

All About the Participant

Participant's Name: _____

Address: _____

Street

Apt

City

State

Zip Code

Is This a New Address? YES NO

Date of Birth: _____

Social Security #: _____

Not required for St. Charles County residents. Call our office if you do not want to provide SSN in written form.

Phone Number: _____

Email Address: _____

Gender: Female Male Prefer Not to Say

Would you like to receive our EMAIL list for Newsletter & Future Voucher Applications, etc? YES NO

If under 18 Years Old:

Parent Name: _____

Address: _____

Phone: _____ Email: _____

Does Participant have a Legal Guardian? YES NO

If Yes, Guardian Name: _____

Guardian Phone Number: _____

Guardian Address: _____

If you are applying for multiple vouchers in St. Louis City or County, use a separate application for each program.

Applicant Feedback: Your answers are used to justify our program to our funder and never impact your funding.

The vouchers I have used in past year(s) have helped me in the following areas: (Check all that apply)

- I needed financial assistance
I participated in a meaningful activity
I made my own recreation choices
My program met my recreation needs
I am satisfied with the services of the Recreation Council

Comments: _____

The Recreation Council Voucher Funds are "Last Dollars In" therefore, we strongly encourage you to inquire with the program you are applying for if they have financial assistance, scholarships, coupons, etc.

ALL INFORMATION ON THIS FORM MUST BE COMPLETED TO BE CONSIDERED FOR THE VOUCHER FUNDS!

Participant Lives in: (Circle One)

St. Louis County

St. Louis City

St. Charles County

Does Participant Have an Intellectual / Developmental Disability? YES NO

Please Specify: _____

Is Participant New to the Recreation Council? YES NO
If yes, complete Eligibility Form (St. Louis City and County only)

Level of Support Needed: 1:1 1:4 1:8 Other

DMH Case Number: _____
required for St. Charles Co residents

Coordinator's Name: _____

Coordinator's Phone Number: _____

Coordinator Location: DMH-Regional Office CHS (St Louis County)

DD Resources (St. Louis City) DDRB (St. Charles County)

Who is the contact person to send notifications and answer questions regarding this application? IMPORTANT!
Name
E-Mail Address
Mailing Address
Phone: Cell:

The Recreation Council Voucher Programs

Statement of Understanding & Releases

I hereby give the Recreation Council permission to verify participant's eligibility by contacting the above listed eligibility verifier and permission to correspond with the program provider or support provider, our funding partners, Productive Living Board for St. Louis County Citizens with Developmental Disabilities (PLB); St. Louis Office for DD Resources, DDRB of St. Charles County, regarding funding issues, and/or other providers involved in which the voucher will be used. I understand my client rights and responsibilities and am aware of the Recreation Council Grievance Policies.

Furthermore, I have read and understand the intent, purpose and guidelines of the Recreation Council voucher program for which the participant has applied. To the fullest extent permitted by law, I shall indemnify and hold harmless the Recreation Council of Greater St. Louis and its Directors, Officers, consultants, agents, employees and volunteers from and against any and all claims, damages, losses and expenses, including but not limited to attorney fees and court costs, arising out of or resulting from the provision of any service, provided that such claim, damage, loss or expense is attributable to bodily injury, sickness, disease or death, or personal injury, or to injury to or destruction of tangible property, which is caused in whole or in part by any acts, omissions or negligence of the service provider. I understand that the Recreation Council of Greater St. Louis is merely acting in the capacity of reimbursing the service provider of my own choice. Lastly, I understand that falsification of any of the information provided in this application and /or billing can and will be cause for disqualification from this program and all Recreation Council programs. With any electronic signature to this form, I agree that I am my own guardian or I am the applicant's legal guardian.

Signature of Participant or Legal Guardian

Date

Return this signed application to: Recreation Council or Fax to 314.726.3454

(St Louis City and County Office)

(St Charles County Office)

11457 Olde Cabin Rd, Suite #235

60 Gailwood Dr.

St. Louis, MO 63141

St. Peters, MO 63376

info@recreationcouncil.org

stchascounty@recreationcouncil.org

Voucher Funding Request

PARTICIPANT: _____

Return both pages to address on page 1

Check funding you are requesting: Overnight Camp CARE (Community Recreation) Adult Adventure (age 18+)
 Rec Supports/Personal Care After School/Extended Day (St. Louis City and County only)

Program Information

Recreation Provider: _____ Telephone Number: _____

Program/Activity: _____

Contact Person: _____ Email Address: _____

Recreation Provider's Address: _____

START Date: _____ End Date: _____ **OR** _____ My Program Dates are NOT available
FUNDING IS NOT APPROVED UNTIL PROGRAM DATES ARE SUBMITTED AND CONFIRMED.

Total Program Cost: \$ _____ Participant's Co-pay (At least 10%): _____

Amount of Voucher funding you need to attend your program: \$ _____

Have you already paid for your program fee or a deposit? Yes No

If yes, what amount: \$ _____ Attach your paid receipts.

Are you eligible for a resident or member rate? YES NO

Scholarship dollars, funding assistance, or discounts you are receiving from the program provider: \$ _____

If you have used one of our vouchers in the past, please answer the survey questions on page 1. Your input is appreciated.

Date Received

\$ Amount Approved

Coordinator

Rec Supports-Personal Care

If attending an **INCLUSIVE COMMUNITY PROGRAM**, you may request funds for RECREATION SUPPORTS / PERSONAL CARE HOURS to be reimbursed at \$8-\$12 per hour for the cost to hire a person to assist with physical, cognitive, or behavioral support needs. Maximum of \$640 per fiscal year.

Recreation Provider: _____ Program/Activity: _____

Program Dates: _____ Contact Person: _____

Assistant Name: _____ Age: _____ Address _____

Personal Care Assistant may be a family member, but may not live in the same home as the applicant.

Total number of hours you are requesting: _____ x \$ _____ per hour = Requested Amount: \$ _____

The care giver must be age 16 or older, and may not reside in the same home as the participant. You must find, screen, hire, and pay your support person. You are expected to pay your support person additional wages beyond the requested reimbursement amount as your co-pay. Hours paid to a support person for transportation to and from your program location are not reimbursable.

We recommend that the personal care provider undergo a security background check through the Missouri Department of Health, Family Care Registry. The family may request funds to cover the cost of doing a background check if needed. Visit www.health.mo.gov/safety/fcsr to get the forms or to complete the check online.

Date Received

\$ Amount Approved

Coordinator

After School / Extended Day Voucher Program - St. Louis City and County ONLY

Indicate How Your Family Will Use Your After School/After-Program Service Hours: *Check all that apply*

In-Home Care Out-of-Home Care

Name of Out-of-Home Care Provider _____

Name of School District _____ *(required if in school)*

Number of Care Hours You Are Requesting: _____ (up to 525 hours per fiscal year)

Please Indicate Number of Hours Needed Per Quarter: *Unused quarterly hours will be cancelled and assigned to other applicants.*

1st Quarter
(August & Sept.)

2nd Quarter
(Oct., Nov., & Dec)

3rd Quarter
(Jan., Feb., March)

4th Quarter
(April, May, June)

NOTE: Parents MUST BE EMPLOYED DURING THIS SERVICE. Are all Parents in the home currently employed? YES/NO

If yes, include required documentation: Employer letter stating parent(s)' regular work schedule, Parent(s)' W2, Employer's Name, Employer's Address and Phone Number

Date Received

\$ Amount Approved

Coordinator