February 1st, 2019

Dear ARISE at the Farm Camp participant,

We hope this letter finds you well and looking forward to summer camp! We can't wait to soak up the summer sun alongside our adult campers. Hopefully, this letter will help explain the application process for Farm Camp.

It's important to note, we will only confirm attendance when certain required materials are in our possession. This includes important documentation from The Office for People with Developmental Disabilities (OPWDD) and your Care Coordination Organization (CCO) which provides us with eligibility information. We will reach out to request any missing documentation before the application is officially approved. Additionally, if this is your first year applying for camp with ARISE, we will schedule a time to complete an intake.

To make the application process more efficient, we have decided to include necessary documents. Included, you will find, the Camper Safeguard Form. This form is necessary for all campers, even returning camp families, so that we have the most accurate and updated information.

Due to recommendations from the Department of Health we have made the decision to offer one (1) week for participants over the age of 21 so that we can provide appropriate programming for all. Any participant over the age of 21 will not be eligible for other sessions of Farm Camp.

Camp dates this year:

(Adult Session) August 5th - August 9th, 2019

NOTE: ALL camper applications for ARISE at the Farm Camp are due no later than **May 1st, 2019.** To aid with your families' summer planning efforts, we will inform families of their approved camp dates by May 17, 2019. Additionally, **all payments are due no later than one (1) week prior to the first day of camp**.

Please complete the entire application before returning, ensuring all information is accurate and current. We look forward to another amazing year at ARISE at the Farm Camp. If you have any questions, please contact Geoff Peppel at (315) 671-3085 or by email at FarmCamp@Ariseinc.org.

Sincerely,

Geoff Peppel

Manager for Inclusive Recreation

315-671-3085

Farmcamp@ariseinc.org

Participant Name_____

Recreation Program Application: Please complete all sections

NOTE: ARISE at the Farm **ADULT CAMP** will provide 1 week of camp in the 2019 summer
The dates for this camp session are August 5th – August 9th 2019

General Contact Information – PLEASE PRINT LEGIBLY AND COMPLETE IN FULL

Participant Information:

Last Name _____ First Name _____Middle_____
Address_____Apartment_____
City _____ State_____ Zip_____
Phone Number: _____ Alternate Phone: _____
Birthdate: _____
Height: _____ Weight: _____ T-shirt size _____ Youth _____Adult

Parents/Guardians Information:

Full Name/s: _____
Address (if different than above) _____
City State Zip
Phone number Alternate Phone E-mail

Emergency Contact: Who do we call if Parent/Guardian cannot be reached?

Full Name _____
Address (if different than above) _____
City _____State _____Zip_____
Phone number _____Alternate Phone_____
E-mail _____ Relationship_____

Full Name _____
Address (if different than above) _____
City _____State _____Zip_____
Phone number _____Alternate Phone_____
E-mail _____ Relationship_____

Participant Name_____

Care Coordination Information

Care Manager Information (If applicable)
Name: _____ Agency: _____
Phone: _____ Email: _____

Self-Direction Information (If applicable):
Broker Name: _____ Agency: _____
Phone: _____ Email: _____

Note* All program/camp services are associated with a cost. If a participant with a self-direct budget decides to participate in any program, the designated amount will need to be entered into their budget and approved before they are able to attend.

Has the person participated in ARISE at Farm Camp in the past?
____ No ____ Yes Program: _____

Who is filling out this application? _____ Parent/Guardian _____ Service Coordinator

Participant Inclusion/Behavioral Information

Inclusion and ARISE at the Farm Camp:
ARISE at the Farm Camp is dedicated to providing the most inclusive and accessible programs possible to best meet the needs of our campers, their families and the community. If you or your camper requires additional accommodations, supports and/or adaptive equipment to participate more successfully in our program please don't hesitate to make a request and our staff will do our very best to meet your individual needs!

Please provide additional information about supports, accommodations and/or adaptive equipment in the space provided below:

_____
_____
_____
_____
_____
_____

Behavioral Needs: (Check all that apply and please explain in the space below):
____ One-to-One support ____ Sensory needs ____ Self-Injurious Behavior ____ PICA-like behavior

_____
_____
_____
_____
_____

Participant "About Me"

Name: _____Preferred Name/Nickname: _____

Please help us get to know you! We would greatly appreciate if you would take the time to answer the questions below. Feel free to provide any additional information that you may think is helpful as well.
Note * Even if you have participated in ARISE Recreation programs for a prolonged period of time this sheet must be updated annually!

The members of my family are (including pets):

Two things I want people to know about me are:

1.

2.

