Easterseals Iowa

Respite 2024 Packet

Please allow up to three weeks for processing

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 at (515) 309-2375

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 will check out on Sundays from 3:00pm-4:00pm.

The following packet forms MUST be submitted together

___ 2024 Application- **all sections must be filled out for the packet to be considered "complete"**

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

___ Physical (valid for 2 years from exam date) + immunization records (Requires non-electronic *signature*

___ Medication List (Please still indicate if no current medications)

*If using waiver funding, waiver documents are not required to be submitted with application

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

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!

2024 Respite 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 campers participate in all the activities that Camp Sunnyside has to offer! This includes boating, swimming, horseback riding and much more.

Easter Seals Camp Sunnyside

If you are new to Easterseals Iowa/Camp Sunnyside, or have not attended camp within the last two years, our intake coordinator will contact you to further discuss your packet.

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

Keep this page for your records

Quarterly Respite Registration

Only completed application packets will be allowed to register quarterly.

Registration is separate from the application packet

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 processed on a first-come-first-serve basis. The online quarterly registration will open on the first of each month, one month prior to the start of the new quarter. The registration 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 12:00am and will **close** December 15th 11:45pm.) You will not be able to submit online registration requests prior to the first of the month. You will receive an email confirming the dates you are registered for within three weeks of submission. 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:

Quarterly registration will be processed on first-come-first-serve basis. Please allow for three weeks to process all requests. You will receive an email confirming dates requested, by the 20th of the month prior to the start of the new quarter. Specific dates can be found on the website.

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 could result in the removal of the participant from their registered weeks for the remaining quarter.

If you have questions, please contact our 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!

Keep this page for your records

If you are using **Waiver Funding:**

- **Please contact your case manager before sending in the application.** We ask that you discuss the number of camp sessions you are interested in, what type(s), and which dates the camps occur, to ensure proper funding will be provided. Funding must be submitted prior to attending.
- 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 any available funding and billing information with the application to our Program and Support Specialist.
- **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 the camp. Easterseals will only bill for the amount of time your camper participates in programming.

Easterseals Iowa

Email: campandrespite@eastersealsia.org

Attn: Camp and Respite
401 NE 66th Ave
Des Moines, IA 50313

Fax: 515-289-1281

Current Waiver Rates

Weekend Respite Non CMH: T2036	Weekend Respite CHM: T2036
$3.41unit	$3.61/unit
184 units per weekend	184 units per weekend

Easterseals Iowa Camp Sunnyside

Respite Application 2024

Office use only
Date and Time Received _____
Date Notified _____

Are you privately paying? [ ] YES [ ] NO

If so, it is $665 full payment, per weekend.

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

Camper 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:

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 ○ Veteran ○ N/A

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:	Relationship:
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:	Relationship:
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*	*Fetal Alcohol*
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)

Eating: ○ Eats Independently ○ Total Assistance
[ ] Monitor Portions [ ] Help Cutting Up Food

Are you on a special diet? ○YES ○NO

○ **G-Tube?** If so, are you NPO? ○Yes ○No
Please add feeding schedules to medication list
○ 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
Please add blood sugars check times to the medication list

Notes:

Assistive Technology

(Select all that apply)

○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
○Tray ○ Slip Mat ○Modified Utensils/plate/cup ○ Insulin Pump ○ CPAP/BiPAP ○ Glucometer
○Tracheostomy ○ Respiratory Equipment ○ 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 **BM Routine/Frequency?**

Assistance with cleaning after BM ○ Yes ○ No

Do you need assistance with the following? ○ Yes ○ No

Camper Utilizes:
[ ] Colostomy Appliance [ ] Digital Stimulation [ ] In-Dwelling Catheter
[ ] Suprapubic Catheter [ ] Ileto Appliances [ ] Urinary Catheter
[ ] Intermittent Catheterization [ ] Urinal

Monitor BM?
○ Yes
○ No

Detail Level of Assistance:

Dressing

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

Detail Level of Assistance:

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

Overnight Supports / Nighttime Routine **(Day camp can skip this section)**

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:

Communication **(Select option for all)**

Communication Device ○Yes ○No **Device Type?**_____	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:_____ ○ N/A
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, team members, or other campers, the Director and Assistance Director will evaluate documentation, current supports of the camper, and the current available team member support. If the Director and Assistance Director determine a new level of support is necessary for the camper, the Director and Assistant Director 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: _____

Easter Seals Camp Sunnyside

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!	

Physical Examination Form

If a different form is submitted, please be sure that any necessary activity restrictions are submitted by the physician.

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. Medications have been reviewed by a licensed health professional in the last 12 months 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: _____

-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