



Easterseals Iowa

Respite 2019 Checklist

Please allow up to 2 weeks of processing of application once ALL paper work from checklist below has been received to the Program and Support Specialist. Please send all items together, in one shipment, in order to begin the process of the application. Sending partial applications does not hold or reserve a spot for your camper.

Respite Camp is for campers ages 4 years or older. If you are new to Easterseals Iowa/Camp Sunnyside or haven't been to Camp in a year or more than once the application has been entered an Outreach Coordinator will be in contact with the guardian to set up a time to discuss the campers and do a tour. Respite is offered two weekends out of the month, year round. This is a waiver and private pay program.

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

- 2019 Application (*Signature on last page*)
- All Release Forms (*Waiver of Liability, Photo Consent Form, Notice of Privacy Practices*)
- Health History
- Physical Form (*valid for 2 years*) + immunization records (*Signature required—we do not accept electronic signature*)
- Current Individual Care Plan (ICP)/Consumer Comprehensive Service Plan (CCSP) and Release of Information (*Valid for 1 year, Please contact your case manager*)
- Funding/Authorization (*please contact your case manager for authorizations*)
 - Respite Non CMH: T2036 \$3.16 per unit 184 units per weekend
 - Respite CMH: T2036 \$3.34 per unit 184 units per weekend
 - Private Pay: \$583 per weekend

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

Email: campandrespite@eastersealsia.org

Mail or Drop Off: Easterseals Iowa
Attn: Camp and Respite
401 NE 66th Ave
Des Moines, IA 50313

Once we have registered you for camp, you will receive a letter via mail confirming the weekend(s) you are registered for. Please contact the Program and Support Specialist 515-309-2375 or campandrespite@eastersealsia.org if you have any questions. Thank you for choosing Easterseals Iowa!



Easterseals Iowa Camp Sunnyside -Respite Application 2019-

Are you privately paying? YES NO

If so, it is \$583 full payment, per respite weekend.

Client Information (Please Print Legibly)		
Last Name:	First Name:	Middle Name:
Address:		
City/State:	County:	Zip Code:
Phone:	Cell Phone:	
Social Security Number:		Medicaid ID:
Email:		Birthdate: / /
Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male Preferred Pronoun: <input type="checkbox"/> He <input type="checkbox"/> She <input type="checkbox"/> Other If Other: _____		
Preferred Language:		
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married/Cohabiting <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Ethnicity: <input type="checkbox"/> Asian American <input type="checkbox"/> African American <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Multiple Ethnicities <input type="checkbox"/> Choose Not to Say <input type="checkbox"/> Other: _____		
Military Status : <input type="checkbox"/> Active <input type="checkbox"/> Member of Military/Vet Family <input type="checkbox"/> National Guard/Reserve <input type="checkbox"/> ON/A <input type="checkbox"/> Veteran		
Waiver Designation:		
<input type="checkbox"/> Brain Injury	<input type="checkbox"/> Brain Injury + DD	<input type="checkbox"/> Children's Mental Health
<input type="checkbox"/> \$100% County Case Management	<input type="checkbox"/> ODD Case Management	<input type="checkbox"/> Elderly
<input type="checkbox"/> Health and Disability	<input type="checkbox"/> Health and Disability + DD	<input type="checkbox"/> HIV/AIDS Waiver
<input type="checkbox"/> Intellectual Disability	<input type="checkbox"/> Physical Disability	<input type="checkbox"/> Physical Disability + DD
Client: Income / Employment (If Applicable)		
Monthly Income:	Source: <input type="checkbox"/> Community Employment <input type="checkbox"/> Other <input type="checkbox"/> SSDI <input type="checkbox"/> SSI	
Notes:		
Employments <input type="checkbox"/> Is Current?		
Employer:		Position:
Employer Contact Info		
Address:		
City/State:	County:	Zip Code:
Supervisor:	Phones:	Regular Hours:
Wage:	Start Date:	End Date:

Guardian Information				
First Name:	Last Name:	Relationships:		
Address:				
City/State:	County:	Zip Code:		
Home Phone:	Cell Phone:	Work Phone:		
Email:		Interpreter: <input type="radio"/> Yes <input type="radio"/> No		
Primary Language:		Preferred Method of Contact:		
Health Information				
Which Managed Care Organization (MCO) are you using?				
<input type="radio"/> United Healthcare Group <input type="radio"/> Amerigroup <input type="radio"/> HIPP/IME				
Managed Care Policy Number:				
Case Manager:		Phone:	Fax:	
Agency:		Email:		
Address:		City/State:	Zip Code:	
Regular Physician:				
Address:		City/State:	Zip Code:	
Daytime Phone:		Fax Number:		
Camper Height:		Camper Weight:		
Preferred Hospital (In the event of an emergency)				
<input type="radio"/> Broadlawns <input type="radio"/> Mercy Medical <input type="radio"/> Unity Point—Lutheran <input type="radio"/> Unity Point—Methodist <input type="radio"/> Unity Point Blank Children's <input type="radio"/> Other _____				
Communication				
Communication Device		Yes	No	Braille
Visual Impairment		Yes	No	Large Font
Non Verbal		Yes	No	Verbal
Other Communication Needs:		ASL		
Yes		No		
Personal Hygiene (Brushing teeth, shower etc.)				
Level of Assistance Needed:		Independent	Some Assistance	Total Assistance
Detail of level of Assistance:		[] Verbal Prompt		

Toileting	
Do you wear Attends/Briefs/Diapers? <input type="radio"/> Yes <input type="radio"/> No If yes, When? <input type="radio"/> All Day <input type="radio"/> Night Only	
Bathroom Assistance: <input type="radio"/> Independent <input type="radio"/> Some Assistance <input type="radio"/> Total Assistance <input type="radio"/> Assistance with cleaning after BM	Monitor BM? <input type="radio"/> Yes <input type="radio"/> No
Uses the following:	
<input type="checkbox"/> Colostomy Appliance <input type="checkbox"/> Digital Stimulation <input type="checkbox"/> In-Dwelling Catheter <input type="checkbox"/> Suprapubic Catheter <input type="checkbox"/> Ileto Appliances <input type="checkbox"/> Urinary Catheter <input type="checkbox"/> Intermittent Catheterization <input type="checkbox"/> Urinal <input type="checkbox"/> Other	
Do you need assistance with the above? <input type="radio"/> Yes <input type="radio"/> No	
Detail Level of Assistance:	
Dressing	
Level of Assistance Needed: <input type="radio"/> Independent <input type="radio"/> Some Assistance <input type="radio"/> Total Assistance <input type="checkbox"/> Verbal Prompts	
Detail Level of Assistance:	
Dietary Information (Please mark all that apply)	
Are you on a special diet? <input type="checkbox"/> YES <input type="checkbox"/> NO	
<input type="radio"/> G-Tube If so, are you NPO? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Mechanical Soft <input type="radio"/> Pureed <input type="radio"/> Fluid Restriction required per Physician <input type="radio"/> Other _____	Are you Diabetic? <input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/> Medication Controlled <input type="checkbox"/> Diet Controlled <input type="checkbox"/> Carb Count <input type="checkbox"/> Insulin Controlled
Eating: <input type="radio"/> Eats Independently <input type="radio"/> Total Assistance <input type="checkbox"/> Monitor Portions <input type="checkbox"/> Help Cutting Up Food	Notes:
Ambulation and Care	
Assistance Needed with Manual Wheelchair: <input type="checkbox"/> No Assistance <input type="checkbox"/> Assist on Rough Ground <input type="checkbox"/> Assist for Distances <input type="checkbox"/> Total Assist <input type="checkbox"/> N/A	
Assistance with Transferring: Current Weight _____ <input type="checkbox"/> No Assistance <input type="checkbox"/> Stand and Pivot Transfer <input type="checkbox"/> 2 Person Lift <i>(must be 80 lbs or less)</i>	
Other Ambulation Needs: <input type="checkbox"/> Some Support on Certain Surfaces <input type="checkbox"/> Support for long distances <input type="checkbox"/> Support due to vision	
Elopement (Select All that Apply)	
<input type="checkbox"/> Stays with the Group <input type="checkbox"/> Wanders Away <input type="checkbox"/> Actively Leaves Group <input type="checkbox"/> Hides <input type="checkbox"/> Declines to Participate	
Please Explain:	
Tips to Redirect:	

