# SCUSD Adult Education

*Offering adult education to developmentally disabled, older adults and parents in the greater Sacramento community*

**2026–2027 REGISTRATION CHECKLIST**

Dear Client, Parents, Care Providers, and Conservators:

The enclosed forms will need to completed by the appropriate individual and returned to Charles A. Jones Career & Education Center for the 2026–2027 session year, which begins on August 11, 2026. These are sent early to allow time for medical appointments. Please complete and return all forms as soon as possible.

## Check-Off List

☐ Program Calendar
☐ Client Online Registration Completed (New Clients ONLY)
☐ Client Attendance Policy
☐ Authorization and Request for Exchange of Information with Alta & Health Providers (If applicable)
☐ Rights of Individuals with Developmental Disabilities
☐ Community Funds Agreement ($60.00/month)
☐ Dentist's Report (exam within the last 12 Months)
☐ Physical Examination Report (exam within the last 12 Months)
☐ Emergency and Health Information
☐ Client Illness Policy
☐ Authorization for Emergency Medical Transportation
☐ Admission Agreement, Exit Process, and Grievance Procedure

***Attendance is of high importance and encourage vacations to be planned during the days that the classes are closed.***
Please assist the client in completing these forms that are to be signed by the client unless they are conserved. Thank you for your cooperation in this process. If you have questions about any of the forms, please do not hesitate to contact (916) 395-5800. ***Clients will not be able to start or resume their day program without the completion of this packet.***

**By signing this document, you acknowledge completion of this packet and receipt and understanding of the above-mentioned forms.**

**Client ASAP ID#:** _____
**Client Print Name:** _____
**Caregiver Print Name:** _____
**Client Signature:** _____
**Date:** _____

Marla Clayton Johnson, Ed.D., Director of Adult Education
Sacramento City Unified School District

# SCUSD Adult Education

# 2026-2027

## Academic Year Calendar

**July 2026**

| Su | M | Tu | W | Th | F | Sa |
|---|---|---|---|---|---|---|
| | | | 1 | 2 | 3 | 4 |
| 5 | 6 | 7 | 8 | 9 | 10 | 11 |
| 12 | 13 | 14 | 15 | 16 | 17 | 18 |
| 19 | 20 | 21 | 22 | 23 | 24 | 25 |
| 26 | 27 | 28 | 29 | 30 | 31 | |

**August 2026**

| Su | M | Tu | W | Th | F | Sa |
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| 16 | 17 | 18 | 19 | 20 | 21 | 22 |
| 23 | 24 | 25 | 26 | 27 | 28 | 29 |
| 30 | 31 | | | | | |

**September 2026**

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| 13 | 14 | 15 | 16 | 17 | 18 | 19 |
| 20 | 21 | 22 | 23 | 24 | 25 | 26 |
| 27 | 28 | 29 | 30 | | | |

**October 2026**

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| 18 | 19 | 20 | 21 | 22 | 23 | 24 |
| 25 | 26 | 27 | 28 | 29 | 30 | 31 |

**November 2026**

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| 15 | 16 | 17 | 18 | 19 | 20 | 21 |
| 22 | 23 | 24 | 25 | 26 | 27 | 28 |
| 29 | 30 | | | | | |

**December 2026**

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| 13 | 14 | 15 | 16 | 17 | 18 | 19 |
| 20 | 21 | 22 | 23 | 24 | 25 | 26 |
| 27 | 28 | 29 | 30 | 31 | | |

**January 2027**

| Su | M | Tu | W | Th | F | Sa |
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| 17 | 18 | 19 | 20 | 21 | 22 | 23 |
| 24 | 25 | 26 | 27 | 28 | 29 | 30 |
| 31 | | | | | | |

**February 2027**

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| 7 | 8 | 9 | 10 | 11 | 12 | 13 |
| 14 | 15 | 16 | 17 | 18 | 19 | 20 |
| 21 | 22 | 23 | 24 | 25 | 26 | 27 |
| 28 | | | | | | |

