



Easter Seals Iowa

Resident Camp 2016 Checklist

Adult: Ages 18 & Up, Youth: 4-17

Check in is Sunday afternoon between 2:00-4:00 p.m. Check out is Friday between 2:00-3:00 p.m.

This program can be paid for with waiver services or private pay. Private Pay Cost: \$600 per week.

As you complete the application, please check off the items from this list:

- 2016 Application
- Health History Form
- Easter Seals Physical Form (*valid for 2 years*) + immunization records
- All Release Forms (*Notice of Privacy Practices, Waiver of Liability, Photo Consent Form*)
- Physical signatures on the required pages (*we do not accept electronic signatures*)
- Financial Information Form
- Resident Camp Registration Form
- \$50 non-refundable deposit or authorized waiver funding (*waiver clients only - please contact your case manager*)
- Current Individual Care Plan/Consumer Comprehensive Service Plan and Release of Information (*waiver clients only - please contact your case manager*)

We require all items on this list to be submitted in order to begin the registration process.

Please send all items together, in one shipment.

You may send them to our Program and Support Specialist, Kate Killeen, by the following methods:

Email: kkilleen@eastersealsia.org
Mail or Drop Off: Easter Seals Iowa
Attn: Kate Killeen
401 NE 66th Ave
Des Moines, Ia 50313

Once we have registered you for camp, you will receive a letter via mail confirming the week(s) you are registered for. Please contact Kate Killeen at 515-309-2375 or kkilleen@eastersealsia.org if you have any questions. Thank you for choosing Easter Seals Iowa!



Easter Seals Iowa Camp Sunnyside -Camp and Respite Application 2016-

What program are you interested in?

Supported Day Camp

Resident Camp

Weekend Respite

Are you privately paying? YES NO

If so, please include the \$50 non-refundable deposit for summer camp or \$583 full payment for respite.

Client Information

Last Name:	First Name:	Middle Name:
Address:		
City/State:	County:	Zip Code:
Phone:	Cell Phone:	Gender:
Social Security Number:		Medicaid ID:
Email:		Birthdate: / /

Ethnicity: Asian American African American Caucasian Hispanic
 Native American Other Choose not to answer

Military Status: Active Duty National Guard/Reserve
 Veteran Member of Family/Spouse Not Applicable

Primary Language: English Spanish Other: _____

Guardian Information

Last Name:	First Name:	Relationship:
Address (if different from above):		
City/State:	County:	Zip Code:
Phone:	Cell Phone:	Work Phone:
Email:		
Primary Language: <input type="radio"/> English <input type="radio"/> Spanish <input type="radio"/> Other:		

Group Home (if applicable)

Name of Home:	Address:
City/State:	County: Zip Code:
Phone:	Contact Person:

Managed Care Information

Which Managed Care Organization (MCO) are you using? <input type="radio"/> United Healthcare Group <input type="radio"/> AmeriHealth Caritas <input type="radio"/> Amerigroup		
Managed Care Policy Number:		
Case Manager:		Phone:
Agency:	Email:	
Address:	City/State:	Zip Code:

Medical Diagnosis

Primary: (please circle)

<i>Mental Disorders</i>	<i>Cerebral Palsy</i>	<i>Scoliosis</i>
<i>Autism</i>	<i>Epilepsy</i>	<i>Spina Bifida</i>
<i>Alcoholism/Drug Abuse</i>	<i>Heart Disease</i>	<i>Cleft Palate</i>
<i>Other Psychological Disorders</i>	<i>Asthma</i>	<i>Down's Syndrome</i>
<i>ADD/ADHD</i>	<i>COPD</i>	<i>Speech, Language & Voice Dysfunction</i>
<i>Developmental Delays</i>	<i>Diseases of the skin & tissue</i>	<i>Spinal Cord Injury</i>
<i>Intellectual Disability</i>	<i>Arthritis</i>	<i>Head Injury</i>

Secondary:

Other:

Activities

Are you new to Camp Sunnyside? Yes [] No []
Last Year Attended:

Current Age:

Please mark the activities that are **restricted**:

- | | | |
|-------------------------------------|--|---------------------------------------|
| <input type="radio"/> Swimming | <input type="radio"/> Horseback Riding | <input type="radio"/> Arts and Crafts |
| <input type="radio"/> Boating | <input type="radio"/> Fishing | <input type="radio"/> Target Sports |
| <input type="radio"/> Sensory Room | <input type="radio"/> Basketball | <input type="radio"/> Volleyball |
| <input type="radio"/> Climbing Wall | <input type="radio"/> Dancing | <input type="radio"/> Singing |
| <input type="radio"/> Camping | <input type="radio"/> Outdoor Cooking | <input type="radio"/> Zip Line |

Please explain why these activities are restricted:

Health Information

Do you have a seizure disorder? Yes [] No [] (if yes, please fill out the rest of this section)

VNS:

What type?

