Welcome

Joe's Club!

We look forward to having you join the party!

Please note: All pages must be completed, and signed by the POA (if applicable)

Please also include the following (if applicable)

☐ Do Not Resuscitate (DNR) Form

☐ Power of Attorney (POA) or other legal paperwork

If you have any questions, don't hesistate to call: 321-253-4430

JOE'S CLUB
Adult Day Health Care
Supported By Alzheimer's Foundation Brevard

ADMISSION AGREEMENT

Club member's Name: _____

I, _____ and Brevard Alzheimer's Foundation Inc.'s (BAFI) representative, agree to the following terms and conditions for the admission of the above named member to JOE'S CLUB.

I agree to complete all required forms prior to the admission of the above named Club Member. I agree that my doctor will certify that the club member is free of communicable tuberculosis and other communicable diseases on the physician's order form prior to admission.

I acknowledge that BAFI has the right to discharge the Club Member should they no longer meet the Club's criteria as outlined in the Discharge Criteria Form.

RATES AND FEES

Daily Rate	Half Day Rate	Showers	Transportation	Late Pick-up Fees
$65	$47	$20 each	$10 each way	$25
Int._____	Int. _____	Int. _____	Int. _____	Int. _____

Monthly billing will be billed through invoice or the secured electronic payment method chosen by financially responsible party on the 1st of each month. If payment is not received by the 30th of each month, the account will be placed on hold. Checks returned for insufficient funds will be charged a $35.00 service fee. Late pick up fees will be charged after 5:35 p.m. If you are going to be late please call and notify BAFI staff as soon as possible. Melbourne / Titusville: Hours of operation are Monday-Friday 7:15 am to 5:30 pm. Micco: Hours of operation are Monday-Friday 8:30 am to 4:30 pm. Half day rate is for up to 4 hours. There is a grace period of 22 minutes. After this, full day rate applies.

Rates are subject to change upon a 30-day written notice to the responsible party.
Any hospitalization or leave of absence from Joe's Club in excess of forty-five days requires a re-evaluation process and new physician orders.

I will not hold BAFI or any related or supporting organization responsible for any injury arising out of my negligence or omission, during the course of the program.

All services, benefits and facilities are provided without regard to race, color, national origin, sex, age, religion or disability.

Revised 08/16/2021

JOE'S CLUB
Adult Day Health Care
Supported Alzheimer's Foundation Brevard

Joe's Club Video Camera Announcement

The Policy

To ensure the safety and security of all client, staff, caregivers, and visitors, as well as the security of our facility, Joe's Club is equipped with a video surveillance system. Security cameras are installed in all dayrooms. Video/security cameras will be positioned in appropriate places within and around our facility and used in order to help promote the safety and security of clients, staff and our center.

Because we respect the privacy of all clients, caregivers, and staff in our facility, our video surveillance system/security cameras are for **internal purposes only**.

Joe's Club pledges to keep all information about your family confidential. This means we will not release any information or video unless we are required to under state law or the legal guardian/caregiver gives us written permission to do so. State law mandates that we release certain information when requested by licensing, law enforcement agencies, adult protection agencies, or government health officials. If at any time it is necessary for caregivers to review video of their loved one, they will only be permitted to view pertinent video of their loved one in the center including dayrooms where other clients may be present and video surveillance/recording consent forms are signed prior from each caregiver whose loved one is present in that video.

_____ _____

Responsible Party's Name (Please print) Member's Name (Please print)

_____ _____

Signature Date

JOE'S CLUB
Adult Day Health Care
Supported By Alzheimer's Foundation Brevard

4676 N Wickham Road
Melbourne, FL 32935
(321)253-4430

Secure Payment Authorization Form

Schedule your payment to be automatically charged to your Checking Account (ACH), Visa, MasterCard or Discover Card. Just complete and sign this form to get started!

Secure Payments Will Make Your Life Easier:

- It's convenient (saving you time and postage)
- Your payment is always on time (even if you're out of town), eliminating late charges

Here's How Secure Payments Work:
You authorize regularly scheduled charges to your or credit card or checking account. You will be charged the first of the month for the previous month's services. A receipt for each payment will be mailed / emailed to you and the charge will appear on your statement as an "Brevard Alzheimer's Foundation" You agree that no prior-notification will be provided.

Please complete the information below:

☐ Credit Card on file **or** ☐ Voided Check on file Client Name: _____

I _____ authorize Brevard Alzheimer's to charge my secure method
(full name)

indicated below monthly for appropriate daycare attendance and related fees.

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

Please fill our below Credit Card information or staple a voided check

☐ Visa ☐ MasterCard ☐ Discover ☐ Amer. Express

Cardholder Name _____

Account Number _____

Exp. Date _____

CVV _____

SIGNATURE _____ DATE _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Brevard Alzheimer's Foundation in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. In the case of an CC Transaction being rejected I understand that Brevard Alzheimer's Foundation may at its discretion attempt to process the charge again within 30 days. I certify that I am an authorized user of this credit card and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form.

The Privacy Act of 1974, 5 USC 552a, provides protection to individuals by ensuring that personal information collected is limited to that which is legally authorized and necessary and is maintained in a manner which precludes unwarranted intrusions upon individual privacy.

The financial agreement is as follows:

_____
_____
_____

I have received a copy of the Notice of Privacy Practices (the "Notice"). The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. In addition, I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling (321) 253-4430, or by requesting one at:

Brevard Alzheimer Foundation's Administrative Office
4676 North Wickham Road
Melbourne, FL 32935

The undersigned has acknowledged that he/she has received the Family Resource Handbook, which includes the following documents: Code of Ethics, Grievance Procedures and Discharge Criteria.

This agreement may be terminated by the request of the responsible party or in writing by the BAFI representative. Fifteen days notice must be given by BAFI except in cases of emergency.

