



2026 Travel Application

True Friends partners with 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. You will not be registered for a session until a completed application has been received.
2. As a Home and Community Based Service, and operating under a 245D license, we must provide you with our policies and procedures. These policies and procedures can be found by visiting <https://truefriends.org/policy-procedures/>. Paper copies available at check-in upon request.
3. 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 questionnaires (see list to the right). Please send copies of these documents with your application, they can be found at the end of the application.
4. Deposits are required to attend a True Friends session. Please see the travel 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 are not required for individuals using Waivered Service Funds, County Funds or Adoption Assistance Funds to pay for their sessions **(except for the Travel program)**.
5. Waivered Funds: Your most recent Coordinated Service Support Plan (CSSP)/ Community Support Plan (CSP) is required for individuals using Waivered Service Funds (BI, CAC, CADI, DD, CDCS, EW). The CSSP/CSP must be sent with your application. Applications will not be confirmed or processed until a CSSP/CSP has been received. Please call your Case Manager to obtain a copy or for additional questions.
True Friends must receive a service agreement, before services are provided, that includes accurate dates, units (quantity), total amount (cost), rate/ unit, and the participant's recipient ID before the participant will be confirmed into their session or trip. If a waiver doesn't cover the total cost of the session the caregiver will be billed accordingly. Unpaid balances will prevent future attendance for a True Friends session.

If you have any questions please contact our Customer Relations team at registration@truefriends.org or 952.852.0101. The team is available Monday - Friday, 8am-4:30pm.

Documents Needed at the time of Registration

Please send the following documents with your application. Your application will not be processed until all of the required documents are received:

Required Documents

- ☐ Annual Physical
- ☐ Medication List from health care professional
- ☐ Medication (MAR) Administration Record
- ☐ Deposit
- ☐ Photo ID
- ☐ CSSP/CSP- See #5.
(if applicable)
- ☐ Adoption Assistance Reimbursement Letter
(if applicable)

If Applicable Documents

- Health care questionnaires
- ☐ Catheter/Colostomy
 - ☐ Diabetes
 - ☐ Feeding Tube
 - ☐ Orthopedic
 - ☐ Seizure Action Plan
 - ☐ Suctioning/Trach.

All health care questionnaires can be found at the back of this application.



True Friends
10509 108th St. NW
Annandale, MN 55302
952.852.0101

FOR OFFICE USE ONLY: Application Rec'd. / / Deposit Rec'd:
By _____

Travel Application

General Information – Tell Us About Yourself

Person filling out the application: _____ Relationship to 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: _____

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

Current Height: _____ Current Weight: _____ Right handed: _____ Left handed: _____ Are you your own guardian?: _____ Yes _____ No

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(with parent/guardian) _____ Lives Independently _____ Foster Home _____

Residential Group Home/Apt. Name: _____

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)

What size t-shirt do you wear?: _____ XS _____ S _____ M _____ L _____ XL _____ 2XL _____ 3XL _____ 4XL Other: _____

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

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/policy-procedures.

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: _____ Work number: (____) _____
Name of company Position/title

#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: _____ Work number: (____) _____

Participant Name: _____ Date of Birth: _____

Social Worker/Case Manager name: _____

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

Email: _____

Emergency Contacts: Please list two *additional* contacts to be reached in the event that the first two contacts cannot be reached:

#1 Emergency Contact name: _____ Relationship to you: _____

Phone #1: (____) _____ Phone #2: (____) _____ Phone #3: (____) _____

#2 Emergency Contact name: _____ Relationship to you: _____

Phone #1: (____) _____ Phone #2: (____) _____ Phone #3: (____) _____

All correspondence regarding the registration of this applicant will be sent to the individual chosen below. Please note True Friends requires a variety of materials to complete registration. Please see the travel catalog for more information or visit www.truefriends.org.

Please choose one:

____ Participant Email ____ #1 Parent/Legal Guardian Email ____ #2 Parent/Legal Guardian Email ____ Social Worker/Case Manager Email

Healthcare Information

Primary Doctor: _____ (____)

Name Address City/State/Zip Phone

Mental Health Provider: _____ (____)

Name Address City/State/Zip Phone

Dental Provider: _____ (____)

Name Address City/State/Zip Phone

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 any additional diagnosis/disability/condition that apply. Conditions in ***BOLD PRINT** require an additional questionnaire, which are available for download at www.truefriends.org/documents-forms/. The questionnaires must be included when you submit your application and are attached at the end of the application.

