



Annual Participant Application

Stepping Stones utilizes a three step process for program enrollment.

The health and safety of the participant is the highest priority of our agency.

Stepping Stones, Inc. is unable to serve: Individuals with an insulin pump, tracheostomies and O₂ other than O₂ concentrator for CPAP (continuous positive airway pressure).

1. The first step is to complete an Annual Participant Application which provides a thorough profile of the participant enrolling for program services.

NOTE: You can now do steps 1 and 2 online by going to www.steppingstonesprograms.org and clicking on the green "Register Now" button. (If you register online, you do not have to fill out a paper Application or Registration.)

2. The second step is to complete a Program Registration selecting program choices from the various seasonal offerings.
3. The third step is to have a Physician complete, sign and date our Master Medical Form.

The Annual Participant Application, Master Medical Form and Registration must all be received before consideration will be given for program enrollment. Partial or incomplete forms will be returned for completion. Forms are good for 1 year from the date of signature.

Last Name _____
 First Name _____ Middle Initial _____
 Nickname _____
 Street _____
 City _____ State _____ Zip _____
 County _____
 Phone (_____) _____
 Age _____ Date of Birth ____/____/____
 Sex: Male _____ Female _____
 Primary Diagnosis: _____
 Secondary Diagnosis: _____
 Demographics (For United Way Reporting)
 Appalachian _____ Asian _____ Black _____ Hispanic _____
 Native American _____ White _____ Other _____
 Yearly Household Income \$ _____
 Household Size _____
 Preferred Communication: Email _____ Text _____ Phone _____
 Legal Guardian: Self _____ Parents _____ Other _____
 Mother/Guardian Last Name _____
 First Name _____
 Relationship to Participant _____
 Cell Phone(_____) _____
 Employer _____
 Work Phone(_____) _____
 Email _____
 _____ check if info below is same as participant (do not fill out if same)
 Street _____
 City _____ State _____ Zip _____
 Phone(_____) _____

Residential Facility Name (If applicable) _____
 Facility Manager _____
 Facility Manager Email _____
 Phone(_____) _____
 Evening/Weekend Contact _____
 Phone(_____) _____
 Service Facilitator/SSA/Third Party Funding Contact (if applicable)
 Name _____
 County _____
 Phone # (_____) _____
 Email _____
 Medicaid # _____ Waiver yes no
 (circle one)
 School District (if applicable) _____
 Intervention Specialist _____
 Phone (_____) _____
 Father/Guardian Last Name _____
 First Name _____
 Relationship to Participant _____
 Cell Phone(_____) _____
 Employer _____
 Work Phone(_____) _____
 Email _____
 _____ check if info below is same as participant (do not fill out if same)
 Street _____
 City _____ State _____ Zip _____
 Phone(_____) _____

Who should we call if we have questions about this application? Name _____
 Best Daytime Contact # (_____) _____ Email _____

For questions about filling out this application please contact Client Services @ 513-965-5108

Please mail application to: **Client Services**
Stepping Stones
5650 Given Rd.
Cincinnati, OH 45243

or email PDF to:
jeannie.ludwig@steppingstonesohio.org
 or fax to: 1-877-913-1293
 (pictures cannot be faxed)

EMERGENCY CONTACTS

We will attempt to contact Parent/Guardian (listed on Page 1) first. Please list 2 additional contacts.

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

PICK UP AUTHORIZATION

I **AUTHORIZE** my child/adult to be released/picked up **ONLY** by the following persons. Please include parents if applicable.
I will notify Stepping Stones of any changes in this information.

PLEASE DO NOT LEAVE THIS SECTION BLANK

1. Name _____	Relationship _____
2. Name _____	Relationship _____
3. Name _____	Relationship _____
4. Name _____	Relationship _____

Is there any individual who is **NOT** allowed to pick up your participant? _____

How would you like to pay for your services?

All payments (cash/check/voucher) must be submitted directly to the Finance Dept. at Given Rd. (513-965-5105)
Program staff are **NOT** permitted to accept payments.

