Gathering Time: A respite program for parents & guardians of young adult ages 18-35 years old with special needs. Our program also offers an opportunity for enrichment and socialization with other peers,

Who is eligible?

This program is intended to provide respite for care givers, but also to enrich the individual by providing socialization with peers while enjoying fun activities. At each event we will have a different theme and activities to go along with them. Attendance is tracked for all Gathering Time sessions and priority is given to those that have never attended and have not attended recently. Overall session safety is the overriding factor. Two staff members, a behavior specialist, and medical professional will attend the events. We will also have volunteers at each event to help with activities. Individuals must have an intellectually or developmental disability, not be on the DD waiver, and reside in their home with either their parents or guardians. At this time, we are not able to accept high behavior needs.

How does it work?

- ☀ Complete this registration packet and return it to Sarah Nolan by email RespitePrograms@tre.org or by mail or fax (see below).
- ☀ We will confirm your attendance and coordinate available sessions.
- ☀ Activities will include arts and crafts, music, dancing, and lots of fun.
- ☀ A meal and snacks will be provided. Please let us know of any dietary restrictions
- ☀ Events will take place twice a month at The ARC (12 N. Meade Avenue 80909). Events are on scheduled Friday evenings and Saturday mid day.
- ☀ All participation must be confirmed prior to the sessions by the Gathering Time Staff. **There is no capability for unscheduled drop-offs**.

6385 Corporate Drive, Suite 100, Colorado Springs, CO 80919
Phone (719) 338-1718 Fax (844) 207-6957

Gathering Time Enrollment Form

Please leave No Unanswered Questions or Blank Pages. Write N/A if not applicable.

Name of Individual with An Intellectual or Developmental Disability: _____

Nickname: _____ Male ❒ Female ❒ Preferred Pronouns: _____

Date of Birth: _____ Primary Language (including ASL):_____

Name of Parent or Guardian #1: _____

Cell Phone # for Parent or Guardian #1:_____ May we text this number? ❒ No ❒ Yes

Name of Parent or Guardian #2: _____

Cell Phone # for Parent or Guardian #2:_____ May we text this number? ❒ No ❒ Yes

Is the individual their own guardian? ❒ No ❒ Yes If they are, please have them sign all spots in the application.

Home Address: _____ Zip Code: _____

Does the individual reside in the home with either their parents or guardians? ❒ No ❒ Yes

Email: _____

Emergency Contact/Name and Phone #:_____

Please list everyone who can pick up the individual:_____

How did you hear about our program?_____

What Diagnoses has been identified to meet criteria for a Intellectual or Developmental Disability over age 5? _____

Have you been determined to receive services through TRE? ❒ No ❒ Yes If yes, what services are you receiving?_____

Is the individual currently enrolled on a waiver? ❒ No ❒ Yes If so, which waiver ?(Please note we can not accept anyone on the DD waiver,)_____

Are All Immunizations up to Date? ❒ No ❒ Yes (If no, which are out-of date?)_____

Name of Primary Care Physician: _____ Phone: _____

Does the individual tolerate wearing a mask well? ❒ No ❒ Yes. Please be advised masks will be worn at all sessions.

Is the individual non-verbal? ❒ No ❒ Yes. If yes, how do they communicate with others?_____

_____

List any allergies _____

Does the individual have any dietary restrictions?_____

Describe **any history or possibility of choking or aspirating while eating**: _____

_____

Does the individual have **any history of seizures** at any time in their life ❒ No ❒ Yes

If applicable, **what will a seizure look like to a caregiver**? _____

_____

List & explain all special equipment used (i.e. wheelchair, oxygen, g-tube, tracheotomy, etc.):

_____

Describe **toileting needs**: _____

Does the individual suffer from any of the following? (Check all that apply.)
❒ Auto Immune Disease ❒ Asthma ❒ Diabetes ❒ High Blood Pressure

Please list any other medical conditions we should be aware of?_____

_____

Gathering Time Behavioral Questionnaire

Please answer all questions as honestly as possible. Please explain all Yes answers. Please note at this time we can not accept high behavior needs

Does the individual suffer from any of the following? (Check all that apply.)

❒ Mood swings (i.e. goes from great sadness to happiness)	❒ Very upset when left by parents	❒ Sexual Inappropriate Behavior	❒An elopement risk
❒ Compulsions	❒ Homicidal Ideation	❒ Obsessions	❒ Developmental Delays
❒ Eating problems	❒ Suicidal Ideation	❒ Substance Abuse	❒

Describe any **legal charges or convictions?** ❒ No ❒ Yes, please explain _____

_____

How do you handle behavioral issues? _____

_____

_____

_____

How does the individual respond to your intervention?_____

Please list at least 5 things **the individual**/enjoys doing: _____

_____

_____

_____

Gathering Time Medication Form

Make copies of this blank if there are more than 2 medications to be administered.

