TRUE FRIENDS

2027 Camp and Respite 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 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.
5. Individuals using 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 if you have additional questions. True Friends must receive a Service Agreement before services are provided. It is not required to enroll, but once you receive your session confirmation email – please forward to your Case Manager. The Service Agreement must include accurate dates, units (quantity), total amount (cost), rate/unit, and the participant's recipient ID. 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, 8 am– 4:30 pm.

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

___ Our MAR (Medication Administration Record) - Caregiver completes

___ Deposit (if applicable)

___ Support Plan - See #5. (if applicable)

___ Adoption Assistance Reimbursement Letter (if applicable)

___ Service Agreement (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_____

2027 Camp and Respite Application
10.15.26

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 always supervised, 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 camp/respite 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
___Anxiety
___Attention Deficit Disorder
___Autism
___Brain Injury
___Developmental-Cognitive or Intellectual Disability
___***DIABETES – Type 2**
___***EPILEPSY/SEIZURES.** If yes, please provide protocols.
___Fetal Alcohol Spectrum Disorder
___MRSA: ___ Active ___ Inactive
___Multiple Sclerosis (MS)
___***ORTHOPEDIC APPLIANCES**
___Parapalegia
___Prader-Willi Syndrome
___Respiratory
___Spina Bifida
___Tourette Syndrome
___Blind ___Vision impaired, no correction
___Deaf ___Hearing impaired, no correction
___Left ear
___Uses Sign Language
___Other disability/diagnosis/condition, please explain: _____

___Alzheimer's or Dementia (Beginning Stage)
___Arthritis
___Attention Deficit Hyperactive Disorder
___Bipolar Disorder
___***CATHETER**
___Depression
___Down Syndrome (with Atlanto-Axial Instability: ___Yes ___No)
___Heart Problems, explain: _____
___Muscular Dystrophy (MD)
___ Obsessive-Compulsive Disorder
___Pica
___Parkinson's
___Quadriplegia
___Rett Syndrome
___Sensory Processing Disorder, explain: _____
___***TRACHEOSTOMY**
___Wears glasses
___Wears hearing aid x 1
___Right ear
___Needs a staff proficient in sign language

___Amputee
___Asthma
___Blood Disorder: _____
___Cerebral Palsy
___***DIABETES – Type 1**
___***FEEDING TUBE**
___Oppositional Defiant Disorder
___ Post Traumatic Stress Disorder
___ Pervasive Developmental Disorder
___ Reactive Attachment Disorder
___Williams Syndrome
___Wears hearing aid x 2

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 at camp? (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? _____

Are you able to wear a mask indoors when not eating or sleeping? ___ Yes ___ No
Can you socially distance yourself from others during your time at camp? ___ Yes ___ No
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: _____

Participant Name: _____ Date of Birth: _____

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 cabin 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?: _____

All upper bunkbeds have attached bed rails, as required by American Camp Association standards. Bed rails can be attached to lower bunkbeds, with that in mind: Do you prefer to have a bed rail on the lower bunkbed? ___ Yes ___ No
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 nighttime 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
___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 ___Shoelaces ___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 BROUGHT TO CAMP.**

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

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
Tubing ___Yes ___No
Water skiing ___Yes ___No
Canoeing ___Yes ___No
Kayaking ___Yes ___No
Tent Camp ___Yes ___No
Ride a bike ___Yes ___No
Zip Lining ___Yes ___No
Swimming ___Yes ___No
Fishing ___Yes ___No
Spend time with animals ___Yes ___No
Art ___Yes ___No
Music ___Yes ___No
Drama ___Yes ___No
Cookout or picnic ___Yes ___No
Climbing Wall or Ropes Course ___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? _____
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 ___ 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 & Transportation

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: _____

_____

**Participants will not be registered for consecutive weeks of residential summer camp sessions; the number of sessions confirmed per participant may be limited due to session availability and consecutive day limits.*

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

Participant Name: _____ Date of Birth: _____

Transportation Options

Transportation is only available during select weeks of summer camp. Please see the camp catalog for sessions that have transportation availability (noted with a "T" next to the session number). Transportation is not available for respite. Transportation checks in and out of Camp Eden Wood in Eden Prairie.

Do you need transportation to a True Friends program? ___Yes ___No

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
- 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 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
- Data Privacy
- Service Suspension
- Maltreatment Reporting
- Service Termination
- Service Recipient Rights
- Emergency Use of Manual Restraint

_____

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

Participant Name: _____ Date of Birth:_____

Deposits, Fee Agreements, Cancellation Policy & Payment Information

Waivers, Adoption Assistance, or County Funds.

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 (FMS)?

_____

If CDCS, what is the FMS billing address?

_____

If CDCS, what is the FMS phone number?

_____

If CDCS, what is the FMS email address?

_____

If using Out-of-State Waiver please list billing 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. You will be prompted to pay a deposit once you have been placed in a session.

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

Camp Deposits

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 or Adoption Assistance to pay for their sessions.

Camp Cancellation Policy

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 privately billed, accordingly.

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 program session confirmation information.

Participant Name: _____ _____
Last First Nickname Middle Initial Date of Birth
Parent/Guardian Name (if applicable): _____ Spouse Name (if applicable): _____

Provide a brief explanation of financial need. Examples: Unemployed or Disability since last tax filing, Out of Pocket Medical, etc.

_____

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