



True Friends
 10509 108th St. NW
 Annandale, MN 55302
 952-852-0101
 Email: registration@truefriends.org
 Website: www.truefriends.org

FOR OFFICE USE ONLY: Application Rec'd. _____
 Deposit Rec'd. _____
 By _____
 _____ WC SLW 1 3 5+
 P H Fb S D G O R C B RS H M L

All pages 1 thru 10 of the application MUST be completed and mailed or e-mailed to our office for registration. We no longer accept faxed applications. Your application will be put ON HOLD until all pages are received. Please contact our office if you didn't receive all the pages. Please do not hesitate to include additional information which you feel may be helpful in the care of this individual.

Who is filling out the application? _____ Relationship to Participant?: _____

Participant Name _____
 Last Legal First Name (Nickname) Middle Initial

Address _____
 Street (include Apt. #, if applicable) City State Zip

Telephone (____) County of Birth _____ County of Residence _____

Age _____ Date of Birth _____ Male _____ Female _____ Email _____

Session #'s and dates desired: 1st choice: _____ 3rd choice: _____
 2nd choice: _____ 4th choice: _____

If requesting to attend multiple sessions, please **explain:** _____

Do you have a cabin mate request? _____ (We will do our best to respect your request, but cannot guarantee it)

I need transportation to camp? ____Yes ____No Transportation **must** be requested at least 2 weeks prior to your session and is only available to non-metro resident camps from designated locations in the Twin Cities.

Can individual transfer out of wheelchair, if applicable: ____Yes ____No

Transportation is available during select weeks only for Summer Camp. See camp catalog for sessions that have transportation availability. Transportation is not available for winter camp.

<input type="checkbox"/> I want my confirmation packet sent by mail to: <input type="checkbox"/> Camper's Address <u>OR</u> <input type="checkbox"/> Alternate address, write below: _____ _____ _____	<input type="checkbox"/> I want my confirmation packet sent via email to: Email: _____
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Religious preference _____ Race: White ____ African-Am ____ Native-Am ____ Asian ____ Hispanic ____ Multi-racial ____ Other ____
 If other, please specify: _____

Parent name: _____ Is parent also the guardian: Yes ____ No ____ Phone number (____) _____ Cell phone (____) _____ Email: _____ Parent Address _____ Street City State Zip Place of employment (parent) _____ Work number: (____) _____ Name of company Position/title	Parent name: _____ Is parent also the guardian: Yes ____ No ____ Phone number (____) _____ Cell phone (____) _____ Email: _____ Parent Address _____ Street City State Zip Place of employment (parent) _____ Work number: (____) _____ Name of company Position/title
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Applicant Name _____ Date of Birth: _____

____ I do not have a legal guardian, I represent myself.

Legal Guardian name, if different than parent: _____ Relationship to applicant _____

Cell phone (____) _____ Email: _____

Guardian address _____
Street City State Zip

Living Situation:

Res. Facility____ Foster Home____ Nursing Home____ SLS____ SILS____ Private Home____ Lives Independently____ ICF-DD____

Residential Facility Name _____ Corporate Owner Name _____

Facility Address, if different from address above:

Facility Contact Person _____ Facility Telephone (____) _____

Facility Email _____ Fax # (____) _____ Facility Cell Phone: (____) _____

Facility Nurse: _____ Nurse Phone: (____) _____

If applicant lives outside of private home, what is the staff/client ratio? 1:1____ 1:2____ 1:3____ 1:4____ 1:5 or more____

Emergency Contacts: Please list two *additional* contacts to be reached in the event that a parent/guardian cannot be reached:

Name _____ Relationship to applicant _____

Home # (____) _____ Cell # (____) _____ Work # (____) _____

Name _____ Relationship to applicant _____

Home # (____) _____ Cell # (____) _____ Work # (____) _____

Social Worker name, if different than guardian: _____ County _____

Phone number (____) _____ Cell phone (____) _____ Email: _____

Social worker address _____

Grandparents: Can be contacted in the event of an emergency ____ yes ____ no

Paternal Grandparents Name _____ Home # (____) _____

Address _____
Street City State Zip

Maternal Grandparents Name _____ Home # (____) _____

Address _____
Street City State Zip

Is participant able to have unsupervised time by themselves? Please indicate for how long each day? (This does NOT mean that this will happen every day only that it is allowed)* NOTE: Waterfront and Pool locations are supervised at all times, when in use.

