

NYSARC, Inc. Broome-Chenango-Tioga County Chapter dba ACHIEVE  
125 Cutler Pond Road Binghamton, NY 13905  
**ACHIEVE YOUTH SUMMER PROGRAM 2026**  
*This application must be filled out completely and submitted by May 31, 2026.*  
*Submit to: [summerprogram@achieveny.org](mailto: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 6-9, 2026 \_\_\_\_\_

**Week 4:** July 27-30, 2026 \_\_\_\_\_

**Week 2:** July 13-16, 2026 \_\_\_\_\_

**Week 5:** Aug 3-6, 2026 \_\_\_\_\_

**Week 3:** July 20-23, 2026 \_\_\_\_\_

**Week 6:** Aug 10-13, 2026 \_\_\_\_\_

**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 \_\_\_

**ACHIEVE YOUTH SUMMER PROGRAM 2026**

***This application must be filled out completely and submitted by May 31, 2026.***

***Submit to: [summerprogram@achieveny.org](mailto:summerprogram@achieveny.org)***

**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. Comments
	YES	NO	YES	NO	
AMBULATORY					
EATING					
TOILETING					
SPEECH					
DRESSES SELF					
UTILIZE ASSISTIVE DEVICES/EQUIPMENT					

**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: \_\_\_\_\_

NYSARC, Inc. Broome-Chenango-Tioga County Chapter dba ACHIEVE

125 Cutler Pond Road Binghamton, NY 13905

**ACHIEVE YOUTH SUMMER PROGRAM 2026**

***This application must be filled out completely and submitted by May 31, 2026.***

***Submit to: [summerprogram@achieveny.org](mailto:summerprogram@achieveny.org)***

**\* 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 \_\_\_\_\_

NYSARC, Inc. Broome-Chenango-Tioga County Chapter dba ACHIEVE  
125 Cutler Pond Road Binghamton, NY 13905  
**ACHIEVE YOUTH SUMMER PROGRAM 2026**  
*This application must be filled out completely and submitted by May 31, 2026.*  
*Submit to: [summerprogram@achieveny.org](mailto:summerprogram@achieveny.org)*

**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 \_\_\_\_\_

**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\***

NYSARC, Inc. Broome-Chenango-Tioga County Chapter dba ACHIEVE  
 125 Cutler Pond Road Binghamton, NY 13905  
**ACHIEVE YOUTH SUMMER PROGRAM 2026**  
*This application must be filled out completely and submitted by May 31, 2026.*  
 Submit to: [summerprogram@achieveny.org](mailto:summerprogram@achieveny.org)

**CAMPER APPLICATION – CONTINUED (Page 7)**

**PAYMENT OPTIONS**

<b>3 WAYS TO PAY</b>
<b>OPWDD MEDICAID WAIVER</b>
<ul style="list-style-type: none"> <li>• For campers who are currently enrolled in OPWDD Medicaid Waiver Program.</li> <li>• Tuition rate is billed to Medicaid as Waiver Respite.</li> <li>• Waiver rate is set by OPWDD, not Achieve.</li> <li>• No out-of-pocket expense.</li> <li>• Contact your Care Manager, as they need to submit additional documentation.</li> </ul>
<b>SELF PAY</b>
<ul style="list-style-type: none"> <li>• <b>\$150/week</b> or <b>\$800</b> for all 6 weeks.</li> <li>• This option is available for campers that are not OPWDD eligible.</li> <li>• Ask about payment plan options and Best Buddy (sibling) discounts.</li> <li>• Applications completed and payment received by May 31, 2025 will receive a 10% discount.</li> <li>• Accepted methods of payment: Visa, Mastercard, Personal Checks (<i>subject to a fee if returned</i>) Cash, &amp; Money Orders.</li> <li>• Please make checks payable to ACHIEVE and include your camper’s name on the memo line.</li> </ul>
<b>SCHOLARSHIP</b>
<ul style="list-style-type: none"> <li>• Families may qualify for tuition assistance.</li> <li>• This option is available for campers that are not OPWDD eligible.</li> <li>• Additional scholarship application required.</li> <li>• Proof of income required.</li> <li>• Income restrictions apply.</li> <li>• Awarded on a first come, first served basis for those that qualify.</li> </ul>

**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**.)