**March 2027**

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| 14 | 15 | 16 | 17 | 18 | 19 | 20 |
| 21 | 22 | 23 | 24 | 25 | 26 | 27 |
| 28 | 29 | 30 | 31 | | | |

**April 2027**

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| 11 | 12 | 13 | 14 | 15 | 16 | 17 |
| 18 | 19 | 20 | 21 | 22 | 23 | 24 |
| 25 | 26 | 27 | 28 | 29 | 30 | |

**May 2027**

| Su | M | Tu | W | Th | F | Sa |
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| 9 | 10 | 11 | 12 | 13 | 14 | 15 |
| 16 | 17 | 18 | 19 | 20 | 21 | 22 |
| 23 | 24 | 25 | 26 | 27 | 28 | 29 |
| 30 | 31 | | | | | |

**June 2027**

| Su | M | Tu | W | Th | F | Sa |
|---|---|---|---|---|---|---|
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| 6 | 7 | 8 | 9 | 10 | 11 | 12 |
| 13 | 14 | 15 | 16 | 17 | 18 | 19 |
| 20 | 21 | 22 | 23 | 24 | 25 | 26 |
| 27 | 28 | 29 | 30 | | | |

Job Center/School Closed/No Testing/No Students

No Academic Student Classes

5451 Lemon Hill Avenue • Sacramento, CA 95824 • (916)-395-5800 • caj.scusd.edu

Marla Clayton Johnson, Ed.D., Director of Adult Education
Sacramento City Unified School District

# Welcome to SCUSD Adult Education Registration!

Please complete the online registration form COMPLETELY before existing the online portal so we can capture the necessary demographic information prior to enrolling the adult student into classes and programs. When the registration form is fully complete - you can now visit our main office to enroll in the program of choice!

**A. Warren McClaskey's Adults with Disabilities Program** does NOT require CASAS testing prior to enrollment. Just complete this online registration form and visit the main office for enrollment where you will receive the required information on what to provide for enrollment.

## To register for A. Warren McClaskey Adults with Disabilities Program

1. **Please scan the QR code to be directed to online registration**

2. **Click on the green Register Now!**

3. **Click on CREATE AN ACCOUNT**

Registration is NOT enrolling for the AWM Program - you must enroll at the CAJ Main Office. The individual enrolling in the AWM Program **MUST bring a physical picture ID** in order to enroll (pictures on phones will not be accepted).

Marla Clayton Johnson, Ed.D., Director of Adult Education
Sacramento City Unified School District

**Client ASAP ID #: _____**

# Client Attendance Policy – 90% Minimum Requirement

To ensure clients receive the maximum benefit from our programs and maintain consistency in their learning and engagement, Sacramento City Unified School District Adult Education has implemented the following attendance policy:

**Attendance Requirement:**
All clients are expected to maintain a minimum of 90% attendance throughout their enrollment in our program. Consistent attendance is essential for client growth, skill development, and successful participation in scheduled activities.

**Excused Absences:**
We understand that clients may occasionally have planned absences or unavoidable circumstances. In such cases, the following guidelines apply:

**- Planned Vacations or Extended Leave: Clients (or their care providers) must notify clients instructor in advance of any planned time away from the program. Independent Study**

**- Illness: If a client is unable to attend in person due to illness independent study may be provided.**

**Non-Compliance:**
Failure to meet the 90% attendance requirement may result in a release of the client's continued placement in the program. Our team will work with care providers and Alta Regional Center Service Coordinators to ensure the best outcomes for each client.

Please return the bottom portion to the Charles A. Jones Career & Education Center.

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I have received the Sacramento City Unified School District Adult Education Client Attendance Policy.

**Client Print Name: _____**

**Client Signature: _____**

**Date: _____**

Marla Clayton Johnson, Ed.D., Director of Adult Education
Sacramento City Unified School District

**Client ASAP ID # _____**

# AUTHORIZATION AND REQUEST FOR EXCHANGE OF INFORMATION

**Client Name: _____**

**Date of Birth: _____**

**Address: _____**

I hereby request and authorize professional personnel of Sacramento City Unified School District Adult Education in the Sacramento City Unified School District, California Department of Education, and Alta California Regional Center, 4151 E Commerce Way Suite 100, Sacramento, CA 95834 to exchange the medical, psychiatric, psychological, educational, and/or social and family information in their possession pertaining to the above-named individual. The purpose of this information is to assist the Sacramento City Unified School District Adult Education staff in planning an appropriate educational program.

