R.E.C. CONNECT
[RECREATION • EXPERIENCE • COMMUNITY]
MEMBER PROFILE

Mail applications to:

IKUS Life Enrichment Services/
Indian Trails Camp
O-1859 Lake Michigan Dr NW
Grand Rapids, MI 49534

Or Faxto: 1 (616) 677-2955

Email: maten@ikuslife.org

These programs and services are made possible with funding from the Community Mental Health of Ottawa County Mental Health Millage.

MEMBERINFORMATION & DEMOGRAPHICS

MEMBER'SNAME (LAST) : ______________________ (FIRST): ______________________

ADDRESS: ____

CITY: ____________________ STATE:________ ZIP: __________ COUNTY: ____________________

HOME PHONE: ______________ CELL PHONE: ______________ WHOSE NUMBER IS THIS? __________

EMAIL ADDRESS: ____

BIRTHDATE: _____/_____/_____ AGE: ☐ 18 -26 ☐ 27 -30 ☐ 31 -40 ☐ 41 -50 ☐ 51 -60 ☐ 61 -70+

SEX: ☐ Female ☐ Male ☐ Prefer to Self Describe______________________ ☐ Prefer Not to Answer

PREFERRED DIAGNOSIS: ____

☐ IDD ☐ MI ☐ Dual Diagnosis

ETHNICITY: ☐ Caucasian/White ☐ Black / African American ☐ Asian ☐ Indigenous American ☐ Middle Eastern / North African
☐ Hispanic Latinx ☐ Pacific Islander ☐ Other______________________

MARITAL STATUS: ☐ Single, Not Married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Prefer Not to Answer

EMPLOYMENT STATUS: ☐ Employed Full Time ☐ Employed Part Time ☐ Other:__________

ANNUAL INCOME: ☐ Less than $10,000 ☐ $20,001 -$30,000
☐ $15,001 -$20,000 ☐ $30,001 -$40,000

HOUSING: ☐ Resides in an Adult Foster Care Home ☐ Resides with Family
☐ Resides in Semi - Independent Housing ☐ Other______________________

AFC INFORMATION (IF APPLICABLE) : ____

EMERGENCY CONTACT (NAME): ______________________ (PHONE NUMBER): ______________

RELATIONSHIP TO MEMBER? ____

DOES MEMBERRECEIVE OTHER IKUS SERVICES? ☐ Yes ☐ No IF YES, WHAT? ______________________

MEDICAL CONDITIONS/NEEDS

ARE THERE ANY MEDICAL CONDITIONS/NEEDS THAT WE SHOULD BE AWARE OF? ______________________

____

ARE THERE ANY ALLERGIES OR INTOLERANCES THAT WE SHOULD BE AWARE OF? ______________________

____

PLEASE LIST SPECIFIC MEDICAL INSTRUCTIONS: ______________________________________

____

OTHER HELPFUL INFORMATION: ____

____

HOBBIES/INTERESTS

- ☐ Board/Card Games
- ☐ Cooking
- ☐ Crafts
- ☐ Dancing
- ☐ Fishing
- ☐ Pickleball
- ☐ Music
- ☐ Nature Exploration
- ☐ Playground Time
- ☐ Sensory Activities
- ☐ Singing
- ☐ Sports
- ☐ Swimming
- ☐ Frisbee Golf
- ☐ Other ________________
- ☐ Other ________________

PHOTO RELEASE

I understand that IKUS Life Enrichment Services (IKUS) loves to take pictures of guests enjoying themselves during participation in activities, and that the photos are often used in marketing and promotional materials. IKUS has my permission to use any media of member for purposes of promoting or describing IKUS programs.

If you prefer that photos are not used, please let us know in writing prior to participating in R.E.C. connect.