Name of Caregiver/Responsible Party: _____

_____ _____
Signature: Caregiver/Responsible Party Signature: BAFI REPRESENTATIVE

_____ _____
Date Date

_____ _____
Date of Termination Requested By

Reason: _____
_____
_____
_____

Billing Information: <u>All Spaces MUST be filled out</u>

Responsible Party: _____ Relationship: _____

Address: _____ City: _____ State: _____Zip: _____

Phone Day: (_____)_____Work: (_____)_____Cell: (_____)_____

Email: _____

Revised 04/29/2021

JOE'S CLUB
Adult Day Health Care
Supported By Alzheimer's Foundation Broward

MEDICATION AUTHORIZATON FORM

I, _____ caregiver of _____
(Club Member's Name) do hereby authorize Joe's Club nursing staff to administer the following medication:

Member Name:_____

Name of Medication:_____

Dosage:_____

Purpose:_____

Route:_____

Time of Day:_____

Duration Prescribed (if applicable):_____

_____ I acknowledge and understand that the first dose of a newly prescribed medication must be administered at home.

_____ I acknowledge that all medication must be brought in original bottle that has clearly printed label.

_____ I acknowledge that I must supply any needed OTC medications that are within date.

_____ I acknowledge that Joe's Club Nurse must follow specific dosing/dispensing directions on packaging.

_____ I acknowledge that member may not keep medication on person.

_____ I acknowledge that BAFI transportation staff cannot transport medications to/from the club. It is the responsibility of the caregiver.

_____ _____

Responsible Party's Name Signature & Date

Joe's Club Nurse & Date

JOE'S CLUB
Adult Day Health Care
Supported By Alzheimer's Foundation Brevard

Club Member Social History Assessment

Full Name: _____

Raised in what area/state: _____

If college graduate, which school/university: _____

Military service: Yes No Which branch: Army Navy Coast guard Air force Marine corp

Primary language: _____ Other languages spoken: _____

Religious preference: _____

Previous occupations: _____

Family Information

Spouse name: _____

How long married: _____ If deceased, when? _____

Children's names: (please include nicknames, ages, special relationships to club member)

_____

_____

_____

Pets (please include a photo if possible): _____

Hobbies, activities, sports, gifts, talents:

Past Present

_____

_____

_____

List five of the club member's favorite places to go (both past and present):

Past Present

1. _____
2. _____
3. _____
4. _____
5. _____

List any group affiliations/memberships (past and present):

Past Present

_____
_____
_____
_____

Significant achievements (prizes, awards):

_____
_____
_____
_____

Additional information:

_____
_____
_____
_____

Name of Responsible Party:_____

Signature: _____Date: _____

BAFI: _____Date: _____

Revised 04/29/2021

PREFERENCES

To provide a great experience with high quality activities, please let us know if _____ _____ **(CLUB MEMBER NAME)** likes or dislikes any of the following items, activities, or events. The more detail the better. Be sure to include past and current preferences.

E X A M P L E

SPORTS?	**YES NO**
What type(s)? *(Circle all that are preferred)*	Baseball Basketball Biking Billiards Bowling Croquet Dance Fishing Football Golf Hockey Hunting Racing Run/Walk Snow Sports Soccer Swimming Tennis Volleyball
Specific likes/dislikes:	He loves the Miami Dolphins and used to golf every Sunday. He does not like tennis!

SPORTS?	**YES NO**
What type? *(Circle all that are preferred)*	Baseball Basketball Biking Billiards Bowling Croquet Dance Fishing Football Golf Hockey Hunting Racing Run/Walk Snow Sports Soccer Swimming Tennis Volleyball
Specific likes/dislikes:	

READING?	**YES NO**
What type? *(Circle all that are preferred)*	Books Magazines Cookbooks Poems
Specific likes/dislikes:	

WATCHING?	**YES NO**
What type? *(Circle all that are preferred)*	Movies TV shows News Sports
Specific likes/dislikes:	

MUSIC?	**YES NO**
What type? *(Circle all that are preferred)*	Alternative Blues Christian Classical Country Folk Gospel Holiday Jazz Latin Opera Pop R&B Rock Showtunes Sing-A-Longs
Specific likes/dislikes:	

ARTS & CRAFTS?	**YES NO**
If yes, what type? *(Circle all that are preferred)*	Beads Crochet Drawing Flower Arrangement Jewelry Knitting Paint Photography Pottery Scrapbooking Sewing Watercolors
Specific likes/dislikes:	

GAMES?	YES NO
If yes, what type? *(Circle all that are preferred)*	Bingo Board Cards Casino Checkers Chess Crosswords Dominoes Puzzles Scrabble Shuffleboard Trivia Word Search
Specific likes/dislikes:	

ANIMALS?	YES NO
If yes, what type? *(Circle all that are preferred)*	Bird Cat Dog Farm Fish Horse Insects Rabbit Reptiles Zoo
Specific likes/dislikes:	

FOOD/DRINKS?	YES NO
If yes, what type? *(Circle all that are preferred)*	Beef Beer Candy Chicken Coffee Cookies Fish Fruit Ice Cream Milk Pastries Pork Nuts Rolls Soda Tea Vegetables Water Wine
Specific likes/dislikes:	

AROUND THE HOUSE?	YES NO
If yes, what type? *(Circle all that are preferred)*	Baking Cooking Coupons Dishes Dusting Feeding pets Gardening Laundry Making bed Roll silverware Sweep/Vacuum
Specific likes/dislikes:	

GROOMING?	YES NO
If yes, what type? *(Circle all that are preferred)*	Face Feet Hair Nails
Specific likes/dislikes:	

OTHER? (Smells, Praise, Photo albums, Babies, Children, Foreign languages, etc.)	
LIKES?	DISLIKES?

TOP PREFERRED ITEMS	
1.	
2.	
3.	

JOE'S CLUB
Adult Day Health Care
Supported By Alzheimer's Foundation Brevard

CONSENT FORM FOR MEMBER

_____
Name of Member

TREATMENT

I do hereby authorize and consent to medical treatment to include first aid provided by the nursing staff of Joe's Club for minor injuries and for the Administration of prescribed medications for above named member, the Club Member taking part in Joe's Club's Adult Day Center Program.

EMERGENCY TREATMENT/TRANSPORTATION

I do hereby authorize emergency treatment at, and transportation to, the nearest hospital in the event a family member or responsible party cannot be contacted, while the Club Member named above is taking part at Joe's Adult Day Center Program.

Hospital of Choice, although not guaranteed, is: _____

PHOTO RELEASE

I hereby authorize Joe's Club at Brevard Alzheimer's Foundation Inc. to use:

photographs , video and audio recordings

of the above mentioned individual; to be used for identification purposes, promotional material, and website content. I hereby release any and all claims against the Foundation. I understand that I may revoke this consent at any time with a written request.

