

AHRC Camping Programs – Summer 2008 Camp Anne & Harriman Lodge

How to Apply:

- Read the attached “Camp and Session Information” sheet. This will tell you more about the two camps as well as session dates, fees and other helpful information.
- Complete the enclosed application form and attach all requested documents. Please return by **February 15, 2008**. We have added a checklist to help you complete your application. Please check off each item – when all the boxes are checked, your packet is ready to mail.
- Once we receive your completed and legible application, it will be reviewed by the directors and nursing coordinator. An incomplete or illegible application will not be processed until all information is received. If this is a new applicant OR a returnee who had medical issues last summer and/or is 70 years of age or older, we will call you to set up a nursing assessment. If this consumer attended camp last year and your application packet is complete, we will assign them a session. Because of increased demands for the limited spaces in our programs, we cannot guarantee a session so please do not make vacation plans until you have received your session dates.
- If accepted into camp, we will send you an acceptance packet, with the date of the session, fees (to be paid by **June 1, 2008**) and a handbook to help you prepare your camper.

**Questions about camp? Please call:
Dorothy at (212) 780-2526
Health Center (518) 329-5649, after June 1 (518) 329-6040
(reguntas acerca de el campamento? Por favor llame:
Edgar (212) 780-2527**

AHRC does not discriminate against program participants for any reason, including race, religion, national origin, creed, age, ethnic background or certain medical conditions such as a positive HIV status or any other disease not transmitted

Checklist for Camper Application

Please use this checklist to complete your application. Incomplete applications cannot be reviewed or accepted. Since we have limited space, this could affect your acceptance into camp.

Personal Data Form (Yellow Page)

Page 3

? General Information, Applicant's Residence, AHRC Involvement and Service Coordinator sections completed.

Page 4

? Emergency Contact #1, #2 and #3 completed

? Insurance information completed

General Medical Information (Lilac Page)

? Complete boxes #1 – 26. Add comments for any questions that you answer "yes."

? Write current medications and doses in #27. If necessary, use another sheet of paper.

? Signature of person completing form required.

Daily Living Skills (Pink Page)

? All boxes on both pages reviewed and checked

? Signature on the bottom of page

Attachments

For insurance information:

? Copy of Medicare card and Medicare Part D card if this applicant has Medicare

? Copy of Medicaid card, if this applicant has Medicaid

? Copy of private insurance card, if this applicant has private insurance

? 3 current photos

? Your non-refundable \$50 application processing fee. Checks or money orders should be made payable to AHRC Camping Department.

*****IMPORTANT Note for Campers:**

? If your camper is applying for the first time **OR** has not attended an AHRC program within the last three years, please attach a copy of current psychological exam and psycho-social exam, dated within the last 3 years (after 1/1/02).

Financial Aid Application attachments:

If you completed the financial aid application, you must attach the following items to be considered for a scholarship:

? Attach a copy of your most recent federal income tax filing (either for 2006 or 2007)

? Attach a copy of a W-2 form for each member of your household

? Attach a copy of the applicant's award letter

Optional Attachments:

Physical Form does not have to accompany this application but, is required at least two weeks before attending camp.

? Copy of physical, dated after September 5, 2007, and including immunizations and PPD

? Behavior plan, if applicable

Signature of person completing this checklist and application:

Signature

Print name

Date

(_____) _____ email address (if available) _____


Phone number where we can usually reach you during daytime hours _____

Please use the self-addressed envelope or mail to:

- **AHRC Camping Programs**
- 83 Maiden Lane 9th Floor**

New York, NY 10038

Camp and Session Information 2008

	CAMP ANNE	HARRIMAN LODGE
Camp Descriptions	<u>Sessions for children, teens, and adults.</u> For individuals who need a high degree of assistance or supervision. Staff to camper ratio ranges from 1:1, 1:2, 1:3, depending on needs. Wheelchair accessible.	<u>For adults only, including young adults (ages 18-29) and seniors.</u> A summer resort for individuals in the mild-to-moderate range of developmental disabilities who need minimal supervision. Staff to camper ratio is 1:4. Wheelchair accessible.
Camp Locations	In Ancramdale, New York approximately 2 ½ hours north of NY City near the Berkshire Mountains.	In East Jewett, New York approximately 3 hours northwest of NY City (near Hunter Ski Resort).
Camp Fees 	An application processing fee of \$50 is due with the application (make checks out to: AHRC Camping Dept.) <p style="text-align: center;"><u>Family Rate</u> \$875 for 13-day sessions (Sessions 1,2, 3, and 4) \$500 for 7-day child's session</p> <p style="text-align: center;"><u>Non-AHRC Group Home Rate</u> \$1400 for 13-day sessions \$675 for 7-day child's session</p>	An application processing fee of \$50 is due with the application (make checks out to: AHRC Camping Dept.) <p style="text-align: center;"><u>Family Rate</u> \$875 for 13-day sessions (Session 1,2,3,4, and 5)</p> <p style="text-align: center;"><u>Non-AHRC Group Home Rate</u> \$1400 for 13-day sessions</p>
Session Dates	#1 June 26- July 8 (Adults 21-60) #2 July 10 – 22 (Adults 21-60) #3 July 24 – Aug 5 (Adults 21-60) #4 Aug 9 – 21 (Teens 13-20) #5 Aug 23 – 29 (Children 5-12)	#1 June 26 – July 8(Adults 30–older) #2 July 10 –22 (Adults 30–older) #3 July 24 – August 5 (Adults 30–older) #4 Aug 8 –20 (Adults 30–older) #5 Aug 22 – Sept 3 (Young Adults 18-29)
Financial Assistance <i>(for New York City Residents only)</i>	<ul style="list-style-type: none"> ❖ Scholarships are available only available for campers who live at home and are NYC residents. ❖ Financial assistance is based on a sliding scale. To be considered, all working members of a household must submit recent income tax forms or paycheck stubs. ❖ Proof of income must be included with your application packet to be considered for financial assistance. (see attached checklist) More information regarding the sliding scale	
Refund Policy	<ul style="list-style-type: none"> ❖ The registration fee of \$50 is not refundable. Application processing 	
Important Reminder	<ul style="list-style-type: none"> ❖ Use the checklist to complete the application and to add all required attachments. Space is very limited in camp and we encourage you to send your completed application as early as possible to avoid disappointment. 	

Emergency Contact Persons (Must include primary caregiver)

1st Parent/Guardian Contact _____ Relationship _____

Phone #1 (____) _____

Phone #2 (____) _____

2nd Emergency Contact (OTHER THAN PRIMARY CAREGIVER) _____

Relationship _____

Phone #1 (____) _____

Phone #2 (____) _____

3rd Emergency Contact (OTHER THAN PRIMARY CAREGIVER) _____

Relationship _____

Phone #1 (____) _____

Phone #2 (____) _____

Insurance Information

APPLICANT NAME: _____

CHECK ALL THAT APPLY: ___ Medicaid # _____ Medicare # _____ Medicare Part D _____ Private Ins.

INCLUDE COPIES OF MEDICAID CARD, MEDICARE CARD, MEDICARE PART D PLAN CARD, PRIVATE INSURANCE CARD(S)

OR PRIVATE INSURANCE

Name of Policy Holder _____

Social Security # of Policy Holder _____

Relationship to Applicant _____

Policy Holder's Employer _____

Employer's Address _____

(City)

(State)

(Zip Code)

Insurance Name _____

Insurance Address _____

(City)

(State)

(Zip Code)

Financial Assistance – Summer 2008
(Only for Applicants living with their families AND residing in NYC)

Directions

- You must submit a copy of your most recent federal income tax filing (either year 2007 or 2008 form).

- If the applicant is listed as a dependent on another person's income tax, submit a copy of their federal income tax form(s) as well

- Be sure to fill in ALL spaces. If a question does not apply, write N/A (for not applicable) in the space provided.

- Please sign the bottom of this form.

Camper's Name: _____

How many members of the family live at home? _____

Submit all annual income for each family member. Please attach (W-2 Form) or paycheck stubs (if you did not file), social security income, social security disability, pensions, alimony/child support, public assistance budget and award letter. (see attached insert)

Print name of responsible party: _____

By signing here as the above listed camper's responsible party, I certify that all of the above information is correct to the best of my knowledge.

