



# Easterseals Iowa

## Supported Day Camp 2020 Checklist

**\*\*\*\*\*Please allow up to 2 weeks of processing of application once ALL paperwork 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.\*\*\*\*\***

Ages 6 -12. Program is Monday—Friday, 8 am until 5 pm. Extended hours are available for this program. This program can be paid for with Waiver Services or Private Pay. Private Pay Cost: \$200 per week, \$250 if extended hours are needed. Waiver Code is T2037 at 180 units per week, with extended hours it will be 220 units per week.

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

- 2020 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)
- Financial Information Form
- Registration Form/Extended Hours (if extended hours are needed)
- \$50 non-refundable deposit or authorized Waiver Funding (Waiver clients only—please contact your Case Manager) \*\*\*Please do NOT send deposit separately.\*\*\*

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

Email: [campandrespite@eastersealsia.org](mailto:campandrespite@eastersealsia.org)

Mail or Drop Off: Easterseals Iowa  
Attn: Camp and Respite  
401 NE 66<sup>th</sup> 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](mailto:campandrespite@eastersealsia.org) if you have any questions. Thank you for choosing Easterseals Iowa!



## Easterseals Iowa Camp Sunnyside -Supported Day Application 2020-

Are you privately paying?  YES  NO

If so, please attach \$50 deposit.

<b>Client Information</b>			<b>(Please Print Legibly)</b>
Last Name:	First Name:	Middle Name:	
Address:			
City/State:	County:	Zip Code:	
Phone:	Cell Phone:		
Social Security Number:		Medicaid ID:	
Email:		Birthdate:     /     /	
<b>Gender:</b> <input type="checkbox"/> Female <input type="checkbox"/> Male                      Preferred Pronoun: <input type="checkbox"/> He <input type="checkbox"/> She <input type="checkbox"/> Other    If Other: _____			
<b>Preferred Language:</b>			
<b>Marital Status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Married/Cohabiting <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
<b>Ethnicity:</b> <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: _____			
<b>Military Status :</b> <input type="checkbox"/> Active <input type="checkbox"/> Member of Military/Vet Family <input type="checkbox"/> National Guard/Reserve <input type="checkbox"/> N/A <input type="checkbox"/> Veteran			
<b>Waiver Designation:</b> <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"/> DD 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			
<b>Client: Income / Employment</b>			<b>(If Applicable)</b>
Monthly Income:	Source: <input type="checkbox"/> Community Employment <input type="checkbox"/> Other <input type="checkbox"/> SSDI <input type="checkbox"/> SSI		
Notes:			
<b>Employments</b>		<input type="checkbox"/> Is Current?	
Employer:		Position:	
<b>Employer Contact Info</b>			
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"/> Iowa Total Care <input type="radio"/> Amerigroup <input type="radio"/> HIPPI/IME		
Managed Care Policy Number:		
<b>Case Manager:</b>	Phone:	Fax:
Agency:	Email:	
Address:	City/State:	Zip Code:
<b>Regular Physician:</b>		
Address:	City/State:	Zip Code:
Daytime Phone:	Fax Number:	
Camper Height:	Camper Weight:	
Preferred Hospital (In the event of an emergency)		
<input type="radio"/> Broadlawn <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 _____		
Seizures		
Do you have a seizure disorder? Yes [ ] No [ ] (if yes, please fill out the rest of this section)		
VNS: Yes <input type="radio"/> No <input type="radio"/>		
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 <input type="radio"/> No <input type="radio"/>	
Do you use a safety helmet? Yes [ ] No [ ]		

## Medical Diagnosis

Primary: (please circle)

*Mental Disorders*

*Cerebral Palsy*

*Scoliosis*

*Autism*

*Epilepsy*

*Spina Bifida*

*Down's Syndrome*

*Arthritis*

*Spinal Cord Injury*

*Other Psychological Disorders*

*Asthma*

*Head Injury*

*ADD/ADHD*

*COPD*

*Speech, Language & Voice Dysfunction*

*Developmental Delays*

*Diseases of the skin & tissue*

*Intellectual Disability*

*Shunts*

Secondary:

Other:

## Allergies

Does the Camper  
need an Epi Pen?

