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:** ☐ **Male** ☐ **Female** ☐ **Other**	
City: **State:** **Zip:**			**Phone #:**	
Height:	**Weight:**	**Identifying Marks:**	**Hair Color:**	**Eye Color:**
School District: ☐ ***Springfield R-12*** ☐ ***Other:***		**Education:**		**City of Birth:**
Citizenship: ☐ **Citizen** ☐ **Legal Alien**	**Language Understood:**		**Language at home:**	
Mo Health Net #:	**Medicare #:**		**Social Security #:**	
Culture/Ethnicity:	**Race:**		**Religion:**	

Service Coordinator	**VR Counselor**
Name:	**Name:**
Phone:	**Phone:**
Email:	**Email:**

Parent/Guardian/Family Information

RELATIONSHIP TO INDIVIDUAL	**RELATIONSHIP TO INDIVIDUAL**
☐ **Mother** ☐ **Foster Parent** ☐ **Guardian** ☐ **Father** ☐ **Other:**_____	☐ **Father** ☐ **Foster Parent** ☐ **Guardian** ☐ **Mother** ☐ **Other:**_____
Name:	**Name:**
☐ ***Same as above. If different, please complete:***	☐ ***Same as above. If different, please complete:***
Home Address:	**Home Address:**
City/State/Zip:	**City/State/Zip:**
Primary Phone: ☐ **Cell** ☐ **Home** ☐ **Message** **Alternate Phone:** ☐ **Cell** ☐ **Home** ☐ **Message**	**Primary Phone:** ☐ **Cell** ☐ **Home** ☐ **Message** **Alternate Phone:** ☐ **Cell** ☐ **Home** ☐ **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)

☐ ***Check this box if a Court Order or other legal document is attached naming any person not allowed visitation or custody.***
☐ ***Check this box if a document is attached showing legal guardianship of the individual named above.***
☐ ***Check this box if a document is attached limiting contact or visitation.***

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:**

DEVELOPMENTAL CENTER OF THE OZARKS
ENROLLMENT/ RE-ENROLLMENT
THERAPY & CHILDCARE

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:** ☐ **Male** ☐ **Female** ☐ **Other**	
City:	**State:**	**Zip:**	**Phone #:**	
School District: ☐ *Springfield R-12* ☐ *Other:*			**City of Birth:**	
Height:	**Weight:**	**Identifying Marks:**	**Hair Color:**	**Eye Color:**
Citizenship: ☐ **Citizen** ☐ **Legal Alien**		**Language Understood:**	**Language at home:**	
Mo Health Net #:			**Medicare #:**	
Culture/Ethnicity:		**Race:**	**Religion:**	

Service Coordinator	**DFS Case Worker**
Name:	**Name:**
Phone:	**Phone:**

Parent/Guardian/Family Information

RELATIONSHIP TO INDIVIDUAL	**RELATIONSHIP TO INDIVIDUAL**
☐ **Mother** ☐ **Foster Parent** ☐ **Guardian** ☐ **Father** ☐ **Other:**_____	☐ **Father** ☐ **Foster Parent** ☐ **Guardian** ☐ **Mother** ☐ **Other:**_____
Name:	**Name:**
☐ *Same as above. If different, please complete:*	☐ *Same as above. If different, please complete:*
Home Address:	**Home Address:**
City/State/Zip:	**City/State/Zip:**
Primary Phone: ☐ **Cell** ☐ **Home** ☐ **Message** **Alternate Phone:** ☐ **Cell** ☐ **Home** ☐ **Message**	**Primary Phone:** ☐ **Cell** ☐ **Home** ☐ **Message** **Alternate Phone:** ☐ **Cell** ☐ **Home** ☐ **Message**
E-Mail Address:	**E-Mail Address:**
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)

☐ ***Check this box if a Court Order or other legal document is attached naming any person not allowed visitation or custody.***
☐ ***Check this box if a document is attached showing legal guardianship of the individual named above.***
☐ ***Check this box if a document is attached limiting contact or visitation.***

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: ☐ *Yes* ☐ *No*	**Date of Last Examination:**	**Date of last TB testing:**
Specialist:	**Address:**	**Telephone:**
Reason for care:		
Therapists:	**Address:**	**Telephone:**
Reason for care:		
Assistive Devices: ☐ **Braces (AFO/SMO)** ☐ **Wheelchair** ☐ **Walker** ☐ **Other**		
Supportive Devices: ☐ **Glasses** ☐ **Hearing Aids** ☐ **Communication Device** ☐ **Other**		

HOSPITAL PREFERENCE (Check Only One)

☐ *Cox South, 3801 S. National Ave., Spfld, MO (417) 269-6000* ☐ *Mercy, 1235 E. Cherokee, Spfld, MO (417) 820-2000* ☐ *Cox Branson, 251 Skaggs Rd* ☐ *Other:*	**Comments**

INDIVIDUAL'S DAYCARE INFORMATION (THERAPY ONLY)

Daycare:	**Contact Person:**
Address:	**Phone #:**

Signature:	**Date:**

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
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:** ☐ **Male** ☐ **Female** ☐ **Other**	
City: **State:** **Zip:**			**Phone #:**	
Height:	**Weight:**	**Identifying Marks:**	**Hair Color:**	**Eye Color:**
School District: ☐ ***Springfield R-12*** ☐ ***Other:***		**Education:**		**City of Birth:**
Citizenship: ☐ **Citizen** ☐ **Legal Alien**	**Language Understood:**		**Language at home:**	
Mo Health Net #:	**Medicare #:**		**Social Security #:**	
Culture/Ethnicity:	**Race:**		**Religion:**	