Date of Last Seizure:

Frequency:

Seizure Time/Length:

Known Triggers:

Behavior / Aura Prior to Seizure:

Type of Behavior During Seizure:

Recovery Time / Behavior After Seizure:

Medical Intervention Plan:

Do you use a safety helmet? Yes [] No []

Dietary Information

Are you on a special diet? Yes [] No [] (please mark all that apply)

Blended Mechanical Soft Pureed G-Tube If so, are you: NPO?

Fluid Restriction required per physician Diabetic If so, are you: Medication Controlled?
 Other: _____ Diet Controlled? Carb Count? Insulin Controlled?

Food Allergies:

Reaction:

Other Non-food Allergies:

Reaction:

Epi Pen? Yes No If yes, please explain:

Eating: No Assistance Monitor Portions Help Cutting Up Food Total Assist

Please explain:

Daily Living

Do you use a wheelchair? Yes [] No []

If yes, what kind? Manual [] Electric []

Assistance with your manual chair:

No Assistance Assistance on Rough Ground Assistance for Distances Total Assist

Do you have a visual impairment? Yes [] No [] Additional support needed:

Assistance with Transferring:

No Assistance Stand & Pivot Transfer 1 Person Lift Hoyer Lift

Weight: **Hoyer Lifts are required for campers over 100 pounds**

Uses the Following:

Walker Hospital Bed Bed Rails Gait Belt CPAP BiPap

It is your responsibility to bring all assistive devices you need while attending sessions including electronic Hoyer Lifts, walkers, and wheelchairs

Dressing and Personal Hygiene

Assistance with dressing: [] None [] Verbal Direction [] Some Assistance [] Total Assistance

Additional Information:

Assistance with hygiene: [] None [] Verbal Direction [] Some Assistance [] Total Assistance

(brushing teeth, toileting, shower, etc)

Additional Information:

Do you wear Attends/Briefs/Diapers? [] Yes [] No If yes, how often? [] All day [] At Night

Do you wear or use any of the following items? *(check all that apply)*

[] Colostomy Appliances [] Ileo Appliances
[] Digital Stimulation [] Urinary Catheter
[] In-dwelling Catheter [] Intermittent Catheterization
[] Supra Pubic Catheter [] Shunt

Other: _____ Do you need assistance with any of these items? [] Yes [] No

Level of Assistance Needed:

Nighttime Assistance

Do you sleep through the night consistently? Yes No

If no, please explain:

What is your preferred bedtime? pm

How can we help you fall asleep if you need assistance?

Communication Needs

How do you communicate? Verbally Non-verbally Both

Alternative Communication Format? Sign Communication Device PEC Cards

Please bring all communication devices with you and label with your first and last name

Does the camper need assistance in the event of a fire, tornado, flood or bomb threat? Yes No

Client Behavior Support

Easter Seals Iowa recognizes that some clients have interfering behaviors. Our intent is to understand the history of the interfering behavior and successful strategies for supporting clients so they can get the most out of their camp and recreational experience. Therefore, this section must be completed in detail in order for the application to be processed. Disclosure of interfering behavior will not exclude you from attending. Failure to disclose interfering behaviors may result in program discharge.

Verbal and Physical Aggression (towards self, others, property, etc.)

