Community Center Application

Applications are needed before attending CI's Community Center for the first time.

Please indicate your *anticipated schedule:* ☐ Check for drop in status

	Mon	Tue	Wed	Thu	Fri
AM Session 9-12	☐	☐	☐	☐	☐
PM Session 12-3	☐	☐	☐	☐	☐

Applicant's Information

Applicant Name:_____

Applicant's Physical Address:_____

City:_____State_____Zip_____Applicant's Home Phone#_____

Applicant's Cell Phone#_____ Birth Date:_____ **(Applicant must be 18 or older)**

Check: Male ☐ Female ☐

Responsible Billing Party

Person responsible for Billing_____

Relationship to member _____Cell phone#_____

Address_____Home phone #_____

City_____State_____Zip_____

Billing E-mail_____

Contact Information

Family Information: ☐ Check if address is same as Applicant's

Family Contact_____**Relationship**_____

Family Address_____

Family home # _____**Cell #**_____

Family E-mail_____

Does Family want to be contacted in case of emergency ☐ Yes ☐ No

Residential Provider Information: Please fill out what is applicable to your residential site:

Residential Provider Name_____

Residential Provider Office Address_____

Residential Provider Office Phone # _____

Residential Provider Cell Phone #_____

Home Site Manager Name _____Cell #_____

Emergency Information: *Please list two emergency contacts, in case one is unavailable.*

First Emergency Contact Name:_____Relationship to Applicant_____

Home Phone #_____Cell #_____

Second Emergency Contact Name:_____Relationship to Applicant_____

Home Phone #_____Cell #_____

Case Manager Name_____Phone #_____Cell #_____

Applicant's Doctor's Name_____

☐ Please check if applicant can be taken to nearest hospital in case of emergency.

Hospital preference_____

Medications (Please provide dosage, *ie. Vitamin C 200mg*)

_____

_____

_____

_____

Allergies: ☐ No known allergies ☐ Seasonal ☐ Bee Stings ☐ Peanuts

Other Allergies_____

Does applicant currently have a behavior plan in place ☐ Yes ☐ No

If "yes" please provide a copy with application.

Please state primary disability_____

Please rate the categories of capabilities below on a scale of 1-5 **(5 being most independent)**

( ) Initiate Activities	( ) Verbal Communication	( ) Uses sign/gestures
( ) Relates to others	( ) Sexually appropriate	( ) Eating/Drinking
( ) Clean and orderly	( ) Needs prompts/reminders	( ) Aware of personal space
( ) Walking	( ) Controls Anger/Emotions	( ) Help with toileting
( ) Receptive communication	( ) Respects property of others	( ) Can follow directions

Please check all disabilities and/or medical conditions that apply. Please explain if marked "yes".

☐ Hearing ☐ Vision ☐ Diabetes ☐ Developmental ☐ Learning/ADD ☐ Dementia
☐ Seizures – Controlled (Yes/No If yes how) _____
☐ Heart condition ☐ Fine motor skills ☐ Gross motor skills ☐ Uses wheelchair
☐ Mental Illness ☐ Physical limitations ☐ Medical issues

Will member be take medications while attending the Center ☐ Yes ☐ No
If yes, do they require assistance?_____

Other pertinent medical information_____

_____

Racial/Ethnic background: *The following information is voluntary (please check all that apply)*

☐ Black/African/American ☐ White/Caucasian ☐ Asian/Pacific Islander
☐ American Indian ☐ Hispanic ☐ Alaska Native ☐ Other_____

1. List specific favorite activities or other interests (puzzles, bowling, computers, art music, etc).

_____
_____
_____
_____

2. What goals does the member have while participating in CI's Community Center Program?

_____
_____
_____
_____

3. Is there any other pertinent information that may help us to support you at the Community Center?_____

_____
_____
_____

4. Which individuals and/or organizations have permission to provide transportation services for you? (e.g. The Arc, public transit, Dial-a-Ride….for individuals, please state relationship)

