Inspiring Personal Independence

SOUTHEAST ALASKA INDEPENDENT LIVING

New Consumer Intake

Name: _____Date of Birth:_____

Physical Address:_____City:_____Zip_____

Mailing Address if Different: _____City:_____Zip_____

Home Phone:_____Work Phone:_____Cell Phone:_____

Email Address:_____Primary Language:_____

How did you hear about SAIL? _____

Marital Status: _____ Gender: Male____ Female_____

How would you like to receive SAIL's Quarterly Newsletter?
Email____ Mailing Address_____ Not interested? _____

Are you registered to vote? Yes__No__ If no, can SAIL help you register? Yes___No___
Do you feel safe in your home? Yes___No___ If no, please discuss with SAIL staff.

Ethnicity:

___African American ___AK Native ___Asian ___American Indian
___Caucasian ___Hispanic/Latino ___Pacific Islander ___Unknown/Other

Disability/Disabilities – Check all that apply (write 'P" next to primary disability)

___AIDS/HIV	___Developmental Disabilities	___Multiple Disabilities
___Alzheimer's	___Diabetes	___Orthopedic Impairment
___Amputation	___Emphysema	___Parkinson's Disease
___Arthritis	___Environmental Sensitivities	___Psychiatric Disability
___Asthma	___Epilepsy	___Respiratory Condition
___Blind (NLP)	___Heart Attack/Bypass	___Schizophrenia
___Cancer	___Head Injury	___Speech Impairment
___Cardiac/Circulatory	___Hearing Impairment	___Spina Bifida
___Cerebral Palsy	___Hepatitis	___Spinal Cord Injury
___Chemical Dependence	___High Blood Pressure	___Stroke
___Deaf	___Learning Disability	___Visual Impairment

Please specify other disability if not listed_____

Current Services:

Division of Vocational Rehabilitation (DVR)? Yes___No___
Tribal Vocational Rehabilitation (TVR)? Yes___No___
Medicare? Yes___No___Not sure___
Medicaid? Yes___No___Not sure___
Care Coordination or Case Management? Yes___No___Not sure___
*If yes, through which agency do you receive CC or CM services _____
What is your Care Coordinator or Case Managers name:_____
Would you sign a release of information for us to speak with this person? Yes___No___
Are you a Veteran:Yes___No___
If yes, are you receiving VA benefits or other services: Yes___No___Not Sure___

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Current Housing Situation:

Is your housing subsidized: Yes___ No___

___Group Home ___Own House/Apt. ___Parent/Guardian Home ___Hotel

___Transitional ___Rent House/Apt. ___Primary Care Facility ___Homeless

Is your residence accessible? Yes___ No___ Accessibility Needed___

___Living alone ___Living w/family/friends ___Assisted living

___Supported living ___Living alone with PC ___Institution (nursing home etc.)

*If living in an institution, do you live there by choice? Yes___No___

Education (highest level):

___No Education
___Special Education
___8th Grade or Less
___Some High School
___GED
___High School Diploma
___Some College
___Some Graduate Work
___Graduate Degree

Employment:

___Full time
___Not Employed – not seeking
___Not Employed – seeking
___Employed part time
___Supported employment
___Self employed – full time
___Self employed – part time
___Retired
___Volunteer
___DVR Consumer

Annual Income:

___0-$4,600
___$4,601-$6,600
___$6,601-$10,000
___$10,001-$15,000
___$15,001-$20,000
___$20,001-$30,000
___$30,001-$40,000
___Above $40,000

Eligibility Statement

In accordance with Department of Education 34 CFR. Parts 364, 365, 366, 367 Subpart D, Paragraph 364.40 this statement of eligibility is necessary. By the signature of the SAIL staff below, it is certified that the applicant has met the basic requirements specified in Paragraph 364.40. These are: The individual applying for or receiving services is an individual with a significant disability.

