2019 Camp and Respite Application

Thank you for choosing True Friends for your next adventure! Over the course of the next several pages you will be asked a variety of questions to help our staff learn more about you or the person you represent. Please answer the questions to the best of your ability. True Friends partners with families and caregivers to provide a successful experience for all parties involved. Please be open and honest with the information you provide.

We collect a lot of detailed information to serve you or the person you represent, below are a handful of reminders:

1. All questions in the application must be answered before the application is submitted. If questions are left unanswered the application will be returned to you. You will not be registered for a session until a completed application has been received.
2. As a Home and Community Based Service, we must provide you with our policies and procedures. These policies and procedures can be found by visiting www.truefriends.org/policies-procedures. Paper copies can be mailed upon request and will be available at check-in.
3. An annual physical and a physician medication list needs be on file before services will be provided.
4. Please allow up to two hours to complete the application. Please work through the application from beginning to end to help prevent questions from being missed. The application is speaking directly to the participant, if you are not the participant, please provide the information as if you were the participant. Throughout the application you may be asked to provide additional reports or documents including, but not limited to: Coordinated Service and Support Plan, Questionnaires, Behavior Support Plan and Range of Motion Exercises. Please send copies of these documents with your application.
5. If additional forms are required, they will be sent to the individual noted under #1 Parent/Legal Guardian. It is the responsibility of the person listed as #1 Parent/Legal Guardian to share and collect information from other parties involved with your application.
6. Deposits are required to attend a True Friends Camp session. 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 of camp. Deposits are not required for individuals using Waivered Service Funds, County Funds or Adoption Assistance Funds to pay for their sessions. In the event of a cancellation, all fees paid will be refunded in full if notice is received in the True Friends office 30 days prior to the participant’s session. If less than 30 days notice is received, all fees paid but the deposit will be refunded. Waivered Service contracts will NOT pay cancellation fees, therefore participants/guardians will be billed accordingly.
7. If you wish to make any session, medication or behavior changes AFTER you submit your application, please call or email with those changes. Changes made in your account following application submission, will go unnoticed, unless a phone call or email is received.

If you have any questions regarding the application or accompanying documents please contact our Customer Relations team at registration@truefriends.org or 952.852.0101. The team is available Monday – Friday, 8 a.m. – 4:30 p.m. For tips on how to register visit www.truefriends.org/register-pay.
### General Information – Tell Us About Yourself

Person filling out the application: ___________________________ Relationship to Participant: ___________________________

Name: 

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<tr>
<th>Last</th>
<th>Legal First Name</th>
<th>(Nickname)</th>
<th>Middle Initial</th>
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Address: 

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<th>Street (include Apt. #, if applicable)</th>
<th>City</th>
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<th>Zip</th>
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</table>

Telephone: (_____) County of Birth: ___________________________ County of Residence: ___________________________

Email: ___________________________

Age: ______ Date of Birth: ___________________________ Male____ Female____

Current Height: ______ Current Weight: ______ Right handed ___ Left handed ___

Attend school: ___Yes ___No If yes, where: ___________________________

Employed: ___Yes ___No Where: ___________________________

Religious preference: ___________________________ Race: White___ African-Am___ Native-Am___ Asian___ Hispanic___ Multi-racial___ Other___

If other, please specify: ___________________________

Living Situation: 

- Res. Group Home/Apt.___
- Nursing Home____
- Private Home_____ Lives Independently____ Foster Home____

Residential Group Home/Apt. Name: ___________________________ Not Applicable: ______

Corporate Owner Name: ___________________________ Facility Address: ___________________________

Facility Contact Person: ___________________________ Facility Telephone: (_____) ___________________________

Facility Email: ___________________________ Facility Cell Phone: (_____) ___________________________

Facility Nurse: ___________________________ Nurse Phone: (_____) ___________________________

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 or Respite and then click on Care Ratio)*

Have there been any changes to medication, behavior or personal concerns since you last attended? ___ Yes ___ No ___ N/A

If yes, please explain: ___________________________

Will you be bringing a service animal? ___ Yes ___ No

If yes, please see our Service Animal Policy at truefriends.org/policies-procedures.