Assistive Technology

(Select all that apply - underlined items are supplied by camp)

- AFO/KAFO Aug/Alt Communication Device Bed Rails Eye Glasses Hearing Aid TTY Shower Chair
- Other Bathing Aid Gait Belt Grab Bars Hospital Bed Hoyer Lift /Sling Crutches Cane
- Walker Manual Wheel Chair Electric Wheelchair Activities of Daily Living Devices Plate Guard
- Modified Utensils Tray Slip Mat Specialized Cup Specialized Plate Other_____

Overnight Supports / Nighttime Routine

Level of Assistance Needed: Independent Some Assistance Total Assistance

Do you use any of the following: CPAP BiPAP Notes:

Do you sleep through the night consistently? Yes No If no, explain:_____

The following works best if having difficulty falling asleep:

Seizures

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

What type of Seizures?	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: Rescue Med: Yes No
- Do you use a safety helmet? Yes [] No []

Verbal and Physical Aggression (towards self, others or property)

- Aggressiveness: Not Aggressive May Strike or Swear Occasionally Regularly Strikes or Swears
- Type: [] Physical [] Verbal [] Self-Injurious Behaviors
- Please Explain:
- Staff Supports:
- Client Coping Strategies:
- Known Triggers:

Transitions

- Transitions Well 5 Minute Warning Visual of Transition Struggles with Transitions

Support Recommendations:

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:		
Allergies		
Does the Camper need an Epi Pen?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please explain:
Food Allergies:		
Reactions:		
Other Notes:		
Other Non-Food Allergies:		
Reactions:		
Other Notes:		

Please send a list of all medications, dosages and instructions and attach to application.

Medication Information for Weekend Respite

-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.

Over-Stimulation	
Causes: <input type="radio"/> Large Groups Situations <input type="radio"/> Noises <input type="radio"/> Smells <input type="radio"/> Other: _____	
Explain:	
Support Recommendations:	
History of Sexual Behavior	
<input type="radio"/> No Sexual behavior observed <input type="radio"/> Unsolicited sexual comments <input type="radio"/> Unsolicited sexual touching <input type="radio"/> Masturbation	
History of Sexual Abuse	
<input type="radio"/> YES <input type="radio"/> NO	
Support Recommendations:	
Does the camper need assistance in the event of a fire, tornado, flood, or bomb threat? <input type="radio"/> Yes <input type="radio"/> No	
<i>By signing here, you give our healthcare staff the permission to provide routine healthcare, dispense medications, and seek emergency treatments.</i>	
Application Completed By: _____	Date: _____
(Print)	
Relationship: _____	
Signature of Legal Guardian: _____	
<i>(Must have guardian signature. If camper is their own guardian camper must sign.)</i>	





-WAIVER OF LIABILITY-

Signature Required

Client Name: _____

Program Name: _____

With the understanding that Easterseals 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 Easterseals 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 if own guardian):

Print Name: _____

Date: _____

Sign Name: _____

Relationship: _____



-Photo Consent Form-

Select 1 box and Signature Required

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 Easterseals Iowa may be used by Easterseals Iowa, and those acting with its permission, for the purpose of illustration, broadcast, or testimonial in connection with any work of Easterseals Iowa and that these materials may be released to the general public. I assign to Easterseals Iowa all of my rights to these materials. All photographs and other media which include your image are the sole property of Easterseals 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 Easterseals 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 Easterseals 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, Easterseals Iowa will use only the first name and the location of the Easterseals Iowa organization where a minor receives services. Easterseals Iowa does not need to submit these materials to me for further approval. I understand that these materials may be modified and that Easterseals Iowa may decide not to use them.

I acknowledge that the rights described above are granted to Easterseals 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 Easterseals 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 Easterseals Iowa to release my protected health information if the information has not already been disclosed. To revoke my consent, I must notify Easterseals Iowa in writing by sending my revocation to Easterseals Iowa Intake/Marketing Coordinator. I understand and agree that once Easterseals 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.

