easterseals Camp Fairlee

22242 Bay Shore Road | Chestertown, MD 21620-4407 USA
410.778.0566 | Toll Free 800.677.3800 | contact@esdel.org
www.de.easterseals.com/fairlee

Registration Check List Instructions

To ensure a successful registration process please make sure you have completed all sections. Everything in RED is required for processing/acceptance. The application will NOT be processed until it is completed in its entirety. Thank you.

Section 1

- ☐ Participant Information
- ☐ Emergency Contacts
- ☐ Choose Sessions and Dates
- ☐ Payment Information
- ☐ Waiver and Release signed and dated
- ☐ Participant Health Information
- ☐ Additional Information
- ☐ Letter of Intent (if agency is paying)

Section 2

- ☐ Participant Information
- ☐ Health Insurance
- ☐ Health History Sections 4-9
- ☐ Immunization History
- ☐ Date of last Tetanus
- ☐ Permission to Treat signed and dated

Please mail back entire application book intact. DO NOT TAKE APART. Thank you

easterseals Camp Fairlee

22242 Bay Shore Rd., Chestertown, MD 21620
Phone: 410-778-0566 Fax: 410-778-0567
E-mail: Fairlee@esdel.org
Web: www.de.easterseals.com/fairlee

RESPITE REGISTRATION FORM

PART 1: Application

Before sending the registration form, please ensure you have included the following:

- Must complete section 1 and 2 (application will not be processed until all parts are complete)
- Signed Waiver and Release (page 3)
- Letter of Intent (if funding to be provided by organization/agency/group)
- $100 deposit to process the registration

Participant Information (Please print clearly or type)

First Name: Last Name: ☐ New Participant ☐ Returning Participant

Physical Address:

City: State: Zip: County:

Mailing Address: (if different than above)

City: State: Zip: County:

Birthdate: Age:

Male/Female: Height: Weight:

Ethnic Origin: (optional-please check one) ☐ Asian ☐ African American ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other

☐ **Parent** ☐ **Guardian** ☐ **Care Provider** ☐ **Case Manger Information** **(please check one)**

Name: Relationship:

Home Phone: Cell Phone: Work Phone:

E-mail:

Best form of contact: ☐ Phone ☐ E-mail

Emergency Contacts (please provide all three)

Name: Relationship:

Home Phone: Cell Phone: Work Phone:

Name: Relationship:

Home Phone: Cell Phone: Work Phone:

Name: Relationship:

Home Phone: Cell Phone: Work Phone:

2018-2019 Respite Weekend Dates

Please select session(s) the participant wishes to attend. Slots are available on a first come first served basis.

October 4-6, 2019	**Moovin'and Groovin'**	All ages	☐ 1:1 $1000	☐ 3:1 $800
October 11-13, 2019	Fall MS Retreat	All ages	☐ 1:1 $800	☐ 3:1 $600
October 18-20, 2019	Spooktacular	All ages	☐ 1:1 $800	
November 15-17, 2019	Music Makers	All ages		☐ 3:1 $600
November 22-24, 2019	Fallin' into Fall	All ages	☐ 1:1 $800	
December 6-8, 2019	Holly Jolly	All ages	☐ 1:1 $800	☐ 3:1 $600
February 15-17, 2020	**Artistic Escapades**	All ages	☐ 1:1 $1000	☐ 3:1 $800
March 20-22, 2020	Spring Fever	All ages	☐ 1:1 $800	☐ 3:1 $600
April 10-12, 2020	**Hopping into Spring**	All ages	☐ 1:1 $1000	☐ 3:1 $800
April 24-26, 2020	Sprouting Spring	All ages	☐ 1:1 $800	☐ 3:1 $600
May 15-17, 2020	Spring MS Retreat	All ages	☐ 1:1 $800	☐ 3:1 $600

(Each weekend will have available 1:1 openings. You must call for approval before registering.) Acceptance is based up-on staff availability. **Moovin' and Groovin', Artistic Escapades and Hopping into Spring respites are EXTENDED weekends. Call for details about our EXTENDED weekends.**

Participants that use Maryland Autism Waiver Program will need 32 hours per weekend added to their Plan of Care. (You must contact your Service Coordinator and have the Plan of Care submitted to Camp prior to coming.) The Plan can be faxed or emailed to camp separate from the registration.







