Dear Parent,

Thank you for your interest in your child attending In-home Camp Woodchuck 2021. It will be an exciting summer! We have many fun activities planned for camp and would like to provide you with information to assist in camp preparation. Please note, camp spots will fill up quickly and are assigned on a first come first serve basis.

All forms in the application must be completed and received in the Rainbows' Kids' Cove office by April 30, 2021 in order to receive a June 1, 2021 start date. Partially completed packets will not be accepted by the office and enrollment in Camp Woodchuck is not finalized until the entire packet is received in the Kids' Cove office. **Upon completion of the packet an appointment must be scheduled.** Please contact Teresa Shackelford at 316-945-7117 ext. 111 or Alice Ridgeway ext. 107 to schedule an appointment to review the packet.

A note about signatures: A doctor's signature on the **Medication Administration and CACFP Meal Modification forms** are required in order to provide appropriate care for your child.

If you have any questions or concerns, please contact Lynlea Southards at 316-945-7117 or Tiffany Graf at 316-945-7177 ext. 140

We are excited for a fun summer!

Lynlea Southards

Lynlea Southards | Family Support Services Program Coordinator | lsouthards@rui.org
Rainbows United, Inc. | 2258 N. Lakeway Circle | Wichita, KS 67205 | RainbowsUnited.org
Office: 316.945.7117 | Fax: 316.945.7447

A true hero is not measured by the size of his strength, but by the strength of his heart. – Hercules

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FAMILY SUPPORT SERVICES
Requests for Services Checklist

Child's Name: _____ **Date Received:** _____

Requests for Services Checklist

- ☐ Request for Services
- ☐ Statement of Responsibility/Appointment of Agent
- ☐ Client Release Form
- ☐ Media Release
- ☐ Income Information and Sliding Fee Scale
- ☐ Payment Agreement
- ☐ Seizure Care Plan (*Required if history of seizures*)
- ☐ Treatment Plan for Seizures (*Required if history of seizures*)

Information below requires a Dr.'s signature

- ☐ CACFP Meal Modifications
- ☐ Request to Administer Medication

Provide current copies of the following information

- ☐ Insurance Card
- ☐ Proof of Income (One month)
- ☐ Individual Education Plan (Schools)
- ☐ Behavior Plan (Schools, Specialists, Psychiatric Facilities)

Information below is obtained from Case Manager

- ☐ Integrated Service Plans (ISP)
- ☐ Family Support Documentation
- ☐ Person Centered Support Plan

Information required for CAMP WOODCHUCK only

- ☐ Camp Woodchuck Request for Hours (Schedule)
- ☐ Camp Enrollment Fee (*$50*) ☐ Credit Card ☐ Cash ☐ Check # _____

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FAMILY SUPPORT SERVICES
REQUEST FOR SERVICES

Legal Name of Child: _____ **Today's Date:** _____

Child ID # _____ Date of Birth: _____ Social Security Number: _____

Sex: M or F Ethnicity: Hispanic Y or N

Race: White Black or African American Asian American Indian or Alaskan Native
Native Hawaiian or Pacific Islander Two or more races Some other race

I would like my child to be enrolled for the following services as of (date) _____

_____ In-Home Support Services

_____ Camp Woodchuck, In-home only (Information sent out in March)

Name of School: _____ Grade in School: _____

Child has: (Indicate all that apply)

_____ Behavior Plan (If yes, indicate where it is from) _____

_____ Takes medications to alter mood or behavior

_____ Diagnosis (examples: Aspergers, PTSD, Bi-Polar, etc.) _____

Attach current photo of child.

I/DD Case Management Agency: _____ Case Manager Name: _____

Case Manager Phone Number: _____ Case Manager E-mail: _____

Parent/Guardian Information

Child lives with: Both Parents Father Mother Grandparents Foster Parents Uncle/Aunt

Parent/Guardian Name: _____	Parent/Guardian Name: _____
Address: _____	Address: _____
City, State, Zip: _____	City, State, Zip: _____
Home Phone: _____	Home Phone: _____
Cell Phone: _____	Cell Phone: _____
Work Name: _____	Work Name: _____
Work Phone: _____	Work Phone: _____
E-mail: _____	E-mail: _____
Relationship to Child: Father Mother Uncle Aunt	Relationship to Child: Father Mother Uncle Aunt
Foster Parent Grandparent Other: _____	Foster Parent Grandparent Other: _____
Education Level: 9-12th Graduated Some College	Education Level: 9-12th Graduated Some College
College Degree: AA BA/BS Grad School Masters PHD	College Degree: AA BA/BS Grad School Masters PHD

How did you hear about RUI: Family Friend Physician School SRS RUI Staff Other:_____

_____	_____	_____
Print Parent/Guardian Name	Signed Parent/Guardian Name	Date

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FAMILY SUPPORT SERVICES
2021 IN-HOME CAMP WOODCHUCK REQUEST FOR HOURS

Child's Name: _____ Date of Birth _____ Today's Date _____

Parent/Guardian Name: _____

Phone: Home _____ Cell _____ Work _____

Schedule: Indicate times your child **will attend** Camp.
Camp Hours: 7:30 AM – 5:30 PM

Put an X through days your child **will not attend** Camp**.**

						Office Use Only	
Week	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Weekly Hours**	**Weekly Total ($)**
	JUNE						
1		1	2	3	4		
2	7	8	9	10	11		
3	14	15	16	17	18		
4	21	22	23	24	25		
5	28	29	30				
					June Total		
	JULY						
5				1	2		
6	5 Agency Closed	**6**	7	8	9		
7	12	13	14	15	16		
8	19	20	21	22	23		
9	26	27	28	29	30		
					July Total		
OFFICE USE ONLY							
Funding	June:		July:			Total:	

Child's shirt included with enrollment, to be provided the first week of June. Please indicate T-Shirt size below:

Youth: _____ Small _____ Medium _____ Large

Adult: _____ Small _____ Medium _____ Large _____ X Large _____ 2X Large

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FAMILY SUPPORT SERVICES
CLIENT RELEASE FORM

Child's Name: _____ **Today's Date:** _____

Child lives with: ____Father ____ Mother ____Other (specify)_____

Indicate the order in which Family Support Staff should contact the parents/guardians and provide a primary and secondary contact number used for contacting in an emergency situation.

Primary Parent/Guardian Contact Name: _____ Father or Mother

Primary phone number: _____

Secondary phone number: _____

Secondary Parent/Guardian Contact Name: _____ Father or Mother

Primary phone number: _____

Secondary phone number: _____

In addition to parents/guardians, I authorize Rainbows United Inc., Family Support Services staff to release my child to the persons listed below to pick up my child from Rainbows United, Inc. center or in-home care. List a minimum of two adults (required) and the preferred order of contact.

Name	Address	Home/Mobile Phone Number	Work/other Phone Number	Relationship to child

Rainbows United, Inc., Family Support Services staff is authorized to place my child on or off a Unified School District transportation vehicle (school bus/van) or MTA bus, or other transportation service vehicles if applicable.

Name of Transportation Services	Contact Person	Approximate Time of Day (RUI arrival or departure)	Location (arrival or departure from)	Company Phone Number

I understand that I am responsible for the following:

1. Notifying Rainbows United, Inc. Family Support Services in writing if any person on this list no longer has my permission to pick up my child.
2. Advising all persons listed above about the need to provide picture identification and that the identification must be presented in order to pick up my child.

_____	_____	_____
Printed Parent/Guardian Name	Parent/Guardian Signature	Date

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FAMILY SUPPORT SERVICES
STATEMENT OF RESPONSIBILITY AND APPOINTMENT OF AGENT

STATEMENT OF RESPONSIBILITY

On behalf of (child's name) _____, my dependent, I wish to receive Family Support Services. I have been fully informed of the scope of the Family Support Services program and agree to supply the staff with any and all information deemed necessary to safeguard the welfare of my dependent while being cared for by a Family Support Services staff.

In the event emergency medical treatment is deemed necessary, and I am not readily available, I authorize such procedures as are necessary to ensure the health and well-being of my dependent. I understand that my dependent may become ill or injured during respite services and I agree that if this occurs through no negligence of the Family Support Services staff, I will not hold Rainbows United, Inc. and/or its employees liable for the illness or injury.

I have fully disclosed to the staff of Family Support Services, Rainbows United, Inc. all pertinent facts about my dependent's needs and problems; and acknowledge full responsibility if I fail to do so.

_____	_____	_____
Print Parent/Guardian Name	Parent/Guardian Signature	Date

APPOINTMENT OF AGENT

I hereby appoint Rainbows United, Inc. as my agent and representative for the purpose of authorization and consent for hospital and/or medical care for (child's name) _____

This appointment is for illness or injury that may occur while (child's name) _____ is in the care or custody of Rainbows United, Inc.

This appointment is effective (today's date) _____ and will remain valid throughout my child's enrollment at Rainbows United, Inc. unless I revoke it in writing. I understand that I remain legally liable for any and all bills for medical and/or hospital services, and I specifically release and hold harmless Rainbows United, Inc., agents, and employees from any liability thereof.

_____	_____	_____
Print Parent/Guardian Name	Parent/Guardian Signature	Date

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Media Release

ASSIGNMENT OF RIGHTS AND RELEASE OF INFORMATION
FOR MEDIA, MARKETING, DEVELOPMENT AND COMMUNICATIONS

Purpose for Release of Information: Media, internal and external awareness, including, but not limited to, websites, social media, artwork, contests, printed material, etc.

I, _____ the legal guardian of (CHILD'S NAME) _____

OR I, _____ an adult eighteen years of age or older do hereby assign ***RAINBOWS UNITED, INC. (and affiliates)*** and all staff members and forever release the right to PHOTOS, ELECTRONIC FILES, ARTWORK, OTHER VISUAL IMAGES, STORIES, QUOTES or PERSONAL INFORMATION taken on or created by this individual.

I understand that the intended use of these visual images, written stories and/or artwork is for media relations, marketing, communication or other means of public relations, advocacy, fund raising and development projects to benefit ***RAINBOWS UNITED***. I understand these images and artwork will become the property of Rainbows United and we will have no claim to future compensation, benefits, rights or royalties. I release ***RAINBOWS UNITED*** from any claim, suit or action based on the use or publication of visual images.

❑ I **do** give my permission for media release

❑ I **do not** give my permission for media release

Executed THIS _____ DAY OF _____, 20_____.

_____
Signature of Legal Guardian or Participant

Participant's Contact Information:

Address: _____

_____

Phone: ( ) _____

Email address: _____

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FAMILY SUPPORT SERVICES
INCOME INFORMATION AND VERIFICATION

Child's Name: _____ **Parent's Name:** _____

Total number of members in household: _____ Number of Adults _____ Number of Children _____

My child has medical insurance (*circle*): Yes or No Medical Card/Insurance Number: _____

My child receives SSI (*circle*): Yes or No

Include the total household income for all people living in the household who receive income**.** If you would like access to the sliding fee scale, please **complete the following chart** and provide **three consecutive months of pay stubs and/or source of income** documentation.

Household Member Name (First & Last)	Relationship to Parent/Guardian	Date of Birth	Gross Wage (pre- tax)	SRS TANF Benefits	SSI Or SSDI	Adoption Subsidy or Child Support	Other Amount (specify source)	Total Monthly Income
							Total Monthly Income	
							Annual Income (Monthly Income x 12) =	

Additional Information

- All care that is not covered by Family Support Funding or HCBS/IDD funding requires full payment before receiving care.
- Families using private or Family Support funds for Camp will be charged for all days scheduled. Credit will not be given for days client does not attend.
- Sliding Fee Rate will not be adjusted according to the level of care a child needs.
- Rainbows does not provide care for typical sibling in either a family's home or Rainbows' Center.
- I will notify Rainbows when there is a change of income or change of number of members in the household.

The above information is true and a correct reflection of our household income. I understand this information is being given in connection with the receipt of Federal Funds; that Rainbows United officials may, for cause, verify information; and that deliberate misrepresentation may subject me to prosecution under applicable State and Federal criminal statutes.

_____ _____ _____
Printed Name of Parent/Guardian Signature of Parent/Guardian Date

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FAMILY SUPPORT SERVICES PAYMENT AGREEMENT

This Agreement is entered between Rainbows United, Inc. and (parent/guardian's name) _____,

the parent(s) and/or legal guardians(s) of (child's name)_____.

As the parent/legal guardian of the above named person, I have asked Rainbows United, Inc. to provide services for him/her. I agree to pay Rainbows United, Inc. for services rendered by a person acting on behalf of this Agency.

I understand that the rate for care is based on the income of my household which may include but is not limited to wages, child support, SSI payments, subsidies (such as Adoption), and any direct financial assistance. Furthermore, I will provide Rainbows with proof of my household income before accessing the sliding fee scale. **Please submit proof of your total household income, for one month, with your application, i.e., pay check stubs , court order for child support, SSI letter showing monthly amount, food stamp notice showing monthly amount.** (Sliding fee scale does not apply to agencies funding a service i.e. foster care agencies.)

Please initial the option that applies:

_____ My child receives **HCBS-I/DD** or **HCBS/Autism Waiver** services, I understand that Medicaid will pay Rainbows for the service provided according to the approved hours of the Plan of Care. I understand that Medicaid requires the Agency to bill private insurance before billing Medicaid. I will ensure that Rainbows has a copy of the Plan of Care and the Prior Authorization. After the approved hours are used, I can access the sliding fee scale for additional hours. My rate for additional hours, according to the sliding fee scale will be $_____ per hour.

_____ My child has supplemental funding from: ❑ (agency) _____ for _____

❑ (other) _____ for _____

I understand that this funding will be billed at the rate of $13.36 per hour until the funding is no longer available. I will then be able to access the sliding fee scale. My rate according to the sliding fee scale will be $_____ per hour.

A $50 returned fee will be charged for any returned bank drafts/checks, in addition to any applicable late fees. Accounts with more than one returned check will be required to pay by money order or credit card.

I understand Rainbows United, Inc. may terminate services for the following reasons for non-compliance of statements:

_____ I do not complete a new application upon request; or
_____ I do not schedule care through the Family Support Services office; or
_____ I provide false and/or inadequate information regarding the above named person's care; or
_____ I refuse to comply with a request for verification of my household income; or
_____ I do not pay for the services received.

I understand Rainbows United, Inc. will not continue services beyond the services listed on the Plan of Care without this signed Payment Agreement on file. The same will apply if payments are not up to date. It is the responsibility of the family and/or guardian to ensure that this signed Payment Agreement has been returned and that payments are made on time.

Please initial one of the following options:

_____ My dated signature on this form signifies my acceptance of this agreement until I revoke it in writing. I understand that all hours of services through Rainbows United must be scheduled with the Family Support Services Scheduler. **I have completed and enclosed the Private Pay Income Information and Sliding Fee Scale form and verification of my household income with this Agreement.**

Printed Parent/Guardian Name	Signature of Parent/Guardian	Date

_____ My dated signature on this form signifies my acceptance of this agreement until I revoke it in writing. I understand that all hours of services through Rainbows United must be scheduled with the Family Support Services Scheduler. **I choose not to complete the Private Pay Income Information and Sliding Fee Scale form and/or enclose proof of total household income.** Therefore, I may not access the Sliding Fee Scale, and my **rate will be $13.36 per hour**.

Printed Parent/Guardian Name	Signature of Parent/Guardian	Date

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SEIZURE CARE PLAN

Child's Name: _____ Date of Birth: _____

Physician: _____

Physician Phone Number: _____

Do we have your permission to call the above physician should questions arise regarding your child's health here at school? ❑ Yes ❑ No

How long has your child been diagnosed with a seizure disorder? _____

I would describe my child's seizures as:

❑ **Simple Partial** – Remains conscious, twitching or numb sensation, usually lasting less than 30 seconds.

❑ **Complex Partial** – Altered consciousness, transient staring, feelings of unreality and detachment. May have hallucinations, unexplained feelings of fear, disrupted memory, teeth grinding, lip smacking, chewing, swallowing, scratching or pulling at buttons. Usually lasts no longer than 1-2 minutes.

❑ **Tonic-Clonic** – Abrupt arrest of activity, loss of consciousness, symmetrical and rhythmical alterations of contraction and relaxation of major muscle groups. Ends suddenly in less than 5 minutes.

❑ **Atonic** – Abrupt loss of postural tone, loss of consciousness, confusion, lethargy and sleep. (May just fall asleep suddenly; when laughing, the child may fall down.)

❑ **Myoclonic** – Brief random contractions of a muscle group, may occur on one side of the body, no loss of consciousness.

❑ **Absence** – Very brief periods of altered awareness, eyelids may flutter or twitch, blank facial expression, lasts 5-10 seconds but can occur repeatedly.

❑ **Tonic** – Lack of movement, stiffening of the entire body musculature, arms flex, legs, neck and head extend. Peculiar, piercing cry, cyanosis (bluish coloring to skin), may temporarily stop breathing, increased salivation.

❑ **Akinetic** – No movement, but muscle tone is maintained. Like "freezing into position," may lose consciousness.

My child ❑ does ❑ does not have an aura before his/her seizures. (An aura is a sensation just before a seizure happens – may be a sound, sight, smell, feeling – they usually can tell if a seizure is about to happen.)
If so, what is the aura? _____

_____ _____
Parent/Guardian Signature Date

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TREATMENT PLAN FOR SEIZURES

Child's Name:_____ Date of Birth: _____

Treatment:

- Assist the student to the floor, if needed.
- DO NOT put anything between teeth or in mouth.
- DO NOT restrain.
- Clear area to protect student from injury.
- Start a written record of the seizure behavior and treatment including length of seizure activity.
- Notify parents.
- CALL 911 IF: seizure activity is different from "usual seizure activity" documented below, child's breathing is affected, it lasts longer than five (5) minutes or child fails to regain consciousness after seizure activity has stopped.
- Child's usual seizure activity includes: _____

  _____

  _____
- Should the seizure activity last longer than_____, 911 should be called. (Please note: 911 will be called by school staff for any seizure activity lasting five (5) minutes.)

After seizure:

- Permit student to rest.
- Continue to document the episode.
- Monitor for second episode.
- Monitor for confusion or lack of consciousness.

If I cannot be reached by phone and my child does not respond to the above medication and treatment, I give my permission for school staff to call the physician listed on front side of care plan and follow his/her instructions. If the physician orders hospitalization or my child is exhibiting symptoms of a medical emergency, my child will be transported to the nearest hospital. I also understand that school staff can and will be informed of my child's health concerns in order to provide safe, appropriate care.

_____ _____

Parent/Guardian Signature Date

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Family Support Services
Request To Administer Medication

FOR THE PHYSICIAN *Please provide all requested information:*

Name of Child: _____ Birth Date: _____

Weight: _____ Height: _____ Diagnosis: _____

Medication Allergies: _____

The above named client is to receive the following medication during his/her regular day. Please complete this form for *all* medications given at home, school and center. A physician's signature is required *prior to* nursing staff administering any medications, and to verify medications given to client.

Medication: Tylenol (Acetaminophen) Dosage: Weight/Age Appropriate

Purpose: _____

Requested Starting Date: Now Expected Duration: 1 year from start date

When to Administer: As Needed Special Consideration: _____

Special Instructions to Administer Medication: _____

Medication: _____ Dosage: _____

Purpose: _____

Requested Starting Date: _____ Expected Duration: _____

Times to Administer: _____ Special Consideration: _____

Special Instructions to Administer Medication: _____

Medication: _____ Dosage: _____

Purpose: _____

Requested Starting Date: _____ Expected Duration: _____

Times to Administer: _____ Special Consideration: _____

Special Instructions to Administer Medication: _____

FOR THE PARENT/GUARDIAN *Please complete the following*:

I hereby certify that (*Child's Name*) _____ has previously had at least one dose of the above prescribed medication and did not have an adverse reaction from it. I request that this medication be administered at school as directed above. I understand that Rainbows United, Inc. and any employee of Rainbow United, Inc. who administers this prescription to my child in accordance with written instructions from the physician or dentist shall not be liable for damages as a result of an adverse drug reaction suffered by the student because of administering such drug or because of mislabeled or altered product. I hereby authorize Rainbows United, Inc. personnel to exchange information regarding this request with the above named attending physician and with the pharmacy as identified on the affixed pharmacy label.

Signature: _____ Date: _____
Lawful Custodian

Please note: Physician's signature required on both sides of form if additional medications are listed on other side.

PHYSICIAN'S SIGNATURE: _____ Date: _____

Medication: ______________________ Dosage: ______________________
Purpose: ______________________
Requested Starting Date: ______________________ Expected Duration: ______________________
Times to Administer: ______________________ Special Consideration: ______________________
Special Instructions to Administer Medication: ______________________

Medication: ______________________ Dosage: ______________________
Purpose: ______________________
Requested Starting Date: ______________________ Expected Duration: ______________________
Times to Administer: ______________________ Special Consideration: ______________________
Special Instructions to Administer Medication: ______________________

Medication: ______________________ Dosage: ______________________
Purpose: ______________________
Requested Starting Date: ______________________ Expected Duration: ______________________
Times to Administer: ______________________ Special Consideration: ______________________
Special Instructions to Administer Medication: ______________________

Medication: ______________________ Dosage: ______________________
Purpose: ______________________
Requested Starting Date: ______________________ Expected Duration: ______________________
Times to Administer: ______________________ Special Consideration: ______________________
Special Instructions to Administer Medication: ______________________

Medication: ______________________ Dosage: ______________________
Purpose: ______________________
Requested Starting Date: ______________________ Expected Duration: ______________________
Times to Administer: ______________________ Special Consideration: ______________________
Special Instructions to Administer Medication: ______________________

Medication: ______________________ Dosage: ______________________
Purpose: ______________________
Requested Starting Date: ______________________ Expected Duration: ______________________
Times to Administer: ______________________ Special Consideration: ______________________
Special Instructions to Administer Medication: ______________________

PHYSICIAN'S SIGNATURE: ______________________ Date: ______________