Name of Responsible Party: _____

Signature: _____ Date: _____

BAFI: _____ Date: _____

Revised 04/29/2021

JOE'S CLUB
Adult Day Health Care
Supported By Alzheimer's Foundation Brevard

Brevard Alzheimer's Foundation, Inc.
Do Not Resuscitate Order

ORGANIZATIONAL POLICY AND PROCEDURE

It is the policy of the Brevard Alzheimer's Foundation, Inc. (BAFI) not to accept "Do Not Resuscitate Orders" for participants attending any of the three Clubs.

If, in the opinion of the trained BAFI staff, a medical emergency occurs involving a participant while in attendance at Joe's Club, the staff will perform the following functions:

1. 911 Emergency will be called immediately; (if a participant is a Hospice patient and a Hospice nurse is on the premises, Hospice will be directed to handle the situation).
2. Trained BAFI staff will administer basic CPR and first Aid, if necessary, and everything possible will be done to comfort the participant;
3. The primary caregiver of record will be contacted; and
4. Documentation of the incident will be included in the participant chart

The foregoing policy and procedure will be followed notwithstanding any directions otherwise.

I have read and fully understand the above policy. I also understand that this form will become a part of my loved one's participant chart.

_____	_____
Responsible Party's Name (Please Print)	Member's Name (Please Print)
_____	_____
Signature	Date

Revised 04/29/2021

JOE'S CLUB
Adult Day Health Care

Supported By Alzheimer's Foundation Brevard

THE ADULT DAY CARE PROGRAM
SUMMARY OF POLICY AND PROCEDURES
FOR CLUB MEMBER CARE

Each Club member is:

1. Allowed to retain the services of his/her personal physician.
2. Assured of services described in the protocol.
3. Offered the opportunity to participate in the planning of his/her care.
4. Assured of remaining free from mental and physical abuse, and free from chemical and physical restraints.
5. Assured of privacy in the terms of his/her medical records.
6. Treated with consideration, respect, and full recognition of his/her dignity, individuality, and the right to privacy.
7. Permitted to participate in the Club activities and to meet with and participate in activities of social, religious, and community groups at his/her discretion.
8. Assured of the opportunity to exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, or any attendance at religious services, is imposed on any Club member. Joe's Club encourages and assists in the exercise of these rights.
9. Not the object of discrimination with respect to participation in activities which include, but are not limited to, recreation, meals, leisure, other social activities because of age, race, religious, sex, or nationality as defined in *Title VI of the Civil Rights Act of 1964,* or *Section 504 of the Rehabilitation Act.*
10. Not deprived of any constitutional civil, and/or legal right solely by reason of admission.
11. Allowed (for the Club member's protection) to discharge him/herself from the Club program upon presentation of a request, in writing; or if the Club member is an adjudicated mentally incompetent, upon the written request of the guardian, next of kin, or "Responsible Party" named at the time of intake; in no case will a Club member be able to discharge him/herself until the Club staff notifies the appropriate person.
12. Allowed to be dismissed or terminated only for a) medical reasons, b) his/her own welfare or that of others, or c) non-payment of fees for services (only after reasonable alternatives have failed, have been given written notification of discharge and are given fifteen (15) days to arrange for alternative services, except in cases of emergency as determined by the governing authority of the Club.
13. To be given reasonable advance notice of any discontinuance of service, except in the case of emergency as determined by the Center Manager or Licensed Nursing Staff or Social Worker and the Executive Director of the Brevard Alzheimer's Foundation, Inc.
14. Informed of his/her rights to report abusive, neglectful, or exploitative practices. The number is: ***1-800-96ABUSE*.**

I, the undersigned, have read and fully understand the above policy.

Responsible Party's name (Please Print)	**Member's Name (Please Print)**
Signature	**Date**

JOE'S CLUB
Adult Day Health Care
Supported By Alzheimer's Foundation Brevard

GRIEVANCE PROCEDURES

For purposes of this policy, a grievance is defined as any dispute between the client (to include both Club Member and Caregiver) and Joe's Club as part of the Brevard Alzheimer's Foundation, Inc. (hereafter referred to as BAFI) involving the interpretation of BAFI's policies and procedures. Any client that is not satisfied with the service provided, feels affirmed, or is facing termination or reduction of services shall discuss the issue with the Center Manager. Any client not satisfied with the results of the discussion may file a written grievance as contained in this policy.

Purpose of Procedure
The purpose of this grievance procedure is to provide each client with the opportunity to review and discuss disputes or differences. The filing of a grievance by a client shall in no way affect the client's status with BAFI.

Action Step One
The aggrieved client must present a grievance in writing to BAFI within ten (10) calendar days after the date of the occurrence. The Center Manager will investigate, report to the Executive Director and the grievance will be addressed in writing to the aggrieved client within ten (10) calendar days after receipt of the grievance. Services may not be reduced or terminated during the ten (10) calendar day period.

Action Step Two
If the client is not satisfied with the written response of the Center Manager/Executive Director, the client may appeal the finding in writing within seven (7) calendar days to the Chairman of the Executive Committee of BAFI. The Chairman will respond in writing to the aggrieved client within seven (7) calendar days. The response will include: a time and place for the review; assignment of one or more unbiased persons appointed to review the case. The client will be given the opportunity to present the argument(s), evidence and witnesses without interference during the review. If necessary, a contact person for any accommodations necessary under the Americans with Disabilities Act will be provided. Once the Chairman of the Executive Committee hears the grievance and makes a decision, the decision is the final step in the BAFI Grievance Procedure.

Action Step Three
Any eligible client who had first followed the hearing complaint procedures established by BAFI, and who still feels the issue is unresolved, may present a complaint to the Area Agency on Aging (AAA) and follow their respective grievance procedures. The local AAA is the Senior Resource Alliance, 3319 Maguire Blvd #100, Orlando, FL 32803.

_____ _____
Responsible Party's Name (Please Print) Member's Name (Please Print)

_____ _____
Signature Date

Revised 08/13/2021

JOE'S CLUB
Adult Day Health Care
Supported By Alzheimer's Foundation Brevard

Persons Authorized to Pick up Club Member from _____ Center

Club Member's Name: _____

Primary Caregiver's Name: _____

Please list all family members, friends, caretakers, etc. who are authorized to pick up your loved one from Joe's Club. Only people on this list will be allowed to pick up the above names Club Member. Any person who is not on the list who attempts to pick up the Club Member will be denied and the primary caregiver listed in the Club Member's chart will be contacted.

If it is necessary for someone other than those listed below to pick up your loved one you must make prior arrangements by notifying the staff at Joe's Club at 321-253-4430. If possible, at least one (1) day notice prior to pick up is requested.

