JIMMY VEJAR SUMMER FUN PROGRAM 2024

Admission Application Packet

SUMMER 2024

JIMMY VEJAR SUMMER FUN AT CPW
1186 King Street Rye Brook NY 10573
Kamesha Pollard, Program Specialist
Phone: 914.937.3800 ext. 640 • kamesha.pollard@cpwestchester.org

Admission Application Table of Contents

Please print all forms (pgs. 2 – 16) and return to CPW via email or mail by May 10, 2024

Return to: Cerebral Palsy of Westchester, 1186 King St, Rye Brook, NY 10573-Attn: JVSF / Kamesha.pollard@cpwestchester.org

**** For participant with OPWDD eligibility, please fill out and return the additional OPWDD Waiver Form. This can be found on the CPW website at cpwestchester.org/summer or by clicking HERE ****

JIMMY VEJAR SUMMER FUN PROGRAM 2024

Summer Fun Program Registration / Basic Information Form

This page is not required if it was previously submitted online

Please return this form with payment to the address below or register online at https://cpwestchester.org/summer/.
To reserve your spot, we need to receive either a deposit of 50% of the total cost OR payment in full along with this Basic Information Form. Full Admissions Application Forms need to be received by **May 10, 2024**.

Program Tuition for 6-Week Session (June 24 - August 2, 2024) - $3,900

Please note: extended session available (Additional add-on weeks available for $650 per week, August 5 – August 23).

Today's Date: _____
Participant's Name: _____
Address: _____
Telephone: _____ Date of Birth: _____

Parent/Guardian Information

Relationship to Participant: __ Mother __ Father __ Other: _____
First name: _____ Last name: _____
Phone number (Home): _____ (Work): _____(Cell): _____
Address: _____
Email Address: _____

Emergency Contacts & Authorized Pick-Up Person(s) (in addition to parent/guardian)

1. Name: _____ 2. Name: _____
Relationship to Participant: _____ Relationship to Participant: _____
Phone: _____ Phone: _____

Participant's Commitment
Participant's Signature**:** _____ Date: _____

Parent/Guardian Agreement
Parent/Guardian Signature Required**:** _____Date**:** _____

☐ **Payment Enclosed. Amount of payment: $_____**

Please make checks payable and mail to: **Cerebral Palsy of Westchester, 1186 King St, Rye Brook, NY 10573-Attn: JVSF**

If you have questions, please call Kamesha Pollard at (914) 937-3800 ext. 640 / email kamesha.pollard@cpwestchester.org

Annual Physical Exam Form

Child's Name: _____ Date of Birth: _____

Date of Exam: _____ Completed By: _____

(To be Completed by Physician, Physician's Assistant or Nurse Practitioner)

Height: _____ Weight: _____ Temp: _____ Pulse: _____ B/P: _____

1. General appearance/Skin/Mental Status/Behavior Patterns Language & Communicative Skills:_____
   _____
   _____
2. Head and Neck (General):
   _____
   _____
3. Eyes: Exam/Visual R/L: _____
4. Ears: _____
5. Nose: _____
6. Mouth: _____
7. Throat: _____
8. Dentition: _____
9. Neck: _____
10. Chest: _____
    Heart: _____
    Lungs: _____
    Breasts: _____
11. Abdomen: Note Liver: _____
    Spleen: _____
    Hernia: _____
12. Genetalia: _____
13. Recto/Procto: _____
14. Back/Spine: _____
15. Extremities: _____
16. Lymph Nodes: _____
17. Neurological: _____
18. Medications: _____
19. Allergies: Please list all other allergies including food:
    _____
    _____

JIMMY VEJAR SUMMER FUN PROGRAM 2024

Child's Name: _____ Date of Birth: _____

(To be Completed by Physician, Physician's Assistant or Nurse Practitioner)

CBC: _____ Test Date: _____

UA: _____ Test Date: _____

Hepatitis Antigen/Antibody: _____ Test Date: _____

PPD/Chest X-Ray: _____ Test Date: _____

Last Tetanus Inoculation: _____ Test Date: _____

Seizures: Type: _____

Medication: _____

Nutrition: Satisfactory: _____ Unsatisfactory: _____

Specify: _____

Diet: Regular ____ Chopped ____ Puree ____ Other _____

Are there any hearing, visual or dental conditions requiring special attention?

