



# Easter Seals Iowa

## Resident Camp 2018 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. \*\*\*\*\***

Adult: Ages 18 & Up, Youth: 4-17

Check in—Sunday afternoon 2:00-4:00 pm. Check out—Friday between 2:00-3:00 pm.

This program can be paid for with Waiver Services or Private Pay. Waiver is code T2036, \$1.24/unit, 484 a week. Private Pay Cost: \$600 per week.

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

- 2018 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 (*Please contact your case manager*)
- Financial Information Form
- Resident Camp Registration Form
- \$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: Easter Seals 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 week(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 Easter Seals Iowa!



Office use only:

# Easter Seals Iowa Camp Sunnyside -Resident Application 2018-

**Are you privately paying?**    YES    NO

If so, please attach \$50 deposit. The other \$550 is due before camper can attend camp.

**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/Cohabiting       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    ON/A    Veteran

**Waiver Designation:**

<input type="radio"/> Brain Injury	<input type="radio"/> Brain Injury + DD	<input type="radio"/> Children’s Mental Health
<input type="radio"/> \$100% County Case Management	<input type="radio"/> DD Case Management	<input type="radio"/> Elderly
<input type="radio"/> Health and Disability	<input type="radio"/> Health and Disability + DD	<input type="radio"/> HIV/AIDS Waiver
<input type="radio"/> Intellectual Disability	<input type="radio"/> Physical Disability	<input type="radio"/> Physical Disability + DD

**Client: Income / Employment (If Applicable)**

Monthly Income:	Source: <input type="radio"/> Community Employment <input type="radio"/> Other <input type="radio"/> SSDI <input type="radio"/> SSI
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Notes: \_\_\_\_\_

**Employments [ ] Is Current?**

Employer:	Position:
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**Employer Contact Info**

Address:		
City/State:	County:	Zip Code:
Supervisor:	Phones:	Contact 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:

Group Home (If Applicable)		
Name of Home:	Address:	
City/State:	County:	Zip Code:
Phone:	Contact Person:	

Managed Care Information		
Which Managed Care Organization (MCO) are you using?		
<input type="radio"/> United Healthcare Group <input type="radio"/> Amerigroup <input type="radio"/> HIPP/IME		
Managed Care Policy Number:		
<b>Case Manager:</b>	Phone:	Fax:
Agency:	Email:	
Address:	City/State:	Zip Code:

Healthcare Provider		
Regular Physician:		
Address:	City/State:	Zip/Code:
Daytime Phone:	Fax Number:	

Preferred Hospital (In the event of an emergency)		
<input type="radio"/> Broadlawns <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 _____		

<b>Communication</b>	
Communication Device <input type="radio"/> Yes <input type="radio"/> No	Braille <input type="radio"/> Yes <input type="radio"/> No
Interpreter <input type="radio"/> Yes <input type="radio"/> No Type: _____	Large Font <input type="radio"/> Yes <input type="radio"/> No
Visual Impairment <input type="radio"/> Yes <input type="radio"/> No	Verbal <input type="radio"/> Yes <input type="radio"/> No
Non Verbal <input type="radio"/> Yes <input type="radio"/> No	ASL <input type="radio"/> Yes <input type="radio"/> No
Other Communication Needs:	
<b>Personal Hygiene (Brushing teeth, shower etc.)</b>	
Level of Assistance Needed: <input type="radio"/> Independent <input type="radio"/> Some Assistance <input type="radio"/> Total Assistance [ ] Verbal Prompt	
Detail of level of Assistance:	
<b>Toileting</b>	
Do you wear Attends/Briefs/Diapers? <input type="radio"/> Yes <input type="radio"/> No If yes, when? <input type="radio"/> All Day <input type="radio"/> 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	Monitor BM? <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 [ ] Verbal Prompts	
Detail Level of Assistance:	
<b>Dietary Information</b> <span style="float: right;">(Please mark all that apply)</span>	
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 100 lbs or less)

Other Ambulation Needs:  Some Support on Certain Surfaces    Support for long distances    Support due to vision**Overnight Supports / Nighttime Routine**Level of Assistance Needed:    Independent    Some Assistance    Total AssistanceDo 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:

**Elopement****(Select All that Apply)**

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

Please Explain:

Tips to Redirect:

**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    NoDo you use a safety helmet? Yes  No

**Verbal and Physical Aggression (towards self, others or property)**

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:

**Medical Diagnosis**

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:

**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.\*\*\***

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

**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 Easter Seals 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 Easter Seals 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 Easter Seals Iowa may be used by Easter Seals Iowa, and those acting with its permission, for the purpose of illustration, broadcast, or testimonial in connection with any work of Easter Seals Iowa and that these materials may be released to the general public. I assign to Easter Seals Iowa all of my rights to these materials. All photographs and other media which include your image are the sole property of Easter Seals 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 Easter Seals 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 Easter Seals 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, Easter Seals Iowa will use only the first name and the location of the Easter Seals Iowa organization where a minor receives services. Easter Seals Iowa does not need to submit these materials to me for further approval. I understand that these materials may be modified and that Easter Seals Iowa may decide not to use them.

I acknowledge that the rights described above are granted to Easter Seals 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 Easter Seals 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 Easter Seals Iowa to release my protected health information if the information has not already been disclosed. To revoke my consent, I must notify Easter Seals Iowa in writing by sending my revocation to Easter Seals Iowa Intake/Marketing Coordinator. I understand and agree that once Easter Seals 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  
EASTER SEALS IOWA INCORPORATED  
NOTICE OF PRIVACY PRACTICES**

*\*Signature Required\**

I, \_\_\_\_\_, acknowledge that I have received a copy of The Easter Seals Iowa Incorporated's Notice of Privacy Practices which summarizes the ways my identifiable health information may be used and disclosed by Easter Seals Iowa and states my rights with respect to my health information. I understand Easter Seals 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 Easter Seals Iowa revises its information practices, a revised Notice will be posted at each Easter Seals Iowa location and that I may obtain a current Notice of Privacy Practices at any time from the Easter Seals 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



Easter Seals 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 Easter Seals 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: \_\_\_\_\_

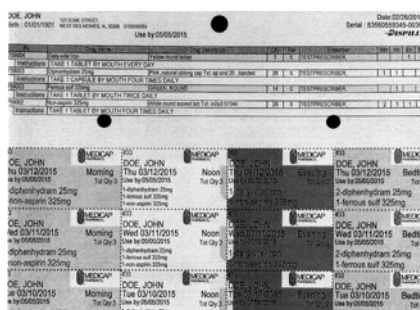
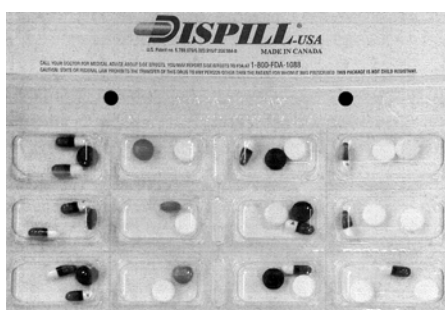
Date: \_\_\_\_\_

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

# Medication Information

## For Summer Resident Camp:

1. Medicap Pharmacy will be working with us to get all camper medications to Camp Sunnyside prior to your session.
2. Please fill out the Medicap Pharmacy Medication Requirement form, on the next page, in order to ensure your Campers medications are prepared for their camp stay.
3. If you should have any questions please contact Medicap at the contact information provided or feel free to contact our Health Center at 515-309-2378.
4. If you are not using Medicap, please send medications in packaging as directed below the pictures.



-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 PRNs at home.

All medication can be sent to:

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

## For Weekend Respite and Supported Day Camp:

-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.





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



Easter Seals Iowa Camp Sunnyside

-2018 Financial Form-

\*This form is required for Resident Camp registration\*

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 Easter Seals 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

**Requesting Campship**  
**(not guaranteed—resident camp only)**

Clients are eligible to receive one Campship per season, not to exceed \$550. Residents of group homes, nursing homes, and other facilities are eligible for a maximum Campship of \$250.

