



## SUMMER PROGRAM 2023

Dear Parent or Guardian:

We are pleased to announce that in the Summer of 2023, 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 2023 Summer Program will be held at Calvin Coolidge Elementary School, 261 Robinson St. Binghamton, 13904.

### 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 2023 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 me at [tstasko@achieveny.org](mailto:tstasko@achieveny.org), or by phone at 607-766-1099.

Hope to see you this summer!

Tami Stasko  
Summer Program Coordinator

125 Cutler Pond Road Binghamton, NY 13905

607.766.1099

fax: 607.231.5311

Email: [info@achieveny.org](mailto:info@achieveny.org) • Website: [www.achieveny.org](http://www.achieveny.org)





# ACHIEVE 2023 Summer Program General Information Sheet

## PROGRAM DATES/TIMES

July 10, 2023 – August 17, 2023  
Monday through Thursday  
8:30 am – 2:15 pm

**Special note: The program will close at 12:00 pm on August 17, 2023. Please make necessary arrangements to pick up students either at the program or at the designated pick-up/drop-off location.**

## PROGRAM LOCATION

Calvin Coolidge Elementary School  
261 Robinson St.  
Binghamton, NY 13904

## 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 **Care Manager (CM)** to obtain the necessary documentation. For your convenience, a letter to CM is included in the application section of your packet, please fill it out and forward it to your CM.

**Self-Pay:** The tuition for each student in 2023 will be \$500.00. 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 19, 2023 will be discounted to \$450.00.**

**Payment Plan Option:** pay \$100 at time of application submission with balance of \$400 due by July 1st or balance of only \$350 if paid in full by May 19th.

Accepted methods of payment are Visa, Master Card, personal checks, cash and money orders. Arrangements to make a cash payment can be made. Please contact me at 607-766-1099 if you need to make a cash payment.

**ACHIEVE Scholarship Opportunity:** Some students may be eligible for financial assistance through ACHIEVE. **Income restrictions apply.** Scholarship spots are limited and will be awarded based on Individual need and receipt of completed application. To apply for this scholarship, you must fill out the ACHIEVE Summer Program Scholarship form and return to ACHIEVE along with a signature and proof of income.

**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 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 19, 2023.** \*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 a limited number of hours 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, teamwork, 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 an "X" in the YES box on **page 2** of the Student Application.

## **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 2023 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

# SECTION ONE

**(Keep for your records)**

## ACHIEVE 2023 SUMMER PROGRAM APPLICATION PACKET

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



## **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.
- Follow COVID 19 safety guidelines if tested positive, and report any symptoms/exposures to the Summer Program Coordinator.

**(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 Binghamton City School District. We are guests at their facility. It is their right to suspend a student should they steal, 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 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 restriction is necessary to protect the health or safety of an individual rights. This is only done when less intrusive approaches have been tried and were not successful or when the.

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

Broome-Chenango-Tioga County Chapter NYSARC, Inc, dba ACHIEVE  
HIPAA/HITECH Policies and Procedures

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**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](mailto:jbush@achieveny.org)

# Broome-Chenango-Tioga County Chapter NYSARC, Inc, dba ACHIEVE HIPAA/HITECH Policies and Procedures

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## **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 through 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.

Broome-Chenango-Tioga County Chapter NYSARC, Inc, dba ACHIEVE  
HIPAA/HITECH Policies and Procedures

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- 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 Your 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](mailto: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](http://www.achieveny.org)

Broome-Chenango-Tioga County Chapter NYSARC, Inc, dba ACHIEVE  
HIPAA/HITECH Policies and Procedures

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**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.

Broome-Chenango-Tioga County Chapter NYSARC, Inc, dba ACHIEVE  
HIPAA/HITECH Policies and Procedures

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**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.

Broome-Chenango-Tioga County Chapter NYSARC, Inc, dba ACHIEVE  
HIPAA/HITECH Policies and Procedures

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**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](http://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.



Broome-Chenango-Tioga County Chapter NYSARC, Inc, dba ACHIEVE  
HIPAA/HITECH Policies and Procedures

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**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](mailto: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 19, 2023)**

## ACHIEVE 2023 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 and Binghamton Students only)

ACHIEVE Scholarship Form

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 19, 2023***

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

**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		Needs Assistance	Comments
	YES	NO		
AMBULATORY				
EATING				
TOILETING				
SPEECH				
DRESSES SELF				
USE OF SPECIAL DEVICES				

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?

**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.*

**ACHIEVE Summer Program**  
**EMERGENCY CONTACT INFORMATION (Page 4)**

Student Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

1. Parent/Guardian \_\_\_\_\_ Home 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** \_\_\_\_\_



**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., Life Plan, 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 \_\_\_\_\_

**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 regarding 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 \_\_\_\_\_

### ACHIEVE 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 \$500.00 with application: **Completed applications received before the deadline date of May 19, 2023 will be discounted to \$450.00.** **Payment Plan option:** Pay \$100 at time of application submission with balance of \$400 due by July 3rd or balance of only \$350 if paid in full by May 19th. Acceptable 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 5/19/23 \$450.00 - 5/20/23 or after \$500.00