Camper Signature

Date

Guardian Signature

Date



**ACKNOWLEDGEMENT OF RECEIPT OF THE
EASTERSEALS IOWA INCORPORATED
NOTICE OF PRIVACY PRACTICES**

Signature Required

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

Signature of Client/Guardian/Representative

Date Signed

If Guardian/Representative - State relationship to client



Easterseals 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 Easterseals Iowa to contact the following **three** individuals: (Please list contacts in the order you would like them to be contacted). In the event of an early discharge please have a plan in place within an hour.

Name: _____ Relationship: _____

Work Phone: _____ Home Phone: _____ Cell Phone: _____

Name: _____ Relationship: _____

Work Phone: _____ Home Phone: _____ Cell Phone: _____

Name: _____ Relationship: _____

Work Phone: _____ Home Phone: _____ Cell Phone: _____

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: _____



-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 can participate in the following adapted activities: Swimming, horseback riding, zip-line, rock wall, adventure tree climbing, 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: _____

Quarterly Registration

Registration for weekend respite is done on a quarterly basis. You will not be able to register for a quarter until the specified opening date listed below. **This online form is a request only and NOT a confirmed registration.** You will receive a letter in the mail with a confirmed or wait list status.

Campers requiring 1:1 support

We have limited spaces available during each session for campers requiring 1:1 support from counselors. Campers will be scheduled on a monthly basis using a computer generated registration system. Campers will only be registered once all paperwork and funding is received. All campers will have the opportunity to attend one session before second sessions are guaranteed. Once all openings have been filled per session, remaining campers will be placed on a wait list. We will notify you of confirmation no later than 1 week prior to the requested session.

Registration will begin at 8:30am and can be found at www.easterseals.com/ia/respite

-1st Quarter-	
Registration opens Monday, December 3, 2018	
January 4-6	Under the Sea
January 18-20	Mission Impossible
February 1-3	Pursuing Picasso
February 15-17	Jungle Safari
March 8-10	Circus!
March 29-31	Camp Sunnyside Olympics

-2nd Quarter-	
Registration opens Monday, March 4, 2019	
April 12-14	Shipwrecked
April 26-28	Shark Week(end)
May 10-12	Survivor
May 24-26	Spring Formal
June 7-9	Slime Time
June 21-23	Splash Off

-3rd Quarter-	
Registration opens Monday, June 3, 2019	
July 5-7	Stars and Stripes
July 19-21	Color War
August 9-11	Blast Off!
August 23-25	Camp Sunnyside Luau
September 6-8	Myth Busters
September 20-22	Wild West

-4th Quarter-	
Registration opens Tuesday, September 3, 2019	
October 4-6	Animal Planet
October 18-20	Monster Mash
November 1-3	Pancakes and Pajamas
November 15-17	Fall Blast
December 6-8	You Can't Do That At Camp!
December 20-22	Holiday Bash

Please note: We will communicate any updates or changes as they occur.

If you have any questions, please feel free to contact our Camp & Respite Program and Support Specialist, Riley Hayes, at campandrespite@eastersealsia.org or 515-309-2375. Additional information can also be found on our website, www.easterseals.com/ia/respite, and in the Camp Sunnyside Handbook.

Thank you for choosing Easterseals Iowa!



March 18 - March 21

8:00AM to 5:00PM

**Activities are subject to change depending on weather. Please pack a swim bag for each day **

Join us for a fun filled week at Camp Sunnyside! Our week will be full of fun and games relating to each themed day. Themed outfits are encouraged!

Mission Impossible Monday

Come in your spy and detective gear as we hope to solve The Case of the Missing Forks!

Tacky Tuesday

Come dressed in your tackiest outfits and ready to take on all of our tack activities. Bring white clothes to tie dye!

Wilderness Wednesday

Come ready for safari, adventure, and wilderness activities. Join in on our shelter building contest, and learn how to make healthy snacks for the trails.

Throwback Thursday

Like the 40s? 50s? 60s? ...90s? Let's throw it on back and live it up in the good ole days!

Funding/Authorization: T2037, \$1.11 per unit, 128 units Private Pay: \$160