Funding Contact/Service Facilitator/SSA Name _____

Funding Contact/Service Facilitator/SSA Email _____

Funding Contact/Service Facilitator/SSA Phone # (_____) _____

Third Party Funding Source

Please check one of the following

Cash Payment

Check or Money Order
Payable to Stepping Stones

Credit Card
Mastercard, Visa, Discover, American Express
Contact 513-965-5105 to make payment

Family Support Services Program

County: _____
Please include voucher if available

Grant or Scholarship
Name of Organization: _____

County Contract or Independent Budget
County: _____

Local School District
Name of District: _____

Waiver - Independent Options (IO)

Waiver - Level One (L1)

Waiver - Self

OhioRise

If you checked waiver:
1. Please provide the contact information above.
2. Notify the funding source of intentions to enroll in the Stepping Stones program
3. Have funding source forward a copy of the annual plan to Nicole Allen at: nicole.allen@steppingstonesohio.org



I like to do:

- | | |
|--------------------------|--------------------------|
| _____ Archery | _____ Playground Time |
| _____ Board/Card Games | _____ Sensory Activities |
| _____ Boating | _____ Singing |
| _____ Cooking | _____ Sports |
| _____ Crafts | _____ Swimming |
| _____ Dancing | _____ Walking |
| _____ Fishing | _____ _____ |
| _____ Group Activities | _____ _____ |
| _____ Music | _____ _____ |
| _____ Outdoor Activities | |

Swimming: (Summer Programs Only)

Swimming Level—Please check one.

- | | |
|----------------------------|--------------------------|
| _____ Non-swimmer/beginner | _____ Puts Face in Water |
| _____ Intermediate | _____ Able to Float |
| _____ Advanced | |
| _____ Requires Lifejacket | |

Swimming Comments: _____

If your camper wears Depends throughout the day, a swim diaper/Depends cover is required.

I could become upset because:

- _____ I am too hot or cold
- _____ I am not getting my way
- _____ I am being told "NO"
- _____ I feel that I am in a "NOT FAIR" situation
- _____ I am being asked to wait
- _____ I am afraid
- _____ I am being asked to take turns
- _____ I am trying to communicate and I am not being understood
- _____ There is a change in my schedule
- _____ Someone is bossing me around
- _____ I am in a crowd
- _____ I am ill
- _____ I am asked to share
- _____ I am hungry/thirsty
- _____ I am homesick

Sensory Sensitivities:

No concerns

Visual (seeing): _____

Auditory (hearing): _____

Olfactory (smelling): _____

Tactile (touching): _____

Proprioceptive (movement): _____

What sensory situations upset him/her? _____

Assistive technology used: _____

I communicate best:

Primary Language: _____

- _____ Non Verbal
- _____ Verbally
- _____ Writing Notes
- _____ Using sign language
- _____ Using gestures/pointing
- _____ Using simple words
- _____ Using simple signs
- _____ Using body language and facial expressions
- _____ Using a PECS book* (Symbol Board)
- _____ Will this be sent to camp? _____ yes _____ no
- _____ Using a communication device*
- _____ Will this be sent to camp? _____ yes _____ no

I do not like or may be afraid of:

- | | |
|--------------------------|-----------------|
| _____ Animals | _____ Toileting |
| _____ Buses | _____ Water |
| _____ Change in Schedule | _____ _____ |
| _____ Emergency Vehicles | _____ _____ |
| _____ Insects | _____ _____ |
| _____ Large Groups | |
| _____ Loud Noises | |
| _____ Nurses/Doctors | |
| _____ Showers | |
| _____ Storms | |
| _____ The Dark | |
| _____ Swinging, Spinning | |

(Please remember the more information we have about each participant, the better we are able to safely serve them!)

My frustrations may appear by:

No behavior concerns

Behavior	Never	Rarely (Yearly)	Sometimes (Monthly)	Frequently (Weekly)	Daily	Additional Comments
Bad Language						
Biting Others						
Biting Self						
Crying						
Food Stealing						
Hair Pulling						
Hiding						
Hitting						
Homesickness						
Inappropriate Touch						
Kicking						
Refusing To Move						
Scratching						
Screaming						
Self-injurious Behavior						
Spitting						
Stealing						
Throwing Things						
Undressing						
Running Away						
Wandering						
Other						

You can help me by:

- _____ Quiet Space
- _____ Offer me water
- _____ Offer me choices
- _____ Speak calmly and in a quiet voice
- _____ Use fewer words
- _____ Take a break inside
- _____ Use a picture prompt or schedule
- _____ Provide sensory input (swings, jumping, running)
- _____ Talk to me about why I'm upset
- _____ Use first/then statement
- _____ _____
- _____ _____

Clarification of the above needs: _____

I have a behavior plan through the county: ___ yes ___ no
(If yes, please attach)

I have a behavior plan at school or other program: ___ yes ___ no
(If yes, please attach)

I have received overnight medical care for psychiatric observation:

_____ yes _____ no
 If yes, give dates and length of stay: _____

I may exhibit sexual behavior: ___ yes ___ no
 Explain Specifically (towards others, self, etc.) _____

Dressing/Undressing _____ Independent _____ Verbal Direction _____ Partial Assistance _____ Full Assistance
Is the participant able to identify and take responsibility for personal belongings? ___ Yes ___ No
 Clarification of above needs _____

Toileting/Washing _____ Independent _____ Verbal Direction _____ Partial Assistance _____ Full Assistance

Clarification of above needs _____

Mobility - Please check all that apply.

