Easter Seals Iowa

Respite 2018 Checklist

*****_Please allow up to 2 weeks of processing of application once ALL paper work from checklist below has been receied to the Program and Support Specialist. Please send all items together, in one shipment, in order to begin the process of the application. Sending partial applications does not hold or reserve a spot for your camper._
Respite Camp is for campers who are 4 years or older. If you are new to Easter Seals Camp Sunnyside or haven't been to Camp in a year or more than once the application has been entered an Outreach Coordinator will be in contact with the guardian to set up a time to discuss the campers and do a tour. Respite is two weekends out of the month. This is a waiver and private pay program. *****

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)*

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 weekend(s) you are registered for. Please contact the Program and Support Specialist 515-309-2375 or campandrespite@eastersealsia.org if you have any questions. Thank you for choosing Easter Seals Iowa!

Office use only:

Easter Seals Iowa Camp Sunnyside
-Respite Application 2018-

Are you privately paying? [ ] YES [ ] NO
If so, it is $583 full payment, per respite weekend.

Client Information (Please Print Legibly)		
Last Name:	First Name:	Middle Name:
Address:		
City/State:	County:	Zip Code:
Phone:	Cell Phone:	
Social Security Number:		Medicaid ID:
Email:		Birthdate: / /

Gender: ○Female ○Male Preferred Pronoun: ○He ○She ○Other If Other:_____

Preferred Language:

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

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

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

Waiver Designation:

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

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

Employments	[ ] Is Current?
Employer:	Position:

Employer Contact Info

Address:		
City/State:	County:	Zip Code:
Supervisor:	Phones:	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: ○Yes ○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?

○ United Healthcare Group ○ Amerigroup ○ 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)

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

○Unity Point Blank Children's ○Other_____

Communication

Communication Device ○ Yes ○ No	Braille ○ Yes ○ No
Interpreter ○ Yes ○ No Type:_____	Large Font ○ Yes ○ No
Visual Impairment ○ Yes ○ No	Verbal ○ Yes ○ No
Non Verbal ○ Yes ○ No	ASL ○ Yes ○ No
Other Communication Needs:	

Personal Hygiene (Brushing teeth, shower etc.)

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

Detail of level of Assistance:

Toileting

Do you wear Attends/Briefs/Diapers? ○ Yes ○ No If yes, When? ○ All Day ○ Night Only

Bathroom Assistance:
○ Independent ○ Some Assistance ○ Total Assistance ○ Assistance with cleaning after BM

Monitor BM?
○ Yes
○ No

Uses the following:

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

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

Detail Level of Assistance:

Dressing

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

Detail Level of Assistance:

Dietary Information

(Please mark all that apply)

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

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

Are you Diabetic? ○ Yes ○ No
[ ] Medication Controlled
[ ] Diet Controlled
[ ] Carb Count
[ ] Insulin Controlled

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

Notes:

Assistive Technology	**(Select all that apply -** underlined items are supplied by camp**)**

○AFO/KAFO ○Aug/Alt Communication Device ○**Bed Rails** ○Eye Glasses ○Hearing Aid ○TTY ○**Shower Chair**

○Other Bathing Aid ○Gait Belt ○**Grab Bars** ○**Hospital Bed** ○ Hoyer Lift /Sling ○ Crutches ○Cane

○Walker ○Manual Wheel Chair ○Electric Wheelchair ○Activities of Daily Living Devices ○Plate Guard

○Modified Utensils ○Tray ○Slip Mat ○Specialized Cup ○Specialized Plate Other_____

Ambulation and Care

Assistance Needed with Manual Wheelchair:

[ ] No Assistance [ ] Assist on Rough Ground [ ] Assist for Distances [ ] Total Assist [ ] N/A

Assistance with Transferring: Current Weight_____

[ ] No Assistance [ ] Stand and Pivot Transfer [ ] 2 Person Lift *(must be 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 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:

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 ○No

Do you use a safety helmet? 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:

Medical Diagnosis

Primary: (please circle)

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

Secondary:

Other:

Allergies

Does the Camper need an Epi Pen?	[ ] Yes [ ] No If yes, please explain:
Food Allergies:	
Reactions:	
Other Notes:	
Other Non-Food Allergies:	
Reactions:	
Other Notes:	

Please send a list of all medications, dosages and instructions and attach to application.

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 ofany

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 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 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 Supported Day Camp:

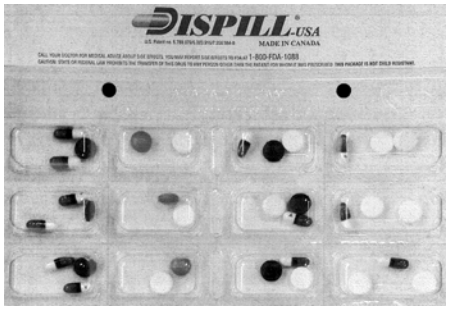
-All medication can be brought with the camper to check-in.

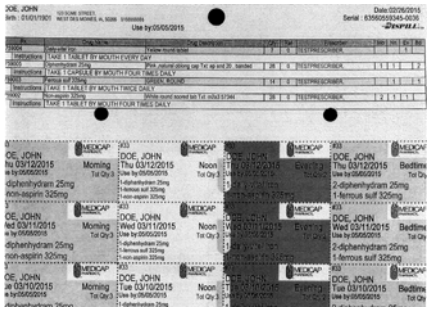
-It must be in a medication bottle with the correct prescription on it. If it is not, the nurse will not be allowed to administer it and your camper may not be allowed to stay at camp.