______________________ ____

DATE MEMBER OR PARENT/LEGAL GUARDIAN

SAFETY NEEDS:

	Never	Rarely (Yearly)	Sometimes (Monthly	Frequently (Weekly)	Daily	Additional Comments
Bad Language						
Food Stealing						
Inappropriate Touch						
Refusing To Move						
Self-Injurious Behavior						
Stealing						
Throwing Things						
Running Away						
Wandering						
Other ________________						

YOU CAN HELP ME BY:

- ☐ Quiet space
- ☐ Offer me water
- ☐ Offer me choices
- ☐ Speak calmly and in a quiet voice
- ☐ Use fewer words
- ☐ Take a break inside
- ☐ Use a picture prompt or schedule
- ☐ Transitioning
- ☐ Provide sensory input (swings, jumping, running)
- ☐ Talk to me about why I'm upset
- ☐ Other ___________________
- ☐ Other ___________________
- ☐ Other ___________________

I COMMUNICATE BEST:

- ☐ Non verbal
- ☐ Verbally
- ☐ Writing notes
- ☐ Using sign language
- ☐ Using gestures/pointing
- ☐ Using simple words
- ☐ Using simple signs
- ☐ Using body language and facial expressions
- ☐ Other ___________________
  ____
  ____

I COULD BECOME UPSET BECAUSE:

- ☐ I am being told "NO"
- ☐ I feel that I am in a "NOT FAIR" situation
- ☐ I am being asked to wait
- ☐ I am afraid
- ☐ I am being asked to take turns
- ☐ I am trying to communicate and I am not being understood
- ☐ There is a change in my schedule
- ☐ I feel someone is "bossing me around"
- ☐ It is loud
- ☐ I am in a crowd
- ☐ I am asked to share
- ☐ I am hungry/thirsty
- ☐ I am homesick
- ☐ Other ____
- ☐ Other ____
- ☐ Other ____

I MAY NEED SOME HELP:

TOILETING

- ☐ Independent
- ☐ Verbal direction
- ☐ Physical assistance
- ☐ Total assistance

MOBILITY-PLEASE CHECK ALL THAT APPLY

- ☐ Ambulatory
- ☐ Ambulatory with assistance
  - ☐ Staff assistance
  - ☐ Cane/Walker
  - ☐ AFO (Type: ___________)
- ☐ Uses wheelchair
  - ☐ Manual
    Can propel self? Y/N
  - ☐ Power

Transfer assistance

- ☐ Independent
- ☐ 1-person pivot
- ☐ 2-person
- ☐ Other ________________

OTHER

Explain ____

FORM COMPLETED BY:

Form completed by: ______________________________________ Signature of member: ______________________________________

NOTE: Individuals needing support are required to have a person accompanying them.
Will member attend independently or accompanied? ☐ Independently ☐ Accompanied

CONSENT TO MEDICAL TREATMENT FORM

MEMBER INFORMATION

First: ____ Last: ________________________________

Address: ____ ________________________________

City: _________________________ County: _______________________ State/Zip: ________________________________

DOB: __________________ Medications: ____

____

Allergies: ____

____

Preferred Hospital or Treatment Center: ____

Other Notes: ____

____

OTHER INFORMATION

Parent(s) ____ Guardian ____

Name: ____ Phone #: ________________________________

Address: ____ City: __________________ State/Zip: ________________

Emergency Contact: ____

Relationship: ____

Phone #: ____ Alt Phone #: ________________________________

I consent IKUS Life Enrichment Services to seek medical attention on my behalf for ____

DOB____________________for emergency/urgent incidents/situations if and when needed.

____
Parent/Guardian (Circle one)

____
Date

____
Witness

____
Date

AUTHORIZATION FOR THE USE/DISCLOSURE/EXCHANGE OF CONFIDENTIAL/PROTECTED INFORMATION

I hereby authorize IKUS Life Enrichment Services to disclose and exchange confidential/protected information regarding ______________________________ in accordance with the terms and provisions of the authorization as described below.

