

**DEVELOPMENTAL CENTER OF THE OZARKS  
APPLICATION and CONSENT for ADULT SERVICES**

I am requesting the Developmental Center of the Ozarks to provide the following services for:

*Name of Individual to Receive Services*

- Technology & Learning Center**
  - Day Habilitation (Classroom activities with skills practiced during community activities/trips)
    - Medical or Behavior Exception
    - Group Services
  
- Community Based Learning**
  - Community Integration (Inclusive activities taking place fully in the Community)
    - Individual Services
    - Group Services
  
  - Individual Skill Development (Specific skills taught in the community)
    - Individual Services
    - Group Services
  
- Adult Day Center**
  - Adult Care (Nurse oversight with Dept. of Health Authorization)
    - Day Habilitation- Medical or Behavior Exception
    - Group Services
  
- Employment Services**
  - Community Employment (Vocational Rehabilitation authorization)
  - Supported Employment
    - (Vocational Rehabilitation authorization)
    - (Regional Office/Support Coordinator Authorization)
  - Job Training Crew (Regional Office/Support Coordinator Authorization)
  - Volunteer Services (SRO/SC Authorization)

**ACKNOWLEDGEMENTS**

The Program Handbook is included in the enrollment information. It includes the Notices of Privacy Practices several Consent and Releases, Grievance Procedure, Rights, etc.

It is important that you review the Handbook and keep it for future reference. If you ever have any questions, please call 417-829-0898.

Emergency Medical Treatment is given for emergency treatment/first aid and notification of the physician on record if needed or for specific orders. Ambulance/paramedics will be called as determined by treating staff when parent or guardian is not present.

**Legally Responsible Person:**

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**Relationship:**

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**Date:**

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**DEVELOPMENTAL CENTER OF THE OZARKS  
ENROLLMENT  
ADULT SERVICES**

**Instructions**

*All blanks **MUST** be filled in. Please write "NA" (Not Applicable) if appropriate. Attach pages for comments or additional information.*

**General Information**

Individual's Name:			Date of Birth:		
Address:			Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other		
City:	State:	Zip:	Phone #:		
Height:	Weight:	Identifying Marks:	Hair Color:	Eye Color:	
School District: <input type="checkbox"/> Springfield R-12 <input type="checkbox"/> Other:			Education:		City of Birth:
Citizenship: <input type="checkbox"/> Citizen <input type="checkbox"/> Legal Alien		Language Understood:		Language at home:	
Mo Health Net #:		Medicare #:		Social Security #:	
Culture/Ethnicity:		Race:		Religion:	

<b>Service Coordinator</b>	<b>VR Counselor</b>
Name:	Name:
Phone:	Phone:
Email:	Email:

**Parent/Guardian/Family Information**

<u>RELATIONSHIP TO INDIVIDUAL</u>	<u>RELATIONSHIP TO INDIVIDUAL</u>
<input type="checkbox"/> Mother <input type="checkbox"/> Foster Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Father <input type="checkbox"/> Other: _____	<input type="checkbox"/> Father <input type="checkbox"/> Foster Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Mother <input type="checkbox"/> Other: _____
Name:	Name:
<input type="checkbox"/> Same as above. If different, please complete:	<input type="checkbox"/> Same as above. If different, please complete:
Home Address:	Home Address:
City/State/Zip:	City/State/Zip:
Primary Phone: <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Message	Primary Phone: <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Message
Alternate Phone: <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Message	Alternate Phone: <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Message
E-Mail Address (required):	E-Mail Address (required):
Employer or School Attending:	Employer or School Attending:
Address:	Address:
City/State/Zip:	City/State/Zip:
Work/School Phone #:	Work/School Phone #:
Work E-Mail Address:	Work/School E-Mail Address:
Work/School Hours:	Work/School Hours:

**Legal Documentation (Required)**

<input type="checkbox"/> Check this box if a Court Order or other legal document is attached naming any person <u>not</u> allowed visitation or custody. <input type="checkbox"/> Check this box if a document is attached showing legal guardianship of the individual named above. <input type="checkbox"/> Check this box if a document is attached limiting contact or visitation.
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**EMERGENCY INFORMATION**

Emergency Contact(s), other than parent(s) or doctor, TWO required.

\* If in Foster Care, the Children's Division assigned Case Worker or Court Appointed person and their title **MUST** be listed.