Yes  No

If yes, please explain:

### Food Allergies:

Reactions:

Other Notes:

### Other Non-Food Allergies:

Reactions:

Other Notes:

**Dietary Information** (Please mark all that apply)

Are you on a special diet?  YES  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	<b>Notes:</b>

**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 \_\_\_\_\_

**Ambulation and Care**

Assistance Needed with Manual Wheelchair:  
 No Assistance  Assist on Rough Ground  Assist for Distances  Total Assist  N/A

Assistance with Transferring: Current Weight \_\_\_\_\_  
 No Assistance  Stand and Pivot Transfer  2 Person Lift *(must be 80 lbs or less)*

Other Ambulation Needs:  Some Support on Certain Surfaces  Support for long distances  Support due to vision

**Personal Hygiene (Brushing teeth, shower etc.)**

Level of Assistance Needed:  Independent  Some Assistance  Total Assistance  Verbal Prompt

Detail of level of Assistance:

**Toileting**

Do you wear Attends/Briefs/Diapers?  Yes  No      If yes, When?  All Day  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	<b>Monitor BM?</b> <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:	

<b>Dressing</b>
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:

Does the camper need assistance in the event of a fire, tornado, flood, or bomb threat? <input type="radio"/> Yes <input type="radio"/> No	
<b>Communication</b>	
Communication Device <input type="radio"/> Yes <input type="radio"/> No	Braille <input type="radio"/> Yes <input type="radio"/> No
Visual Impairment <input type="radio"/> Yes <input type="radio"/> No	Large Font <input type="radio"/> Yes <input type="radio"/> No
Non Verbal <input type="radio"/> Yes <input type="radio"/> No	Verbal <input type="radio"/> Yes <input type="radio"/> No
Other Communication Needs:	ASL <input type="radio"/> Yes <input type="radio"/> No

<b>Verbal and Physical Aggression (towards self, others or property)</b>
Aggressiveness: <input type="radio"/> Not Aggressive <input type="radio"/> May Strike or Swear Occasionally <input type="radio"/> Regularly Strikes or Swears
Type: <input type="checkbox"/> Physical <input type="checkbox"/> Verbal <input type="checkbox"/> Self-Injurious Behaviors
Please Explain:
Staff Supports:
Client Coping Strategies:
Known Triggers:

<b>Elopement</b>	<b>(Select All that Apply)</b>
<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:	

<b>Transitions</b>
<input type="radio"/> Transitions Well <input type="radio"/> 5 Minute Warning <input type="radio"/> Visual of Transition <input type="radio"/> Struggles with Transitions
Support Recommendations:

**Over-Stimulation**

Causes:  Large Groups Situations  Noises  Smells  Other: \_\_\_\_\_

Explain:

Support Recommendations:

**History of Sexual Behavior**

No Sexual behavior observed  Unsolicited sexual comments  Unsolicited sexual touching  Masturbation

**History of Sexual Abuse**

YES  NO

Support Recommendations:

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

**Application Completed By:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(Print)

**Relationship:** \_\_\_\_\_

**Signature of Legal Guardian:** \_\_\_\_\_  
*(Must have guardian signature. If camper is their own guardian camper must sign.)*





# -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](http://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: \_\_\_\_\_

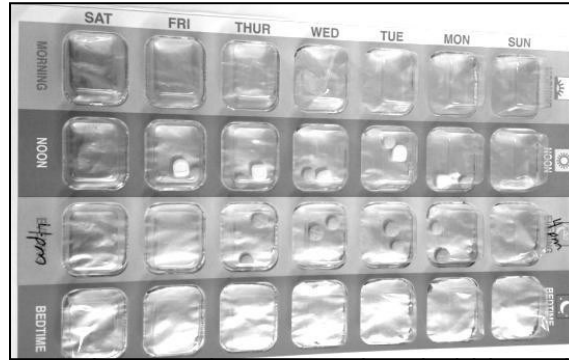
Date: \_\_\_\_\_

Contact Number: \_\_\_\_\_

# 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.**

-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 creams, ointments, and other PRN's at home.

-Any questions regarding medication, please contact our health center at 515-309-2378.

-Please plan on 2-3 hours to complete check in process.

All medication can be sent to:

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

## For Supported Day Camp/Teen and Young Adult Day:

-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 able 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.