-Please only bring the amount needed for each day of camp with one (1) additional dose.

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

Easter Seals Iowa

-Physical Examination Form-

Client Name:_____ **Birthdate:**_____

This form is to be completed by a licensed physician or by a physician's assistant. **Other exam forms will not be accepted.**

Height:_____ **Weight:**_____

BP:_____ **Pulse:**_____

	Normal	Abnormal
EENT		
Heart		
Lungs		
Resp.		
GI		
Abdomen		

State the most recent date of occurrence:

[ ] Chicken pox_____

[ ] Measles_____

[ ] German Measles_____

[ ] Mumps_____

[ ] Hepatitis carrier_____

[ ] Rheumatic Fever_____

Known allergies and reaction:_____

Epi-Pen? [ ] Yes [ ] No

	Yes	No	Please Explain
The applicant is under the care of a physician for a medical diagnosis/disability.			
The applicant can participate in the following adapted activities: Swimming, horseback riding, zip-line, rock wall, adventure tree climbing, and other outdoor activities			
The applicant has received a Tetanus Booster within the last ten years.			
Date of most recent Tetanus Booster: _____ **please attach all immunization records**			

I have examined the person herein described and reviewed his/her health history. It is my opinion that he/she is physically able to engage in any required activities, except as may be noted above, and is free of communicable or contagious disease.

_____ _____

Signature of examining physician or physician's assistant Please print name

Fax:_____ Telephone:_____

Date of Exam: _____ **Date Form Completed:**_____

Thank you for choosing Easter Seals Iowa!

For the weekend respite application, please go to www.easterseals.com/ia/respite. Please read below for information regarding registration.

Requirements for Registration

To be registered for a weekend respite session, there must be an open spot available and we must have all required documents. Campers will be registered on a first come, first serve basis. If we are missing a required document, you will not be eligible to be registered for the camp until we have received it.

-Required Documents-

2018 Application: Includes Health History Form and 3 Release Forms with physical signatures.

Easter Seals Physical Form: Physicals are valid for 2 years and must be on the Easter Seals Physical Form. Other exam forms will not be accepted. The physical must also include the date of the client's most recent Tetanus Booster.

CCSP/ICP: Care Plan (provided by the case manager) produced every year at annual meetings.

Funding: Waiver/Notice of Decision (provided by the case manager) or a private payment of $583.

Online Registration Request Form: See next section for more information.

If you are using a waiver, please remember it is your responsibility to communicate with your case manager regarding how many respite sessions your waiver will provide. It is our policy that you must have 184 waiver units available for each respite weekend you want to attend. If you do not have 184 units available for a session, you will not be registered for it. Please talk to your case manager before submitting the online registration request in order to make sure you have enough units to cover all of the respites you want to attend. Below are the codes and rates:

Respite Non CMH:	T2036	$3.16 per unit	184 units per weekend
Respite CMH:	T2036	$3.34 per unit	184 units per weekend

One to One Ratio Campers

If you need 1:1 support while attending respite, we have limited spaces for each session. Campers will be selected each month prior to the month by a computer program that assigns sessions randomly. Once all paperwork and funding is received, you will be registered for the available sessions requested and a confirmation will be sent to you in the mail. After these spaces have been filled, we will place the remaining 1:1 campers on a waiting list. If we can add campers to the weekend, we will notify you the week before the scheduled session.

Quarterly Registration

Registration for weekend respite is done on a quarterly basis. You will not be able to register for a quarter until the specified opening date. Listed below are the respite quarters and the date each quarter will open for registration. **This online form is a request only and NOT a confirmed registration.** You will be contacted via mail when you are registered for your sessions.

Once you have handed in all paperwork and completed the intake, to register for a respite session, you must fill out the online request form at www.easterseals.com/ia/respite on the opening date of the quarter. **Registration opens at 8:00am**. If you do not have access to the internet, please contact your case manager to assist you with filling out the online form.

-1st Quarter- **Registration opens Friday, December 1, 2017**	
January 5-7	Camp Sunnyside's Got Talent
January 19-21	Mission Possible
February 2-4	Valentine's
February 16-18	Up, Up, and Away
March 2-4	Amazing Race
March 23-25	Camp Sunnyside Olympics

-2nd Quarter- **Registration opens Thursday, March 1, 2018**	
April 6-8	Pursuing Picasso
April 20-22	Shipwrecked
May 4-6	Survivor-Outwit, Outplay, Outlast
May 25-27	Spring Formal
June 8-10	Slime Time
June 22-24	Splash Off

-3rd Quarter- **Registration opens Friday, June 1, 2018**	
July 13-15	Stars and Stripes
July 27-29	Color War
August 10-12	You Can't Do That At Camp!
August 24-26	Hawaiian Hullabaloo
September 7-6	Myth Busters
September 21-23	Wild West

-4th Quarter- **Registration opens Monday, September 3rd, 2018**	
October 5-7	Animal Planet
October 19-21	Monster Mash
November 2-4	Movies Under the Moon
November 16-18	Turkey Bowl
December 7-9	Choose Your Own Adventure
December 28-30	Winter Wonderland – Snow Ball

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

If you have any questions, please feel free to contact our Camp & Respite Program and Support Specialist, Aubrey Herd, at campandrespite@eastersealsia.org or 515-309-2375. Additional information can also be found on our website, www.easterseals.com/ia/respite, in the Camp Sunnyside Handbook.
Thank you for choosing Easter Seals Iowa!