**Emergency Contact #1**

**Emergency Contact #2**

Name:	Name:
Address:	Address:
City/State/Zip:	City/State/Zip:

Home Phone:	Home Phone:
Cell Phone:	Cell Phone:
Relationship to Individual:	Relationship to Individual:

**Medical Information**

Physician:	Address:	Telephone:
Current Immunizations: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Last Examination:	Date of last TB testing:
Specialist:	Address:	Telephone:
Reason for care:		
Therapists:	Address:	Telephone:
Reason for care:		
Assistive Devices: <input type="checkbox"/> Braces (AFO/SMO) <input type="checkbox"/> Wheelchair <input type="checkbox"/> Walker <input type="checkbox"/> Glasses <input type="checkbox"/> Hearing Aids <input type="checkbox"/> Communication Device <input type="checkbox"/> Other		

**HOSPITAL PREFERENCE (Check Only One)**

<input type="checkbox"/> Cox South, 3801 S. National Ave., Spfld, MO (417) 269-6000	Comments
<input type="checkbox"/> Mercy, 1235 E. Cherokee, Spfld, MO (417) 820-2000	
<input type="checkbox"/> Cox Branson, 251 Skaggs Rd	
<input type="checkbox"/> Other:	

I authorize DCO staff to be able to communicate using any contact information given in the Parent/Guardian and/or Daycare sections via phone/fax/voicemail/text/email/public facing media platform. (i.e. Zoom) I understand that these forms of communication will result in the information being insecure. Documents can be picked up by Parent/Guardian. I understand that this means that person(s) not authorized to view it could access my Protected Health information.

I understand that this Release of information will automatically expire in 1 year or if the individual receiving services is discharged, whichever occurs first.

I understand that I can revoke this authorization at any time with a written request to DCO at 1545 E. Pythian, Springfield, MO 65802 or by giving the written request directly to a staff person.

\_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent, Guardian, Legally Responsible Person

Signature of Case Worker if Foster Care: \_\_\_\_\_ Date: \_\_\_\_\_

Privacy Officer Approval: \_\_\_\_\_ Date: \_\_\_\_\_

**DEVELOPMENTAL CENTER OF THE OZARKS  
ADULT SERVICES AGREEMENT**

Technology & Learning Center  Adult Day Center  Community Based Learning  Employment

<b>Individual's Name:</b>	<b>Birthdate:</b>
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REQUESTED SCHEDULE			REQUESTED CARE	
<b>Monday</b>	<b>From:</b>	<b>To:</b>	<input type="checkbox"/> Partial Week <input type="checkbox"/> Full Week	
<b>Tuesday</b>	<b>From:</b>	<b>To:</b>		
<b>Wednesday</b>	<b>From:</b>	<b>To:</b>		
<b>Thursday</b>	<b>From:</b>	<b>To:</b>		
<b>Friday</b>	<b>From:</b>	<b>To:</b>		

<input type="checkbox"/> <b>Initial Agreement</b>	<input type="checkbox"/> <b>Amended Agreement</b>
<b>Payment Source:</b>	<b>Rate: \$</b>

**AGREEMENTS**

<ol style="list-style-type: none"> <li>1. I understand that the above schedule must be maintained in order to continue services.</li> <li>2. I understand that the Program Coordinator will schedule a meeting to discuss continued enrollment if the schedule is not maintained. This includes more than 1 occurrence of late pick-ups.</li> <li>3. I understand that all individuals are enrolled on "trial basis" and that if an individual's needs are greater than the Program can provide. I will be notified of a discharge date.</li> <li>4. I understand that I am responsible for any charges not covered by MO Health Net (Medicaid) <b><u>including Medicaid Spend down.</u></b></li> <li>5. If Medicaid status is inactive, I understand my services will be suspended until resolved.</li> <li>6. If I have made Private Pay arrangements, I understand that I am responsible for all charges.</li> <li>7. I understand I will be billed monthly with any charges for which I am responsible. The due date is upon receipt of bill. If not paid a discharge notice will be issued.</li> </ol>
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<b>Conditions of Continued Enrollment:</b>	
<b>Transportation has been arranged:</b> <input type="checkbox"/> <b>Yes</b> <b>Source:</b>	
<b>Start Date:</b>	<b>Effective Date of Change:</b>

<b>Individual or Guardian's Signature:</b>	<b>Date:</b>
<b>Finance Department's Signature:</b>	<b>Date:</b>

**DEVELOPMENTAL CENTER OF THE OZARKS**  
**AUTHORIZATION TO RELEASE INDIVIDUALS**

**NAME:** \_\_\_\_\_ **BIRTHDATE:** \_\_\_\_\_

**ADDITIONAL PERSONS AUTHORIZED TO PICK UP:**

1. \_\_\_\_\_ 3. \_\_\_\_\_  
2. \_\_\_\_\_ 4. \_\_\_\_\_  
5. \_\_\_\_\_ 6. \_\_\_\_\_

The following individuals **DO NOT**\*\* have authorization to pick up the above named person:  
**Legal documentation must be attached if restricting biological parents or parent of record.**

1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_

**\*\*NOTE:** If the above individual(s) is one of the parents or legal guardian, we must have appropriate documentation, such as a court approved visiting restriction, restraining order, or other legal document, to prevent contact or picking up. If the individual(s) does indicate the desire to leave, DCO staff will attempt to prevent them from leaving while another staff calls you and/or 911.

