

INDIAN TRAILS CAMP 2010 SPRING RESPITE APPLICATION

NAME: _____ DOB: ____/____/____

ADDRESS: _____ PH #: ____-____-____

_____ EMAIL: _____

Ethnic Background _____ COUNTY _____
(optional)

Deposit Enclosed \$ _____ or Name of Agency _____

LEVEL OF CARE 1 2 3

I have reviewed the new criteria for the level of care _____ (initials)

Has camper attend Indian Trails Camp before? Yes No

Did you submit current medical forms dated less than 12 months from respite date? Yes No (if no, you will need to submit updated medical form prior to the respite)

SESSIONS

	<u>SESSION</u>	<u>THEME</u>	<u>DATES</u>
_____	FEBRUARY 2-DAY	France	2/5 – 2/7
_____	MARCH 2-DAY	Ireland	3/5 – 3/7
_____	MARCH 2-DAY	Italy	3/26 – 3/28
_____	APRIL 2-DAY	Middle East	4/16 – 4/18
_____	MAY 2-DAY	China	5/7 – 5/9
_____	MAY 2-DAY	America	5/21 – 5/23

Check in times for respites are 4:00 - 6:00 pm. Pick up time is 2:00 - 3:00 pm

Final acceptance will be sent upon receipt of all required paperwork. Required paperwork includes a completed application, level determination form, current physical form, copy of insurance card and financial form.

Level Determination

Indian Trails Camp is going to a point system to determine the level of care a camper needs. This system should provide us with more comprehensive information that will allow us to provide the best care possible for each camper. Please mark all that apply and total the points to determine what level the camper should be registered at. Scholarship funds may be available to help offset any increases in camper fees as a result of a change in level. Please see the green financial form, section D, to apply for a scholarship.

Medication

- Takes Medication 1 time daily **(1-Point)**
- Takes medication 2-3 times daily **(2-Points)**
- Takes Medication more then 3 times daily. **(3-Points)**

Eating

- Requires some assistance with cutting food or needs verbal **(1-Point)** prompting to guide through tasks.
- Requires some physical assistance with accessing food at meals. **(2-Points)**
- Requires specialized diet/nutrition (ex. Puree food) **(2-Points)**
- Requires total assistance with eating (not feeding tube-see medical) **(3-Points)**

ADL's (Bathing, Grooming, Dressing)

- Camper requires verbal prompting to ensure completion of all hygiene needs **(1-Point)**
- Camper requires some physical assistance with hygiene needs **(2-Points)**
- Camper requires full-assistance in caring for hygiene needs **(3-Points)**

Toileting

- Camper requires verbal prompting **(1-Point)**
- Camper requires some physical assistance **(2-Points)**
- Camper requires full-staff assistance **(3-Points)**

Medical (Please mark all that apply)

- Camper requires respiratory treatments**(2-Points)**
- Camper requires routine catherization by nursing staff-**(3-Points)**
- Camper requires colostomy care-**(3-Points)**
- Camper requires a feeding tube-**(3-Points)**

Non-Medical

- Camper requires 1 on 1 staffing **(10-Points)** Please Explain_____

Level 1	Level 2	Level 3
0-5 points	6-9 points	10 or more points

2010

INDIAN TRAILS CAMP

SPRING RESPITE FINANCIAL FORM

CAMPER NAME: _____ AGE _____ COUNTY: _____

RESPITE DATES (select sessions to attend)	___ FEB. 5-7	___ MAR. 5-7	___ MAR. 26-28
	___ APR. 16-18	___ MAY 7-9	___ MAY 21-23

___ LEVEL ONE - MINIMUMAL DEPENDENCE, 0 - 5 points \$254.00 2-day

___ LEVEL TWO - MODERATE DEPENDENCE, 6 - 9 points \$372.00 2-day

___ LEVEL THREE - COMPLETE DEPENDENCE, over 10 points \$512.00 2-day

Please complete the attached Level determination form and submit with application.

If at any time after receipt of this form and camper application, the Camp Director and or Health Director find the camper to be at a different level than indicated, ITC reserves the right to make the appropriate change. In the event of a change, the camper and or family will be notified.

TOTAL DUE \$ _____ = _____ 2-day sessions @ \$ _____ a session

- DEPOSIT \$ _____ Chk # _____ or _____ Credit Card

BALANCE DUE \$ _____

A) PARENT, GUARDIAN OR SELF WILL PAY BALANCE. INCOMMING DAY OR \$ _____ EVERY _____

B) CREDIT CARD PAYMENT ___ VISA ___ MASTERCARD SECURITY CODE _____ EXP ____/____

CARD NUMBER _____ - _____ - _____ - _____ ZIP CODE _____

NAME AS IT APPEARS ON CARD _____ Ph # _____ - _____ - _____

C) Bill Organization: _____
Name address Ph #

Attention _____ Amount to be paid: \$ _____, ____ Before ____ After Session

D) Scholarship Requested in the amount of \$ _____ for the following reasons: (check all that apply)

Financial Considerations: _____ Low family income _____ Live independently _____ Unemployed

Special Circumstances: _____ Hospitalization/major medical _____ Unexpected hardship _____
(explain)

Scholarship funds are allocated on availability & need. Amount requested may not be amount allocated. You will be notified of scholarship granted with your final acceptance.

X _____
Signature of parent, guardian or camper

____/____/____
Date