Yes ___ No ___

Past Medical History: _____

Diagnosis & Impressions: _____

Recommendations: _____

Restrictions/Limitations: _____

On the basis of my findings as indicated above and on my knowledge of the above-named child, I find that he/she is free from contagious and communicable disease Yes___ No___ and is able to participate in a summer day program. Yes___ No___

Physician's Name: (please print): _____

Physician's Signature: _____ Date: _____

Address: _____

Phone: _____ Fax: _____

Individual Behavior/Plan _____

If your child has an Individual Behavior Plan, the plan must be included with this application packet.

JIMMY VEJAR SUMMER FUN PROGRAM 2024

Child's Name: _____ Date of Birth: _____

(To be Completed by Physician, Physician's Assistant or Nurse Practitioner)

IMMUNIZATION RECORD

If one or more of the required medical immunizations is deemed detrimental to this child's health, attach written information specifying which immunization(s) and sign medical exemption statement on bottom of form.

(Include All Dates)

DPT	**1st**	**2nd**	**Booster**	**Booster**	**Booster**
ORAL POLIO	**1st**	**2nd**	**3rd**	**Booster**	**Booster**
Hepatitis B	**1st**	**2nd**	**3rd**		
MMR	**1st**	**2nd**			
Varicella					
Haemophilus Influenza Type B					
Other:					

TUBERCULIN TEST: Mantoux **Date: _____/_____/_____**	**Results:** **Positive Negative**

If <u>positive</u>, attach physician's statement documenting treatment and follow up.

MEDICAL EXEMPTIONS

The physical condition of the above-named child is such that immunization would endanger life or health.

_____ _____

Physician's Signature Date

Lab (required: if results not available please forward reports)

Physician's Swimming Authorization

It is Jimmy Vejar Summer Fun Participant's policy that any participant diagnosed with a seizure disorder must have a swimming release on file from the physician.

I, _____ (Print Name of Physician) authorize

_____ (Name of Child) to participate in the swimming

activities at Jimmy Vejar Summer Fun Program.

_____ Date: _____

Signature of Physician

Emergency Response Form

TO: PARENTS, GUARDIANS, PARTICIPANTS

In the event that a participant is injured or becomes seriously ill (requiring treatment beyond first aid), while at the Summer Fun Program, and emergency medical attention is required, he/she will be taken to the hospital deemed most appropriate by the responding Ambulance Company.

Should a participant require emergency medical attention, a staff member will accompany him/her if available. Staff is not able to make medical judgments or make decisions on behalf of a participant, therefore it is requested that the Primary Caregiver respond to our call, and arrive at the hospital within 45 minutes, or as soon as possible. Jimmy Vejar Summer Fun Program staff cannot assume responsibility for remaining with a participant beyond 45 minutes, arranging for hospital admission, signing for testing, or arranging transportation home from the Emergency Room.

Additionally, should Jimmy Vejar Summer Fun Program's staff identify that a participant is presenting with signs and symptoms of illness (i.e., including but not limited to vomiting, diarrhea or fever) and needs to return home, the Primary Caregiver will be asked to arrive at program within 45 minutes or as soon as possible to pick up participant.

If the Primary Caregiver is unable to meet their responsibility, two alternate contacts must be designated by the Primary Caregiver to assume the same responsibilities for the participant in the absence of the Primary Caregiver.

