2024/2025 Registration

Participant Information:

Last Name: _____ First Name: _____ Age: _____

DOB:___/___/___ TABS#: _____ Medicaid#: _____

Address:_____Zip: _____

City:_____State: _____

Gender**:** _____ Race/Ethnicity**:** _____

Parent/Guardian Information #1:

Parent/Guardian Name: _____

Relationship to Participant_____Cell Phone: _____

Home Phone:_____Work Phone: _____

Parent/ Guardian Email: _____

Parent/Guardian Information #2:

Parent/Guardian Name: _____

Relationship to Participant_____Cell Phone: _____

Home Phone:_____Work Phone: _____

Parent/ Guardian Email: _____

Emergency Contacts:

Please list below persons, **not yourself**, who can be called if we are unable to contact you.

Name	**Relationship to Participant**	**Phone**

Print Name	**Signature**	**Date**

All About the Participant:

School I attend:_____ Grade: _____

Day Habilitation Program I attend: _____

Other Programs I Attend:

_____

_____

COVID Vaccination Status:

Vaccinations are not required for participants but if so, please send updated vaccination cards

_____

_____

Personal / Family Information: Siblings (Names & Ages):

_____

_____

_____

Pets (Types of pets & ages):

_____

_____

_____

Hobbies and/or Activities I like:

_____

_____

_____

Favorite Food/Drinks:

_____

_____

_____

Pick Up Release Form

Participant's Name: _____

Parent/Guardian's Name:_____Phone Number: _____

I give permission for the following persons to pick up the participant from the GRACE FoundationPrograms:

Name	**Relationship to Participant**	**Phone**
_____	_____	_____
_____	_____	_____
_____	_____	_____

The following DO NOT have permission to pick up the participant from the GRACE FoundationPrograms

Name	**Phone**
_____	_____
_____	_____

Is there an Order of Protection in place? ☐ Yes ☐ No

I understand that if the information above changes at any time, I must notify the GRACE office inwriting as soon as possible.

_____ _____ _____

Print Name **Signature** **Date**

Alerts

Name:_____ Diagnosis: _____

Medical Alerts: (For seizures, please indicate seizure protocol) N/A _____

_____

_____

_____

Allergies: EpiPen Prescribed? Yes / No

_____

_____

Asthma: Yes / No Inhaler/Nebulizer treatment: Yes /

Fears or Aversions: N/A_____

_____

_____

How is this best handled? N/A _____

_____

_____

_____

Behavioral Challenges Behavior Description: N/A _____

_____

_____

When does this behavior occur? N/A _____

_____

_____

Does the participant require assistance in the bathroom and/or a bladder or bowel chart? N/A _____

_____

_____

Please use this page to describe any other medical alerts and/or anything important that we need to know about the participant: (Please be as specific as possible)

Intake Form

Does the participant have a waiver eligibility? Yes / No
If yes, please answer the following:

Care Manager Name: _____

Care Manager Agency:_____Care Manager Phone: _____

Care Manager Email: _____

Does the participant have Self-Direction? Yes / No
Are you in the process of transitioning to Self-Direction? Yes/No
If yes, please answer the following:

Self-Direction Broker Name: _____

Self-Direction Broker Phone: _____

Self-Direction Broker Email: _____

GRACE personnel only:

ICD-10 Code/s for participant: _____

Intake Notes: _____

_____

_____

Intake Information About the Participant:

Does the participant know they have ASD/DD? _____

Would you like staff to address the diagnosis during social skills and/or other programs? _____

Communication Skills:

In what way/s does the participant communicate? ***Circle all that apply to the participant.***

Has conversational language	Gestures/Points
Verbal – speaks in sentences	Sign Language
Verbal – one or two words	Leads others to get what is wanted
Communication Device	Independently gets what is wanted

Other: _____

Does the participant use a spell to communicate letter board?

Yes/No-Is the participant toilet trained? Yes / No

How does the participant communicate the need to use the restroom?