SAIL Staff Signature Date

I acknowledge that SAIL staff has explained the purpose of the Client Assistance Program (CAP) to me and provided contact information for offices statewide. Please initial _____

I would like to create an Independent Living Plan: Yes____ No____ Initial_____
I would like to waive my right to create an Independent Living Plan, I understand that I can create an IL Plan with SAIL in the future if I so choose: Yes___ No____ Initial____

Consumer Signature Date

SAIL Staff Signature Date

Parent or Guardian (If Applicable) Date

For Office Use Only

Initial Intake Date:_____ MiCIL Date:_____ Exceed Date:_____ Exit Date:_____
ROI____ Photo Release___ IL Plan (If Requested)____
*If ORCA or other activities: ROL____DSUSA____ Activity Form____

Juneau, AK: 3225 Hospital Dr Suite 100, 99801, 1.800.478.SAIL, ph/tty: 907.586.4920, fx: 907.586.4980
Ketchikan, AK: 602 Dock St, Suite 107, 99901, 1.888.452.SAIL, ph/tty: 907.225.4735, fx: 907.247.4735
Sitka, AK: 514 Lake St, Suite C, 99835, ph/tty: 907.747.6859, fx: 907.747.6783
Haines, AK: PO Box 183, 99827, ph/tty: 907.766.3297, fx: 907.766.2753 REVISED April 2012

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Independent Living Plan

Consumer Name:_____ Date of Birth:_____

Date of Plan:_____

The following goals have been established cooperatively by the consumer and an Independent Living Advocate. The goals are specific in addressing independent living needs of the consumer, and focus on enhancing the consumer's ability to live independently.

If the consumer elects to waive a written IL Plan, the waiver must be in writing and must be in the consumer file.

Goal 1: _____

Completed: Yes___ No___

Goal 2: _____

Completed: Yes___ No___

Goal 3:_____

Completed: Yes___ No___

Goal 4: _____

Completed: Yes___ No___

Consumer Signature:_____ Date:_____

SAIL Staff Signature:_____Date:_____

Parent/Guardian (If Applicable):_____Date:_____

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SOUTHEAST ALASKA INDEPENDENT LIVING

Consent/Request for Release of Information

Consumers Name:_____ Date of Authorization:_____

Date of Birth:_____Date of Expiration: **90 days post file closure OR** expires on this date:_____

I, _____, authorize: **Southeast Alaska Independent Living** to:
Consumer, Parent or Legal Guardian

Please initial all that apply (do no mark with an 'X')

_____Send Info to, _____Request Info from: The **following person or agency**:

_____
Person or agency

Please send atten: _____

Address: _____ Fax:_____

This information is for the purposes of: (Initial all that apply)
_____Medical _____Psychological _____Educational _____Financial
_____Vocational _____Social _____IL Assessment _____PCA
_____Housing _____Other: _____(Please specify)

This information may be released in the following formats (Initial all that apply):

Verbal Written Electronic

Consumer Signature Date

SAIL Staff Signature Date

Parent or Guardian (If Applicable) Date

This consent is subject to revocation in writing at any time except to the extent that action has been taken thereon. Without written revocation, it will expire on the above date.

DISABLED SPORTS USA INSURANCE WAIVER & RELEASE OF LIABILITY FORM

In consideration of being allowed to participate in any way in Disabled Sports USA and Southeast Alaska Independent Living related events and activities, I and/or the minor participant, for myself, and on behalf of my heirs, assigns, personal representatives and next of kin, the undersigned:

1. Agree that prior to participating, I will inspect, or if a parent and/or legal guardian I will instruct the minor participant to inspect, the facilities and equipment to be used, and if I believe, to the best of my ability, that anything is unsafe, I and/or the minor participant will immediately advise Disabled Sports USA and Southeast Alaska Independent Living of such condition(s) and refuse to participate.
2. Acknowledge and fully understand that I and/or the minor participant will be engaging in activities that involve risk of serious injury, including permanent disability and death, and severe social and economic losses which might result only from my own actions, inactions or negligence of others, the rules of play, or the condition of the premises or any equipment used. Further, that there may be other risks not known to me or not reasonably foreseeable at this time.
3. Assume all the foregoing risks and accept personal responsibility for the damages following such injury, permanent disability or death.
4. Release, waive, discharge and covenant not to sue Disabled Sports USA and Southeast Alaska Independent Living, its affiliated clubs, their representative administrators, directors, agents, coaches, other employees, and volunteers of the organization, other participants, sponsoring agencies, sponsors, advertisers, their heirs, and if applicable, owners and leasers of premises used to conduct the event, all of which are hereinafter referred to as "releasees", from demands, losses or damages on account of injury, including death or damage to property, caused or alleged to be caused in whole or in part by the negligence of the releasee or otherwise.

I/WE HAVE READ THE ABOVE WAIVER AND RELEASE, UNDERSTAND THAT I/WE HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, HAVE NOT CHANGED IT ORALLY, AND SIGN IT VOLUNTARILY.

