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Skillsacademyvc.org

Day Program Enrollment Application

Skills Academy Vocational Center is a day program for special needs adults with intellectual and/or developmental disabilities. Day program/Vocational Program is open Tuesday through Friday, 9:00 AM-3:00 PM.

*INSTRUCTIONS: Please **COMPLETE ALL ITEMS**; IF AN ITEM DOES NOT APPLY, ENTER "N/A."* Return to Skills Academy Vocational Center in person or via email (info@skillsacademyvc.org).

All enrollment needs to be turned in with a copy of: ID, Social Security Card, medical insurance card

******THIS COMPLETED FORM MUST BE RECEIVED PRIOR TO CLIENT'S FIRST DAY OF ATTENDANCE.******

Today's Date:	Target Start Date:
Full Name:	Medicaid ID #:
Date of Birth:	Student's Phone Number:
Are you on a IDD, DD or SLS waiver? Other, please explain Circle Primary Payment Method: The Resource Exchange (TRE) * School District * Self-Pay Other (Agency Name, Email, Phone Number):	
Home Address (street, city, state, zip code):	
Who do you live with (circle one): Parent Guardian Host Home Self	
Legal Guardian (circle one): Parent Student Other (explain relationship): Name: Phone: E-mail:	
Host Home (if applicable): Name: Phone: E-mail:	

Emergency Contact:

Name/Relationship:

Phone:

E-mail:

Service Coordinator at Developmental Pathways, Blue Skies, Imagine, TRE (or applicable agency): Name: Phone: Email:

Name:

Phone:

Email:

Medical Diagnosis:

Medical/Health Concerns:

Current Medications:

Prescription:

Over the counter:

Note: Please provide the doctor's order for any medication (Rx or OTC) that must be taken during the day program; all medication dispensing will be supervised and logged by SAVC QMAP staff. SAVC staff cannot administer any medication without the doctor's order.

Protocols? If you have a copy, please provide

Alone time allowed? How many minutes per day?

Elopement risk?

Explanation, if yes

Line of sight required?

Explanation, if yes:

Food Allergies:

Medicine Allergies:

Other Allergies:

CLIENT INFORMATION (CONT'D) Advance Directives:

DNR Date: _____

Living Will Date: _____

MOST -Date: _____

MDPOA Medical Durable Power of Attorney Date: _____

Name of MDPOA: _____ Phone number : _____

POA General Power of Attorney Date: _____

Name of POA: _____ Phone number : _____

Guardian Date: _____ Name of Guardian: _____

Phone number : _____

***We will need a copy of any directives & POA's before starting Skills Academy.**

Preferred Hospital:

Primary Care Physician's Name, Address & Telephone Number:

Other Physician's Name, Address & Telephone Number:

When was the last time the client saw a physician?

In the past year, approximately how many times did the client see a physician?

What problems was the client seen and treated for? What treatment was provided?

Dentist's Name, Address & Telephone Number:

Name, Address, & Telephone Number of Client's Pharmacy:

How would you best describe the client's behavior and/or medical status?

Alert (awake and alert)

Oriented (knows person, place, time)

Confused/Disoriented (does not know person, place, time)

Cooperative (gets along with others / follows physician orders)

Uncooperative (does not get along with others / does not follow physician orders)

Lonely/Depressed (has experienced many losses and is sad)

Combative (strikes out against others at times)

Wanders (is at risk for losing his/her way)

Mobility:

Ambulates Independently

Gait Steady

Gait Steady with Adaptive Device

Gait Unsteady

Requires assistance – explain:

Independent with use of wheelchair

Unable to propel wheelchair

Requires assistance with transfers – explain:

Elimination:

Continent (bowel)

Incontinent (bowel)

Continent (urine)

Incontinent (urine)

Independent

Requires assistance – explain:

Hair/nail:

Independent

Requires assistance – explain

Eating:

Eats Independently

Eats independently with adaptive devices – explain:

Requires assistance in feeding self – explain:

***If G-tube feeding is necessary, do you have a protocol for this? If so, we need a copy**

Vision:

No impairment

Some impairment

Wears glasses Hearing

No impairment

Some impairment

Wears hearing aid

Speech:

No impairment

Some impairment

Language(s) spoken:

Smell:

No impairment

Some impairment

Taste:

No impairment

Some impairment

Touch:

No impairment

Some impairment

Has there been any physical aggression in the past? When was the last time this happened and explain in detail.

Has there been any sex offender charge(s) in the past? If so, when did this happen and please explain the incident

Dietary Restrictions:

Support Needed at Day Program (food prep/eating/drinking, personal hygiene, walking, elopement risk, etc.) **please take notice that Skills Academy Vocational Center is in no way responsible for supplying food to students, food needs to be provided by the student and/or student's provider*:*

Interests, Likes (Provide Details):

Behaviors (provide details):

Triggers (provide details):

Stressors (provide details):

Coping Mechanisms (provide details):

Are you interested in Behavioral Services? Yes No

Any restricted visitors? If so, please list in detail:

Status of monthly menstrual cycle?

Support needed for the monthly menstrual cycle? If so, please explain.

Any additional Restrictions/Rights Modifications currently in place, if yes, please explain.



PLEASE READ CAREFULLY!!!

Please choose one of the following programs.

Vocational Programs

- _____ Culinary
- _____ Maintenance
- _____ Computers/IT

Day Programs

- _____ Track 1: Life Skills, Crafts, STEAM, Music, Joy of Cooking
- _____ Track 2: Independent Living, Art, Band, Joy of Baking, Computer Basics

Supported Community Connections _____

Days you plan on attending Skills Academy (circle days):

Tuesday / Wednesday / Thursday / Friday

SCHOOL DISTRICT INFORMATION

School District:

Contact Name:

Contact Phone Number:

Contact Email:

TO ENROLL

1. Contact Skills Academy Vocational Center info@skillsacademyvc.org or 719-722- 5551, to confirm enrollment.

2. Contact service coordinator at TRE (or applicable agency) to update the day program provider to Skills Academy Vocational Center, as needed.

Name, phone number & email for agency service coordinator:

3. Contact the school district program coordinator to confirm the attendance plan, as needed.

4. Medicaid (TRE): Provide copies of client's current Service Plan/PAR, Document 100.2, and applicable health/medical protocols.

5. School district: Provide copies of IEP and daily agency (goal) report.

6. Return completed enrollment application and supporting documents to Skills Academy Vocational Center.