Are you able to have unsupervised time by yourself? Please indicate for how long each day? (Unsupervised time is time that you can be alone without staff where you can travel where you like onsite, and then check in with staff. This does NOT mean that this will happen every day only that it is allowed.) Please 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

I am able to direct my own wants and needs

### Contact Information

| #1 Parent/Legal Guardian name: ___________________________ Is parent also the guardian: Yes_____ No_____ |
|---|---|
| Phone number (_____) | Cell phone (_____) | Email: ___________________________ |
| Address: ___________________________ Street | City | State | Zip |
| Place of employment: ___________________________ | Name of company | Position/title |
| Work number: (_____) | |

| #2 Parent/Legal Guardian name: ___________________________ Is parent also the guardian: Yes_____ No_____ |
|---|---|
| Phone number: (_____) | Cell phone: (_____) | Email: ___________________________ |
| Address: ___________________________ Street | City | State | Zip |
| Place of employment: ___________________________ | Name of company | Position/title |
| Work number: (_____) | |
Applicant Name __________________________ Date of Birth: ____________

Social Worker/Case Manager name, if different than guardian: _____________________________ Not Applicable: ______

County: ___________________________ Phone number (____) ___________________ Cell phone (____) ___________

Email: _____________________________ Address: _____________________________

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

Name: _____________________________ Relationship to you: _____________________________

Home number: (____) _______________ Cell number: (____) _______________ Work number: (____) _______________

Name: _____________________________ Relationship to you: _____________________________

Home number: (____) _______________ Cell number: (____) _______________ Work number: (____) _______________

Best “First Contact”: Who is the Best First Contact we should reach out to if we need to contact someone while you’re here?

Name: _____________________________ Relationship to you: _____________________________

Home number: (____) _______________ Cell number: (____) _______________ Email: _____________________________

Healthcare Information

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 to registration@truefriends.org.

Medical Assistance #: __________________________ Medicare #: __________________________

Primary Health Care Insurance Provider Name: __________________________

Policy #: __________________________ Policy holder’s name __________________________

Diagnosis/Disability/Condition

What is your Primary Diagnosis? __________________________ Secondary Diagnosis: __________________________

Please check all boxes that apply. Conditions in *BOLD PRINT require an additional questionnaire, which are available for download at www.truefriends.org/forms. The questionnaires must be included when you submit your application. If you need the forms sent to you please call 952.852.0101 or email registration@truefriends.org.

___ No Diagnosis/Disability/Condition ___ Alzheimer’s or Dementia (Beginning Stage) ___ Amputee

___ Anxiety ___ Arthritis ___ Bipolar Disorder ___ Blood Disorder: ___

___ Attention Deficit Disorder ___ Attention Deficit Hyperactive Disorder ___ Cerebral Palsy ___*DIABETES – Type 1

___ Autism ___ Bipolar Disorder ___ Down Syndrome ___*FEEDING TUBE

___ Brain Injury ___ Depression ___ Down Syndrome ___

___ Developmental-Cognitive or Intellectual Disability ___ Depression ___*DIABETES – Type 2 ___

___ Epilepsy/Seizures. If yes, please provide protocols.___ Epilepsy/Seizures. If yes, please provide protocols. ___

___ Fetal Alcohol Spectrum Disorder ___ Heart Problems, explain: _____________________________

___ Mental Health Explain: _____________________________ MRSA; location _____________________________

___ Multiple Sclerosis (MS) ___ Oppositional Defiant Disorder ___ Orthopedic Appliances ___

___ PTSD ___ Paraplegia ___ Parkinson’s ___

___ Pervasive Developmental Disorder ___ Prader-Willi Syndrome ___ Quadriplegia ___

___ Reactive Attachment Disorder ___ Rett Syndrome ___

___ Spina Bifida ___ Sensory Processing Disorder, explain: _____________________________ ___

___ Tourette Syndrome ___ Tracheostomy ___ Williams Syndrome ___

___ Blind ___ Wears glasses ___ Muscular Dystrophy (MD) ___

___ Deaf ___ Wears hearing aid x 1 ___ Orthopedic Appliances ___

___ Uses Sign Language ___ Wears hearing aid x 2 ___

___ Other Sign Language ___ Needs a staff proficient in sign language ___

In treatment for any condition, is there an order for Medical Cannabis or Synthetic THC? ____ Yes _____ No

* Due to federal regulations neither, medical cannabis or synthetic THC is allowed on True Friends property.

