Office # 509-475-7185
Brett 509-413-3042
Bob 509-879-3372
Billing information:
Lada 509-280-0579

Project id
Identity Beyond Disability

You can print this form, fill out all sections and mail to:
Project id
P.O. Box 18703
Spokane, WA 99228
or
Drop the form off at
Project id
4209 E Pacific ave.

DAY & EVENING PROGRAM APPLICATION

Applications are necessary and acceptance contracts MUST be signed before attending any Project id programs.

Start Date_____ STA# _____

1. MEMBER INFORMATION

Name_____

Preferred Name_____

Physical Address _____

City _____State _____Zip _____

Home Phone:_____Cell Phone:_____

Birth Date:_____Age_____ ☐-Male ☐-Female

2. CONTACT INFORMATION

Family Contact_____Relationship _____

Family Address_____

City _____State _____Zip _____

Home Phone_____Cell Phone_____

Adult Family Home (AFH) Name _____

In-Home Contact/Caregiver _____

Relationship _____

Address (if other than client) _____

Home Phone _____Cell _____

Home-Site Email_____

Project id Day & Evening Programs

Monthly Program Rates

Day Program - Monday through Friday 9:00 a.m.- 3:30 p.m. (flat rate fee)
Evening Program - Tuesday – Friday 5:00 p.m. – 8:00 p.m.

Invoices are billed on the 1st of each month. Payment is due by the 15th of each month.

We will be unable to serve any member with an overdue balance.

We do NOT pro-rate.

Please make payments to the order of:

Project Id P.O Box 18703 Spokane, WA 99228

For any billing questions call Lada at 509-280-0579

Please Check all that apply		Monthly Price
	1 day a week for the month	$160.00
	2 days a week for the month	$190.00
	3 days a week for the month	$200.00
	4 days a week for the month	$240.00
	5 days a week for the month	$300.00
	Evening Program	$30.00

PAYEE SIGNATURE: _____ Date:_____

MEMBER NAME: _____

For Day Program days that member will be attending.

☐ **Monday** ☐ **Tuesday** ☐ **Wednesday** ☐ **Thursday** ☐ **Friday**

Legal Guardian _____ Phone _____

Emergency Contact _____
Relationship _____
Phone _____

3. Responsible Billing Party

Person Responsible for Billing: _____
Relationship to Participant: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone _____ Cell _____
Billing Email Required: _____

4. CLIENT HEALTH INFORMATION

Current Diagnosis:

_____
_____
_____

Allergies: _____
_____
Medications: _____
_____
_____

Primary Health Care Provider Name:_____

_____

Address:_____

City:_____ State:_____Zip:_____

Preferred Hospital:_____

5. SPECIAL HEALTH CONDITIONS (Please check all that apply)

☐Seizures ☐Dizziness/Fainting ☐Incontinence ☐Heart Problems
☐High/low blood pressure ☐Diabetes ☐Swallowing/Choking
☐Heat/Cold Sensitivity ☐Asthma/Breathing ☐Vision ☐Hearing
☐Other:_____

_____

6. SPECIAL EQUIPMENT USED (Please check all that apply)

☐Wheelchair ☐Walker ☐Glasses/contacts ☐Prosthesis
☐Cane ☐Hearing aid ☐ Dentures

7. TOILETING: Must be independent or have caregiver.

8. BEHAVIORS (please check all that apply)

☐Sociable ☐Agitative ☐Confusion ☐Cooperative ☐Pacing ☐Wandering
☐Talkative ☐Verbally Aggressive ☐Hallucinations ☐Anxious
☐Physically Aggressive ☐Unaware of surroundings
☐Helpful ☐Socially withdrawn
☐Other _____

_____

What methods work **BEST** to handle behaviors?_____

_____

_____

_____

Any history of violence? ☐ yes ☐ no
If yes, explain: _____

_____

_____

Any history of crimes against property or persons? ☐ yes ☐ no
If yes, explain: _____

_____

_____

_____

Is there any other pertinent information that may help us to support the Participant while at the center? _____

_____

_____

_____

9. Sharing Your Information:
The dissemination of information relating to people receiving our services to persons outside of our program without authorization is prohibited, except were permitted by law. The things we talk about with you are private and are not to be shared with anyone without your permission, except under special circumstances. These circumstances are when our staff knows about or suspects abuse or neglect of a child or dependent adult, or if our staff hears of a person we serve, threaten to cause harm to him or herself or to other people. In these instances, we are obligated to report this to the Division of Developmental Disabilities case management in accordance with their policies and to other appropriate authorities.

DDA Case Manager:_____

10. CLIENT SOCIAL INFORMATION

The following information will help to increase his or her abilities, Self-esteem, and social contact.

Any club memberships past and present? _____

_____

_____

_____

11. Current Interests Hobbies (please check all that apply)

☐ Reading ☐ Music ☐ Walking ☐ Sports ☐ Gardening ☐ Singing
☐ Crafts ☐ Sewing ☐ Exercise ☐ Concerts ☐ Cooking ☐ Games
☐ Movies ☐ T.V. ☐ Dancing ☐ Pets ☐ Plays an instrument

Other: _____

_____

_____

_____

I UNDERSTAND THIS INFORMATION WILL BE GIVEN TO PROJECT ID'S SERVICES AND PROGRAMS AND WILL BE KEPT ON FILE IN THEIR OFFICE. THIS INFORMATION IS CONFIDENTIAL AND WILL NOT BE RELEASED TO ANY OTHER PERSON OR ORGANIZATION WITHOUT MY WRITTEN PERMISSION.

