



# Easterseals Iowa

## Respite 2020 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:

- 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*)
- 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](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 -Respite Application 2020-

**Are you privately paying?**    YES    NO

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

<b>Client Information</b> (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:    /    /
<b>Gender:</b> <input type="checkbox"/> Female <input type="checkbox"/> Male      Preferred Pronoun:    He    She    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      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> (If Applicable)		
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:

<b>Guardian Information</b>		
First Name:	Last Name:	Relationships:
Address:		
City/State:	County:	Zip Code:
Home Phone:	Cell Phone:	Work Phone:
Email:	Interpreter: Yes No	
Primary Language:	Preferred Method of Contact:	
<b>Health Information</b>		
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:	
<b>Preferred Hospital (In the event of an emergency)</b>		
Broadlawns	Mercy Medical	Unity Point—Lutheran
Unity Point Blank Children's	Other _____	
<input type="checkbox"/> Unity Point—Methodist		
<b>Seizures</b>		
Do you have a seizure disorder? Yes [ ] No [ ] <b>(if yes, please fill out the rest of this section)</b>		
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 No	
Do you use a safety helmet? Yes [ ] No [ ]		

<b>Medical Diagnosis</b>		
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 &amp; Voice Dysfunction</i>
<i>Developmental Delays</i>	<i>Diseases of the skin &amp; tissue</i>	<i>Spinal Cord Injury</i>
<i>Intellectual Disability</i>	<i>Arthritis</i>	<i>Head Injury</i>
Secondary:		
Other:		
<b>Allergies</b>		
Does the Camper need an Epi Pen?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please explain:
<b>Food Allergies:</b>		
Reactions:		
Other Notes:		
<b>Other Non-Food Allergies:</b>		
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.

**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? Yes 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
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Eating: Eats Independently Total Assistance  
 Monitor Portions  Help Cutting Up Food

**Notes:**

**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: Independent Some Assistance Total Assistance Assistance with cleaning after BM	<b>Monitor BM?</b> <input type="radio"/> Yes <input type="radio"/> No
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Uses the following:  
 Colostomy Appliance  Digital Stimulation  In-Dwelling Catheter  
 Suprapubic Catheter  Ileto Appliances  Urinary Catheter  
 Intermittent Catheterization  Urinal  Other

Do you need assistance with the above? Yes No

Detail Level of Assistance:

**Dressing**

Level of Assistance Needed:  
Independent    Some Assistance    Total Assistance    [ ] Verbal Prompts

Detail Level of Assistance:

**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:

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

**Communication**

Communication Device	Yes	No	Braille	Yes	No
Visual Impairment	Yes	No	Large Font	Yes	No
Non Verbal	Yes	No	Verbal	Yes	No
Other Communication Needs:			ASL	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:

**Elopement (Select All that Apply)**

[ ] Stays with the Group    [ ] Wanders Away    [ ] Actively Leaves Group    [ ] Hides    [ ] Declines to Participate

Please Explain:

Tips to Redirect:

**Transitions**

Transitions Well    5 Minute Warning    Visual of Transition    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: \_\_\_\_\_



## -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: \_\_\_\_\_

## 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](http://www.easterseals.com/ia/respite)**

<b>-1<sup>st</sup> Quarter-</b>	
<b>Registration opens Monday, December 2, 2019</b>	
January 10-12	Under the Sea
January 24-26	Mission Impossible
February 7-9	Futuristic Fun!
February 21-23	Jungle Safari
March 6-8	Circus!
March 20-22	Camp Sunnyside Olympics

<b>-2<sup>nd</sup> Quarter-</b>	
<b>Registration opens Monday, March 2, 2020</b>	
April 3-5	Shipwrecked
April 24-26	Shark Week(end)
May 15-17	Survivor
May 29-31	Spring Formal
June 12-14	Slime Time
June 26-28	Splash Off

<b>-3<sup>rd</sup> Quarter-</b>	
<b>Registration opens Monday, June 1, 2020</b>	
July 10-12	Stars and Stripes
July 24-26	Color War
August 14-16	Blast Off!
August 28-30	Camp Sunnyside Luau
September 11-13	Myth Busters
September 25-27	Wild West

<b>-4<sup>th</sup> Quarter-</b>	
<b>Registration opens Monday, September 7, 2020</b>	
October 9-11	Animal Planet
October 23-25	Monster Mash
November 6-8	Pancakes and Pajamas
November 20-22	Fall Blast
December 4-6	You Can't Do That At Camp!
December 18-20	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, at [campandrespite@eastersealsia.org](mailto:campandrespite@eastersealsia.org) or 515-309-2375. Additional information can also be found on our website, [www.easterseals.com/ia/respite](http://www.easterseals.com/ia/respite), and in the Camp Sunnyside Handbook.

*Thank you for choosing Easterseals Iowa!*



# 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