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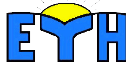


Expanding YOUR Horizons

34017 SR 681 Albany, OH 45710
(740) 416-1103

# YOUR Path to Unique and Exciting Community Opportunities Starts Here!

| YOUR Name: | DOB: | SS#: |
|---|---|---|
| Address: | City, State Zip Code: | |
| Mailing Address (If Different): | City, State Zip Code: | |
| Home Phone: | Other Phone: | Email: |
| YOU Live: With Family With Housemate(s) Alone Other: | | |
| Event Coordinator: | Phone: | Email: |
| Natural Support: | Phone: | Email: |
| Provider: | Phone: | Email: |
| SSA/County: | Phone: | Email: |
| Emergency Contact: | Phone: | Email: |
| Other Contact: | Phone: | Email: |
| Legal Guardian: | Phone: | Email: |
| Address: | City, State Zip Code: | |
| Funding: IO Waiver Level 1 Waiver SELF Waiver Private Pay Other: | | |
| Acuity Group: A A-1 B C | 12 Digit Medicaid Number: | |
| Span Start Date: | # Events YOU Would Like to Attend Each Month: | |

| Medical Information (Does not need completed by a doctor) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Seizures | Yes | No | Heart Issues | Yes | No | Blood Sugar Issues | Yes | No |
| Allergies | Yes | No | Breathing Issues | Yes | No | Food Restrictions | Yes | No |
| If YOU answered "Yes" above, please explain: | | | | | | | | |
| Other Medical Issues: | | | | | | | | |
| Primary Care Physician or Medical Facility: | | | | | | Phone: | | |

| Medication (Attach MAR) | Dosage | Medication (Attach MAR) | Dosage |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

| **Emergency Medical Authorization:** In the event of an emergency, I hereby give my consent for any medical treatment deemed as necessary. | ***Signature/Date:** |
|---|---|

***Guardian Signature if Applicable**

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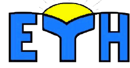


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# Habilitation Assessment

**Individual's Name**: ______________________________ **DOB:** ______________

**Instructions:** Please make sure that the person filling out this series of questions knows the applicant well. The accuracy of this information is important to meet the applicant's needs while attending Expanding YOUR Horizons Events. This information will be used to develop community skills and assist the individual to achieve their goals when attending community Events with EYH. If an individual requires assistance with a task, please specify what level of assistance in the notes. If not enough room is available in the notes column for important information, more space is available at the end of the evaluation.

| Questions | YES | NO | Notes |
|---|---|---|---|
| Does the individual require assistance with verbal communication? | | | |
| Does the individual require any assistance with mobility while in the community? | | | |
| Does the individual require assistance with safe pedestrian skills in the community? | | | |
| Does the individual need physical assistance with eating or assistance with following a doctor prescribed diet? | | | |
| Does the individual require assistance with any personal care tasks? | | | |
| Does the individual have any medical concerns that they may require assistance with while in the community? | | | |
| Does the individual require assistance with their medications? ___Independent ___Physical ___Verbal ___Total ___Other | | | |
| Does the individual require assistance with appropriate social interactions in the community? | | | |
| Does the individual engage in any violent, aggressive or self-abusive behavior when in the community? | | | |
| What level of supervision is needed at while in the community? ___General _____Auditory ___Visual ___ Arms length ___ 1:1 | | | |
| Does the individual need reminders to stay with assigned group during community activities? | | | |
| Does the individual require supervision when interacting with others in the community including strangers? | | | |
| Does the individual require assistance with reading common community signs (men's and women's restrooms, exits, crosswalks, ect.)? | | | |
| Does the individual require assistance with money management tasks while in the community? | | | |
| Does staff or a family member need to be present for individual to be dropped off at home? | | | |

**Outcome:** ____________________________________________

**Additional Notes:** ____________________________________________

____________________________________________

____________________________________________

**Habilitation Assessment Completed by** ____________________ ____________________ ______________

**Printed Name** **Signature** **Date**

***Guardian Signature if Applicable**

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# EYH Policies

**Individual's Name**: ________________________________________ **DOB:** ____________________

**Instructions:** Please review each EYH policy and **initial on the line next to each policy** to indicate you understand and agree to that specific policy.

_________ **Dress Code**: We encourage everyone to be well dressed and to not wear clothes that could offend others. Inappropriate clothing includes but is not limited to: Drugs, Alcohol, Weapons, or sexually suggestive. If you decide to wear an outfit that is inappropriate, you may be asked to change. Every individual is expected to be showered and well groomed (hair clean, clothes clean with no holes). For health and safety reasons, EYH reserves the right to have a participant not attend an event if he or she has poor hygiene. We encourage everyone to wear clothes appropriate for the activity for the day. For example when we go to the Zoo, or on other field trips, we should wear clothes and shoes that are comfortable, along with hats or sunscreen. When we go to a theater performance or other nice places, we might wear more formal clothing. We encourage everyone to look and feel his or her best and be comfortable in every situation.