_____	_____
Name of Participant (Print)	Date
_____	_____
Primary Caregiver (Signature)	Best Contact Number:
_____	_____
Alternate Emergency Contact #1 (Print Name)	Best Contact Number:
_____	_____
Alternate Emergency Contact #2 (Print Name)	Best Contact Number:

Emergency Treatment Authorization

Permission:

I hereby authorize the below named participant's admission to the hospital deemed most appropriate by ambulance company or emergency personnel and/or it's clinical departments or divisions (the "Hospital"), and I authorize the hospital, the physicians, dentists, and allied health professionals and its staff to provide medical and/or dental care and to administer diagnostic tests and procedures, including but not limited to: diagnostic x-rays; the administration and/or injection of or pharmaceutical products and medications; the drawing of blood and administration of blood derivatives, as the patient's care. I understand the Hospital will attempt to contact me before performing other than routine medical and/or dental care; however, if I cannot be reached, I hereby grant the Hospital permission to provide such care and perform such procedures as are deemed necessary or advisable by the patient's attending physician or the Hospital.

No guarantees:

I acknowledge that no guarantee or assurances have been made to me concerning the treatments or examinations performed upon the patient in the Hospital.

Understanding of this form:

I confirm that I have read this form and fully understand its contents.

Name of Participant (Print): _____

Parent/Guardian (Signature): _____

Date: _____

Medical Insurance Carrier: _____

Identification Number: _____

Mealtime Questionnaire & Special Dietary Needs

If not applicable, please check here and sign below: N/A ____

Name of participant: _____ DOB: _____

Parent/Guardian's Name: _____

Phone Number: _____

1. Does the Participant require any special equipment during mealtime? If so, please describe:
   Dish_____ Cup_____ Spoon_____ Other_____
2. How is the Participant positioned during mealtime?
   At the table _____ In wheelchair: _____
   Other accommodations: _____
3. Does the Participant require assistance with meals?
   Eats independently: _____ Other (explain): _____
4. What is the Participant's food consistency?
   Regular solids _____ Chopped _____ Ground _____ Pureed _____
   Other (explain): _____
5. What is the drink consistency?
   Regular Liquids _____ Slightly Thickened (Nectar-like) _____ Thickened (Honey-like) _____
   No Liquids _____ Other (explain): _____
6. Allergies:
   No known allergies ____ Food allergies include _____
7. Swallowing status (If swallowing issues, please provide a swallowing evaluation)
   _____
8. Additional comments / information:
   _____

Parent/Guardian's Name (please print): _____Date: _____

Parent/Guardian's Signature: _____

Personal Care Profile

Participant's Name: _____Date: _____/_____/_____

Parent/Guardian's Name: _____ Phone _____/_____ /_____

Check if Applies:

____ Not Applicable

____ Wears disposable briefs / disposable diapers

____ Uses toilet

- ____ Independent
- ____ Requires trunk support
- ____ Requires grab bar
- ____ Requires one staff assist
- ____ Requires two staff assist
- ____ Requires mechanical lifter
- ____Can bear weight for transfer

____ Uses Changing Table

- ____ Stands leaning over table
- ____ Requires one staff assist
- ____ Requires two staff assist
- ____ Requires two staff lift for transfer
- ____ Requires mechanical lifter

Swimming Permission

Swimming Permission

I, _____ (Print Name of Parent/Guardian) give permission for _____ (Print Name of Participant) to participate in swimming activities with a certified Water Safety Instructor at the pool at the Jimmy Vejar Summer Fun Program.

_____ _____
Signature of Parent/Guardian Date

_____
Print

Sunscreen Permission

Sunscreen Permission

I give permission to have sunscreen applied to my child during outdoor activities.
(THE SUNSCREEN MUST BE SUPPLIED BY PARENT/GUARDIAN) Minimum acceptable SPF +40

_____ _____
Signature of Parent/Guardian Date

_____
Print

Insect Repellent Permission

Insect Repellent Permission

I give permission to have insect repellent applied to my child during outdoor activities.
(THE INSECT REPELLENT MUST BE SUPPLIED BY PARENT/GUARDIAN)

_____ _____

Signature of Parent/Guardian Date

_____

Print

Light Group Exercise/ Recreation Permission

Light Group Exercise / Recreation Permission

I hereby grant Jimmy Vejar Summer Fun Program permission to involve and assist_____ (Individual's Name) in voluntary, light group exercise and recreation, which may be planned during regular hours and may be a part the regular recreation program.