☐ No Diagnosis/Disability/Condition	☐ Alzheimer's or Dementia (Beginning Stage)	☐ Amputee
☐ Anxiety	☐ Arthritis	☐ Asthma
☐ Attention Deficit Disorder	☐ Attention Deficit Hyperactive Disorder	
☐ Autism	☐ Bipolar Disorder	☐ Blood Disorder: _____
☐ Brain Injury	☐ *CATHETER	☐ Cerebral Palsy
☐ Developmental-Cognitive or Intellectual Disability	☐ Depression	☐ *DIABETES – Type 1
☐ *DIABETES – Type 2	☐ Down Syndrome	☐ *FEEDING TUBE
☐ *EPILEPSY/SEIZURES. If yes, please provide protocols.		
☐ Fetal Alcohol Spectrum Disorder	☐ Heart Problems, explain: _____	
☐ MRSA: ☐ Active ☐ Inactive	☐ Muscular Dystrophy (MD)	
☐ Multiple Sclerosis (MS)	☐ Obsessive-Compulsive Disorder	☐ Oppositional Defiant Disorder
☐ *ORTHOPEDIC APPLIANCES	☐ Pica	☐ Post Traumatic Stress Disorder
☐ Paraplegia	☐ Parkinson's	☐ Pervasive Developmental Disorder
☐ Prader-Willi Syndrome	☐ Quadriplegia	☐ Reactive Attachment Disorder
☐ Respiratory	☐ Rett Syndrome	
☐ Spina Bifida	☐ Sensory Processing Disorder, explain: _____	
☐ Tourette Syndrome	☐ *TRACHEOSTOMY	☐ Williams Syndrome
☐ Blind	☐ Vision impaired, no correction	☐ Wears glasses
☐ Deaf	☐ Hearing impaired, no correction	☐ Wears hearing aid x 1
	☐ Left ear	☐ Wears hearing aid x 2
☐ Uses Sign Language	☐ Needs a staff proficient in sign language	
☐ Other disability/diagnosis/condition, please explain: _____		

Participant Name: _____ Date of Birth: _____

Allergies

Do you have a food allergy? ☐ Yes ☐ No If yes, please explain the food allergy and specify your reaction to the food allergy: _____

Do you have a medication allergy? ☐ Yes ☐ No If yes, please explain the medication allergy and specify your reaction to the medication allergy: _____

Do you have an environmental allergy? ☐ Yes ☐ No If yes, please explain the environmental allergy and specify your reaction to the environmental allergy: _____

All medications received for a True Friends service must be PRE-SET. All medications must include a current medication list from a health care professional and a medication assessment form to avoid service interruptions. This does not need to include non-prescription medications. Please bring any necessary equipment and instructions needed to provide medications to check-in.

How many regularly scheduled medications will you take? (please provide a number): _____

How do you take your 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: _____

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.*

Do you carry an Epi-pen? ☐ Yes ☐ No (if yes, please also list this with your medications)

Are you bringing a rescue medication? ☐ Yes ☐ No If yes, what rescue medication are you bringing? _____

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/documents-forms.

Social Interactions & Behaviors

Ever been away from home before? ☐ Yes ☐ No

Is home sickness anticipated? ☐ Yes ☐ No

Any fears such as animals, thunderstorms, night time, heights, large crowds, water, etc.? ☐ Yes ☐ No Explain: _____

Explain method for dealing with fears: _____

Does the participant display any behavioral issues? ☐ Yes ☐ No If yes, please check all behaviors below:

☐ Self-injurious behaviors	☐ Temper tantrums	☐ Removes clothing
☐ Uses inappropriate language	☐ Inappropriate sexual behaviors	☐ History of stealing
☐ Physically aggressive toward others:		
☐ biting ☐ slapping ☐ punching	☐ kicking ☐ choking ☐ spitting	☐ Rectal digging
☐ Physically aggressive toward property	☐ Stubbornness	☐ Food related (stealing/eating inedible objects)
☐ Elopes/runs away unintentionally	☐ Elopes/runs away intentionally	☐ Fecal smearing
☐ Displays unusual behavior toward male staff		☐ Displays unusual behavior toward female staff
☐ Exaggerates/fabricates information	☐ Suicidal tendencies/thoughts	
☐ Other, describe: _____		

What will or may trigger the above behaviors? Please check all triggers below:

☐ Happens "out of the blue"	☐ Not getting what he/she wants	☐ Unwanted peer interaction
☐ Unwanted authoritative interaction	☐ Attention-seeking	
☐ Environmental factors (noise, temperature, sensory over/under stimulation). Please explain: _____		

