



Easter Seals Iowa

Teen and Young Adult Day 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. *******

Ages 13-21. Program is Monday—Friday. Extended hours are available for this program. This program can be paid for with Waiver Services or Private Pay. Private Pay Cost: \$200 per week, \$250 if extended hours are needed. Waiver Code is T2037 at 180 units per week, with extended hours it will be 220 units 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
- Registration Form/Extended Hours (*if extended hours are needed*)
- \$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

Mail or Drop Off: Easter Seals 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 week(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 Easter Seals Iowa!



Office use only:

Easter Seals Iowa Camp Sunnyside Teen and Young Adult Day Camp Application 2018-

Are you privately paying? YES NO

If so, please attach \$50 deposit.

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: Community Employment Other SSDI SSI

Notes: _____

Employments [] Is Current?

Employer: _____ Position: _____

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:		
Case Manager:	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 _____		

Communication	
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:	
Personal Hygiene (Brushing teeth, shower etc.)	
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:	
Toileting	
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:	
Dressing	
Level of Assistance Needed: <input type="radio"/> Independent <input type="radio"/> Some Assistance <input type="radio"/> Total Assistance [] Verbal Prompts	
Detail Level of Assistance:	
Dietary Information (Please mark all that apply)	
Are you on a special diet? [] YES [] NO	
<input type="radio"/> G-Tube If so, are you NPO? <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	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 100 lbs or less)

Other Ambulation Needs: Some Support on Certain Surfaces Support for long distances Support due to vision**Elopement****(Select All that Apply)**

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

Please Explain:

Tips to Redirect:

SeizuresDo 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 & Voice Dysfunction</i> |
| <i>Developmental Delays</i> | <i>Diseases of the skin & 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.

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: _____

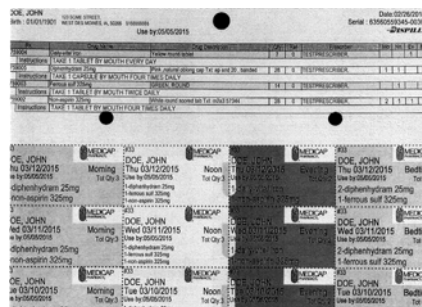
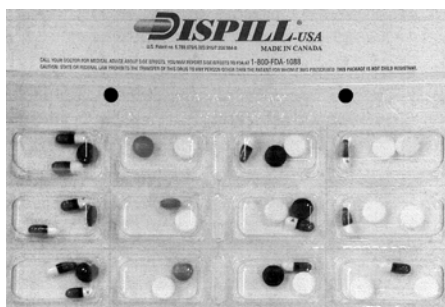
Medication Information

For Weekend Respite and Teen-Young Adult/Supported Day Camp:

- Please bring medication(s) to the Health Center after you check-in your camper Monday morning.
- 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.

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 (see Resident Camp Application), 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



-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
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: _____ <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: _____

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

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

[] HIP/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 - Teen and Young Adult Day Camp - Registration 2018

Private Pay Cost: \$200 per week

Waiver Rate: \$1.11 per unit, 180 units per week

Client Name: _____ Today's Date: _____

Medicaid: _____ Date of Birth: _____

Guardian Name: _____ Guardian Email: _____

Check in is Monday—Friday 8 am until 5 pm. Extended hours are available, 7 am until 6 pm. All applications are completed in the order received so please allow two weeks to process. ****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 for more information regarding the registration process.****