YES NO N/A

_____ _____

Signature of Parent/Guardian Date

_____

Print

Photo Permission and Media Release Form

An agency photographer may document daily activities of participants, this means someone from the Agency may take pictures of your child. The photos may be used in Jimmy Vejar Summer Fun Program publications, CPW website, social media, or local media to promote the Jimmy Vejar Summer Fun Program or CPW. On occasion, photos may be used in local print media in Jimmy Vejar Summer Fun Program ads or stories. Please sign below to permit the use of your child's photograph for Jimmy Vejar Summer Fun Program purposes.

I, the undersigned, give permission to Jimmy Vejar Summer Fun Program /CPW to photograph my child for whom I am parent/guardian, and give unlimited consent and permission (waiving all claims for any compensation by reason thereof), to use, publish/broadcast, republish/rebroadcast or exhibit in the furtherance of its work any photograph taken. I give my consent for the photograph(s) to be used with or without first name identification of my child for whom I am a parent/guardian. I also give Jimmy Vejar Summer Fun Program permission to include statements referring to my child for whom I am guardian in conjunction with these photos.

_____ _____

Participant's Name (print) Date

_____ _____

Parent/Guardian's Name (print) Signature

I grant permission to use:

- ☐ Participant's first name only
- ☐ Participant's first and last name
- ☐ Comments/Special considerations:

_____

_____

Transportation Release

I hereby grant Jimmy Vejar Summer Fun Program permission to provide transportation for

_____ (Name of participant).
This may include transportation to and from a variety of recreational activities.

YES ___ NO ___ N/A ___

** Please note that Jimmy Vejar Summer Fun Program does not provide transportation to and from program.**

TRANSPORTATION INFORMATION

(All Information Must Be Filled Out)

Does your child use a wheelchair: ___ Yes ___ No

If child has a wheelchair, please indicate ____ Power Chair ____ Manual Chair

If yes: Can child be moved to a seat? ____ Yes ___ No

___ I will be driving my child

___ My child will be taking ParaTransit

___ Other _____

_____ _____
Guardian's Print Date

_____ _____
Guardian's Signature Date

Food Restriction Notice

These foods should NOT be sent to program. They present either a choking or allergy hazard:

1. Peanut Butter / Peanuts
2. Raw Vegetables
3. Hot dogs / Sausage
4. Hard candy, gum, lollipops
5. Popcorn
6. Any meat on a bone or having small bones (e.g., chicken, fish). These foods are permitted if the meat is removed from the bone.
7. Fruits and vegetables with a skin should be peeled and should be seedless (e.g., apples, zucchini)
8. Grapes
9. Marshmallows

Notice of Privacy Practices

Our Privacy Commitment to You

At Cerebral Palsy of Westchester (CPW), we understand that information about you and your family is personal. We are committed to protecting your privacy and that of your records. Information is shared only when authorized, when necessary for treatment, payment, or health care operations or as mandated by State or Federal Law. In accordance with the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH Act), our privacy commitment to you is:

- All people involved in your care will protect your privacy and information will be shared only with the persons/organizations that you have authorized to view the information or for purposes permitted or required by law.
- Protected Health Information (PHI) includes records we keep or create that are related to your service provisions. This includes your past, present or future information, service plan, name, address, birth date, social security number, payment for services and other identifying information.
- CPW will comply with the breach notification requirements of HIPAA and the HITECH Act, and will notify you of a breach of unsecured health information.

This privacy notice describes how your health information may be used and disclosed, and how you may access your information. Please review it carefully. This privacy notice was updated on February 23, 2024.

CPW's Responsibility for Your Information

CPW is required by law to:

- Maintain the privacy of your records.
- Give you notice of our legal duties and practices concerning your health information.
- Follow the rules contained in this notice.
- Inform you of any material changes in privacy practice or your rights, based on our right to revise the privacy notice.
- You may obtain a copy of the most current privacy notice at cpwestchester.org or by calling CPW at 914-937-3800.