When do you see most behaviors occurring? ☐ Hungry ☐ Uncomfortable ☐ Hurt ☐ Bored ☐ Dysregulated ☐ Unknown

Other: _____

How often do these behaviors occur? ☐ Seldom (1x/month) ☐ Often (1x/week) ☐ Frequently (More than 1x/week) ☐ Daily

What behavioral indicators might exist that show the person is in distress, before a behavior exists? _____

Please explain what the behavior typically looks like, what redirection is done, and what the typical response is to redirection: _____

What are effective tools for de-escalation of the behavior?: _____

Do you anticipate any concerns with this participant going out into the community? ☐ Yes ☐ No If yes, please explain: _____

Does the participant ever require physical intervention? ☐ Yes ☐ No If yes, please explain type of intervention, purpose, and frequency: _____

Is there any physical intervention that is contraindicated medically? ☐ Yes ☐ No If yes, please explain: _____

Activities of Daily Living Information – What Does Your Day Look Like?**Special Appliances/Ambulation – Please provide needed equipment and complete the Orthopedic Appliance Questionnaire.**

Wheelchair? ☐ Yes ☐ No If yes, please explain: ☐ Manual ☐ Electric ☐ Stroller ☐ Long distances only
 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.

Sleeps through the night? ☐ Yes ☐ No ☐ Not Applicable
 If no, please explain sleeping patterns/supervision needs: _____
 Will you leave the room at night? ☐ Yes ☐ No
 Bed time rituals? ☐ Yes ☐ No If yes, please explain: _____
 If you wake at night, what helps to get you back to sleep?: _____
 Do you feel comfortable sleeping on an upper bunkbed?: ☐ 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
 Do you use a CPAP machine? ☐ Yes ☐ No
 Further instructions: _____

Eating – Please provide needed utensils and 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 Sugar ☐ Vegan ☐ Vegetarian ☐ Low calorie
☐ Pureed ☐ Chopped ☐ Low sodium ☐ Low cholesterol ☐ Nectar thick liquids ☐ Honey thick liquids
 Is a shower bench/chair needed? ☐ Yes ☐ No
 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 bathe
 Requires assistance with: ☐ Washing body ☐ 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 Please complete Catheter and Colostomy Questionnaire.

Schedule: _____

Do you have a Bowel Program?: ☐ Yes ☐ No

**Bowel program medications must be included on the 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.**

Participant Name: _____ Date of Birth: _____

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 Able to write?: ☐ Yes ☐ No
Can you indicate pain?: ☐ Yes ☐ No Please explain how: _____
Further instructions: _____

Activity Interests, Abilities, Alcohol and Tobacco Use

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 you have a fear of water?: ☐ Yes ☐ No

Do you need ear plugs when in the water?: ☐ Yes ☐ No If yes, please bring them to camp.

Do you need a Personal Flotation Device when swimming or wading?: ☐ Yes ☐ No Will you swim in a lake?: ☐ Yes ☐ No

Are there other activities you want to try?: _____

Trip Fund Management

Will the Applicant manage their own funds? If the Applicant cannot manage their own funds, funds will be held by staff.

Please share any money management concerns: _____

Alcohol and Tobacco Use

The Applicant may go to a social function/restaurant where alcohol is served.

May the Applicant have alcohol? ☐ Yes ☐ No

If yes, what type of alcoholic beverage may be chosen? _____ Alcohol limit per day? _____

Does the Applicant smoke cigarettes/cigars? ☐ Yes ☐ No If the Applicant smokes cigarettes/cigars, what is the daily limit? _____

If the Applicant smokes cigarettes/cigars, can they manage their own cigarettes/cigars? ☐ Yes ☐ No*

*If no, staff will carry the cigarettes/cigars on their person.

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 ☐ Travel ☐ Team Quest ☐ True Strides

☐ Conference and Retreat (school or business retreat)

Check location(s) attended:

☐ Camp Friendship, Annandale ☐ Camp Eden Wood, Eden Prairie ☐ Camp Courage, Maple Lake ☐ Camp Courage North, Lake George

How did you hear about True Friends?:

☐ Social worker ☐ Teacher ☐ Friend/family ☐ ARC ☐ DSAM ☐ AUSM ☐ Conference/Event ☐ Other: _____

☐ Internet search. Which site: _____

Session Request

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 process your application in your session preference 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 roommate request? Name: _____ (We will do our best to respect your request, but cannot guarantee it).