_________ **Money Management**: I agree to bring money for meals or bring food to eat as well as the required money for the chosen day's Event that may require a fee unless other arrangements are made with EYH.

_________ **Cancelation**: If I cannot attend an EYH Event I have previously signed up for, I or someone who supports me will contact EYH as soon as possible to cancel my participation. If another individual cannot be found to take my place, I may be responsible for the cost of the Event unless other arrangements are made with EYH.

_________ **Photo Release**: I authorize and give consent to the use of my photograph or video on EYH promotional materials such as websites, brochures, and presentations. I understand that I have the right to request specific pictures not be used or removed from promotional materials. I understand that I will not receive compensation for any use of photographs/video.

_________ **HIPPA**: ***EYH must:*** Not tell others about your health information. Give you this notice and tell you how EYH is going to keep your health information a secret. EYH will do everything this notice says we must do.
***Your Rights:*** You can ask EYH not to give or tell your health information to certain people or give to certain agencies. You can ask to get letters or papers about your health information in a different way or at a different place. You can ask to see papers about your health information at any time. You can ask that your health information be changed, but this does not mean that it will be changed. You may ask EYH for the names of people that EYH gave your health information. If you would like to see the complete EYH HIPPA policy, please contact EYH at 740-416-1103.

_________ **Medical**: If I need assistance with my medications, I will provide EYH with current doctor's orders for each medication, a Medication Administration Record, and Medication Self-Administration Assessment. If I do not have access to these forms, I give consent for my family, provider, or local county board of DD to release those forms to EYH and give EYH updated forms as they are needed or become available. If there are any changes to my health status or medications, I or someone who supports me will notify EYH and provide doctor's orders to substantiate those changes.

_________ **Rescind**: I understand that in order to rescind this authorization or any portion of the authorization that I must notify the Executive Director of EYH of my rescission.

**Policy Agreement:** ____________________________ ____________________________________ _________________

| **Printed Name** | ***Signature** | **Date** |
|---|---|---|

***Guardian Signature if Applicable**

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# Doctor's Order for Current Prescribed Medications

**Individual's Name**: ______________________________ **DOB:** ________________

Please fill out the form below with the requested information. **A physician MUST sign this form.**

| Name of Medication | Dosage | Frequency | Diagnosis |
|---|---|---|---|
| | | | |
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Additional information:___________________________________________________________

___________________________________________________________________________

Physician's Name (Printed):_________________________________ Date:____________________

Physician's Signature:_________________________________

Physician's Address & Phone Number:_________________________________________________

***Guardian Signature if Applicable**

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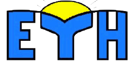

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# Physician's Standing Orders

**Individual's Name**: ________________________________ **DOB:** __________________

**State law requires individualized standing orders for each participant in order for EYH staff to legally administer over the counter medications (OTC). A physician MUST sign this form.**
**Please cross out each medication the individual may not take or make additional notations below.**
**This form should be updated each year.**

| Name of Medication | Dosage | Indications |
|---|---|---|
| Acetaminophen (500 mg tablets) | 2 Tabs | Pain/Fever |
| Bismuth Subsalicylate (262 mg tablets) | 2 Tabs | Upset Stomach/Diarrhea |
| Calcium Carbonate (1000 mg tablets) | 2 Tabs | Heartburn |
| Ibuprofen (200 mg tablets) | 1 Tab | Pain/Fever |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| LIST BELOW ANY OTC MEDICATIONS WHICH YOU MAY WISH TO SEND ALONG WITH PARTICIPANT FOR STAFF TO ADMINISTER | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Chemically equivalent/generic substitutes may be used for brand names.**

**Additional information:**________________________________________________
________________________________________________________________

**Physician's Name (Printed):** ______________________________ **Date:**__________

**Physician's Signature:** ____________________________________

**Physician's Address & Phone Number:**________________________________

***Guardian Signature if Applicable**

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# Consent for Required Documentation

**Individual's Name**: ________________________________ **DOB:** _________________

**Instructions:** The following documents are needed for an individual to attend EYH Events. You can use this form as a checklist. If you are unable to obtain these forms, please ask your family, provider, or SSA to assist you. This form also serves as your consent for your family, provider, or local county board of DD to release the specific documents below to Expanding YOUR Horizons (EYH).

## All documents must be received BEFORE your first EYH Event.

**Complete Enrollment Packet with Signatures:**
***YOUR Path Starts Here**
***Habilitation Assessment**
***EYH Policies**
***Consent for Required Documentation**

**Current Individual Service Plan (ISP) – Electronic Version**

**Medication Self-Administration Assessment**

**If you take medications:**

**Doctor's Orders for Each Medication**

**If Applicable:**

**Behavior Support Plan (BSP)**

**I Give Consent for Release of All the Above Information**:

| ________________________ | ______________________________ | ______________ |
|---|---|---|
| **Printed Name** | ***Signature** | **Date** |

***Guardian Signature if Applicable**