____NONE ____15-30 min ____30 min-1 hr. ____1-2 hrs. ____Rest time only ____Participant is able to direct own wants and needs

Applicant Name _____ Date of Birth _____

Supervision or Support Need is: _____ High (1:1) _____ Medium (1:3) _____ Low (1:5)
(For additional care ratio guidelines, visit www.truefriends.org and click on Camp & Respite and then click on Care Ratio on right side of the screen)

Please check all boxes that apply. Conditions in bold print* require an additional questionnaire, which will be sent to you.

No Disability Alzheimer's or Dementia Amputee
(Beginning Stage) Arthritis
 Asthma Attention Deficit Disorder Attention Deficit Hyperactive Disorder
 Autism; Type: _____
 Blood Disorder; _____ Brain Injury *CATHETER
 Cerebral Palsy Down Syndrome
 Developmental-Cognitive or Intellectual Disability *DIABETES Fetal Alcohol Syndrome
 *EPILEPSY or SEIZURES *FEEDING TUBE
 Heart Problems, explain: _____
MENTAL HEALTH* explain: _____
 MRSA; location _____ MD (Muscular Dystrophy)
 MS (Multiple Sclerosis) Needs a staff proficient in sign language Oppositional Defiant Disorder
 *ORTHOPEDIC APPLIANCES Paraplegia Parkinson's
 Pervasive Developmental Disorder Prader-Willi Syndrome Quadriplegia
 *RESPIRATORY Rett Syndrome Spina Bifida
 Tourette Syndrome *TRACHEOSTOMY Uses Sign Language
 Williams Syndrome
 Other disability/diagnosis, please explain: _____
 Blind Vision impaired, no correction Wears glasses Uses cane
 Deaf Hearing impaired, no correction Wears hearing aid x 1 Wears hearing aid x 2
 Left ear Right ear

Special Appliances/Ambulation – PLEASE PROVIDE NEEDED EQUIPMENT

Wheelchair? Yes No _____ long distances only Manual Electric Stroller
Slow Walker? Yes No
What are the scheduled times out of the wheelchair? _____
Assistance in walking? Yes No support from another person cane walker crutches
Assistance in transferring? Yes No
What type of transfer is used? _____ Mechanical Lift: Yes No
Require **range of motion** exercises? Yes No If yes, please attach a copy of exercises.
Does applicant wear/use? Orthotics circle: left or right Prosthesis circle: left or right Braces/night braces
Further Instructions: _____

Sleeping

Sleeps through the night? Yes No If no, please explain sleeping patterns/supervision needs: _____
Will this person leave the cabin at night? Yes No
Bed time rituals? Yes No If yes, please explain: _____
Require repositioning during sleeping hours? Yes No If yes, how often: _____
Is able to sleep in lower bunk without bed rails? Yes No Can applicant sleep in top bunk? Yes No
What time does this person wake up in the morning, typically: _____ What time does this person go to bed, typically: _____
Does the participant experience night time bed wetting? never occasional weekly nightly
Further instructions: _____

Eating – PLEASE PROVIDE NEEDED SUPPLIES

Assistance level: Independent Some assistance Cut food (eats independently) Total assistance
 right-handed left-handed Typical appetite is: large medium small Current height: _____ Current weight: _____
Special diet? none diabetic lactose intolerant gluten free low calorie pureed chopped low sodium
 low cholesterol nectar thick liquids honey thick liquids Other restrictions? _____
Difficulty with: swallowing chewing drinking liquids
Applicant requires: special utensils (bring) chopped food dietary supplement (bring) bite size pieces straw feeding tube
Further instructions/information about eating or diet: _____

