Reset Form

LEAP Program Application for Services

Section I - Participant Information

Name (Last) _____ (First) _____ (Middle) _____

Home Address _____

Email Address _____ Phone (____) _____

Date of Birth_____ Age _____ Place of Birth_____

Medicaid Number_____

Primary Disability_____Secondary Disability _____

Section II— Family Information

Father's Name _____ Mother's Name _____

Home Address _____

Phone (___) _____ Email Address _____

Legal Guardian (if applicable) _____ Relationship _____

Address _____

Phone (___) _____ Email Address _____

Emergency Contact (other than parent or guardian) _____

Phone (___)_____Alternate Phone (___) _____

Section III - Medical Information

Medical Coverage_____

Primary Physician_____ Phone (___) _____

Hospital Preference_____

Medical Conditions (please list all) _____

_____

Current Medications _____

_____

Date of last physical _____Physician _____

Assistive Devices _____

Additional Medical Concerns _____

Section IV - Educational/Vocational History

Highest Grade Completed_____ School _____

Last School or Program Attended _____

General Program Description _____

Work Experience (if applicable) _____

Section V- Reason for Referral

Please indicate training needs expressed by individual

_____

_____

_____

_____

Additional Information_____

_____

_____

_____

_____

Reset Form

Easter Seals Florida, Inc.
LEAP Program

Member Choices & Preferences

Name: _____ **Date:** _____

I like to:	Yes	No	Comments
Work alone			
Work in a group			
Other			
What kinds of jobs do you like to do?			
Assembly			
Recycling			
Sorting			
Packaging			
Labeling			
Other			
What activities would you like to participate in?			
Volunteering			
Arts & Crafts			
Exercise			
Community outings			
Other			
Things I would like to learn about:			
Computer skills			
Money skills			
Community employment			
Other			

Member Signature: _____ **Date:** _____

Guardian Signature, if applicable: _____

Assisted by, if necessary: _____

Staff Signature & Title

EASTER SEALS FLORIDA, INC.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO YOUR MEDICAL INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice is effective as of April 14, 2003.

We are required by law to maintain the privacy of protected health information, and must inform you of our privacy practices and legal duties. You have the right to obtain a paper copy of this Notice upon request.

We are required to abide by the terms of the Notice of Privacy Practices that is most current. We reserve the right to change the terms of the Notice at any time. Any changes will be effective for all protected health information that we maintain. The revised Notice will be posted in lobby, reception area and on our web site. You may request a copy of the revised Notice at any time.

We have designated a Privacy Officer to answer your questions about our privacy practices and to ensure that we comply with applicable laws and regulations. The Privacy Officer also will take your complaints and can give you information about how to file a complaint.

Our Privacy Officer is Rikesha Blake. You can contact the Privacy Officer at 407-588-7133.

Use and disclosure of your protected health information that we may make to carry out treatment, payment, and health care operations.

We may use information in your record to provide treatment to you. We may disclose information in your record to help you get health care services from another provider, a hospital, etc. For example, if we want an opinion about your condition from a specialist, we may disclose information to the specialist to obtain that consultation.

We may use or disclose information from your record to obtain payment for the services you receive. For example, we may submit your diagnosis with a health insurance claim in order to demonstrate to the insurer that the service should be covered.

We may use or disclose information from your record to allow "health care operations." These operations include activities like reviewing records to see how care can be improved, contacting you with information about treatment alternatives, and coordinating care with other providers. For example, we may use information in your record to train our staff about your condition and its treatment.

Your rights

You may ask us to restrict the use and disclosure of certain information in your record that otherwise would be allowed for treatment, payment, or health care operations. However, we do not have to agree to these restrictions.

You have a right to receive confidential communications from us. For example, if you want to receive bills and other information at an alternative address, please notify us.

You have a right to inspect the information in your record, and may obtain a copy of it. This may be subject to certain limitations and fees. Your request must be in writing.

If you believe information in your record is inaccurate or incomplete, you may request amendment of the information. You must submit sufficient information to support your request for amendment. Your request must be in writing.

You have the right to request an accounting of certain disclosures made by us.

You have the right to complain to us about our privacy practices (including the actions of our staff with respect to the privacy of your health information). You have the right to complain to the Secretary of the Department of Health and Human Services about our privacy practices. You will not face retaliation from us for making complaints.

