Family Supported Services: Adventure Program

Application

Please return application and attachments to:
Living Resources
300 Washington Ave Extension
Albany, NY 12203-7303
Attn: Jacqueline M. Calder

https://www.livingresources.org/
518-218-0000

Dear Families,

Adventure Program is a respite funded by Office for People with Developmental Disabilities (OPWDD) Family Support Services (FSS) focusing on community inclusions, recreation and social goals, while giving family caretakers a chance to work or have time to themselves.

The Adventure Program is open individuals with developmental disabilities who are 11 years of age or older and who live at home with family. The program serves individuals meeting OPWDD's eligibility criteria who live in the Capital Region. Participation in any given activity depends on the abilities of each individual and the nature of the activity.

Program operates during gap weeks of the school year and the extended school year with possible various dates throughout the year when schools are closed for a holiday. Adventure Program activities range from water park visits, gyms, museums, trips to NYC or Boston, holiday themed parties/outings, movies and much more.

Program dates include the winter break in February and the last two weeks in June with the possibility of dates on school holiday closures.

Thank you for applying to Living Resources Corporation for Adventure Program. Please contact Jacqueline Calder, Fiscal Intermediary Specialist, using the contact information provided below with any questions or assistance needed in completing the application*.

Best Regards,

Jacqueline M. Calder
Community Living Coordinator
P: 518-218-0000x5414
C: 518-209-8595
E: jcalder@livingresources.org

*All applications must be complete in order to be reviewed.

Adventure 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 #: ____________________

Parent/ Guardian Information:

Name (First/Last): ____

Relationship to applicant: ________________________Home Phone: __________________

Work Phone: ___________________ Cell Phone: __________________

Email Address: ____

Address (if different then 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: ____

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

____

Is Living Resources listed in the budget for Family Supported Services? Yes / No

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 #: _______________________

COVID vaccinations? Yes / No

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 1-2 step instructions? ________________________________

How well does the applicant manage in public? ____

Documents needed:

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

- Life Plan
- Approved Self Directed Budget with Living Resources listed for FSS in contracted Services (if applicable)
- LCED
- OPWDD Letter of Eligibility

How would you like to be notified about upcoming Adventure Program dates and activities?

- ☐ Mail
- ☐ Email to ____

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. All Signatures are required.

Signature of Parent/Guardian: ____
Date: _____________

Signature of Care Manager: ____
Date: ______________