_____ Walks Independently	_____ Uses Wheelchair	Transfer Assistance
_____ Walks with assistance	_____ Manual	_____ Independent
_____ Staff assistance	_____ Can propel self? Y/N	_____ 1-person pivot
_____ Cane/Walker	_____ Power	_____ 2-person
_____ AFO (Type: _____)	_____ Uses Stroller	_____ Other _____

If participant walks with full physical assistance, how can we assist? _____

Clarification of above needs: _____

ALL DIETARY INFORMATION MUST BE COMPLETED

(Participant will not be enrolled if this information is not complete.)

You are responsible for updating client services if the participant's dietary information changes.)

Eating _____ Independent _____ Verbal Direction _____ Assistance _____ G-tube

Drinking _____ Independent _____ Verbal Direction _____ Assistance

Clarification of above needs _____

I require the following special dietary equipment: PLEASE MARK ALL THAT APPLY

Equipment	Clarification:
Adaptive Spoon	
Clothing Protector	
Divided Deep Dish	
Dycem	
Nosey Cup	
Plate Guard	
Sippy Cup	
Straw	
Other	

I need FOOD prepared in the following way: PLEASE CHECK ONLY ONE

Consistencies	Clairification:
Chopped Meat (Meat Only)	
Chopped (Bite/Dime Size Pieces)	
Mechanical (Ground like crumbs)	
Mechanical/ Dental Soft (Ground Wet like Crumbs)	
Puree (Pudding Consistency)	

After screening your application, you may receive a call from a program staff to discuss all of your information.

I need thickened liquids / supplements: Yes No

Liquids/Supplements		Other
Nectar Thick		
Honey Thick		
Pudding Thick		
Supplements: Ex. Ensure, Boost		
Supplements:		

I am a Diabetic: Yes No

I am a...		Clarification
Pre-Diabetic		
Type 1 Diabetic		
Type 2 Diabetic		
Requires Carbohydrate Count		
Insulin		
Other		

I have food related allergies/ intolerances or foods to avoid:

Yes, see below None known at this time

Type	Allergic	Avoid	Reaction/Treatment—PLEASE CLARIFY
Aspartame			
Caffeine			
Chocolate			
Citrus/Citrus Juice			
Corn			
Eggs			
Fish			
Gluten			
Milk			
Direct Dairy			
Indirect Dairy			
Peanuts			
Pork			
Sugar			
Tomatoes			
Tree Nuts			
Wheat			
Food Coloring/Dye Specific Color(s) and Number(s)			
Other:			
Other:			

NON FOOD ALLERGIES (Ex. Bees, Medications)

I am allergic to: _____ Reaction _____ Treatment _____

____ I have an Epi-Pen

I take medication _____ breakfast _____ lunch _____ dinner _____ bedtime _____ other
 I take medication by _____ mouth _____ G-tube _____ w/applesauce or pudding _____ with water _____ crushed

Number of medications taken daily: _____

Clarification: _____

Immunizations

Is your participant up-to-date on immunizations: _____ Yes _____ No

If no, please explain: _____

Seizure History _____ N/A

I will bring with me: _____ Diastat
 _____ Versed
 _____ VNS Magnet

I have a history of seizures _____ yes _____ no

I have had a seizure within the last year _____ yes _____ no

Type of seizure _____ grand mal _____ petit mal _____ partial _____ complex partial _____ simple partial

Protective Headgear _____ yes _____ no

Usual length of seizures _____

Triggers _____

My seizure looks like _____

Night Time Routine - (for overnight participants only)

_____ No concerns; sleeps through night

_____ Wakes to toilet independently

_____ Wakes to toilet with assistance

_____ Requires bedrails

_____ Can sleep in a cabin and/or share a room with others

Other nighttime needs: _____

_____ Wanders at night

_____ Wakes early; please note time: _____

_____ Requires medications to help sleep

_____ Requires adjustment/repositioning at night

Please describe _____

T-Shirt Size: Youth S - Youth M - Youth L - Adult S - Adult M - Adult L - Adult XL - Adult XXL - Adult XXXL - Adult XXXL
 (Please circle one)

PLEASE CHECK FOR PHOTO RELEASE

PHOTO RELEASE

I DO ___ DO NOT ___ consent to and authorize the use of photographs and other audio/visual materials taken of participant for promotional materials, educational activities, publications, exhibitions or for any use for the benefit of the program. Your photo release helps other families learn about Stepping Stones and helps tell the Stepping Stones story to financial supporters whose contributions help keep programs vibrant and affordable.