Except as described in this Notice, we may not make any use or disclosure of information from your record unless you give your written authorization. You may revoke an authorization in writing at any time, but this will not affect any use or disclosure made by us before the revocation. In addition, if the authorization was obtained as a condition of obtaining

insurance coverage, the insurer may have the right to contest the policy or a claim under the policy even if you revoke the authorization.

Use or disclosure of your protected health information that we are required to make without your permission

In certain circumstances, we are required by law to make a disclosure of your health information. For example, state law requires us to report suspected abuse or neglect. Also, we must disclose information to the Department of Health and Human Services, if requested, to prove that we are complying with regulations that safeguard your health information.

Use or disclosure of your protected health information that we are allowed to make without your permission

There are certain situations where we are allowed to disclose information from your record without your permission. In these situations, we must use our professional judgment before disclosing information about you. Usually, we must determine that the disclosure is in your best interest, and may have to meet certain guidelines and limitations.

If you receive mental health care, including treatment for substance abuse, information related to that care may be more protected than other forms of health information. Communications between a psychotherapist and patient in treatment are privileged and may not be disclosed without your permission, except as required by law. For example, psychotherapists still must report suspected child abuse, and may have to breach confidentiality if you appear to pose an imminent danger to yourself or others, in order to reduce the likelihood of harm to you or others.

We may report births and deaths to public health authorities, as well as certain types of diseases, injuries, adverse drug reactions, and product defects. We may disclose information from your record to a medical examiner or coroner. We may disclose information to funeral directors to allow them to carry out their duties upon your death. We may disclose information from your record to facilitate organ, eye, or tissue donation and transplantation

We may assist in health oversight activities, such as investigations of possible health care fraud.

We may disclose information from your record as authorized by workers' compensation laws.

We may disclose information from your record if ordered to do so by a court, grand jury, or administrative tribunal. Under certain conditions, we may disclose information in response to a subpoena or other legal process, even if this is not ordered by a court.

We may disclose information from your record to a law enforcement official if certain criteria are met. For example, if such information would help locate or identify a missing person, we are allowed to disclose it.

If you tell us that you have committed a violent crime that caused serious physical harm to the victim, we may disclose that information to law enforcement officials. However, if you reveal that information in a counseling or psychotherapy session, or in the course of treatment for this sort of behavior, we may not disclose the information to law enforcement officials.

We may use or disclose information from your record for research under certain conditions.

Under certain conditions, we may disclose information for specialized government purposes, such as the military, national security and intelligence, or protection of the President.

We may contact you with information about treatment alternatives or other health-related benefits or services that may be of interest to you.

We may contact you for fundraising efforts.

_____ _____

Signed Dated

EASTERSEALS FLORIDA, INC.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY

Notice to patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

Please print your name here

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this client but it could not be obtained because:

- The client refused to sign
- Other *(please provide specific details)*

_____

_____

_____

_____

_____ _____

Employee signature *Date*

Reset Form

Easterseals Florida, Inc. – Services Contract
Life Skills, Employment readiness, Advocacy and Participation Program (LEAP)
Self-pay/Medicaid Waiver/iBudget/CDC

Name: _____ Primary Disability:_____

Address:_____

Home Phone:_____ Cell Phone:_____

Date of Birth:_____ Sex: ◯ Male ◯ Female

I, _____request the following services from Easterseals Florida, Inc.:

☐ **LEAP**

I agree I have received an LEAP Program Handbook, a copy of this contract and completed all required forms before admission.

I do hereby agree to the following terms and conditions for the admission of:

Name _____

As a self-payee, **PAYMENT IS DUE ONE WEEK IN ADVANCE** and payable weekly unless other arrangements have been made. Established rate is $_____per day but may be subject to change upon written notice. The LEAP Program is a daily rate regardless of the number of hours spent in the workshop. The Client will not be retained in the program if she/he requires services beyond ability of the program.

Medicaid Waiver/iBudget/CDC Clients: I understand I am financially responsible for services not covered by the iBudget/CDC Program.

