Participant Name:
Week:

Dear Participants, Families, and Caregivers:

As you may have already suspected, the 2021 summer season will look very different from past summers. This year we will be taking a limited number of participants each week. These spots are first come, first serve. We will still expect the same application and requirements as usual, so below you will find specific instructions on completing this packet.

We're glad to be able to get back to some type of normalcy and spend Helping Hands' Fun 'n Sun 2021 with you!

**** Please make sure to attach a copy of your Covid-19 vaccination card. Participants will not be able to attend without this proof of vaccination. ****

Application Procedure:

1. The mandatory registration deposit of $50.00 for each week is to be submitted to Helping Hands, Inc to confirm your reservation, unless this week will be waiver funded. This deposit will be applied toward the total cost of the program. This deposit is non-refundable. The remainder of the balance is due four weeks prior to the scheduled week, unless other arrangements have been made with our office. There is no $50.00 deposit required if utilizing waiver funding. If you plan to utilize waiver money, contact your supports coordinator ASAP for approval in the ISP.
   Note: If your summer program is being paid by the county/outside agency, and must be paid in full by that resource, you must still pay your $50.00 deposit and it will be reimbursed to you at the end of the summer season. With any questions regarding the above, feel free to contact Connie Panepinto at cpanepinto@helpinghandsinc.com.

2. Please complete the enclosed forms fully and with accurate information. Please utilize additional paper for any forms if necessary. Failure to supply information will delay the application process. Please keep in mind that the summer programs are completely separate from any other agency programs, therefore, with the exception of physical forms, information from other programs is **not transferable.** The packets are extensive yet provide necessary information for the staff who will be working the programs.

3. Physical Form- all participants MUST have a completed physical examination form signed by a licensed physician within one year prior to their arrival. This form may be brought with the participant upon arrival to their scheduled session, if need be. However, failure to supply us with this information may result in refusal of admittance to the program. Note: Physical forms from other programs may be accepted, but please contact Jaimee Scott for further information.

4. All application forms will be processed in the order in which they are received. Complete and return your application as quickly as possible. **Within two weeks of our receipt of your application, you will receive notice regarding acceptance and scheduled sessions, along with a suggested packing list for the week and directions to the Helping Hands Office.** It is **NOT** included in this packet.

5. NOTE: As part of your registration, we are asking for a photo of the participant (scanned photos are acceptable) and photocopies of insurance cards and identification card.

6. If you have any additional questions and need more information regarding specialized issues and/or circumstances, please contact our office at 610-754-6491 or email me at jscott@helpinghandsinc.com.

Jaimee Scott
Summer Program Director

Summer Fun N' Sun 2021

Please return this page with application

Participant's Name _____

SESSION NO.	DATES
1.	June 6 – 11, 2021
2.	June 13 – 18, 2021
3.	June 20 – 25, 2021
4.	June 27 – July 2, 2021
5.	July 11 – 16, 2021
6.	July 18 – 23, 2021
7.	July 25 – 30, 2021
8.	August 1 – 6, 2021
9.	August 8 – 13, 2021
10.	August 15 – 20, 2021
11.	August 22 – 27, 2021

-Family/Caregiver E-mail address: _____

-FUNDING- What will the funding source be for the summer program?

- _____This will be paid with Waiver Funding
  - Supports Coordinator: Agency, Name, and Phone Number:
    _____
  - Supports Coordinator Email Address: _____
  - Has your supports coordinator been notified of the usage of waiver funding? _____

-_____Self/Care Giver Funding- $_____

-_____ Other Funding Resources (specify) $_____
  -Contact information phone number/email _____

-TOTAL BALANCE- $1000.00 per week _____

-How did you hear about the Helping Hands Summer Program?

_____

-Will the participant be attending any other programs this summer? _____
  If yes, where?_____

Total Payment, unless other arrangements have been made, is due 4 weeks before the start of the session checked. If you have any questions regarding payment, please contact Connie Panepinto at cpanepinto@helpinghandsinc.com
Please make checks payable to: Helping Hands, Inc.