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Questions? Call 952.852.0101 or registration@truefriends.org.
Allergies
List ALL types, food, drug, environmental, etc.:

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

Do you carry an Epi-pen? ___Yes ___No (if yes, please also list this with your medications)

Diabetes Information
Are you ___ Insulin dependent ___ Oral medication managed? How often are glucometer checks completed in 24 hours? ______

Seizure Information
Type of seizures: ________________ Length of seizures: ________________ Frequency of seizures: ________________

Medications Taken While at True Friends

All medications received for a True Friends service must be PRE-SET or in their ORIGINAL CONTAINERS. All pre-set medications must include a current physician medication list. A physician medication list is required for True Friends programs. To avoid service interruptions a physician medication list must be provided for you to receive services. This does not need to include non-prescription medications.

Please check all that apply: ___swallows whole with water ___whole in applesauce or pudding ___crush meds in applesauce or pudding ___uses oral syringe (please send) ___uses medicine spoon (please send) ___other, explain: ________________

Will you be bringing more than 15 medications to be administered at camp, either scheduled or as needed? ___Yes ___No

How many regularly scheduled medications do you take? ______ How many “As Needed” medications will be brought to camp? ______

<table>
<thead>
<tr>
<th>Medication</th>
<th>Reason for use:</th>
<th># tabs</th>
<th>Frequency</th>
<th>AM 8 am</th>
<th>AFT 12:30 pm</th>
<th>PM 5:30 pm</th>
<th>HS 8:30 pm</th>
<th>Special Instructions:</th>
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All medications will be reviewed at check-in. Standing Orders of over-the-counter medications will be reviewed at check-in. For our current list, please visit www.truefriends.org/forms.

Social Interactions & Behaviors

Social Interaction & Behaviors - Check behaviors that apply to applicant:

___ No unusual behavior ___ Temper tantrums ___ Withdrawn/shy
___ Inappropriate language ___ Inappropriate sexual behaviors ___ History of stealing
___ Physically aggressive toward others: ___ biting ___ slapping ___ punching ___ kicking ___ choking ___ rectal digging ___ fecal smearing
___ Physically challenging toward property ___ Stubbornness
___ Elopement unintentionally ___ Elopement or intentionally runs ___ Self-injurious behavior
___ Attaches to ___ male staff ___ female staff
___ Other, describe: ________________________

Are you on a behavior management plan or a positive support transition plan? ___Yes ___No. If yes, attach a copy.

Do you 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: ________________________

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.
Activities of Daily Living Information – What Does Your Day Look Like?

Special Appliances/Ambulation – Please provide needed equipment.
Wheelchair? _____Yes _____No ______long distances only _____manual _____electric _____stroller
Assistance in walking? _____Yes _____No _____support from another person _____cane _____walker _____slow walker _____may fall easily
What are the scheduled times out of the wheelchair? ________________
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.
Do you wear/use? ___Orthotics circle: left or right _____Prosthesis circle: left or right _____Braces/night braces
Further Instructions:

Sleeping – Please note: True Friends does not provide overnight awake staff. Staff only assist with typical needs at night.

Slept through the night? _____Yes _____No Not Applicable
If no, please explain sleeping patterns/ supervision needs: _____________________________
Will this person leave the cabinet at night? _____Yes _____No
Bed time rituals? _____Yes _____No If yes, please explain: ___________________________
Require repositioning during sleeping hours? _____Yes _____No If yes, how often: _______________________
If you wake at night, what helps to get you back to sleep?: ______________________________________
Are you able to sleep in lower bunk without bed rails? _____Yes _____No _____Not Applicable
Are you able to sleep in top bunk?: _____Yes _____No
What time do you wake up in the morning, typically: ___________ What time do you go to bed, typically: ___________
Do you experience night time bed wetting? ______never ______occasional ______weekly ______nightly
Further instructions: ________________________________

Eating – Please provide needed supplies.