Fill out this form completely and accurately. If the individual is on medications, but will not be receiving them during Gathering Time, please just attached a copy of all current medications they are on.

Bring a sufficient amount of medication, in a current, prescription container. Over-the-counter medications, ointments and sunscreens must be delivered in original containers with instructions and warnings clearly visible. Medications that are brought to sessions in any other manner cannot be administered during Gathering Time or even left at the facility. You will have to choose between coming back at medication time or skipping a dose. The Registered Nurse must approve those options and may decide to reschedule. ****Caregivers do not administer or accept possession of any medications.****

Today's Date_____ **Name**_____

Name of Medicine #1:_____**Dosage:**_____

Reason the child needs the medication:_____

Method of Administration:_____

Any difficulties giving? (suggestions for nurse)_____

Times(s) to be given:_____

Side effects to watch for:_____

Does this medication need to be refrigerated? (please circle) Yes No

Name of Medicine #2:_____**Dosage:**_____

Reason for the medication:_____

Method of Administration:_____ _____

Any difficulties giving? (suggestions for nurse)_____

Times(s) to be given:_____

Side effects to watch for:_____

Does this medication need to be refrigerated? (please circle) Yes No

Individual/Guardians Signature_____

CONSENT TO RELEASE INFORMATION/PHOTOS, VIDEOS, STATEMENTS.

PLEASE FILL OUT EACH SECTION BELOW

Name:	Birth Date:	

I hereby authorize: **The Resource Exchange** To release information to: **The Resource Exchange**

1. **Authorization:** Initial ONE OF THE FOLLOWING CHOICES BELOW:

   A. _____I authorize The Resource Exchange to photograph
   B. _____I do not authorize The Resource Exchange to photograph
   (name)_____or use likeness to promote The Resource Exchange.

2. **Information Request:** Initial ALL THAT APPLY or mark "N/A" if not applicable to this consent.
The following information is requested:

	Photos, Videos, Statements, printed material. These may be used with or without my name and for any lawful purpose for TRE Marketing and promotions both internally with staff and externally with the community via TRE's website and social media.
	_____ (please initial) I understand that photos, videos, statements and printed materials released between the effective date of this authorization and the date of revocation may still be used in the public domain.
	Other: (please specify)

3. **Identification Authorization:** Initial your preference.

	TRE may use my full name on marketing and promotions materials.
	TRE may only use my first name on marketing and promotions materials.
	I wish to remain anonymous.

4. **Information Usage:** The above information may be utilized for: (please specify):

5.Consent Term: This consent will remain in effect until (not to exceed one year: _____(Date of Expiration)

5. **Signatures:** I/We do understand that I may revoke this authorization at any time, provided that I/we do so in writing to The Resource Exchange.

Date

Signature of Individual/Guardian

Permission Slips

gathering Time staff will call 911 to obtain emergency services for your child in any situation that is perceived to be life threatening. <u>Please attach copies of all applicable insurance cards to avoid treatment delays</u>.

The granted permissions and signed authorizations below are for: (name) _____

Contact Individual/guardian: Name_____

Phone number(s) where you can be reached: _____

Other desired action:_____

Please read and sign the following authorizations (<u>Write "Not Approved" in the date for any denied permissions</u>).

In case of a non-life threatening emergency, illness, or accident, the staff of Break Time is authorized to provide transportation, including ambulance service deemed necessary by the Break Time staff which includes a registered nurse.

Individual/Guardian_____ Date_____

I authorize and consent to any medical diagnostic tests, procedures and treatment to be performed by an appropriate physician, relating to or arising out of any accident, illness, or injury occurring at, or in conjunction with, any Gathering Time activity.

Individual/Guardian_____ Date_____

Required for attendance if applicable: My child _____ uses a wheelchair, and I give my permission for caregivers and professional staff to push/operate his/her wheelchair under the supervision of the Gathering Time staff.

Individual/Guardian_____ Date_____

<u>Per TRE policy, any granted permission can be immediately revoked by a parent, guardian or participant by any means of communication. This includes a verbal, written or digital notice to TRE.</u>

All information will be kept confidential and for the exclusive use of Gathering Time staff only.

Your signature signifies that the information you have or will provide is, to the best of your knowledge, true and accurate.

_____ _____

(Signature of Individual/Guardian) (Date)

Please provide us with any information that you would like us to know. Finish incomplete answers to previous questions below as well. If there is not enough space, please attach your narrative of important medical, behavioral, or any information that we may need.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Do you have any questions at this time?

_____

_____

_____

Do you know of another family that might benefit from our program? Please include their name, phone number, and email address:_____

_____