Please check one of the following lines:

____ This information is to be shared only with professional personnel.

____ This information may be shared with parents/care providers and others with additional authorization.

_____

**Signature of Client or Conservator**

_____

**Date**

SCUSD ADULT EDUCATION

Marla Clayton Johnson, Ed.D., Director of Adult Education
Sacramento City Unified School District

**Client ASAP ID#: _____**

# Rights of Individuals with Developmental Disabilities

Each person receiving services in this facility has the following rights:

- You have the right to go to school.
- You have the right to be treated well and with respect.
- You have the right to see your friends, family, girlfriends or boyfriends every day.
- You have the right to services that help you live, work and play in the most normal way possible.
- You have the right to keep and spend your own money on the things that you want, and to keep
- You have the right to meet people and take part in your community activities.
- You have the right to exercise and have fun.
- You have the right to say "NO" to the things that will put you in danger.
- You may have other rights as provided by law or regulation.

**Client Print Name**: _____

**Client Signature**: _____

**Date**: _____

**Administrator Signature**: _____

**Date**: _____

CHARLES A. JONES CAREER & EDUCATION CENTER
Sacramento City Unified School District

Marla Clayton Johnson, Ed.D, Director of Adult Education

**Client ASAP ID#: _____**

# COMMUNITY FUNDS

The Community Access component of our curriculum has expanded to the community in which the students are better able to learn life skills.

One of the important life skills the students learn is budgeting. In order for budgeting to be taught effectively, it is necessary for them to “deposit a paycheck” at the beginning of each month. For this reason, we are asking that you send in $60.00 cash at the beginning of each month. The client then knows how much they need to budget for the month, which encourages planning, saving, and evaluating the importance of specific purchases.

The cash will be deposited into their personal consumer account. The banking skills involved help clients learn and promote budgeting skills. Some items for which the students have budgeted and saved funds include gifts, electronics, and articles of clothing.

Budget records are kept. Although the clients keep the records, like a checkbook register, staff assist clients to help keep an accurate budget.

Thank you for your cooperation in this valuable program. If you have any questions and/or concerns, please do not hesitate to contact the main office (916)395-5800 or email adulteducation@scusd.edu.

SCUSD ADULT EDUCATION

Marla Clayton Johnson, Ed.D., Director of Adult Education
Sacramento City Unified School District

**Client ASAP ID#: _____**

# DENTIST REPORT FOR SCHOOL USE

Client's Name _____ Date of Birth _____
(Last) (First)

Authorization of person responsible for client _____
Relationship to client _____
Address _____

Three essential kinds of care necessary to protect your student's dental health are:
(1) adequate nutrition (2) daily dental hygiene and cleanliness and (3) regular periodic dental examination. We call your attention to needs of periodic dental care.

## DENTAL EXAMINATION AND RECOMMENDATIONS

| | |
|---|---|
| Arch growth and development:<br>1. Normal _____<br>2. Abnormal _____ | (Comments) |
| Problems which may affect speech: | |
| Active caries present? _____<br>If yes, outline the treatment plan. | |
| Is there evidence of periodontal disease?<br>Indicate severity of problem, and treatment plan. | |

Recommendations:

1. Repair of caries _____
2. Prosthesis (specify) _____
3. Orthodontia _____
4. Return for further care in _____ months
5. Other comments or recommendations:

_____

_____

This examination included: X-rays _____ Scaling and cleaning _____
Teaching (films or demonstration) _____ Fluoride applications _____

_____ _____
Name of examining Dentist Address

_____ _____
Name of Dental Hygienist Date of exam

Marla Clayton Johnson, Ed.D., Director of Adult Education
Sacramento City Unified School District

**Client ASAP ID#: _____**

# PHYSICAL EXAMINATION REPORT OF STUDENT

Reason for referral: _____

Name: _____

*I hereby give my consent to the school nurse and my physician to exchange information concerning the above student.*