Assistance level: _____independent _____verbal reminders _____cut food (eats independently) _____some assistance _____total assistance
Typical appetite is: _____large _____medium _____small 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
Do you require: ____special utensils (bring) ____chopped food ____dietary supplement (bring) ____bite size pieces ____straw ____feeding tube
Further instructions/information about eating or diet: ____________________________

Bathroom Use

Assistance in bathroom? _____independent _____some assistance _____total assistance
____Will use either shower or bath ____Will only shower ____Will only bath
Requires assistance with: _____washing face and hands _____brushing teeth _____hair care _____shaving _____menstrual care
_____bathing _____showering _____adjusting water temperature
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: ______________

Use of incontinent product? _____Yes _____No (if yes, please be sure to supply plenty of products, and extras, to accommodate your stay):
AM product: ______________ PM product: ______________

Bathroom schedule? _____Yes _____No Please explain: ______________________________
Designated overnight times: ____11 p.m. _____3 a.m. _____7 a.m. Other: __________________________
Do you use: ____urinal ____bedpan ____commode ____intermittent catheter: Schedule: ___________________

Bowel Program (check all that apply): _____Not Applicable _____Yes _____No
*Bowel program medications must be included on the Physician Medication List for Medication Administration at True Friends.
____I have a different bowel program (please explain): ________________________________________________

Dressing/Clothing & Personal Items

Assistance with dressing: _____Independent _____Some assistance _____Total assistance
Help with: ____buttons ____shoes ____shoe laces ____socks ____fasteners ____zippers ____shirt ____undergarments ____pants
Assistance with: ____reminders to wear clean clothes ____separating clean and dirty/soiled clothes
Further Instructions: ______________

Are you able to care for and keep track of your own belongings? _____Yes _____No PLEASE LABEL ALL ITEMS.

Applicant Name_________________________________________________________ Date of Birth______________________________________

2019 True Friends Application – Page 4
Questions? Call 952.852.0101 or registration@truefriends.org.
Communication
Able to communicate wants/needs? ___Yes ___No
___Verbal-speaks clearly ___Verbal-difficult to understand ___Uses a communication device ___Sign Language ___Non-verbal/gestures ___Uses Picture Exchange Communication System (PECS) Other 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 Can you communicate pain? ___Yes ___No Please explain how: __________________________________________
Able to write? ___Yes ___No
Communicates by: ____________________________________________

Further Instructions: _________________________________________

Activity Interests & Abilities

Activity Interests & Abilities. What activities are you interested in participating in while attending True Friends?
*Activities are seasonal and may not be available for each program.

Boating ___Yes ___No Fishing ___Yes ___No
Tubing ___Yes ___No Spend time with animals ___Yes ___No
Water skiing ___Yes ___No Art ___Yes ___No
Canoeing ___Yes ___No Music ___Yes ___No
Kayaking ___Yes ___No Drama ___Yes ___No
Tent Camp ___Yes ___No Cook out or picnic ___Yes ___No
Ride a bike ___Yes ___No Climbing Wall or Ropes Course ___Yes ___No
Zip Lining ___Yes ___No
Swimming ___Yes ___No

What is your swimming ability level? ___Does not swim ___Prefers wading ___Beginner ___Intermediate ___Experienced
If you do not enjoy swimming, do you want to be at the lake or pool during swim time? ___Yes ___No
If not a swimmer, do you enjoy splashing your feet in the water? ___Yes ___No Do they have a fear of water? ___Yes ___No
Do you need ear plugs when in the water? ___Yes ___No If yes, please bring them:
Do you need a Personal Floating Device when swimming or wading? ___Yes ___No Will you swim in a lake? ___Yes ___No
Are there other activities you want to try?: __________________________________________________________
I really enjoy: __________________________________________________________

I give permission to engage in all activities, except: __________________________________________________________

Tell Us About Your History With True Friends

Have you ever attended True Friends services? ___Yes ___No
___Respite ___Summer/Day Camp ___Winter Camp ___Adventure Trip ___Ventures Travel ___Team Quest ___True Strides
___Conference and Retreat (school or business retreat)
Check location(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: ______________________________________________________

