After School Program Application

Please return application and attachments to:

Living Resources After School Program

300 Washington Ave Extension

Albany, NY 12203-7303

Attn: Jacqueline M. Calder

https://www.livingresources.org/

518-218-0000
After School Program Application

Date: _______________

Name of Applicant: ________________________________________________________________

Street Address: ________________________________________________________________

City: ___________________ State: ___________ Zip Code: ______________

Age: ______ D.O.B. ___/___/_____ Male / Female / Other (please circle one)

SSN: _____-____-______ TABS ID: ___________ Medicaid #: ________________________

School Attending: ______________________________________________________________

Home School District: _________________________________ Classroom Ratio: __________

Grade: ___________ Special Services Received (OT/PT/Speech): ________________________

Transportation Services for School: ________________________________________________

Parent/ Guardian Information:

Name (First/Last): ________________________________________________________________

Relationship to applicant: ___________________Home Phone: ______________________

Work Phone: ________________ Cell Phone: __________________

Email Address: _________________________________________________________________

Address (if different than applicant) ______________________________________________

City: ___________________ State: _______________ Zip Code: ______________

Name (First/Last): ________________________________________________________________

Relationship to applicant: ___________________Home Phone: ______________________

Work Phone: ________________ Cell Phone: __________________

Email Address: _________________________________________________________________
Address (if different then applicant) ____________________________________________________

City: ________________________ State: ____________________ Zip Code: ______________

**Emergency Contact Information (other than parents):**

Name (First/Last): _________________________________________________________________

Relationship to applicant: _________________________ Home Phone: ___________________

Work Phone: ____________________ Cell Phone: __________________

Email Address: _________________________________________________________________

(Please note that emergency contact must be available when parent/guardian is not available)

**Care Coordinator Information (best completed with or by coordinator):**

Care Coordinator Name: _________________________________________________________

Corporate Name: ________________________ Phone #: _______________________________

Street Address: _________________________________________________________________

City: ____________________________ State: _________________ Zip Code: _____________

Email Address: _________________________________________________________________

Is the applicant waiver approved? ________________ Amount of units allocated: _________

Enrolled in Self Direction? Yes / No Broker Contact Information: ________________________

__________________________________

**Medical Information:**

Physician’s Name: _________________________________ Phone #: __________________

Address: _________________________________________________________________

Hospital Preferred (in case of emergency) __________________________________________

Dates of last medical exam: __________________________ Dental: ______________________

Allergies: __________________________________________________________________

Height: _________ Weight: _________ Are they up to date on immunizations? Yes / No

Insurance Company name: __________________________ Policy #: ____________________
Disability Information (please check all that apply)

Intellectual Disability _____ Cerebral Palsy _____ Epilepsy _____ Autism _____ TBI _____
Down Syndrome _____ Visually Impaired _____ Hearing Impaired _____ Spinal Bifida _____
Other: ______________________________________________________________________

Any other medical concerns: __________________________________________________________

Medications taken and what it controls: _____________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Getting to know the applicant:

Is the applicant on a special diet?

Does the applicant need assistance when eating?

Is the applicant physically aggressive?

Is the applicant aggressive towards self?

How well does the applicant interact with others?

Is the applicant verbal or non-verbal? If non-verbal how do they communicate?

If verbal, does the applicant use obscene language?

How does the applicant react when frustrated?

What coping methods does the applicant utilize?

Does the applicant need help when utilizing the bathroom?

Can the applicant walk independently?

How well does the applicant follow instructions?
How well does the applicant manage in public?

Please take this page to let us know anything you feel is important for us to know about the applicant and how would the After School Program would benefit the applicant and their family.

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
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______________________________________________________________________________

Documents needed:

With this application, please send in the following most recent documents needed.

Immunization records

Individualized Support Plan (ISP)

Individual Educational Plan (IEP)

Psychological Evaluation

By signing below, I hereby certify that the above information given are true and correct as to the best of my knowledge. I authorize Living Resources Corporation to verify any and all information given in this application and attachments.

Signature of applicant: ________________________________________________
Date: _____________

Signature of Parent/Guardian: __________________________________________
Date: _____________