Easterseals Iowa

Respite Packet 2023

Please allow up to 2 weeks to process

Only completed Packets will be processed

We will communicate via email. Please be sure to list a valid email

If you do not have access to an email, please call our Program and Support Specialist for Accommodations

Respite weekends are available for campers ages four years and older. Respite is a year round program offering two weekend camps a month. Campers will check in on Fridays between 6:30pm-7:30pm, and check out will take place on Sundays from 3:00pm-4:00pm.

The following Packet forms MUST be submitted together

___ 2023 Application– **all sections must be filled out for the packet to be considered "complete"**

___ Medication List

___ All Release Forms *(Notice of Privacy Practices, Waiver of Liability, Photo Consent Form, Message Consent)*

___ Physical Form *(valid for 2 years from exam date)* + immunization records (Requires *non-electronic signature - Only provided physical form will be accepted)*

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

Fax: 515-289-1281

Incomplete Packets will not be accepted

We will notify you by email when your packet has been received, and again when processed. 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!

2023 CAMP INFORMATION

The Easterseals Iowa Respite program provides temporary care for children and adults with disabilities for ages four and older. Respite is a non-goal oriented program that allows caregivers a break while providing their loved ones with a safe and supported environment.

Regularly scheduled respite weekends are held at Camp Sunnyside. This year-long program offers two weekend respites a month. Respite services participates in all the activities that Camp Sunnyside has to offer! This includes boating, swimming, horseback riding and much more.

Please be sure to review the registration page (pg. 3) to see how you can start attending Respite Weekends!

Easter Seals Camp Sunnyside

If you are new to Easterseals Iowa/Camp Sunnyside, or haven't attended Camp within the last two years, our intake coordinator will be in contact to further discuss your completed packet.

401 NE 66th Ave Des Moines Iowa 50313 Phone number: 515-289-1933 Fax: 515-289-1281

Important!

Quarterly Respite Registration

Only completed application packets will be allowed to register quarterly.

The registration request forms will open the on first of each month, one month prior to the start of the next quarter.

Registration request form link: www.eastersealsia.com/ia/respite

Registration request forms:

Registration for Respite weekends will be completed online on a quarterly basis. All forms will be registered on a first-come-first-serve basis. The quarterly registration request forms will open on the first of each month, one month prior to the start of the new quarter. The registration request forms will close on the 15th of each month, one month prior to the start of the new quarter. (i.e. Quarter 1: January-March, registration request forms **open** December 1st and will **close** December 15th.) You will not be able to submit a registration request form prior to the first of the month. You will receive an email confirming the dates you are registered for. You will be notified if any of your requested dates are full, and we will provide any available alternate dates. Specific dates can be found on the website.

1:1 support services:

Registration request forms will be registered on first-come-first-serve basis. Please allow for two weeks to process all request forms. You will receive an email confirming dates requested. You will be notified if any of your requested dates are full, and we will provide any available alternate dates. Specific dates can be found on the website.

Note: All registration requests are processed in the order received on a first-come-first-serve basis

Cancellation Policy:

The Camp and Respite Department require that all cancelations are received, via email or phone call, a minimum of 24 hours prior to your registered check in time. The second violation of this policy will result in the removal of the participant from their registered weeks for the remaining quarter.

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

If you have questions, please contact out Camp and Respite Program and Support Specialist at campandrespite@eastersealsia.org or (515)309-2375. Additional information may be found on our website,www.eastersealsia.com/ia/respite or in the Camp Sunnyside Participant Handbook

Thank you for choosing Easterseals Camp Sunnyside!

Important!

If you are using **Waiver Funding:**

- **Please contact your Case Manager before sending in the application.** We recommend that you discuss the number of camp sessions you are interested in, what program(s), and which dates the camping sessions occur to ensure that adequate funding will be allocated.
- Please contact our Program and Support Specialist if there are barriers with the Case Manager being able to submit funding and care plan to Easterseals within the requested time frame
- Please send all available funding and billing information with the application to our Program and Support Specialist:

Email:	Easterseals Iowa Attn: Camp and Respite 401 NE 66th Ave Des Moines, IA 50313	Fax:
CampandRespite@eastersealsia.org		515-289-1281

Current Waiver Rates

Weekend Respite Non CMH: T2036		**Weekend Respite CHM: T2036**
$3.41/unit	**OR**	$3.61/unit
184 Units per weekend		184 Units per weekend

Please Note:

- The entire unit amount per camp is required to be authorized by the waiver, even if the camper will not attend the entirety of camp. Easterseals will only bill for the amount of time the camper participates in programming.

Easterseals Iowa Camp Sunnyside

Respite Application 2023

Office use only
Date and Time Received _____
Date Notified _____

Are you privately paying? [ ] YES [ ] NO
If so, it is $628 full payment, per weekend.

