RISING TREETOPS AT OAKHURST

(formerly CAMP OAKHURST)

111 Monmouth Road Oakhurst, NJ 07755 P: 732.531.0215 F: 732.531.0292 Email: info@risingtreetops.org



1140 Broadway, Suite 903 New York, NY 10001 P: 212.533.4020 F: 212.533.4023 Email: info@risingtreetops.org

Inspiring confidence and joy in those with special needs

APPLICATION FOR SERVICE

(To be filled out by the applicant/family)

Name		Gender Id	entity	DOB			
			Soc. Sec. No				
City	State	Zip	Phone		E-Mail		
Type of Disability & I	Diagnoses						
				Onset:			
Name of Doctor or Cli	inic						
Address							
				one	Fax		
Medical Insurance:	Uninsured	Medicaid or	Medicare	A COPY	OF MEDICAL INSURANCE		
Private Insurance:	Name of Compan	У		CARD(S) MUST BE SUBMITTED			
In case of emergency							
Name		Relationship to Applicant					
Home Phone		Work Phone		Cell P	hone		
Name		Relationship to Applicant					
Home Phone		Work Phone Cell Phone					

STATEMENT OF CONSENT

Rising Treetops at Oakhurst (The Agency) has permission to contact the professionals (Doctors, Caseworkers, Teachers, Therapists) listed on this application for further information, including evaluations. Based on an ongoing evaluation of level of care needs, acceptance and enrollment at Rising Treetops for services may be revoked at any time. The Agency also has permission to use photographs and video of the applicant in its promotional materials, both in print and digital form. The Agency also has permission to take the applicant on escorted trips off Rising Treetops grounds. In the case of emergency, the person or person(s) listed above will be notified. The Camp Director or an authorized representative is granted permission to arrange for emergency medical treatment should it be required before notification is achieved.

Name of Parent or Guardian

Signature of Adult Client if there is no Guardian

Services Requested: Year-Round Respit	e 🛛 Day Camp		
Summer Camp Session: Adult Session	☐ Young Adult 23-35	□Youth Session	□Autism Session

SOCIAL INFORMATION

If the Applicant or Applicant Family has a Caseworker or Service Coordinator complete the following: Name of Agency Name of Caseworker or Coordinator If the Applicant is under age 21 and attends the school, complete the following: Name of School Teacher Phone Teacher Grade or Class Address City State If the Applicant (adult or child) lives with his or her family, complete the following: Head of Household Marital Status of the Head of Household: Size of Family Unit: Number of Adults (over 18) living at home Number of Children (under 18) living at home

FEE SETTING

Limited scholarships for non-Autism sessions are available, and eligibility is based on family income and family size. In order to quality, a <u>Scholarship Request Form</u> and appropriate documentation must be submitted. In some situations fees can be paid by other agencies.

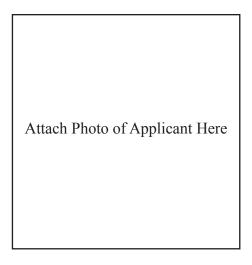
Please indicate if the Applicant or Applicant Family desires a scholarship by completing the following:

A scholarship is needed.

A scholarship is not needed, the full fee will be paid by the applicant or applicant family.

The fee will be paid by another Agency:

(If the fee will be paid by another Agency, the applicant/family must assume responsibility for communicating with that Agency)



PERSONAL CARE NEEDS

(Check all that apply)

<i>Use of a Wheelchair or Scooter</i> Never uses one Uses one all of the time							
Uses one some of the time: for trips for sports when tired Other							
Applicant owns: 🗋 Manual Wheelchair 🗋 Power Wheelchair 🗋 Electric Scooter							
Name and number of repair service or technician:							
If Applicant uses a manual chair does he/she need to be pushed? Yes No							
<i>Walking Ability</i> Uklks without assistance Needs help when walking Does no walking							
When walking applicant uses: Crutches Walker Braces Cane							
Other orthopedic appliances used:							
Describe how long during the day they are used:							
If the applicant is an adult and would like to bring his/her own personal attendant, check here							
<i>Ability to Transfer to and from a Wheelchair</i> Needs no help Needs to be completely lifted							
□ Needs some help □ Can bear weight and pivot □ Cannot bear weight or stand							
<i>Communication Skills</i> Uverbal Non-Verbal Uses a communication device							
<i>Dressing Ability</i> Needs no help Needs help with everything							
Needs help with the following:							
<i>Eating Ability</i> Needs no help Needs help with everything							
Needs help with the following:cutting foodpour liquidsserving							
Bathing Ability Deeds no help Deeds help with everything							
Needs help with the following:getting into the showerwashing bodywashing hair							
<i>Toileting Ability</i> Needs no help Needs help with everything							
Needs help with the following:							
If Applicant is incontinent check all that apply in his/her management program.							
Self catheterizes Needs help with catheterizing							
Uses diapers all day Uses diapers at night only Can change own diaper							
Independent bowel program Needs help with bowel program							
How successful is applicant with his her continent management programs?							
Has the applicant ever had a skin breakdown? If yes, describe when and where							

The information contained in this section of the application does not substitute for a <u>Health Examination</u> <u>& History</u> form, which must be completed by a physician and updated annually.

Is the Applicant up to date with his/her required immunizations? If not, explain	Yes	🗋 No	Not Sure
Does the Applicant have a history of seizures or convulsions? If yes, describe type, frequency and date of most recent episo	Yes	🗋 No	Not Sure
Has the Applicant been hospitalized in the past three years? If yes, indicate reason for hospitalization and date	Tes Yes	🗋 No	Not Sure
Has the Applicant been injured or ill during the past 6 months? If yes, describe	Tes Yes	🗋 No	Not Sure
Does the Applicant take medication daily or on a regular basis? If yes, list name of medication and dosage	Tes Yes	🗋 No	Not Sure
Is the Applicant allergic to any medication, food or other substances If yes, describe		🗋 No	Not Sure
Is there any reason why the Applicant cannot go into the swimming p If yes, explain		—	No 🗋 Not Sure
Has the Applicant ever attended Rising Treetops or other similar prog		Tes Tes	🗋 No

Please mail or deliver this application to the NJ office 111 Monmouth Road, Oakhurst, NJ 07755