

West Allis-West Milwaukee Recreation Department

2450 S 68th St
West Allis, WI 53219
(414) 604-4900 Fax: (414) 256-6322



COMMUNITY-BASED TRANSITION PROGRAM APPLICATION FORM 2020-2021

IMPORTANT INFORMATION

Forms must be fully completed and turned in two business days before the participant can attend the program. If the participant shows up without previously turning in the paperwork a parent guardian will be contacted and the participant may be asked to leave. This also goes for all returning participants. If you are a NEW participant you are required to briefly meet with Tamra Kaczmarowski, Program Coordinator cbtp@wawmsd.org and/or Dan Steenrod, Program Manager 414-604-4951 or steenrodd@wawmsd.org. This is for the safety and well-being of your participant. Paperwork can be turned in at the Recreation Department, 2450 S 68th St, West Allis, WI 53219.

SELF-CARE

All participants must be able to provide self-care including but not limited to toileting/bathroom needs and taking medication. CBTP staff is not authorized to provide these services but can provide reminders to participants to take medication and provide verbal self-care instructions. If the participant cannot provide self-care independently, participant/guardian will need to assist them or make arrangements for a service provider to assist them. Any medication (prescription or over the counter) brought to the program must be in the original container/packaging it was provided in and contain proper dosage directions.

ATTENDANCE

What days will the applicant be attending the program? Check all that apply.

- Monday Tuesday Wednesday
- Thursday (Bowling) Friday

APPLICANT INFO

Name _____ Birthdate ____ / ____ / ____

Address _____ City _____ Zip _____

Phone Home _____ Cell _____

E-mail address _____

PARENT/GUARDIAN INFO

Name _____ Relationship _____

Address (if different from Applicant) _____

Phone Home _____ Cell _____ Work _____

Email address _____

AGENCY/CASE MANAGER INFOMUST PROVIDE PROPER AGREEMENT FORMS****

Name _____ Contact person _____

Address _____

Phone Work _____ Cell _____

Email _____

Program Revenue Code: (REQUIRED INFO): _____

Date Received: _____

PERSONAL HAPPINESS

1. Who/what are the people/things that are most important to the applicant?

Please explain: _____

2. When is he/she most happy?

Please explain: _____

3. When is the applicant most uncomfortable/unhappy?

Please explain: _____

MOBILITY INFORMATION

1. Does applicant use a wheelchair? • yes • no • manual • electric
3. Does applicant need help transferring? • yes • no
Please explain: _____
4. Does the applicant use other assistive devices used for ambulation such as a walker? • yes • no
Please explain: _____

PERSONAL CARE

1. Does applicant need assistance in the bathroom? • yes • no
Please explain: _____
2. Does applicant require diapers? • yes • no
3. Does applicant have bladder/bowel control? • yes • no
Please explain: _____
4. Does applicant need menstrual assistance? • yes • no
Please explain: _____
5. Are scheduled bathroom times needed? • yes • no
Please explain: _____
6. Can the applicant undress and dress himself/herself independently? • yes • no
Please explain: _____

ASSISTIVE DEVICES

Please check: • glasses • hearing aid • other: _____
Please explain: _____

COMMUNICATION

Please check which forms of communication the applicant uses:

• verbal language • sounds • gestures • sign language
• communication board • other: _____

DIETARY NEEDS

1. Does applicant have a special diet or food restrictions/allergies? • yes • no
Please explain: _____

2. Can applicant feed himself/herself independently? • yes • no
Please explain: _____
3. Does applicant need straw, bib, adaptive spoons, feeding tube, etc.? • yes • no
Please explain: _____

HEALTH

1. Please list any medication the applicant takes: _____

2. Please indicate any dressings the applicant requires: _____

3. Has applicant had an operation or serious injury within the last year? • yes • no
If yes, specify: _____
4. Please list any medication allergies: _____
5. Does the applicant suffer from seizures? • yes • no
Date of last seizure? _____
How would you like staff to handle if a seizure were to occur? _____

6. Please indicate any other medical needs: _____

SAFETY

1. Is applicant willing to stay with the group? • yes • no
Please explain: _____
2. Can the applicant recognize his/her own belongings? • yes • no
Please explain: _____
3. Can the applicant recognize danger? • yes • no
Please explain: _____
4. Will the applicant wander or run? • yes • no
Please explain: _____
5. Does the applicant interact with others safely? • yes • no
Please explain: _____
6. Is applicant prone to engage in conversation with strangers? • yes • no

BEHAVIOR/PERSONALITY

1. Does the applicant have any phobias/fears, i.e., fear of dogs, heights, confinement, etc.?
• yes • no Please explain: _____
2. Are there any settings or activities that may cause behavior difficulties, i.e. loud surroundings, flashing lights, etc.? • yes • no
Please explain: _____
3. Please describe the best way to introduce or explain new tasks or transitions: _____

4. Please indicate what types of things frustrate or anger the applicant: _____

5. Please indicate the best way to redirect or engage the applicant's attention: _____

6. Is the applicant using a specific plan for behavior? • yes • no

Please explain: _____

*If a formal plan is in place, please include a copy.

8. What type of behavior management or reinforcement works best? _____

9. What type of additional assistance do you think the applicant might require to participate successfully in a day program setting? _____

ACTIVITIES

1. What activities does the applicant enjoy?

Please explain: _____

2. What activities should be restricted?

Please explain: _____

EDUCATIONAL EXPERIENCE

High School Attended _____ City _____

Vocational training agencies worked with _____

Has the applicant attended any other recreation or day programs? Please list _____

Employment (Please include volunteer work): _____

TRANSPORTATION

Transportation is not provided by the Recreation Department for the program. How will the applicant get to and from program activities? _____

If participant receives transportation please list company name and phone number.

FAMILY INVOLVEMENT

This program is family and community oriented. You are welcome to visit the program at any time and are encouraged to attend special events and lunches. Volunteers are needed, especially on community outings.

Volunteers are subject to a background check. If you are willing to volunteer for activities with the applicant please contact Monica Veitch, Program Coordinator or Kyle Holbach, Program Manager.

IMPORTANT NOTES

Individuals in the Recreation Department Community Based Transition Program must be able to participate within the parameters of the program, which include but are not limited to transitioning from activity to activity, participate in group settings and utilize appropriate social skills in a community setting. Any applicant who becomes a danger to himself or others, or becomes unmanageable in the group setting of this program, will be asked to discontinue attendance either temporarily or permanently. The Recreation Department and the volunteers are not responsible for accidents that may occur to any of the applicants in this program. You will be notified whether or not your application is accepted.

Signature of Applicant

Signature of Parent/Guardian

Date

Signature of Person Completing Application

Date