When I am happy, I will:

When I am unhappy, I will:

Some things I like to do are:

Some of my favorite things are:

Some things that I do well are:

Some things that others can do to help me are:

Some things that people try to do but that are not helpful are:

ARISE Participant Information: Please provide as much detail as possible

Participant Name:_____ **DOB: _____**

Emergency Contacts:

(Please indicate who should be contacted per Jonathan's Law)

1. Name:
   Relationship to Individual:
   Address:
   Phone Number(s):
2. Name:
   Relationship to Individual:
   Address:
   Phone Number(s):
3. Name:
   Relationship to Individual:
   Address:
   Phone Number:

Safeguards:

(Fire Safety, Level of Supervision, Personal Care Assistance needed, Medication/Dietary Needs/Allergies, Behaviors/Behavior Guidelines or Plans to reference, Hospital of Choice

-Assistance needed in event of an emergency:

- Bathroom supervision:

- Behavior guidelines:

- Hospital of choice:

- Personal Care needs:

- Medication/dietary/allergies:

- General Fears:

-Supervision in pool/swimming:

Participant Health History/Medical Information

Name: Last _____First _____Middle_____

Allergy Information (check all that apply) __ No Allergies __ Hay Fever __ Insect Stings/Bites
__ Foods (explain below) __ Medications (explain below) __Use of Epipen __Other (explain below)
_____
_____

Health History (check all that apply) __ Asthma/Wheezing/Shortness of Breath __ Measles
__ German Measles __ Chicken Pox __ Mumps __ Headaches __ Hepatitis __ Rheumatic Fever
__ Heart Murmur __ Diabetes __ Convulsions __ Fainting/Dizziness __ Seizure Disorder __ ADHD

Special dietary needs including food restrictions and/or modified diet:
_____

Answer all questions in relation to participant (Circle "yes" or "no". Explain all "yes" answers below)

Hospitalized within last 12 months?	No	Yes
Surgery within last 12 months?	No	Yes
Recent infectious disease within last 12 months?	No	Yes
Mononucleosis (mono) within last 12 months?	No	Yes
Been out of the country within last 12 months?	No	Yes
Take medication regularly?	No	Yes
Injuries within last 12 months?	No	Yes
Chronic/Recurring illness?	No	Yes
Passed out/had chest pain w/exercise?	No	Yes
Back/neck problems?	No	Yes
Use a wheelchair/other support?	No	Yes
Communication needs?	No	Yes
Bowel concerns/issues?	No	Yes
Wear glasses, contacts, or protective eyewear?	No	Yes
Wear hearing aids?	No	Yes
Do activities need to be limited for any reason?	No	Yes
Is participant under medical care for any reason?	No	Yes

Please note if assistance is needed with the following:
_____Eating ____Toileting _____Dressing _____Mobility _____ Communication

Please provide any additional information about the participant and/or their diet, health and/or pre-existing medical, physical or psychological conditions and illnesses that will help us ensure that they have a successful experience
_____
_____
_____
_____
_____
_____

Participant Name_____

Participant Health History/Medical Information (Continued)

Please note: The Camp Medical Director will call or set up an appointment to discuss the camper's health needs and concerns prior to the start of camp.

Will the participant be taking any medication during this program? Yes No

Current Medications

For all medications given at camp, including prescription and over-the-counter, a written order signed by the participant's physician/provider must be submitted at the start of camp (per Department of Health 7.2-5). Medications will not be given without written orders. All medications must be in the original/pharmacy container, with only one type of medication per container.

Please list below any medications the participant is currently taking.

Medication	Date started	Reason	When given	Dose	How is it Administered

Immunization History – a current record is required

In order to attend day programming with ARISE the parent/guardian must attach a current copy of the participant's immunization record from the doctor's office. This is necessary to comply with New York State Health Law Chapter 1 Sub-part 7-2.8c. **Without the immunization record, the application is not complete**.

Participant's Physician: _____

Physician's Address & Phone:_____

Note* Participants will not be permitted to attend camp without submitting current immunization records!

For participants with Down Syndrome at high risk for Atlanto-axial Instability (AAI)

For pre-participation in high risk activities at camp such as high ropes and horseback riding, a focused history and neurological examination of participants with Down Syndrome should be undertaken by an appropriately qualified medical professional who cares for the participant regularly. To ensure safe participation ARISE requests approval from the attending physician by indicating/initialing below whether participation is restricted or unrestricted.