EMERGENCY MEDICAL TREATMENT RELEASE

CONSENT PLAN

In the event that emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on Stepping Stones' or Camp Allyn's property, I authorize Stepping Stones to:

1. Secure and retain medical treatment and transportation necessary
2. Release information upon request from the individual/agency involved in the emergency medical treatment.

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision will only be involved if the person designated is unable to be reached.

NON-CONSENT PLAN

I **DO NOT** give consent for emergency medical aid/treatment in the case of injury or illness while receiving services on Stepping Stones' or Camp Allyn's property. I wish the following to take place:

PLEASE CHECK ONE BOX FOR MEDICAL TREATMENT RELEASE

CONSENT

DO NOT CONSENT

SUNSCREEN RELEASE

All individuals enrolled in programs operated by Stepping Stones will have sunscreen applied by staff as needed. Please provide your choice of application of sunscreen.

PLEASE CHECK ONE BOX FOR SUNSCREEN RELEASE

SPRAY

LOTION

BUG SPRAY RELEASE

I consent to bug spray being applied at Stepping Stones' Recreation and Leisure Programs. I understand that bug spray contains Deet and harsh chemicals and may cause reactions to those with sensitive skin.

Please provide your consent for bug spray

PLEASE CHECK ONE BOX FOR BUG SPRAY RELEASE

CONSENT

DO NOT CONSENT

GENERAL RELEASE AND INDEMNITY AGREEMENT

In consideration of the acceptance of participant named below for any of the programs provided by Stepping Stones Hub, collectively "Stepping Stones " the undersigned hereby assumes complete and sole responsibility for any loss, injury to person or death or damage to property sustained or incurred by the participant arising out of and/or relating to any activity including, but not limited to, (the word activity is defined as any activity that takes place at any Stepping Stones Programs), transportation to and from Stepping Stones Hub, transportation to and from all outings and participation in any of the above contemplated services. The undersigned agrees to allow the participant to participate in outings and in travel involved as a part of Stepping Stones programs.

The undersigned, for himself/herself or as a parent and legal guardian hereby releases, acquits and forever discharges Stepping Stones, Camp Allyn, Rotary of Cincinnati, any agency with which any of these organizations may be affiliated, their officers, employees, trustees, volunteers, agents and any members of each of them, from and against any and all damages, liabilities, causes of action or injuries, or obligations of any nature whatsoever, past, present or future, known or unknown, arising out of or in any way relating to any activity including, but not limited to transportation to and from any Stepping Stones Programs. It is my further intention to release the aforementioned entities and individuals from any and all actions, causes of action, claims, damages, judgments, loss, cost or expenses, including attorney fees, known or unknown at this time whenever incurred, of whatever nature, related to any harm, personal loss injury, illness, addiction, emotional trauma, or death the undersigned incurs, contracts or suffers whether caused by or in any way contributed to by the negligence of any of the aforementioned organizations.

Stepping Stones reserves the right to exclude any participant that may pose a risk of harm. Program Administration will consider behavior, health and safety and potential risk before recommending exclusion. In further consideration of acceptance I agree to defend, indemnify and hold harmless Stepping Stones, Rotary Club of Cincinnati and any agency with which any of these organizations may be affiliated, their officers, employees, trustees, volunteers, agents and any members of each of them, from and against any and all claims, demands, actions, causes of action or injuries, or obligations of any nature whatsoever, arising out of or in any way related to any activity including, but not limited to transportation to and from Stepping Stones Hub Programs, transportation to and from all outings and participation in any of the above contemplated services.

If you are utilizing third party funding, your signature is authorizing us to contact the Service & Support Administrator (SSA) County for additional information as needed.

PERSONAL MEDICAL INSURANCE: I DO _____ I DO NOT _____ carry medical insurance
Health Insurance Provider _____ **Policy / Medicaid Number** _____

Does the participant have a DNR (DO NOT RESUSCITATE) and/or a LIVING WILL? _____ yes _____ no
If yes, please attach legal documentation. (Please call 513-965-5108 with questions.)

PARTICIPANT NAME _____

I have read and agreed to the above statements.

_____/_____/_____
DATE SIGNATURE OF LEGAL GUARDIAN PRINT NAME

Please Note: This page cannot be faxed.
Please send in mail or email per instructions below:

Please mail page to: Client Services
Stepping Stones
5650 Given Rd.
Cincinnati, OH 45243

Or email photo (jpg. or pdf.) to: jeannie.ludwig@steppingstonesohio.org

A new photo will be required each year.



**Please attach recent photo
which clearly shows
Participant's face.**

**If there is no photo attached,
you do not need to return this page**

Photos will not be returned