Personal Care

Assistance level: Independent Some assistance Verbal reminders Minimal assistance Total assistance
 Will use either shower or bath Will only shower Will only bathe
Requires assistance with: washing face and hands brushing teeth hair care shaving menstrual care bathing showering
Denture use? Yes No Removes dentures at night? Yes No Orthodontics? Yes No Retainers? Yes No
Please explain in detail the type of assistance needed in each area. Attach a separate sheet with specific details:

Applicant Name _____ Date of Birth _____

Bathroom Use

Assistance in bathroom? Independent Reminders Minimal assistance Total assistance
Use of incontinent product? Yes No (if yes, please be sure to supply plenty with extra to make it through the duration of their camp stay)
AM product: _____ PM product: _____
Bathroom schedule? Yes No Please, explain: _____
Designated overnight times: 11pm 3am 7am Other _____
Applicant uses: urinal bedpan commode intermittent catheter: Schedule _____

Bowel program? Yes No Explain: _____
Further Instructions: _____

Dressing/Clothing & Personal Items

Assistance with dressing? Independent Some assistance Total assistance
Help with: buttons shoes shoe laces socks fasteners zippers shirt bra pants
Assistance with: reminders to wear clean clothes separating clean and dirty/soiled clothes
Further Instructions: _____

Is able to care for and keep track of their own belongings? Yes No
If No, all clothing and personal items need to be labeled with the camper's first and last name. **Please label all clothing.**

Communication

Able to communicate wants/needs? Yes No
 Verbal-speaks clearly Verbal-difficult to understand Uses a communication device Sign Language Non-verbal/gestures
Type of communication device: _____
Understands/responds to questions? Yes No
Needs extra time to process information Yes No
Has difficulty understanding the communication of others Yes No
Has difficulty expressing thoughts Yes No
Able to read? Yes No Able to write? Yes No
Can individual communicate pain? Yes No
Further Instructions: _____

Please visit our online store at <https://squareup.com/market/true-friends>.

Has the camper ever attended True Friends services? Yes No
 Respite Summer Resident/Day Camp Winter Resident Camp Adventure Trip
Check site(s) attended:
 Camp Friendship Camp Eden Wood Camp Courage Courage North
How did you hear about True Friends?
 social worker teacher friend/family Arc DSAM AUSM other support organization
 internet search/which site: _____

Attends school? Yes No
Where: _____ Type of Class: _____
Employed? Yes No Where: _____
What do they do at their job? _____
Each camper may have the option, in some programs, to send a postcard to a family member/friend.
Please list the name/address/city/state/zip code where postcard should be sent.

What is the camper's relationship to this person(s)? _____

Please list any additional information regarding applicant, which may be helpful to the camp staff:

Applicant Name: _____ Date of Birth: _____

Activity Interest:

Does the applicant want to participate in the following activities?

- Boating Yes No
- Tubing Yes No
- Water skiing Yes No
- Canoeing Yes No
- Kayaking Yes No
- Tent Camp Yes No
- Ride a bike Yes No
- Fishing Yes No
- Spend time with farm animals Yes No
- Art Yes No
- Music Yes No
- Drama Yes No
- Attend a cook out or picnic Yes No
- Climbing Wall or Ropes Course Yes No
- Zip Lining Yes No

If yes, what is their biking ability level? Beginner Intermediate Experienced
 Rides a 2 wheel bike Rides a 3 wheel bike Would like to learn how to ride bike?

Swim Yes No

What is their swimming ability level? Prefers wading Beginner Intermediate Experienced

If the applicant does not enjoy swimming, will they want to be at the lake or pool during swim time? Yes No

If not a swimmer, will they enjoy splashing their feet in the water? Yes No Do they have a fear of water? Yes No

Does the applicant need ear plugs when in the water? Yes No If yes, please bring them to camp.