Client: _____

Parent/Guardian/Caregiver: _____

Date: _____

AUTHORIZATION AND CONSENT FORM

Member Name: _____Date: _____

GUARANTEE OF PAYMENT: For and in consideration of services rendered or to be rendered to this Member by EASTERSEALS FLORIDA, I/WE, individually and jointly, here to agree to pay any and all bills rendered for said Member which are not covered by insurance and/or third party payers, or otherwise paid. I understand and agree that all bills are payable and become due upon presentation.
X _____

ASSIGMENT OF INSURANCE BENEFITS: I/WE authorize and direct payment of the medical benefits arising from insurance or other coverage through which the Member is insured and covered, any and all other proceeds from any insurance and/or settlement or judgment, or out of a claim or lawsuit, directly to EASTERSEALS FLORIDA, but not to exceed the regular charges for services provided. I understand that I am responsible for all charges not paid through the above sources. I understand that I am responsible for any insurance deductible, co-pay and co-insurance.
X _____

AUTHORIZATION TO RELEASE INFORMATION: I/WE authorize EASTERSEALS FLORIDA to release medical and all other information as required for collection of benefits from insurance carriers or other third party sources of payment in connection with the illness or injury of the Member, and I/WE authorize benefits be made in my behalf to EASTERSEALS FLORIDA. I/WE authorize release of medical information regarding Member's care and treatment at the center to referring physicians and other I/WE may determine.
X _____

SIGNATURE ON FILE: I authorize use of this form on all my insurance submissions, I authorize EASTERSEALS FLORIDA to act as my agent in helping me obtain payment directly to EASTERSEALS FLORIDA. I permit a copy of this authorization to be used in place of the original.
X _____

I CERTIFY THAT I FULLY UNDERSTAND THE NATURE OF THE ABOVE STATEMENTS.

Signature: _____ Date: _____

Member:_____

Witness: _____

RE:_____

Parents/Guardians/Support staff,

In order for Easterseals to remain in compliance with the Agency for Persons with Disabilities regulations for the administration of medications please find enclosed:

- An **Informed consent** form which needs to be signed and witnessed by the client or legal representative of the client

- An **Authorization for Medication Administration,** which must be filled out and **signed** by the client's **Health Care Provider.**

Easterseals will also need a copy of a current prescription or order legibly displaying the following information:

- Name of Medication
- Prescription number
- Prescribed dosage
- Specific directions for use of medication
- LEAP dosage responsibility (what time and how much medication is to be administered by Easterseals staff)
- Medications must be in the original container

Medications cannot be crushed, diluted or mixed without instructions from the doctor. ***Specifically, Easterseals will not be permitted to open capsules or mix medications with food or drink without written instruction from the doctor.**

Without this information, Easterseals will not be compliance with the Agency for Persons with Disabilities regulations and therefore, **cannot administer** the necessary medications.

These rules also apply to OTC (over the counter) and PRN (as needed) medications.

This information needs to reach us no later than October 31, 2016 for uninterrupted administration of medications to continue. Without the updated information, Easterseals will not administer medications, and will not resume until all files are in compliance. To expedite this process, forms may be faxed directly from the doctor's office to Easter Seals. (Fax # (239)403-0368.)

Thank you for your cooperation in this matter.

Easterseals LEAP staff

I understand and will above information

_____ _____

Client Signature Date

_____ _____

Parent/Guardian Signature Date

Easterseals Florida, Inc.
LEAP Program

Member Safety / Emergency Medical Release Agreement

As a condition of participation, I do hereby agree to comply with the following safety procedures:

1. I agree to follow established departmental safety procedures as outlined in the Program Handbook.

2. I agree to report any accident or injury to my supervisor or closest available staff member as soon as it occurs, prior to seeking medical attention but no later than the end of the program day.

3. If I require medical treatment due to an illness or injury during program hours, I agree to the following procedure:

    a. If illness or injury requires immediate medical attention, Easterseals staff will call 911 and Member's parent or emergency contact person. Staff will accompany Member to the hospital in the event that parent of emergency contact person is not present. Staff will remain with Member at the hospital until family is present.

    b. If illness or injury does not require immediate medical attention, Easterseals staff will contact Member's parent or emergency contact person to remove the Member from program if necessary.

I understand that failure to comply with the above procedures could result in disciplinary action.

I hereby grant permission to Easterseals Florida, Inc. and staff members thereof to secure emergency medical treatment for my son/daughter/consumer in the event it is needed.

_____ _____
Member Signature Date

_____ _____
Signature of Parent/ Guardian/Caregiver Date

_____ _____
Witness/Guardian, if applicable Date

Is the individual listed above legally competent? ◯ Yes ◯ No

EASTERSEALS FLORIDA, INC
Life Skills Employment readiness, Advocacy and Participation Program

Emergency Medical Release

I hereby grant permission to Easterseals Florida, Inc. and staff members thereof to secure emergency medical treatment for my son/daughter/consumer in the event it is needed.

