMEDIATELY of any unusual, illegal, unsafe, or prohibited behavior by another Member. \_\_\_\_\_
10. Member will be responsible for any personal items brought to the Foundation, including: purses, wallets, cameras, phones, electronics, ear phones or food items. These items should not be shared for health and safety reasons. \_\_\_\_\_
11. Members will not bring weapons, knives, guns, etc on to the TXFH property at any time. Violation could result in suspension from the program.



***Members will be counseled for 1<sup>st</sup> and 2<sup>nd</sup> offenses. Further consequences for infractions of any of the above rules will result in suspension (up to 3). To return, parent or guardian must attend a staffing w/ the TXFH Executive Director (or designee). After the third suspension the member will be released from the Texas Foundation of Hope program and will not be allowed to return. Should the member decide to leave voluntarily they may reapply (new application process) after six months. Readmission will be at the discretion of the Admission Committee.***

\_\_\_\_\_  
New Member

\_\_\_\_\_  
Parent or Guardian

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Receiving TXFH Staff

## Please Read & Sign

**Permission to Obtain Medical Treatment:** I give my consent by signature below for medical treatment to be obtained for my Participant by a representative of TXFH in the event I (or my designee) am unable to be reached.

**Agreement to Pay for Medical Treatment:** I understand that in the event of a medical emergency affecting my Participant, EMS may be called and my Participant may undergo hospitalization and/or treatment. I agree to assume all costs associated with such summoning of emergency medical care, hospitalization, and treatment, and I hold

Texas Foundation of Hope, its staff, Board of Directors, and volunteers harmless for any liability, medical or financial, arising from such.

Participant Signature \_\_\_\_\_

Date \_\_\_\_\_

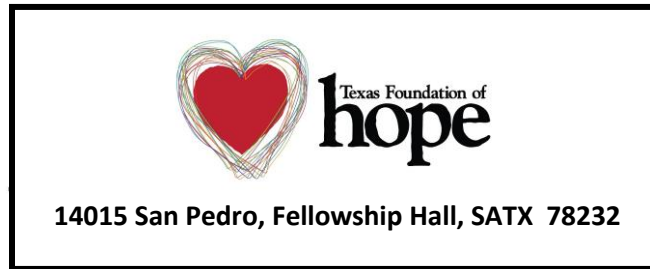
Parent/Legal Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_



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### KEEP THIS PART FOR YOUR RECORDS



***Main Office***  
**210.265.3351**

***FAX***  
**877.696.0497**

**Beatrice Stephens    Executive Director    [beatrice@sathgroup.com](mailto:beatrice@sathgroup.com)**

**Laura Randol    Program Services    [txfhlaura@gmail.com](mailto:txfhlaura@gmail.com)**

**Russell Rangel    Admissions    [Rangel.Russell@gmail.com](mailto:Rangel.Russell@gmail.com)**

**Frank Vernon    Tour Guide    [FEVernon4TXFH@gmail.com](mailto:FEVernon4TXFH@gmail.com)**



What do I do now that I have completed the application?

- 1.) Call Texas Foundation of Hope at 210-265-3351 and schedule a tour with Admissions. Please bring your completed application and application fee to the tour. All tours are scheduled by appointment only. Please note that the application must be completed before it can be accepted by Texas Foundation of Hope and application fee needs to be submitted at the same time as the application.
- 2.) You will be notified no more than 10 days after application has been accepted unless otherwise instructed by Texas Foundation of Hope of the acceptance or decline of admission into the program as a potential member.
- 3.) Start date for the two-week trial will be arranged (Mondays) for the potential member. At the end of the two-week trial an evaluation by TXFH Staff will be made as to the potential members "fit" into the program.
- 4.) If it is determined that the potential member is a good "fit", then they will continue to attend as agreed upon in application. If it is determined that the potential member is not a good "fit" into the program, then they will no longer attend Texas Foundation of Hope.

Thank you for your interest in Texas Foundation of Hope.