_____

_____

Can the participant share an idea? Yes / No

Can the participant use their imagination and then explain their ideas? Yes/No

Social Skills:

How does the participant socialize? *Circle all that apply to the participant.*

Has friends	Can read facial expressions
(emotions)Can identify why they are friends	Can read tone of voice (emotions)
Plays games with friends	Can read body language
Will ask friends questions	Offers help
Can follow game rules	Knows when to take turns
Shows Empathy	Can resolve a conflict
Talks to friends or peers even perspectivethere are adults in the room	Can accept another person's

Anything particular that the participant has difficulty dealing with?
(For example: Changes in routine; transitions; the word "no"; seated activities; performing tasks; stayingattentive and focused; etc.)

_____

_____

_____

Can the participant problem solve?

Yes/ No

Please explain:

_____

_____

Please explain any behaviors/skills you would like addressed during these programs:

_____

_____

_____

_____

What activities do you think the participant would enjoy learning or doing?

_____

_____

_____

Are there any specific interests the participant has (trains, dinosaurs, movies, history, etc.)?

_____

_____

_____

What makes the participant laugh?

_____

_____

_____

VIDEO/PHOTO RELEASE

I give permission for my son/daughter_____to be videotaped and/or photographed for materials/promotion of the GRACE Foundation within our agency and for us in print,social media, and all other forms of media.

Permission Granted: ☐ **YES** ☐ **NO**

_____

Parent/Guardian (Please print)

_____ _____

Parent/Guardian Signature **Relation to child**

_____

Date

Participant Scheduling & Availability

So that we can get a better understanding of our participants scheduling and availability, please fill out the days and times the participant is available for respite programs (both on zoom and in person):

Monday Yes / No	**Tuesday** Yes / No	**Wednesday** Yes / No	**Thursday** Yes / No	**Friday** Yes / No	**Saturday** Yes / No	**Sunday** Yes / No
Time/s of the day available: __________ __________ __________ __________	Time/s of the day available: __________ __________ __________ __________	Time/s of the day available: __________ __________ __________ __________	Time/s of the day available: __________ __________ __________ __________	Time/s of the day available: __________ __________ __________ __________	Time/s of the day available: __________ __________ __________ __________	Time/s of the day available: __________ __________ __________ __________

Consent to Participate in Programs at the GRACE Foundation:

________________________ __________________________ ___________

Print Name **Signature** **Date**

Program Availability and Selection

The following categories are implemented into various program curriculums to ensure that interests and personal choices are respected, encouraged, and nurtured. Categories are subject to change and consist of both in-person and online platforms. Please see the program descriptions for further clarification on any programs weoffer, if needed.

Please circle the following methods of program delivery you are interested in:

In-Person Only

Please circle any interests the participant has:
(Please Note: This does not guarantee availability in all program interests)

• Art • Sensory • Social Skills • Health & Wellness • Science • History • Cooking • Animation • Creative Writing • Cartooning • World Culture • Playground Play • Fashion • Problem Solving	• Community Service • Acting • Singing • Dancing • Games • Physical Fitness • Travel • Poetry • Movies/Entertainment • Decision Making • Parties • LEGOs • Trains • Geography	• Jokes/Comedy • Discussion • Communication • Ethics • Self-Advocacy • Social Club • Dinner Club • Lunch Club • Breakfast Club • Video Games • Independent Living Skills • Disney • Themed Parties	• Trips in the Community • Museums • Money Management • Nutrition • Guessing Games • Art History • Food History • Karaoke • Music • Music Trivia • Jeopardy

Other Services Available: In-Home Respite Community Habilitation

If interested in the GRACE Day Habilitation Program, please reach out to: Carol Berliavsky, Manager of Day Habilitation Services.
Email: (cberliavsky@graceofny.org) Phone: 718-983-3800 ext. 220

COVID-19 Safety Guidelines and Protocols

The Office of People with Developmental Disabilities has **MANDATED** the following:

- If a **participant or anyone in the participants family** has experienced any COVID-19 like symptoms or may have encountered anyone who tested positive for COVID- 19, please do **NOT** come to the GRACE building. A participant must wear a mask after 5 days of testing positive for COVID-19. If the participant c annot tolerate a mask, they **must** self-quarantine for **at least 10 days** before attending programs again.