Restricted_____ Unrestricted_____ (Please initial a choice to the left)

Name of Licensed Physician (print)_____

Signature of Licensed Physician_____

Date:_____

Participant Name_____

Farm Camp Release and Consent Forms 2019

Liability Release: I would like to participate in the ARISE at the Farm program. I acknowledge the risks and potential risks that my son/daughter/self is taking, but feel that the potential benefits outweigh the risks assumed. I hereby, intending to be legally committed for myself, my heirs and assignees, executors and administrators, waive and release forever all claims for damages against ARISE Child and Family Service, Inc. (ARISE), ARISE at the Farm, its Board of Directors, volunteers, and employees for any and all injuries and/or losses that I or my son/daughter/client may sustain while a participant in the ARISE at the Farm Program.

Health/Emergency Release: This application and health history is true and correct to the best of my knowledge. In the case of an emergency, when the person listed as Emergency Contact or other named person cannot be contacted, I hereby authorize the Director of Recreation to take action deemed necessary for the best interest of the camper.

Horseback Riding/Cart Driving Permission: **I ___Do ___Do Not** grant permission for participation in supervised equestrian activities.

Transportation Consent if applicable: I, as Parent/Guardian/Custodian of the participant named above give consent to ARISE at the Farm to transport this camper to ARISE at the Farm's summer programs at ARISE at the Farm in Chittenango, NY.

High Ropes Consent: I ___Do ___Do Not grant permission for participation in the High Ropes Activity. I, the Participant/Parent/Guardian/Custodian understand that parts of the Project Adventure elements may be physically and emotionally demanding. I agree to follow all safety instructions given by ARISE at the Farm staff during the camp session. I recognize the inherent risk of injury or disability in High Ropes activities. I understand that each participant must assume the risk of injury or disability that could result from any of these activities. I release ARISE, ARISE at the Farm, Project Adventure, Inc., their staff members and Board of Directors, from all liability for any injury to me from participation in any High Ropes activity.

Photo/Film Release: I ___Do ___Do Not grant permission to ARISE Child and Family Service, and ARISE at the Farm, their successors, licensees, and assigns, the right to use photographs or films taken of me, or members of my family, without compensation, for the purpose of publication, promotion, illustration, advertising, or trade, in any manner or in any medium. I understand that use of the photographs/films taken of me may reveal or imply information about myself/my family member.

Mail List: I __Do __Do not wish to be on the ARISE mailing list for information, volunteer and other opportunities.

Cancellations: There will be no refunds for camp cancellations made less than 24 hours in advance. Notice of cancellation must be made via email to or phone call to the Camp Director; gpeppel@ariseinc.org or via phone call to Geoff Peppel at (315) 671-3085.

Participant or Parent/Legal Guardian

Participant Name: _____Parent/Guardian: _____

Signature: _____ Date: _____

Participant Name_____

Sunscreen and Insect Repellent Consent Form **2019**

1. I grant permission, as the parent/guardian of _____, for the ARISE Camp Health Director to apply sunscreen on said camper throughout the camp day.

2. I grant permission, as the parent/guardian of _____, for the ARISE Camp Health Director to apply insect repellent on said camper throughout the camp day.

Participant or Parent/Legal Guardian

Participant Name: _____

Printed Name Guardian: _____

Signature: _____ Date: _____

ATTENTION: The following provides a description of the next three application pages

Note* All required fillable sections are highlighted for your convenience. If you have any questions regarding these forms we encourage you to contact us at farmcamp@ariseinc.org.

- **Mandatory Reporting at ARISE Child and Family Services**
  This form is in relation to acknowledging that all ARISE employees are Mandated Reporters. This means all staff are legally required to report any suspicion of child abuse or neglect to the relevant authorities. These laws are in place to prevent children from being abused and to end any possible abuse or neglect at the earliest possible stage. By signing off on the form, you recognize that ARISE staff are Mandated Reporters.
- **Consumer Independent Living Plan Goal/Objectives Form**
  This form provides us with an overall goal for the participant, and what they would like to get out of their time at Farm Camp. In the section labeled 'Goal 1' please indicate what the goal or hope for the participant's time at Farm Camp is. Examples may include: making friends, socializing positively, experiencing new activities of interest, time away from home in a safe environment, etc.
- **ARISE: Authorization for Disclosure and Use of Protected Health Information**
  This form allows appropriate ARISE staff to communicate and share information with the indicated Care Manager in order to coordinate services and obtain necessary eligibility information. Only necessary information will ever be released, and only to those indicated on the disclosure form.

Dear Individuals and Families:

It is ARISE's highest priority to promote the safety and well-being of individuals we serve. We are providing information in this letter to individuals, parents, guardians, correspondents, and advocates of individuals who receive OPWDD services. This letter is to keep you informed and reminded of policies and procedures that ARISE follows to ensure the safety and well-being of individuals we serve. Below is an overview of these established requirements, and how you can access more information.

