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

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!

Office use only:

Easterseals Iowa Camp Sunnyside
-Respite Application 2020-

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: ◯ Female ◯ Male Preferred Pronoun: ◯ He ◯ She ◯ Other If Other:_____

Preferred Language:

Marital Status: ◯ Single ◯ Married/Cohabitating ◯ Separated ◯ Divorced ◯ Widowed

Ethnicity: ◯ Asian American ◯ African American ◯ Caucasian ◯ Hispanic ◯ Native American
◯ Multiple Ethnicities ◯ Choose Not to Say ◯ Other: _____

Military Status : ◯ Active ◯ Member of Military/Vet Family ◯ National Guard/Reserve ◯ N/A ◯ Veteran

Waiver Designation:

◯ Brain Injury	◯ Brain Injury + DD	◯ Children's Mental Health
◯ $100% County Case Management	◯ DD Case Management	◯ Elderly
◯ Health and Disability	◯ Health and Disability + DD	◯ HIV/AIDS Waiver
◯ Intellectual Disability	◯ Physical Disability	◯ Physical Disability + DD

Client: Income / Employment (If Applicable)	
Monthly Income:	Source: ◯ Community Employment ◯ Other ◯ SSDI ◯ SSI
Notes:	

Employments	☐ 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 ◯ Yes ◯ No
Primary Language:	Preferred Method of Contact:	

Health Information

Which Managed Care Organization (MCO) are you using?

◯ Iowa Total Care ◯ Amerigroup ◯ 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)

◯ Broadlawns ◯ Mercy Medical ◯ Unity Point—Lutheran ◯ Unity Point—Methodist

◯ Unity Point Blank Children's ◯ Other_____

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 ◯	

Medical Diagnosis		
Primary: (please circle)		
Mental Disorders ☐	*Cerebral Palsy* ☐	*Scoliosis* ☐
Autism ☐	*Epilepsy* ☐	*Spina Bifida* ☐
Alcoholism/Drug Abuse ☐	*Heart Disease* ☐	*Cleft Palate* ☐
Other Psychological Disorders ☐	*Asthma* ☐	*Down's Syndrome* ☐
ADD/ADHD ☐	*COPD* ☐	*Speech, Language & Voice Dysfunction* ☐
Developmental Delays ☐	*Diseases of the skin & tissue* ☐	*Spinal Cord Injury* ☐
Intellectual Disability ☐	*Arthritis* ☐	*Head Injury* ☐
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:	

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

- ☐ G-Tube If so, are you NPO? ◯ Yes ◯ No
- ☐ Mechanical Soft
- ☐ Pureed
- ☐ Fluid Restriction required per Physician
- ☐ Other _____

Are you Diabetic? ◯ Yes ◯ No

- ☐ Medication Controlled
- ☐ Diet Controlled
- ☐ Carb Count
- ☐ Insulin Controlled

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

Monitor BM?
◯ Yes
◯ No

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.)

Easter Seals Camp Sunnyside

-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 herby 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 herby 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:** _____

Easterseals 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:**_____

	Normal	Abnormal
EENT		
Heart		
Lungs		
Resp.		
GI		
Abdomen		

State the most recent date of occurrence:

[ ] Chicken pox_____

[ ] Measles_____

[ ] German Measles_____

[ ] Mumps_____

[ ] Hepatitis carrier_____

[ ] Rheumatic Fever_____

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: _____ **please attach all immunization records**			

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 2, 2019	
January 10-12	Under the Sea
January 24-26	Mission Impossible
February 7-9	Futurastic Fun!
February 21-23	Jungle Safari
March 6-8	Circus!
March 20-22	Camp Sunnyside Olympics

-2nd Quarter- Registration opens Monday, March 2, 2020	
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

-3rd Quarter- Registration opens Monday, June 1, 2020	
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

-4th Quarter- Registration opens Monday, September 7, 2020	
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 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!

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