Also, please be sure to note the name of the participant on the check or attach a note.

-Participants Name: _____ Age _____

Week Scheduled: _____

Home Address: _____

City:_____ State:_____ Zip Code:_____

County: _____ Date of Birth: _____ Nationality: _____

Phone Number: _____

-Parent/Guardian: _____

Phone Number _____

Email Contact: _____

Emergency Contact Information: (While participating in Summer Programs)

Contact Person #1 _____ Cell Number_____

Work Phone Number_____ Home Number _____

How is this contact related to the participant? _____

Contact Person #2 _____ Cell Number_____

Work Phone Number_____ Home Number _____

How is this contact related to the participant? _____

-If the participant lives in a residential program/lifesharing:

Provider Agency _____Contact Person_____

Email Contact _____

Contact Number- _____

Supports Coordinator and Agency_____

Supports Coordinator email: _____ Phone Number _____

Is participant utilizing waiver funding? _____

Other Funding Resources: _____

Participant's Day Program:_____

Location: _____

MEDICAL SUMMARY:

Does the participant have a Lifetime Medical History? If yes, please attach/photocopy

Medical Insurance Company Name _____ Policy Number _____

ACCESS or Medical Assistance Number: _____

Social Security Number: _____

Secondary Insurance: _____

Primary Physician: _____ Phone Number: _____

Primary Diagnosis: _____

Secondary Diagnosis: _____

Seizure Activity: Yes_____ No _____ Type: _____

Brief Description: _____

Symptoms of Onset: _____

Aftercare Instructions/Protocols: (when to call 911, rest, etc.)
_____
_____

Frequency: _____ Date of Last Seizure: _____

Any Known Allergies: (bees/animals/flowers/seafood or any other food items, etc…)
_____
_____

Activity Limitations: (hiking, swimming, lifting, amusement rides, flashing lights etc…)
_____
_____

ISP/BEHAVIORAL SUMMARY:

Will there be suggested goals/outcomes carried out while at the summer programs? If yes, please attach.
_____

-Is the participant following a behavior management plan? _____**If yes, please attach plan and attach instructions if necessary)**

-What plans will be utilized/followed during summer sessions? _____

-Any behavioral information/tips: _____
_____
_____
_____
_____
_____

-**Does the participant have any current/history of the following**: If yes, please explain in detail and utilize additional paperwork if necessary

1. Self-Injurious Behavior: _____
   _____
2. Abuse of others: (physically/verbally) _____
   _____
3. Sleeping Problems/concerns in unfamiliar surroundings: _____
   _____
   Has the participant slept away from home/provider in the last year? _____
4. Elopement: _____
5. Loud Noise Behavior: _____
6. Other Pertinent Information/Concerns (refusals/history)
   _____
   _____

PLEASE CHECK THE FOLLOWING, AS ACCURATELY AS POSSIBLE:
Some sections may have more than one check.

Level of Intellectual Disability: Mild_____ Moderate_____ Severe_____ Profound_____

Vision:
-Normal_____ -Blindness_____
-Glasses _____ -Utilizes Cane _____
-Contacts_____ -Patch_____
-Fear of Darkness_____ -Sleeps with night light _____
-Depth Perception _____
-Visual Concerns not being treated _____
-Other/Explain_____
_____

Hearing: Normal_____ Hearing Aid(s) _____ Impaired_____ Other/Explain _____

Speech:
-Speaks Clearly_____ -Utilizes own communication skills _____
-Makes Self Understood_____ -Utilizes Communication Device/Boards_____
-Difficult to Understand_____ -Nonverbal but understands_____
-No communication skills_____
-Utilizes Sign Language _____ ASL _____ Self Taught_____ Other _____
-Other Helpful information: _____
_____
_____
-Can the participant safely utilize and avoid toxic materials? _____
-Can the participant be in the kitchen safely with the stovetop and cutlery? _____

Ambulation: Please check all that apply:

-Walks without difficulty _____
-Climbs Stairs easily _____
-Can walk on uneven ground ____
-Tires easily_____
-Holds onto staff arm/hand _____
-Fearful of unfamiliar Areas_____
-Fearful of falling_____
-Manual Wheelchair_____
-Self propelled wheelchair_____
-Utilizes Arm Braces_____
-Utilizes Walker_____
-Utilizes Walker with a seat_____
-Utilizes Cane_____
-Depth Perception Issues _____

-Needs assistance with transferring- (tips for staff/weightbearing information) _____
_____
-Other/Instructions/tips_____
_____

Dietary Information: Please check all that apply:

-Feeds Self_____
-Uses Utensils Easily_____
-Needs Assistance with Cutting_____
-Needs assistance with feeding_____
-Chokes Easily_____
-Eats very quickly _____
-Eats very slowly _____
-Specialized Cup_____
-Specialized Plate _____
-Specialized Silverware _____
-Needs Full Assistance _____
-Gluten Free _____
-Sugar Free_____
-Low Sugar_____
-Low Salt_____
-Diabetic_____
-Prefers or needs straws_____
-Finely Chopped _____
-Food Pureed_____
-Mechanical Soft _____
-Liquid Needs (Thick-IT/Consistency) _____
_____

-Dietary Guidelines with Preparation- Please Explain: -Restrictions/Instructions/Explain:_____

-After meal instructions if necessary (Stay upright, etc):_____
_____
-Other _____

Toileting Needs: Please check all that apply:

-Incontinence_____
Diapers_____ Pull Ups_____ Liners _____ Pads _____ Other _____
-Self Toileting_____
-Needs Reminders _____ Frequency for reminders _____
-Needs to "sit" for a while occasionally _____
-Other information: special equipment, assistance necessary, diapering techniques, transferring tips, number of diapers/pull ups, overnight changes, daytime routine, etc. _____
_____
_____

Showertime/Dressing Needs: Please check all that apply:

Bathing: Does the participant usually take: Showers _____ Baths _____
-Is the participant fearful of water?_____
-Does participant usually shower in the AM? ____ PM? _____
-Any routines that might be helpful? _____
_____
-Does the participant wash his/her own hair?_____
-Is the participant able to regulate his/her own water temperature? _____
-Does the participant need assistance with shaving? Tips for staff (before shower/after shower, razor/electric?
_____
_____

Dental information/Teeth Brushing Routine:

-Does the participant wear dentures? (If so, are they full dentures or partials?) _____
-Does the participant brush his/her own teeth at home? _____
-How much/what kind of assistance is needed, if necessary?_____

Adaptive/Medical Equipment to be utilized: Please check/describe all that apply:

-Leg Braces (Special instructions)_____
-Arm/Hand Braces- Please attach instructions:_____
-Physical Therapies while attending: (Details: Frequency/special instructions)
_____
_____
-Communication Devices (Details: Frequency/How to recharge device/special instructions) _____
_____
-Feeding adapters (Describe) _____
-C-Pap Machine _____
-Side Bed Rails (we can provide) _____
-Wheelchair/Electric Wheelchair _____
-Walker or Walker with a seat _____
-Bed Wedges (we can provide)- Provide instructions_____
-Does the participant have a rotation schedule during the overnight hours? Explain_____
-Does the participant have a schedule for repositioning during the day/overnight hours? Explain:
_____
_____
-Other-_____

Any other pertinent information relative to the participant that might be helpful: (further details on anything listed prior, etc.) _____
_____
_____

Signature _____ Date _____

Relationship to Participant_____

PERSONAL SKILLS PROFILE 2021

Name_____ Age _____ Sex _____

This information regarding the functional level of the participant is used to help the staff members in their understanding of each participant, in the planning and preparation of appropriate program activities, and in forming groups appropriately. Please be as accurate as possible to help insure a good experience for each participant.