Please mark this box if your camper utilizes any 1:1 services ☐

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

Employments

Is the camper employed? [ ] Yes [ ] No

1. Emergency Contact		
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:	

2. Emergency Contact

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 ○ Molina

Managed Care Policy Number:

Case Manager:	Phone:	Fax:
Agency:	Email:	
Address:	City/State:	Zip Code:

Legal Guardian (Camper 18+ Only)

Name:

Phone:

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)

Brain Health (mental illness)	*Cerebral Palsy*	*Scoliosis*	*Brain Injury*
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:	

Personal Hygiene (Brushing teeth, shower etc.)

Level of Assistance Needed: ○ Independent ○ Some Assistance ○ Total Assistance [ ] Verbal Prompt

Detail of level of Assistance:

Dietary Information

(Please mark all that apply)

Are you on a special diet? [ ] YES [ ] NO

○ G-Tube If so, are you NPO? ○Yes ○No

G-tube Regimen:

○ Mechanical Soft

○ Pureed

○ Fluid Restriction required per Physician

Other _____

Are you Diabetic? ○Yes ○No

[ ] Medication Controlled

[ ] Diet Controlled

[ ] Carb Count - How many Carbs? _____

[ ] 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** ○**Grab Bars** ○**Hospital Bed** ○ **Shower Chair**

○Other Bathing Aid ○Gait Belt ○Eye Glasses ○Hearing Aid ○Hoyer Lift /Sling ○Crutches ○ Cane ○TTY

○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)* [ ] Hoyer lift

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

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 ○Yes ○ No Bowel Movement Routine/Frequency:

Uses the following:

[ ] Colostomy Appliance [ ] Digital Stimulation [ ] In-Dwelling Catheter

[ ] Suprapubic Catheter [ ] Ileto Appliances [ ] Urinary Catheter

[ ] Intermittent Catheterization [ ] Urinal [ ] Other

Monitor BM?

○Yes

○ No

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:

*If at any time the team experiences behaviors that interfere with the health and safety of the camper, staff, or other campers, the Director and Assistance Director of Recreational Programming will evaluate documentation, current supports of the camper, and the current available team member support. If the Director and Assistance Director of Recreational Programing determine a new level of support is necessary for the camper, the Director and Assistant Director of Recreational Programing will inform legal guardian and/or case manager of support changes, frequency of services, and whether or not the program is able to support the current camper's needs. Easterseals will attempt to service and support campers who experience interfering behavior using PBS and accommodations. The safety of all campers and team members will be priority in determining ability to serve campers.

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.)

Side

Easter Seals Camp Sunnyside

Physical Examination Form

Other exam forms will not be accepted

This form is to be completed by a licensed physician or by a physician's assistant.

Patient Name: _____ Date of Birth: _____Today's Date: _____

Medical History: _____

_____

Surgical History: _____

_____

Height: _____ Weight: _____

Vitals Signs: Temp _____ HR: _____ _BP: _____ RR: _____ Pulse Ox: _____

	Normal	Abnormal Findings
Neuro		
Head/EENT		
Respiratory		
Cardiac		
Gastrointestinal		
Genitourinary		
Musculoskeletal		
Integumentary		

Are immunizations up to date? YES ____ NO _____ (*Please attach a copy of all immunization records*)

Is the applicant under the care of a physician for non-preventative care? YES _____ NO _____

I agree that medication will be a part of service provided as needed. YES__ NO_____

The applicant can participate in the following adapted activities: Swimming, horseback riding, zip-line, rock wall, and other outdoor activities: YES _____ NO _____ If no, please explain: _____

_____

I have examined the above individual and reviewed his/her health history. It is in 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 at this time.

Signature of Licensed Medical Professional:_____ **Exam Date**: _____

Printed Name: _____ Phone Number: _____

Medication Name including dose of pill (mg/ml/ect.)	Quantity	Times of Administration {AM/PM)	Special Instructions
Example- Tylenol 325mg	2 capsules	*8am, 8pm, and as needed*	*whole in applesauce*
Example- Omeprazole 20mg	1/2 tablet (10mg)	*7:30 am, 4:00 pm*	*crushed through G-tube*
**For any questions regarding medication lists or med changes, please email:* *CampandRespite@easterseals.org ATTN: Nurse in subject line*		** Medications are typically administered at 08:00 am (before Breakfast); 12:00 pm (before Lunch); 5:00 pm (before Dinner); and 8:00 pm (Bedtime). Please list specific times if medication/treatment is otherwise scheduled. **To minimize long check in times, we ask that you ONLY bring the number of pills that are needed for the duration of stay plus ONE extra dose. ** All medications must have presciptions attatched, Over-the-counter pills should be in original packaging. Thank you!	

-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

Client Name:_____ Program Name:_____

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

Consent to Leave Phone Messages/Release of Information

Client Name:_____ Program Name:_____

By completing the consent below, you authorize us to release information or leave a detailed message on voicemail or with a specific individual. All campers must have an emergency contact listed who will answer their phone and respond to messages while the camper is at camp.

Option 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

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

Client Signature Date

Guardian Signature (if applicable) Date