Not aggressive May strike or swear occasionally Regularly strikes or swears

Please explain:

Tips to redirect:

Elopement:

Stays with group Wanders away Hides Actively leaves group N/A

Please explain:

Tips to redirect:

Over-Stimulation

Large group situations Noises Smells N/A Other: _____

Please explain:

Tips to redirect:

History of Sexual Aggression

Not sexually aggressive Unsolicited sexual comments/touching
 Documented sexual aggression

Please explain:

Tips to redirect:

History of Sexual Abuse

Victim of Abuse? Yes No

Please explain:

Support Recommendations:

Lifestyle

Are you seeking a health or wellness goal? Yes No N/A

Height:

Weight:

Are you Employed Not in Labor Force Seeking Employment Unemployed

Not in Labor Force Due to Client Choice Guardian Choice Over 65
 Skills/Train Edu (Ex Workshops) Under 16

Signatures

By signing here, you give our healthcare staff the permission to provide routine healthcare, dispense medications, and seek emergency treatments.

Completed by: _____

Date: _____

Relationship: _____

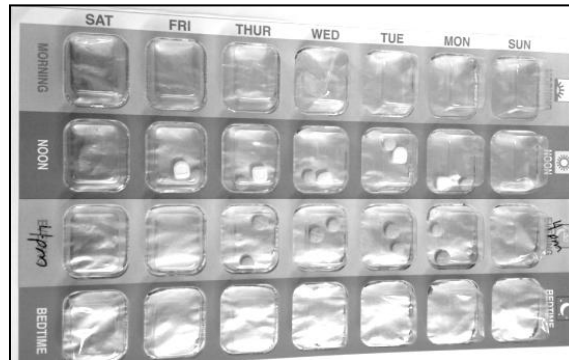
Signature of Legal Guardian (*if applicable*): _____

If you have a CCSP or ICP, please attach it

Medication Information

For Summer Resident Camp:

- All medication must be in a 7 day compliance unit-dose bubble pack. Do not send medication in original bottles, envelopes or at-home containers.



7 day compliance unit dose bubble pack

- We require medications sent to us **three weeks prior to your camp session. Do not bring your medications with you when you arrive at camp.**
- Clearly identify your medication package with the dates of your camp session, first and last name, and date of birth.
- Due to the significant volume of medications administered here at camp, please consider leaving all non-essential topical crèmes, ointments, and other PRNS's at home.
- Any questions regarding medication, please contact our health center at 515-309-2378.

All medication can be sent to:

Easter Seals Iowa
Attn: Patty Gilmore
401 NE 66th Ave
Des Moines, IA 50313

For Weekend Respite and Supported Day Camp:

- All medication can be brought with the camper to check-in.
- It must be in a medication bottle with the correct prescription on it. If it is not, the nurse will not be allowed to administer it and your camper may not be allowed to stay at camp.
- Please only bring the amount needed for each day of camp with one (1) additional dose.



Easter Seals Iowa
-Health History Form-

Client Name: Birthdate:

please complete all fields and return this form

In the event of an emergency, I give permission for Easter Seals Iowa to contact the following individuals:
(Name, Relationship, Work Phone, Home Phone, Cell Phone) x3

Regular Physician: Daytime Phone:
Preferred Hospital: Medicaid ID:
Insurance Carrier: Policy #:

Please list all allergies and reactions:

Do you carry an Epi Pen? [] Yes [] No *If so, please bring your Epi Pen with you to your sessions*

Any recent surgery or illness?

Any chronic or recurring illness?

Any other information?

Does this person have a seizure disorder? [] Yes [] No Date of Last Seizure:

Scheduled, PRN (as needed) and Non-Prescription Medications: Dosage:

Name of Person Completing Form:

Date: Contact Number:



Easter Seals Iowa
-Physical Examination Form-

Client Name: _____ Birthdate: _____

This form is to be completed by a licensed physician or by a physician's assistant.
Other exam forms will not be accepted.

Height: _____ Weight: _____
 BP: _____ Pulse: _____

State the most recent date of occurrence:

- Chicken pox _____
- Measles _____
- German Measles _____
- Mumps _____
- Hepatitis carrier _____
- Rheumatic Fever _____

	Normal	Abnormal
EENT		
Heart		
Lungs		
Resp.		
GI		
Abdomen		

Known allergies and reaction: _____

Epi-Pen? Yes No

	Yes	No	Please explain
The applicant is under the care of a physician for a medical diagnosis/disability.			
The applicant is cleared to participate in an adapted active recreational program.			
The applicant can participate in the following adapted activities: Swimming, horseback riding, zip-line, rock wall, and other outdoor activities			
The applicant has received a Tetanus Booster within the last ten years.			
Date of most recent Tetanus Booster: _____ <i>*please attach all immunization records*</i>			

I have examined the person herein described and reviewed his/her health history. It is my opinion that he/she is physically able to engage in any required activities, except as may be noted above, and is free of communicable or contagious disease.