I confirm and acknowledge that my electronic signature on this document constitutes my valid and legally binding signature. I understand and agree that providing my name on the signature line below is the electronic equivalent of my written signature.

Signature of Member: _____

Date: _____

Signature of Guardian /Caregiver: _____

Date: _____

Project id
Wolf Den Eligibility and Member Code of Conduct

Eligibility:

I, _____, acknowledge and if requested can provide verification that I am 18 years or age (or older) and have had a diagnosis of an intellectual disability at some point in my life.

Name: _____ Date: _____
Parent/Guardian (if required):_____Date: _____
Witness: _____ Date: _____

Member Code of Conduct:

As a member of the Wolf Den, I agree to:

1. Treat all participants, staff and volunteers with respect and dignity in my speech, my actions and my attitudes as follows (but not limited to) –

   Refrain from use of profanity and/or verbal abuse.
   Refrain from unwanted physical or verbal sexual overtures.
   Refrain from violent or disruptive behaviors.
   Refrain from rude or taunting/teasing comments.

2. Maintain good hygiene of my body and clothing.
3. Follow all rules, instructions and requests laid out by staff and volunteers of the Wolf Den while I am in attendance.
4. Help maintain the building, grounds and programming of the Wolf Den as requested by staff and volunteers of the Wolf Den for a minimum of 2 hours per month (during routine attendance unless otherwise arranged with staff and volunteers).
5. Pay my monthly fee within five days of the 5th of each month unless otherwise arranged with a Project id board member.

6. Refrain from smoking (including e-cigs or chew) on Project id/Wolf Den property except in designated smoking areas.
7. Never use alcohol, street drugs, marijuana or any medications not prescribed for you while on Project id/Wolf Pack premises or attend Wolf Den activities while under the influence of the above noted substances.
8. Submit to drug or alcohol testing if requested by Wolf Den staff or volunteers.
9. Be honest in all my communications with participants, staff and volunteers of the Wolf Den.
10. Sign releases of information for members of my treatment team regarding information pertaining to diagnoses, medications, specific care requirements and other information deemed pertinent to Wolf Den involvement.
11. Inform Project id/Wolf Den staff of any changes in address, phone, legal status, or other pertinent issues.

Failure to follow the above standards will result in the following progressive disciplinary measures:

- Verbal warning given
- Suspension (time frame to be determined)
- Personal meeting with the member, Program Director and any other person, members who would like to be present more staff/volunteers re: a plan of action to correct the behavior/concern
- Permanent removal from all Project id programs

Name: _____ Date: _____
Parent/Guardian (if required):_____ Date: _____
Witness: _____ Date: _____

If the above identified member is not their own guardian, please attach copies of guardianship paperwork. Thank you!

Project id Program Financial Agreement

I, _____, agree to pay Project id, Inc. the amount for program services I choose for the month in full. Which will give me full use of Project id programming and recreational facilities. (Unless otherwise noted below)

Billing address: _____City_____St___ Zip_____

Payee Email:_____ Required

Method of payment: (check one)

☐ Cash or Check (due by the 15th of the month unless otherwise arranged/noted)

☐ Credit or Debit: (Processed the 3rd of the month unless otherwise arranged)

☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

_____ _____

Name on card Card Number

_____ _____

Expiration date 3 digit security code

_____

Printed name of Payee / Organization

_____

Phone number of Payee / Organization

_____ _____

Signature of Payee Date:

Additional Information:

_____

_____

_____

Signature of Project id, Inc. Staff: _____

MEDIA RELEASE FORM

I, _____ grant permission to Project id, hereinafter known as the "Media" to use my image (photographs and/or video) for use in Media publications including:
(Check All That Apply)

☐ Videos ☐ Email Blast ☐ Newsletter ☐ Magazine ☐ Publications

☐ Website and / or Affiliates ☐ Recruiting Brochures ☐ Other:_____

I hereby waive any right to inspect or approve the finished photographs or electronic matter that may be used in conjunction with them now or in the future, whether that use is known to me or unknown, and I waive any right to royalties or other compensation arising from or related to the use of the image.

Please initial the paragraph below which is applicable to your present situation:

☐- I am 20 years of age or older and I am competent to contract in my own name. I have read this release before signing below, and I fully understand the contents, meaning and impact of this release. I understand that I am free to address any specific questions regarding this release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this release.

☐- I am the parent or legal guardian of the below named child. I have read this release before signing below, and I fully understand the contents, meaning and impact of this release. I understand that I am free to address any specific questions regarding this release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this release.