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. True Friends emphasizes safety first; however, participation in True Friends programs has inherent risks that may result in injury. I acknowledge and accept this fact and agree to hold harmless True Friends, 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 HIPPA 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 parties:

- Applicant
- Case manager and other county personnel
- Residential providers
- Applicant's legal guardian
- Department of Human Services
- Medical personnel including primary doctor, psychologist, psychiatrist

I know that state and federal laws protect my/applicants records. I understand:

- Why I am being asked to release this 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.
- I do not have to consent to the release of information.

Signature _____ Date _____

Policy Receipt and Signature Information

I have been informed of and provided copies of the following policies and procedures affecting a person's rights under section 245D; visit <https://truefriends.org/policy-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

Signature _____ Date _____

Funds and Property Authorization

True Friends may assist you with the safekeeping of funds or other property. For a full description of program requirements and restrictions visit www.truefriends.org/policy-procedures.

____ I authorize the program to assist me in safekeeping of funds and property.

____ I do not authorize the program to assist me in safekeeping of funds and property.

Signature _____ Date _____

Participant Name: _____ Date of Birth: _____

Medication Administration and Emergency Medical Authorization

Please review and sign to provide your understanding of the information below. To read the full policy visit www.truefriends.org/policy-procedures.

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

____ Yes, I agree.

____ No, I refuse*. *If you refuse, True Friends is unable to serve you. Your application will be returned, and registration will be cancelled.

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.

____ Yes, I agree.

____ No, I refuse*. ***If you refuse, True Friends is unable to serve you. Your application will be returned, and registration will be cancelled.**

Person

Name

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. When your name or story is utilized for promotional purposes, a member of True Friends will contact you for awareness and consent.

____ 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. They will not be featured through the True Friends website, social media, or other communication medium.*

Signature

Date

True Friends Communications Acknowledgement

When participating in programs and services at True Friends you will be sent various communications regarding fundraising opportunities as well as general information about the organization. Upon receipt of these communications, you will have the ability to opt out of future communications. All communications regarding your experience at True Friends will be sent via CampSite or via True Friends Staff.

Participant Name: _____ Date of Birth: _____

Deposits, Fee Agreements, Cancellation Policy & Payment Information

Waivers, Adoption Assistance, or County Funds*

***Please contact your Case Manager before choosing a Waiver for your Trip. Waivers will not pay for the entire cost of a trip.**

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:

☐ EW ☐ BI ☐ CAC ☐ CADI ☐ DD ☐ CDCS ☐ Out-of-State Waiver ☐ Other: _____

If CDCS, who is your Financial Management Services? _____

If using Out-of-State Waiver please list bill name and address: _____

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

Private Pay. Please attach your deposit to your application or call 952.852.0101 to speak to someone in Customer Relations.

I will be privately paying for services? ☐ Yes ☐ No ☐ Full payment enclosed ☐ Deposit enclosed

Fee will be paid by:

Name of Payee	Address	City	State	Zip
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Deposits

Deposits are required to attend a trip. All trips require a nonrefundable* \$500 deposit at the time of application that will be applied toward the total cost (\$100 Deposit for Day Trips). Additional Payments A payment of 50% of the trip cost is due 60 days prior to departure. Final invoices will be sent upon completion of the trip and are due 30 days after receipt. Failure to submit payments in a timely manner may result in removal from your trip and forfeiture of your deposit. Applications received within 60 days of departure require a 50% down payment at the time of application.

Travel Cancellation Policy

Vacations which require pre-paid purchases (airline tickets, hotel rooms, etc.) have strict cancellation policies set by airline, cruise or train companies. True Friends has no control over these penalties; therefore our cancellation policies must reflect their restrictive guidelines. If a traveler wishes to cancel their trip, any non-refundable expenses will not be refunded to the traveler. If you wish to cancel your trip you MUST notify us by email or letter. Phone conversations or voicemail messages are insufficient notification, and if no formal notice is received, we will consider you a 'no show'.

* Trips may be cancelled due to low registrations. If this occurs, True Friends will provide a full refund (including the deposit) or transfer any fees paid to the vacation of your choice, pending availability.

Additional & Fluctuating Costs

Travelers are responsible for additional expenses incurred on their behalf during a vacation including but not limited to: property damage, overweight or excess luggage, pay-per-view television charges, phone charges, prescription re-fills, personal care items, equipment rentals, and travel expenses related to travel disruption or delay. Airline and rail services adjust their schedules for many reasons. When this occurs, True Friends reserves the right to adjust your itinerary accordingly and will notify you as soon as possible. In the event that we are unable to secure seats or accommodations due to conditions beyond our control, such as strikes, schedule, price changes, or regulation updates, we reserve the right to contact each guest to pay an additional fare or notify of a schedule change.