Visa \_\_\_\_\_ Master Card \_\_\_\_\_ Discover \_\_\_\_\_

Name as it appears on card \_\_\_\_\_

Billing Address \_\_\_\_\_

Credit Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ / \_\_\_\_\_ 3 Digit Security Code: \_\_\_\_\_

Signature \_\_\_\_\_

- 3. ACHIEVE Scholarship Program:** Income restrictions apply. Fill out the *attached ACHIEVE Scholarship Program Application and Provide Documentation for Income* as instructed on the forms. **Scholarships are limited and will be awarded based on Individual need and receipt of COMPLETED application.**

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





## 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

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

Female Head of Household: \_\_\_ Yes \_\_\_ No      No. of family members currently employed: \_\_\_\_\_

Family Income (please circle):

No. of family members living in household	Level 1	Level 2	Level 3
1	\$15,200	\$25,350	\$40,500
2	\$17,420	\$28,950	\$46,300
3	\$21,960	\$35,550	\$52,100
4	\$26,500	\$36,150	\$57,850
5	\$31,040	\$39,050	\$62,500
6	\$35,580	\$41,950	\$67,150
7	\$40,120	\$44,850	\$71,750
8+	\$44,660	\$47,750	\$76,400

*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  
 Social Services Budget  
 Pay Stub  
 W-2 Form  
 Social Security Income Form



# 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 \$15,200	\$15,201- \$25,360	\$25,361- \$40,500
2	Up to \$17,420	\$17,421- \$28,950	\$28,951- \$46,300
3	Up to \$21,960	\$21,961- \$32,550	\$32,551 - \$52,100
4	Up to \$26,500	\$26,501- \$36,150	\$36,151- \$57,850
5	Up to \$31,040	\$31,041- \$39,050	\$39,051- \$62,500
6	Up to \$35,580	\$35,581- \$41,950	\$41,951- \$67,150
7	Up to \$40,120	\$40,121- \$44,850	\$44,851- \$71,750
8	Up to \$44,660	\$44,661- \$47,750	\$47,751 \$76,400

*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**





# ACHIEVE SUMMER PROGRAM SCHOLARSHIP APPLICATION

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 \$15,200	\$15,201- \$25,360	\$25,361- \$40,500
2	Up to \$17,420	\$17,421- \$28,950	\$28,951- \$46,300
3	Up to \$21,960	\$21,961- \$32,550	\$32,551 - \$52,100
4	Up to \$26,500	\$26,501- \$36,150	\$36,151- \$57,850
5	Up to \$31,040	\$31,041- \$39,050	\$39,051- \$62,500
6	Up to \$35,580	\$35,581- \$41,950	\$41,951- \$67,150
7	Up to \$40,120	\$40,121- \$44,850	\$44,851- \$71,750
8	Up to \$44,660	\$44,661- \$47,750	\$47,751 \$76,400

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

**Acceptable Documentation for Income:**

- |                               |                                     |
|-------------------------------|-------------------------------------|
| Unemployment Payment          | Social Security Income Form         |
| Veteran’s Administration Stub | Pay Stub                            |
| W-2 Form                      | Social Services Identification Card |



## Forward to your Care Manager

Dear Care Manager,

I wish for my child \_\_\_\_\_ (name) to attend ACHIEVE's 202 Summer Program which will run this year from July 10 through August 17, 2023.

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 (552 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](mailto:tstasko@achieveny.org)

Questions by phone: 607-766-1099

\_\_\_\_\_  
Parent or Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name



# SECTION THREE

**(Academic Section – Return to ACHIEVE  
by May 19, 2023)**

## ACHIEVE 2023 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 19, 2023. 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 Rd

Binghamton NY, 13905

Email to: [tstasko@achieveny.org](mailto:tstasko@achieveny.org)

Phone: 607-766-1099

Fax: 607-723-8338



# SECTION FOUR

**(PHYSICIAN – Return to ACHIEVE by May 19, 2023)**

## ACHIEVE 2023 SUMMER PROGRAM APPLICATION PACKET

1. Physician's Certificate (including PPD information)
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 19, 2023.***

***Note: If this form will be delayed due to insurance restrictions, please provide date of Physical.***

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**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.***

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

(Form continued on reverse side)

**PHYSICAL ASSESSMENT**

***Are there any areas that might be a concern during the six week Summer Program:***

<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Head</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Nose</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Neck</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Back</b>
<input type="checkbox"/>	<input type="checkbox"/>	<b>Ears</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Mouth</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Chest</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Lungs</b>
<input type="checkbox"/>	<input type="checkbox"/>	<b>Heart</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Abdomen</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Allergies</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Lungs</b>
<input type="checkbox"/>	<input type="checkbox"/>	<b>Nervous System</b>				<input type="checkbox"/>	<input type="checkbox"/>	<b>Genitourinary</b>			

***If Yes to any, please describe:***

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**COVID 19 Vaccination**

**Date(s) of vaccination:**

**Johnson & Johnson:** \_\_\_\_\_ **Moderna:** \_\_\_\_\_ and \_\_\_\_\_

**Pfizer:** \_\_\_\_\_ and \_\_\_\_\_ **Booster:** \_\_\_\_\_

**Additional Comments:**

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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  
[tstasko@achieveny.org](mailto:tstasko@achieveny.org)  
Phone: 607-766-1099 Fax 607-231-5311

