INSPIRE Continuing Care

FULL TIME **$800/month**
5 days/week

PART TIME ***not available***

Hours of Operation 7:30am-5:00pm
(community activities will be planned between 9am-3pm, participants must be @ ICC during this time)

2025 Shutdown Weeks & Holidays
(ICC will be closed during these dates):

January 1 - 3, 2025
January 20, 2025
March 17 - 21, 2025
April 18 & Apr 21, 2025
May 26, 2025
June 30 - July 4, 2025
September 1, 2025
November 11, 2025
November 24 - 28, 2025
December 22, 2025 - January 2, 2026

A $25.00 application fee will be due at the time of registration.

ADMISSION IS SUBJECT TO REVIEW BY THE ICC BOARD OF DIRECTORS AND THE FOLLOWING GUIDELINES APPLY:

- **Participants must allow others in the program, as well as members of the community, to enjoy the activity with very limited disruption**
- **Participants must demonstrate flexibility and ability to reasonably cope with changing situations and demonstrate social skills that promote a healthy environment**
- **Participants must demonstrate behavior that will not affect the safety of any individual, including him/herself**
- **Participants must respond to verbal or visual instructions and remain with the group in community environments and while in the ICC building (no wandering or running away)**

TUITION PAYMENT POLICY: Payment must be prepaid monthly by the first business day of the current month. *(ICC is private-pay only and is not authorized to accept state or federal funding sources.)*
Individuals interested in attending ICC but unable to afford tuition may submit a written request for consideration of a full tuition waiver. The ICC Board of Directors will work with the individual and their family to determine eligibility.

- I agree to pay the total participation fees accrued.
- I agree to pay any additional fees that may result from a returned or invalid check, collection fees, etc.
- I understand that I forfeit any money paid, if my child does not attend his/her prepaid sessions.

I have read/understand and agree to the Inspire Continuing Care admission guidelines, tuition rates and payment policies.

_____ _____

Parent/Guardian Signature Date

INSPIRE
Continuing Care

Participant's Name_____ Birthday_____

Mother/Guardian Name_____

Father/Guardian Name_____

Adress_____
Address City/State/Zip

Contact Information (please indicate the order you wish to be contacted)

- Home phone_____
- Work phone _____
- Cell phone _____
- Email _____

Sibling Information (optional)

_____
Name Birthday

_____
Name Birthday

_____
Name Birthday

_____
Name Birthday

In the event of an emergency, the care provider staff is authorized to obtain Emergency Medical or Dental Care even if the care center staff is not able to make immediate contact with parents/guardians. During an Emergency, the care center staff is authorized to contact the following people:

Emergency Contacts:

Name	Relationship	Phone
Name	Relationship	Phone

Medical Information: Please complete the following entirely.

Doctor's name_____

Adress_____

Phone_____

Dentist's name_____

Adress_____

Phone_____

Significant illness and surgeries participant has had (give age at time)

Specify_____

_____

_____

Any special health related needs of the participant?

Specify_____

_____

_____

Does the participant take any medication? (include name and dose) Y N

Medication/dose_____

Medication/dose_____

Medication/dose_____

Does the participant use the following emergency medication?

Epi-pen Inhaler/Nebulizer Diastatic/Seizure Medication

Other_____

Does the participant have any allergies? Y N

Specify_____

_____

Does the participant have any food allergies/restrictions? Y N

Specify_____

_____

Physical Assessment: To be completed by parent/guardian

1. Does the participant have any visual, hearing or speech limitations which ICC should be aware of or can compensate by reasonable accommodations?

_____

_____

_____

2. Does the participant have any condition(s) which may result in an emergency?

_____

_____

_____

3. Does the participant have any medical or physical condition(s) for which he/she should remain under periodic medical observation?

_____

_____

_____

4. Does the participant have seizures? If so, what happens during a seizure?

_____

_____

_____

5. Is the participant independent in the bathroom? Yes No
    a. If no, please explain:

    _____

6. Is the participant independent with feeding? Yes No
    a. If no, please explain:

    _____

7. How does the participant express his/her needs to others? Circle all that apply...

Eye contact	PECS symbols
Moves others	AAC device
Gestures	Words
Vocalizations	Phrases
Jargon	Sentences
Sign language	Conversation
Asks Questions (Yes/No, WH)	
Answers questions (Yes/No, WH)	

Additional Information to share:_____

Adaptive Behavior: (1 easily/no problems → 5 big challenge)

How participant adapts to transitions: 1 2 3 4 5

Does the participant have any sensory sensitivities (light, noise, touch, etc)?

_____

_____

Safety Awareness

Does the participant understand danger?

- Yes...is very conscious of danger
- Has some concept of danger
- Has no awareness of danger

Does the participant wander away unannounced?