Session Request, Transportation & Confirmation Information

Please identify the session(s) number you would like to attend:
1st choice: __________________________________________________ 2nd choice: __________________________________________________
3rd choice: __________________________________________________ 4th choice: __________________________________________________
Do you want to attend each session listed above, if possible? ___Yes ___No
If no, we will confirm you for the first available session; in the preferred order listed above.
Do you want to attend more session(s) than what is listed above? ___Yes ___No
If yes, please list each additional session you wish to attend:

Do you have a cabin mate request? Name: __________________________ (We will do our best to respect your request, but cannot guarantee it.)
Transportation Options
Transportation is only available during select weeks of summer camp. Please see the camp catalog for sessions that have transportation availability. Transportation is not available for winter camp or respite.
Do you need transportation to a True Friends program?   Yes   No

Session Confirmation Information
Once you have been approved and registered for your session(s) a confirmation packet will be sent to you in approximately three weeks. The packet will include details regarding your stay with True Friends, check-in, check-out times and other important details. The individual who will be dropping you off and picking you up at True Friends is the most ideal person to receive this packet.
I want my confirmation packet sent by MAIL to (please choose one):
   ___ Participant Address   ___ Parent/Legal Guardian Address   ___ Emergency Contact Address   ___ Social Worker/Case Manager
Other, please provide address: ________________________________________________________________
 OR I want my packet sent by EMAIL to: ________________________________________________________

Release & Authorization Information

Admission Authorization
I hereby give permission for the applicant 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.
   ___ Yes.
Signature ____________________________ Date ____________________________

Release of Information Authorization
In order to provide the best services, True Friends may need to obtain information from you or share information with other individuals, programs, or providers. Without your permission to release information True Friends may not be able to provide the services needed or True Friends’ assistance may be hindered. The below information meets the requirements of the federal Data Privacy and HIPAA regulations.
I (representing myself or applicant’s legal guardian) request and authorize True Friends to receive and disclose information needed to provide services to the applicant from the following (check all that apply):
   ___ Applicant
   ___ Case manager and other county personnel
   ___ Residential providers
   ___ Applicant’s legal guardian
   ___ Department of Human Services
   ___ Medical personnel including primary doctor, psychologist, psychiatrist
   ___ Other, please provide address: __________________________________________________________

I know that state and federal laws protect my/applicant’s records. I know (please check all that apply):
   ___ Why I am being asked to release this information
   ___ I do not have to consent to the release of information.
   ___ If I do not consent the information will not be released unless the law otherwise allows it.
   ___ I may stop this consent with written notice at any time but this written retraction will not affect information True Friends had already released.
   ___ The person or agency receiving my information may be able to pass it on to others.
   ___ If my information is passed on to others by True Friends, it will no longer be protected by this authorization.
This consent will end one year from the signed date.

Signature ____________________________ Date ____________________________

Policy Receipt and Signature Information
I have been informed of and received copies of the following policies and procedures affecting a person’s rights under section 245D; visit www.truefriends.org/policies-procedures to learn more. Please call 952.852.0101 to have policies and procedures mailed directly to you.
   ___ Grievance Policy
   ___ Service Suspension
   ___ Service Termination
   ___ Emergency Use of Manual Restraint
   ___ Data Privacy
   ___ Maltreatment Reporting
   ___ Service Recipient Rights

   ___ Yes.
Signature ____________________________ Date ____________________________

Funds and Property Authorization
True Friends may assist you with the safekeeping of funds or other property. Please identify needs below. For a full description of program requirements and restrictions visit www.truefriends.org/policies-procedures

   ___ I authorize the program to assist me in safekeeping of the following funds and property:

Continued on the next page.
Applicant Name __________________________________________ Date of Birth ________________________

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Questions? Call 952.852.0101 or registration@truefriends.org.