Signature of Program Member: _____

Date: _____

Signature of Parent/ Guardian/Caregiver: _____

Date: _____

Signature of Witness: _____

Date: _____

Is the individual listed above legally competent? ☐ Yes ☐ No

Easterseals Academy – LEAP Program

List of current medication

MEMBER NAME: _____

Please complete for all medications taken at home and to be administered while attending LEAP (if applicable).

MEDICATION	DOSAGE	TIMES ADMINISTERED	SIDE EFFECTS EXPERIENCED

Easterseals Academy – LEAP Program

Authorization for Medication Administration

Participant's Name: _____ **Date of Birth:** _____

Primary/Administering Provider: _____

Address: _____

Telephone: _____ **Fax:** _____

Email: _____ **Secured** ☐ **Unsecured** ☐

I am a physician, physician's assistant, or Advanced Registered Nurse Practitioner licensed to practice in the State of Florida, and a provider of health care services for the above named individual attending Easterseals LEAP Program. It is my professional opinion, based on my knowledge of the student's health status and physical condition, that he/she:

Requires medication administered by a validated medication administration provider.

Please provide the specifications, including, name of medication, dosage, and any additional special instructions:

_____

_____

_____ _____

Health Care Provider's Signature **Date of Authorization***

**Authorization will be valid for one year from this date.*

FIELD TRIPS AND COMMUNITY ACTIVITIES

PERMISSION FORM

Member's Name_____ Date: _____

By signing below, I acknowledge that community based instruction will be provided and I give my permission for my child to be transported by Easterseals for group community activities and will follow all transportation rules.

EASTERSEALS TRANSPORTATION RULES

l. Stay on the curb until the bus/van has stopped and is ready to load.

2. Sit in your seat on the bus/van at all times. Seat belts MUST be worn.

3. No smoking, eating, drinking, swearing, yelling, whistling, fighting, shoving or inappropriate behavior.

4. ONLY the driver may open or close windows; you must keep your arms and hands inside the bus/van at all times.

5. Electronic devices such as phones, tablets, hand held games, etc. are not to be used on the bus/van. Please do not take excessive "luggage". A book bag or small carry-on bag would be appropriate.

6. If you need assistance in boarding or leaving the bus/van the driver will assist you.

7. The driver is responsible for you when you are boarding or leaving the bus/van. It is your responsibility to get to and from the bus/van.

Failure to follow the above rules will result in the following disciplinary actions:

lst Offense: Verbal Warning
2nd Offense: Written Warning
3rd Offense: Suspension/Expulsion, if needed.
Depending on the severity of the violation, a warning and suspension may be omitted.

I understand and will obey the above rules when riding the Easterseals vans.

_____ _____
Member Signature Date

_____ _____
Parent/Guardian Signature Date

EASTERSEALS VAN RULES

l. Be ready for the bus/van in the mornings. Stay on the curb until the bus/van has stopped and is ready to load.

2. Sit in your seat on the bus/van at all times. Seat belts <u>MUST</u> be worn.

3. No smoking, eating, drinking, swearing, yelling, whistling, fighting, shoving or inappropriate behavior.

4. ONLY the driver may open or close windows; you must keep your arms and hands inside the bus/van at all times.

5. Electronic devices such as phones, tablets, hand held games, etc. are not to be used on the bus/van. Please do not take excessive "luggage". A book bag or small carry-on bag would be appropriate.

6. If you need assistance in boarding or leaving the bus/van the driver will assist you.

7. The driver is responsible for you when you are boarding or leaving the bus/van. It is your responsibility to get to and from the bus/van.

Failure to follow the above rules will result in the following disciplinary actions:

lst Offense: Verbal Warning
2nd Offense: Written Warning
3rd Offense: Suspension/Expulsion, if needed.
Depending on the severity of the violation, a warning and suspension may be omitted.

I understand and will obey the above rules when riding the Easterseals vans. I also understand that pick-up and drop-off times <u>may change</u> from time to time based on transportation needs.

Member Signature	**Date**
Parent/Guardian Signature	**Date**

Consent to Release Information/Medical Care Release

This document must be signed by Member or by legal guardian if Member is adjudicated incompetent. It is valid while participating in any Easterseals program and becomes void on the date of Easterseals closure.