1. Format of the disclosure being authorized: Oral Information: ☒ Yes ☐ No Written Information: ☒ Yes ☐ No

2. Person(s), class of persons, and/or entities whom I have authorized to request, receive and use confidential/protected information:

Yes No :Kent or Ottawa County DHHS
Yes No : Social Security Administration
Yes No : Community Mental Health: Ottawa County
Yes No : Payee: ______________________________
Yes No : Case Manager/Supports Coordinator: ______________
Yes No : School: ______________________________
Yes No : Primary Care Physician: ______________________
Yes No : Specialist: ______________________________
Yes No : Hospital (Medical or Psychiatric): ________________

Yes ☐ No ☐: Family Member: ______________________
Yes ☐ No ☐: Family Member: ______________________
Yes ☐ No ☐: Family Member: ______________________
Yes ☐ No ☐: Family Member: ______________________
Yes ☐ No ☐: Family Member: ______________________
Yes ☐ No ☐: Other: ______________________
Yes ☐ No ☐: Other: ______________________

3. This authorization for disclosure/exchange of information is limited to the extent of information identified below:

Yes No : Clinical Records (excluding psychotherapy notes. Substance abuse history needs separate authorization) Identify what from Clinical Record is being released: PCP, assessments as needed, updates on status and progress, quarterlies and periodic reviews.
Yes No : Medical/Health Records (Separate authorization required for the following serious communicable diseases: HIV, AIDS, ARC, TB and Hepatitis) Identify what from Medical/Health Record is being released: diagnosis, medications, doctor orders, discharge papers, and recommendations
Yes No : Admission/Discharge information
Yes No : Information on current status of *R.E.C. Membership*

Yes ☐ No ☐: School Records
Yes ☐ No ☐: Family Assessment
Yes ☐ No ☐: Publication of Personal Information
Yes ☒ No ☐: Photo Release
Yes ☐ No ☐: Other: ______________________

4. Purpose of Disclosure/Exchange of Information:

Yes No : To provide comprehensive case coordination service
Yes No : To determine need for service
Yes No ☐: To verify benefits/wage information
Yes No : To provide service R.E.C.Connect:

Yes ☐ No ☐: Exploration of possible employment *
Yes ☐ No ☐: Exploration of possible roommate*
Yes ☐ No ☐: Other To provide emergency medical treatment
Yes ☐ No ☐: Employment Services: ______________________

* It is possible that the person may be recognized as a consumer of mental health services as a result of the disclosure of the above information.

5. Personal Statements about this disclosure of confidential/protected information:

- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain services/treatment.
- I understand that I may withdraw my authorization at anytime. I understand also that such withdrawal of authorization may not be effective to prevent disclosure of information previously authorized or to stop previous action that has been taken in reliance on this authorization.
- I understand that, if the person or entity receiving this information is not covered by the Federal Privacy Regulations, such information may no longer be protected from further disclosure (Unless it is also covered by the Substance Abuse Confidentiality Act – 342 CFR Part 2: Further disclosure prohibited).
- My signature means that I have read this form and/or have had it read to me and explained in language I can understand. I know what information will be disclosed and give my voluntary consent to its release.
- All the blank spaces have been filled in except for the spaces reserved for my signature, signature of witness, and dates.
- I understand I have the right to inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- I understand that I have the right to receive a copy of this authorization, containing my signature.

I have been made aware of IKUS's Privacy Practices. The statements included in this authorization are binding on IKUS Life Enrichment Services.
The Effective Date of this Authorization is no longer than one (1) year from the signature date. This authorization will expire once the purpose for this disclosure ceases to exist, but not later than one-year from the original date of signing. If you have questions or need further information please call: 616-677-5251

Signature of Guardian:______________________________ **Date:** ______________

Print Name of Witness	Signature of Witness	Authorizing Dates
Print Name of Witness	Signature of Witness	Authorizing Dates

Note: Photocopy or facsimile of this document shall be as effective as the original.