Does the applicant need a Personal Flotation Device when swimming or wading? Yes No

Will they swim in a lake? Yes No

Other things they want to do at camp: _____

Social Interaction & Behavior Issues - Check behaviors that apply to applicant:

- No unusual behavior
- Inappropriate language
- Physically aggressive toward others: biting slapping punching kicking choking
- Physically challenging toward property
- Elopes unintentionally due to distractions
- Self-injurious behavior
- Temper tantrums
- Inappropriate sexual behaviors
- Elopes or intentionally runs *Provide a behavior support plan
- Attaches to male staff female staff
- Stubbornness
- Withdrawn/shy
- History of stealing

Other, describe: _____

Is applicant on a behavior management plan or a positive support transition plan? Yes No. If yes, attach a copy.

Does applicant have a Coordinated Service & Support Plan (CSSP)? Yes No. If yes, attach a copy.

Ever been away from home before? Yes No

Is home sickness anticipated? Yes No

Any fears such as animals, thunderstorms, heights, large crowds, water, etc.? Yes No

Explain method for dealing with fears: _____

Explain all checked behaviors, their frequency and method/interventions of dealing with behavior. Use other paper to explain, as needed.

Applicant Name _____ Date of Birth: _____

_____ We are unable to obtain signatures at this time. A copy of this section has been sent to the appropriate individual for signatures and will be mailed to True Friends one month prior to applicant's arrival.

RELEASE SIGNATURE:

Attendance Release: I hereby give my permission for the applicant named above, to participate in True Friends (TF) sponsored and supervised programs. I certify that the information on the application is true, accurate and complete. TF emphasizes safety first; however participation in TF programs has inherent risks that may result in injury. I acknowledge and accept this fact and agree to hold harmless TF, its employees, and agents.

Emergency Release: I hereby give permission to the non-medical staff selected by TF to provide routine health care, administer prescribed and comfort/first aid medications, and if needed, seek emergency medical treatment including x-rays, routine tests and treatment for applicant named above. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by TF to secure and administer treatment including hospitalization, injections, anesthesia or surgery, for the applicant named above. I give permission to obtain copies of treatment and health records from any provider and I agree to release information and records necessary for treatment. TF cannot assume responsibility for any medical expenses that may occur if medical care must be sought.

(REQUIRED) Signature of applicant, if legally represents self; parent; legal guardian or authorized person

Date signed

Media Release – Photography

Release and Authorization for use of photographs, images, video and/or sound recordings:

I hereby grant True Friends and all of its subsidiaries, the irrevocable right and permission, throughout the world, in connection with the photograph(s), images, video or sound recordings that were taken of me by, or which I provided to, True Friends the following: the right to use and reuse, in any manner at all said photographs, images, video, and/or sound recordings in whole or in part, modified or altered, either by themselves or in conjunction with other photographs, images, video and/or sound recordings, in any medium or form of distribution, and for any purposes whatsoever including, without limitation, all promotional, marketing and advertising uses, and other trade purposes, as well as using my name in connection therewith, if True Friends so desires. This permission is granted in perpetuity.

I hereby forever release and discharge True Friends from any and all claims, actions and demands arising out of or in connection with the use of said photographs, images, video and/or sound recordings including, without limitation, any and all claims for invasion of privacy and libel. This release shall inure to the benefit of the assigns, licensees and legal representatives of True Friends.

Participants/Guardian on behalf of Participant:

Please initial your preferred option.

_____ **Yes.** I agree to allow True Friends to use photograph(s), images, video or sound recording as stated above.

_____ **No.** I do NOT allow True Friends to use photograph(s), images, video or sound recording as stated above.

** Please note by stating no, the participant will NOT be featured in group, or activity photos during their stay.*

Applicant Name _____ Date of Birth _____

Health History

(This page should be completed by a caregiver, not a physician)

Height: _____ Weight: _____ Primary Diagnosis: _____

Secondary Diagnosis: _____

Allergies: List **ALL types**, food, drug, environmental, etc. (continue on back, if needed): _____

Please specify type of reaction for each allergy (i.e. hives, nausea, trouble breathing): _____

Does participant carry an Epi-pen? ___Yes ___No (if yes, please also list this with their medications)

Primary Doctor: _____ (____) _____

Name Address City/State/Zip Phone

Mental Health Provider: _____ (____) _____

Name & credentials Address City/State/Zip Phone

Dental Provider: _____ (____) _____

Name Address City/State/Zip Phone

PLEASE SEND PHOTOCOPY OF ALL INSURANCE, PMI & MEDICARE CARDS

MA # _____ Medicare # _____

Does applicant have *any other* health insurance coverage?

