TRUE FRIENDS
Camps. Respite. Programs. Travel.

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.*

☐ **I want my confirmation packet sent by mail to:**	☐ **I want my confirmation packet sent via email to:**
☐ Camper's Address OR ☐ Alternate address, write below:	Email:_____
_____	
_____	
_____	

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

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 (Beginning Stage)
___Amputee
___Arthritis
___Asthma
___Attention Deficit Disorder
___Attention Deficit Hyperactive Disorder
___Autism; Type: _____
___Blood Disorder; _____
___Brain Injury
___***CATHETER**
___Cerebral Palsy
___Developmental-Cognitive or Intellectual Disability
___***DIABETES**
___Down Syndrome
___***EPILEPSY** or **SEIZURES**
___***FEEDING TUBE**
___Fetal Alcohol Syndrome
___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**
___Parapalegia
___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
_____Temper tantrums
_____Stubbornness
_____ Withdrawn/shy
_____ Inappropriate language
_____ Inappropriate sexual behaviors
_____ History of stealing
_____Physically aggressive toward others: ___ biting ___ slapping ___ punching ___ kicking ___ choking
_____Physically challenging toward property
_____Elopes unintentionally due to distractions
_____Elopes or intentionally runs *Provide a behavior support plan
_____Self-injurious behavior
_____Attaches to ___male staff ___female staff

_____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:								
for:								
for:								
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for:								
for:								
for:								
for:								
for:								

**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:**_____/_____/_____

Applicant Name_____ Date of Birth_____

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