Referral Information (Please complete, even if you are a returning participant)

Name of Teacher/Caseworker/Coordinator:

Agency:

Address:

Phone:

How did you hear about us? Print ad Internet Resource Fair Social Media Friend Past Camper

PAYMENT INFORMATION AND OPTIONS (MUST be completed and signed. Please check all that apply)

_____ Choice 1: Full payment enclosed

_____ Choice 2: $100.00 deposit enclosed (for each session choice)

_____ Choice 3: Paying by credit card (Visa/MasterCard/Discover/American Express—Please call with card information.)

_____ Choice 4: Paying balance monthly

_____ Choice 5: Autism Waiver (A copy of your Plan of Care must be submitted to Camp with the number of hours needed.)

Amount Enclosed: $_____ Balance left to be paid: $_____

Signature of individual responsible for payments/balance: _____

We encourage you to contact clubs, businesses, organizations and agencies for funding assistance. Please note: If a funding source is paying your deposit and/or balance, a completed **Letter of Intent** must be completed and on file (page 9).

_____ Choice 6: Balance to be paid by an agency or organization. (Please complete information below.) **$**_____

_____ Choice 7: Deposit and balance to be paid by an agency or organization. (Please complete information below.) **$**_____

Agency/Organization Name:_____ Contact Name: _____

Address:_____

City:_____ State:_____ Zip Code:_____ Phone:_____

WAIVER AND RELEASE (MUST have a signature in order to process the application)

This document must be signed by either the participant and or the parent or legal guardian if applicable. All references to the participant include the parent or legal guardian.

As a condition of participation in the summer camp program, the participant agrees to the following:

Participant acknowledges that a wide variety of activities will be conducted, including swimming, challenge course and waterfront. Participant acknowledges that some of the activities may subject him/her to certain stresses and hazards, not all of which can be foreseen. Participant desires and consents to take part in all such activities unless otherwise indicated in writing prior to the summer camp program. Participant assumes all the risks incident to the nature of the activities to be conducted and agrees that neither Easterseals Delaware and Maryland's Eastern Shore, Inc., nor any of its representatives shall be held responsible for any damages or injuries resulting to the participant in the program. In the event the program staff determine that the participant cannot meet the program eligibility requirements, the participant may be dismissed. Supervision and transportation resulting from dismissal of such participant are the responsibility of the participant.

Participant understands that Easterseals and its representatives are not responsible for loss or damage to the personal property and possessions of the participant.

Participant is liable for any damage to the property of Easterseals resulting from the acts of the participant.

Participant consents to the use of any film/photographs/video taken during the program, whether for advertising, social media, promotion and/or publicity purposes by Easterseals unless otherwise indicated in writing prior to the program. The participant waives all claims of compensation for such use.

Permission is granted for participant to attend all program field trips, Participant acknowledges that transportation may be provided for program related purposes in a vehicle provided by Easterseals and its representatives. It is the participant's responsibility to adhere to all safety requirements (using seat belts and remaining seated).

Participant represents that all of the information provided in this application, including the health forms, is true and correct and that Easterseals and its representatives have full right and authority to rely on the information contained therein. Participant further recognizes that Easterseals and its representatives reserve the right to reject any participant in the event of the failure or refusal of the participant to accurately complete and sign all of the required documents.

I have read and fully understand the program details, waiver and release.