Please sign that you understand and acknowledge these safety guidelines and protocols:

Print Name	**Signature**	**Date**

Any comments or concerns:

THE GRACE FOUNDATION
2024-2025 MEDICAL CLEARANCE FORM

Name: _____ Date of Birth: _____

Address: _____ Telephone No.: _____

MEDICAL/PHYSICAL

Height: _____Weight: _____Blood Pressure: _____P. P. D. Result: _____Date of Last Tetanus: _____

Diagnosis

☐ Autism Spectrum Disorder ☐ Cerebral Palsy ☐ Sensory Impairment

☐ Intellectual Disability ☐ Epilepsy ☐ Spina Bifida

☐ Neurological Impairment ☐ Learning Disabled ☐ Traumatic Brain Injury

☐ Other: _____ ☐ COVID Vaccination Dates (If applicable):_____

Does this individual have Down Syndrome? ☐ Yes ☐ No

Does this individual have Seizures? ☐Yes ☐No

Seizure Protocol: _____

Physician indicates seizures under control:
Yes☐ No ☐

Indicate satisfactory or explain if problematic:
Vision:_____
Hearing:_____
Cardiovascular:_____
Respiratory:_____
Pulmonary: _____

Current Medications: _____

List any allergies: _____

Epipen: Yes☐ No☐ If yes, can the participant administer it him/herself: Yes ☐ No ☐

Limited Physical Restrictions: _____

Uses Adaptive Equipment: _____

List any medical/behavioral/other comments that may warrant our attention: _____

_____

PHYSICIAN'S STATEMENT OF CLEARANCE

On this date_____, I examined the above named individual and my findings indicate that he/she is capable pf participating in the GRACE Foundation Programs.

Physician's Signature:_____ **M.D. #** _____

Phone: (___)_____ **Fax:** (___)_____

2024-2025 PPD TEST RESULT FORM

Name: _____ Date of Birth: _____

Address: _____ Telephone No.: _____

Date of Examination: _____

Date of Most Recent PPD Implantation: _____

Date of Most Recent PPD Reading: _____

Results: _____ mm (Check one) Negative: _____ Positive: _____

If Positive: Date of Most Recent CXR: _____ Results: _____

Based on today's evaluation, the above-named individual was found to be free of any sign or symptom of active Tuberculosis.

_____ _____

Name/Stamp of Examiner/Degree Signature of Examiner

_____ _____

Address Telephone No.

GRACE FOUNDATION
Individual Rights & Responsibilities

Policy

All individuals served by the Grace Foundation have the following rights and responsibilities:

1. No person shall be deprived of any civil or legal right solely because of a diagnosis of developmental disability. (See Glossary)

2. All persons shall be given the respect and dignity that is extended to every person regardless of race, religion, national origin, creed, age, gender, ethnic background, developmental disability, or other handicap.

3. A person shall not be denied:

    a. A safe and sanitary environment.
    b. Freedom from unnecessary or psychological abuse.
    c. Freedom from Corporal Punishment.
    d. Freedom from unnecessary use of mechanical restraining devices.
    e. Freedom from unnecessary or excessive medication.
    f. Protection from commercial or other exploitation.
    g. Confidentiality regarding all information contained in the person's record, and access to such information, subject to the provisions of Article 33 of Mental Hygiene Law and the commissioner's regulations. In addition, confidentiality regarding HIV related information shall be maintained in accordance with Article 27-F of the Public Health Law, 10 NYCRR Part 63 .and the provisions of section 633.19 of this part.
    h. A written individual plan of services (see Glossary) which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency; which includes meaningful recreation and community programs and contact with non-handicapped persons; and which enables the person to live as independently as possible. Such right also include:

        i. The opportunity to participate in the development and modification of an individualized plan of service, unless constrained by the person's ability to do so.
        ii. The opportunity to object to any provision within an individualized plan of services and the opportunity to appeal any decision, with which the person disagrees, made in relation to his or her objection to the plan.
        iii. The provision for meaningful and productive activities within the person's capacity although some risk may be involved, and which take into account his or her interests.