1. I authorize general verbal or written communication between Easterseals representative(s) and:

	YES	NO
Funding/Referral Agency	_____	_____
Medical Practitioner	_____	_____
Psychological Practitioner	_____	_____
Family Members	_____	_____
Social Security Representatives	_____	_____
Employers	_____	_____
Support Coordinators	_____	_____
Other (Specify)_____	_____	_____

Any contact will only be in reference to my program at Easterseals.

2. I authorize use of my photograph, audio or visual representation in my program setting only.
   YES____ NO____

3. I authorize an Easterseals representative to arrange emergency medical transportation, as needed, to the nearest medical facility and their release of any Easterseals medical information that may be needed.
   YES____ NO____

If no mark is present above, it will be considered a NO answer.

---

4. I understand that release of specific information (other than emergency situations) requires my separate written consent and that I may change my authorization or authorized representative at any time by completing a new form.

5. I have been informed of my right under **Title VI of the Civil Rights Act of 1964**, which assures that I will not be excluded from participation in or be denied benefit of or otherwise subjected to discrimination under any program or activity on the grounds of my race, color, or national origin.

6. I have been informed of the suspension and termination process, notified of my appeal rights, and given a copy of the Easterseals handbook.

Member Name: _____ Date: _____

Member Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

This form will expire on the date of the next yearly IP meeting date. If the Member leaves the program before this date, the form is considered expired.

ADULT MEDIA RELEASE

I hereby consent that any narratives, depictions, pictures, film, photographs, audio-visual or sound recordings or testimonials of me made by Easterseals Florida or its respective employees and agents may be used by Easterseals Florida, and those acting with its permission, for the purpose of illustration, broadcast, or testimonial in connection with any work of Easterseals Florida and that these materials may be released to the general public. I assign to Easterseals Florida all of my rights to these materials.

I understand that these materials made by Easterseals Florida, its employees and agents are owned by Easterseals Florida and that they may copyright them. I will allow Easterseals Florida, their respective employees and agents, and those acting with Easterseals Florida's permission, to use my protected health information, as defined under 45 C.F.R. 164.501, for the purpose of illustration, broadcast, or testimonial in connection with the work of Easterseals Florida and to release this information to the general public.

I understand that these materials may be published on Easterseals Florida's network of Web sites and this may disclose my personal and protected health information online.

Easterseals Florida does not need to submit these materials to me for further approval. I understand that these materials may be modified and that Easterseals Florida may decide not to use them.

I acknowledge that the rights described above are granted to Easterseals Florida on an unlimited basis without any compensation or payment being made for any current or future use. I understand that this authorization is voluntary and that Easterseals Florida will not condition any treatment or funding to me on the completion of this authorization. I also understand that I may revoke my consent to allow Easterseals Florida to release my protected health information if the information has not already been disclosed. To revoke my consent, I must notify Easterseals Florida in writing by sending my revocation to _____. I understand and agree that once Easterseals Florida, its respective employees and agents, and those acting with its permission, disclose my protected health information as contemplated by this release, this information is subject to re-disclosure and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996. This release and authorization expires three years from the date of my signature below.

I certify that I am over the age of 18 years old.

I have read this release and authorization before signing below, and I fully understand its contents.

_____

Signature of Adult or Parent/Guardian Witness for Easterseals Florida

_____

Printed Name of Adult or Parent/Guardian Date

_____

Date

_____

Address

_____

City, State, Zip Code

EASTERSEALS FLORIDA, INC

Life Skills, Employment readiness, Advocacy and Participation Program

MEMBER GRIEVANCE PROCEDURE

Procedure- To Resolve any Issues that the Member has regarding their Program
And involve all Resources (Family, Guardians, and/or Provider)

Grievance: – If you feel that you have been treated unfairly or disagree with any element of your program at Easterseals, you should contact your Group Supervisor. You can make contact verbally or in writing. It is important to contact someone immediately (or at least within two (2) weeks of the occurrence). A copy of all complaints will be kept in the Area Director's office.

If you feel more comfortable discussing your concerns with your family or Support Coordinator, they can assist you and participate in the problem solving process with your Supervisor or Lead Activities Trainer.

Resolution- A meeting with the Area Director will be scheduled to discuss and resolve the problem. You may invite anyone you wish to attend this meeting with you. The Area Director will respond to your problem verbally and in writing within five (5) days. A copy of the written response will be kept in the Area Director's office.