Name: _____

Relationship: _____

Phone Number: _____

Name: _____

Relationship: _____

Phone Number: _____

Name: _____

Relationship: _____

Phone Number: _____

Name: _____

Relationship: _____

Phone Number: _____

Name: _____

Relationship: _____

Phone Number: _____

Name: _____

Relationship: _____

Phone Number: _____

JOE'S CLUB
Adult Day Health Care
Supported By Alzheimer's Foundation

Acknowledgement of Transportation Policy

The following policies are designed to ensure our passengers receive the best service in the safest possible manner, and include the responsibility of both the driver and Caregiver.

Loading/Unloading:

Caregivers are responsible for:

1) Pick Up: Bringing the passenger from the residence to the van and assisting in the loading process.
2) Drop Off: Assisting in the unloading process and taking the passenger to the residence.

- Drivers are prohibited from leaving passengers unattended in the van.
- It is BAFI's policy that if a passenger uses a cane, walker or wheelchair, or if there are any other concerns for the safety of the passenger on the stairs of the van, a wheelchair lift SHALL be used.

  1) For the safety of all concerned, a van driver operating a wheelchair lift shall remain on the ground while the lift is being raised or lowered and must stay at the van at all times. CAREGIVER / CNAs are responsible to bring the client onto and off the van at home/facility. If the client is too unsteady or requires assistance while riding the lift, the caregiver/CNA will need to assist. If too unsteady, or if the caregiver is unable to assist, a wheelchair shall be used to make the transition onto and off of the van. The driver will load and unload wheelchairs onto or off of the lift platform and operate the lift.
- Passengers shall correctly wear safety belts at all times. All passengers using wheelchairs shall be secured using a four-point tie-down system with the appropriated lap belts and shoulder straps.

Scheduling:

- While we strive to maintain an accurate schedule, the arrival time at a residence varies daily depending on attendance at Joe's Club and other outside influences (traffic, weather, etc).
- BAFI asks that passengers and caregivers be ready 10 minutes before and beyond the scheduled pick-up time. Every attempt shall be made to contact the passenger. Passengers who do not make themselves available within that window will be considered a no-show.
  1) In the event of a No Show, the caregiver will be charged the equivalent of a one-way trip to Joe's Club.
- When a driver becomes aware that they will be late for a scheduled pick-up by 10 minutes or more, the driver will notify the passenger or the designated caregiver directly, or contact the BAFI office.

Name of Caregiver/Responsible Party (Please Print): _____

Signature:_____ Date: _____

BAFI: _____ Date: _____

Revised 08/13/2021

The Brevard County Special Needs Program is a space-limited program for which people with specific health and medical conditions can register, providing sheltering and transportation with the resources available in Brevard County.

The Special Needs Registry is a confidential listing of those people who meet program criteria, and is updated on an annual basis. Patients with colostomy assistance needs, nebulizers, oxygen, feeding tubes, or Alzheimer's disease are examples of medical criteria that are eligible for the registry.

While the Office of Emergency Management recommends sheltering with friends or family members, public shelters are available for those who do not have other alternatives.

Individuals who elect to use a Special Needs or other public shelter should bring with them items such as cots, bedding, medicine, medical supplies, and food supplies, preparing to be self-sufficient for 72 hours. The community pages of the telephone book provide lists of recommended items to take to a shelter. Special Needs registrants should also be accompanied by at least one caregiver.

Most shelters are located in public schools, and offer neither privacy nor luxuries. Occupants' comfort will be determined by their preparedness.

The Special Needs registration request form can be found on-line at: http://web.brevardcounty.us/specialneeds/registration.aspx or for more information call (321) 637-6670.

JOE'S CLUB
Adult Day Health Care
Supported By Brevard Alzheimer's Foundation

Service Form

I have been offered the opportunity to apply for evacuation assistance from the Brevard County Special Needs Program.

☐ **I Do Not Want Assistance**
for transportation or shelter placement at this time.

If I desire assistance in the future, I understand it is my responsibility to contact the Office of Emergency Management: (321) 637-6670

PLEASE PRINT:

Last Name:_____First Name: _____

Client Address: _____

Client Telephone: _____

CLIENT SIGNATURE_____ DATE: _____
Signature of Registrant or Guardian (Required)

AGENCY: Brevard Alzheimer's Foundation, Inc.

Please complete this form and return to: Brevard County Emergency Management
1746 Cedar Street
Rockledge FL 32955
(321) 637- 4088
(321) 633-1738 (Fax)

JOE'S CLUB
Adult Day Health Care
Supported By Alzheimer's Foundation Brevard

Dear Families,

We pride ourselves in being able to provide families with quality care at a low cost. As you are aware, lunch and a snack are included in both our half-day and full-days programs. We are able to offer this to our families by participating in the Florida State Adult Food Program.

The food program allows us to submit a monthly census report and reimburses us for a portion of the meals. Reimbursement varies on the category club members are eligible for. These include: Free, Reduced and Non-Needy. For those meals that are categorized as free/non-needy we are reimbursed at a higher rate. The money that we are reimbursed goes right back into providing for our members. You will be given this form to complete annually.

We ask that you please take a moment to complete this form. Please be aware, it does ask for you to provide income information. While we do have an annual audit for the food program, the financial information provided remains confidential and you will not be asked to provide verification of income. We are aware that finances are a private subject so do respect that some will not want to provide this information. In the event that you do, please sign the form and write DECLINED.

For those of our members that are receiving state/organizational funding assistance, this form must be completed in its entirety.

Should you have any questions or concerns regarding the completion of this form, please feel free to give us a call.

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Adult Care)

Part 1. All Household Members

Name of Enrolled Adult(s): (List name under Names of Adult Participants)

Names of Adult Participants (First, Middle Initial, Last)	CHECK IF NO INCOME
	❑
	❑
	❑

Part 2. Benefits: If any member of your household received [State SNAP], [FDPIR], [State SSI] or [Medicaid], provide the name and case number for the person who receives benefits**. If no one receives these benefits, skip to part 3.**
NAME: _____ CASE NUMBER _____

TYPE OF BENEFIT (CHECK ONE): ❑ SNAP ❑ FDPIR ❑ SSI ❑ Medicaid

Part 3. Total Household Gross Income—You must tell us how much and how often

A. Name (List **only** the participant(s), spouse and dependent children of participant(s))	**B. Gross income and how often it was received**			
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
(Example) Jane Smith	$ 200/weekly	$ 150/ twice a month	$100/monthly	$____/_____
	$_____/_____	$_____/_____	$_____/_____	$____/_____
	$_____/_____	$_____/_____	$_____/_____	$____/_____
	$_____/_____	$_____/_____	$_____/_____	$____/_____
	$_____/_____	$_____/_____	$_____/_____	$____/_____

Part 4. Signature and Last Four Digits of Social Security Number

An adult household member must sign this form. **If Part 3 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.** (See Statement on the back of this page.)