Signature

Date



General Medical Information - 2008

(Complete Both Sides **SIGN** and **DATE** by Parent/Caregiver)

Applicant Name: _____

1.	Is Primary Diagnosis Mental Retardation	<input type="checkbox"/> yes	<input type="checkbox"/> no	Profound Severe	<input type="checkbox"/>	Moderate Mild	<input type="checkbox"/>	<input type="checkbox"/>	
				(Note: Selected category must match psychological / psychosocial report)					
2.	Secondary Diagnosis	Please List:							
3.	Allergies to Medications	<input type="checkbox"/> yes	<input type="checkbox"/> no	Please List:					
4.	Allergies to Food or Environment	<input type="checkbox"/> yes	<input type="checkbox"/> no	Please List:					
5.	Asthma	<input type="checkbox"/> yes	<input type="checkbox"/> no	Nebulizer treatment	<input type="checkbox"/> Daily	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Never		
				Inhalers	<input type="checkbox"/> Daily	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Never		
6.	Respiratory (breathing) Difficulties	<input type="checkbox"/> yes	<input type="checkbox"/> no	Requires Oxygen treatment:					
				<input type="checkbox"/> All the time <input type="checkbox"/> Occasionally <input type="checkbox"/> Never					
				Requires CPAP, BiPap or other treatment during nighttime:					
				<input type="checkbox"/> Yes <input type="checkbox"/> No					
7.	Arthritis	<input type="checkbox"/> yes	<input type="checkbox"/> no	Medications	<input type="checkbox"/> yes	<input type="checkbox"/> no			
8.	Constipation	<input type="checkbox"/> yes	<input type="checkbox"/> no	Requires suppository	<input type="checkbox"/> yes	<input type="checkbox"/> no			
				Enema	<input type="checkbox"/> yes	<input type="checkbox"/> no			
					<input type="checkbox"/> Routinely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Never		
9.	Blood/Metabolism Disorder	<input type="checkbox"/> yes	<input type="checkbox"/> no	If 'Yes' provide diagnosis: _____					
				Requires laboratory work during stay at camp? <input type="checkbox"/> yes <input type="checkbox"/> no					
10.	Diabetes	<input type="checkbox"/> yes	<input type="checkbox"/> no	Oral medications	<input type="checkbox"/> yes	<input type="checkbox"/> no			
				Insulin injections	<input type="checkbox"/> yes	<input type="checkbox"/> no			
				Requires blood glucose monitoring (MD order needed):					
				<input type="checkbox"/> Daily <input type="checkbox"/> 2 times/day <input type="checkbox"/> 3 times/day					
				<input type="checkbox"/> 4 times/day <input type="checkbox"/> Monthly <input type="checkbox"/> Other					
11.	Bowel Incontinency Urine Incontinency	<input type="checkbox"/> yes	<input type="checkbox"/> no	Requires incontinence protection:					
		<input type="checkbox"/> catheter	<input type="checkbox"/> At all times <input type="checkbox"/> At night only <input type="checkbox"/> Sometimes						
			<input type="checkbox"/> During Transport						
12.	Epilepsy / Seizure activity	<input type="checkbox"/> yes	<input type="checkbox"/> no	Date of last Seizure	_____				
				Type of seizure activity	_____				
				Has seizures:	<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly			
					<input type="checkbox"/> Monthly	<input type="checkbox"/> Other _____			
				Utilizes protective helmet**	<input type="checkbox"/> yes	<input type="checkbox"/> no			
				Requires bed rails**	<input type="checkbox"/> yes	<input type="checkbox"/> no			
				**MD order needed					
13.	Frequent Ear Infections	<input type="checkbox"/> yes	<input type="checkbox"/> no	Wears ear plugs when	<input type="checkbox"/> Shower	<input type="checkbox"/> Swimming			
					<input type="checkbox"/> Both	<input type="checkbox"/> Never			