_____
_____
_____
_____

CI COMMUNITY CENTER PHILOSOPHY

1. **We believe that the rights and responsibilities of personal choice belong to all people with or without disabilities.**

2. **We encourage those at the Center to choose and direct their own activities as much as possible.**

3. **We provide staff to assist members in choosing healthy, safe, creative and appropriate activities within the Center and our communities.**

Membership Guidelines

1. **Membership Eligibility & Application:**
   Applications may be returned in person or by mail. Eligibility will be determined on age (High School 16+) submission of a completed application, a commitment to the center Rights and Responsibilities, and the general level of support required. A personal tour of the Center is required prior to participation to determine the appropriateness of membership, (this may last up to 2 hours) and continuing participation requires the payment of all member fees as outlined in #3.

2. **Application Review:**
   The Community Center Manager and Activity Supervisor will review applications as promptly as possible to determine if we can effectively support the applicant in our program. After the application is reviewed, a letter of regret will be sent to the address provided on the application if you have been declined services. The Center is committed to working with individuals to insure their success at the Center. In order to ensure a successful, on-going relationship, the Center Manager and Activity Supervisor will periodically review our ability to support each individual member. If it is determined that the Center can't support a member, that individual will not be able to continue to attend sessions at the Center.

3. **Payment of Fees:**
   CI's Community Center offers two half-day sessions, one morning session (9-12), and one afternoon session (12-3). Note that if you attend for a full day, you will be billed for two sessions. Please contact the Activity Supervisor if you need an alternate schedule, such as a mid-day option. **Attendance fees are billed the beginning of the month for the previous month's attendance. Payment is due within 10 days of invoice date. Late payment notices are written on current invoice each month. Payment should be sent**

or taken to CI's main office at 900 S. Dayton St., Kennewick, WA 99336. When an invoice becomes 60 days late, a notice will be sent suspending the member's attendance until the account is paid in full. Fees are set-up in the following categories:

Rate of $30 per session for DDA paid clients (45% less than competitors)
Private pay clients will be charged a discounted rate of $20 per session
If a client maxes out their DDA funding they will be moved to the private pay rate

4. Member Responsibility:

Participants need to act in an appropriate manner. This includes, but is not limited to: showing respect and consideration for each participant and staff member, following staff instructions, managing anger, respecting others' personal property, etc. The Community Center is not equipped to resolve severe behavioral issues. Therefore, if a member has behavioral issues that are highly irritating to others or is violent towards himself/herself or others, he or she will not be allowed to continue membership with the Community Center. Any member can be sent home immediately if they have inappropriate behavior that cannot be managed on-site. Immediate dismissal will occur with any act of violence.

5. Supervision:

The ratio of participants to staff can vary. We cannot provide one-on-one supervision at any time. Anyone requiring this level of supervision in order to maintain safe and respectful behavior will not be able to participate in our Center's program.

6. Personal Assistance:

CI staff will provide on-going personal assistance except for the following:

- Administering medications.
- Providing full toileting assistance.

We will assist people with food prep, including cutting fruits, vegetables, sandwiches, opening snacks, dressing and undressing (coats, hats, gloves, etc.) and other personal care routines. With minimal assistance in the rest room such as buttoning and unbuttoning pants, hand washing and hygiene. Personal assistance onto van for transportation and on community outings will be provided. CI staff will offer verbal prompts and reminders. Physical redirection will be used only to prevent immediate danger from occurring.

7. Emergencies:

In the event of an emergency, CI's Community Center will follow standard first-aid and CPR procedures, and then contact the home-site as soon as possible. For non-911 emergencies, the home provider will be expected to pick the person up within 30 minutes, therefore, it is imperative that we have a working emergency number in each member's file.

8. Participation:

We provide a variety of activities each day and encourage all members to participate. Those who choose not to participate will be allowed to find their own productive activities. Ay activity that is limited to a certain number of people will be offered on a first-come, first serve basis. Some outings may cost additional money as noted on the quarterly calendar. For members who regularly choose not to participate in Center activities, we recommend that the member's care provider have the member bring something from home that the member would enjoy doing.