LIFE SKILLS	SELF	NEEDS ASSISTANCE	CAN NOT
Hair Brushing			
Combing Hair			
Toileting- urine			
Toileting- bowels			
Dresses Self			
Buttons/Zippers			
Choosing Appropriate Clothing			
Knows when to change clothing			
Ties own shoes			
Makes own bed			
Takes care of personal belongings			
Can identify a stranger			
Can evacuate safely in an emergency			
Can utilize a phone for 911			

GENERAL BEHAVIOR	YES	NO	EXPLAIN, IF NECESSARY
Friendly/Happy			
Cooperative			
Has a sense of Humor			
Conscientious/Dependable			
Enjoys Peer Relationships			
Enjoys Staff Relationships			
Generally a Loner			
Needs/Takes Time for Self			
Needs Encouragement to Participate			
Combative			
Frustrates Easily			
Follows Directions			
Understands Directions That Require a Decision			
Sociable			
Can be reasoned with			
Will utilize manners appropriately			
Enjoys being helpful			
Discusses interests, hobbies, family, etc.			
Relates well to male authority figures			
Relates well to female authority figures			
Can the participant read?			
Can the participant write?			

PERSONAL SKILLS PROFILE- CONTINUED….

PROGRAM ACTIVITY	ENJOYS	WILL WATCH / MAY TRY	FEARFUL/WILL NOT ATTEMPT	UNKNOWN
Swimming/water activities				
Athletics/sports				
Group activities/games				
Arts and Crafts				
Walking/ Nature activities				
Activities with animals (Zoos/Aquariums)				
Cooking/baking desserts/snacks				
Music Activities				
Campfires				
Shopping				
Down time				
Gambling				
Spending money				
~~Going out for a meal~~				
~~Community involvement~~				
Reading				
Activities that might get messy				

Please fill in the following questions as accurately as possible, again, as it is helpful for the staff to prepare for and to make the summer experience the best possible for the participant.

Favorites:

Color: _____

Food/Snack: _____

-Does the participant like seafood? _____

Activities: _____

Music Style: _____

Friends at summer program: _____

General Likes: _____

_____

General Dislikes: _____

_____

Fears: (birds, heights, water, campfire, animals, bees, storms, darkness, balloons, etc….)

_____

_____

Is the participant permitted to have any alone time at the shore house? In the community? Describe:

_____

Is the participant intimidated by crowded settings? _____

Does the participant prefer coffer at home or do they prefer tea? _____How much/how frequently?_____

Regular or decaf? _____

Is the participant permitted to drink alcohol? If yes, how much? _____

Please utilize this space to describe anything about the participant that is not covered in the preceding categories, but might be helpful for staff to respond more effectively to the participant. _____

_____

Signature_____ Date_____

Relationship to Participant_____

MEDICATION INFORMATION 2021

Will the participant take medication during summer sessions? Yes_____ No _____

If yes, please describe IN DETAIL how medications are administered: (e.g. with applesauce, crushed, with water. Utilize the reverse of this page if necessary) Please be sure to include any PRN Medications and topical medications that the participant takes while attending the summer sessions. Thank you.

MEDICATION	DOSAGES	TIME(S) ADMINISTERED	HOW ADMINISTERED

1. Is the participant self-medicating?_____
2. Can the participant recognize his/her own medications? _____
3. Is the participant permitted to have Tylenol, Acetaminophen, Aspirin, Ibuprofen, etc. while attending, if necessary? Please describe the best option:_____
4. Is the participant permitted to have cough syrup if necessary? _____
5. Is the participant permitted to have Imodium if necessary? _____
6. Is the participant permitted to have Benadryl if necessary?_____
7. Other pertinent information regarding medications: _____
_____