Appeals- If the Area Director is unable to solve your grievance, the next step in the process is to meet with the CEO. You may invite anyone you wish to attend this meeting with you. The CEO will respond to your problem either verbally or in writing within ten (10) days and the decision will be final.

==========

I have read (or have had someone read to me) and understand the procedure that is in place to resolve any problem that I have with my LEAP Program

I also understand that Easterseals Florida, Inc. does not allow any form of retaliation (negative actions, ignoring, laughing at, termination) against employees who file a grievance or who participate in an investigation.

_____ _____

Member Date

_____ _____

Parent/Guardian Date

EASTERSEALS FLORIDA, INC.

MEMBER'S CIVIL AND ABUSE RIGHTS

Easterseals Florida, Inc. agrees that it will comply with Title VI of the Civil Rights Act of 1964, as amended, 42 U.S.C. 2000d et seq., prohibiting discrimination on the basis of race, color, or national origin in programs and activities receiving or benefiting from federal financial assistance.

Easterseals Florida, Inc. agrees that it will comply with Section 504 of the Rehabilitation Act of 1973, as amended 29 U.S.C. s.794(a), et.seq., in regard to employees or applicants for employment.

Easterseals Florida, Inc. agrees that it will comply with Title XI of the Education Amendments of 1972, as amended, 29 U.S.C. 2000e, et seq., which prohibits discrimination on the basis of sex in education programs and activities receiving or benefiting from federal financial assistance.

Easterseals Florida, Inc. agrees that it will comply with the Omnibus Budget Reconciliation Act of 1981, P.L. 97-35, prohibiting discrimination on the basis of sex or religion in programs and activities that receive or benefit from federal financial assistance.

Easterseals Florida, Inc. agrees that it will comply with Chapter 415.1034, F.S. stating that an employee of the provider who knows, or has reasonable cause to suspect, that a individual receiving services from Development Disabilities is being abused, neglected, or exploited, shall immediately report such knowledge or suspicion to the central abuse registry and tracking system of DCF using the statewide toll-free telephone number (1-800-96ABUSE).

Easterseals Florida, Inc. agrees that it will comply with the Americans with Disabilities Act of 1990 P.L.101-336, prohibiting discrimination, based on disability, in employment, public accommodations, transportation, state and local government services and telecommunications.

Easterseals Florida, Inc. agrees that it will comply with Title 42, Code of Federal Regulations (CFR) 431.51, which states that each individual served will be afforded freedom of choice within the scope of available funding levels.

Easterseals Florida will uphold the rights and privileges of recipients with developmental disabilities as specified in Chapter 393.13, F.S. "The Bill of Rights of Persons Who Are Developmentally Disabled".

I have been informed (verbally and in writing) and understand my civil and abuse rights.

_____ _____

Date Member Signature or Authorized Representative

EASTERSEALS FLORIDA, INC.
LEAP Handbook

I, _____,
have read/or have had read to me and understand the contents of the LEAP Program Handbook. I have received a copy of the handbook upon admission to the Life Skills, Employment Readiness, Advocacy & Participation Program. The Handbook contains important information regarding transportation, medication administration and grievances procedures.

_____ _____
Date **Member Signature**

_____ _____
Date **Parent/Caregiver/Guardian Signature**

EASTERSEALS FLORIDA, INC.
LEAP PROGRAM
MEMBER FACT SHEET

Member Name _____

Member Address _____

_____

Member Email address _____

Member phone number _____

Member cell number _____

Date of Birth _____

Private Pay _____ **Medicaid Waiver**_____

Medicaid Number _____

Days Attending LEAP Program:_____

Arrival Time: _____ **Departure Time:** _____

Parent/Guardian Name_____

Parent/Guardian Address:_____

_____

Parent/Guardian Email address:_____

Parent/Guardian Home phone #: _____

Parent/Guardian Work #: _____

Parent/Guardian Cell #: _____

Physician_____**Phone**_____

Allergies:_____

Assistive or adaptive equipment: _____

_____

_____

Primary Disability _____

Secondary Disability _____

Legally Competent **Yes** **No**

EMERGENCY CONTACTS:

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

PERSONS AUTHORIZED TO REMOVE FROM CENTER:

_____

_____

SUPPORT COORDINATOR INFORMATION, IF APPLICABLE:

Name: _____

Address:_____

_____

Phone:_____ **Cell:**_____ **Fax:**_____

Email Address:_____