Signature of Parent/Guardian: **Date:**

Signature of Participant (if over 18 years of age): **Date:**

PARTICIPANT INFORMATION

Participant Information (Please print clearly or type)

Name:	Last Name:	Nickname:

Disability Information (Please **check** the **primary** and underline all that apply)

- ☐ Speech-language
- ☐ Hearing impaired
- ☐ Visually impaired
- ☐
- ☐ Peripheral Nerve Injury/Disorder
- ☐ Muscular Dystrophy
- ☐ Central Nervous System Injury/Disorder
  - ☐ Stroke
  - ☐ Epilepsy/Seizure Disorder
  - ☐ Multiple Sclerosis
  - ☐ Head Injury
  - ☐ Spinal Cord Injury
- ☐ Neurological Condition(s) at Birth
  - ☐ Cerebral Palsy
  - ☐ Down Syndrome
  - ☐ Spinal Bifida
- ☐ Social/Psychological
  - ☐ Autism
  - ☐ Behavior
  - ☐ Alcohol/Drug Disorders
  - ☐ Psychosis
- ☐ Learning/Developmental Delay
- ☐ Intellectual Disability

Level: ☐ Mild ☐ Moderate ☐ Severe/ Pro-

- ☐ Attention Deficit Disorder
- ☐ Orthopedic Impairments at Birth
- ☐ Postural Disorders
- ☐ Heart, Circulatory, Respiratory
- ☐ Asthma
- ☐ Skin and Cellular Tissue Disorder
- ☐ Allergic/Metabolic/Nutritional
- ☐ Cystic Fibrosis
- ☐ Diabetes
- ☐ Geriatric Aging
- ☐ Other Disabilities (please list)

_____

General Background (Please check all that apply)

Communication

- ☐ Speaks clearly
- ☐ Uses sign language
- ☐ Speaks, but may be difficult to understand
- ☐ Uses communication board
- ☐ Gestures
- ☐ Other: _____

Language Spoken/Understood_____

Vision

- ☐ normal ☐ mild/moderate loss
- ☐ severe/total loss

Does participant wear corrective lenses? ☐ Y ☐ N

Hearing

- ☐ Normal ☐ Mild/Moderate Loss
- ☐ Severe/Total Loss

Does participant wear hearing aids? ☐ Y ☐ N

Mobility

- ☐ Walks independently
- ☐ Walks with assistance
- ☐ Walks with cane/crutches/walker
- ☐ Walking ability affected, but walks independently
- ☐ Uses wheelchair
  - ☐ manual ☐ power
- ☐ uses AFOs ☐ bed rails

Personal Care (Please check all that apply and provide a complete description if participant requires assistance)

Task	Independent	Requires Some Assistance	Requires TOTAL Assistance	Description of Assistance Needed
Dressing				
Showering				
Toileting				
Teeth Brushing				
Shaving				
Transferring				
Menstruation				

Aids used (check all that apply)	☐ Diapers	☐ Bedpan	☐ Urinal	☐ Toilet chair
Bladder control	☐ Normal	☐ Has accidents	☐ Incontinent	☐ Wets bed
Bowel control	☐ Normal	☐ Has accidents	☐ Incontinent	☐ Colostomy
Eating assistance	☐ No assistance	☐ Partial assistance	☐ Total assistance	☐ Can feed self finger foods ☐ G-Tube ☐ Uses Straw

What adaptive devices are used for eating? (must be sent to camp)_____

Does participant have difficulties swallowing? ☐ Solids ☐ Liquids

Does participant have any known food allergies or problems with foods?_____

Additional Information

Has the participant previously attended a residential camp? ☐ Yes ☐ No
If yes, what camp: _____

If yes, was it a positive experience? ☐ Yes ☐ No
If no, please explain: _____
_____
_____

Does the participant follow direction? ☐ Yes ☐ No ☐ Occasionally
If no or occasionally, please explain: _____
_____

Does the participant have any behaviors of which the staff need to be aware of? ☐ Yes ☐ No
If yes, please explain:_____
_____

Are there key actions, words, or phrases used to stop behavior and redirect? ☐ Yes ☐ No
If yes, please explain: _____
_____

Is a behavior management plan currently being used with the participant? ☐ Yes ☐ No
If yes, please send a copy with the application. Easterseals prohibits most restrictive behavior intervention techniques. Acceptance will be based on our ability to follow plans within agency policies.

