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 O_2 other than O_2 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 # (_____)_____

☐ **Cash Payment**

☐ **Check or Money Order**
Payable to Stepping Stones

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

☐ **Third Party Funding Source**
Please check one of the following

☐ **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

Participant Name _____

I like to do:

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

Swimming: (Summer Programs Only)

Swimming Level—Please check one.

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

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

***Stepping Stones is not responsible for loss or damage to mechanical devices**

Participant Name _____

(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
_____ Walks with assistance
_____ Staff assistance
_____ Cane/Walker
_____ AFO (Type: _____)

_____ Uses Wheelchair
_____ Manual
Can propel self? Y/N
_____ Power
_____ Uses Stroller

Transfer Assistance
_____ Independent
_____ 1-person pivot
_____ 2-person
_____ 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		Clairfication:
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 Diary			
Peanuts			
Pork			
Sugar			
Tomatoes			
Tree Nuts			
Wheat			
Food Coloring/Dye Specific Color(s) and Number(s)			
Other:			
Other:			

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

Participant Name _____

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

_____ Wanders at night

_____ Wakes early; please note time: _____

_____ Requires medications to help sleep

_____ Requires adjustment/repositioning at night

Please describe _____

_____

Other nighttime needs: _____

_____

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.

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

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