X_____ _____ _____
Participant's Signature | **Participant's Name (PLEASE PRINT CLEARLY)** | **Date**

Date of Birth _____ **FOR PARTICIPANTS UNDER THE AGE OF 18**

This is to certify that I, as parent/guardian with legal responsibility for this participant, do consent and agree to his/her release as provided above of the Releasees, and, for myself, my heirs, assigns, and next of kin, I release and agree to indemnify and hold harmless the Releasees from any and all liabilities incident to my minor child's involvement or participation in these programs as provided above, EVEN IF ARISING FROM THEIR NEGLIGENCE.

X_____ _____ _____ _____ _____
Parent/Legal Guardian Signature | **Parent/Legal Guardian Name** | **Relationship** | **Emergency Phone** | **Date**

MEDIA RELEASE FORM

MEDIA/PHOTO WAIVER: I hereby authorize and give my full consent to Disabled Sports USA and Southeast Alaska Independent Living to copyright and/or publish any and all photographs, digital recordings, videotapes and/or film in which I appear may be used for public view. I further agree that Disabled Sports USA and Southeast Alaska Independent Living may transfer, use or cause to be used, these digital recordings, photographs, videotapes, or films for any exhibitions, public displays, publications, commercials, art and advertising purposes, television programs, and internet without limitations or reservations.

X_____ _____ _____
Participant's Signature | **Participant's Name (PLEASE PRINT CLEARLY)** | **Date**

FOR PARTICIPANTS UNDER THE AGE OF 18

X_____ _____ _____ _____ _____
Parent/Legal Guardian Signature | **Parent/Legal Guardian Name** | **Relationship** | **Emergency Phone** | **Date**

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ORCA Activity Information Form

Name:_____ **Today's Date:** _____

Birthdate: _____ **_Address**:_____

Phone:_____ **Disability**:_____

Please describe any behavior related issues (i.e. following directions, language, responds well to positive feedback):

_____

_____

_____

Medications	**Times Taken**

Who and how administered (i.e. needs reminder, taken with food, etc): _____

_____

Date of last Tetanus:_____

Seizure History

Frequency: _____ **Most Recent Date**: _____

Characteristics: _____

Triggers: _____

Allergies:_____

Emergency Contact Information:

Name:_____ **Relation**: _____**Phone**:_____

Name:_____ **Relation**: _____**Phone**:_____

Name:_____ **Relation**: _____**Phone**:_____

Doctor and Clinic:_____**Phone:** _____

Turn Over →

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Authorization for Medical Care: I authorize SAIL to call for medical care and/or to transport me to a medical facility or hospital if medical attention is needed. I agree that upon transport to any such medical facility or hospital SAIL shall not have any further responsibility for me. Further, I agree to pay all costs associated with such medical care and related transportation and shall indemnify and hold harmless SAIL from any costs incurred therein.

ORCA/SAIL staff reserve the right to refuse service to anyone intoxicated through the abuse of alcohol or illicit drugs, due to safety of all participants, volunteers, staff, and/or others. I agree to pay for broken/lost items issued to me by ORCA/SAIL staff and understand ORCA/SAIL is not responsible for any personal items of mine, which may be lost or stolen.

Signature/ Parent or Guardian if under 18 **Date**

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3225 Hospital Drive, Suite 300 · Juneau, Alaska 99801· (907) 586-0104 (phone) · 586-4980 (fax)

ORCA Financial Aid Application

Consumer receiving Scholarship: AGE:

Mailing Address:_____

Parent/Guardian/Care Coordinator Contact:_____

Day Phone: _____Evening Phone: _____

Total # wage earners in house____ Total in household including yourself____

Report ALL household income for the past calendar **YEAR**. Fill in an amount for each category, even if it is zero.

Gross wages:	Child Support/alimony:
PFD income:	Disability Benefits
Workers Comp:	Public Assistance:
Unemployment:	Social Security:
Veteran's pymts:	Rentals/Estates:
Trust/Royalty pymt:	Tips/other:
Pension:	**TOTAL ALL INCOME:**

Additional financial considerations that we should be aware of: _____

_____

Are you applying for funding for a specific ORCA activity or trip? Y/N
If Yes, which ones)_____

_____

_____

_____

OFFICE USE ONLY

Date received_____ Amount funded_____

Funding Source_____ Date awarded_____