 Signature of examining physician or physician's assistant Please print name

Fax: _____ Telephone: _____

Date of Exam: _____ Date Form Completed: _____



-Photo Consent Form-

Client Name: _____

Program Name: _____

I hereby consent that any narratives, depictions, pictures, film, photographs, audio-visual or sound recordings or testimonials of me made by Easter Seals Iowa may be used by Easter Seals Iowa, and those acting with its permission, for the purpose of illustration, broadcast, or testimonial in connection with any work of Easter Seals Iowa and that these materials may be released to the general public. I assign to Easter Seals Iowa all of my rights to these materials. All photographs and other media which include your image are the sole property of Easter Seals Iowa. Such photos may be used at various times unless you revoke this photo consent in writing. Any revocation is valid from the date it is received by Easter Seals Iowa and will not apply to photos that have been used prior to the revocation in any publication or other media.

I understand that these materials may be published on Easter Seals Iowa's network of Web sites and this may disclose my personal and protected health information. To ensure the privacy of any person under age 18, Easter Seals Iowa will use only the first name and the location of the Easter Seals Iowa organization where a minor receives services. Easter Seals Iowa does not need to submit these materials to me for further approval. I understand that these materials may be modified and that Easter Seals Iowa may decide not to use them.

I acknowledge that the rights described above are granted to Easter Seals Iowa on an unlimited basis without any compensation or payment being made for any current or future use. I understand that this authorization is voluntary and that Easter Seals Iowa will not condition any treatment or funding to me on the completion of this authorization. I also understand that I may revoke my consent to allow Easter Seals Iowa to release my protected health information if the information has not already been disclosed. To revoke my consent, I must notify Easter Seals Iowa in writing by sending my revocation to Easter Seals Iowa Intake/Marketing Coordinator. I understand and agree that once Easter Seals Iowa, and those acting with its permission, disclose my protected health information as contemplated by this release, this information is subject to re-disclosure and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996.

 Yes - please take and/or use my picture.

No - please do not take and/or use my picture.

I fully understand the contents of this release and authorization.

Consumer Signature

Date

Guardian Signature

Date

Witness for Easter Seals Iowa

Date



-WAIVER OF LIABILITY-

Signature Required

Client Name: _____

Program Name: _____

With the understanding that Easter Seals Iowa (hereafter known as ESI) will make reasonable efforts to prevent accidents, injuries, or other mishaps, I acknowledge the following:

- The undersigned, individually or as a parent or natural guardian, in partial recognition of services rendered claims, demands, or actions, causes of action or suits of whatsoever kind or nature for damages sustained by the normal client or accruing to the undersigned in consequence of any accident or occurrence resulting from the use of durable medical equipment and/or participation in any activity or program of ESI and regardless of whether the named client is not on the premises of said ESI, and is engaged in any venture or solely on his or her own behalf.
- I give permission for the applicant to attend ESI sponsored programs and to ride in vehicles operated or leased by ESI.
- I agree to not send this applicant to an ESI program if he or she has been exposed to contagious disease within three weeks of the starting date of the program and to notify Easter Seals Iowa Camping, Recreation, and Respite services immediately if this situation arises.
- The applicant has permission to engage in all prescribed activities except those noted by an examining physician or physician assistant and me. In the case of an emergency or ill health, I hereby give permission to the physician selected by ESI to order x-rays, routine test, and treatments. In the event I cannot be reached in an emergency, I hereby give my permission to the physician selected by ESI to hospitalize, secure proper treatment for, to order injections and/or anesthesia and/or surgery for the named participant.
- I understand that the participant is responsible for his/her own medical coverage and associated cost.
- This release may be revoked in writing except to the extent action has been taken in reliance upon the release.

I understand and agree to the above section.