9. Transportation:

Rides to and from the Center must be arranged by the participant or provider and must coincide with session times. The official session times are 9:00 – 12:00 and 12:00 – 3:00. Arrival and departure from the Center should be within 15 minutes of noted times. Non-compliance of this will result in an additional fee of $5 per 15 minutes for any additional supervision unless non-compliance is the result of The Arc or Dial-a-Ride transportation delay.

Thank you for considering CI's Community Center. If you have any questions or need further assistance with this application, please contact us at 582-4142 x 1130. Please return this application to:

Columbia Industries Community Center
900 S. Dayton St.
Kennewick, WA 99336
Fax: 586-3825

To the best of my knowledge, I affirm the above is true. I have read, understood and agree to CI Community Center's Membership Guidelines in this document and the Rights and Responsibilities attached to this application. I accept full responsibility for my participation on any equipment, or as a passenger in any vehicle, operated by Columbia Industries or its staff. I accept full responsibility for payment of CI Community Center fees. **If any of the information required in this application changes, I will notify CI Community Center staff as soon as possible at 582-4142. If I fail to do so, I understand that it may affect the Community Center's ability to safely serve me.**

Applicant Signature _____Date_____

Signature_____Date_____
(Home Provider/Guardian/Parent

Background Check Authorization

Section 1. Required: Applicant Information (All sections completed by the applicant, the person receiving a background check). The requesting entity will submit the applicant's information through the online Background Check System (BCS).

1. **REQUIRED:** LEGAL NAME AS IT IS LISTED ON YOUR DRIVER'S LICENSE OR GOVERNMENT ISSUED PHOTO IDENTIFICATION (ID)
   FIRST | MIDDLE | LAST

2. **REQUIRED:** OTHER ALIAS FIRST, MIDDLE, AND LAST NAMES YOU HAVE USED
   FIRST | MIDDLE | LAST

3. **REQUIRED:** DATE OF BIRTH (MM/DD/YYYY)

4. **REQUIRED:** PHONE NUMBER (INCLUDE AREA CODE)
   ☐ I authorize BCCU to leave a detailed message.

5. EMAIL ADDRESS
   ☐ By checking this box, I consent to and authorize BCCU to email my confidential and sensitive background check information, including a fingerprint rap sheet (if applicable), to the email address I have provided. By NOT checking this box, BCCU will use the mailing address provided to send me my background check information.

6. SOCIAL SECURITY NUMBER

7A. **REQUIRED:** VALID DRIVER'S LICENSE OR STATE ID **(WRITE NONE IF NONE)**

7B. **REQUIRED:** ISSUING STATE

8. **REQUIRED:** HAVE YOU LIVED IN ANY STATE OR COUNTRY OTHER THAN WASHINGTON STATE WITHIN THE LAST THREE YEARS (36 MONTHS)?
   ☐ Yes ☐ No

9. **REQUIRED:** MAILING ADDRESS WHERE WE CAN SEND YOU CONFIDENTIAL INFORMATION
   STREET | APT. NO. | CITY | STATE | ZIP CODE

10. **REQUIRED:** PHYSICAL ADDRESS WHERE YOU LIVE NOW (WRITE "SAME" IF ADDRESS IS THE SAME AS YOUR MAILING ADDRESS)
    STREET | APT. NO. | CITY | STATE | ZIP CODE

Section 2. Required: Self-Disclosure Questions for ALL convictions and pending charges from any state or jurisdiction. You must answer Questions 11A through 14. Attach Page 2 if you have crimes or pending charges. **SEE INSTRUCTIONS.**

11A. Have you been convicted of any crime? If yes, complete Page 2, Section 3. ☐ Yes ☐ No

11B. Do you have charges (pending) against you for any crime? If yes, complete Page 2, Section 4. ☐ Yes ☐ No

12. Has a court or state agency ever issued you an order or other final notification stating that you have sexually abused, physically abused, neglected, abandoned, or exploited a child, juvenile, or vulnerable adult? ☐ Yes ☐ No