Service Coordinator	**VR Counselor**
Name:	**Name:**
Phone:	**Phone:**
Email:	**Email:**

Parent/Guardian/Family Information

RELATIONSHIP TO INDIVIDUAL	**RELATIONSHIP TO INDIVIDUAL**
☐ **Mother** ☐ **Foster Parent** ☐ **Guardian** ☐ **Father** ☐ **Other:**_____	☐ **Father** ☐ **Foster Parent** ☐ **Guardian** ☐ **Mother** ☐ **Other:**_____
Name:	**Name:**
☐ ***Same as above. If different, please complete:***	☐ ***Same as above. If different, please complete:***
Home Address:	**Home Address:**
City/State/Zip:	**City/State/Zip:**
Primary Phone: ☐ **Cell** ☐ **Home** ☐ **Message** **Alternate Phone:** ☐ **Cell** ☐ **Home** ☐ **Message**	**Primary Phone:** ☐ **Cell** ☐ **Home** ☐ **Message** **Alternate Phone:** ☐ **Cell** ☐ **Home** ☐ **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)

☐ ***Check this box if a Court Order or other legal document is attached naming any person not allowed visitation or custody.***
☐ ***Check this box if a document is attached showing legal guardianship of the individual named above.***
☐ ***Check this box if a document is attached limiting contact or visitation.***

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: ☐ *Yes* ☐ *No*	**Date of Last Examination:**	**Date of last TB testing:**
Specialist:	**Address:**	**Telephone:**
Reason for care:		
Therapists:	**Address:**	**Telephone:**
Reason for care:		
Assistive Devices: ☐ **Braces (AFO/SMO)** ☐ **Wheelchair** ☐ **Walker** ☐ **Glasses** ☐ **Hearing Aids** ☐ **Communication Device** ☐ **Other**		

HOSPITAL PREFERENCE (Check Only One)

☐ *Cox South, 3801 S. National Ave., Spfld, MO (417) 269-6000* ☐ *Mercy, 1235 E. Cherokee, Spfld, MO (417) 820-2000* ☐ *Cox Branson, 251 Skaggs Rd* ☐ *Other:*	**Comments**

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.

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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
CHANGE OF PERSONAL ENROLLMENT INFORMATION

Individual's Name: _____Program: _____

Name of Person Providing Updated Information: _____Relationship_____

Current Information	**Changed Information**
Name:	
Address:	
Telephone (home, cell, work):	
Email:	
County & School District:	
Parent/Guardian (circle correct title):	
Support Coordinator, Case Worker, VR Counselor (circle correct title)	
MO Health Net Number:	
Parent/Guardian Work Address:	
Parent/Guardian Work Phone:	
Emergency Contact:	
Emergency Contact Address:	
Emergency Contact Phone:	
Physician:	
Specialist:	
Hospital:	
Medications/Surgeries/Seizures:	

Comments/Additional Information:

Individual's Name: _____ Program: _____

Birthdate: _____

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. 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: _____

ENR 9 11/04, 10/05, 8/06, 9/10, 8/14, 8/15, 6/16, 9/16, 8/19, 10/19, **7/20**

DEVELOPMENTAL CENTER OF THE OZARKS
ADULT PHYSICAL EXAMINATION

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

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

NEUROLOGICAL	
MOTOR:	*Tone*
	Gait
	Strength
	Reflexes

LABORATORY RESULTS *TB Testing (Reading* **MUST** *be marked.)*			
Date Given:	*Date Read:*	☐ *Negative*	☐ *Positive*
Results of others as recommended by physician:			

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

PHYSICAL EXAMINATION
Page 2

Individual's Name:	*Date of Birth:*

RECOMMENDATION(S)	SPECIFIC ORDERS
☐ *Assistive/Supportive Equipment*	
☐ *Special/Restricted Diet Orders*	
☐ *Food Allergies*	
☐ *Medication Allergies*	
☐ *Other Allergies*	
Specialized Treatments *(Please describe & attach a protocol if appropriate.)*	

NOTE: The following information MUST be completed for enrollment.

The above named individual is free from communicable disease/condition: ☐ ***Yes*** ☐ ***No***
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.

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

Additional Comments:

Physician's Signature:	**Physician's Stamp:**	**Date:**
MO HealthNet Provider Number:		

PLEASE ATTACH CURRENT SIGNED PHYSICIAN'S ORDERS

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
ADULT PHYSICAL EXAMINATION

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

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

NEUROLOGICAL	
MOTOR:	*Tone*
	Gait
	Strength
	Reflexes

LABORATORY RESULTS *TB Testing (Reading* **MUST** *be marked.)*			
Date Given:	*Date Read:*	☐ *Negative*	☐ *Positive*
Results of others as recommended by physician:			

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

PHYSICAL EXAMINATION
Page 2

Individual's Name:	*Date of Birth:*

RECOMMENDATION(S)	SPECIFIC ORDERS
☐ *Assistive/Supportive Equipment*	
☐ *Special/Restricted Diet Orders*	
☐ *Food Allergies*	
☐ *Medication Allergies*	
☐ *Other Allergies*	
Specialized Treatments *(Please describe & attach a protocol if appropriate.)*	

NOTE: The following information MUST be completed for enrollment.

The above named individual is free from communicable disease/condition: ☐ ***Yes*** ☐ ***No***
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.

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

Additional Comments:

Physician's Signature:	**Physician's Stamp:**	**Date:**
MO HealthNet Provider Number:		

PLEASE ATTACH CURRENT SIGNED PHYSICIAN'S ORDERS

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:*_____