I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Sign here: _____ Print name: _____
Date: _____
Address: _____ Phone Number: _____
City: _____ State: _____ Zip Code: _____
Last four digits of Social Security Number: ***-**- _____ ❑ I do not have a Social Security Number

Part 5. Participant's ethnic and racial identities (optional)

Mark one ethnic identity:	Mark one or more racial identities:	
❑ Hispanic or Latino ❑ Not Hispanic or Latino	❑ Asian ❑ White ❑ Black or African American	❑ American Indian or Alaska Native ❑ Native Hawaian or Other Pacific Islander

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Adult Care)

Don't fill out this part. This is for official use only.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x26, Twice a Month x24, Monthly x12

❑ ❑ ❑ ❑ ❑

Total income: _____ Per: Week, Every 2 Weeks, Twice a Month, Month, Year Household size:_____

Categorical Eligibility: _____ Date Withdrawn: _____ Eligibility: Free: _____ Reduced: _____ Paid _____ Denied_____

Reason:_____

Determining Official's Signature: _____ Date: _____

Household size	Yearly- Free	Yearly- Reduced-Price
1	$ 0 – $16,744	$ 16,745- $23,828
2	$ 0 – $22,646	$ 22,647- $32,227
3	$ 0 – $28,548	$ 28,549- $40,626
4	$ 0 – $34,450	$ 34,451- $49,025
5	$ 0 – $40,352	$ 40,353- $57,424
6	$ 0 – $46,254	$ 46,255 - $65,823
7	$ 0 – $52,156	$ 52,157- $74,222
8	$ 0 – $58,058	$ 58,059 - $82,621
Each additional person:	+ 5,902	+ 8,399

The participant in the day care facility may qualify for free or reduced price meals if your household income falls within the limits on this chart.

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program.

Non-discrimination Statement: "The U.S. Department of Agriculture (USDA) prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or if all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.

Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (in Spanish). USDA is an equal opportunity provider and employer."

JOE'S CLUB
Adult Day Health Care
Supported By Alzheimer's Foundation Brevard

PATIENT HIPAA ACKNOWLEDGEMENT AND CONSENT FORM

We at Joe's Club are providing this Acknowledgement and Consent Form ("Consent") to you in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which provides guidelines to healthcare providers and other parties on safely sharing and protecting patient health information. By signing this Consent, you acknowledge that you understand its contents and you consent to our collection of your personal information, including individually identifiable health information (protected health information or "PHI") such as your name, address, social security number, and insurance information.

Use & Disclosure

Signing this Consent also represents your consent to our use and disclosure of your private personal information, including PHI, to carry out your diagnosis, treatment, payment and health care operations. You are entitled to a copy of this Consent.

Notice of Privacy Practices

Our Notice of Privacy Practices ("Notice") provides information about how we may use and disclose your protected health information. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review the Notice before signing this Consent, and by signing you acknowledge that you had the chance to review it. The terms of our Notice may change. If we change our Notice, we may notify you that a change has been made and you can obtain a revised copy by contacting our office.

Restrictions and Revocation

You have the right to request that we restrict how PHI about you is used or disclosed. You may revoke this Consent in a signed writing, at any time, and all disclosures from that point on will cease. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent.

Protecting and Sharing Your Information

We will do our best to protect all private personal information that we receive, yet the sharing of such information with us is at your own risk. Information used or disclosed pursuant to this Consent may be redisclosed by the Joe's Club and may no longer be protected by federal or state law.

Conditions and Application

The Practice may provide treatment to you upon your execution of this Consent. This Consent applies to any services the Practice provides or any interactions you have with us.

This consent is signed by:
Member or Representative: _____

Relationship to Member (if other than Member): _____ Date: _____

JOE'S CLUB
Adult Day Health Care
Supported By Alzheimer's Foundation Brevard

Dear Member:

In compliance with HIPAA regulations, Joe's Club is committed to protecting your private health information. We need to know the names of the people that you will allow us to discuss your medical information, if any.

Please list below the names of the people that you will allow Joe's Club staff and providers/physicians to talk about your health and medical information, and then at the bottom write your name and sign to give us permission to do so.

Name	Relationship	Phone Number

_____ _____

Responsible Party's Name (Please Print) Member's Name (Please Print)

_____ _____

Signature Date

Revised 08/13/2021

Alzheimer's Foundation
Brevard
25 YEAR ANNIVERSARY
Home of the Award-Winning Joe's Club

Due to the outbreak of the novel Coronavirus (COVID-19), the Brevard Alzheimer's Foundation is taking extra precautions with the care of every member to include health history review and enhanced sanitation/disinfection procedures in accordance with the Florida Department of Professional Regulation guidance.

Symptoms of COVID-19 include:

- Fever
- Fatigue
- Dry Cough
- Difficulty Breathing

I understand that Brevard Alzheimer's Foundation cannot be held liable for any exposure to the COVID-19 virus caused by misinformation on this form or the health history provided by each member.

Brevard Alzheimer's Foundation is following these enhanced procedures to prevent the spread of COVID-19:

- Members, staff, vendors, and visitors are required to sanitize hands upon arrival and before leaving.
- Members, staff, vendors, and visitors are temperature checked upon entry of the building.
- All staff providing direct care must wear eye shields and face mask.
- All staff will refrain from coming to work if demonstrating any symptoms. Must be symptom free for 72 hours.
- Any member presenting any symptoms will not be permitted to remain in ADC (Including but not limited to temperature, cognitive changes, decreased 02 sats, cough, runny nose, etc). Caregiver will be contacted to pick member up. Must be symptom free for 72 hours before returning.
- All surfaces will be wiped thoroughly with hospital grade disinfectant before and after each use by the member according to the manufacturer's directions.

By signing below, I agree to each statement above and release Brevard Alzheimer's Foundation from any and all liability for the unintentional exposure or harm due to COVID-19.