    i. Services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely, and humanely, with full respect for the person's dignity and personal integrity.
    j. Appropriate and humane health care and the opportunity to the extent possible, to have input either personally or through parent(s), guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion.

k. Access to clinically sound instructions on the topic of sexuality and family planning services and information about the existence of these services, including access to medication or devices to regulate conception, when clinically indicated. This right includes:

   i. Freedom to express sexuality as limited by one's consensual ability to do so provided such expression do not infringe on the rights of others.
   ii. The opportunity to carry a pregnancy to term.
   iii. The right of facilities to reasonably limit the expression of sexuality including time and location thereof, in accordance with a plan for effective facility management.

l. Observance and participation in the religion of his or her choice, though the means of his or her choice, including the right of choice not to participate.
m. The opportunity to register and vote and the opportunity to participate in activities that educate him or her in civic responsibilities.
n. No person shall be denied freedom from discrimination, abuse or any adverse action based on his or her status as one who is subject for an HIV-related test or who has been diagnosed as having HIV infection, AIDS, or HIV-related illness.
o. The receipt of information on or prior to admission, regarding the supplies and services that the facility will provide or for which additional charges will be made and timely notification of any changes thereafter.
p. The use of his or her personal money and property, including regular notice of his or her financial status and the provision of assistance in the use of his or her resources, as appropriate.
q. Respect for his or her cultural identity.
r. A balanced and nutritious diet, served at appropriate times and in as normal manner as possible, and which is not altered or totally denied for behavioral management of disciplinary (punishment) purposes.
s. Individually owned clothing which fits properly, is maintained properly, and is appropriate for age, season and activity, and the opportunity to be involved in the selection of that clothing.
t. Adequate, individually owned grooming and personal hygiene supplies.
u. A reasonable degree of privacy in sleeping, bathing, and toileting areas.
v. No person shall be denied a reasonable amount of safe, individual accessible storage space for clothing and other personal belongings used on a day-to-day basis.
w. The opportunity to request an alternative residential setting whether a new residence or change of room and involvement in the decision regarding such changes.
x. The opportunity, either personally or through parent(s), guardian(s), or correspondent, to express without fear of reprisal grievances, concerns, and suggestions to the facility director, the Commission on Quality of Care, and for developmental center residents, the Mental Hygiene Legal Service and the board of visitors.
y. The opportunity to receive visitors at reasonable times, to have privacy when visited, provided such visits avoid infringement on the rights of others, and to communicate freely within or outside the facility.

Purpose, Goals, and Objectives: The New York State Office for People with Developmental Disabilities (NYS-OPWDD) HCBS Waiver was initiated in 1991 creating a new service provision model that encouraged increased use of community resources to meet the needs and enrich the lives of persons with developmental disabilities. The initial goal of the waiver was to serve more people with a wider range of community-based services that were more individualized and less

expensive than institutional care. This goal continues to be a central focus of OPWDD's waiver which today continues to provide the framework within which individualization and "putting people first" have been put into practice. Waiver participants, their families, the non-profit provider community, and state authorities continue to collaborate to create a

person-centered service environment that is innovative and focused on community resources and self-direction principles. OPWDD's customers have made it clear that they want a "life, not a program" and a real life is based on four primary person-centered outcomes that support OPWDD's mission of "helping people lead richer lives". An important goal of OPWDD's HCBS waiver is to facilitate these outcomes for participants:
a) to live in the home of their choice.
b) to work or engage in activities that contribute to the community.
c) to have meaningful relationships; and
d) to have good health. This OPWDD HCBS waiver amendment continues to build on this foundation to provide participants with a life that offers person-centered and individualized alternatives and to enable people to lead more typical lives in their communities. The HCBS waiver amendment continues to offer more choice, control and community membership through currently approved waiver services and service modifications.