_____ _____

Client/Conservator's Signature Date

| | Normal | Abnormal | Not Examined | EXPLAIN |
|---|---|---|---|---|
| Height _____ Weight _____ | | | | |
| Blood Pressure _____ | | | | |
| General Appearance, Posture & Gait | | | | |
| Skin | | | | |
| Nose & Throat | | | | |
| Eyes: Acuity (Right) | | | | |
| Acuity (left) | | | | |
| ***Current hearing test: Yes / No*** | | | | |
| | | | | |
| Heart | | | | |
| Lungs | | | | |
| Abdomen | | | | |
| Bone, Joints & Muscles | | | | |
| Neurological Exam | | | | |
| | | | | |
| **Other:** Blood Sugar (FBS) | | | | |
| Thyroid issues | | | | |
| Cholesterol issues | HDL | LDL | Total | |
| Blood Count | | | | |
| Vitamin D Level | | | | |
| | | | | |

**Immunizations:**

**Tetanus Booster** Date:_____ **Pneumonia** Date: _____ **Influenza** Date: _____

**Hepatitis B Immunization:** Yes _____ No _____ Dates: _____

**Rubella Booster Immunization:** (if born in or after 1957 & immunized prior to 1968) _____

**COVID-19 Immunization: Date:** _____ **Date:** _____ **Date:** _____ **Date:** _____

**TB skin test** _____**neg**_____**pos**_____ **Date:** _____

MEDICAL OR MENTAL DIAGNOSIS (Please list): _____

_____

Regular Medication: Yes _____ No _____ PRN Medication: Yes _____No _____

Drug: _____ Dosage: _____Date Begun: _____

Drug: _____ Dosage: _____Date Begun: _____

Any plan for further medical studies, treatment, or management: _____

_____

**Physician's Signature** _____**Phone #** _____

**Physician's Name (please print)** _____**Date of Examination** _____

Marla Clayton Johnson, Ed.D., Director of Adult Education
Sacramento City Unified School District

**Client ASAP ID#: _____**

**Health History**:

Autism Spectrum Disorder Yes No
Explain:

Mental Health Yes No
Explain:

Down Syndrome Yes No
Explain:

Diabetes Yes No
Type:

Heart Problems/BP elevated Yes No
Explain:

Seizures Yes No
Type/Frequency:

Bleeding Problems Yes No
Explain:

Past Head Injury Yes No
Explain:

Dizzy/Fainting Spells Yes No
Explain:

Bone or Joint Problems Yes No
Explain:

Other
Explain:

**Medications:**

1.
2.
3.
4.
5.

**Physician's Statements:**

I have received health information on and examined _____

and certify there is no medical evidence available to me which would preclude her/his

participation in an aerobic exercise class and using the above-mentioned equipment.

**Physician Signature**: _____

**Physician Name Printed**: _____

**Address**: _____

**Phone**: _____

Marla Clayton Johnson, Ed.D., Director of Adult Education
Sacramento City Unified School District

**Client ASAP ID#:** _____

1. **LIST ALL MEDICATIONS TAKEN BY STUDENT**
**(attach sheet if necessary)**

**PLEASE NOTIFY SCHOOL OF ANY ADDITIONS OR CHANGES AS THEY OCCUR THROUGHOUT THE YEAR**

| DRUG NAME | DOSAGE | TIMES TAKEN | WHO ORDERED (Doctor) | WHAT TAKEN FOR |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

2. ALLERGIES: (include medications, foods, insect bites, pollen, etc.) _____
***IS ALLERGY LIFE THREATENING:*** YES ☐ NO ☐