Client Age: _____		
Please mark only the session(s) you want to be registered		
(When attending camp)		
Week 1: June 11-15	Ages 13-21	<input type="radio"/> TAD1 Myth Busters
Week 2: June 18-22	Ages 13-21	<input type="radio"/> TAD2 Under the Sea
Week 3: June 25-29	Ages 13-21	<input type="radio"/> TAD3 Western Week
Week 4: July 2-6	Ages 13-21	<input type="radio"/> TAD4 Stars and Stripes
Week 5: July 9-13	Ages 13-21	<input type="radio"/> TAD5 Camp Explore/Superheroes
Week 6: July 16-20	Ages 13-21	<input type="radio"/> TAD6 Amazing Race
Week 7: July 23-27	Ages 13-21	<input type="radio"/> TAD7 Rock and Roll
Week 8: July 30-Aug 3	Ages 13-21	<input type="radio"/> TAD8 Choose Your Own Adventure
Week 9: Aug 6-Aug 10	Ages 13-21	<input type="radio"/> TAD9 Animal Planet
Week 10: Aug 13-Aug 17	Ages 13-21	<input type="radio"/> TAD10 Slime Time

If you need to cancel a week or make changes please contact the Program and Support Specialist at least a week in advance. Failure to notify the Program Support Specialist of your cancellation could mean cancellation of future registrations.

-2018 Extended Hours- Teen and Young Adult Day Camp

Name: _____

Date: _____

Normal check-in and check-out times for Day Camp are 8:00 am—9:00 am and 4:00 pm—5:00 pm.

Extended hours run from 7:00 am—8:00 am and 5:00 pm—6:00 pm.

If You chose to utilize these hours, you must fill out and turn in this form.

Private Pay Clients: Extended hours are available for an additional fee of \$50 per week. This payment must be paid in full before the session starts.

Waiver Clients: Payment for extended hours will need to be reflected in the Notice of Decision (NOD) provided by your case manager. The units for one week of camp will need to increase from 180 units to 220 units to accommodate extended hour services. Please make prior arrangements with your case manager. We must have an NOD with the additional units before the session starts.

Please check each week that you will be using extended hours and if they will be between 7-8 am, between 5-6 pm or both times.

	Between 7-8 AM	Between 5-6 PM	Both AM & PM
TAD1– June 11-15			
TAD2– June 18-22			
TAD3– June 25-29			
TAD4– July 2-6			
TAD5– July 9-13			
TAD6– July 16-20			
TAD7– July 23-27			
TAD8– July30-Aug 3			
TAD9– Aug 6-10			
TAD10– Aug 13-17			

Late Fees

The Day Camp Programs will maintain strict adherence to the 6:00 pm closure time. If a client is not picked up by the appropriate designee by this time, a late charge will be enforced.

For private pay clients: There will be a late charge of \$10 due at the time of pick-up if a parent comes for a client between 6:00 pm—6:10 pm. After 6:10 pm there is an additional charge to \$1 per minute.

For waiver clients: NOD hours will be utilized for services provided on 15 minute increments.

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 week of 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.
- Failure to cancel registration could lead to cancellation of future registration weeks.
- If you are using extended hours, please remember the Teen Day Camp Programs will maintain a strict adherence to the 6:00 pm closure time. There will be a late charge of \$10 due at the time of pick-up if a parent comes for a client between 6:00 pm – 6:10 pm. After 6:10 pm, there is an additional charge of \$1 per minute.

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/Teen/Young Adult Day: T2037

\$1.11/unit

180 units a week

(220 units per week for extended hours)

Weekend Respite Non CMH: T2036

\$3.16/unit

184 units per weekend

Resident Camp: T2036

\$1.24/unit

484 units per week

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.
- Failure to call in to cancel registration could lead to cancellation of future registration weeks.



2018 Teen and Young Adult Day

Camp Theme Descriptions

TAD1 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!

TAD2 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.

TAD3 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!

TAD4 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.

TAD5 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!

TAD6 Shipwrecked: Oh no! You've been shipwrecked at camp! Complete treasure hunts, search for gold, and learn survival skills. Plus join in on the fun of the Regatta!

TAD7 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.

TAD8 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?

TAD9 Animal Planet: Learn all about the farm and wildlife animals of Camp Sunnyside. Get a chance to learn to care for, feed and spend some time with the domestic animals of Sunnyside. Then while out and about get a chance to see the wild side of camp.

TAD10 Slime Time: Let's get ready for some slime time! Make some goop, or slide down our banana split and slide. Prepare to get ewwy during this super slimy week.