NYSARC, Inc. Broome-Chenango-Tioga County Chapter dba ACHIEVE
125 Cutler Pond Road Binghamton, NY 13905

ACHIEVE YOUTH SUMMER PROGRAM 2025

This application must be filled out completely and submitted by May 31, 2025.

Submit to: summerprogram@achieveny.org

CAMPER APPLICATION (Page 1)

CAMPER INFORMATION

Camper Name _____ Date of Birth _____ Age _____

Social Security # _____ Camper Gender: F____*M*____*Other*_____

Is Camper in Foster Placement? Yes _____ No _____ Youth Home? Yes _____ No _____

Primary Disability _____ Secondary Disability _____

Street Address/PO Box _____ City_____

State _____ Zip Code _____ Town _____ County_____

Name of Parent/Guardian _____ Phone Number _____

Parent email address _____

Is this the first time the camper is attending ACHIEVE's Summer Program? Yes _____ No _____

If not, what previous years has the camper attended? _____

What are some unique characteristics about your camper we should know that would help them have the best Summer Program experience possible?

Describe the things you do to encourage desired behaviors and/or discourage inappropriate behaviors.

Is Camper enrolled in OPWDD Medicaid Waiver? Yes _____ No_____ Medicaid # _____

Care Manager _____ Care Management Agency _____

Care Manager Agency Phone Number _____

DESIRED SESSIONS

Week 1: July 7-10, 2025 _____

Week 2: July 14-17, 2025 _____

Week 3: July 21-24, 2025 _____

Week 4: July 28-31, 2025 _____

Week 5: Aug 4-7, 2025 _____

Week 6: Aug 12-14, 2025 _____

All 6 Weeks _____

WORK STUDY PROGRAM

Is camper (14 – 21 years of age) interested in participating in the Summer Work Study Program?
(NY State working papers must be obtained for campers under 18)

Yes _____ No _____

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CAMPER APPLICATION – CONTINUED (Page 2)

SCHOOL INFORMATION

Please submit the following via email, if applicable:

- current IEP or 504 plan
- Behavior Intervention Plan

School District _____ Name of School _____

Teacher Name _____ School Telephone Number _____

Does camper have a **full-time personal aide** provided by the school? Yes _ _ No_____

Does camper have a **part-time personal aide** provided by the school? Yes _____ No _____

Does camper have a **full-time monitor** provided by the school? Yes _ _ No _____

Does camper have a **part-time monitor** provided by the school? Yes _____ No _____

Does camper have a **Behavior Plan** in place at school? Yes _ _ No _____

Is camper on a **12-month** education program? Yes _____ No _____

Does camper have **confirmed placement** in **BT Boces Summer School**? Yes _ _ No _____

Is your camper eligible for a free school lunch? Yes _ _ No _____ Reduced lunch? Yes ____ No ____

Does camper require transportation?

To Program_____ From Program_____

None Needed (Parent/Guardian will provide transportation) _____

Please answer the following questions:

DAILY LIVING SKILLS	Independent?		Needs Assistance?		Please provide details for any assistance needed.
	YES	NO	YES	NO	Comments
AMBULATORY					
EATING					
TOILETING					
SPEECH					
DRESSES SELF					
UTILIZE ASSISTIVE DEVICES/EQUIPMENT					

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CAMPER APPLICATION – CONTINUED (Page 3)

WATER ACTIVITIES

Does camper have tubes present in one or both ears? Yes _____ No _____

Does camper enjoy water activities? Yes _____No _____ Comments: _____
Is there a reason that the camper should not be allowed to participate in water activities?

Yes _____ No __ ___

If yes, please explain _____

HEALTH HISTORY

Does camper have a seizure disorder? Yes _____ No _____

Type _____ Frequency _____

Date of Last seizure _____Duration _____

Emergency protocol in case camper has a seizure while at Program

Does camper have a cardiac condition that limits their activities? Yes _ __ No _ __

If yes, please explain _____

Is camper allergic to any foods? Yes _____ No _____

If yes, please explain _____

Is camper on a special diet or have any dietary restrictions? Yes _____ No _____

If yes, please explain _____

Does camper have any other medical conditions or injuries that would restrict their activity?

Yes _____ No _____

If yes, please explain _____

Please list any allergies below (food, medications, Latex, environmental, bee stings, etc)

ALLERGEN	Allergic?		Medication Used to treat	Allergic reaction symptoms & protocol
	Yes	No		

Does the camper take any medication that will need to be administered during Program?

Yes _ __ No _ __

If yes, please list: _____

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*** A PRESCRIPTION WILL BE REQUIRED FOR ALL MEDICATIONS, INCLUDING OVER THE COUNTER. ***

CAMPER APPLICATION – CONTINUED (Page 4)

EMERGENCY CONTACT INFORMATION

Camper Name _____ Age _____ Date of Birth _____

Parent/Guardian _____ Home Phone _____

Employment _____ Work Phone _____

Relationship to Camper _____ Cell Phone_____

Email Address _____

Address (if different than Camper) _____

Parent/Guardian _____ Home Phone _____

Employment _____ Work Phone _____

Relationship to Camper _____ Cell Phone_____

Email Address _____

Address (if different than Camper) _____

Primary Care Physician: _____ Phone _____

Preferred Hospital in an Emergency _____

List health concerns or injuries

BACKUP EMERGENCY CONTACT (REQUIRED)

If my child needs to be taken home because of minor illness, injury or behavior and I cannot be reached; I give permission for the following people to assume responsibility for my child. I understand that those listed below will be required to show proper identification and must sign my camper out:

Name of Emergency Contact _____ Phone _____

Relationship to Camper _____Address _____

Name of Emergency Contact _____ Phone _____

Relationship to Camper _____Address _____

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CAMPER APPLICATION – CONTINUED (Page 5)

AUTHORIZATIONS

PERMISSION TO PICK UP

I give permission for the following people to pick up my camper.
I understand that those listed below will be required to show proper identification and must sign my camper out:

Name of Relative/Friend _____ Phone _____

Relationship to Camper _____Address _____

Name of Relative/Friend _____ Phone _____

Relationship to Camper _____Address _____

Name of Relative/Friend _____ Phone _____

Relationship to Camper _____Address _____

PERMISSION FOR MEDICAL ATTENTION

In the event of an emergency, I hereby authorize the personnel of ACHIEVE's Youth Summer Program to see that my camper receives proper medical attention.

Yes _____ No _____

CARE MANAGER INFORMATION

**For OPWDD Medicaid eligible campers only. Select N/A if your camper does not have this eligibility.*
I give permission for ACHIEVE staff to contact my camper's Care Manager to obtain the necessary documentation (i.e., Life Plan, OPWDD eligibility, Waiver enrollment, psychological reports) to enroll my camper in the ACHIEVE's Youth Summer Program.

Yes _____ No _____ N/A _____

FIELD TRIP/TRANSPORTATION

I give my camper permission to participate in all field trips and ride in agency provided vehicles, which are included as part of normal Summer Program activities.

Yes _____ No _____

PHOTO RELEASE

I give permission for ACHIEVE staff to take pictures and/or video of my camper. I understand that campers' images may be used for promotional purposes (i.e., brochures, web site, social media)

Yes _____ No _____

MEDICATION ADMINISTRATION

I give permission for ACHIEVE's Youth Summer Program medication certified staff to administer medications to my camper.

Yes _____ No _____

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CAMPER APPLICATION – CONTINUED (Page 6)

AUTHORIZATIONS

PARENT/GUARDIAN RESPONSIBILITIES

I acknowledge that I have received a copy of ACHIEVE Summer Program General Information Sheet, and I understand my responsibilities regarding registration, payment, transportation and obtaining Physician's Certificate.

Yes _____ No _____

CODE OF CONDUCT

I acknowledge that I have received a copy of ACHIEVE Summer Program Code of Conduct and understand the policies and procedures within. I have reviewed the contents of the Code of Conduct with my camper.

Yes _____ No _____

RIGHTS/FREEDOM FROM ABUSE

I acknowledge that I received the Individual Rights and Freedom from Abuse, Neglect and Mistreatment information. *Instructions on who to contact if you feel your rights have been violated or you suspect abuse or neglect are included in the same document.*

Yes _____ No _____

HIPAA

I acknowledge that I have received a copy of **Broome-Chenango-Tioga County Chapter NYSARC, Inc, dba ACHIEVE** Notice of Privacy Practices (HIPAA)

Yes _____ No _____

I would like to receive a copy of any amended Notice of Privacy Practices Yes _____ No _____

to: _____
Address

*** A PRESCRIPTION WILL BE REQUIRED FOR ALL MEDICATIONS, INCLUDING OVER THE COUNTER. PARENT/GUARDIAN IS RESPONSIBLE FOR DROPPING OFF MEDICATIONS BEFORE CAMP BEGINS, AND RESPONSIBLE FOR PICKING UP REMAINING MEDICATIONS ON THE LAST DAY OF CAMP***

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CAMPER APPLICATION – CONTINUED (Page 7)

PAYMENT OPTIONS

3 WAYS TO PAY
OPWDD MEDICAID WAIVER
• For campers who are currently enrolled in OPWDD Medicaid Waiver Program. • Tuition rate is billed to Medicaid as Waiver Respite. • Waiver rate is set by OPWDD, not Achieve. • No out-of-pocket expense. • Contact your Care Manager, as they need to submit additional documentation.
SELF PAY
• **$150**/week or **$800** for all 6 weeks. • This option is available for campers that are not OPWDD eligible. • Ask about payment plan options and Best Buddy (sibling) discounts. • Applications completed and payment received by May 31, 2025 will receive a 10% discount. • Accepted methods of payment: Visa, Mastercard, Personal Checks *(subject to a fee if returned)* Cash, & Money Orders. • Please make checks payable to ACHIEVE and include your camper's name on the memo line.
SCHOLARSHIP
• Families may qualify for tuition assistance. • This option is available for campers that are not OPWDD eligible. • Additional scholarship application required. • Proof of income required. • Income restrictions apply. • Awarded on a first come, first served basis for those that qualify.

Please Indicate your method of payment below:

◯ OPWDD Medicaid Waiver

◯ Self-Pay

◯ Scholarship (I understand that I must submit a **completed scholarship application** and supporting **proof of income** in addition to a **completed camper application**.)