1802 W. Parkside Lane Phoenix, AZ 85027 602.943.5472 UCPofCentralAZ.org

UCP United Cerebral Palsy™ of Central Arizona

UCP Ambassador Program

It's Your Time to Shine!

What makes UCP of Central Arizona so great?

It's YOU, the members and families that UCP serves throughout the year! That's why we are asking for your assistance in showcasing UCP's programs.

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We are recruiting for:
UCP AMBASSADORS
And we hope you will join us!

What is a UCP Ambassador?

UCP Ambassadors and their families represent UCP to the public and create awareness of our services. They have the option of participating in UCP special events, community meetings, and appearing in organization marketing materials, and being a media spokesperson.

What does it take to be a UCP Ambassador?

A UCP Ambassador can be a member of any age that is currently receiving services from UCP or has received services from UCP in the past.

How do we sign up?

If you are interested in becoming a UCP Ambassador Family please complete this registration packet and return it to UCP at 1802 W. Parkside Lane Phoenix, Arizona 85027 with a recent digital photograph. If additional information is needed, please contact the **Development Department, at 602-943.5472.**

Involvement Interest:

There are several options to choose from in the Ambassador Program. You may choose one, two, or all three options depending on your preferred level of participation in the program.

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___ My family is interested in receiving invitations to participate in special events.

___ My family is interested in public speaking on behalf of UCP of Central Arizona at events, to corporate sponsors, on video and to the media.

___ My family is interested in being featured in UCP of Central Arizona's marketing materials and advertisements including: van wraps, brochures, websites, billboards, corporate reports, social media, ads, etc.

Ambassador Questionnaire

Name of UCP Member: _____

Gender: _____ **Age:** _____ **DOB:** _____

Start date of services: _____

Service(s) that member receives or have received at UCP:

Therapy
- ◯ Occupational
- ◯ Physical
- ◯ Speech
- ◯ Feeding

HCBS
- ◯ Attendant Care
- ◯ Habilitation
- ◯ Respite

- ◯ Day Treatment for Adults
- ◯ Early Learning Center

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Does the member use any type of adaptive or medical equipment? (For example, wheelchair, walker, braces, feeding tube, hearing aids, etc.)

_____

_____

_____

_____

Is there additional information about the member that UCP should be made aware of? For example: Food allergies, sensory issues, health needs/behaviors, claustrophobia etc.

_____

_____

_____

_____

_____

_____

Member's shirt size:

☐ Youth small ☐ Youth medium ☐ Youth large ☐ Youth x-large ☐ Adult small
☐ Adult medium ☐ Adult large ☐ Adult x-large ☐ Adult xx-large ☐ Other _____

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Ambassador Family Information

School member attends (if applicable): _____

Other children in home (if applicable):

Name:_____ **Age:**_____

Name:_____ **Age:**_____

Parent or Guardian name(s):_____ _____

Relationship to Member: _____ **Language Preference:** _____

Home (mailing) address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone: (_____)-_____
Best time to be reached? _____

2nd Phone: (_____)-_____
Best time to be reached? _____

Email address: _____

Mother's employer: _____ **Phone:** _____
Father's employer: _____ **Phone:** _____
Guardian's employer: _____ **Phone:** _____

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About the Ambassador

How has UCP helped your child/adult and your family? Please share your story. Include:

- **How has UCP helped your child, adult, and family?**
- **Improvements seen in him or her, since utilizing UCP's programs and services.**
- **What does the child, adult, and family like most about UCP?**
- **What goals would you like to see the child or adult accomplished?**

(For story examples please refer to our Ambassador page on our UCP website at) www.UCPofCentralAZ.org

My UCP story!

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Please provide us with a digital photo(s) of member through email events@UCPofcentralaz.org or text them to 602.621.3443.
Note: UCP may have the ability to utilize a professional photographer to photograph ambassadors upon special occasions.

Are you interested in receiving UCP electronic newsletters? ____Yes ____No

Are you interested in volunteering at UCP, if needed? ___Yes ___ No

Are there any community or business members, that you can connect UCP with, in effort to collaborate, or begin a partnership with? ___Yes ___ No

If yes, please list:

_____

_____

_____

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Please complete the attached HIPAA and media release forms.

HIPAA Release Authorization

Section I

I authorize United Cerebral Palsy of Central Arizona (UCP) to release, disclose, and discuss any and all protected
health information (PHI) in UCP's possession regarding:

Patient's Name _____ Date of Birth _____

Date(s) of service _____ (if known)

Section II

The information to be released includes the following information and records in UCP's possession, custody, or control regarding the Patient (Check all that apply):

☐ Patient's name ☐ Likeness ☐ Attributes Description ☐ Image ☐ Conditions

I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment for my health care will not be affected if I do not sign this form.

I understand that UCP may not set a condition on treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

I understand that there may be a fee for obtaining these records. A copy of this authorization is as valid as the original.

FORM VALIDATION

_____ _____

Signature of Patient Date

_____ _____

Signature of Patient's Representative Printed Name of Patient's Representative

_____

Relationship to Patient or Legal Authority to Act for Patient (Attach Supporting Documentation)

☐ By checking this box, with my signature above, I decline authorizing UCP to release, disclose, and discuss any and all protected health information (PHI) in UCP's possession.

[Provide copy of signed authorization to Patient]

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CONSENT & RELEASE

I hereby grant to United Cerebral Palsy Association of Central Arizona, Inc. ("UCP"), its parents, affiliates, subsidiaries, successors, nominees, agents, and assigns, my free and unlimited consent and permission to, in furtherance of its work and with or without identification of me by name, to (1) take photographs, moving pictures, and video recordings of me, record my voice, and produce other likenesses of me; (2) use, copyright, store, have stored, publish, or republish the same with or without identification of me by name; (3) use my name and/or identifying information referring to me in conjunction therewith; and (4) authorize any newspaper, company, or other organization to use, store, have stored, publish, or republish the same.

I hereby waive any right to inspect or approve the materials or publications discussed above as they are used by UCP, its parents, affiliates, subsidiaries, successors, nominees, agents, assigns, licensees, or other authorized organizations, both now and in the future, whether that use is known to me or unknown, and I waive the right to any royalties or other compensation arising from or related to the use of the aforementioned materials or publications. I hereby convey, transfer and assign any and all copyrights I may have in and to the aforementioned materials and any right to copyright renewals of the same to UCP.

I hereby agree to release and hold harmless UCP for any claims, damages, or other liability arising from or related to the use of such materials and publications. UCP has complete discretion to use, re-use, or discard all materials and publications. This release is without time limitation.

By signing below, I certify that I have read this release in its entirety and fully understand its contents, and am either:

(1) Eighteen (18) years of age and competent to contract in my own name; or

(2) The parent or guardian of the undersigned, and I attest that I am competent to contract in my own name and on behalf of the undersigned.

CONSENT & RELEASE

Member's Name:_____

Member's Signature:_____

Home Address:_____

City:_____ **State:**_____ **Zip:**_____

Parent or Guardian's Name:_____

Relationship to Member:_____

Parent or Guardian's Signature:_____

Date:_____

Please return the completed registration package to:

Development Department
UCP of Central Arizona
1802 W. Parkside Lane
Phoenix, Arizona 85027
602-621-3443