



## PARTICIPANT APPLICATION

If you or your SSA/SC have any questions or need assistance, please contact us at:  
Danielle at 614-271-8999 or [danielle@dreamshine.org](mailto:danielle@dreamshine.org)

Name: \_\_\_\_\_ Phone# \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Date of Birth: \_\_\_\_\_ Medicaid # \_\_\_\_\_

SSA/SC Name (Case Manager): \_\_\_\_\_

SSA/SC Phone# \_\_\_\_\_ SSA/SC Fax #: \_\_\_\_\_

SSA/SC Email address: \_\_\_\_\_

County and Agency \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone# \_\_\_\_\_

Relation of Emergency Contact: \_\_\_\_\_

Funding Source: (please circle): *IO* *Level 1* *County funding* *Private Pay*  
*Other* \_\_\_\_\_

Living situation: (please circle): *Supported Living* *Family* *Independent*

Are you currently attending a day program or have you in the past? \_\_\_\_\_

**The hours of Dreamshine are 9:30am – 2:45pm Monday-Friday**

Days you plan to attend program: (please circle) *M* *T* *W* *TH* *F*

Date that you are available to begin attending Dreamshine's Adult Day Program: \_\_\_\_\_

### Guardian Information:

Guardian: \_\_\_\_\_

Address: \_\_\_\_\_

Phone# \_\_\_\_\_

Email Address: \_\_\_\_\_

Guardian emergency number (if not able to reach on number listed above): \_\_\_\_\_

**Please sign below to indicate that we may discuss the above named person with the following list of individuals or agencies (list below) in regards to the IEP, Psych Eval, Behavior or other documentation provided:**

**Agency or individual names:** \_\_\_\_\_

**Guardian signature and date** \_\_\_\_\_

Add Guardian email to Dreamshine's mailing list? (circle one) Yes No



## Documentation Needed

We would like to thank you for your interest in Dreamshine at Autumn Lakes, LLC. ☺ In order to ensure we can best meet your needs, we are going to need some information. Please work with your County Board Service Support Administrator and/or your guardian to send us copies of the following information along with the application:

- A copy of your most recent ISP
- A copy of your most recent IEP (if you graduated more than two years ago, this is not needed unless requested).
- Consents/agreements/Policies that must be given to Dreamshine prior to the individuals first day: (If you do not already have these forms, they will be sent to you once the individual is accepted into the Dreamshine program).
  1. Dreamshine Service Agreement
  2. Authorization to Photograph/ Video
  3. Holiday Closings
  4. Hot Tub Consent
  5. Attendance agreement
  6. Participant belongings and money
  7. Dreamshine IPAD, computer, Wii use policy
  8. Dreamshine Weather Related Closings and Delays
  9. Massage Consent
  10. PRN (As Needed) Medication/ Treatment
- Health Form and medical form (part of the application document)
- Most recent Psychological and/or Psychiatric evaluation
- Behavior Support Plan or behavior guideline (if no behavior plan or guideline, please provide a summary of behavioral challenges (if any). Please include a summary of any incidents that resulted in injuries to self or others. Indicate if there is any history with law enforcement.

As the County Board SSA (Case Manager) or Guardian for \_\_\_\_\_  
(Potential Participant)

I hereby verify that to the greatest of my knowledge, no information related to behavioral challenges or incidents has been omitted.

\_\_\_\_\_  
Service Coordinator or Guardian signature

\_\_\_\_\_  
Date



**Dreamshine Health Form**

**Participant Name:** \_\_\_\_\_ **Social Security #:** \_\_\_\_\_  
**Date of Birth:** \_\_\_\_\_ **Medicaid #:** \_\_\_\_\_  
**Home Phone #:** \_\_\_\_\_ **Emergency #:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **City/State/Zip:** \_\_\_\_\_  
**Guardian Name:** \_\_\_\_\_ **Guardian #:** \_\_\_\_\_  
**Guardian email** \_\_\_\_\_  
**Emergency Contact Name and #:** \_\_\_\_\_

**Does participant have any food restrictions?** Yes \_\_\_\_\_ No \_\_\_\_\_ **Initial** \_\_\_\_\_  
**Please specify:** \_\_\_\_\_  
**May staff apply sunscreen and bugspray?** Yes \_\_\_\_\_ No \_\_\_\_\_ **Initial** \_\_\_\_\_  
**May staff apply first aid cream?** Yes \_\_\_\_\_ No \_\_\_\_\_ **Initial** \_\_\_\_\_  
**Does participant have any allergies?** Yes \_\_\_\_\_ No \_\_\_\_\_  
**Please specify:** \_\_\_\_\_

\*A Dr's order will be needed in order for PRN medications to be taken at Dreamshine, this includes sunscreen, first aid cream and bugspray.

**Additional comments to any of the above:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Any concerns or physical limitations the participant might have in participating in recreational activities:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please fill out the table below with all medications the individual regularly takes – attach additional sheets/documentation if needed. PLEASE INCLUDE PRN/AS NEEDED MEDS SUCH AS PAIN RELIEVER.**

| Medications | Dosage and Times | Reason for Medications | Drug Allergies/Signs |
|-------------|------------------|------------------------|----------------------|
|             |                  |                        |                      |
|             |                  |                        |                      |
|             |                  |                        |                      |
|             |                  |                        |                      |

**Will any of the above medications be taking at Dreamshine? Yes \_\_\_\_\_ No \_\_\_\_\_**  
**If Yes, please list which medication(s) will be taken at Dreamshine:**



## EMERGENCY MEDICAL AUTHORIZATION

In the event that reasonable attempts to contact the parent or guardian have been unsuccessful or time is not safely permitted to contact the guardian prior to seeking medical care for the individual: I hereby Give my consent for admission to a hospital or emergency treatment for As deemed necessary by a medical professional.

\_\_\_\_\_  
Participant Name

Doctor's  
name

\_\_\_\_\_ number

Doctor's phone

\_\_\_\_\_

\_\_\_\_\_  
Guardian Signature (if own guardian, please sign)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of person completing form:

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship



**Please return all requested documentation along with this application to:**

Dreamshine  
Attention: Danielle Horne  
3821 Blue Church Road  
Sunbury, Oh 43074  
Fax: 740-936-5038  
[danielle@dreamshine.org](mailto:danielle@dreamshine.org)

**Thank You! We look forward to hearing from you!**