Easterseals Iowa

Super Weekend Respite 2021 Checklist

Please allow up to 2 weeks of processing of application once ALL paper work 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 client.

Super Weekend Respite is for clients ages 4 years or older. Super Weekend Respite is offered one weekend out of the month, for June, July, and August. This is a waiver and private pay program.

Check in Friday 10am-11am; Check out Monday 1pm-2pm

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

___ 2021 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 *(Valid for 1 year, Please contact your case manager)*

___ Funding/Authorization *(please contact your case manager for authorizations)*

Respite Non CMH:	T2036	$3.16 per unit	304 units per session
Respite CMH:	T2036	$3.34 per unit	304 units per session
Private Pay:	$965 per session		

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

Once we have registered you for session, you will receive a letter via email 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 Easterseals Iowa!

Office use only:

Super Weekend Respite Application 2021

Are you privately paying? [ ] YES [ ] NO

If so, it is $965 full payment, per respite session.

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:	Regular 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:	

Health Information

Which Managed Care Organization (MCO) are you using?

○ Iowa Total Care ○ Amerigroup ○ HIPP/IME

Managed Care Policy Number:		
Case Manager:	Phone:	Fax:
Agency:	Email:	
Address:	City/State:	Zip Code:
Regular Physician:		
Address:	City/State:	Zip Code:
Daytime Phone:	Fax Number:	
Client Height:	Client Weight:	

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)

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 client 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.

Medication Information for Super Weekend Respite

-All medication can be brought with the client 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 client may not be allowed to stay overnight.

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

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 ESI**)**

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 80 lbs or less)*

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

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:

Overnight Supports / Nighttime Routine

Level of Assistance Needed: ○ Independent ○ Some Assistance ○ Total Assistance

Do you use any of the following: ○ CPAP ○ BiPAP   Notes:

Do you sleep through the night consistently? ○ Yes ○ No   If no, explain:________________

The following works best if having difficulty falling asleep:

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

Communication

Communication Device Yes No	Braille Yes No
Visual Impairment Yes No	Large Font Yes No
Non Verbal Yes No	Verbal Yes No
Other Communication Needs:	ASL Yes No

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

Aggressiveness: Not Aggressive   May Strike or Swear Occasionally   Regularly Strikes or Swears

Type: [ ] Physical   [ ] Verbal   [ ] Self-Injurious Behaviors

Please Explain:

Staff Supports:

Client Coping Strategies:

Known Triggers:

Elopement (Select All that Apply)

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

Please Explain:

Tips to Redirect:

Transitions

Transitions Well   5 Minute Warning   Visual of Transition   Struggles with Transitions

Support Recommendations:

Over-Stimulation

Causes: ○ Large Groups Situations ○ Noises ○ Smells ○Other:___________________

Explain:

Support Recommendations:

History of Sexual Behavior

No Sexual behavior observed Unsolicited sexual comments Unsolicited sexual touching Masturbation

History of Sexual Abuse

○YES ○NO

Support Recommendations:

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 client is their own guardian client must sign.)

-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.

____ ______________________

Client Signature Date

____ ______________________

Guardian Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF THE EASTERSEALS IOWA INCORPORATED

NOTICE OF PRIVACY PRACTICES

Signature Required

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

Easterseals 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 Easterseals 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:

____ ___________

____ ___________

____ ___________

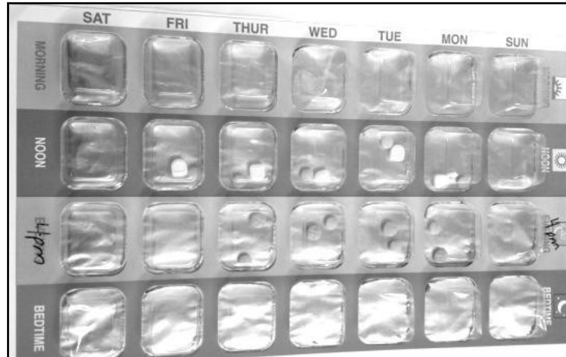
Name of Person Completing Form:______________________________

Date:______________ **Contact Number:** ______________________

Medication Information

For Super Weekend Respite:

-All medication must be in a 7 day compliance unit-dose bubble pack. Do not send medication in original bottles, envelopes or at-home containers.



7 day compliance unit dose bubble pack

-We require medications sent to us **two weeks prior to the session.**

-Clearly identify your medication package with the dates of your session, first and last name, and date of birth.

-Due to the significant volume of medications administered here at Easterseals, please consider leaving all non-essential topical creams, ointments, and other PRN's at home.

-Any questions regarding medication, please contact our health center at 515-309-2378.

-Please plan on 1 hour to complete check in process.

All medication can be sent to:

Easterseals Iowa
Attn: Health Center
401 NE 66th Ave
Des Moines, IA 50313

For Bright Side, Sunny Days, and Team Cheerio sessions:

-All medication can be brought with the client 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 able to administer it and your client may not be allowed to stay.

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

Easterseals 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:**______________

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: ______________________ **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:**____________

- Super Weekend Respite -

Registration 2021

Private Pay Cost: $965 per session

Waiver Rates—

Non CMH: T2036 $3.16 per unit, 304 units per session

CMH: T2036 $3.34 per unit, 304 units per session

Client Name: ___________________________________ Today's Date:___________________

Medicaid:_______________________________________ Date of Birth:__________________

Guardian Name:_______________________ Guardian Email:___________________________

Guardian Home Number:________________ Guardian Cell Number:_____________________

Check in is Friday 10am-11am. Check out is Monday 1pm-2pm. Registration closes the Wednesday before the desired session. All applications are completed in the order received so please allow two weeks to process. **If your client has never attended Easterseals 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 client needs 1:1 assistance, please go to www.easterseals.com/ia/camp for more information regarding the registration process.**

Client Age:_________ (When attending)	***Please mark only the session(s) you want to be registered***
Week 1: June 25-28	○ SW1 Western Weekend
Week 2: July 9-12	○ SW2 Stars and Stripes
Week 3: August 13-16	○ SW3 Rock and Roll

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.

-2021 Financial Form-

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 Easterseals 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 Scholarship

(not guaranteed—Super Weekend Respite only)

Clients are eligible to receive one Scholarship per season, not to exceed $482.50. Residents of group homes, nursing homes, and other facilities are eligible for a maximum Scholarship of $100.00.

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 session.
- Any application turned in **after July 1st will require the payment to be made in full** before the client can be registered.

Are you paying with a waiver? [ ] Yes [ ] No

If yes, please fill out this section only

Managed Care Organization (MCO):

[ ] Iowa Total Care

[ ] Amerigroup Iowa

[ ] HIPP/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.

Case Manager Name:__________________________

Case Manager Phone Number:___________________

Case Manager Email:__________________________

Consent to Leave Phone Messages/Release of Information

By completing the consent below you authorize us to release information or leave a detailed message on voicemail or with a specific individual.

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

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

Client Signature Date

Guardian Signature (if applicable) Date