3. Does student require medication during school hours? YES ☐ NO ☐ **If yes call Nurse at 916-395-5780 for forms**

4. Does staff have permission to give over the counter pain medication as needed? YES ☐ NO ☐

5. Please check below any health problems pertaining to your client:

_____Seizure Disorder (Describe type, frequency, and duration) _____
_____Hepatitis B Carrier ☐
_____Heart Problems _____
_____Diabetes
_____Autism Spectrum Disorder
_____Mental Health
_____Shunt
_____Visual Problems. Wear glasses? YES ☐ NO ☐
_____Hearing Problems. Uses hearing Aides? YES ☐ NO ☐
_____Gastrointestinal Bowel isssues YES ☐ NO ☐ Urinary issues YES ☐ NO ☐
_____Migraines YES ☐ NO ☐
_____Psychological/Behavioral (describe) _____
_____Other _____

6. Date of last tetanus/diphtheria immunization shot: _____

7. Date of last TB skin test: _____ Results: _____

Marla Clayton Johnson, Ed.D., Director of Adult Education Sacramento City Unified School District

**Client ASAP ID#:** _____

**SACRAMENTO CITY UNIFIED SCHOOL DISTRICT (S.C.U.S.D.)**
**ADULT EDUCATION**
**EMERGENCY AND HEALTH INFORMATION**

| Client Last Name | Client First Name | Birthdate (Month / Day / Year) | Birthplace (City) | State | SEX M | SEX F |
|---|---|---|---|---|---|---|
| | | | | | | |

**Social Security #** - -

**Transportation for client provided by:** RT ☐ UCP ☐ OTHER: _____ (please specify)

Student lives: By SELF ☐ With Parent ☐ in a Care Home ☐ in a Mentor Home ☐

1. Client Address: _____
   City: _____ ZIP: _____
   Phone #: Email _____
   Address: _____

**IN CASE OF EMERGENCY CALL:**

2. Parent ☐ Care provider ☐ Mentor ☐
   a. Name: _____
      Address (if different from above): _____
      Wk./ Emerg./ Cell #: _____
   b. Name: _____
      Wk./ Emerg./ Cell #: _____
   c. Name: _____
      Wk./ Emerg./ Cell #:

3. Alta Worker: _____
   Phone # / Email: _____
4. ***Does client have a Conservator?*** **YES** ☐ **NO** ☐
   **(this does not mean payee)** **Name:** _____
   **IF YES, PLEASE SUBMIT** **Address:** _____
   **COPY OF CURRENT** **Phone #:** _____
   **LEGAL PAPERWORK** **Email Address:** _____
5. **DNR?** **YES** ☐ **NO** ☐ (If yes, provide doctor's statement)
6. Medical Insurance Coverage **(PLEASE PROVIDE ALL NUMBERS):**
   Medicare ☐ # _____
   Medi-Cal ☐ # _____ **Issue Date:** _____
   Insurance ☐ # _____
   Military ☐ # **Other: #**

| | | |
|---|---|---|
| **PRIMARY PHYSICIAN:** | **Address:** | |
| **Phone #:** | **Email of physician, or group, if applicable:** | |
| **PHARMACY:** | **Address:** | **Phone #:** |

7. ***IMPORTANT: PLEASE READ AND COMPLETE***

In the event of an accident or other emergency, when parent or other person responsible for the client is unavailable, I hereby authorize a representative of the school to make such arrangements as he/she considers necessary for the client to receive medical or hospital care, including necessary transportation and including all pertinent information to health providers.

Under such circumstances, I further authorize the physician named to undertake such care and treatment of my student as he/she considers necessary. In the event said physician is not available at the time, I authorize such care and treatment to be performed by any licensed physician/surgeon.

The undersigned hereby agrees to bear all costs incurred as a result of the above.

**Signature:** _____ **Date:** _____

SCUSD ADULT EDUCATION

Marla Clayton Johnson, Ed.D., Director of Adult Education
Sacramento City Unified School District

**Client ASAP ID#: _____**

# Illness Policy

Dear Clients, Families, and Care Providers:

Illness will affect both clients and staff throughout the program year. We have learned that some symptomatic clients have been attending the program or have been sent to school while showing signs of sickness. This has resulted in the spread of infections to classmates and staff, including individuals with compromised immune systems. It is essential that we work together to maintain a healthy and safe learning environment for everyone.