14.	High Blood Pressure	<input type="checkbox"/> yes <input type="checkbox"/> no	Requires blood pressure monitoring: <input type="checkbox"/> More than once a day <input type="checkbox"/> Daily <input type="checkbox"/> Twice a week <input type="checkbox"/> Once a week		
15.	Hepatitis (infectious)	<input type="checkbox"/> yes <input type="checkbox"/> no	Type: _____		
16.	Heart Disease	<input type="checkbox"/> yes <input type="checkbox"/> no	If 'Yes' provide diagnosis: _____		
17.	Hearing difficulty	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> Total hearing loss <input type="checkbox"/> Severe loss <input type="checkbox"/> Mild loss <input type="checkbox"/> Right ear only <input type="checkbox"/> Left ear only <input type="checkbox"/> Both ears Wears hearing aid <input type="checkbox"/> All the time <input type="checkbox"/> Sometimes <input type="checkbox"/> Never		
18.	Psychiatric Diagnoses	<input type="checkbox"/> yes <input type="checkbox"/> no	Diagnosis: _____ Behavior plan <input type="checkbox"/> yes <input type="checkbox"/> no Reminder: Please send copy of plan with application		
19.	Tuberculosis	<input type="checkbox"/> yes <input type="checkbox"/> no	Has received treatment in the past? <input type="checkbox"/> yes <input type="checkbox"/> no Start date of treatment: _____		
	Was PPD result positive	<input type="checkbox"/> yes <input type="checkbox"/> no			
20.	Skin Condition	<input type="checkbox"/> yes <input type="checkbox"/> no	Open areas present <input type="checkbox"/> yes <input type="checkbox"/> no History of open areas: ? yes ? no		
21.	Stomach Problems	<input type="checkbox"/> yes <input type="checkbox"/> no	Describe: _____		
22.	Swallowing Difficulty	<input type="checkbox"/> yes <input type="checkbox"/> no	Special Diet <input type="checkbox"/> Ground <input type="checkbox"/> Chopped (knife)		
	Chewing Difficulty	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> Pureed ? Ground (food processor)		
			Thickened liquids consistency of: <input type="checkbox"/> Nectar <input type="checkbox"/> Honey <input type="checkbox"/> Pudding		
			Adaptive equipment: <input type="checkbox"/> Plate <input type="checkbox"/> Spoon <input type="checkbox"/> Cup		
23.	Vision - Normal	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> Legally Blind <input type="checkbox"/> Partially blind <input type="checkbox"/> Right Eye <input type="checkbox"/> Left eye <input type="checkbox"/> Both eyes Wears corrective lenses: <input type="checkbox"/> All the time <input type="checkbox"/> Sometimes <input type="checkbox"/> Never		
24.	Osteoporosis (bone disorder)	<input type="checkbox"/> yes <input type="checkbox"/> no	Explain: _____		
25.	Period/ Menstrual Difficulties	<input type="checkbox"/> yes <input type="checkbox"/> no	Menses occur every _____ days.		
	Period, Irregular, painful	<input type="checkbox"/> yes <input type="checkbox"/> no	Date of last menses cycle: _____		
26.	Any recent injury	<input type="checkbox"/> yes <input type="checkbox"/> no	Please give details: _____		
	Illness	<input type="checkbox"/> yes <input type="checkbox"/> no			
	Hospitalizations	<input type="checkbox"/> yes <input type="checkbox"/> no			
	Emergency Room Visit	<input type="checkbox"/> yes <input type="checkbox"/> no			
	History of Falls	? yes ? no			
27.	Please provide details of current medications: Use another page if necessary	Medication	Dose in mg	How often	Time

Person Completing Form: _____ Date: _____

Sign Here

Daily Living Skills - 2008

Please complete **both** sides of the following questionnaire.
Your answers will assist to ensure a safe and enjoyable vacation experience.