Brevard Alzheimer's Foundation agrees to abide by these standards and affirms the same.

_____ _____

Responsible Party's Name (Please Print) Member's Name (Please Print)

_____ _____

Signature Date

JOE'S CLUB
Adult Day Health Care
Supported By Alzheimer's Foundation Brevard

DISCHARGE CRITERIA

The following list includes possible reasons for recommending the discharge of a Club Member:

1. When Club Member can no longer stand and pivot to toilet, or requires more than two staff members to toilet, discharge is imminent. Discharge due to decline in mobility will be determined by BAFI staff.
2. Verbally or physically disruptive behaviors will be documented in the Club Member's chart. Club Members exhibiting a pattern of verbally and/or physically disruptive behaviors and behaviors considered potentially harmful to self or others may warrant discharge.
3. After environmental and behavioral modifications are attempted without success, Club Member may be discharged.
4. Withdrawal may occur anytime upon request of the Caregiver.

The Caregiver will receive written notification of intent to discharge. Fifteen (15) calendar days notice of termination is given to arrange for alternate care, except in cases of emergency. An interdisciplinary care team meeting will be scheduled to discuss the conditions of discharge. A staff member will assist you with interim planning including possible placement.

In emergency situations where the health and safety of both Club Members at large and staff are put at risk, immediate discharge will be issued and activated verbally.

_____ _____

Responsible Party's Name (Please Print) Member's Name (Please Print)

_____ _____

Signature Date

Revised 08/13/2021

JOE'S CLUB

Adult Day Health Care

Supported By Brevard Alzheimer's Foundation

The Brevard Alzheimer's Foundation has partnered with Merritt Island Medical Research to provide you and your loved ones with access to clinical research and drug trials. Please provide information below if you would like a representative from Merritt Island Medical Research to contact you with more information.

☐ Yes, I would like more information

_____
Age

I am interested in:

❑ Research Studes

❑ Memory Screening

☐ No, I am not interested at this time

_____ _____
Printed Name of Interested Party Date

_____ _____
Signature of Interested Party or Legal Guardian Phone Number

JOE'S CLUB
Adult Day Health Care
Supported By Alzheimer's Foundation Brevard

PROGRAM REFERRAL FORM (Joes' Club Staff to complete)

CLUB MEMBER NAME: _____

CAREGIVER NAME: _____

DATE OF REFERRAL: _____

____ NO REFERRAL NECESSARY

____ MEDICAL

____ FOOD

____ FINANCIAL

____ CAREGIVER SUPPORT/EDUCATION

Revised 08/06/2021

JOE'S CLUB
Adult Day Health Care
Supported By Alzheimer's Foundation Brevard

Joe's Club is CLOSED on:

December 31, 2021 (New Year's Day Observed)

May 30, 2022 (Memorial Day)

July 4, 2022 (Independence Day)

September 5, 2022 (Labor Day)

November 24, 2022 (Thanksgiving Day)

December 26, 2022 (Christmas Day Observed)

January 2, 2023 (New Year's Day Observed)

JOE'S CLUB
Adult Day Health Care
Supported By Alzheimer's Foundation Brevard

Dear Families,

We pride ourselves in being able to provide families with quality care at a low cost. We do this by applying for state and county grants as well as collaborations with various county agencies. The following forms pertain to our food program, transportation program and our member safety program. Information about each can be found below. If you have any questions or concerns about any of the following forms, please give us a call or discuss with staff at time of admission.

FOOD

The food program allows us to submit a monthly census report and reimburses us for a portion of the meals. Reimbursement varies on the category club members are eligible for. These include: Free, Reduced and Non-Needy. For those meals that are categorized as free/non-needy we are reimbursed at a higher rate. The money that we are reimbursed goes right back into providing for our members. You will be given this form to complete annually. For those of our members that are receiving state/organizational funding assistance, this form must be completed in its entirety.

TRANSPORTATION

Our transportation grants allow us to provide services to our families well below other transport services. In addition to bringing members to and from program, our transportation services can be utilized by members of the community for life sustaining appointments such as doctor visits and grocery shopping.

MEMBER SAFETY

In collaboration with Brevard County Sheriff's Office, members can be registered for the CHANCE alert card program. It's purpose is to provide member with a card to carry on their person that can be given to law enforcement during an encounter, as well as compile and maintain a list of individuals who have "special needs" in Brevard County. By signing this form, you give Joe's Club permission to provide BSCO with a picture of member for CHANCE program enrollment.

The City of Palm Bay Florida

ATTACHMENT VI
COMMUNITY DEVELOPMENT BLOCK GRANT
SELF-DECLARATION OF ELIGIBILITY

To ensure that the program benefits households who meet the CDBG Program eligibility requirements, please take a moment to complete the form below. This information is confidential and will only be used for the purpose of determining your family's eligibility for the program.

Name: _____

Address: _____

Street/City/State/Zip

Step 1: *Circle the number of persons in your household*	***Step 2:*** *Circle the income range to the right of the circled household size that describes your household's annual gross income.* *			
	30% Extremely Low	***50% Very Low***	***80% Low***	***81% and Above Income***
1 Person	$17,050 or less	$17,051 - $28,450	$28,451 - $45,500	$45,501 or more
2 Persons	$19,500 or less	$19,501 - $32,500	$32,501 - $52,000	$52,001 or more
3 Persons	$23,030 or less	$23,031 - $36,550	$36,551 - $58,500	$58,501 or more
4 Persons	$27,750 or less	$27,750 - $40,600	$40,601 - $64,950	$64,951 or more
5 Persons	$32,470 or less	$32,471 - $43,850	$43,851 - $70,150	$70,151 or more
6 Persons	$37,190 or less	$37,191 - $47,100	$47,101 - $75,350	$75,351 or more
7 Persons	$41,190 or less	$41,190 - $50,350	$50,351 - $80,550	$80,551 or more
8 Persons	$46,630 or less	$46,631 - $53,600	$53,601 - $85,750	$85,751 or more

HUD Income Limits effective 4/18/2022

**NOTE: Your household's annual gross income is the total of ALL income received by ALL persons living in your home including employment, social security, SSI, SSD, unemployment, WAGES, child support, alimony, retirement, investment income, etc.*

The following information is for reporting purposes only:

Are you a female head of household? ☐ Yes ☐ No
Are you Hispanic or Latino? ☐ Yes ☐ No

Please indicate your race/ethnic group (Check only one):

☐ White
☐ Black/African American
☐ Asian
☐ American Indian/Alaskan Native
☐ Native Hawaiian/Other Pacific Islander
☐ American Indian/Alaskan Native & White
☐ Asian & White
☐ Black/African American & White
☐ American Indian/Alaskan Native & Black/African American
☐ Other

I understand that under U.S.C. Title 18, Section 1001, any untruthful or deliberately misleading information given by me can result in a fine and/or imprisonment if found guilty.