Parent/Guardian/Caregiver Signature_____
Date _____

EXPECTATIONS AND CONCERNS 2021

1. Bring to Shore:
   ** Please bring your vaccination card if you did NOT already send a copy with your application **
   - A. A completed item check sheet. This sheet should be brought to the program upon check-in. It will be checked upon arrival and departure. **You will receive this packing list with your final confirmation information.**
   - B. Extra linens and plastic mattress covers for individuals that tend to have accidents. If you do not provide this and damage is done, you will be responsible for payment of damages.
   - C. Extra clothing for the participant to wear during the week period. Limited laundry will be done. **ALL clothing and other items should be marked with participant's name.** If they are not labeled, staff might mark them upon arrival to avoid confusion at the end of the week. Helping Hands is NOT responsible for lost articles- So, if it is priceless, please leave it at home.
2. Medication: Medication MUST be in the original container with correct instructions on the label. We are **required** to give the medications as directed on the bottle. If any dosages or dispensing times are different than marked on the label, please get a new label on the bottle before arrival. Please document any special instructions on the application. Please include the average time the participant takes these medications if times are not specified on the bottle.
3. Damages: Participants will be held responsible for any damages that are done during their stay with us. This includes physical, personal and property damages.
4. It is our expectation that all participants attending the program do not have abusive behaviors either toward themselves or others; and that all participants do not have any sleeping disorders, or nighttime behavioral problems.
5. Full payment for each session is expected **four** weeks prior to the arrival, unless a written agreement with Helping Hands has been made.
6. All information on the application must be completed accurately and correctly.

I/we have read the above expectations and concerns and acknowledge that they must be followed in order to provide a safe and organized camping environment for all those attending. Helping Hands retains the right to refuse or terminate the stay of anyone who does not follow agency policies and procedure at any time.

_____ _____
Signature of Parent/Caregiver/Provider Date

_____ _____
Signature of Participant Date

In addition, Helping Hands Inc. reserves the right and its SOLE discretion to send home any participant we feel presents a problem to the operation of the program. It will be the responsibility of the family, caregiver, or provider agency to provide **immediate** pick-up and transportation for the individual. Helping Hands will determine any refunds for program fees at the end of the season.

_____ _____
Signature of Parent/Caregiver/Provider Date

_____ _____
Signature of Participant Date

*****This page must be signed by both the participant and the responsible caregiver/provider, or the application will not meet the processing requirements.**

HELPING HANDS, INC.
PERMISSION FORM 2021

EMERGENCY TREATMENT CONSENT FORM

I grant permission for _____ to receive medical attention/treatment by a doctor/hospital and/or any First Aid/CPR/Water Safety trained staff member if it is so required while he or she is attending any agency programs.

_____ _____
Signature of Parent/Caregiver Date

MEDICATION ADMINISTRATION

I grant permission for _____ to be administered prescription medication by program staff when necessary. For anyone who takes medication, please be sure to have it in the **PRESCRIPTION CONTAINER(S)**

_____ _____
Signature of Parent/Caregiver Date

PICTURES

I give my consent for the taking and using of pictures of _____ via advertising, social media, fundraising, etc. for the purpose of furthering services for persons served by Helping Hands, Inc.

_____ _____
Signature of Parent/Caregiver Date

SHORT TRIPS

I grant my permission for _____ to participate in short trips as part of the agency's programs.

_____ _____
Signature of Parent/Caregiver Date

HELPING HANDS, INC.

2021 – Summer Camp/Shore Vacation Programs Liability Waiver Form

Participant Name:_____

Address:_____

Father/Mother/Guardian/Caregiver/Provider:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Emergency Contact Name & Phone Number:_____

Parent/Guardian/Caregiver/Provider Signature:_____

Date:_____

As the parent/caregiver/legal guardian of the above named individual. I hereby grant permission for the individual to participate in the Helping Hands, Inc. Summer Camp/Vacation Program. I assume full responsibility for any/all injuries or damages which may occur to the individual in, on, or about the shore camp/vacation site, or arising out of its on site or off site activities. I do hereby release and discharge Helping Hands, Inc. and all persons associated with it from any and all claims, demands, rights of action, or causes of action, present or future, whether same be known, anticipated, or unanticipated, resulting from or arising out of the individual participation in the programs and activities of the foresaid Summer Camp/Vacation Program. I further grant permission to provide emergency first-aid and/or medical care to the individual in case of injury or illness as deemed appropriate by Helping Hands, Inc. or a physician. I assume full responsibility for all medical expenses incurred for the treatment.

Parent/Guardian/Caregiver/Provider Signature Date