Grievance & Complaints Policy

Grievance Procedure under the Americans with Disabilities Act This Grievance Procedure is established to meet the requirements of the Americans with Disabilities Act of 1990 ("ADA"). It may be used by anyone who wishes to file a complaint alleging discrimination based on disability in the provision of services, activities, programs, or benefits by the NYS Office for People with Developmental Disabilities (OPWDD). Employment-related complaints of disability discrimination are covered elsewhere, in policies available from the NYS Equal Employment Opportunity in New York State Rights & Responsibilities Handbook. The complaint should be in writing and contain information about the alleged discrimination such as name, address, phone number of complainant and location, date, and description of the problem. No particular format of the complaint is required. Alternative means of filing complaints, such as personal interviews or a tape recording of the complaint, will be made available for persons with disabilities upon request. The complaint should be submitted by the grievant and/or his or her designee as soon as possible but no later than 60 calendar days after the alleged violation to:

Dana K. Scalere ADDRESS: NYS Office for People with Developmental Disabilities 44 Holland Avenue Albany, NY 12229-0001

Within 15 calendar days after receipt of the complaint, the ADA Coordinator or his or her designee will meet with the complainant via telephone or in person to discuss the complaint and the possible resolutions. Within 15 calendar days of the meeting, the ADA Coordinator or his or her designee will respond in writing, and where appropriate, in a format accessible to the complainant, such as large print, Braille, or audio tape. The response will explain the position of the NYS Office of People with Developmental Disabilities and offer options for substantive resolution of the complaint. If the response by the ADA Coordinator or his or her designee does not satisfactorily resolve the issue, the complainant and/or his or her designee may appeal the decision within 15 calendar days after receipt of the response to the Commissioner of NYS OPWDD or her designee. Within 15 calendar days after receipt of the appeal, the Commissioner or his or her designee will respond in writing, and, where appropriate, in a format accessible to the complainant, with the agency's final resolution of the complaint, or indicating that the matter has been returned to the ADA Coordinator for further action.

If further action is indicated, the complainant will be contacted within 15 days from the written response. All written complaints received by the ADA Coordinator or his or her designee, appeals to the Commissioner or his or her designee, and responses from these two offices will be retained by the NYS office of People with Developmental Disabilities for at least three years.

The following persons and agencies are available to receive concerns and complaints from Individuals and their parent(s}, guardian(s), or correspondents:

- Director, Staten Island DDRO
  1150 Forest Hill Road
  Staten Island NY 10314
  (718) 983-5200

- Commissioner
  NYS Office for People With Developmental Disabilities
  44 Holland Avenue
  Albany, NY 12229
  (518) 473-1997

- State of N.Y. Mental Hygiene Legal Services (MHLS)
  Staten Island Developmental Disabilities Regional Office (SIDDRO)
  930 Willowbrook Road, Bldg. 15
  Staten Island, NY 10314
  (718) 979-3300

- NYS Justice Center for the Protection of People with Special Needs
  161 Delaware Avenue
  Delmar, NY 12054-1310
  (518) 549-0200

Individual Rights and Responsibilities
Review and Signature Form

By signature below, I indicate that I have received and reviewed a copy of the Agency's revised Individual Rights and Responsibilities listing.

I have also received a list of persons and agencies available to receive concern and complaints, along with their addresses and telephone numbers.

I have also been informed of the Agencies 633 code by OPWDD, HCBS Wavier Services Rights, Grievance Policy, and Compliant Process.

Re:

_____ _____

Signature of Parent, Guardian or Correspondent Date

_____

Printed name of Parent, Guardian or Correspondent

***<u>PLEASE</u> submit the last page <u>only</u> of the individual rights for registration and keep all other pages for your records. ***

PROTECTION OF PEOPLE WITH SPECIAL NEEDS

If you would like to access the regulations pertaining to The Protections of People with Special Needs, please go to the Justice Center website: www.justicecenter.ny.gov

To report suspected abuse or neglect: 1-855-373-2122. For any questions call 1-800-624-4143.