_____ _____

Applicant's Signature ***Date***

_____ _____

Co-Applicant's Signature ***Date***

ATTACHMENT G
HOUSING AND HUMAN SERVICES
SELF-DECLARATION OF ELIGIBILITY

EFFECTIVE APRIL 1, 2021

To ensure that the program benefits households who meet the U.S. Department of Housing & Urban Development (HUD) eligibility requirements, please take a moment to complete the form below. This information is confidential and will only be used for the purpose of determining your family's eligibility for the program. **(LIST ONLY THOSE RECEIVING SERVICES IN THE HOUSEHOLD)**

PARTICIPANT NAME (S): _____

_____

ADDRESS: _____
STREET ADDRESS CITY ZIP

HUD 2021 AREA MEDIAN INCOME (AMI) LIMITS
PROGRAM

***Step1**: Circle the number of persons in your household. **Step 2**: Circle the income range to the right of the circled household size that describes your household's annual gross income.*

	UP TO 30% AMI (EXTREMELY LOW)	UP TO 50% AMI (VERY LOW)	UP TO 80% AMI (LOW)	INELIGIBLE
1 PERSON	$0 to $15,300	$15,301 to $25,450	$25,451 to $40,700	Over $40,701
2 PERSON	$0 to $17,450	$17,451 to $29,050	$29,051 to $46,500	Over $46,501
3 PERSON	$0 to $21,960	$21,961 to $32,700	$32,701 to $52,300	Over $52,301
4 PERSON	$0 to $26,500	$26,501 to $36,300	$36,301 to $58,100	Over $58,101
5 PERSON	$0 to $31,040	$31,041 to $39,250	$39,251 to $62,750	Over $62,751
6 PERSON	$0 to $35,580	$35,581 to $42,150	$42,151 to $67,400	Over $67,401
7 PERSON	$0 to $40,120	$40,120 to $45,050	$45,050 to $72,050	Over $72,051
8 PERSON	$0 to $44,660	$44,661 to $47,950	$47,951 to $76,700	Over $76,701

NOTE: Your household's annual gross income is the total al ALL income received by ALL persons living in your home including employment, social

security, SSI, SSD, unemployment WAGES, child support, alimony, retirement, investment income, etc.

The following information is needed for reporting purposes only:

Please indicate your race. (MUST CHECK ONE)

- ☐ White
- ☐ Black/African American
- ☐ Asian or Pacific Islander
- ☐ American Indian or Alaskan Native
- ☐ American Indian/Alaskan Native & White
- ☐ Asian & White
- ☐ Black African American & White
- ☐ American Indian/Alaskan Native & Black African American
- ☐ Native Hawaiian/Other Pacific Islander

Please indicate ethic group. (MUST CHECK ONE)

- ☐ Hispanic
- ☐ Non-Hispanic

Is this a female-headed household? (MUST CHECK ONE) Yes ☐ No ☐

I understand that under U.S.C. Title 18, Section 1001, any untruthful or deliberately misleading information given by me can result in a fine and/or imprisonment if found guilty.

PARTICIPANT SIGNATURE DATE

PARTICIPANT SIGNATURE DATE

PARTICIPANT SIGNATURE DATE

PARTICIPANT SIGNATURE DATE

Housing and Human Services
2725 Judge Fran Jamieson Way Building B, Suite 106
Viera, Florida 32940
Phone (321) 633-2076 • Fax (321) 633-2170

SHERIFF WAYNE IVEY
BREVARD COUNTY SHERIFF'S OFFICE
700 Park Avenue ★ Titusville, Florida 32780-4095 ★ www.BrevardSheriff.com

C.H.A.N.C.E Alert Card

(**C**itizen **H**as **A** **N**oticeable **C**risis **E**pisode)

What is the C.H.A.N.C.E. Alert Card?
The C.H.A.N.C.E. Alert Card is an initiative of the Brevard County Sheriff's Office. Its purpose is to provide our citizens with a card to carry on their person that can be given to law enforcement during an encounter, as well as compile and maintain a list of individuals who have "special needs" due to mental or neurological disabilities and who may reside or frequently visit Brevard County. Residents are invited to proactively provide information about a loved one with special needs of any age, who may require special assistance in an emergency or interaction with Deputies. The program is completely voluntary.

Who is eligible?
The program has been developed with the intent to serve all members (adult or juvenile) of our community or people who frequent our community who have a "special need" and want to register with the Brevard County Sheriff's Office.

How do I sign up?
To sign up for the C.H.A.N.C.E Alert Card, complete the C.H.A.N.C.E. Registration Form and turn it into the Brevard County Sheriff's Office. A photograph of sufficient quality may be submitted with the form. The photograph should be a single portrait shot of the person identified on the form and should not contain other people. If a photo is not available, we will take a photo at the precinct during the registration process. Parents and caregivers may enroll a person of any age with any type of medical condition or disability, including but not limited to: Autism Spectrum Disorder, Alzheimer's or Dementia, Bipolar Disorder and Down Syndrome. Adults with special needs may also enroll themselves.

What do I need to bring?
Parents/Guardians should bring proof of guardianship (birth certificate/court documentation), proof of home address (deed or lease, and a utility bill), and if the person is school-aged, a copy of their Individual Education Plan (IEP) that lists their current disabilities. If you're not bringing a picture, please make sure you bring your child/adult with you so we may take the photograph.

As soon as I register, will the information be immediately available in case police response is required?
No. The registration form will need to be entered in order to capture all relevant information. Every effort will be made to upload this form as expediently as possible; however the process may take up to two (2) weeks to be processed. You will, however be provided a C.H.A.N.C.E. Alert Card immediately during the visit to the precinct.

What happens once the person is registered?
When a Deputy has contact with the person on this form, our 911 center can provide us with the information needed to successfully interact and communicate with your loved one, as well as provide us with your contact information.

Who has access to my child's profile?
Brevard County Sheriff's Office personnel who require this information in the performance of their duties will have access to the information. There are strict regulations with respect to accessing and disseminating information. The sharing of this information with other police agencies during an emergency can be helpful when a person is registered in the county area, but wanders off in another jurisdiction.