ARISE adheres to Title 14 of New York Codes, Rules and Regulations Part 624 (14NYCRR Part 624), a regulation designed to protect people receiving OPWDD services. This regulation includes steps ARISE is required to take when a person we serve experiences an incident that may affect his or her well-being.

Upon the discovery of an incident, ARISE staff are required to provide immediate care and protection to individuals involved in, or affected by an incident. Staff report all incidents to their supervisor, and ARISE maintains documentation of all reported incidents. In some cases, ARISE may be required to notify state agencies, and investigate the incident. This also applies if a state agency and/or the police have conducted their own investigation for the same incident. We would appreciate your participation in an interview in the event that an ARISE staff person contacts you for further information. ARISE has developed an Incident Review Committee that reviews specific incidents and helps ARISE revise procedures in order to prevent further incidents from occurring. This review process also helps ARISE to improve staff training, program oversight, and the overall quality of services provided. Another benefit to the process is that individuals may be linked to other services which they may find helpful.

We have made available in electronic format a copy of resources related to this letter: We encourage you to access our website at http://www.ariseinc.org/about-us/quality-compliance/ to review the following:

- OPWDD brochure, Learning About Incidents
- 14NYCRR Part 624 Regulations
- ARISE's Incident Management Policy

If you have any concerns about this letter, or if you would like a paper copy of any listed resources, please contact the supervisor of the ARISE program from which you or your family member receives services. By signing below, you acknowledge that a copy of this letter was reviewed and provided to you:

Participant: Print Name	Signature	Date
Guardian: Print Name	Signature	Date
ARISE Staff: Print Name	Signature	Date

ARISE

Consumer Independent Living Plan Goal/Objective Form

Check One:		Date:
Original	____	_____
Change	____	_____
6 Mo Update	____	_____

The Rehabilitation Act Amendments of 1992 require that services be provided in accordance with an independent living plan mutually agreed upon by service users and service providers. A formal independent living plan can help facilitate the development and achievement of the independent living goals selected by each individual using ARISE, Inc. Services. This plan is subject to change at the request of the consumer.

Consumer's Name (print):_____

Goal and Action Steps	Goal Start Date	Target End Date	Progress	Cnsmr Initials
Goal #1:			☐ **Met Goal Date**_____ ☐ **Dropped** ☐ **Unsatisfactory** ☐ **Fair** ☐ **Good** ☐ **Excellent**	
Action Steps:				

Significant Life Areas (Write the number of the corresponding goal number next to the category below):

__ Self-Advocacy/Self-Empowerment	__ Community Based Living	__ Personal Resource Management	__ Educational
__ Communication	__ Information Access/Technology	__ Relocation to Community Based Living	__ Vocational
__ Mobility/Transportation	__ Self Care	__ Community/Social Participation	__ Other

_____ _____

Consumer's Signature **Date** **Staff Signature** **Date**

ARISE: Authorization for Disclosure and Use of Protected Health Information

Note* Please fill all highlighted areas

Name of Individual: _____ D.O.B. _____/_____/_____

Address: _____

Information is to be disclosed BY: ARISE Inc. _____

Address: 635 James St. Syracuse, NY 13023

Information is to be disclosed TO: ___Care Manager name: _____

Address: _____

Type of Information to be Used or Disclosed:

□ Medical Records (Most current Immunization records, most current medications list)

□ Education Record (Most recent IEP, Behavior Plan)

□ Psychological Assessment (Most recent, if applicable)

□ Eligibility Information (NOD, LifePlan, Letter of Eligibility, LCED, etc.)

Purpose of Use or Disclosure:

□ Advocacy

□ Treatment

□ Coordination of Services

□ Program Eligibility Determination

□ Other_____

Date or event on which this authorization expires: _____

Comments (optional): _____

Check to approve use of text _____ Check to approve use of email _____

"I choose to use email and/ or text messaging to communicate with my ARISE representatives and have ARISE communicate with others by email and/or text messaging on my behalf. I am aware that email and text messaging are not a secure form of communication. I have been advised that there is some level of risk that information could be read by a third party."

initial_____ date_____

Acknowledgements:

This Authorization may be revoked in writing at any time, except to the extent that the entity disclosing the information has already relied upon it. Signing this Authorization is not a condition for treatment, payment, enrollment, or eligibility for benefits. I understand that if this Authorization allows my protected health information to be disclosed to a recipient that is not a health care provider or a health plan, the information disclosed may no longer be protected under the HIPAA Privacy Rule.

SIGNATURE **Date signed:**

_____ _____

If this authorization is signed by a personal representative of the individual, the representative's authority to act on behalf of the individual is:

Authority/Relationship_____ Print Name_____