TOUCH BASE: CENTER FOR THE DEAFBLIND

For people with deafblindness, and those who support them, to build connections with the community, promote self-respect, improve communication and daily living skills, while creating moments of joy.

REGISTRATION PACKAGE

Dear new member and guardian,

Welcome to Touch Base: Center for the Deafblind!

In an effort to provide the best possible service to our members, we would like for you to complete some paperwork.
The forms include the following:

1. Registration form
2. Medical information form
3. Medication administration form (if needed)
4. Insurance information
5. Materials fee payment form
6. Media release form
7. Transportation Form
8. "My Needs" form
9. Attendance schedule
10. IPP (to be filled out with Touch Base Staff)

(Staff Only)
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

We also request you to read our Policies and Procedures Handbook and sign below that you understand and agree with our policies.

Member's name: _____

Guardian's name: _____

Guardian's signature: _____

Date: _____

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REGISTRATION FORM

MEMBER'S NAME: _____ DOB: _____

ADDRESS: _____

PROVIDER INFO : _____

INSURANCE: _____

GUARDIAN'S NAME: _____

GUARDIAN'S ADDRESS: _____

GUARDIAN'S PHONE NUMBER: _____

EMAIL ADDRESS: _____

EMERGENCY CONTACT NAME: _____

EMERGENCY CONTACT ADDRESS: _____

EMERGENCY CONTACT PHONE: _____

PREFERRED HOSPITAL FOR EMERGENCY: _____

I am authorized to consent for the member's healthcare.

GUARDIAN'S SIGNATURE: _____ DATE: _____

15 AZALEA TRAIL LANE, BELLAIRE, TEXAS 77401, PHONE: 832-877-3333, CONTACT@TOUCHBASECENTER.ORG

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MEDICAL INFORMATION

NAME: _____ DOB: _____

DIAGNOSES: 1) _____

2) _____

3) _____

MEDICATIONS: 1)_____

2) _____

3) _____

PAST MEDICAL HISTORY: _____

_____

ALLERGIES: _____

BEHAVIORAL STATUS: _____

_____

SPECIAL NEEDS/ LIMITATIONS: _____

_____

PHYSICIAN'S NAME: _____ PHONE: _____

GUARDIAN'S SIGNATURE: _____ DATE: _____

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REQUEST FOR MEDICATION ADMINISTRATION

NAME: _____ DOB: _____

Medication: _____

Dose: _____ Time:_____

Reason: _____

Possible side-effects: _____

Medication: _____

Dose: _____ Time:_____

Reason: _____

Possible side-effects: _____

Physician's name: _____

Physician's signature: _____ Date: _____

Clinic number: _____ Emergency number: _____

The medication is to be furnished by the member's guardian and brought in its original container with a label, including the member's name, the medication name and complete directions.

Guardian's name: _____

Guardian's signature: _____ Date: _____

Program Coordinator's signature: _____

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INSURANCE AND PAYMENT INFORMATION

NAME: _____ DOB: _____

INSURANCE: _____

PROVIDER: _____

GUARANTOR: _____

PRIVATE-PAY: _____

PAYMENT PLAN: $13/HR FOR _____ HRS/DAY AND _____ DAYS/MTH

TOTAL PAYMENT REQUIRED: $ _____/ MTH

EFFECTIVE DATE: _____

GUARDIAN'S NAME: _____

GUARDIAN'S SIGNATURE: _____

DATE: _____

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MATERIALS FEE PAYMENT FORM

MEMBER'S NAME: _____

MATERIALS FEE: _____

MATERIALS REQUIRED: _____

_____

AMOUNT PAID: _____ Cash / CC / Check / Paypal / Other

RECEIVED BY: _____

DATE: _____

Every year, I will pay the annual materials fee of $50 by January 31st to the order of Touch Base.

SIGNATURE: _____

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MEDIA RELEASE FORM

I, _____ (self/guardian), give my permission to **Touch Base: Center for the Deafblind** to use my/my ward's (named below) photos and videos publicly. I understand that the images may be used in print publications, online publications, presentations, websites and social media such as Facebook. I also understand that no royalty fee or other compensation shall become available to me by reason of such use. I am aware that I can revoke this permission at any time, by notifying Touch Base staff. Unless revoked, this consent will remain in effect indefinitely.

Member's name: _____

Guardian's name: _____

Guardian's signature: _____

Date: _____

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TRANSPORTATION SERVICES WAIVER AND RELEASE

Please read this form carefully as you will be expressly assuming the risk and legal liability and waiving and releasing all claims for injuries, damages or loss which you might sustain as a result of said services, including but not limited to, vehicle operations and boarding and exiting the vehicle.

I recognize and acknowledge that Touch Base: Center for the Deafblind is neither a common carrier nor in the business of providing transportation services to the public. I further recognize and acknowledge that there are certain risks of physical injury to vehicle passengers, and I voluntarily agree to assume the full risk of any injuries, damages or loss, regardless of severity, that I, _____ (particpant name), may sustain as a result of participating in any and all activities connected with or associated with receiving transportation services, including, but not limited to, injuries, damages and loss arising out of negligent operation or supervision of the vehicle. I further agree to waive and relinquish all claims I may have (or accrue to me) against Touch Base, including its respective officials, agents, volunteers and employees (hereinafter collectively referred to as "Party").

