COMMUNITY LIVING Hamilton

# In the Know & On the Go Registration Form

| **Participant Name:** | **Phone:** | **D.O.B:** |
|---|---|---|
| Full Address: | | |
| **Transportation Arrangements:** | | |
| ☐DARTS # (if applicable): | ☐HSR ☐Other: | |

| **Contact Name:** | **Phone:** |
|---|---|
| Full Address (if different from above): | |
| Relationship: | Email: |
| **Billing Name/Address (if different from above):** | |

**In the Know & On the Go Selections:**

| **Activity** | **Start Date** | **End Date** | **Fee** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| I give permission to Community Living Hamilton to take payment from CLH Administered Passport Funding. Yes ☐ No ☐<br>Name: _____<br>Signature:_____ | | Total: | |

**This program is designed for adults 18 years of age and older who can participate independently with a ratio of 1 staff to 6 participants.**

For any other questions, please contact:
**Suzana Serravalle, Administrative Coordinator**
**Phone: 905-528-0281 x262**
**Please email forms to: directfundingforms@clham.com**
**Or Mail: 191 York Blvd, Hamilton, ON L8R 1Y6**

**Please DO NOT send payment with registration form. Invoice will follow.**

**For office use only.**
Method of payment:
☐ Fee For Service (Direct Billing) ☐ Passport – Agency Services ☐ Other

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| **Communication Information:** |
|---|
| ☐ Verbal ☐ Non-verbal ☐ Gestures/ Sign Language ☐ Communication system |
| **Medical/Behavioural Information:** |
| Does the client have seizures? ☐ Yes ☐ No If yes, please describe: |
| Does the client require behavioural re-direction? ☐ Yes ☐ No<br>If yes, please list strategies that would be helpful: |
| Is there a Behaviour Support Plan in place? ☐ Yes ☐ No If yes please attach |
| We are **unable** to administer medication or support any medical care needs in these supported leisure programs. Are there any other needs you want us to know about (e.g. asthma, hearing, sight)? |
| **Allergy Information:** |
| Do you have life threatening allergies? ☐ Yes ☐ No Do you carry an Epipen? ☐ Yes ☐ No |
| Identify: |
| Any other allergies: |
| **Mobility Information:** |
| Mobility aids? ☐ Wheelchair ☐ Walker ☐ Cane(s) ☐ Staff Guide ☐ N/A |
| Mobility/ transfer support? ☐ Yes ☐ No If yes please describe |
| Support for personal hygiene/ toileting? ☐ Yes ☐ No If yes please explain |
| Assistance with eating and drinking? ☐ Yes ☐ No If yes please explain |
| I give permission to Community Living Hamilton to take my photograph for identifications purposes and for any promotional purpose ☐ Yes ☐ No |

| **Alternate Contact Information: (Reachable During Activity)** | |
|---|---|
| Name:<br>Relationship: | Phone:<br>Work/Mobile #: |
| Name:<br>Relationship: | Phone:<br>Work/Mobile #: |

***At times our programs may be unable to accommodate every registrant.***
***We will contact you directly to discuss any questions or concerns.***

All activities are held based on the number of registrants. Fees support staffing, transportation and other costs. We are not able to provide a refund if registered individuals cannot attend any scheduled In The Know or On The go sessions.