Welcome to Pathfinder Summer Day Academy!

Pathfinder, Inc. is pleased to offer a Summer Day Academy this year. Pathfinder Summer Day Academy is a Medicaid Early Intervention Day Treatment ("EIDT") program. Children enrolled receive a variety of services including instruction in areas of cognition, communication, social/emotional, motor, and adaptive skills, nursing services, speech therapy, occupational therapy, and physical therapy. An individualized treatment plan ("ITP") is created for each child based on the child's specific needs. Your child's specific goals and objectives will be worked on during activities throughout the day as well as during individual therapy sessions.

Eligibility Requirements: Ages 6-21

1. Child has to be a Medicaid covering EIDT Summer Day Habilitative services
2. Child has to have one of the diagnoses (as defined in DDS Policy 1035) (ID; SB; CP; ASD; Epi; DownS)
3. Child has to qualify for 1 (one) of: Speech Therapy, Occupational Therapy, or Physical Therapy)

Steps to Enrollment:

1. Contact your child's primary care physician ("PCP") regarding your interest in the Summer Day Academy in order to let them know we will be sending evaluation prescriptions.
2. Return the attached Referral Packet along with copies of your child's current evaluations for Occupational Therapy, Physical Therapy, and Speech Therapy to Pathfinder, Inc. If your child is 10 years old and receiving Speech Therapy, a copy of your child's IQ test is also required. Once this packet is received, your child will be placed on the waiting list. Children will be enrolled on a first come, first served basis; therefore, early enrollment is encouraged. You may return the Referral Packet:
   - To Pathfinder, Inc.;
   - By mail to 2520 W. Main Street, Jacksonville, AR 72076;
   - By fax to 501.982.1781
   - By email to lindsey.lang@pathfinderinc.org
3. Once the Referral Packet is received, Pathfinder will review the documents to ensure your child's evaluations are current. If your child's current evaluations do not meet the required guidelines, Pathfinder will send a request to your child's PCP for an evaluation prescription.
4. Once the signed evaluation prescription is received from the PCP, someone will contact you to set up your child's initial evaluations (Psychological, ST, OT and PT) if needed.
5. After the evaluations are completed or approved upon review of the Enrollment Packet, an ITP appointment will be set up with our Summer Day Academy Staff if your child meets all other program requirements for the summer program. The ITP appointment includes a brief meeting and medical evaluation that the parents and the child must attend.
6. After the ITP, the EIDT and treatment prescriptions are sent to your child's PCP.
7. Once the signed EIDT and treatment prescriptions are received, you will be contacted with additional information about the Summer Day Academy.

Please feel free to contact us with any questions or concerns you may have. We appreciate your interest in Pathfinder services for your children & family!

Pathfinder Summer Day Academy

Pathfinder Summer Day Academy Program operates ***June 6-August 5 , 2022*** to provide the continuity and engagement that help children with designated disabilities to thrive during the summer months. Each child's unique strengths and interests are celebrated and incorporated in the daily discoveries and interactions in our program activities to strengthen social skills and responsibility.

SUMMER DAY ACADEMY ENROLLMENT

Summer Sessions for 2022: June 6th – August 5th, 2022.

Weekly Hours Required This Summer: Mondays through Fridays from 7:30am to 3:30pm. Attendee slots will be filled as accepted applications are received.

The Summer Day Academy serves ages 6-21 with one of 6 disability diagnoses, and receives at least 1 of PT/OT/SP therapies.

Transportation options may be available to attendees.

Summer Food Program

Pathfinder Summer Day Academy 2022

SUMMER DAY ACADEMY APPLICATION

Date of this application: ____/____/__________

ATTENDEE INFORMATION

Name:____ Birth Date:____/____/_______
Last First Middle

Gender: *(circle)* *male* *female* T-shirt Size:_______________________________

Where is your child's primary residence? ___with both parents ___with mother ___with father ___with guardian

Name of Primary Care Physician:_________________________Physician's office phone: (____)______________

Address: _____ ______________________________ City: ____________ State: _______ Zip: ______________

Primary Medical Diagnosis/Condition (if not applicable write "none"): _____________________________________

List any Secondary Diagnoses/Conditions:____

How did you hear about Pathfinder Summer Day Academy? ___________________________________

PARENT/GUARDIAN INFORMATION

Mother or Guardian **Check if custodial parent**

Name:____________________________________ Relationship to attendee:________________________
Last First

Telephone Numbers: Primary _____/____________________ Secondary _____/____________________

Email: ____

Address:____________________________________ City:__________________________________

County: ______________________ State: _________ Zip: __________________________________

Employer:_____________________________ Job Title:______________________

Father or Guardian

☐ **Check if custodial parent** ☐

Name: ______________________________ Relationship to attendee: ____________________
Last First

Telephone Numbers: Primary ______/____________ Secondary ______/____________

Email: ______________________________

Address: ______________________________ City: ______________________________

County: ______________ State: ________ Zip: ______________________________

Employer: ______________________________ Job Title: ______________________________

EMERGENCY CONTACT INFORMATION

Who will be the primary contact while your child is at the Summer Day Academy? *(Circle): Mother Father other*

Best phone number to call:____________________________________

If unable to reach parent/guardian, please notify*: (Two different individuals not living in the same household are required.)*

1) Full Name: ____________________________________ Relationship to camper: ______________________________________

Primary telephone:_______________________________ Secondary telephone:____________________________________

Address: ____City, State, Zip:____

2) Full Name: ___________________________________ Relationship to camper: ______________________________________

Primary telephone: ________________________________ Secondary telephone:______________________________________

Address: ____City, State, Zip:____

PARENT/GUARDIAN AUTHORIZATION

The following authorization MUST be signed before applicant can be accepted for Summer Day Academy.

The health history I have provided in this application is correct and complete as far as I know. I agree to inform Pathfinder Summer Day Academy of any significant health related issues that may arise following submission of this application and prior to my child's participation and understand additional information and/or physician authorization may be requested.

Pathfinder Summer Day Academy may not be able to accommodate all medical conditions and/or disabilities. We reserve the right to make the final decision regarding admittance and dismissal of participants to the programs. This policy is to insure that adequate provisions can be made for participants while they are in the care of the Summer Day Academy.

Pathfinder Summer Day Academy serves those who do not require personal caregivers other than Pathfinder staff or engage in aggressive and/or abusive behavior. Summer Day Academy attendees are recruited on a non-discriminatory basis, without regard to race, color, creed, sex, national-origin, religious or political affiliation.

Signature of Parent/Guardian: ____ Date:_______________________

INSURANCE INFORMATION

Primary Funding Information

Company Name:____________________________________ Phone: ______________________________________

Address:____ City, State, Zip: ________________________________

Member ID or Policy #: ______________________________ Group #: _____________________________________

Name of Policy Holder: ______________________________ Date of Birth: _________________________________

Secondary Funding Information (if applicable)

Company Name:____________________________________ Phone: ______________________________________

Address:____ City, State, Zip: ________________________________

Member ID or Policy #: ______________________________ Group #: _____________________________________

Name of Policy Holder: ______________________________ Date of Birth: _________________________________

PERSONAL CARE AND ACTIVITY INFORMATION

The following specific applicant information is to be completed by parent/guardian for Academy medical staff. A copy will be given to the applicant's Academy staff. Please attach any additional information necessary to assist the staff to care for your child.

Does your child like to be called by any other name? ______________________ Age : _____ ________

Current grade in school: ________ Height: _________ Weight: _________ Gender: *(circle)* *male* *female*

Please indicate (√) the level of assistance needed for the following daily activities

Personal Care Activity	needs no assistance	minimal assistance	total assistance	notes/needs	
brushing teeth					
showering					
dressing					
hair brushing					
transfer (to and from wheelchair)					
Camp Activity	**needs no assistance**	**minimal assistance**	**total assistance**	**should not participate**	**notes/needs**
swimming					
fishing					
outdoor sports and games					
nature trails					
arts/crafts					

Please circle/write the appropriate information below (attach additional page if needed)

Ambulation: wheelchair: *manual* *electric* walker
crutches braces walks alone - no devices
wanders? yes no occasionally

Sleeping: no problems needs help turning over
needs help getting in or out of bed needs bed rails
wets bed wears diapers at night walks in sleep
usual sleep time: from ______ p.m. to ______ a.m.

Behavior: no problems use time out (minutes:__________)
problems triggered by:________________________________
positive reinforcers:________________________________
suggestions:________________________________

Toilet Management: no problems diapers training pants
catheterization every ______ hours self-catheterization
catheter size ______ brand ____________ type____________
usually has bowel movement every _________ day(s)
needs help with:________________________________

What does the applicant take for pain/discomfort:
____

Eating: no assistance needed at meals regular diet
G-Tube NG-Tube tube feedings every ______ hours
food must be: cut chopped mashed pureed
must be fed special utensils:________________________________
needs help with:________________________________
special diet:________________________________

Seizures: none has seizures date of last one______________
Type________________________________
usual duration________________ usual frequency______________
triggered by________________________________

Communication: no problems non-verbal sign language
limited abilities can communicate personal care needs
communication device (type ______________________)

Hearing: no problems oral deaf
hearing impaired wears aides

Vision: normal wears glasses limited blind

Heat Tolerance: good fair poor

SPECIAL INSTRUCTIONS AND DAILY ROUTINES

Pathfinder Summer Day Academy strives to make each child's participation a safe, comfortable, and fun experience. It is important that we have as much information as possible regarding what your child is used to and comfortable with. Sometimes following routines or special ways of doing things helps a child feel more at ease with a new environment. Please take a few moments and share with us your child's typical daily routine (especially consistent behavior problems, as well as personal care and mealtime procedures) and include any special instructions, techniques of motivating and rewarding your child, hobbies, likes/dislikes, etc. Everything that you provide will help us better care for your child. (Example: "My child will only settle down if I rock her. She will smile each morning if I hum a song to her".) Also include any goals you would like the applicant to achieve while attending Pathfinder Summer Day Academy,(examples: improve personal care skills, make new friends, learn to float in pool, etc.) Enclose extra pages if necessary.

____

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IMMUNIZATION HISTORY

We are required to have a copy of each attendee's immunization record on file.

New Summer Attendees - a ***complete*** copy of his/her immunization record **MUST** accompany this application.

Applications submitted without the required immunization information cannot be processed until this information is received. Pathfinder Summer Day Academy adheres to immunization guidelines used by most educational facilities. ***Please check with your school nurse or administration about obtaining a copy of your child's record***

OTHER INFORMATION

Name: ______________________________ **Date of Birth:** ____________________

HEALTH HISTORY AND PHYSICIAN'S AUTHORIZATION

The Health History and Physician's Authorization (both sides of this form) is to be completed by the applicant's Primary Care Physician. It will be used by the camp's medical staff to determine medical eligibility, be reviewed by the Academy staff, and will be kept on file in central records.

Dear Physician,

Pathfinder Summer Day Academy is an Early Intervention Day Treatment summer program for children with medical conditions, physical disabilities, and developmental delays. Although activities have been adapted so children of all abilities can participate, they may require physical exertion and/or travel to and from various locations.

Please complete both sides of this form. Attach additional information you feel the Summer Day Academy medical staff should be aware of.

Primary Medical Diagnosis:*(if not applicable write "none")*______________________________

List any Secondary Diagnoses:______________________________

Current Medication(s) (please indicate if pill, inhaler, injection, etc.)	Strength	Dosage	Time(s)			
			breakfast	lunch	dinner	other

ALLERGY INFORMATION

Is this child allergic to any:

Medications	Name	Reaction (be specific)	Age of last reaction
Foods	Name	Reaction (be specific)	Age of last reaction
Animals Insects Plants	Name	Reaction (be specific)	Age of last reaction
Other	Name	Reaction (be specific)	Age of last reaction

Is this child latex sensitive? yes no

Attendee Name: ______________________________ **Date of Birth:** ______________________

Date of last tetanus shot: __________ height:______________ weight:____________________

blood pressure: _______/_______ heart rate:______________ respiration rate:____________

PHYSICAL EXAMINATION			
Body System	normal	abnormal	If abnormal, please explain
HEENT			
Cardiovascular			
Respiratory			
Gastrointestinal			
Skeleto-muscular			
Genitourinary			
Other – please explain			

Please circle/write the appropriate information below

General: *frequent ear infections* heart defect/disease seizures bleeding/clotting disorders hypertension rashes/ringworm

comments regarding circled items: ____

*Surgeries (specify):*____

Childhood Diseases: chicken pox mumps measles german measles other (specify): ____________________

For Female Applicants - Has this applicant menstruated? yes no If so, is her menstrual history normal? yes no

Special consideration: ____

Medical Equipment

wheelchair charger hearing aids dialysis cycler other:___

Bi-PAP C-PAP ventilator inhaler hospital bed other: ____________________

Has Down syndrome been diagnosed in this applicant? yes no

If yes, is the applicant clear of Atlantoaxial Dislocation Condition confirmed by diagnostic x-ray? yes no

*Restrictions/limitations on participation in any camp activities:*______________________________

Additional Comments:

PHYSICIAN'S AUTHORIZATION

I have examined ______________________________ within the past 6 months (date examined: ________) and in my opinion, his/her condition **DOES NOT** preclude his/her participation in an active Summer Day Academy program. __________

Physician's Printed Name:______________________________Phone: /________________

Address:______________________________City: ____________________State:_____Zip:_____

Licensed Physician Signature (or Advanced Practice Nurse/Registered Nurse Practitioner representing the physician):

X ______________________________ Date: ____________________

MEDICAL AND SOCIAL HISTORY

Patient's Birth History (please be as thorough as possible)

Child was born at _______ weeks. Birth weight: _______ lbs. _______ ozs.

Please describe any medical problems during pregnancy: ____

____

____

Child's Health at birth (NICU, Oxygen, any other complications):____

____

____

General Developmental and Social History: *Please list the age at which your child has met the following developmental milestones, if applicable:*

Babble (use of consonants): _____

Single word use: _____ How many? _____

Sit w/o support: ______

Crawl: _____

Pull to Stand: _____

Walk: _____

Finger Fed: _____

Potty Trained: _____

Can child follow simple daily instructions? ____

Does your child attend: School Daycare Both

If so, please list name of school and/or daycare: ____

If your child is in school, what type of classroom is he/she in? ___________________________________

Family Medical History

Please list others living in the same household:

Name:	Relationship to patient:
____	____
____	____
____	____
____	____
____	____
____	____
____	____

Has anyone in the child's family ever had any of the following? (Please mark which family member in the corresponding box):

	Mother	**Father**	**Sibling**	**Grand-mother** (indicate M for maternal and P for paternal)	**Grand-father** (indicate M for maternal and P for paternal)	**Extended Family** (aunt, uncle, cousin, etc.)
Attention/ADHD Problems						
Speech Problems						
Motor/Vocal Tics						
Depression						
Anxiety						
Bipolar						
Schizophrenia						
Learning Disability						
Sickle Cell Disease						
Seizure Disorder						
Alcoholism						
Drug Abuse						
High Blood Pressure						
Lung Problems/Asthma						
Heart Problems						
Behavior Problems (please specify):						
Other (please specify):						

What are your primary concerns about your child? ____

____

____

____

____

Name of School your child currently Attends:____

I, the undersigned, certify that I have provided accurate information and answered all questions on this form truthfully to the best of my knowledge. I authorize Pathfinder, Inc. to release any information including the diagnosis and the records of any treatment and examination or any other personal health information rendered to my child to custodial parents and/or legal guardians, Pathfinder, third- party payers, health practitioners, and/or any other person or institution to whom I have given a separate Release for Medical Information, as necessary. I authorize and request my insurance company to pay directly to Pathfinder, Inc. benefits otherwise payable to me.

I understand that it is my responsibility to keep Pathfinder, Inc. informed of any change in the above information.

____

Parent/Guardian Signature Date

____

Parent/Guardian Printed Name

<u>AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION</u>

Child's Name: ______________________________ DOB: ____

Address: ____

I authorize Pathfinder, Inc.

☒ to disclose my health information to ___________________________________ Primary Care Physician
(Name of Physician, clinic, hospital, self, etc)

☒ **and I authorize the Covered Entity** ____________________________________ Primary Care Physician
(Name of Physician, clinic, hospital, self, etc)

to disclose my health information to Pathfinder, Inc..

Purpose of use, disclosure, or request: ☒ Continuity of care & treatment; □ At the request of the patient; □ Payment; ☒ Medical history; □ Other issues (specify)

Information to be used and/or disclosed:

☒ Clinical (Example: History & testing; therapist reports; EI treatment plan; clinic treatment plans)

□ Other (specify) ____

I understand that the disclosure of my personal health information may include information regarding diagnosis and/or treatment for any of the following: alcohol or drug abuse; psychiatric or mental illness; domestic violence; child abuse; incarceration; legal difficulties; and/ or sexually transmitted diseases, including HIV or AIDS virus.

This authorization will expire upon termination unless you specify a different expiration date, event or condition:
Please specify: ____

I understand that I have a right to revoke this authorization at any time except to the extent that the release of information has already occurred in reliance on my prior authorization.

I understand that to revoke an authorization, a written document stating the intent of the patient is to be either delivered in person or by certified mail to Pathfinder, Inc. The revocation document is to contain the signature of the patient or patient's legal representative.

I understand that authorizing the disclosure of health information is voluntary. I can refuse to sign this authorization. Refusal to sign this form will not affect my receipt of treatment. I understand that it is my responsibility to inquire with the party requesting my health records regarding the effect of my refusal to sign this form.

I understand that any disclosure carries with it the potential for re-disclosure by the recipient of this information and such re-disclosure may not be protected by federal confidentiality laws.

____

Parent/Guardian Signature Date

____

Parent/Guardian Printed Name

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Child's Name: ______________________________ DOB: ____

Address: ____

I authorize Pathfinder, Inc.

☒ to disclose my health information to: __________________

(Name of Physician, clinic, hospital, self, etc)

☒ **and I authorize the Covered Entity** __________________

(Name of Physician, clinic, hospital, self, etc)

to disclose my health information to Pathfinder, Inc..

Purpose of use, disclosure, or request: ☒ Continuity of care & treatment; □ At the request of the patient; □ Payment; ☒ Medical history; □ Other issues (specify)

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____

Parent/Guardian Signature Date

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Parent/Guardian Printed Name