## Policy Expectations

- Clients must stay home if they are experiencing ANY symptoms that may be related to COVID-19, flu, or the common cold.
- Do NOT send symptomatic clients to the program.
- If a client begins to feel unwell while at the program, they must notify a staff member immediately.
- If McClaskey staff contacts you to pick up a client due to illness, please do so promptly—ideally within one hour of being notified.
- A client may return to the program once they have been symptom-free for at least 48 hours, without the use of medication.

## Acknowledgement

By signing below, I acknowledge that I have read, understand, and agree to follow this Illness Policy.

**Client Print Name:** _____

**Client Signature:** _____

**Parent/Caregiver Print:** _____

**Parent/Caregiver Signature:** _____

Marla Clayton Johnson, Ed.D., Director of Adult Education
Sacramento City Unified School District

**Client ASAP ID#: _____**

# Authorization for Emergency Medical Transport

Client Name: _____

Date of Birth: _____

In the event of a medical emergency, I authorize staff at Sacramento City Unified School District Adult Education to call emergency medical services (911) and allow my client to be transported by ambulance to the hospital or an appropriate medical facility.

I understand that the cost of ambulance transport and hospital care will be the responsibility of the client, parent, guardian, or authorized representative.

## Emergency Contact Information

Primary Contact Name: _____

Relationship to Client: _____

Phone Number: _____

## Authorization

By signing below, I consent to the above authorization.

Parent/Guardian/Authorized Representative:

**Printed Name**: _____

**Signature**: _____

**Date**: _____

Marla Clayton Johnson, Ed.D., Director of Adult Education
Sacramento City Unified School District

# Adults with Disabilities Program Admission Agreement

## Admission

**Age Range of the Clients to be Served:**
18 years and above with a high school diploma/high school equivalency or 22 years and above.

**Ambulatory / Non-ambulatory Status:**

Regardless of ambulatory status, clients must be able to manage all self-care and mobility needs independently. Clients must be able to access the restrooms independently. Clients must be able to independently access public transportation. Ambulatory status should not impact basic self-care needs.

**Regional Center Referral:**

- Clients have to be referred by ACRC
- Adult Education's committee reviews prospective clients IPP to determine if the client's needs can be supported/if the program is an appropriate fit for the client
- If the Adult Education's committee feels that the client is appropriate for one of our programs, a tour will be scheduled.

**Involvement of Client's ID Team:**

- Clients may invite members of their ID team to join them on a site tour.
- The ID team will be a part of clients yearly IPP meetings at client's discretion.

**Other Prerequisites Required for Participation in the Program:**

- The Adult Education's team has up to 30 days to determine if client placement is appropriate. Determination can be made prior to 30 days. The team will decide if either A) Our Adult Education's program is not appropriate for the client or B) another class at our Adult Education program would be more appropriate for the client.
- If within the first 30 days, the client is deemed unsafe or deemed a danger to self or others, or exhibits defiant behaviors, an emergency meeting will be held to discuss the appropriateness of this placement
- If after 30 days, a client is deemed appropriate for our Adult Education program, placement/class level will be discussed and specified for the client, and individual goals will be developed.

**Self-Help Skills:**

- Must be able to keep track of personal belongings
- Must be able to listen to instructions and be willing to follow directions
- Must be willing to participate

**Physical and Medical Conditions (to include Restricted Health Care Conditions):**

- Clients must be continent
- Must be able to feed oneself independently
- Independent toileting (bowel and bladder)
- If a client is in a wheelchair, uses a walker or any other mobility aid, they must be able to use these devices independently

**Behavioral Characteristics:**

- Clients must have mild to moderate intellectual disabilities.
- Must have socially appropriate behaviors. Inappropriate behaviors include but are not limited to:
    - History of sexually inappropriate behaviors
    - Physical and verbally aggressive behaviors
    - Behaviors that cannot be re-directed
    - Stealing
    - History of leaving sites instructional grounds or institution areas without permission.
    - Repeated failure to comply with staff directions/directives