Amount Requested: \$ \_\_\_\_\_

**\$50 deposit required**

**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):

[ ] United Healthcare Plan

[ ] Amerigroup Iowa

[ ] HIPPI/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: \_\_\_\_\_



# Easter Seals Iowa Camp Sunnyside - Summer Resident Camp - Registration 2018

Private Pay Cost: \$600 per week

Waiver Rate: \$1.24 per unit, 484 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 Sunday 2 pm. Check out is Friday 2-3 pm. Camp registration closes the Wednesday before the desired camp session. All applications are completed in the order received so please allow two weeks to process. \*\*If camper has never attended Extreme Nature in a previous summer you must be approved by the Director of Camp to be registered. If your camper has never attended Easter Seals 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: \_\_\_\_\_ How many weeks are you registering for? \_\_\_\_\_

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

Week 1: June 10-15	Ages 18 and Up	<input type="radio"/> C1 Myth Busters
Week 2: June 17-22	Ages 4—17	<input type="radio"/> C2 Under the Sea
Week 3: June 24-29	Ages 18 and Up	<input type="radio"/> C3 Western Week <input type="radio"/> S2 Extreme Nature 1
Week 4: July 1-6	Ages 18 and Up	<input type="radio"/> C4 Stars and Stripes
Week 5: July 8-13	Ages 4—17	<input type="radio"/> C5 Camp Explore/Superheroes
Week 6: July 15-20	Ages 18 and Up	<input type="radio"/> C6 Amazing Race <input type="radio"/> S2 Extreme Nature 2
Week 7: July 22-27	Ages 18 and Up	<input type="radio"/> C7 Rock and Roll
Week 8: July 29-Aug 3	Ages 18 and Up	<input type="radio"/> C8 Choose Your Own Adventure

Please choose two alternative sessions the camper would like to attend in case your first choices are full.

1. \_\_\_\_\_ 2. \_\_\_\_\_



# 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:  
Easter Seals 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:  
Easter Seals 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, 2018 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.

## How to apply for a Campship:

Easter Seals Iowa receives funding from a variety of sources, including private donations, government agencies, and fee-for-service. To make our services accessible to as many people as possible, Easter Seals Iowa also relies on contributions. Public contributions help cover the difference between actual program costs and for those who are unable to pay for all or part of the service. Each camper is supported by donors who participate in the Annual Fund Campaign. The Annual Fund raiser donated funds for these financial gaps. Campships are scholarships that are gifts from the Pony Express Riders of Iowa, the Annual Campaign, foundations, organizations, and individuals.

- To apply, please fill out the Campship request section on the 2018 Financial Information page.
- If applying for Campship, we still require the non-refundable \$50 deposit. Deposits are not covered under the Campship. Please send the deposit with your application.
- If awarded a Campship, you will receive a statement reflecting that it has been applied to your balance due.
- Clients are eligible to receive one Campship per season, not to exceed \$550. Residents of group homes, nursing homes, and other facilities are eligible for a maximum Campship of \$250.
- There are limited Campships and we award them on a first come, first serve basis. If you are interested in receiving one, we strongly encourage you to turn in all required documents for camp as soon as possible.

# 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:

Easter Seals 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.

# 2018 Resident Camp Themes

**Myth Busters**—Fact or Myth: A Sasquatch (Big Foot) resides at Camp Sunnyside. Help us bust this mystery after an evening Sasquatch hunt and join us for other myth busting activities! This is an adult session.

**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. This is a youth session.

**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! This is an adult session.

**Extreme Nature 1&2**—As you can see, Extreme Nature is offered 2 times this summer, because of its EXTREME popularity. Campers get to sleep in tents, cook food over an open fire, and hike through the woods. This camp is suitable for campers who can sleep on the ground and maintain a ratio of 1:7. Camp Sunnyside reserves the right to adjust the group if we feel health and/or safety is compromised. This is an adult session.

**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. This is an adult session.

**Camp Explore/Superheroes**—Camp Explore is being offered to all children in Iowa with visual impairments. Easter Seals Iowa is collaborating with Iowa Braille School to make this a special session designed for persons with visual impairments, but anyone is welcome to join in the fun. You will also get to experience being a crime-fighting superhero in this fun filled week so bring your superhero costumes! This a youth session.

**Amazing Race**—Join in on Camp Sunnyside's Amazing Race! Travel around the world completing challenges and activities during this amazing week adventure. This is an adult session.

**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. This is an adult session.

**Choose Your Own Adventure**—This week is all about choosing your own adventure. Work together with your cabin to decide your fate throughout the week. Are you ready for the adventure that lies ahead? This is an adult session.