- Never has
- Occasionally
- Frequently

Does the participant have any history of significant physical aggression? Y N

Specify_____

_____

_____

Does the participant exhibit self-injurious behavior? Y N

Specify_____

_____

_____

Does the participant verbally threaten to hurt others? Y N

Specify_____

_____

_____

The following will not be tolerated and will result in a warning, corrective action and/or dismissal:

- Violence (includes verbal and physical assaults, fights, threats and property destruction)
- Inappropriate sexual conduct
- Stealing
- Running away
- Any behavior that endangers or jeopardizes the participants, staff and/or program

Staff will document corrective action and discuss with parent/guardian on the date of the occurrence.

The Staff and Board of Directors of ICC seeks to provide a safe environment for all participants with unique needs, providing excellence in care and community engagement, where all can find acceptance and fulfillment. ICC desires to accommodate all participants in need of physical and communication assistance and will work with the family to ensure a successful transition into the program. In the regretful event that the safety of staff and peer participants is compromised ICC will reserve the right to review the incident, which may result in immediate termination from the program.

I have answered all of the questions honestly and to the best of my ability

_____ _____

Parent/Guardian Signature Date

Supporting Documents/References:

- Please include a copy of applicant's
  - Exit/Transition IEP
  - Summary of Performance document (this may be a part of the exit/transition IEP)

- Please provide name and contact information of three (3) reference individuals who have had extended interaction with applicant in a community-based environment (school, work, church, club . . . a non-home environment)
  - _____
  - _____
  - _____

MEDICAL CONSENT FORM

I, _____, hereby voluntarily consent to the rendering of such care, including, but not necessarily limited to, diagnostic procedures, surgical and medical treatment and blood transfusions, by medical doctors, hospitals or their authorized designees, as may in their professional judgement be necessary to provide for the medical, surgical or emergency care of the participant, _____ (hereinafter "Dependent").

I further give my consent to any employees and/or board members of INSPIRE CONTINUING CARE (hereinafter "ICC"), who will be caring for my Dependent. In the event that my Dependent is injured or ill while under the care of the ICC, I hereby give permission to the ICC to provide first aid for said Dependent and to take all appropriate measures necessary to provide care for my Dependent, including transportation to the nearest emergency medical facility.

In making medical decisions on my behalf for the benefit of my Dependent, I direct that the ICC attempt to contact me. However, if medical care becomes essential, I give permission to the ICC to make such decisions regarding such treatment as deemed appropriate by the medical doctor, hospital or their authorized designee. In furtherance of any treatment decisions to be made by the ICC on my behalf for the benefit of my Dependent, I authorize the ICC to request, obtain, review and inspect any and all information bearing upon my Dependent's health and relevant to any such decisions to be made respecting any such treatment.

I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment of my Dependent and that I am responsible for all reasonable charges in connection with the care and treatment rendered to my Dependent during this period.

_____ _____

Signature of Parent/Legal Guardian Date

Allergies: Dependent Medications:

Health Insurance Policy # and Group #: _____

CONSENT FOR PARTICIPATION

I _____, legal guardian of _____ do hereby give consent for my child (named above) to participate in Inspire Continuing Care (ICC) programs.

I agree to release, hold harmless, and waive all claims and causes of action that may hereafter accrue to me against Inspiring Continuing Care, and any of their officers, directors, employees, agents, independent contractors, representatives, or volunteers associated with any injury that may be caused as a result of any action other than the sole negligence of Inspiring Continuing Care, their officers, directors, employees, agents, independent contractors, representatives, or volunteers.

I further agree to indemnify and hold harmless Inspiring Continuing Care, and any of their officers, directors, employees, agents, representatives, or volunteers, from any action or inaction of my child that may cause any injury or damage whatsoever.

I hereby give full permission for my child to participate in all activities and agree to notify group leaders of any precautionary measures that should be noted or taken during group classes. I agree to pay the total class fees accrued. I also agree to pay any additional fees that may result from a returned or invalid check, collection fees, etc. I agree to pay 10% late fees on any balances due over 30 days, and understand that I will pay an additional 30% collection fee for any outstanding balances 90 days delinquent. I understand that I may forfeit any money paid, if my child does not attend his/her prepaid sessions.

In the event of any injury to my child, I hereby grant full power of attorney to Inspire Continuing Care, their directors, employees, agents, independent contractors, representatives, or volunteers to obtain any emergency medical treatment they (in their sole discretion) deem necessary in the best interest of my child.

_____ _____

Legal Parent/Guardian (print) Child's Name (print)

_____ _____

Legal Parent/Guardian Signature Date

MEDIA RELEASE

Photographs and/or videos may be taken during the participant's time at Inspire Continuing Care. I, _____, grant permission for my participant to be photographed or videotaped. (Check all that apply)

- ❏ Display in the office (i.e. recognition board, pictures on walls)
- ❏ ICC public social media pages to highlight programs/trips/activities
- ❏ ICC website
- ❏ Media (such as when a news station/news paper visits for a story)
- ❏ Brochures/other promotional materials

❏ I do not grant permission for my participant to be photographed or videoed for display, educational purposes, or marketing.

_____ _____

Print participant's name Date

_____ _____

Parent/guardian signature Relationship