# -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
<b>The applicant is under the care of a physician for a medical diagnosis/disability.</b>			
<b>The applicant can participate in the following adapted activities:</b> Swimming, horseback riding, zip-line, rock wall, adventure tree climbing, and other outdoor activities			
<b>The applicant has received a Tetanus Booster within the last ten years.</b>			
<b>Date of most recent Tetanus Booster:</b> _____ <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: \_\_\_\_\_



Easterseals Iowa Camp Sunnyside

-2020 Financial Form-

Client Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Do you live in a group home?  Yes  No

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 Easterseals Iowa)
Amount Enclosed: \$ \_\_\_\_\_
 Credit Card  Visa  MasterCard  Discover
Amount Authorized: \$ \_\_\_\_\_
Card Number: \_\_\_\_\_
Expiration Date: \_\_\_\_\_ 3 Digit Code: \_\_\_\_\_
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

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):
[ ] Iowa Total Care
[ ] Amerigroup Iowa
[ ] HIP/IME
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, provided by your case manager, is required by registration. Resident Camp waiver code T2036 at \$1.24 a unit, 484 units total per week.

Case Manager Name: \_\_\_\_\_
Case Manager Phone Number: \_\_\_\_\_
Case Manager Email: \_\_\_\_\_

# 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 at:

Easterseals Iowa  
Attn: Camp and Respite  
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:

Easterseals 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, 2020 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 the Program and Support Specialist 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.
- Failure to cancel registration could lead to cancellation of future registered weeks.
- If you are using extended hours, please remember the Day Camp Programs will maintain a strict adherence to the 6:00 pm closure time. There will be a late charge of \$10 due at the time of pick-up if a parent comes for a client between 6:00 pm – 6:10 pm. After 6:10 pm, there is an additional charge of \$1 per minute.

# 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:

Easterseals Iowa  
Attn: Camp and Respite  
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.
- As we transition to new Managed Care Organizations, we may need to make some adjustments to the registration process. We will communicate those updates as more information becomes available.



# Easterseals Iowa Camp Sunnyside



## - Supported Day Camp -

### Registration 2020

Private Pay Cost: \$200 per week      Waiver Rate: \$1.11 per unit, 180 units per week

Extended Hours: \$1.11 per unit, 220 units per week

Client Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Medicaid: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Guardian Name: \_\_\_\_\_ Guardian Email: \_\_\_\_\_

Guardian Home Number: \_\_\_\_\_ Guardian Cell Number: \_\_\_\_\_

Check in is Monday—Friday 8 am until 5 pm. Extended hours are available, 7 am until 6 pm. All applications are completed in the order received so please allow two weeks to process. \*\*If your camper has never attended Easterseals Camp before, an Intake Process will need to occur before you will be registered and may result in a delay in processing your application. If your camper needs 1:1 assistance, please go to [www.easterseals.com/ia/camp](http://www.easterseals.com/ia/camp) for more information regarding the registration process.\*\*

Client Age: \_\_\_\_\_

**\*Please mark only the session(s) you want to be registered\***

Week 1: June 15-19	Ages 6-12	<input type="radio"/> D1 Renaissance
Week 2: June 22-26	Ages 6-12	<input type="radio"/> D2 Western Week
Week 3: June 29-July 3	Ages 6-12	<input type="radio"/> D3 Stars and Stripes
Week 4: July 6-10	Ages 6-12	<input type="radio"/> D4 Rock and Roll
Week 5: July 13-17	Ages 6-12	<input type="radio"/> D5 Under the Sea
Week 6: July 20-24	Ages 6-12	<input type="radio"/> D6 Mad Science
Week 7: July 27-31	Ages 6-12	<input type="radio"/> D7 Superheroes
Week 8: Aug 3-7	Ages 6-12	<input type="radio"/> D8 Challenge Week
Week 9: Aug 10-14	Ages 6-12	<input type="radio"/> D9 Disney
Week 10: Aug 17-21	Ages 6-12	<input type="radio"/> D10 Nature Unleashed

*If you need to cancel a week or make changes please contact the Program and Support Specialist at least a week in advance. Failure to notify the Program Support Specialist of your cancellation could mean cancellation of future registrations.*

# -2020 Extended Hours- Supported Day Camp

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Normal check-in and check-out times for Day Camp are 8:00 am—9:00 am and 4:00 pm—5:00 pm.**

**Extended hours run from 7:00 am—8:00 am and 5:00 pm—6:00 pm.**

**If You chose to utilize these hours, you must fill out and turn in this form.**

**Private Pay Clients:** Extended hours are available for an additional fee of \$50 per week. This payment must be paid in full before the session starts.