Signature: _____ Date: _____
Name (please print): _____
Address: _____
Signature of parent or legal guardian: _____
(if under 20 years of age)

*****Please note that this is for Project id. We are not able to control pictures taken by other participants.**

Project id

Participant Waiver and Release of Liability

In consideration of the risk of injury while participating at the Project id, Inc. center, programming and activities, and as consideration of the right to participate in programming and activities at and through the Project id, Inc. organization, I hereby, for myself, heirs, executors, administrators or personal representatives, knowingly and voluntarily enter into this waiver and release liability and waive any and all rights, claims or causes of action of any kind whatsoever arising out of my participation in Project id, Inc activities and programming and do release and forever discharge Project id, Inc. located at 4209 E Pacific Ave, Spokane, WA 99202, their affiliates, managers, members, agents, attorneys, staff, volunteers, heirs, representatives and assigns for any physical or psychological injury that I may suffer as a direct result of my participation in the aforementioned activities and programming, including traveling to and from events related to Project id, Inc. programming and activities.

I am voluntarily participating in Project id, Inc. programming and activities and am participating at my own risk. I am aware of the risks that may be associated with both this participation and travel to and from this programming. Nonetheless, I assume all related risks both known and unknown.

I agree to indemnity and to hold harmless Project id, Inc. against all claims, suits, or actions of any kind whatsoever for liability, damages, compensation or otherwise brought by me or anyone on my behalf, including attorney fees and any related costs. To the extent that statute or case law does not prohibit releases for negligence, this release is also for negligence on the part of Project id, Inc., its agents, employees, and volunteers.
If I should require medical care or treatment, I agree to be financially responsible for any costs incurred because of such treatment.

If any damage to equipment or facilities occurs because of me or my families or support system's neglect, recklessness, or malicious intent, I acknowledge and agree to be held responsible and liable of any and all cost associated with these actions.

This agreement is entered into without duress or coercion. I, _____, and Project id, Inc. agrees that this agreement is clear and unambiguous in its terms.

Member Name: _____
In the event of an emergency, please contact the following person(s) in the order listed:

Emergency Contact	Relationship	Telephone number

In the event of an emergency requiring medical intervention, contact and/or transport the participant to the following medical person and/or facility:

Physician Address Phone Number

Hospital/Emergency Facility of Preference: _____

(Please note that in life and death situations participant with be transported to the nearest facility).

Participant Name (please print): _____
Participant Address: _____
_____

Participant Signature: _____
Date: _____

Parent/Guardian Waiver

If the participant is under the age of consent or has been deemed in need of and appointed a guardian by a court of law, this release must be signed by that parent or guardian.

I hereby certify that I am the parent or guardian of _____ and do hereby give my consent to the above waiver and release of liability without reservation on behalf of this individual.

I confirm and acknowledge that my electronic signature on this document constitutes my valid and legally binding signature. I understand and agree that providing my name on the signature line below is the electronic equivalent of my written signature.

Parent/Guardian Name (please print): _____

Relationship to Participant: _____

Parent/Guardian Address: _____

Parent/Guardian Signature: _____

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COVID-19 Liability Waiver

Date: _____

First Name: _____ (print)

Last Name:_____ (print)

I acknowledge the contagious nature of the Coronavirus/COVID-19 and that the CDC and many other public health authorities still recommend practicing social distancing.
I further acknowledge that Project id has put in place preventative measures to reduce the spread of the Coronavirus/COVID-19.
I further acknowledge that Project id cannot guarantee that I will not become infected with the Coronavirus/Covid-19. I understand that the risk of becoming exposed to and/or infected by the Coronavirus/COVID-19 may result from the actions, omissions, or negligence of myself and others, including, but not limited to, volunteers and staff, and other members and their families. I voluntarily seek services provided by Project id and acknowledge that I am increasing my risk to exposure to the Coronavirus/COVID-19. I acknowledge that I must comply with all set procedures to reduce the spread while attending my appointment.
I attest that: **Please Check**

* ☐ I am not experiencing any symptom of illness such as cough, shortness of breath or difficulty breathing, fever, chills, repeated shaking with chills, muscle pain, headache, sore throat, or new loss of taste or smell.
* ☐ I have not traveled internationally within the last 14 days.
* ☐ I have not traveled to a highly impacted area within the United States of America in the last 14 days.
* ☐ I do not believe I have been exposed to someone with a suspected and/or confirmed case of the Corona V irus/COVID-19.
* ☐ I have not been diagnosed with Coronavirus/Covid-19 and not yet cleared as non-contagious by state or local public health authorities.
* ☐ I am following all CDC recommended guidelines as much as possible and limiting my exposure to the Corona Virus/COVID-19.

I hereby release and agree to hold Project id harmless from, and waive on behalf of myself, my heirs, and any personal representatives any and all causes of action, claims, demands, damages, costs, expenses and compensation for damage or loss to myself and/or property that may be caused by any act, or failure to act of Project id, or that may otherwise arise in any way in connection with any activities received from Project id. I understand that this release discharges Project id from any liability or claim that I, my heirs, or any personal representatives may have against Project id with respect to any bodily injury, illness, death, medical treatment, or property damage that may arise from, or in connection to, any activities from Project id. This liability waiver and release extends to volunteers and employees.

Authorized Care Representative: (print)

Signature Authorized Care Representative