Youth Services | Department of Services for the Blind

LEAP Program Information

LEAP Mt. Vernon 2020

Please complete and return the completed application package by APRIL 1, 2020

Program Dates: Monday, July 27, 2020 – Monday, August 7, 2020

Time: 10:00 am – 3:00 pm

Location: Our meeting point may vary from day to day. A schedule will be sent to participants at the beginning of June.

Application Package contents:

- ❑ Application
- ❑ Parent Interview Form
- ❑ DSB Consent Form
- ❑ Photo Release Form
- ❑ Permission to Transport

Note: The "Consent Form" must be hand signed. Scanned copies are accepted in electronic submissions.

Submission Methods:

Please send all Application documents **by April 1, 2020** to:

By mail
LEAP 2020
Washington State Department of Services for the Blind
ATTN: Janet George
3144 S. Alaska Street

By email janet.george@dsb.wa.gov

Contact information:

If you have questions about completing this application or about the LEAP Program, please contact Janet George at 206-906-5530 or janet.george@dsb.wa.gov.

Youth Services

Department of Services for the Blind

LEAP Application

SECTION 1: Applicant Information

Applicant Name:

Social Security Number (**last four digits only**): xxx-xx-

Birth Date:

Age as of July 1:

Current School Grade:

Home Address, including street, city, state, and zip:

Mailing address, if different than home address:

Applicant's email address:

Applicant's cell phone number:

SECTION 2: Parent / Guardian and Teacher / School Counselor Contact Information

Parent or Guardian 1

Name:

Home Address, including street, city, state, and zip:

Mailing address, if different from home address:

Best contact phone number:

Second phone number:

Email address:

Parent or Guardian 2

Name:

Home Address, including street, city, state, and zip:

Mailing address, if different from home address:

Best contact phone number:

Second phone number:

Email address:

Alternate Emergency Contact

Name:

Relationship to applicant:

Best contact phone number:

Second phone number:

Email address:

Teacher of the Visually Impaired / Orientation and Mobility Specialist

Name of TVI:

Email address:

Best contact phone Number

Name of school:

Name of O&M specialist:

Email address:

Best contact phone Number:

Name of school:

Would you like the final report sent to your TVI/school advocate?

○ Yes ○ No

If yes, don't forget to check this box on the Consent Form, so DSB is authorized to send report and share information with your TVI and/or O&M specialists.

SECTION 3: Visual Impairment and/or Additional Disabilities

You may attach additional pages at the end of the application if you need to provide more information.

Cause of vision loss:

Please select the description of your child's vision:

- ○ Low vision
- ○ Legally blind
- ○ Totally blind

Please select the appropriate description below:

- ○ Light Perception Only
- ○ Waving Fingers at _____ feet (distance)

If you know your child's best corrected visual acuity and visual fields, please indicate below:

Please describe how your child's daily activities are affected by their vision loss.

List and describe any other challenges associated with your child's eye condition (for example, loss of field, light sensitivity, etc.):

SECTION 4: Medical Condition and Special Needs Information

To ensure that your child has the best experience possible please provide full disclosure to the following questions. Lack of disclosure or incomplete information regarding a medical/behavioral/emotional condition could threaten your child's participation in the program. Complete information is vital to a student's ability to fully participate, to their safety, and is essential to our being able to work most effectively with each participant. Non-disclosure could be grounds for termination from the program.

One at a time, list any medical conditions and describe how they affect your daily activities.

Condition number 1:

Condition number 2:

Condition number 3:

Will your child need to take medications during the time they are at LEAP? This can include the need to carry an Epi-Pen in case of emergency, over the counter medication, etc.

○ Yes ○ No

If yes, please complete the following information for **each medication** your child takes and indicate their level of independence in taking it.

Name of medication number one:

Level of independence:

- ○ Independent. No help needed.
- ○ Semi-independent. Some help needed.
- ○ Low or no independence. A lot of help needed/must be administered.

Name of medication number two:

Level of independence:

- ○ Independent. No help needed.
- ○ Semi-independent. Some help needed.
- ○ Low or no independence. A lot of help needed/must be administered.

