RISING TREETOPS AT OAKHURST

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Rising Treetops
at Oakhurst
Inspiring confidence and joy in those with special needs

www.risingtreetops.org
facebook.com/risingtreetops
instagram.com/risingtreetops

APPLICATION FOR SERVICE

(To be filled out by the applicant/family)

Name _____ Gender _____ DOB _____

Address_____Apt._____ Email_____

City _____State _____ Zip_____Phone _____

Type of Disability & Diagnoses _____

_____ Onset:_____

Name of Doctor or Clinic_____

Address_____

City_____State_____Zip_____Phone_____Fax _____

Medical Insurance: Uninsured Medicaid or Medicare **A COPY OF MEDICAL INSURANCE CARD(S) MUST BE SUBMITTED**

Private Insurance: Name of Company_____

In case of emergency notify the following person or persons:

Name_____Relationship to Applicant _____

Home Phone_____Work Phone_____Cell Phone _____

Name_____Relationship to Applicant _____

Home Phone_____Work Phone_____Cell Phone _____

STATEMENT OF CONSENT

Rising Treetops at Oakhurst (RTO) has permission to contact the professionals (Doctors, Caseworkers, Teachers, Therapists, etc.) listed on this application for further information, including evaluations. Based on an ongoing evaluation of level of care needs, acceptance and enrollment at RTO for services may be revoked at any time. RTO also has permission to use photographs and video of the applicant in its promotional materials, both in print and digital form. RTO also has permission to take the applicant on escorted trips off RTO's grounds. Assistant Director of Services or an authorized representative must be notified in writing of any medical treatments that the agency is not authorized to provide. 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.

_____ _____

Signature of Parent or Guardian Date Signature of Adult Client if no Guardian Date

_____

Print Name of Person(s) Signing Consent

Services Requested: __ Overnight Respite __ After School Respite __General Overnight Summer Camp __Autism Overnight Summer Camp __ Summer Day Camp

SOCIAL INFORMATION

If the Applicant or Applicant Family has a Care/Case Manager or Service Coordinator complete the following:

Name of Agency _____

Name of Care/Case Manager/Coordinator _____ Phone _____

Email _____

If the Applicant is age 21 or younger and attends school, complete the following:

Name of School _____ Phone _____

Teacher _____ Grade or Class _____

Address _____ City _____ State _____ Zip _____

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: O Single O Married 0 Divorced or Separated or Widowed

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 overnight camp and overnight respite sessions are available, and eligibility is based on family income and family size. In order to qualify, a Scholarship Request Form 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)

Attach Photo of Applicant Here

PERSONAL CARE NEEDS

(Check all that apply)

Use of a Wheelchair or Scooter 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

Walking Ability Walks without assistance Needs help when walking Does no walking

When walking applicant uses: Crutches Walker Braces Cane

Other orthopedic appliances used: Prostheses Other_____

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. _____

Ability to Transfer to and from a Wheelchair Needs no help Needs to be completely lifted

Needs some help Can bear weight and pivot Cannot bear weight or stand

Communication Skills Verbal Non-Verbal Uses a communication device

Dressing Ability Needs no help Needs help with everything

Needs help with the following:_____

Eating Ability Needs no help Needs help with everything

Needs help with the following:_____cutting food_____pour liquids_____serving

Bathing Ability Needs no help Needs help with everything

Needs help with the following:_____getting into the shower_____washing body____washing hair

Toileting Ability 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. _____

_____

MEDICAL INFORMATION

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

Is the Applicant up to date with his/her required immunizations? □ Yes □ No □ Not Sure

If not, explain _____

Does the Applicant have a history of seizures or convulsions? □ Yes □ No □ Not Sure

If yes, describe type, frequency and date of most recent episode _____

_____

_____

Has the Applicant been hospitalized in the past three years? □ Yes □ No □ Not Sure

If yes, indicate reason for hospitalization and date _____

_____

_____

Has the Applicant been injured or ill during the past 6 months? □ Yes □ No □ Not Sure

If yes, describe _____

_____

Does the Applicant take medication daily or on a regular basis? □ Yes □ No □ Not Sure

If yes, list name of medication and dosage _____

_____

_____

_____

Is the Applicant allergic to any medication, food or other substances? □ Yes □ No □ Not Sure

If yes, describe _____

_____

Is there any reason why the Applicant cannot go into the swimming pool? □ Yes □ No □ Not Sure

If yes, explain _____

_____

Has the Applicant ever attended Rising Treetops or other similar programs? □ Yes □ No

If yes, when and where _____

Please submit this application by email to info@risingtreetops.org, by fax to 732-531-0292, or by mail to Rising Treetops at Oakhurst's New Jersey office at 111 Monmouth Road, Oakhurst, NJ 07755