FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

GATEWAY REGION YMCA
CHILD CARE & DAY CAMP
INCLUSION/ADAPTIVE SUPPORT SERVICES
INITIAL PARTICIPANT INCLUSION INFORMATION

Thank you for your interest in the Gateway Region YMCA!

You are receiving this packet as you indicated when registering for the program that your child has an IEP, 504 Student Accommodation Plan, Behavior Intervention Plan, or other support document. Collecting the following information is a requirement for YMCA and State Licensing Guidelines.

Process for Inclusion/Adaptive Support:

1. Complete and sign all documents in the **Initial Participant Inclusion Packet**
2. Submit all **current** IEP, 504, BIP, etc.
3. Return all applicable forms/ documents to your local **Y branch** location
4. Y branch will check to ensure all items completed, then forward packet to the Inclusion/Adaptive Support Services Department for review
5. Inclusion/Adaptive Support Services Department reviews documents and provides recommendations to Y branch
6. Y branch will contact you to confirm the status of your child's registration in the program

Important Information:

- All registrations are processed in the order they are received at the branch, then by the Inclusion/Adaptive Support Services Department.
    - Failure to complete and/or return any documents may delay your registration process.
- Allow a **minimum** of two weeks to process paperwork before attending the program, especially during peak times.
- Your child's start date is dependent upon the individual branch staffing situation regardless of their level of support needs.
- Information will be kept appropriately secured according to HIPAA guidelines
- Additional information may be requested

The Gateway Region YMCA will be available to individuals without regard to race, color, religion, national origin, sex, disability, age, military or veteran status, sexual orientation, gender identity, or any other factor prohibited by law. Our goal is to create an avenue for meaningful inclusion opportunities for all community members throughout our programs. Although every effort is made to provide reasonable accommodations, there may be instances where a child's needs may exceed the parameters of the scope of our recreational, non-therapeutic program.

Thank you again for choosing the YMCA! If you need further assistance, please contact your local Y branch or the Inclusion/Adaptive Support Services department by phone at 314-436-1177 or by email at inclusionservices@gwrymca.org.

Sincerely,

Meredith Nero
Senior Program Director of Adaptive Support for
Youth and Family Programs

Required Documentation

- ☐ Full IEP, Section 504 Student Accommodation Plan and/or Behavior Management Plan or other support documents from school
- ☐ Information Release Form
- ☐ Medical Verification Form
  - We are required to have a medical verification form on file if your child has a medical diagnosis.
  - If your child's diagnosis is educational only, check the box on form and return.
- ☐ Regional Center/Department of Mental Health (DMH) Verification Form
  - We are required to have your child's DMH number.
  - If your child is not part of DMH, check the box on form and return.

The Inclusion Services Department of the Gateway Region YMCA is generously supported through grant funding. For more information on our funders please visit: Productive Living Board at plboard.org, St. Charles Developmental Disabilities Resource Board at ddrb.org. Thank you to our funders for helping to support the Inclusion Services Department.

For more information on the Department of Mental Health please visit dmh.mo.gov. For more information on HIPAA please visit hhs.gov.

First Name:		**Last Name:**	
Social Security Number:		**DMH Number:**	
Program:	☐**YClub** ☐**Camp** ☐**ECEC**	**Year:**	
Diagnosis:		**County of Residence:**	

Any other information that may not be included in the paperwork provided?

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INCLUSION/ADAPTIVE SUPPORT SERVICES
INFORMATION RELEASE FORM

Child's Name: _____

Birth Date: _____

Address: _____

Social Security # (required): _____

I hereby give my permission to the Gateway Region YMCA, Inclusion Services, to obtain/release information to/from the following if applicable:

1. Regional Center/Department of Mental Health (DMH), if applicable
2. Your child's appropriate school personnel
3. Division of Family Services (DFS), Division of Children & Family Services (DCFS)
4. Funding sources, as required (Local SB40 Boards)
5. Appropriate YMCA staff
6. Your child's physician/relevant medical personnel
7. All relevant Case Managers

Please complete addresses and phone numbers of the school, case managers, social workers and therapists/physicians to enable us to obtain this information in a timely manner.

DMH and/or other Case Managers:
_____

DFS Social Worker:
_____

Classroom Teacher:
_____

Therapists/Physicians:
_____

A copy of this release shall be as valid as the original. This release of information will expire when child no longer receives services or one (1) year from the date this release is signed, whichever occurs earlier.

Parent/Guardian Name Printed: _____ Date:_____

Parent/Guardian Signature: _____

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INCLUSION/ADAPTIVE SUPPORT SERVICES
MEDICAL VERIFICATION FORM

☐ Check here if your child has an **educational only** diagnosis.

Dear Dr. _____:

_____ is enrolling in one of our YMCA programs.
(Participant's name)

To ensure successful participation and to meet grant-funder/YMCA guidelines the following document must be completed in full:

Birth date: _____

Social Security Number (**required**): _____

<u>The following section is to be completed by a licensed physician:</u>

Diagnosis:
_____

Adaptations/Concerns:
_____
_____
_____

Please check the areas the above named child struggles with on a daily basis:

- ☐ Capacity for Independent Living
- ☐ Receptive and Expressive Language
- ☐ Learning
- ☐ Self-Care
- ☐ Mobility
- ☐ Self-Direction or Economic Self-Sufficiency

Doctor's Name Printed: _____

Doctor's Address: _____

Doctor's Phone Number: _____

Doctor's Signature:_____ Date: _____

Thank you for your help!

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GATEWAY REGION YMCA
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INCLUSION/ADAPTIVE SUPPORT SERVICES
DEPARTMENT OF MENTAL HEALTH VERIFICATION FORM

☐ Check here if your child is **not** part of the Department of Mental Health/ Regional Center.

Dear Case Manager:
_____ is enrolling in one of our YMCA programs.
(Participant's name)

To ensure successful participation and to meet grant-funder/YMCA guidelines the following document must be completed in full:

Birth date: _____

Social Security Number (**required**): _____

The following section is to be completed by the Regional Center Case Manager:

Diagnosis:
_____

Adaptations/Concerns:
_____
_____
_____

Please check the areas the above named child struggles with on a daily basis:

- ☐ Capacity for Independent Living
- ☐ Receptive and Expressive Language
- ☐ Learning
- ☐ Self-Care
- ☐ Mobility
- ☐ Self-Direction or Economic Self-Sufficiency

Child's Regional Center ID Number: _____

Please include one of the following documents as required by our funders:

- ◯ CIMOR diagnosis access list
- ◯ Letter of Eligibility Determination
- ◯ DMH Client Profile Form

Case Manager's Name Printed:_____ Date:_____

Case Manager's Signature: _____ Work #: _____

Thank you for your help!