I do hereby fully release and forever discharge the Party from any and all claims for injuries, damages or loss that I may have or which may accrue to me and arising out of, connected with, or in any way associated with said transportation services.

I further agree that this agreement shall be governed by the laws of the State of Texas. I have read and fully understand the above waiver and release of all claims. If registering on-line or via fax, my on-line or facsimile signature shall substitute for and have the same legal effect as an original form signature.

Participant's Name (PRINTED): _____

Participant's Signature (or guardian): _____

Date: _____

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MY NEEDS FORM

Please fill out this form so we can better serve this deafblind individual.
This form will be utilized by interveners, volunteers, and staff.

My Full **Name** is: _____
I like to be called: _____
My sign name is: _____
Date of Birth: _____

I **communicate** using (i.e. speech, preferred language, sign language, communication devices or aids, non-verbal sounds): _____

_____

_____

Also, please state if is extra time/support is needed and how: _____

_____

My **mobility** needs are (i.e. "I can move independently", devices/equipment I use, "I use a white cane", "I need help with balance"): _____

_____

_____

_____

In the **bathroom** you can assist me by (i.e. if i need to be changed, frequency, "I need help wiping", "I need assistance buttoning my pants"): _____

_____

_____

_____

When **eating**, you can assist me by (i.e. cutting my food into small pieces): _____

When **drinking**, you can assist me by (i.e. providing me a straw): _____

Foods/Drinks that I **like/can have**: _____

Foods that I **dislike/ cannot have**:

I am **very sensitive** to (specific sounds, textures, odors, touch): _____

If I am **upset or distressed**, I show it by (i.e. biting my wrist, hitting my head, yelling, running): _____

If I am **upset or distressed**, the best way you can help be is by (i.e. play my favorite music, giving me a 10 minute break): _____

If I am in **pain**, I show it by (i.e. saying "hurt", hitting my head, yelling): _____

_____

_____

If I am in **pain**, the best way you can help be is by (i.e. allowing me time to breath through it, giving me medication): _____

_____

_____

My current **medications** are: _____

_____

I take my **medications** at: _____

_____

Medications I am allergic too (i.e. ibuprofen, Benadryl): _____

_____

Other things of note (i.e. I LOVE CHOCOLATE, I cannot touch dogs, I recently had surgery): _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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MEMBER ATTENDANCE SCHEDULE

MEMBER'S NAME: _____ DOB: _____

I am requesting that the member named above attend Touch Base: Center for the Deafblind (#) _____ day(s) a week, on the days and timings indicated below:

Mondays _____ Tuesdays _____

Wednesdays _____ Thursdays _____

Fridays _____

I understand that this is a commitment and I will be responsible for payment on days that my ward is unexpectedly absent as explained in the Touch Base Policies and Procedures Manual.

I have had the opportunity to meet with the Touch Base Program Coordinator and have created a program of activities and goals for my deafblind ward. This program involves teamwork between the Program Coordinator, myself, the intervener/caregiver and my ward. I understand that I may adjust this program at any time, if I am not satisfied.

Guardian's name: _____

Guardian's signature: _____ Date: _____

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Touch Base IPP

Goal obtained from CM: _____

_____

Touch Base Goal:

- ❑ **FUNCTIONAL LEISURE SKILLS** (highlight/✔ focus below)

↑ *Cognitive Skills*	↑ *Physical Skills*	↑ *Socialization/Emotional Skills*

- ❑ **LEISURE EDUCATION:** To develop and acquire leisure related skills/attitudes, knowledge for the establishment of an appropriate leisure lifestyle.
- ❑ **RECREATION PARTICIPATION:** To demonstrate leisure independence and personal enjoyment through participation in appropriate leisure opportunities.

Touch Base Objectives: (highlight/✔ focus below)

FUNCTIONAL LEISURE SKILLS

Cognitive Skills	*Physical Skills*	*Socialization/Emotional Skills*
↑ Concentration/Attention Span	↑ Strength and Endurance	↑ Social Skill and Interaction
↑ Memory/Orientation	↑ Fine/Gross Motor	↑ Adjustment to disability/illness
↑ Problem Solving Skills	↑ Relaxation Response	↑ Self image, confidence, esteem
↑ Communication Skills	↑ Balance	↑ Self expression (body language, ASL/SEE, verbalization, etc.)
↑ Academic Skills		
other:	other:	other:

LEISURE EDUCATION
to increase or sustain:

Leisure Awareness
Social/Interaction Skills
Leisure Skills/Knowledge
Adapted Equipment
Community Resources
other:

RECREATION PARTICIPATION
to maintain or increase:

Sense of autonomy by choosing his/her level of participation
Motivation and activity level through successful participation
Social Skills
Positive attitudes leading to a healthy leisure lifestyle
other:

Methods

- ❑ Attend _____ days/hours a week/month.
- ❑ Leisure Exploration
- ❑ Structured leisure activities participation (ex: group activities, step by step activities…)
- ❑ Independent leisure activities participation (self directed activities)
- ❑ Community integration/reintegration
- ❑ Utilize calendar system
  - ❑ establish foundation
  - ❑ continue current system
  - ❑ increase complexity
- ❑ Utilize choice boards/boxes
- ❑ Implement other DB techniques
  - ❑ details: _____
- ❑ Other:

Comments: _____

_____

_____

_____

Program Coordinator Signature:_____ Date: _____ Time: _____