Company: _____ Policy # _____ Policy holder's name _____

Vaccinations Has participant's physician identified the need for participant to have TB testing? ___Yes ___No *If positive, provide a chest xray. Date of last TB test? ____/____ (month/year) What were the results of the TB test? ___positive ___negative
I, the undersigned, attest that all immunizations are up to date in accordance with school requirements. ___Yes ___No (If no, please explain)

Bowel Program (check all that apply): ___Not Applicable ___MOM 2nd day without BM
___Suppository following day, if no results from MOM ___Fleets enema following day, if no results from suppository
___Camper has a different bowel program, explain: _____

Check if individual is subject to the following:

- ___sunburn ___frequent colds ___dizziness/fainting spells ___constipation ___menstrual problems
- ___frostbite ___bronchitis ___ear infection ___diarrhea ___vaginal infections
- ___sore throat ___pneumonia ___sinus infection ___nausea/vomiting ___urinary infections
- ___skin rash ___stay out of water ___must not get water in ears ___decubiti/skin breakdown
- ___other: _____

Please comment on the above checked items regarding treatment routine: _____

Describe the mental, emotional or psychological needs that will impact participant's interaction or participation:

Psycho/Social Function: Please include information that will be helpful in supporting and encouraging participant. Things that are helpful to know are; what do they enjoy doing in their leisure time, relationships-family structure, companion animals (include name), fears/concerns, work/school (include grade completed), any information that will get participant talking/opening up: _____

TREATMENTS/PROCEDURES FOR CABIN STAFF TO ASSIST PARTICIPANT WITH this should include things like acne cream, dandruff shampoo, non-prescription nasal spray, mouth washes, etc. If there is nothing being sent that cabin staff will be assisting with, write NONE _____

Applicant Name _____ Date of Birth _____

MEDICATIONS: All medications received for a True Friends service **must be PRE-SET or in their ORIGINAL CONTAINERS.** If bringing pre-set medications in a pill caddy, box or pill envelopes you must include a **current medication list, preferably from your clinic.** This does not need to include non-prescription medications.

****NOTE:** Bringing medications Pre-Set will aid in decreasing your wait time at check in. ******

Please **check all that apply:** ___swallows whole with water ___break in half and swallows with water ___whole in applesauce or pudding ___cut in half in applesauce or pudding ___crush meds in applesauce or pudding ___uses oral syringe (please send) ___uses medicine spoon (please send) ___other, explain: _____

Will participant be bringing **more than 15 medications** to be administered at camp, either scheduled or as needed? ___Yes ___No
If yes, **please attach current medication list (from clinic, if possible)**

How many regularly scheduled meds does participant take? _____
How many PRN/As Needed medications will participant be bringing to camp? _____

Medication:	Reason for use:	mg.	# tabs	Frequency	Brkfst	Lunch	Dinner	Bed	Special Instructions: before, with or in food/crushed
	for:								
	for:								
	for:								
	for:								
	for:								
	for:								
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****You may be sent questionnaires requesting further information which must be completed and returned to our office no less than 2 weeks prior to check-in.**

This Health History is correct, to the best of my knowledge, and the applicant has permission to engage in all activities, except as noted.

Exceptions: _____

PERSONS CHECKING-IN PARTICIPANTS must be the applicant's guardian and/or legal representative.

- A. Medication and health details.
- B. Special diet details.
- C. Special appliances or other medical needs.

If there is a change in the participant's health or medications, or if they have had surgery within 3 weeks prior to arrival, PLEASE contact the Director of Health Care at (952) 852-0105 to determine if we are able to care for this participant.