# Reason to be Exited from the Program:

- Need for supervision decreases to warrant a less restrictive program
- Requiring more supervision than our Adult Education staff is equipped to provide
- Inappropriate social media etiquette
- Bullying behavior
- Client's non-participation in the program
- Client chooses to leave program
- ID Team determines during review this program no longer meets the client's needs
- Exhibiting inappropriate behaviors including but not limited to:
    - History of sexually inappropriate behaviors
    - Physical and verbally aggressive behaviors
    - Behaviors that cannot be re-directed
    - Stealing
    - History of leaving sites without permission
    - Repeated failure to comply with staff directions
    - Less than 90% attendance

# Exit Process:

**If at any point during their time at our Adult Education program the staff or client feels that client should be exited from the program:**

- An emergency meeting with Adult Education's staff, client, Regional Center Service Coordinator, and any authorized client representative will be scheduled to discuss client/staff concerns. In instances of inappropriate client behavior, a behavioral contract will be presented describing desired behavioral changes.
- If the staff feels that the client is a danger to themselves, other clients, or staff, the client will need to stay home until an emergency meeting is held. The Regional Center Service Coordinator and authorized client representatives will be informed immediately of the temporary change in service.
- If it becomes clear that the client has met the needs of the contract within 30 days of the initial meeting, no further meetings are required.
- If it is clear that the client IS NOT able to meet the requirements of the contract, a meeting must be scheduled 30 days from the initial meeting to exit the client from our Adult Education program.
- If client meets goals of initial behavioral contract within the allotted 30 days, but regresses in the future, a second emergency meeting will be held to either exit the client or review the previous behavioral contract and or drafting a new behavioral contract.

# Grievance Procedure

**Each Client or any representative acting on behalf of any client, who believes that any right to which a is entitled has been abused, punitively withheld, or improperly or unreasonably denied by Sacramento City Unified Adult Education Program, you may pursue a complaint as detailed in the "Rights, Advocacy, and Appeals" section of the Alta California Regional Center website.**
**Rights, Advocacy, and Appeals - Alta California Regional Center (altaregional.org)**

- Clients should be familiar with our Adult Education's Programs **Rights of Individuals with Developmental Disabilities (pursuant to Title 17 §56710(a) and Welfare and Institution Code, Section 4705)** to determine if their rights have been violated. Rights of Individuals with Developmental Disabilities is reviewed annually with clients.

- Annually, staff and client review the "Rights of Individuals with Developmental Disabilities" as well as grievance procedures. Clients sign acknowledgement of review of grievance procedure and "Rights of Individuals with Developmental Disabilities"

- Annually, after staff/client review of "Rights of Individuals with Developmental Disabilities" and our Adult Education's grievance procedures, the Adult Education's administrator provides to ACRC community liaison a list of all students who participate.

# Conflict Resolution Process:

- Level I: Per SCUSD's Annual Employee Notification handbook: The complainant shall first meet informally with the administrator of the school or department where the alleged grievable act occurred. If the complainant's concerns are not clear or cannot be resolved through informal discussion, the administrator shall prepare, within 10 working days, a written summary of his/her meeting(s) with the complainant. This report shall be provided to the client's Alta Service Coordinator no more than seven business days after the initial ten days mentioned above.
- Level II: If the complaint cannot be resolved at Level I, the client may pursue a complaint as detailed in the "Rights, Advocacy, and Appeals" section of the Alta California Regional Center website (https://www.altaregional.org/).

**Duty: To provide client planning team availability to meet and discuss alternatives services in attending a day program. To provide 30-day notice to clients prior to changing, reducing or terminating day program services.**

**Standard of Care:**

**§ Title 17 56718 (c) requires 30 days advance notice including reasons for changing or reducing services. This step was not taken by the vendor.**

**§ Title 17 56718 (g) requires a vendor to schedule a meeting with Regional Center Service Coordinator, client, vendor and authorized client representative prior to any change in service delivery. This step was not taken by the vendor.**

**§ Title 22 80072 (a)(3). Personal Rights. (3) To be free from punishment and coercion.**

**§ 441.301(d) – The licensee shall ensure that each client is accorded the personal rights as specified in this section and the applicable sections of chapters 2 through 7.**

**Client ASAP ID#: _____**

**Client Print Name: _____**

**Clint Signature: _____**

**Date: _____**