PARTICIPANT ENROLLMENT AGREEMENT
2026–2027 Program Year

Participant Name:_____ Date of Birth:_____
Parent/Guardian Name:_____
Relationship to Participant:_____
Phone Number:_____ Email Address:_____
Enrollment Date:_____

Program Schedule	**Tuition**	**Payment Method**
2 Day Program	Annual Tuition: $6,700	Please select all that apply:
Monday & Tuesday	Program Year:	□ Private Pay
8:30 AM – 2:30 PM	9/7/26 - 5/19/2027	□ FES-UA Scholarship

Agreement Terms

Please initial each statement below.

_____(Initials) I understand and agree that enrollment at The Collective Orlando, LLC is a commitment for the full 2026–2027 program year, or the remaining portion of the year at the time of enrollment.

_____(Initials) I understand that tuition reserves my participant's placement in the program and may be paid in full or through monthly installments. Monthly payments are due on the 1st of each month.
A late fee of $25 may be applied after the 7th of the month.

_____(Initials) I understand and agree that if scholarship or funding payments are delayed, denied, or not approved, I remain financially responsible for tuition balances owed to The Collective.

_____(Initials)I understand that The Collective is a community-based faith-centered program focused on life skills, vocational experiences, community engagement, and social development. The program does not provide medical care, behavioral therapy, crisis intervention services, or one-to-one support services.

_____(Initials)I understand that enrollment decisions are based on staffing ratios, participant support needs, and the program's ability to safely support participants within the group environment.

_____(Initials)I understand that no refunds or credits will be issued for absences, vacations, illness, withdrawal, or dismissal from the program.

By signing below, I acknowledge that I have reviewed and agree to the terms outlined in this enrollment agreement and understand the financial and program commitments associated with enrollment at The Collective.

Parent/Guardian Signature: _____ Date:_____
Participant Signature (if applicable): _____

THE COLLECTIVE
COMMUNITY | PURPOSE | INDEPENDENCE

Participant Application

2026–2027 Program Year

Participant Name:_____ Date of Birth:_____

Primary Diagnosis: _____ Age: _____

Address:_____

Phone Number:_____ Email Address:_____

Current or last school/program attended:_____

Parent/Guardian #1 Name:_____

Relationship to participant: _____ Phone #:_____

Email Address:_____

Parent/Guardian #2 Name:_____

Relationship to participant:_____ Phone #:_____

Email Address:_____

Power of Attorney or Guardianship Completed?_____if yes, which one_____

Allergies: _____

Diet Restrictions: _____

Behavior / Support Needs: _____

_____

Parent/ Guardian Signature: _____ Date: _____

THE COLLECTIVE
COMMUNITY | PURPOSE | INDEPENDENCE

Participant Interests and Goal

2026–2027 Program Year

Participant Name:_____

The participant enjoys: _____

_____

The participant's strengths include:_____

_____

Areas where the participant would like additional support:_____

_____

Does the participant hope to explore volunteer or vocational opportunities?___Yes. ___ No

Does the participant enjoy social interaction with peers?_____Yes _____No

What goals do you hope The Collective will help support?_____

_____

_____

Please check all skills the participant can complete independently:

□ Brushing teeth. □ Dressing independently. □ Bathing independently. □ Laundry

□ Ordering food independently. □ Grocery shopping. □ Preparing simple meals

□ Using a phone independently. □ Community safety awareness.

□ Managing personal belongings. □ Following a schedule/routine □ Manage Money

Additional notes regarding independence skills: _____

_____

_____

Parent/Guardian Signature: _____ Date: _____

THE COLLECTIVE
COMMUNITY | PURPOSE | INDEPENDENCE

PARTICIPANT RELEASE & WAIVER OF LIABILITY

2026–2027 Program Year

Participant Name:_____

Parent/Guardian Name: _____Date: _____

I acknowledge that participation in activities through The Collective Orlando, LLC involves certain inherent risks associated with community-based programming, outings, recreational activities, volunteer experiences, vocational exploration, transportation, and life-skills activities.

In consideration for participation in The Collective, I voluntarily release and hold harmless The Collective, its owners, employees, volunteers, church partners, and representatives from any and all liability, claims, demands, injuries, illnesses, damages, or losses arising from participation in program activities, whether on-site or off-site.

I understand and agree that:

- The Collective does not provide medical care, behavioral therapy, crisis intervention, psychiatric treatment, or one-to-one support services unless otherwise agreed upon in writing.
- Participants may participate in community outings, volunteer opportunities, and activities at public or community locations. Transportation is provided by collective staff. I understand the risks associated with community outings and transportation.
- The Collective does not provide medical or accident insurance coverage for participants.
- In the event of illness or emergency, I authorize staff to obtain emergency medical treatment if I cannot be reached immediately.
- I am responsible for providing accurate information regarding medical conditions, allergies, medications, behavioral concerns, and support needs.
- The Collective reserves the right to determine whether the program can safely support a participant within the group setting.

I also grant permission for The Collective to use photographs or videos of the participant for newsletters, social media, promotional materials, and program communications unless I indicate otherwise below.

□ I DO NOT grant permission for photographs/videos to be used publicly.

By signing below, I acknowledge that I have read and understand this waiver and voluntarily agree to its terms.

Parent/Guardian Signature: _____ Date: _____

Participants Signature (if applicable): _____

THE COLLECTIVE
COMMUNITY | PURPOSE | INDEPENDENCE

Emergency Contact Information

2026–2027 Program Year

Participant Name:_____ DOB: _____

Parent/Guardian Names: _____

Home Address: _____

Primary Phone Number: _____Secondary Phone Number:_____

Emergency Contact #1: _____ Relationship: _____

Phone Number: _____ Alternate Phone Number:_____

Emergency Contact #2:_____ Relationship:_____

Phone Number:_____ Alternate Phone Number:_____

Primary Physician / Phone Number: _____

Preferred Hospital: _____

Please list any allergies, medical conditions, or important medical information: _____

_____

_____

List Medications, Dosages, and reason for taking:

_____

_____

Will the participant need to take medication while at The Collective? _____

In the event of illness or emergency, I authorize The Collective staff to obtain emergency medical treatment for my participant if I cannot be reached immediately.

Parent/Guardian Signature: _____ Date: _____