13. Has a government agency ever denied, terminated, or revoked your contract or license for failing to care for children, juveniles, or vulnerable adults; or have you ever given up your contract or license because a government agency was taking action against you for failing to care for children, juveniles, or vulnerable adults? ☐ Yes ☐ No

14. Has a court ever entered any of the following orders against you for abuse, sexual abuse, neglect, abandonment, domestic violence, exploitation, or financial exploitation of a vulnerable adult, juvenile, or child? ☐ Yes ☐ No
    - Permanent vulnerable adult protection order / restraining order, either active or expired.
    - Sexual assault protection order.
    - Permanent civil anti-harassment protection order, either active or expired.

I am the person named above. If I do not tell the whole truth on this form, I understand I can be charged with perjury and I may not be allowed to work with vulnerable adults, juveniles, or children. I understand and agree my signature in the box below means:

- I give DSHS permission to check my background with any governmental entity and law enforcement agency.
- My background check result may include prior self-disclosure information and fingerprint results that are contained in the DSHS Background Check System and that this information will be reported as allowed by federal or state law.
- If a final finding is identified, DSHS will report only my name and that a final finding was identified on the background check result.
- DSHS will give my background check result to the persons or entities requesting my background check and those persons or entities may release my background check results to other persons or entities when the law authorizes or requires DSHS to do so. Fingerprint rap sheets are provided if allowed by federal or state law.

15. **REQUIRED:** SIGNATURE. YOUR PARENT OR GUARDIAN'S SIGNATURE IF YOU ARE UNDER 18.

16. **REQUIRED:** TODAY'S DATE (MM/DD/YYYY)

Background Check Authorization

List of Crimes and Pending Charges

This page **MUST** be attached to Page One of the Background Check Authorization form if 11A or 11B are marked "Yes."

Important information about answering self-disclosure questions: Your answers to self-disclosure questions become part of your background check history and are stored in the DSHS database. It is recommended that you refer to charging papers, court records, or other official documents and that you list criminal convictions, pending charges, dates, and other information exactly as they are listed in those documents.

REQUIRED: PRINT YOUR NAME AS IT IS LISTED ON YOUR DRIVER'S LICENSE OR GOVERNMENT ISSUED PHOTO ID		
FIRST:	MIDDLE:	LAST:
REQUIRED: DATE OF BIRTH (MM/DD/YYYY)		

Section 3. Question 11A. If you check **YES**, you must enter the crime name, degree (if any), state, conviction date, and crime information.

1. CRIME NAME	DEGREE (IF ANY)	STATE	CONVICTION DATE (MM/DD/YYYY)
Other crime information: ☐ Attempted ☐ Conspiracy ☐ Domestic Violence ☐ Solicitation ☐ With Sexual Motivation ☐ N/A			
DESCRIPTION OF CRIME (REQUIRED WHEN CRIME IS COMMITTED OR CONVICTED OUTSIDE OF WASHINGTON STATE)			

2. CRIME NAME	DEGREE (IF ANY)	STATE	CONVICTION DATE (MM/DD/YYYY)
Other crime information: ☐ Attempted ☐ Conspiracy ☐ Domestic Violence ☐ Solicitation ☐ With Sexual Motivation ☐ N/A			
DESCRIPTION OF CRIME (REQUIRED WHEN CRIME IS COMMITTED OR CONVICTED OUTSIDE OF WASHINGTON STATE)			

3. CRIME NAME	DEGREE (IF ANY)	STATE	CONVICTION DATE (MM/DD/YYYY)
Other crime information: ☐ Attempted ☐ Conspiracy ☐ Domestic Violence ☐ Solicitation ☐ With Sexual Motivation ☐ N/A			
DESCRIPTION OF CRIME (REQUIRED WHEN CRIME IS COMMITTED OR CONVICTED OUTSIDE OF WASHINGTON STATE)			

Section 4. Question 11B. If you check **YES**, you must enter the PENDING charge name, degree (if any), state, and crime information.