**Waiver Clients:** Payment for extended hours will need to be reflected in the Notice of Decision (NOD) provided by your case manager. The units for one week of camp will need to increase from 180 units to 220 units to accommodate extended hour services. Please make prior arrangements with your case manager. We must have an NOD with the additional units before the session starts.

**Please check each week that you will be using extended hours and if they will be between 7-8 am, between 5-6 pm or both times.**

	Between 7-8 AM	Between 5-6 PM	Both AM & PM
D1– June 15-19			
D2– June 22-26			
D3– June 29-July 3			
D4– July 6-10			
D5– July 13-17			
D6– July 20-24			
D7– July 27-31			
D8– Aug 3-7			
D9– Aug 10-14			
D10– Aug 17-21			

**Late Fees**

The Day Camp Programs will maintain strict adherence to the 6:00 pm closure time. If a client is not picked up by the appropriate designee by this time, a late charge will be enforced.

**For private pay clients:** There will be a late charge of \$10 due at the time of pick-up if a parent comes for a client between 6:00 pm—6:10 pm. After 6:10 pm there is an additional charge to \$1 per minute.

**For waiver clients:** NOD hours will be utilized for services provided on 15 minute increments.

# 2020 Supported Day Themes

**D1 Renaissance**—This week we are going back in time to the renaissance era! Join us for juggling classes, magic shows, sword fighting, archery, jousting, belly dancing and try not to get placed in the stockade.

**D2 Western Week** —Yeehaw! It's back again for another time around the barrel! Enjoy a rodeo, horseback riding, and lots of Country Western Music during this honky-tonk week. We will also turn camp into the Wild West with demonstrations from the Pony Express Riders of Iowa. Costumes and Western wear are encouraged!

**D3 Stars and Stripes**—Celebrate our great Nation this week with our Fourth of July celebration! This week will be filled with many fun, patriotic activities – including a Parade! Come wearing your red, white, and blue.

**D4 Rock and Roll**—If you like to rock and roll, this camp is for you! With music blaring all week long on the patio and a live performance by a cover band, this week totally ROCKS! We also encourage our campers' creativity by making music and instruments of our own.

**D5 Under the Sea** —Mermaids, Sharks, and Sea Creatures OH MY! This week is all about fun filled water activities! Get ready to spend countless hours at Lake Cheerio, search for the Lochness monster, and get wet and wild as we go on an adventure under the sea.

**D6 Mad Science**—Whaahaahaahaa! Do you like science experiments? Do you like exploding things? How about rocket ships, and bubbles, and mixing ingredients? Then this week is for you! Come and take part in science experiments and activities, explode watermelons and make magnetic slime!

**D7 Superheroes**—This week you will get to experience being a crime-fighting superhero in this fun filled week so bring your superhero costumes. You will get to design your own superheroes logos, draw comics, do the hulk smash and so much more!

**D8 Challenge Week**—This week is all about overcoming obstacles and trying new things. Can your cabin succeed? Color Wars, Olympics, Team Initiatives, Capture the Flag, and many more activities will challenge you to push past your limits and achieve greatness.

**D9 Disney**—This week you will get to enjoy the magic of Disney while at the Happiest Camp on Earth. You will get to eat lunch with Mickey, make your own flubber, have a Lion King karaoke, play Captain Hook toss, pin the carrot on Olaf, and use your fairy dust to make magic happen.

**D10 Nature Unleashed**—This Do you like outdoors? Come learn about the wilderness, wildlife, shelter building, and cooking food over a campfire. This week is dedicated to all thing nature! Come join us and embrace the elements as we learn about nature, wildlife, and survival techniques.



# Consent to Leave Phone Messages/Release of Information

By completing the consent below you authorize us to release information or leave a detailed message on voicemail or with a specific individual.

A. I give my consent to Easterseals to release and/or leave messages regarding services as necessary in the following situations:

1. On cell phone via voicemail
2. On cell phone via text message
3. On answering machine at home
4. On voicemail at work
5. With \_\_\_\_\_ (relationship) \_\_\_\_\_

Client Signature

Date

Guardian Signature (if applicable)

Date

B. I do not consent to messages being left. Please contact directly.

Client Signature

Date

Guardian Signature (if applicable)

Date