Unless notified otherwise, our staff will allow the above named individual(s) to leave with and/or have contact with their Service/Support Coordinator, Case Worker, Residential Staff (if applicable), and immediate family members.

\_\_\_\_\_  
Relationship                                      Legally Responsible Person                                      Date

\_\_\_\_\_  
Caseworker                                      Service Coordinator

**NOTE: No individual will be voluntarily released to an authorized person who is obviously incapacitated due to alcohol, substance abuse, or mental condition. If the authorized person insists on picking up the individual served, staff will immediately contact 911 to report the incident.**

**DEVELOPMENTAL CENTER OF THE OZARKS  
MEDIA and INFORMATION RELEASE – AUTHORIZATION**

*DCO has several media events each year in which we highlight individuals attending our Programs. If you authorize the use of pictures or video, you have the right to revoke the authorization at any time by completing the bottom portion of this form and sending it to the Privacy Officer at the above address. We are also expanding our services to conduct them virtually. This release will also give permission for our individuals to participate in those activities. Actions already taken based on this authorization, prior to revocation will not be affected. Services are in no way affected by the authorization of this release.*

**MEDIA RELEASE**

Events where pictures/photographs/video are used include:

1. *Annual Report – published one (1) time annually to individuals, families, and donors.*
2. *Brochures – used to highlight the Agency services and/or specific Programs. Distributed to those having an interest, touring the Program, or inquiring about services.*
3. *Annual Campaign Letter – annual letter announcing the new year for contributions to donors, foundations and other contributors.*
4. *Pictures taken for the above reasons may be used on the DCO website depicting the appropriate Program.*
5. *Numerous marketing and fundraising efforts take place annually which support all DCO Programs.*
6. *Public Service Announcements and video for news reports/articles may include videotaping of you, son, daughter, or ward interactions in a specific Program and/or activity. It may be used in conjunction with a special event or to provide information about the Developmental Center and its Programs.*
7. *Virtual services conducted via Zoom or another platform. These will not be recorded and will offer live interaction.*

*Yes, you have permission to send me information through email, text, video, voice mail, fax and phone.*

*No, you do not have permission to send me information through email*

*Yes, you have permission to take and use pictures for the specific purposes listed above including DCO's social media accounts.*

*No, you do not have permission to take or use pictures.*

*This Authorization is good for 1 year from the date signed below unless revoked by the legally responsible party. Please indicate below and return this release if we have permission to include pictures. If you do not return this release, we will not include yourself, son, daughter, or ward in the event.*

*I understand that I can revoke this authorization at any time with a written requests to DCO at 1545 E. Pythian, Springfield, MO 65802 or by giving the written request directly to a staff person.*

*Name of Individual:* \_\_\_\_\_

*Signature of Legal Representative:* \_\_\_\_\_ *Date:* \_\_\_\_\_

*Privacy Officer:* \_\_\_\_\_ *Date:* \_\_\_\_\_

**NOTICE OF REVOCATION**

*I, \_\_\_\_\_ (Individual or Legal Representative) hereby revoke my authorization of this disclosure of information. This revocation effectively makes null and void any permission for disclosure of information expressly given by the above authorization. I understand that any actions based on this authorization, prior to revocation, will not be affected. I also understand that I can revoke my approval at any time in the future if I communicate in writing to the Program Coordinator or Secretary.*

*Signature of Legal Representative:* \_\_\_\_\_ *Date:* \_\_\_\_\_

*Signature of Privacy Officer (acknowledging revocation):* \_\_\_\_\_ *Date:* \_\_\_\_\_

# DEVELOPMENTAL CENTER OF THE OZARKS HISTORY AND INDIVIDUAL INFORMATION

(Adult Services)

<b>Name of Individual to Receive Services:</b>
<b>Residence:</b> <input type="checkbox"/> Own home <input type="checkbox"/> With Parent/guardian <input type="checkbox"/> Residential (ISL) <input type="checkbox"/> Other:

<b>Culture/Ethnicity:</b> (family culture, beliefs, ethnic, important to you and/or individual to receive service)