1. CRIME NAME	DEGREE (IF ANY)	STATE
Other crime information: ☐ Attempted ☐ Conspiracy ☐ Domestic Violence ☐ Solicitation ☐ With Sexual Motivation ☐ N/A		
DESCRIPTION OF CRIME (REQUIRED WHEN CRIME IS COMMITTED OR CONVICTED OUTSIDE OF WASHINGTON STATE)		

2. CRIME NAME	DEGREE (IF ANY)	STATE	CONVICTION DATE (MM/DD/YYYY)
Other crime information: ☐ Attempted ☐ Conspiracy ☐ Domestic Violence ☐ Solicitation ☐ With Sexual Motivation ☐ N/A			
DESCRIPTION OF CRIME (REQUIRED WHEN CRIME IS COMMITTED OR CONVICTED OUTSIDE OF WASHINGTON STATE)			

Instructions for Completing the Background Check Authorization form, DSHS 09-653

These instructions provide general directions for completing the Background Check Authorization form. This form is used by multiple DSHS programs to meet varying background check needs. The DSHS oversight program requiring the background check may have additional instructions that you must follow.

Important: The requesting entity cannot submit your background check unless ALL required boxes are complete. Required boxes have the word "REQUIRED:" next to the box number. The requesting entity will submit your completed background check through the online Background Check System (BCS).

This form is to be completed by the applicant, the person whose background DSHS is checking.

BOX NO.	INSTRUCTIONS
1	Current Legal Name: List your first, middle, and last name as they are listed on your current Driver's License or other primary photo ID. Accepted government-issued photo ID includes any federal, state, or local government-issued ID, US military ID, US or foreign passport, or federally recognized tribal ID. Write **N/A** in each field that you do not have a name to enter.
2	Other Alias Names: Print all other first, middle, or last names you have used. Other names include nicknames, birth names, maiden names, etc. If you have not used any other first, middle, or last names, you must enter **N/A** in the appropriate box. Do not leave any of the boxes blank.
3	Print your date of birth listing the month, day, and year (MM/DD/YYYY).
4	Phone number where you can be reached Monday through Friday between 8:00 AM to 5:00 PM. By checking the box, you are authorizing BCCU to leave a detailed message.
5	By providing your email address and checking the consent box, you are giving BCCU consent to send you confidential and sensitive background check information, including a fingerprint rap sheet (if applicable). BCCU will not mail or email when no background information is found (No Record). Contact BCCU if you have questions.
6	You may choose to provide your Social Security Number. Your Social Security Number helps the Background Check Central Unit (BCCU) match your name and date of birth to existing records in our database and may speed up completion of your background check.
7A	Print your Driver's License or state-issued ID number.
7B	The state where your Driver's License or ID was issued.
8	If you have continuously lived in Washington State without living in another state or country for the last three years (36 months), answer **NO**. If you have lived in any state or country other than Washington State within the last three years (36 months), answer **YES**.
9	Print your mailing address where BCCU can send you confidential information such as a copy of your background check results.
10	Print your street address if it is different than your mailing address. If you street address and mailing address are the same, enter **SAME**.
11A	You must check **YES** or **NO**. If you check **YES**, complete Page 2, Section 3, List of Crimes and Pending Charges, of the form by entering the crime name, degree (if any), state, and the conviction date (MM/DD/YYYY). Mark the correct other crime information box or **N/A**. If the crime was committed outside of Washington State, provide a brief description. If you need to list additional convictions, attach additional copies of Page 2, to the form. Include your name and all the required information listed above.
11B	You must check **YES** or **NO.** If you check **YES**, you must complete Page 2, Section 4, List of Crimes and Pending Charges, of the form by entering the pending charge name, degree (if any), and state. Mark the correct other crime information box or **N/A**. If the crime was committed outside of Washington State, provide a brief description. If you need to list additional pending charges, attach additional copies of Page 2, to the form. Include your name and all the required information listed above.
12 – 14	Read each question carefully before answering. You must check **YES** or **NO**. **Question 14: Permanent means the order was issued either following a hearing or by stipulation of the parties.**
15	Read the statements above and sign your name as it is listed in Box 1. If you are not 18 years old, a parent or guardian must sign for you.
16	Enter the month / day / year (MM/DD/YYYY) you signed Box 15.