Please list any allergies student may have:

Food:

Medication:

Other: (e.g., to bees)

Please describe any dietary restrictions student may have:

List any and all behavioral, social, and emotional condition(s) student may have and describe how it impacts their daily activities:

SECTION 5: Special Accommodations

List any special accommodations and or services student will need in order to participate in the program (e.g., wheelchair access, interpreter, etc.):

Parent/Guardian Name (Please print)

Signature

Date:

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LEAP Parent Interview

In order to determine both the level of proficiency and to plan a program that will be most beneficial to your child, we need to have this form completed by you. **Your child's application will not be complete without this form.**

Name of student:

Parent/guardian:

Date:

Format student uses in school (Select any format(s) used)

☐ Braille ☐ Large Print ☐ Regular print ☐ Electronic/audio

If your child uses large print, what size font is preferred?

1. Describe how your child's vision affects their daily activities. For example, participating in household chores, helping in the kitchen, taking out the trash, choosing clothes, matching colors, etc.

2. Is your child sensitive to bright glare? Does s/he see best with high contrast?

3. Describe your child's use low vision tools, for example, monoculars or magnifiers:

4. Describe problems related to speed, fatigue, and accuracy with visual tasks:

5. Does your child travel independently in their neighborhood?

To the store?	○ Yes	○ No
To school?	○ Yes	○ No
Use public transportation?	○ Yes	○ No

6. When traveling, do they use a

Cane?	○ Yes	○ No
Monocular?	○ Yes	○ No

7. Describe your child's personality, for example, shy, quiet, assertive, aggressive, hyperactive, etc.

8. Does your child get along well with

Peers?	○ Yes	○ No
Adults?	○ Yes	○ No

9. During LEAP we will be walking up to ¾ of a mile daily and using public transportation whenever possible.

   Is your child able to walk ¾ of a mile daily? ○ Yes ○ No

10. Describe your child's leisure/recreational activities.

11. Does your child exhibit appropriate social behavior when out in public?

12. Does your child advocate for their needs?

Daily Living Skills Assessment

Completing this section gives us an understanding of the self-care areas in which your child is proficient and the areas in which they may need additional assistance. Your child's level of independence in these skills is not a determining factor for their acceptance to the program. Good descriptions help us better understand their skills.

SKILL	LEVEL OF INDEPENDENCE		
Plans Menu	○ Independent	○ Semi-independent	○ Not independent
Creates shopping list	○ Independent	○ Semi-independent	○ Not independent
Solicits assistance while shopping	○ Independent	○ Semi-independent	○ Not independent
Uses stove	○ Independent	○ Semi-independent	○ Not independent
Uses oven	○ Independent	○ Semi-independent	○ Not independent
Uses microwave	○ Independent	○ Semi-independent	○ Not independent
Prepares nutritious snacks & meals	○ Independent	○ Semi-independent	○ Not independent
Cuts, chops, peels	○ Independent	○ Semi-independent	○ Not independent
Washes dishes by hand	○ Independent	○ Semi-independent	○ Not independent
Cleans toilet, sink, & counters	○ Independent	○ Semi-independent	○ Not independent
Sweeps	○ Independent	○ Semi-independent	○ Not independent
Mops	○ Independent	○ Semi-independent	○ Not independent
Vacuums	○ Independent	○ Semi-independent	○ Not independent
Attentive, respectful in meetings and classes	○ Independent	○ Semi-independent	○ Not independent
Able to take care of toileting & hygiene needs	○ Independent	○ Semi-independent	○ Not independent

Additional comments (attach additional pages if needed)

Name (Please print)

Signature Date:

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Department of Services for the Blind

Permission to Seek/Share Information

NOTICE TO CLIENTS: The Department of Services for the Blind (DSB) can help you better if we are able to work with other agencies and professionals that know you and your family. By signing this form, you are giving permission for DSB and the agencies and individuals listed below to use and share confidential information about you. DSB cannot refuse you benefits if you do not sign this form unless your consent is needed to determine your eligibility. If you do not sign this form, DSB may still share information about you to the extent allowed by law. If you have questions about how DSB shares client confidential information or your privacy rights, please consult the DSB Notice of Privacy Practices or ask the person giving you this form.