Signature of legally responsible person (parent, guardian, or applicant):

Print Name: _____

Date: _____

Sign Name: _____

Relationship: _____

Witness: _____

Date: _____



ACKNOWLEDGEMENT OF RECEIPT OF THE EASTER SEALS IOWA INCORPORATED NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge that I have received a copy of The Easter Seals Iowa Incorporated's Notice of Privacy Practices which summarizes the ways my identifiable health information may be used and disclosed by Easter Seals Iowa and states my rights with respect to my health information. I understand Easter Seals Iowa has the right to revise these information practices and to amend the Notice of Privacy Practices. I have been informed that in the event Easter Seals Iowa revises its information practices, a revised Notice will be posted at each Easter Seals Iowa location and that I may obtain a current Notice of Privacy Practices at any time from the Easter Seals Iowa State Office or the website at www.eastersealsia.org.

Signature of Client/Guardian/Representative

Date Signed

If Guardian/Representative - State relationship to client

Signature of Witness

Date Signed

IMPORTANT!

If you are **PRIVATELY PAYING:**

- A non-refundable \$50 deposit is required to register a camper. The camper cannot be registered until we have received this and we do not reserve or hold spots. The \$50 will be applied to the first camp session. **Please send the deposit with the application** to our Program and Support Specialist, Kate Killeen, at:

Easter Seals Iowa
Attn: Kate Killeen
401 NE 66th Ave
Des Moines, IA 50313

- **Full payment is due three weeks before the client attends his/her camp session.** Failure to pay in advance may result in a loss of registration for that session. If the remaining balance is sent separately from the deposit and application, please send it to our Accounting Department at:

Easter Seals Iowa
Attn: Accounting
401 NE 66th Ave
Des Moines, IA 50313

- The entire amount is required to be paid even if the camper will not attend the entire camp.
- Any application turned in after July 1st, 2016 will require the camp payment to be made in full before the camper can be registered.
- If the camper can no longer attend the registered camp sessions, please contact Kate Killeen at 515-309-2375. Failure to cancel the camp session at least one week before the camp session begins may result in the billing contact identified on the Financial Form being charged for the full camp session.

How to Apply for a Campship:

Easter Seals Iowa receives funding from a variety of sources, including private donations, government agencies, and fee-for-service. To make our services accessible to as many people as possible, Easter Seals Iowa also relies on contributions. Public contributions help cover the difference between actual program costs and for those who are unable to pay for all or part of the service. Each camper is supported by donors who participate in the Annual Fund Campaign. The Annual Fund raises donated funds for these financial gaps. Campships are scholarships that are gifts from the Pony Express Riders of Iowa, the Annual Campaign, foundations, organizations, and individuals.

- To apply, please fill out the Campship request section on the 2016 Financial Information page.
- If applying for a Campship, we still require the non-refundable \$50 deposit. Deposits are not covered under a Campship. Please send the deposit with your application.
- If awarded a Campship, you will receive a statement reflecting that it has been applied to your balance due.
- Clients are eligible to receive one Campship per season, not to exceed \$550. Residents of group homes, nursing homes, and other facilities are eligible for a maximum Campship of \$250.
- **There are limited Campships and we reward them on a first come, first serve basis.** If you are interested in receiving one, we strongly encourage you to turn in all the required documents for camp as soon as possible.

IMPORTANT!

If you are using **WAIVER FUNDING:**

- **Please contact your case manager before sending in the application.** We ask that you discuss with them how many camps you are interested in, what type(s), and what dates the camps occur on to ensure the proper funding is in place.
- **A camper cannot be registered without the correct waiver funding in place** and we cannot register outside of what the funding authorizes. We also do not reserve or hold spots.
- Please send all funding and billing information with the application to our Program and Support Specialist, Kate Killeen, at kkilleen@eastersealsia.org or:
Easter Seals Iowa
Attn: Kate Killeen
401 NE 66th Ave
Des Moines, IA 50313
- Please also have the case manager send the client's Individual Care Plan/Consumer Comprehensive Service Plan (ICP/CCSP) with the application. This document is also required for registration.
- The entire unit amount per camp is required to be authorized by the waiver, even if the camper will not attend the entire camp.
- Below are our waiver rates:

Supported Day Camp: T2037

\$1.11/unit

180 units a week

(220 units per week for extended hours)

Resident Camp: T2036

\$1.24/unit

484 units per week

Weekend Respite Non CMH: T2036

\$3.16/unit

184 units per weekend

or

Weekend Respite CMH: T2036

\$3.34/unit

184 units per weekend

PLEASE NOTE:

- The CMH waiver (Children's Mental Health Waiver) can only be used on our weekend respite camps.
- All other waivers (such as the Intellectual Disabilities Waiver, the Ill and Handicapped Waiver, and the Brain Injury Waiver) are eligible for both weekend respite camps and our summer resident and supported day camps.
- Due to Medicaid transitioning to Managed Care, we may need to make some adjustments to the registration process. We will communicate those updates as more information becomes available.