Your Health/Clinical Information Rights

You have the right to:

- **Review your health records and obtain a copy of the record.** We may charge a reasonable fee for the copies not to exceed $0.75 per page. We may deny your request under limited circumstances. If you are denied, you may request a review by CPW's Executive Director.
- **Request that CPW change or amend your health information** if you believe it is incorrect or incomplete. However, CPW may deny this request if we believe that the information is accurate. If the request is denied you may file a statement of disagreement with us, and we may prepare a rebuttal to your statement and will give you a copy. If the amendment is approved, your record will be changed, and we will inform others that need to be made aware. Information in reports not created by CPW may not be changed.
- **Request to receive confidential communication from us.** We will accommodate reasonable requests. We may condition this accommodation by asking for information on how payment will be handled or specifying an alternative address or method of contact.

- **Restrict use or disclosure of your health information.** You may ask us not to use your information for treatment, payment, or health care operations. You may request that any part of your information not be disclosed to family or friends involved in your care. CPW is not required to agree to a restriction you request, except as required by law or related to when the service is paid in full and out-of-pocket by yourself or someone else. If CPW believes that it is in your best interest to use/disclose your information, it will not be restricted. If CPW agrees with the restriction, we will follow the directive of that restriction unless it is needed to provide emergency treatment. Restriction must be requested in writing.
- **If the organization uses or maintains an electronic health record, you have the right to obtain such information in electronic format.**
- **Request a list of certain disclosures CPW has made of your health information**. The list of disclosures will not include disclosures for treatment, payment, or health care operations or disclosures made to yourself or disclosures to family members or friends involved in your care, per your request or notification purposes.
- **Receive a paper copy of the CPW privacy policy.**

Uses and Disclosures that Require Your Agreement and Authorization

- For marketing purposes
- Specific authorization is required for release of HIV/AIDS, mental health and psychotherapy notes and information.

How CPW Uses and Discloses Health Care Information

CPW may use and disclose health information without your permission only in the following situations:

- For treatment purposes within CPW and to outside health care providers who are part of your care. For example, CPW staff may discuss your health information with other individual health providers or organizations who are providing care, such as your physician or case manager.
- To provide health information needed to obtain payment for our services, such as making a determination of eligibility or coverage for insurance benefits. Bills may be sent to you or to third party payers such as insurance/health plans. This information may identify you, your diagnosis and service provided.
- For healthcare operations in support of the business activities of CPW. Activities may include, but are not limited to, quality assessment, training and education, licensing, audits, contracted third party "business associates" that perform activities for CPW, to contact you related to CPW fundraising activity. You may opt out of receiving fundraising information by calling the CPW Privacy Coordinator at 914-937-3800 ext. 721.
- For public health purposes to a public health authority permitted by law to receive such information for the purpose of controlling disease, injury, or disability.
- When required by federal or state law or when requested by authorized federal officials for intelligence or national security, protective services to the President, or military command authorities.
- To the governmental agency authorized by state or federal law to receive information on possible domestic violence, child abuse or neglect.
- For judicial, and law administrative proceedings, in response to a court order or in response to other lawful processes.
- To coroners, medical examiners, funeral directors, and organ donation organizations so they may carry out their duties as authorized by law. We may disclose such information in reasonable anticipation of death.

- Workers Compensation cases may require the disclosure of health information to comply with law.
- If authorized by law, to a person who may have been exposed to a communicable disease or at risk of contracting or spreading the disease.
- To a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.
- To law enforcement for suspicious death, pertaining to crime victims, in the event of a crime at CPW, medical emergency related to a possible crime, other legal processes required by law.
- For criminal activity to prevent or lessen the threat to health/safety of a person or the public or to identify and apprehend a person.
- To a person or company required by the Food & Drug Administration to report adverse effects, product defects, to enable product recalls, to report biologic product deviations or for other FDA activities required by law.
- To the extent that it is required by law. You will be notified as required by law of any such uses/disclosures.
- To the Department of Health & Human Services to determine our compliance with local and federal law.