If you have a problem accessing information, please contact either of the following:

Katherine Modena: 718-983-3800 EXT 225
Director of Services

Julie Gottesman: 718 983 3800 EXT 207
Director of Respite Services

Caroll Berliavsky: 718-983-3800 EXT 220
Manager of Day Habilitation

John Malczewski: 718 983 3800 EXT 229
Assistant Manager of Day Habilitation

Angela Jasmin: 718-983-3800 EXT 228
Case Manager/Supervisor of
Community Habilitation and In-Home Respite Services

Signature
_____

Print Name
_____

Date
_____

Fitness Program for Non-Waiver Eligible Participants

Individual's Name: _____

Individual's Primary Language: _____

How did you find out about our Fitness Program?

_____

_____

_____ _____

Parent Signature Date

A Message to Our GRACE Families

Please know that the GRACE Foundation is dedicated to our mission to support our families. We want you to know that we are here to encourage and support. Going forward, we will continue to adhere to guidelines from OPWDD as they are mandated, regarding both restrictions and the possible changes in protocols and procedures. As with everything else, we look forward to offering extraordinary respite activities and opportunities throughout the year. Thank you for your trust in GRACE!

Together with teamwork!

If you have any further questions or concerns, please reach out to:
Julie Gottesman, Director of Site-Based and Recreational Respite.

Registrations can be emailed, faxed, or dropped off.

Email: JGottesman@GRACEofNY.org

Fax: (718) 351-3131

460 Brielle Avenue

Staten Island, NY

10314

INDIVIDUAL'S INFORMATION Last Updated_____

Name (Last, First, MI)	DOB	Residence Phone	Hospital Preference
Address	Medicaid ID	Medicare ID	Other Insurance
	Language Spoken	Communication	Legal Status
	Religion		

REASON FOR VISIT

To Be completed at time of transfer:
Pre-sedation given prior to leaving residence: Yes ☐ No ☐
If YES to the above, names of medications:
Does the individual have a guardian? Yes ☐ No ☐ If YES, provide name, relationship, and contact number:

CONSENT

Person(s) Authorized to Give Consent:		
Individual		
Name (First and Last)	Relationship	Telephone Numbers (h)
Address (City, State, Zip)		(w) (c)
Name (First and Last)	Relationship	Telephone Numbers (h)
Address (City, State, Zip)		(w) (c)

ADVANCED DIRECTIVES

Non-Hospital DNR Order In Effect? Yes ☐ No ☐ Unknown ☐	Attach Copy of Order If Applicable
Health Care Proxy? Yes ☐ No ☐ Unknown ☐	Attach Copy of Order If Applicable
Other Yes ☐ No ☐ Unknown ☐	Attach Copy of Order If Applicable
If YES to Other, specify (i.e. MOLST, Living Will):	

DIET AND CONSISTENCY

ALLERGIES

Medication Allergies (list with description of reaction if known):
Food Allergies (List)
Other (Latex, environmental, etc.)

MEDICATIONS (See Attached Copy of Current Medication Administrative Record)

Routine medication given: If Other, Specify:

INDIVIDUAL'S NAME: Last Updated:_____

PRIMARY HEALTH CARE PROVIDER

Name	Address (City, State, Zip)	Phone: Fax:

PHARMACY

Name	Address (City, State, Zip)	Phone: Fax:

MEDICAL HISTORY

Diagnosis
Past Procedures/Surgery

BASELINE

Vital Signs	T	P	R	BP	HT	WT	WT Date
Neurological/Mental Status (describe typical)							
Behavioral (PICA, etc.)							

IMMUNIZATIONS (most recent)

Tetanus Date	Pneumovax Date	Influenza Date	Varicella Date	Varicella Status	Other
TB Status (mm)	PPD Date	Hepatitis B Status	Hepatitis C Status		

ADDITIONAL CONTACT INFORMATION

Agency Name: Administrator/designee	Telephone Day Time: After Hours:
RN	Telephone Day Time: After Hours:
Service Coordinator	Telephone Day Time: After Hours:
Other Relationship	Telephone Day Time: After Hours:

INDIVIDUAL'S NAME: Last Updated:_____

ADDITIONAL INFORMATION
Other:

_____ _____ _____

Print Name **Signature** **Date**

*__PLEASE__ NOTE THAT THIS READY TO GO FORM NEEDS TO BE SUBMITTED FOR EMERGENCY USE ONLY. *