Easter Seals Iowa Camp Sunnyside -Financial Form-

this form is required for summer camp registration

Client Name: _____

Birthdate: _____

Are you privately paying? [] Yes [] No **If yes, please fill out this section only**

Where would you like us to send the invoice?

Name: _____

Phone: _____

Address: _____

City, State, Zip: _____

I prefer electronic billing statements Email Address for billing: _____

Method of Payment:

Check *(make payable to Easter Seals Iowa)*

Amount Enclosed: \$ _____

Credit Card Visa MasterCard Discover

Amount Authorized: \$ _____

Card Number: _____

Expiration Date: _____ 3 Digit Code *(on back of card)*: _____

Name on Card: _____

Signature: _____

\$50 deposit required

Would you like us to charge your card for the remaining balance the Wednesday before the session? [] Yes [] No

Requesting Campship

(not guaranteed – resident camp only)

Clients are eligible to receive one Campship per season, not to exceed \$550. Residents of group homes, nursing homes, and other facilities are eligible for a maximum Campship of \$250.

Amount Requested: \$ _____

\$50 deposit required

Please note:

- The non-refundable \$50 deposit must be sent with the application. **Please do not send the deposit separately.** It will be applied to the first camp session.
- Any application turned in **after July 1st will require the camp payment to be made in full** before the camper can be registered.

Are you paying with a waiver? [] Yes [] No **If yes, please fill out this section only**

Managed Care Organization (MCO):

[] United Healthcare Plan of the River Valley, Inc.

[] AmeriHealth Caritas Iowa, Inc.

[] Amerigroup Iowa, Inc.

MCO ID Number: _____

Medicaid ID Number: _____

Please contact your case manager before sending in the Application and Registration forms to ensure the proper funding is in place. A current care plan, also provided by your case manager, is also required for registration.

Case Manager Name: _____

Case Manager Phone Number: _____

Case Manager Email: _____



Easter Seals Iowa Camp Sunnyside - **SUMMER RESIDENT CAMP** - Registration 2016

Private Pay Cost: \$600 per week Waiver Rate: \$1.24 per unit, 484 units per week

Client Name: _____ Today's Date: _____

Medicaid or Social Security Number: _____ Date of Birth: _____

Guardian Name: _____ Guardian Email: _____

Guardian Home Number: _____ Guardian Cell Number: _____

Check in is Sunday 2-4pm. Check out is Friday 2-3pm.
Camp registration closes the Wednesday before the desired camp.

Client Age: _____

Please mark the session(s) you would like to attend



Week 1: June 5 - June 10	Ages 18 and Up	<input type="checkbox"/> C1 Rock N' Roll Daze
Week 2: June 12 - June 17	Ages 4-17	<input type="checkbox"/> C2 Superheroes/Fantasyland
Week 3: June 19 - June 24	Ages 18 and Up	<input type="checkbox"/> C3 Western Week
	Ages 18 and Up	<input type="checkbox"/> S3 Extreme Nature 1
Week 4: June 26 - July 1	Ages 4-17	<input type="checkbox"/> C4 Rainbow Connection
	Ages 4-17	<input type="checkbox"/> S4 Camp Explore/IBS Week
Week 5: July 3 - July 8	Ages 18 and Up	<input type="checkbox"/> C5 Sunnyside Olympics/Around the World
	Ages 18 and Up	<input type="checkbox"/> S5 Extreme Nature 2
Week 6: July 10 - July 15	Ages 18 and Up	<input type="checkbox"/> C6 Movin & Groovin/Music Through the Decades
Week 7: July 17 - July 22	Ages 4-17	<input type="checkbox"/> C7 Splash Off!
Week 8: July 24 - July 29	Ages 18 and Up	<input type="checkbox"/> C8 Sports Extravaganza
	Ages 15-18	<input type="checkbox"/> S8 Career Camp

Please list any alternative sessions you can attend in case your first choices are full.

1. _____ 2. _____