Permitted & Required Uses and Disclosures That May Be Made with Your Authorization or Opportunity to Object

For all other types of uses and disclosures not described in this notice, CPW will use or disclose health information only with a written authorization signed by you or your authorized personal representative.

- To a family member, relative, close friend, or other person you identify that is involved in your healthcare
- To notify or assist in notifying a family member or personal representative or other person responsible for your care, location, general condition or passing.
- To an authorized public or private entity to assist in disaster relief and to coordinate use/disclosure to family or others involved in your care.

You may revoke your authorization at any time, but you must do so in writing. If you revoke your authorization in writing, we will no longer use or disclose your information for the reasons stated in the authorization. We cannot retrieve any disclosures made prior to revoking your authorization. We must also retain your health information that indicated the services we have provided to you.

If you cannot give permission or object to a disclosure, CPW may release health information if we determine it is in your best interest based on our professional judgment.

CPW Privacy Coordinator

Questions or concerns about CPW privacy policy, privacy practices, access to health information or this notice may be forwarded to the Privacy Coordinator at (914) 937-3800 ext.721. Written correspondence about these policies may be sent to: Privacy Coordinator, Cerebral of Westchester, 1186 King Street, Rye Brook, NY 10573.

Complaints

If you believe your privacy rights have been violated, you may file a complaint through the Cerebral Palsy of Westchester Hotline at (914) 937-3800 ext. 210. Written complaints may be sent to:
CPW Privacy Coordinator
Cerebral Palsy of Westchester
1186 King Street
Rye Brook, NY 10573

You may contact the Department of Health and Human Services at 877-696-6775 or at:
Department of Health and Human Services
200 Independence Ave. SW
Washington, DC 20201

You may file a grievance with the Office of Civil Rights by calling 866-627-7748 or 866-788-4989 (TTY), or at the following address:
Office of Civil Rights Region II
Federal Building
26 Federal Plaza, Room 3312 New York, NY 10278
All complaints made by telephone must be followed with a written complaint. You will NOT be penalized for filing a complaint.

Notice of Rights

At the Jimmy Vejar Summer Fun Program, all participant, without distinction of any kind, have equal rights to the following:

- To be treated with dignity and respect while in our care.
- To be protected from any form of abuse or harm.
- To a safe environment.
- To individualized, quality care and treatment based upon needs identified in the admission application.
- To an enjoyable, fun-filled, and memorable experience

At the Jimmy Vejar Summer Fun Program, every parent, without distinction of any kind, has the right to the following:

- Confidential written and/or verbal communications from the Program personnel regarding their child's well-being. *This includes responses to parent inquiries in a time-sensitive manner and/or notifications initiated by the Program personnel to the parent regarding their child's well-being.*
- To visit the program after coordinating with the Program Specialist.

The Jimmy Vejar Summer Fun Program reserves the right to the following:

- Request for a Participant to be immediately picked up if they pose a detrimental threat to themselves or others.
- Request for a Participant to be immediately picked up if the Nursing Director deems the child to have a health issue which cannot be safely managed at program and threatens the well-being of others.
- Request for a meeting with a parent if a parent is more than 15 minutes late to pick up their Participant after three (3) occurrences.

Please visit our website to view a copy of the full 'Notice of Rights & Responsibilities' at https://cpwestchester.org/jvsdc-rights-responsibilities/

OPWDD Waiver Services/Respite

Summer Fun Program Individuals who have OPWDD waiver eligibility must complete questions 1-6 below and submit the following documents along with completed application packet.

Individual's Name:
_____

Date of Birth: _____

1. Care Manager Name: _____
2. Care Manager Telephone: _____
3. Care Manager Email: _____
4. Care Manager Agency: _____
5. Enrolled in Medicaid: Yes ___ No ___
6. Medicaid Number (or N/A): _____

Please submit the following with your application.

☐ Current Life-plan

☐ Notice of Decision

☐ Service Authorization

☐ Level of Care Eligibility Determination (LCED)