(Check Yes or No and describe any limitations on the amounts the program is authorized to handle)

<table>
<thead>
<tr>
<th>Type</th>
<th>Yes</th>
<th>No</th>
<th>Limitation on amounts</th>
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<tbody>
<tr>
<td>Cash</td>
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<tr>
<td>Checking Account, including knowledge of or access to my account number(s) or my Personal Identification Number (PIN).</td>
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<td>Savings Account, including knowledge of or access to my account number(s) or my Personal Identification Number (PIN).</td>
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<td>Property</td>
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<td>Other (specify)</td>
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Signature __________________________________________ Date ________________________

Medication Administration and Emergency Medical Authorization
Please check each line to provide your understanding of the information below. To read the full policy visit www.truefriends.org/policies-procedures.

___ I authorize staff trained by the program to provide medication assistance, setup and/or medication administration (prescription medications, including psychotropic medications, and over-the-counter medications) or treatments to me ordered for me by a health care professional.

___ I authorize administration of injectable medications according to my prescriber’s order and written instructions. Only licensed health professionals are allowed to administer psychotropic medications by injection.

___ I refuse to authorize staff trained by the program to administer medications (prescription and over-the-counter) or treatments to me ordered for me by a health care professional.

- If I refuse to provide authorization I understand that the program is required to report my refusal to the person who prescribed the medication or treatment as soon as possible.
- If I refuse to provide authorization for use of psychotropic medications I understand that the program will notify the prescriber and must also follow any directives or orders given by the health care professional who prescribed the psychotropic medication; however the program will not administer the medication. I also understand that the program must seek a court order to override my refusal. Refusal to authorize the use of a specific psychotropic medication is not grounds for service termination. Refusal does not constitute an emergency and the program is not allowed to manually restrain me if I do refuse.

I authorize the program to act in a medical emergency when the person or the person’s legal representative cannot be reached or is delayed in arriving.

Person ____________________________

Legal Representative ____________________________

Name ____________________________ Signature ____________________________ Date ________________________

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 check 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.
**Fee Agreement**

- I/We will pay cost of $__________
- I/We will apply for Financial Assistance – must complete Financial Assistance Form in its entirety and submit with completed application. Financial assistance will not be awarded after the service has occurred.

Fee will be paid by:

<table>
<thead>
<tr>
<th>Amount</th>
<th>Name of Payee</th>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
<tbody>
<tr>
<td>$__________</td>
<td></td>
<td></td>
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</table>

- 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 Waivered Service Funds? Yes_____ No_____ If yes, please check the waiver that is approved to bill: __EW__ __BI__ __CAC__ __CADI__ __DD__ __CDCS__ __Other:__________

- If CDCS, who is your FSE?________
- I will be paying for services with Wisconsin Waivered Service Funds? Yes_____ No_____ If yes, please check the waiver that is approved to bill: __WPS__ __iLIFE/IRIS__ __Premier Financial Mgmt. Services/IRIS__

- If using MN Waivered Service Funds, please include a copy of your Coordinated Service & Support Plan (CSSP) with your application.

**Deposits & Cancellation Policy**

Deposits are required to attend a True Friends program. 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 of camp. Deposits are not required for individuals using Waivered Service Funds, county or Adoption Assistance to pay for their sessions.

In the event of a cancellation, all fees paid will be refunded in full if notice is received in the True Friends office 30 days prior to the participant’s session. If less than 30 days notice is received, all fees paid but the deposit will be refunded. Waivered Service contracts will NOT pay cancellation fees. Participants/guardians will be billed accordingly.

**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)

**To make a credit card payment please create an account online or call 952.852.0101 ext. 360.**

**Financial Assistance Application – If Applicable**

Please complete the application 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. Financial Assistance Awards will be included in your confirmation letter.

**Participant Name:**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Nickname</th>
<th>Middle Initial</th>
<th>Date of Birth</th>
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**Parent/Guardian Name (if applicable):**

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<tbody>
<tr>
<td>Total Number of Dependents (including yourself and spouse if applicable): _______</td>
<td>Total amount you are able to contribute toward the cost: $__________</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Examples: Extenuating Circumstances (loss of income, significant out of pocket expense)</th>
<th>Wage Earner or Dependent Affected</th>
<th>Additional hardship since last tax filing</th>
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</table>

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**

<table>
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<th>Date</th>
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</table>

**Questions? Call 952.852.0101 or registration@truefriends.org.**