### Immediate Family

Name	Relationship	Age

### Medical & Health Information

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Exposure to Tobacco/secondhand smoke	<input type="checkbox"/>	<input type="checkbox"/>	Concerns with Hearing: _____
<input type="checkbox"/>	<input type="checkbox"/>	History of use of tobacco/tobacco products	<input type="checkbox"/>	<input type="checkbox"/>	Uses a Walker
<input type="checkbox"/>	<input type="checkbox"/>	History of use of alcohol	<input type="checkbox"/>	<input type="checkbox"/>	Recent Falls/Injuries: _____
<input type="checkbox"/>	<input type="checkbox"/>	History of use of drugs	<input type="checkbox"/>	<input type="checkbox"/>	Uses a Wheel Chair
<input type="checkbox"/>	<input type="checkbox"/>	Seizures/Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease or Condition: _____
<input type="checkbox"/>	<input type="checkbox"/>	Assistive/Protective Devices: _____	<input type="checkbox"/>	<input type="checkbox"/>	Medication Reactions: _____
<input type="checkbox"/>	<input type="checkbox"/>	Concerns with vision: _____	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Treatment: _____

### EDUCATION/VOCATIONAL TRAINING HISTORY

Level of Education	<input type="checkbox"/> Elementary School <input type="checkbox"/> High School <input type="checkbox"/> GED <input type="checkbox"/> College
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### PREVIOUS PROGRAM/SERVICE EXPERIENCES

What type Program:
Still Attending? <input type="checkbox"/> Yes <input type="checkbox"/> No   If not, Why?

**Any other information which would help us understand the person to receive services:**

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\_\_\_\_\_  
Signature of Person completing form

Date: \_\_\_\_\_

**DEVELOPMENTAL CENTER OF THE OZARKS  
ADULT PHYSICAL EXAMINATION**

<i>Individual's Name:</i>		<i>Date of Birth:</i>
<i>Address:</i>		
<i>Medical/Physical Diagnosis:</i>		
<i>Physical Findings:</i>	<i>Height:</i>	<i>Weight:</i>

	<i>Normal</i>	<i>Abnormal</i>	<i>Comments</i>
<i>Head/Eyes</i>			
<i>Impression of Vision</i>			
<i>Ears</i>			
<i>Impression of Hearing</i>			
<i>Nose</i>			
<i>Throat</i>			
<i>Lungs</i>			
<i>Heart</i>			
<i>Breasts</i>			
<i>Abdomen</i>			

<i>NEUROLOGICAL</i>	
<i>MOTOR:</i>	<i>Tone</i>
	<i>Gait</i>
	<i>Strength</i>
	<i>Reflexes</i>

<i>LABORATORY RESULTS</i>			
<i>TB Testing (Reading MUST be marked.)</i>			
<i>Date Given:</i>	<i>Date Read:</i>	<input type="checkbox"/> <i>Negative</i>	<input type="checkbox"/> <i>Positive</i>
<i>Results of others as recommended by physician:</i>			

<i>IMMUNIZATION RECORD</i>				
<i>Booster</i>	<i>Date</i>	<i>Date</i>	<i>Date</i>	<i>Booster</i>
<i>DT/DTaP</i>				
<i>HEPATITIS A</i>				
<i>HEPATITIS B</i>				
<i>HPV</i>				
<i>INFLUENZA</i>				
<i>MMR</i>				
<i>PNEUMOCCAL</i>				
<i>SHINGLES</i>				
<i>VARICELLA</i>				
<i>MENINGOCOCCAL CONJUGATE</i>				

MED 1 1/87, 6/91, 6/92, 8/93, 1/94, 8/94, 8/95, 6/97, 7/99, 6/02, 6/03, 10/05, 11/08, 1/10, 10/12, 10/14, 10/15, 1/16, 11/16, 10/17, 10/18

PHYSICAL EXAMINATION

Page 2

<i>Individual's Name:</i>	<i>Date of Birth:</i>
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RECOMMENDATION(S)	SPECIFIC ORDERS
<input type="checkbox"/> <i>Assistive/Supportive Equipment</i>	
<input type="checkbox"/> <i>Special/Restricted Diet Orders</i>	
<input type="checkbox"/> <i>Food Allergies</i>	
<input type="checkbox"/> <i>Medication Allergies</i>	
<input type="checkbox"/> <i>Other Allergies</i>	
<i>Specialized Treatments (Please describe &amp; attach a protocol if appropriate.)</i>	

**NOTE: The following information MUST be completed for enrollment.**

<i>The above named individual is free from communicable disease/condition:</i> <input type="checkbox"/> <i>Yes</i> <input type="checkbox"/> <i>No</i>
<i>If "Not Free of Communicable Conditions", please indicate the circumstances under which the individual would be considered "Free of Communicable Conditions" and could attend program activities.</i>

<i>ANY PROGRAM OR ACTIVITY LIMITATIONS/RESTRICTIONS (Please be aware that the individual may be participating in a group setting.)</i>

<i>Additional Comments:</i>

<b>Physician's Signature:</b>	<b>Physician's Stamp:</b>	<b>Date:</b>
<b>MO HealthNet Provider Number:</b>		

**PLEASE ATTACH CURRENT SIGNED PHYSICIAN'S ORDERS**