GENERAL PROGRAM APPLICATION
(rev. 9/2018)

KEEP THIS PAGE!!!

What: Work and Activity Program

Who: Adults 18 years old and older with intellectual disabilities

Where: 2845 Thousand Oaks, San Antonio, Texas 78232

Start Time: Monday through Friday - 9:00 AM (open at 8:00am)
End Time: Monday through Friday - 4:00 PM (close at 5:00pm)

Please note that Texas Foundation of Hope is not responsible for clients/members who arrive before the Foundation opens (8:00 a.m.) nor is Texas Foundation of Hope responsible for clients/members who remain after the Foundation closes (5:00 p.m.)

Late fee: Please note that Texas Foundation of Hope will charge a late fee of $10.00 for every 15-minute increment a consumer remains after 5:00 pm.

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 and is non-refundable.

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TXFH does not accept participants requiring one-on-one supervision and participants requiring such supervision will be withdrawn.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
2845 Thousand Oaks
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 ________________

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: What program is the Applicant a part of? Circle one: ICF, HCS, Other __________

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 ___________________________

Applicants are required to attend a minimum of 4 days.

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 ___________________________

Attachments

Attach Photo Here

Start Date: ________________

TXFH Staff Only

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**Service Provider** (All slots must be filled out.)  
*(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 #: ___________

Service Provider Accounts Payable contact and phone #: ________________________________

*(Important)* Email: _______________________________________________________________

Who is legally responsible for payment of day hab fees? ___________________________________

**Payroll:** Where will consumer payroll checks be mailed?

__________________________________________________________________________________

If given on-site, may we give the check directly to the applicant? Yes  No

Please NOTE: Checks are paid once a month for the prior month.

**NOTE:** *In accordance with Texas law, all members must go through a Texas Work Force Commission, (TWC) certification process before we are allowed to pay them.* (See TWC Packet)

**Parent/Guardian Information** (Please do not answer N/A. We must have this information. If the person is their own guardian, please say so.)

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: ____________________________________________
Email: __________________________________________________________
Contact in case of emergencies: _____Yes _____ No
Please provide a copy of Legal Guardianship paperwork

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)
_________Please initial that you understand that Texas Foundation of Hope assumes no responsibility or liability
for any client/member who arrives prior to TXFH opening at 8:00 a.m.
_________Please initial that you understand that Texas Foundation of Hope assumes no responsibility or liability
for any client/member who remains on campus after TXFH closes at 5:00p.m.

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: ____________
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Medication: ___________________________ Dosage: ____________ Time of Day: ____________
Reason Taken: ______________________________

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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.

PLEASE CIRCLE YES OR NO FOR EACH OTC MEDICATION

_____ (initials) YES NO - Tylenol;  _____ (initials) YES NO - Motrin/Ibuprofen;  _____ (initials) Yes No – Benadryl;

 _____ (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. ____________

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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 _____________________
**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.

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<td>1. Wanders off or runs away</td>
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<td>2. Oppositional toward staff</td>
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<td>3. Throws objects, bites or scratches</td>
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<td>4. Displays emotional outbursts</td>
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<td>5. Tantrums when angry or frustrated</td>
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<td>6. Physically fights with others</td>
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<td>7. Injures self</td>
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<td>8. Steals or destroys property</td>
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<td>9. Uses electronics inappropriately</td>
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<td>10. Uses foul or inappropriate language</td>
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<td>or talks constantly</td>
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<td>11. Continually complains of unfounded illness</td>
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<td>12. Hallucinates to the point of dysfunction</td>
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<td>13. Needs assistance for toileting needs</td>
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<td>14. Does not respond to authority</td>
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<td>15. Difficulty adjusting to new environment</td>
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<td>16. Difficulty working with peers</td>
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<td>17. Needs one-on-one supervision</td>
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<td>18. Demonstrates sexual advances toward others</td>
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<td>19. Taunts or bullies others</td>
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<td>20. Requires medication to control behavior</td>
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Explanation & date of last occurrence for any of the above that were answered “yes”:

____________________________________________________________________

____________________________________________________________________

Explanation & date of last occurrence 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
__________________________________
__________________________________
__________________________________
__________________________________
______________

DISLIKES
__________________________________
__________________________________
__________________________________
__________________________________

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 THEREAFTER.

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) Consent/permission for the participant’s confidential information to be shared with the participant’s Service Coordinator, Case Manager, QMRP or Provider.
3) Consent/permission for the participant’s confidential information to be shared with (Please Indicate Who):

Name: ___________________________________________ Relationship: _______________________

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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 is 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 1st and 2nd 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 _____________

--------------------------------- cut here

KEEP THIS PART FOR YOUR RECORDS

Main Office
210.265.3351
Beatrice Stephens Executive Director beatrice@sathgroup.com
Frank Vernon Admissions Frank@texasfoundationofhope.org
Frank Vernon Tour Guide Frank@texasfoundationofhope.org
Sarah Molina Activity Sarahm@texasfoundationofhope.org

FAX 877.696.0497
14015 San Pedro, Fellowship Hall, SATX 78232
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.