Can I update my profile if there are changes? How do I do that?
This form must be completed and submitted **every two years**. You may update the information between renewals; however, only information that has a significant impact on policing response will be necessary. Some examples would include a change in address, school, or emergency contact. You do not need to report a change in hair cut or color, for example, as the police are familiar with the changes that can be made and are more likely to notice height, weight and eyecolor. Changes can be made on a new registry form. Photographs may be updated by email or postal mail. The photographmust be accompanied with the person with special needs, name, address, person submitting photographs name andcontact number.

Contact Crime Prevention @ 321-264-7755

SHERIFF WAYNE IVEY
BREVARD COUNTY SHERIFF'S OFFICE
700 Park Avenue ★ Titusville, Florida 32780-4095 ★ www.BrevardSheriff.com

C.H.A.N.C.E. ALERT CARD

(**C**itizen **H**as **A** **N**oticeable **C**risis **E**pisode)

After my child/dependent adult is registered, and if there is an incident, do I need to do something to notify the police?
It is preferable that you let the police know that the individual is already registered. In doing so, the information will be immediately disseminated to the vehicles without having to ask the parents/guardians during a high stress situation.

How will this program help if my child/dependent adult goes missing?
If the individual goes missing and is reported by the parent/guardian, information about his/her physical appearance, the most likely places where he/she would go to, as well as triggers, stimulants, and de-escalation techniques will be sent to every police officer in the area to look for the missing person. If the individual has not been reported and is incapable of effectively communicating his/her name to an officer, a computer check of the neighborhood, coupled with the physical appearance, may allow us to identify the individual more quickly. This will then allow us to use the contact information to connect with the parents/guardians.

Contact Crime Prevention @ 321-264-7755

SHERIFF WAYNE IVEY

BREVARD COUNTY SHERIFF'S OFFICE

700 Park Avenue ★ Titusville, Florida 32780-4095 ★ www.BrevardSheriff.com

C.H.A.N.C.E. REGISTRATION FORM

Identification Information: *Please enter the identifying information for the person with special needs*

First Name:_____ Middle Name:_____ Last Name: _____

Date of Birth: _____ Race:_____ Sex:_____

Height:_____ Weight:_____ Eye Color:_____ Hair Color:_____

Please describe any SCARS, BIRTHMARKS, TATTOOS, or OTHER identifying information:

A photograph of sufficient quality may be submitted with this form. The photograph should be a single portrait shot of the person identified on the form and should not contain other people.

Disability/Special Need Information:

Primary Diagnosis:_____ Co-Existing Diagnosis:_____

Please list any characteristics that are associated with this person:
(Examples include sensory issues, certain behaviors, physical aggression, past dealings with police, calming strategies that work, etc.).

How does this person communicate? (words, pictures, devices, etc.)

I have, ☐ have not ☐ submitted a non-returnable photo of the person with special needs listed on this form.

Initial: _____

Residence Information:

Home Address:_____ City:_____ Zip Code:_____

Parent/Guardian Information:

1. Full Name: _____ Relationship: _____

Primary Phone:_____ Secondary Phone:_____ Work Phone:_____

Place of Employment:_____

2. Full Name: _____ Relationship: _____

Primary Phone:_____ Secondary Phone:_____ Work Phone:_____

Other Emergency Contact Information:

1. Full Name:_____ Phone:_____

Home Address:_____ City:_____ Zip Code:_____

2. Full Name:_____ Phone:_____

Home Address:_____ City:_____ Zip Code:_____

Contact Crime Prevention @ 321-264-7755

SHERIFF WAYNE IVEY
BREVARD COUNTY SHERIFF'S OFFICE
700 Park Avenue ★ Titusville, Florida 32780-4095 ★ www.BrevardSheriff.com

C.H.A.N.C.E. REGISTRATION FORM

This portion of the form must be signed in front of a NOTARY (a notary is available at the precinct)

I,_____, am the lawful and legal parent and/or guardian of the person with special needs listed on this form. Relationship: _____

I understand the program is location based and the information I provided is tied to the residence address and may not be available if an incident occurs away from the residence. I understand this information will be retained for a period of one year from submission, to expire on the first business day following the last day of the month of submission. I understand the information provided to the Brevard County Sheriff's Office is for law enforcement to have all the necessary information to better handle a situation and that information may be subject to public records laws, - F.S.S. Ch. 119 ***- however, special needs are protected under HIPPA laws and will be redacted when necessary.***

Initial: _____

RELEASE OF INFORMATION

I,_____ , hereby give my permission for the Brevard County Sheriff's Office to retain and distribute the information contained in this registration form to other first responder personnel for the sole purpose of identification and protection of the person identified above in an emergency or crisis situation. I acknowledge that the information I provide does not guarantee the identified persons safety and/or health and wellbeing. I further understand that it is my sole responsibility to keep this information updated and provided to the Brevard County Sheriff's Office 911 Communications Center and that I will not hold the Brevard County Sheriff's office responsible for any outdated, false, inaccurate or incomplete information that I provide.

I,_____, first party for and in consideration of privilege of submitting information to the Brevard County Sheriff's Office, Florida 911 Communications Section or other valuable considerations received from or on behalf of the Brevard County Sheriff's Office, second party, the receipt where is hereby acknowledged. HEREBY remise, release, acquit, satisfy and forever discharge the said second party of and from all and all manner of actions which said first party ever had, now has, hereafter can, shall or may have, against said second party, for, upon or by reason of submitting information on this form to the Brevard County Sheriff's Office 911 Communications Section. Signature of Parent/Guardian:

*Important! First page of application needs to be renewed every two years, otherwise application will be cancelled after two full years.

***Important!** The first page of the application needs to be renewed **every two years**, otherwise, the application will be canceled after two full years.

STATE OF FLORIDA,
COUNTY OF BREVARD.

Sworn to (or affirmed) and subscribed before me by means of ☐ Physical Presence or ☐ Online Notarization, this _____ day of _____, 202__, by _____.

_____
Signature of Notary Public OR Law Enforcement Officer as provided in FSS 117.10.

NOTARY SEAL

_____
Print or Type Commissioned Name of Notary Public or Law Enforcement Officer

☐ Personally, known OR ☐ Produced valid identification Type of Identification produced _____

Contact Crime Prevention @ 321-264-7755