Important Information about Answering Self-Disclosure Questions (11A-14): Your answers to self-disclosure questions become part of your background check history and are stored in the DSHS database. Self-disclosures are reported as part of your background check result like any other background check history we receive. It is important that your answers to self-disclosure questions are accurate and consistent. It is strongly recommended that you answer self-disclosure questions the same way each time you complete the Background Check Authorization form unless the question has changed or the previous answer was wrong. It is also recommended that you refer to charging papers, court records, or other official documents and that you list criminal convictions, pending charges, dates, and other information exactly as they are listed in those documents.

Questions about the Background Check Process: Contact the Background Check Central Unit (BCCU) by email bccuinquiry@dshs.wa.gov or phone at 360-902-0299.

CI Community Center
Rights and Responsibilities

I have the RIGHT to make my own choices.
I have the RESPONSIBILITY to make choices that will not hurt me, others, or property that does not belong to me.

I have the RIGHT to participate in the activities I choose.
I have the RESPONSIBILITY to choose activities that are not already filled and are currently being offered.

I have the RIGHT to express my feelings.
I have the RESPONSIBILTY to express myself in a way that does not harm anyone or anything.

I have the RIGHT to be angry.
I have the RESPONSIBILITY to express my anger in a calm voice, or to go away from others until I can do this.

I have the RIGHT to interact (do things) with other people.
I have the RESPONSIBILITY to treat them with respect, and to make sure they want to do things with me.

I have the RIGHT to do things when I want.
I have the RESPONSIBILTY to make sure I am ready to go when the activity starts, or when my ride comes to pick me up.

I have the RIGHT to bring things to the center with me.
I have the RESPONSIBILTY to keep track of these things and to keep them out of the way of other people.

I have the RIGHT to use any and **public** rooms in the Center.
I have the RESPONSIBILTY to ask before using any offices, storerooms, or locked places.

I have the RIGHT to use anything that belongs to the Center members.
I have the RESPONSIBILITY to keep these things in good shape, to put them away when I am finished, and to share them with anyone else who wants to use them.

I have the RIGHT to ask Center staff for help and attention.
I have the RESPONSIBILTY to ask in a nice way, and to let them help others as well.

I agree that these are my rights and responsibilities and that I will follow them to the best of my ability at all times.

_____ _____

Name Date

PERSONAL/EMERGENCY INFORMATION

Participant:	Date of Birth:	Date:	DDA Case Manager:
Address:			Home Phone: Cell: Work:
Emergency Contact:		Legal Guardian: **Y** ☐ **N** ☐	Home Phone: Cell: Cell:
Emergency Contact Address**:**			Relationship to Member:
Transportation:			Phone:
Physician:			Phone:
Disability/Limitations:			
Preferred Activities:			
Behavioral Concerns:			
Dietary Restrictions:			
Medications:		Allergies:	
Hours allotted per month:		***Referral Source:***	
Service (Funding): **DDA** ☐ **Recreational** ☐ **Private Pay** **DVR** ☐ **IL**			

Consent for Mutual Exchange of Information

Participant Name: _____

I authorize Columbia Industries to obtain from or release to the below identified agencies information concerning:

- **Budgeting and financial records**
- **Medical diagnostic and treatment records**
- **Psychiatric diagnostic and treatment records**
- **Counseling and treatment records**
- **Employment history, job application, resumes and work restrictions**
- **Rehabilitation plan and treatment records**

I understand this form will be valid for 1 year after signing.

I also understand that I have a right to review and receive a copy of any records shared by Columbia Industries with another agency and that I may revoke this release through written notification to Columbia Industries, however any information released prior to that revocation cannot be retrieved.