Applicant's Name _____

Communications	
<input type="checkbox"/> Uses speech, full and/or short sentences <input type="checkbox"/> Clear, single words <input type="checkbox"/> Difficult to understand <input type="checkbox"/> Attempts words, unclear <input type="checkbox"/> Non Verbal	If non-verbal: <input type="checkbox"/> Uses sign language <input type="checkbox"/> Uses gestures <input type="checkbox"/> Has communication board, other device or pictures <input type="checkbox"/> Does not outwardly appear to communicate
Activity Level	
<input type="checkbox"/> Initiates own activities, shares interests with others <input type="checkbox"/> Very active, at times impulsive <input type="checkbox"/> Requires occasional encouragement to complete activity	<input type="checkbox"/> Does not initiate activities however participates with continual encouragement and/or supervision <input type="checkbox"/> Does not willingly participate in most activities
Comprehension	
<input type="checkbox"/> Understands most conversations <input type="checkbox"/> Understands most directions	<input type="checkbox"/> Limited understanding of conversations/ directions <input type="checkbox"/> Does not outwardly respond
Interests	
<input type="checkbox"/> Dance <input type="checkbox"/> Acting <input type="checkbox"/> Music <input type="checkbox"/> Drawing <input type="checkbox"/> Cooking <input type="checkbox"/> Writing <input type="checkbox"/> Photography <input type="checkbox"/> Basketball <input type="checkbox"/> Soccer <input type="checkbox"/> Pool <input type="checkbox"/> Boating <input type="checkbox"/> Horses <input type="checkbox"/> Gardening <input type="checkbox"/> Animal Care <input type="checkbox"/> Running <input type="checkbox"/> Reading <input type="checkbox"/> Singing Other: _____	Favorite leisure activity is _____ _____ While on vacation applicant is most looking forward to: _____ Does applicant have any known fears? If so, please explain _____ _____
Socialization	
<input type="checkbox"/> Enjoys activities with others <input type="checkbox"/> Accepts limited contact with others <input type="checkbox"/> Prefers solo activities Engages in behavior that can be harmful to self or others <input type="checkbox"/> Rarely <input type="checkbox"/> Often <input type="checkbox"/> Never Please explain : _____ _____	Applicant is currently working toward goals outlined in a behavioral plan. <input type="checkbox"/> Yes <input type="checkbox"/> no <i>NOTE: To ensure quick response regarding your application, please provide a copy of the behavior plan when you return this application.</i>
Mobility	
<input type="checkbox"/> Walks independently <input type="checkbox"/> Requires occasional physical assistance walking over uneven ground, up stairs and over difficult terrain <input type="checkbox"/> Utilizes cane or walker (please circle which) <input type="checkbox"/> Requires direct physical assistance of one person while walking at all times <input type="checkbox"/> Wheelchair for long distances only <input type="checkbox"/> Wheelchair at all times (<input type="checkbox"/> Manual <input type="checkbox"/> Electric)	For wheelchair users: (complete attached Orthopedic Appliance Questionnaire) <input type="checkbox"/> Unable to self propel, requires total assistance <input type="checkbox"/> Can stand and "pivot" during transfers <input type="checkbox"/> Unable to stand and "pivot", is non-weight bearing <input type="checkbox"/> Provides upper body assistance during transfers <input type="checkbox"/> Unable to provide upper body assistance during transfers <input type="checkbox"/> Can transfer to a bus seat <input type="checkbox"/> Can sit in a regular bus seat for 3 hours
Bathing and Showering	
<input type="checkbox"/> Independent, no assistance <input type="checkbox"/> Requires verbal prompting, reminders	<input type="checkbox"/> Hand over hand physical assistance required to complete task <input type="checkbox"/> Total assistance required with all bathing tasks

Applicant Name: _____

Dining Room Skills

- Uses fork, knife and spoon
- Uses fork and spoon only
- Requires adaptive spoon or fork
- Requires plate guard
- Requires assistance to drink hot and cold liquids from cup/ glass
- Drinks liquids from adaptive cup with no assistance
- No known risks for choking
- Needs constant supervision while eating

- Wears dentures
- Eats rapidly
- Difficulty with chewing
- May "stuff" food

Generally appetite is:

- Fair Average Excessive

Favorite foods include: _____

Toileting Skills

- Uses toilet independently
- Requires supervision on toilet

Requires incontinence pads

- Day Night Both

Uses words or other method to indicate need. Explain:

Usual time of day for bowel movement _____
Usually has a bowel movement every _____ day/s.

(Female only)

- Independent with menstrual care
- Some assistance required with menstrual care
- Total assistance needed with menstrual care

Dressing

- Independent, no assistance
- Requires verbal prompting, assist with appropriate clothing selection

- Physical support needed with buttons, zippers, tying shoes
- Total assistance required with all tasks

Sleeping Habits and Routines

Usually goes to sleep at _____ PM.
Usually wakes at _____ AM

Has difficulty sleeping at night

- Rarely Sometimes Always

Gets out of bed during the night

- Rarely Sometimes Always

Requires repositioning throughout night

Explain: _____

- Requires bed rails at night (*Script required for bed rails*)
- Wets the bed at night

Requires special equipment to maintain position and prevent skin breakdown

- Straps Egg Crate Pillows
 Wedges Cushions Bolsters

If individual has difficulty sleeping, the usual intervention is to:

Medications /Medical Care

- Independent with medications
- Requires some verbal prompting, reminders
- Requires some physical assistance and verbal prompting
- Requires full physical assistance

Fully cooperative with receiving medications and medical treatment

- Always Usually Sometimes Not usually

Medication is usually given;

- As whole tab or pill Crushed As liquid

Crushed or liquid medications are usually given with

- Water Juice Applesauce

Ice Cream Other _____

Person Completing Form: _____ Date: _____