CLIENT IDENTIFICATION

NAME	DATE OF BIRTH	LAST 4 DIGIT OF SS OR ID NUMBER

ADDRESS:

TELEPHONE NUMBER (INCLUDING AREA CODE):	FORMER NAMES(S) USED:

CONSENT:
I consent to the use of confidential information about me within DSB to plan, provide, and coordinate services, treatment, payments, or for other purposes authorized by law. I further grant permission to DSB and the below listed agencies, providers, or persons to use my confidential information and disclose it to each other for these purposes. Information may be shared verbally or by computer data transfer, mail, or hand delivery. **Please check all below who are included in this consent in addition to DSB and identify them by name and address:**

- ☐ Mental Health Care Providers:
- ☒ DSB: Youth Services staff
- ☐ Vocational Evaluation Information:
- ☐ Housing Programs:
- ☐ Department of Corrections:
- ☐ Health Care Providers:
- ☐ Social Security Administration or federal agency:
- ☐ Community Rehabilitation Providers:
- ☐ DSHS/DVR:

☒ School Districts or Colleges:

☒ Teacher of the Visually Impaired and/or O&M Instructor:

Other:

I authorize and consent to sharing the following records and information (check all that apply):

☐ All my client records

☐ Records on attached list

☐ Only the following records:

- ☒ Family, social and employment history
- ☒ Health Care information
- ☐ Individual Assessments
- ☐ Payment records
- ☐ Treatment or care plans
- ☒ School, education, and training

PLEASE NOTE: **If your client records include any of the following information, you must also complete this section to Include these records.** I give my permission to disclose the following records (check all that apply): ☐ Mental health
☐ HIV/AIDS and STD test results, diagnosis, or treatment (RCW
☐ 70.24.105) Chemical Dependency (CD) services (42CFR2.32)

This consent is valid until December 31, 2020. I may revoke or withdraw this consent at any time in writing, but that will not affect any information already shared. I understand that once the health information I authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose, at which time it may no longer be protected under privacy laws. A copy of this form is valid to give my permission to share records.

SIGNATURE	DATE	AGENCY CONTACT/WITNESS SIGNATURE	DATE
PARENT OR OTHER REPRESENTATIVE'S SIGNATURE (IF APPLICABLE)		PHONE NUMBER (INCLUDE AREA CODE)	DATE

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Consent for Use of Image, Information, and Persona

I hereby grant to Department of Services for the Blind (DSB) the right to publish, broadcast, webcast, or disseminate the Image, Information, and Persona of the individual listed below in any other form or medium any or all of the following:

- Stories and/or information about myself (or the minor of whom I am legal guardian) for use in news stories, publications, promotional materials, web features and/or any other agency purposes.
- Photographs, video, audio, and other images or likenesses of myself (or the minor of whom I am legal guardian) for use in news stories, publications, promotional materials, web features and/or any other agency purposes.
- All photographs, video, audio, images, likenesses, stories, and other materials will remain the property of DSB.

Participant Name (please print) _____

I have read and understood this agreement and I am *over the age of 18*. This Agreement expresses the complete understanding of the parties.

Signature _____ Date: _____

Witness Name (Please print) _____

Signature _____ Date: _____

Parent/Guardian Consent for individuals under age 18

In addition to the uses above, please note that, on occasion, media outlets – such as television, radio, newspaper, magazine, and online media outlets – send reporters and photographers to interview participants and take photos. DSB cannot control the final article or its distribution. We want to make sure you are aware of this visit and to know your feelings on your child's participation. If you do not want your child included in this activity, we will not allow the reporter to interact with them.

- Allow participant to be interviewed by media ○ YES ○ NO
- Allow participant to be photographed by media ○ YES ○ NO

I am the parent or guardian of the minor named above. I have the legal right to consent to and do consent to the terms and conditions of this model release.

Parent/Guardian Name (Please print) _____

Signature _____ Date: _____

Witness Name (Please print) _____

Signature _____ Date: _____

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Permission to Transport Student

As a parent/legal guardian for student named above, I give my permission to employees of Washington State Department of Services for the Blind (DSB) to transport my child/youth to DSB-sponsored workshops, programs, and activities.

I understand the following modes of transportation may be used:

- State-owned vehicles and that the DSB employee/driver has completed a background check and possesses a valid driver's license and good driving record.
- Municipal Mass Transportation including but not limited to buses, light rail systems, trolleys, etc.
- Licensed Taxi/Limousine services. DSB will not use ride-hailing services to transport students.
- Walking distances up to 1 mile.

Dates valid: **July 27, 2020 - August 7, 2020**

Parent/Guardian Name (Please print)

Signature Date: