ACHIEVE
Find Yourself Here
Broome Chenango Tioga

SUMMER PROGRAM 2020

Dear Parent or Guardian:

We are pleased to announce that in the Summer of 2020, ACHIEVE will again be sponsoring our Summer Program. ACHIEVE's Summer Program provides a variety of activities and experiences for students who have special needs while maintaining the skills they learned during the school year in a fun and challenging way. It runs for a six week period during July and August; please refer to the attached information packet for exact dates, times, and payment information. Our 2020 Summer Program will remain at the Chenango Forks High School, at 1 Gordon Dr. Binghamton, NY 13901.

ELIGIBILITY FOR THE PROGRAM

Students attending the ACHIEVE Summer Program must meet the following criteria:
- Reside in Broome, Chenango or Tioga County
- Must be between 5-21 years of age
- Must have an Individualized Education Plan (IEP) or a 504 plan in the school

Please Note: All new applicants will be reviewed, students who require 1-1 supervision, intensive treatment, or who have serious emotional and/or behavioral issues **may not be appropriate** for this program. We strive to be as inclusive as possible, so please contact myself with any specific concerns.

Attached please find your 2020 Summer Program Application Packet:
- Section One: Information Packet – including program cost (Keep for your records)
- Section Two: Student Application – including payment information (Return Completed to ACHIEVE)
- Section Three: Academic Information (Return to ACHIEVE with IEP or 504)
- Section Four: Physician's Certificate (Return to ACHIEVE with PPD test results if applicable)

For more information about ACHIEVE Summer Program, or questions about the application process, please contact myself at tstasko@achieveny.org, or by phone at 607-231-5235.

Hope to see you this summer!

Tami Stasko
Summer Program Coordinator

SECTION ONE

(Keep for your records)

ACHIEVE 2020 SUMMER PROGRAM APPLICATION PACKET

1. General Information Sheet
2. Student Code of Conduct
3. Policies

ACHIEVE 2020 Summer Program
General Information Sheet

PROGRAM DATES/TIMES

July 6, 2020 – August 13, 2020
Monday through Thursday
8:30 am – 2:15 pm

Special note: The program will close at 12:00 pm on August 13, 2020. Please make necessary arrangements to pick up students either at the program or at the designated pick-up/drop-off location.

PROGRAM LOCATION

Chenango Forks High School
1 Gordon Dr.
Binghamton, NY 13901

COST OF PROGRAM 3 Ways to Pay

Medicaid Waiver: For students who are currently enrolled in OPWDD Medicaid Waiver Program there is no out of pocket expense to the family, please contact your **Medicaid Service Coordinator (MSC)** to obtain the necessary documentation. For your convenience, a letter to MSC is included in the application section of your packet, please fill it out and forward it to your MSC.

Self-Pay: The tuition for each student in 2020 will be $400.00. This will cover the entire six weeks of the program. Payment must be included with the application packet. Full applications and payment received before the application deadline of **May 22, 2020 will be discounted to $350.00.**

New This YearPayment Plan Option: pay $100 at time of application submission with balance of $300 due by July 3rd or balance of only $250 if paid in full by May 22nd.

Accepted methods of payment are Visa, Master Card, personal checks, cash and money orders. Cash payments must be dropped off in person to ACHIEVE's Riverside Dr. Offices.

Town of Union & City of Binghamton Grant Opportunity: Some students may be eligible for financial assistance through CDBG Grant. **Income and residency restrictions apply.** Grant spots are limited and will be awarded based on Individual need and recite of completed application. To apply for this grant you must fill out the CDBG Funded Public Service Program form and return to ACHIEVE along with a signature and proof of income and residency as directed on the form.

All Town of Union & City of Binghamton Students will be required to complete the *CDBG Funded Public Service Program* form along with a signature and proof of income and residency regardless of whether or not the student is applying for a grant. This is for demographic reporting purposes only, and all information will be kept confidential.

REGISTRATION DEADLINE: Applications, payment, and all required documentation must be submitted by **May 22, 2020**. *If Physician's certificate is not obtained due to insurance restrictions, please submit all other documents and provide a date when it will be available. Space is limited; enrollment will be on a "first come first serve" basis. Please mail completed application packets and payment to:

ACHIEVE
ATTN: Tami Stasko, Summer Program Coordinator
125 Culer Pond Road
Binghamton, NY 13905

LUNCHES

It is possible that we may be able to offer free lunches as was provided in past years, however, we are not able to make that determination at this time. Therefore, parents/guardians should be prepared to have a packed lunch each day for their student. Notifications will be sent as soon as a determination has been made.

ACCEPTANCE NOTIFICATION

Program acceptance letters and additional program details, including if we will be able to offer free lunches again this year will be mailed the week of June 15th.

TRANSPORTATION

Transportation may be provided by your home school district. **Pick up and drop off times will be determined at a later date and communicated through the local school districts**. ACHIEVE does not provide transportation to and from program, If your school district does not provide transportation you will be responsible. **Please direct transportation questions to your home School District.**

SUMMER WORK STUDY PROGRAM

The Summer Work Study Program offers students (15-21 years of age) a unique opportunity to work an hour per day, learning valuable vocational skills they will need to transition out of school into employment. Additionally, 2 hours a week of curriculum time reinforces these skills. This successful program teaches them to; follow directions, team work, communication skills, responsibility, and much more, all while earning a paycheck! Space is limited. If you would like your student to be considered for this program please indicate by placing and "X" in the YES box on **page 2** of the application packet.

Individualized Education Plan (IEP) or 504

For a student to attend Summer Program they must have a current IEP or 504. Your packet includes an Academic Sheet, (Section Three), **Please sign the top of the form and give it to your child's teacher to be completed.** Attach the IEP or 504 to the form and return it to ACHIEVE. Students graduating in 2020 are still eligible to attend ACHIEVE Summer Program.

Physician's Certificate and PPD MANTOUX TEST

Arrangements should be made with your physician's office for your student to have a PPD Mantoux test as well as a follow up appointment with your physician to have the test read. The Summer Program medical staff must review the Physician's Certificate form (Section 4) before a student is accepted for the Summer Program. **Again this year;** Students who have attended ACHIEVE's Summer Program for **TWO consecutive years,** will not be required to have a PPD test this year. The Physician's Certificate form must still be completed.

Communication

Parents can download the Remind App on their phone or tablet to get reminders from counselors as well as communicate directly with the Head Counselors.

Looking forward to a great summer!

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

ACHIEVE Summer Program Participant Code of Conduct

It is the goal of ACHIEVE Summer Program to provide your child with a memorable fun-filled summer while maintaining the skills they learned through their school year, in a safe and respectful environment. We recognize that harassment; bullying and bad behavior of others can be a detriment to these goals. Please review the following with your student.

Each Student at ACHIEVE Summer Program will:

- Be polite and respectful of everyone, including; students, counselors, staff and visitors.
- Not use profanity or insult others.
- Bring a positive attitude to program every day.
- Keep hands, feet and objects to myself and never intentionally harm another student or counselor.
- Not Bully, witnessing another student being bullied must be reported to a counselor.
- Not Cyber-Bully another student through social medial. Cyberbullying is the use of cell phones or other devices to send or post emails, text messages or images intended to harass another person.
- Follow my individual Counselor's instructions, class rules and expectations at all times.
- Not litter, steal, damage property or make false 911 calls.
- Only use cell phones and other electronic devices during times designated by my counselor.
- Be encouraging and supportive of my fellow students and never tear them down.
- Participate to the best of my ability in all Summer Program activities.

(Continued on Reverse Side)

Failure to follow the code of conduct could result in disciplinary actions, including: a letter of warning sent home, a phone call for pickup from program, suspension from the program and possible removal from the program. The discipline will depend on severity of the action(s) and the frequency that they occur.

I recognize that ACHIEVE Summer Program is held at Chenango Forks School District. We are guests at their facility. It is their right to suspend a student should they steal or damage property, or make false 911 calls.

Your signature on the acknowledgement page of your application (Page 6), attesting you have read and understand this code of conduct, and reviewed it with your student is required for acceptance to Summer Program.

Individual Rights and Freedom from Abuse, Neglect and Mistreatment

ACHIEVE

Find Yourself Here

Achieve strives to enhance the quality of life of the individuals that we serve through advocacy, inclusion, integration and increased independence.

It is essential to our mission that we protect the rights of the individuals we serve and provide them with a safe environment free from abuse, neglect and mistreatment.

Individuals receiving services are entitled to the same civil and legal rights as all other people, these rights include but are not limited to

1. The right to a safe and sanitary environment.
2. Freedom from physical or psychological abuse.
3. Freedom from unnecessary use of mechanical or physical restraint.
4. Freedom from unnecessary or excessive medication.
5. Protection from commercial or other exploitation.
6. Confidentially with regard to all information contained in the personal record.
7. A written individualized plan of services that fosters social interaction with the community and enables the individual to live as independently as possible.
8. The opportunity to participate in the development or modification of the individualized plan of services.
9. The opportunity to object to any part of an individualized plan of services.
10. Access to appropriate and humane health care and, to the extent possible, the ability to have input in their healthcare plan and make decisions regarding their own care.
11. The opportunity to vote and participate in civic activities.
12. The right to observe and participate in the religion of his or his choice.
13. A reasonable degree of privacy in personal areas of the house.
14. The opportunity to request an alternative residential setting.
15. The ability to express grievances, concerns or suggestions to the chief executive officer of the facility.
16. The opportunity to have visitors and to have privacy when visited.

Abuse and Neglect can be broken down into the following categories.

Physical Abuse
Intentional contact (hitting, kicking, shoving, etc.) corporal punishment, injury which cannot be explained and is suspicious due to extent or location, the number of injuries at one time, or the frequency over time

Psychological Abuse
Taunting, name calling, using threatening words or gestures

Sexual Abuse
Inappropriate touching, indecent exposure, sexual assault, taking or distributing sexually explicit pictures, voyeurism or other sexual exploitation. All sexual contact between a Custodian and a service recipient is sexual abuse, unless the Custodian is also a person receiving services

Neglect
Failure to provide supervision, or adequate food, clothing, shelter, health care; or access to an educational entitlement

Deliberate misuse of restraint or seclusion
Use of these interventions with excessive force, as a punishment or for the convenience of staff

Controlled Substances
Using, administering or providing any controlled substance contrary to law

Aversive conditioning
Unpleasant physical stimulus used to modify behavior without person-specific legal authorization

Obstruction
Interfering with the discovery, reporting or investigation of abuse / neglect, falsifying records or intentionally making false statements

Rights restrictions: There are times when interventions are put into place that restrict or modify individual's rights. This is only done when less intrusive approaches have been tried and were not successful or when the restriction is necessary to protect the health or safety of an individual.

When rights restrictions are in place the following must be met

1. Positive and less intrusive approaches must be identified in the Individuals Behavior Plan.
2. Restrictions are subject to the individual's informed consent or that of an authorized surrogate.
3. Rights modifications are reviewed periodically for effectiveness and necessity and phased out as soon as it is determined that they are no longer necessary.

If you feel that your rights or the rights of an individual you care for have been violated or unnecessarily restricted or that you or someone you care for has been the victim of abuse or neglect.

Call the ACHIEVE corporate compliance line at 607.723.8361 Select #8

You can make a report 24/7 365 days a year to the New York State Justice Center by calling

1-855-373-2122

ACHIEVE
NOTICE OF PRIVACY PRACTICES

This notice describes the privacy practices of NYSARC, Inc, Broome-Tioga County Chapter, dba ACHIEVE (Organization) and the privacy rights of the people we serve. It will describe how information about you may be used and disclosed and how you can get access to this information.

The Health Insurance Portability and Accountability Act (HIPAA) Privacy rule DOES NOT CHANGE the way you get services from the Organization, or the privacy rights you have always had under New York State Mental Hygiene Law. The Privacy rule adds some details about how you can exercise your rights.

PLEASE REVIEW THIS NOTICE CAREFULLY.

This notice is effective as of December 1, 2013

Our Privacy Commitment to You:

The Organization provides many different services to you. We understand that information about you and your family is personal. We are committed to protecting your privacy and sharing information only with those who need to know and are allowed to see the information to assure quality services for you. The Organization is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. This notice tells you how the Organization uses and discloses information about you. It describes your rights and what the Organization's responsibilities are concerning information about you. When we use the word "you" in this Notice, we also mean your personal representative. Depending on your circumstances and in accordance with state law, this may mean your guardian, your health care proxy, or your involved parent, spouse, or involved adult family member.

If you have questions about any part of this notice or if you want more information about the privacy practices at the Organization, please contact:

Julye L. Bush, Corporate Compliance Officer, *Privacy Officer*
Address: 125 Cutler Pond Rd, Binghamton, NY. 13905
Phone: Corporate Compliance Hotline (607) 723-8361, Select #8
E-mail: jbush@achieveny.org

Who will follow this Notice:

All people who work for the Organization will follow this notice. This includes employees, persons the Organization contracts with who are authorized to enter information in your record or need to review your record to provide services to you, and volunteers who the Organization allows to assist you.

What information is protected:

All information that we create or keep that relates to your health or care and treatment, including but not limited to your name, address, birth date, social security number, your medical information, your service or treatment plan, and other information (including photographs or other images) about your care in our programs, is considered protected information. In this Notice, we refer to protected information as protected health information or "PHI". We create and collect information about you and we keep a record of the care and services you receive though this agency. The information about you is kept in a record; it may be in the form of paper documents in a chart or on a computer. We refer to the information that we create, collect, and keep as a "record" in this Notice.

Your Health Information Rights:

Unless otherwise required by law, your record is the physical property of the Organization, but the information in it belongs to you and you have the right to have your information kept confidential. You have the following rights concerning your PHI:

- You have a right to see or inspect your PHI and obtain a copy of the information. Some exceptions apply, such as information compiled for use in court or administration proceedings. NOTE: The Organization requires you to make your request for records in writing to the Privacy Officer. You may request copies in paper format or in an electronic form such as a CD, portable device, or memory stick. In some instances, the Agency may charge you for copies.
- If we deny your request to see your information, you have the right to request a review of that denial. The CEO/designee will appoint a licensed health care professional to review the record and decide if you may have access to the record.
- You have the right to ask the Organization to change or amend information that you believe is incorrect or incomplete. We may deny your request in some cases, for example, if the record was not created by the Organization or if after reviewing your request, we believe the record is accurate and complete.
- You have the right to request a list of the disclosures that the Organization has made of your PHI. The list, however, does not include certain disclosures, such as those made for treatment, payment, and health care operations, or disclosures made to you or made to others with your permission.

- You have the right to request a restriction on uses or disclosures of your health information related to treatment, payment, health care operations, and disclosures to involved family. The Organization, however, is not required to agree to your request.
- You have the right to request that the Organization communicates with you in a way that will help keep your information confidential. You may request alternate ways of communication with you or request that communications are forwarded to alternative locations.
- You will be notified if there is a breach of unsecured PHI containing your information; we are required by federal law to provide notification to you.
- To request access to your clinical information or to request any of the rights listed here, you may contact:

Julye L. Bush, Corporate Compliance Officer, Privacy Officer
Address: 125 Cutler Pond Rd, Binghamton, NY. 13905
Phone: Confidential Hotline – (607) 723-8361, Select #8
E-mail: jbush@achieveny.org

We will require you to submit your requests in writing to the Privacy Officer.

NOTE: Other regulations may restrict access to HIV/AIDS information and federally protected drug and alcohol information. See any special authorizations or consent forms that will specify what information may be released and when, or contact the Privacy Officer listed above.

Our Responsibilities to You:

We are required to:

- Maintain the privacy of your information in accordance with federal and state laws.
- Give you this Notice that tells you how we will keep your information private.
- Tell you if we are unable to agree to a limit on the use or disclosure that you request.
- Carry out reasonable requests to communicate information to you by special means or at other locations.
- Get your written permission to use or disclose your information except for the reasons explained in this notice.
- We have the right to change our practices regarding the information we keep. If practices are changed, we will tell you by giving you a new notice. Notices will be posted on our website: www.achieveny.org

How Organization Uses and Discloses Your Health Information:

The Organization may use and disclose information without your permission for the purposes described below. For each of the categories of uses and disclosures, we explain what we mean and offer an example. Not every use or disclosure is described, but all of the ways we will use or disclose information will fall within these categories.

- **Treatment:** The Organization will use your information to provide you with treatment and services. We may disclose information to doctors, nurses, psychologists, social workers, and other Organization personnel, volunteers, or interns who are involved in providing your care. For example, involved staff may discuss your information to develop and carry out your treatment or service plan and other Organization staff may share your information to coordinate different services you need, such as medical tests, respite care, transportation, etc. We may also need to disclose your information to other providers outside of the Organization who are responsible for providing you with services.
- **Payment:** The Organization will use your information so that we can bill and collect payment from you, a third party, an insurance company, Medicare or Medicaid, or other government agencies. For example, we may need to provide your health care insurer with information about the services you received in our agency or through one of our programs so they will pay us for the services. In addition, we may disclose your information to receive prior approval for payment for services you may need.
- **Health Care Operations:** The Organization will use clinical information for administrative operations. These uses and disclosures are necessary to operate Organization programs and to make sure all individuals receive appropriate, quality care. For example, we may use information for quality improvement to review our treatment and services and to evaluate the performance of our staff in serving you.

We may also disclose information to clinicians and other personnel for on-the-job training. We will share your health information with other Organization staff for the purposes of obtaining legal services from our attorneys, conducting fiscal audits, and for fraud and abuse detection and compliance through our Compliance Program. We may also disclose information to our business partners who need access to the information to perform administrative or professional services on our behalf.

Other Uses and Disclosures that Do Not Require your Permission:

In addition to treatment, payment, and health care operations, the Organization will use your information without your permission for the following reasons:

- When we are **required to do so by federal or state law**.
- For **public health reasons**, including prevention and control of disease, injury or disability, reporting births and deaths, reporting child abuse or neglect, reporting reactions to medication or problems with products, and to notify people who may have been exposed to a disease or are at risk of spreading the disease.
- To report **domestic violence and adult abuse or neglect** to government authorities if necessary to prevent serious harm.
- For **health oversight activities**, including audits, investigations, surveys and inspections, and licensure. These activities are necessary for government to monitor the health care system, government programs, and compliance with civil rights laws. Health oversight activities do not include investigations that are not related to the receipt of health care or receipt of government benefits in which you are the subject.
- For **judicial and administrative proceedings**, including hearings and disputes. If you are involved in a court or administrative proceeding we will disclose information if the judge or presiding officer orders us to share the information.
- For **law enforcement purposes**, in response to a court order or subpoena, to report a possible crime, to identify a suspect or witness or missing person, to provide identifying data in connection with a criminal investigation, and to the district attorney in furtherance of a criminal investigation of client abuse.
- Upon your death, to **coroners or medical examiners** for identification purposes or to determine cause of death, and to **funeral directors** to allow them to carry out their duties.
- To organ procurement organizations to accomplish cadaver, eye, tissue, or **organ donations** in compliance with state law.
- For **research** purposes when you have agreed to participate in the research and the Privacy Oversight Committee has approved the use of the clinical information for the research purposes.
- To **prevent or lessen a serious and imminent threat** to your health and safety or someone else's.
- To authorized federal officials for intelligence and other **national security** activities authorized by law or to provide **protective services to the President** and other officials.
- To **correctional institutions** or **law enforcement officials** if you are an inmate and the information is necessary to provide you with health care, protect your health and safety or that of others, or for the safety of the correctional institution.
- To **governmental agencies that administer public benefits** if necessary to coordinate the covered functions of the programs.

Uses and Disclosures that Require Your Agreement:

The Organization may disclose information to the following persons if we tell you we are going to use or disclose it and you agree or do not object:

- To **family members and personal representatives** who are involved in your care if the information is relevant to their involvement and to notify them of your condition and location.
- To **disaster relief organizations** that need to notify your family about your condition and location should a disaster occur.
- For **fundraising** purposes, we may disclose information to a charitable program that assists us in fundraising with your permission. You have the right to refuse or opt out if you previously agreed to communications regarding fundraising.
- For marketing of health- related services, we will not use your health information for marketing communications without your permission.

Authorization Required For All Other Uses and Disclosures:

- For all other types of uses and disclosures not described in this Notice, Organization will use or disclose information only with a written authorization signed by you that states who may receive the information, what information is to be shared, the purpose of the use or disclosure and an expiration for the authorization. Written authorizations are always required for use and disclosure for marketing purposes, such as agency newsletters and press releases.

  Note: If you cannot give permission due to an emergency, the Organization may release information in your best interest. We must tell you as soon possible after releasing the information.

  You may revoke your authorization at any time. If you revoke your authorization in writing we will no longer use or disclose your information for the reasons stated in your authorization. We cannot, however, take back disclosures we made before you revoked and we must retain information that indicates the services we have provided to you.

Changes to this Notice:

We reserve the right to change this Notice. We reserve the right to make changes to terms described in this Notice and to make the new notice terms effective to all information that the Organization maintains. We will post the new notice with the effective date on our website at www.achieveny.org and in our facilities. In addition, we will offer you a copy of the revised notice at your next scheduled service planning meeting.

Complaints:

If you believe your privacy rights have been violated, you may file a complaint with:

- Julye L. Bush, Corporate Compliance Officer, Privacy Officer
  Address: 125 Cutler Pond Rd, Binghamton, NY. 13905
  Phone: Confidential Hotline – (607) 723-8361, Select #8
  E-mail:jbush@achieveny.org
- Or, you may contact the Director of Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F HHH Bldg., Washington, D.C. 20201, and Secretary of the Department of Health and Human Services. You may call them at (877) 696-6775 or write to them at 200 Independence Ave. S.W., HHH Building Room 509H, Washington DC, 20201.
- You may file a grievance with the Office of Civil Rights by calling or writing Region II – US Department of Health and Human Services, Jacob Javits Federal Building, 26 Federal Plaza, Suite 3312, New York, New York 10278, Voice Phone (800) 368-1019, FAX (212) 264-3039, TDD (800) 537-7697.

All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

SECTION TWO

(Complete and Return to ACHIEVE BY MAY 22, 2020)

ACHIEVE 2020 SUMMER PROGRAM APPLICATION PACKET

1. Student Application (6 pages)
   Including; Emergency Contact Information sheet, Permission Form, and Acknowledgement Page

2. Payment Information

   Including: CDBG Grant form (Town of Union Students only)

   CM Letter (Waiver Eligible Students Only)

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

ACHIEVE Summer Program

STUDENT APPLICATION (Page 1)

This application must be filled out completely and returned by May 22, 2020

STUDENT INFORMATION

Student Name _____ Date of Birth _____ Age _____

Social Security # _____ Student Sex: M F

Is Student in Foster Placement? Yes _____ No _____ Children's Home? Yes _____ No _____

Primary Disability _____ Secondary Disability _____

Street Address/PO Box _____ City_____ _____

State _____ Zip Code _____ Town _____

Name of Parent/Guardian _____ Phone Number _____

Parent email address _____

Is this the first time the student is attending ACHIEVE's Summer Program? Yes _____ No _____
If not, what previous years has the student attended? _____

Is Student enrolled in OPWDD Medicaid Waiver? _____ Medicaid # _____

Care Manager _____ Agency _____

Care Manager Agency Phone Number _____

SCHOOL INFORMATION:

School District _____ Name of School _____

Teacher Name _____ School Telephone Number _____

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

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

Is student on a 12-month program? Yes _____ No _____
Is your student eligible for a free school lunch? Yes ____ No _____ Reduced lunch? Yes ____ No ____

Does student require transportation? To Program_____ From Program_____ None Needed_____

(form continued on next page)

ACHIEVE Summer Program

STUDENT APPLICATION – CONTINUED (Page 2)

Please answer the following questions:

Swimming:

Does student have difficulty swimming in chlorinated pools? Yes_____ No _____

If yes, please explain _____

Does student have tubes present in one or both ears at this time? Yes _____ No _____

Does student know how to swim? Yes _____No _____ Comments: _____

Is there a reason that the student should not be allowed to swim? Yes _____ No _____

If yes, please explain _____

Does student have a history of seizures? Yes _____ No _____

Independence Skill Level, please provide comments for any "Needs Assistance"

	Independent			
	YES	NO	Needs Assistance	Comments
AMBULATORY				
EATING				
TOILETING				
SPEECH				
DRESSES SELF				
USE OF SPECIAL DEVI				

Is student (14 – 21 years of age) interested in participating in the Summer Work Program? **(NY State working papers must be obtained for students under 18) Contact Program Coordinator for More Information.**

Yes _____ No _____

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

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

(form continued on next page)

ACHIEVE Summer Program

STUDENT APPLICATION – CONTINUED (Page 3)

Please answer the following questions:

Health History:

Does student have a seizure disorder? Yes _____ No _____

Type _____ Frequency _____

Date of Last seizure _____ Duration _____

Emergency protocol in case student has a seizure while at Program _____

_____

Does student have a cardiac condition that limits his/her activities? Yes _____ No _____

If yes, please explain _____

Is student allergic to any foods? Yes _____ No _____

If yes, please explain _____

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

If yes, please explain _____

Does student have allergic reactions to any medical treatments or drugs? Yes _____ No _____

If yes, please explain _____

Does student have any other medical conditions or injuries that would restrict their activity?
Yes _____ No _____

If yes, please explain _____

Does student have allergies to bee stings requiring medication? Yes _____ No _____

Medication _____

Does student have other allergies requiring medication? Yes _____ No _____

Name of Allergies _____ Medication _____

_____ _____

_____ _____

Does the student take any Medication that will need to be administered during Program?
Yes _____ No _____ *If yes, list medication in Section 4. A prescription will be required for all medications including over the counter.*

(form continued on next page)

ACHIEVE Summer Program

EMERGENCY CONTACT INFORMATION (Page 4)

Student Name _____ Age _____ Date of Birth _____

1. Parent/Guardian _____ Home Phone _____

Relationship to Student _____ Cell Phone _____

Employment _____ Work Phone _____

Address (if different than Student) _____

2. Parent/Guardian _____ Home Phone _____

Relationship to Student _____ Cell Phone _____

Employment _____ Work Phone _____

Address (if different than Student) _____

3. Doctor to Contact in an Emergency _____ Phone _____

Preferred Hospital in an Emergency _____

List health concerns or injuries _____

_____

In the event that 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.

At least one emergency contact is required

Name of Relative/Friend _____ Phone _____

Relationship to Student _____ Address _____

Name of Relative/Friend _____ Phone _____

Relationship to Student _____ Address _____

Name of Relative/Friend _____ Phone _____

Relationship to Student _____ Address _____

Legal Guardian Signature _____ **Date** _____

(form continued on next page)

ACHIEVE Summer Program
AUTHORIZATION/RELEASE FORM (Page 5)

Indicate Yes or No for Each Item and Sign the bottom of the form

Student Name _____

MEDICAL EMERGENCIES

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

_____ Yes _____ No

CARE MANAGER INFORMATION

I give permission for ACHIEVE staff to contact my student's Care Manager to obtain the necessary paperwork (i.e.; ISP, OPWDD eligibility, Waiver enrollment, psychological reports) to enroll my student in the ACHIEVE's Children's Summer Program.

_____ Yes _____ No _____ N/A

FIELD TRIP RELEASE

I give my student permission to participate in all field trips which are included as part of normal Summer Program activities.

_____ Yes _____ No

PICTURE RELEASE

I give permission for ACHIEVE staff to take pictures and/or video of my student. My student's images may be used for promotional purposes (i.e.; local newspaper, brochures, web site, Facebook)

_____ Yes _____ No

MEDICATION ADMINISTRATION (A physician's order must be sent for all medications including over the counter.) List Medications in Section 4.

I give permission for ACHIEVE's Children's Summer Program nursing staff/medication certified staff to administer medications to my student.

_____ Yes _____ No

Legal Guardian Signature _____ **Date** _____

(form continued on next page)

ACHIEVE Summer Program

Acknowledgement Page (Page 6)

Please read and Sign below your acknowledgment of the following:

Student Name _____

I hereby acknowledge that I have received a copy of ACHIEVE Summer Program General Information Sheet, and I understand my responsibilities in regards to; registration, payment, transportation and Obtaining Physician's Certificate and PPD if applicable.

_____ Yes _____ No

I hereby 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 student.

_____ Yes _____ No

I hereby acknowledge that I received the Individual Rights and Freedom from Abuse, Neglect and Mistreatment pamphlet. Included on this pamphlet are instructions on who to contact if you feel your rights have been violated or you suspect abuse or neglect.

_____ Yes _____ No

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

_____ Yes _____ No

Yes / No (circle one) I would like to receive a copy of any amended Notice of Privacy Practices

to: _____
Address

Legal Guardian Signature _____ **Date** _____

(form continued on next page)

ACHIEVE Children's Summer Program

Payment Options

Circle your method of payment

Student Name: _____

1. **Medicaid Waiver Program:** Please contact your Care Manager (CM) to obtain the necessary documentation for enrollment in ACHIEVE Summer Program. Attached, for your convenience, please find a letter to your CM requesting the required documentation. Simply fill it in and forward to your CM.

2. **Self-Pay:** include your payment of $400.00 with application: **Completed applications received before the deadline date of May 22, 2020 will be discounted to $350.00. *New this year* Payment Plan option: Pay $100 at time of application submission with balance of $300 due by July 3rd or balance of only $250 if paid in full by May 22nd.** Expectable methods of payment are; check, money order, or credit card. *Please Make Checks Payable to ACHIEVE and include your Student's Name on the memo line of your check.*

Credit Card Authorization: If paying by Credit Card, please fill in the information below

I hereby Authorize ACHIEVE to charge my credit card $_____

Prior to 5/22/20 $350.00 - 5/23/20 or after $400.00

Visa _____ Master Card _____ Discover _____

Name as it appears on card _____

Billing Address _____

_____

Credit Card Number: _____

Expiration Date: _____ / _____ 3 Digit Security Code: _____

Signature _____

3. **Grant Application, (City of Binghamton and Town of Union Residents Only)** Income and residency restrictions apply. Fill out the *attached CDBG Funded Public Service Program Application* ***(Make sure you select the correct form for your residency)*** *and Provide Documentation for Residency and Income as* instructed on the forms. **Grant spots are limited and will be awarded based on Individual Need and Recite of COMPLETED application.**

Please Note: All residents of the City of Binghamton & Town of Union must fill out the attached CDBG form, regardless of payment type. The information is kept confidential and is used for demographic reporting purposes only. Thank You!

CDBG FUNDED PUBLIC SERVICE PROGRAM

Restoring The Pride

Name of Applicant: _____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

ETHNICITY (select only one):

_____ Hispanic or Latino _____ Not Hispanic or Latino

RACE (select one or more):

_____ American Indian or Alaska Native _____ Asian

_____ Black or African American _____ White

_____ Native Hawaiian or Other Pacific Islander

Is applicant and/or any household member an employee for the City of Binghamton: ___ Yes ___ No

Female Head of Household: ___ Yes ___ No **No. of household members currently employed:** ___

Household Income (please circle):

No. of household members	Level 1 (at or below)	Level 2 (at or below)	Level 3 (at or below)
1	$14,050.00	$23,450.00	$37,450.00
2	$16,460.00	$26,800.00	$42,800.00
3	$20,780.00	$30,150.00	$48,150.00
4	$25,100.00	$33,450.00	$53,500.00
5	$29,420.00	$36,150.00	$57,800.00
6	$33,740.00	$38,850.00	$62,100.00
7	$38,060.00	$41,500.00	$66,350.00
8	$42,380.00	$44,200.00	$70,650.00

In order to be considered eligible for the CDBG program, applicants must provide current proof of residency and income for all currently employed household members. Listed below are acceptable forms of documentation.

Acceptable Documentation for Residency
Cable Bill
Phone Bill
Utility Bill
Driver's License
Sheriff's Identification Card

Acceptable Documentation for Income
Unemployment Payment
Social Services Budget
Pay Stub
W-2 Form
Social Security Income Form

PLEASE REVIEW AND SIGN REVERSE SIDE OF FORM

If you are unable to provide current proof of residency and income, please explain why.

I understand that all information provided herein meets the eligibility requirements for the CDBG program and will be used for HUD reporting purposes only. By signing below, I declare that the above information is true and correct to the best of my knowledge.

Signature of Applicant: _____ Date: _____

CDBG FUNDED PUBLIC SERVICE PROGRAM

Name of Applicant: _____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

ETHNICITY (select only one):

_____ Hispanic or Latino _____ Not Hispanic or Latino

RACE (select one or more):

_____ American Indian or Alaska Native _____ Asian

_____ Black or African American _____ White

_____ Native Hawaiian or Other Pacific Islander _____ Asian *and* White

_____ American Indian or Alaska Native *and* White _____ Black or African American *and* White

_____ American Indian or Alaska Native *and* Black or African American

_____ Other or More than one race

Female Head of Household: ___ Yes ___ No **No. of family members currently employed:** _____

Family Income (please circle):

No. of family members living in household	Extremely Low (30% of Median)	Very Low (50% of Median)	Low (80% of Median)
1	Up to $13,800	$13,801- $23,000	$23,001- $36,800
2	Up to $16,240	$16,241- $26,300	$26,301- $42,050
3	Up to $20,420	$20,421- $29,600	$29,601 - $47,300
4	Up to $24,600	$24,601- $32,850	$32,851- $52,550
5	Up to $28,780	$28,781- $35,500	$35,501- $56,800
6	Up to $32,960	$32,961- $38,150	$38,151- $61,000
7	Up to $37,140	$37,141- $40,750	$40,751- $65,200
8	Up to $41,320	$41,321- $43,400	$43,401- $69,400

In order to be considered eligible for the CDBG program, applicants must provide current proof of residency and income for all currently employed family members living in the household. Listed below are acceptable forms of documentation.

Acceptable Documentation for Residency
Cable Bill
Phone Bill
Utility Bill
Driver's License
Sheriff's Identification Card

Acceptable Documentation for Income
Unemployment Payment
Veteran's Administration Stub
Social Services Identification Card
Pay Stub
W-2 Form
Social Security Income Form

PLEASE REVIEW AND SIGN REVERSE SIDE OF FORM

If you are unable to provide current proof of residency and income, please explain why.

I understand that all information provided herein meets the eligibility requirements for the CDBG program and will be used for HUD reporting purposes only. By signing below, I declare that the above information is true and correct to the best of my knowledge.

Signature of Applicant: _____ Date: _____

Waiver Eligible Students
Forward to your Care Manager

Dear Care Manager,

I wish for my child _____ (name) to attend ACHIEVE's 2020 Summer Program which will run this year from July 6 through August 13, 2020.

Please forward the following information to ACHIEVE so they can enroll my child.

All Students:

- Life Plan (with addendum stating ACHIEVE as hourly respite with valued outcome)
- LCED
- Most Recent Psychological Report
- Notice of Decision*
- Request for Service Authorization (543 quarters)*

Thank You,

I authorize my CM to forward the necessary paperwork for _____ (student name) to ACHIEVE.

Please Send to: ACHIEVE
Attention: Tami Stasko, Summer Program Coordinator
125 Cutler Pond Road
Binghamton, NY 13905

Email: tstasko@achieveny.org

Questions by phone: 607-231-5235

_____ _____
Parent or Guardian Signature Date

_____
Print Name

*Not needed for students who attended Summer Program in 2019

SECTION Three

(Academic Section – Return to ACHIEVE by May 22, 2020)

ACHIEVE 2020 SUMMER PROGRAM APPLICATION PACKET

1. Academic Information Form – to be completed by Teacher
2. Attach current:
   - IEP

   -OR-
   - 504

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

ACHIEVE Children's Summer Program

ACADEMIC INFORMATION

FOR THE PARENT

I give permission to release the following information to ACHIEVE for my student _____.
(student name)

Signature of Parent/Guardian _____ Date _____

Print Name _____

FOR THE TEACHER

Please attach a current IEP or 504 plan with this document and return to ACHIEVE by May 22, 2020. Thank you.

In order to provide a safe, structured environment for our students during ACHIEVE's Children's Summer Program we are requesting that you *forward a detailed behavior management plan that is successful for the student.*

Student Name _____ Age _____

Classification _____ School District _____

Current placement and/or grade level _____

Teacher Name _____ Special Ed Teacher Name _____

Is a behavior plan necessary? Yes _____ No _____

Does student require a personal aide? Yes _____ No _____

If yes, please explain _____

List behavioral concerns:

List one summer goal for reading:

List one summer goal for math:

(form continued on reverse side)

Please give specific information regarding the student's academics in the following areas:

Reading Level _____ Comments:

Writing Level _____ Comments:

Speech/Language: Verbal _____ Non-Verbal _____ Use of Communication device _____

Comments:

Daily Living Skills:

Fine/Gross Motor:

Additional Comments:

_____ _____ _____

Signature of person completing form **Title** **Date**

_____

Contact Email Address

Please Return Form To:

ACHIEVE
Attn: Tami Stasko
125 Cutler Pond Road
Binghamton, NY 13790
Email to: tstasko@achieveny.org
Phone: 607-231-5235 Fax 607-231-5311

Please give specific information regarding the student's academics in the following areas:

Reading Level _____ Comments:

Writing Level _____ Comments:

Speech/Language: Verbal _____ Non-Verbal _____ Use of Communication device _____

Comments:

Daily Living Skills:

Fine/Gross Motor:

Additional Comments:

_____ _____ _____

Signature of person completing form **Title** **Date**

_____

Contact Email Address

Please Return Form To:

ACHIEVE
Attn: Tami Stasko
125 Cutler Pond Road
Binghamton, NY 13790
Email to: tstasko@achieveny.org
Phone: 607-231-5235 Fax 607-231-5311

SECTION FOUR

(PHYSICIAN – Return to ACHIEVE by May 22, 2020)

ACHIEVE 2020 SUMMER PROGRAM APPLICATION PACKET

1. Physician's Certificate (PPD not required if student attended Program for **2 consecutive years.)**

2. Medication Authorization

Note: If physical will be delayed due to insurance restrictions please provide the date it will be available.

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

ACHIEVE Summer Program
PHYSICIAN'S CERTIFICATE

This form is to be completed by the student's physician. Form must be returned by May 22, 2020.
Note: If this form will be delayed due to insurance restrictions, please provide date of Physical.

Student Name: _____ Date of Birth: _____

Height: _____ Weight: _____n

PPD MANTOUX TUBERCULIN SKIN TEST: (A tine test is not accepted)
As an OPWDD certified Agency, ACHIEVE requires all students to receive a PPD Mantoux Tuberculin Skin Test within one year of the start of program.

NOTE: If the student has attended Summer Program for two consecutive years this requirement has been fulfilled and a PPD will not be required.

Test Date: _____ Test Material Used: _____

Signature of Person Administering Test: _____

Size of Reaction in MM: _____ Interpretation:

_____

Date Read: _____ Signature of Person Evaluating Test: _____

MEDICATION AUTHORIZATION:
ACHIEVE's Certified Nursing Staff requires a physician's order to administer medications. Please include all routine and PRN medications including over the counter medication. Please provide dosage, frequency, and time given (i.e. before or after lunch)

Date Ordered	Physician Order (include dosage, frequency, time given)	Stop Order Date

Physician Signature _____ Date _____

Print Name _____

(form continued on reverse side)

PHYSICAL ASSESSMENT:

Please check any area that might be a concern during the six week Summer Program. Please give detailed explanation.

Head ____ Comments: _____

Nose ____ Comments: _____

Neck ____ Comments: _____

Back ____ Comments: _____

Ears ____ Comments: _____

Mouth ____ Comments: _____

Chest ____ Comments: _____

Lungs ____ Comments: _____

Heart ____ Comments: _____

Abdomen ____ Comments: _____

Genitourinary ____ Comments: _____

Nervous System ____ Comments: _____

Allergies ___Comments: _____

Additional Comments:

Signature of Health Care Professional _____ Date _____

Print Name _____

Address _____

Phone _____

Please Return Form To:

ACHIEVE
Attn: Tami Stasko
125 Cutler Pond Rd
Binghamton , NY 13905
Email: tstasko@achieveny.org
Phone: 607-231-5235 Fax 607-231-5311