List of Agencies I authorize Columbia Industries to share information/records:

ARC of Tri-Cities (transportation)	☐	Department of Services for the Blind (DSB)	☐
Ben Franklin Transit (transportation)	☐	Parents/Family	☐
B/F Dept. of Human Services (County)	☐	School District	☐
Developmental Disabilities Administration (DDA)	☐	Background Check	☐
Division of Vocation Rehabilitation (DVR)	☐	Other: CARF	☐
		Other: NISH	☐
Mental Health Provider	☐	Other: ☐	
Residential Provider	☐		
Substance Abuse Provider	☐		

Comments: _____

_____

Participant: _____ **Date:** _____

Parent/Legal Guardian: _____ **Date:** _____

Columbia Industries Staff: _____ **Date:** _____

CI Support, LLC and Columbia Industries Media Release

Participant Name: _____

In consideration of my employment with either **CI Support, LLC,** parent company Columbia Industries and/or as an employee of Columbia Industries and as part of the services being furnished by me to both, I hereby give my consent to the photographing of myself and to the recording of my voice. The company is hereby authorized to use or cause to be used said still photographs or motion picture footage, recordings of my voice for advertising, publicity, commercial or other business purposes. Said photographs and/or recordings may be used singularly or in conjunction with other photographs and/or recordings. This includes social media.

The company has my authorization to reproduce, or cause to be reproduced and used such photographs and voice recordings. The same may be exhibited in all domestic and foreign markets. I understand that others may use and/or reproduce said photographs and/or recordings with or without the company's consent.

I hereby release the company, any of its associated or affiliated companies, their directors, officers, agents, employees, customers and the company's appointed advertising agencies, officers, directors, agents and employees, from all claims of any kind on account of such use.

☐ You **do** have my permission to use my picture, or voice in any form of media as described above.

☐ You **do not** have my permission to use my picture, or voice in any form of media.

This release will supersede any previous releases on file

_____ _____
Participant (signature) **Date**

_____ _____
Guardian (signature) **Date**

_____ _____
Columbia Industries Staff (signature) **Date**

MEDICAL TREATMENT RELEASE

I,_____ as legal guardian of _____, hereby authorize medical treatment as deemed necessary for the health and well being of this individual while participating in Columbia Industries' programs.

_____ _____
Legal Guardian (signature) Date

_____ _____
Witness (signature) Date

Insurance Carrier: _____

_____

Allergies: _____

Medications: _____

_____

CI Support, LLC, parent company CI Support, LLC

Disclosure and Authorization Regarding Procurement of Background Reports

In connection with employment (including contract for services), I understand that investigative background inquiries are to be made which include the (WSP), Washington State Patrol Background Check, DSHS Background Check and Background Source International. I understand that you will be requesting information regarding any criminal background and/or any criminal convictions I may have. I am being given the opportunity to disclose any information and authorize the (WSP), Washington State Patrol Background Check, DSHS Background Check and Background Source International Check to be run by CI Support, LLC, parent company Columbia Industries as per yearly (WSP) and every three year, (DSHS Background Check) contract requirements. In addition, background checks may be conducted on prospective employees, volunteers, or adoptive parents who will be or may have unsupervised access to children less than 16 years of age, developmentally disabled persons, or vulnerable adults. The (WSP) Washington State Patrol Background check, DSHS Background Checks and Background Source International Checks are used for initial employment decisions and done regularly per contract. The revised code of Washington (RCW) 43.43.830-43.43.845 gives complete information as to the law. Child/Adult Abuse Information Act background checks may be conducted by Washington State businesses or organizations.

1. I have been convicted of a crime:☐yes☐no

   Please explain what crime and the circumstances:

2. I have had findings made against me for a civil adjudicative proceeding: ☐yes☐no

   Please explain:

3. I have had both a conviction and findings made against me: ☐yes☐no

You will be notified of the findings of the Washington State Patrol Background results within 10 days of their return.

Please print and then sign your full name with middle initial below:

_____ _____ _____ _____

First name middle name last name Date of Birth

_____ _____

Full name including middle initial signature Date