By signing this application, I agree that the information included throughout is complete and true to the best of my knowledge. If there are any changes to medications or condition of participant I agree to notify True Friends **at least 2 weeks prior to the camp session the participant will be attending.**

Form completed by: _____ **Date:** ____/____/____

Fee Agreement Authorization

_____ I will pay cost of \$_____

_____ I will apply for Financial Assistance – **must complete Financial Assistance Form (Pg. 10) in its entirety and submit with completed application.** Financial assistance will not be awarded after the service has occurred.

Fee will be paid by:

\$ _____
 Amount Name of Payee address city state zip

I will be privately paying for services? Yes _____ No _____

I will be paying for services with Adoption Assistance funds? Yes _____ No _____

I will be paying for services with County Funds? Yes _____ No _____

I will be paying for services with Waivered Service Funds? Yes _____ No _____

If yes, please check the waiver that is approved to bill:

BI CAC CADI DD CDCS, If yes, who is your FSE? _____

Please attach a Coordinated Service & Support Plan (CSSP) if available.

Method of Payment

_____ Full payment of \$_____ enclosed. _____ Partial payment of \$_____ enclosed.
 _____ Bill me later for a Single payment of \$_____ _____ Bill me for Monthly payments (minimum \$75/month)

_____ Credit Card: Bill \$_____ To my: MasterCard VISA Discover American Express

Credit Card # _____

Print name on card _____

Card Holder Billing Address _____

City/State/Zip _____

Expiration Date: _____ CVV Code: _____ (3 digit # on back of card)

Deposit Required

Deposits are required to attend camp. Please see the camp catalog to identify the deposit amount required for your session(s). Applications will not be confirmed or processed until a deposit has been received. Deposits will be applied toward the total cost. Deposits can be paid by credit card or check. Deposits are not required for individuals using Waivered Funds to pay for their sessions.

Funds

Seeking Funds: True Friends uses campers name to seek funds from donors for Financial Assistance. This applicant's first name and last initial **WILL be included** in seeking funds unless you contact Registration in writing.

Cancellation Policy

All advanced fees paid will be refunded in full if notice is received in the True Friends office 30 days prior to the applicant's session. If less than 30 days notice is received, all but the registration deposit will be refunded. Waivered Funds will NOT pay cancellation fees. Participants/guardians will be billed accordingly.

When will I hear from True Friends about my session(s)?

Most applications are processed within three weeks. If this time frame has passed, please contact Registration.

I/We verify that the information on this application is true and accurate.

 Signature of applicant or guardian Date

FINANCIAL ASSISTANCE APPLICATION

Please complete in its entirety to be considered for Financial Assistance.

Due to limited Financial Assistance funds available, financial assistance requests must accompany the initial application. Funds are awarded on a first come, first served basis and will not be awarded after the service has occurred.

Please note: if you are using waiver funds to pay for any portion of your fees, financial assistance is not available.

Camper's Name:				
	Last	First	Nickname	Middle Initial
Date of Birth:				
Parent/Guardian Name (if applicable):				
Spouse name (if applicable):				

Adj. Gross Income: \$	
Adj. Gross Income of spouse (if separate returns filed) \$	
(From: Line 36-IRS 1040 Form OR Line 21-IRS 1040A Form OR Line 4-IRS 1040EZ Form)	
Total Number of dependents (including yourself and spouse, if applicable)	

Total Amount you are able to contribute towards the cost: \$ _____

Provide a brief explanation of financial need (Please list extenuating circumstances on back of application or additional page if needed) Examples: Unemployed or Disability since last tax filing, Out of Pocket Medical, etc.

Examples: Extenuating Circumstances (loss of income, significant out of pocket expense)	Wage Earner or Dependent Affected	Additional hardship since last tax filing

I/We verify that the above information is true and accurate. If requested, I/We agree to provide verification of income.

Signature of camper/parent/guardian
Date

Financial Assistance Awards will be included in your confirmation letter.

True Friends, 10509 108th St. NW, Annandale, MN 55302
 (952) 852-0101
www.truefriends.org