Does the participant sleep through the night? ☐ Yes ☐ No
If no, please explain: _____
_____

Please list any strong fears the participant may have: _____
_____

Please list any activities the participant especially dislikes: _____
_____
_____

Please list any activities the participant especially enjoys: _____
_____

Please use this space for any other information you feel would be helpful in providing the best experience for the Participant: _____
_____
_____
_____
_____

PROGRAM INFORMATION

Horseback Riding: The program is held at Worthmore Farms, a KART riding center accredited by the Professional Association of Therapeutic Horsemanship (PATH). Instruction is provided under the direction of a PATH certified therapeutic riding instructor. All riders use a leader and side walkers.

Swimming: Swimming is a lifeguard supervised activity. All lifeguards, hold an American Red Cross certified on a yearly basis that covers CPR, First Aid & AED and Lifeguard certification. Participants who are unable to swim wear life jackets and all campers must pass a swim test to be able to swim in the deep end.

Challenge Course: A Challenge Course program is accredited through ACA and the ACCT. Inspections are conducted annually on all equipment and the tower. Staff participate in yearly training. Participants are required to have trunk and head control to participate. Our challenge course is based on challenge by choice and is a Universal Climbing program for all abilities.

Canoeing: A lifeguard supervised activity, all of which are CPR, First Aid certified, as well as trained canoeing instructors. Participants must have trunk and head control to participate.

Transportation: Camp Fairlee transports all participants by bus to waterfront and horseback riding activities. All buses are inspected on a routine bases.

Hiking: The trails at Camp Fairlee are flat and not strenuous: It is a 1 mile hike, and appropriate shoes are required. All trails are supervised.

Hayrides and Campfires are weekly program activities. All participants have the option of participating in.

Activity Restrictions (All activities are accessible for people with disabilities.)

A wide variety of programs are offered at Camp Fairlee, including those listed below. Please indicate which activities the participant should or should not engage in.

ACTIVITY	Ok To Participate	CANNOT Participate	ACTIVITY	Ok To Participate	CANNOT Participate
Horseback Riding			Transportation		
Swimming			Hayrides		
Challenge Course			Hiking		
Canoeing/Kayak			Campfire		

Please list any other activities which you feel the participant be engaged in:

Ratio Descriptions

1:1 Ratio

This ratio applies to participants who need constant supervision and individual assistance, such as:

- Verbal prompts
- Reminders, gestures, schedules
- Hand-over-hand assistance during their daily schedule meals and morning/night routines
- Participants can be ambulatory or use a wheelchair.
- They may bear weight or need full assistance from the staff, such as a 1/2/3 person transfer or Hoyer lift.
- Total assistance with bathing, toileting and brushing teeth
- Poor balance

This also applies to a participant that has a history or current history of disruptive behaviors:

- Elopement
- Non-compliance
- Inappropriateness
- Sleeping issues or any other behavior that could be considered disruptive to self or others.
- Participants who do not attend planned camp activities on a regular basis

This ratio also applies to participants who require hourly health services such as:

- Tube feedings
- Overnight tube feedings or other health treatments that must be given by a nurse periodically throughout the day.

3:1 + Ratio

This ratio applies to participants who are typically independent or need minimal assistance from staff such as:

- Verbal prompts
- Reminders, or gestures during their daily camp schedule
- Participants can be ambulatory and/or use a wheelchair
- Must be able to transfer independently or with minimal assistance.
- Participants must also follow directions from their assigned staff on a regular basis
- They must participate in activities on a regular basis with no disruptive behaviors.
- No assistance with bathing, toileting and brushing teeth

PART 2: Participant Health History

american CAMP association®

Developed and reviewed by: American Camp Association, American Academy of Pediatrics Council on School Health & Association of Camp Nurses

easterseals Camp Fairlee

Address: 22242 Bay Shore Road

Chestertown, MD, 21620

Phone: (410) 778-0566

Fax: (410) 778-0567

E-mail: fairlee@esdel.org

TO PARTICIPANT/PARENT(S)/GUARDIAN(S)/CARE PROVIDERS(S): Please follow the instructions below. Attach additional information if needed. All information is kept confidential.

1) Complete ALL sections of the PARTICIPANT HEALTH HISTORY (PART 1 — pages 9-13).

2) Sign the Participant/Parent/Guardian Authorization (SECTION 14) and stop here.

3) After it has been completed & signed, return the form to camp via mail/fax/e-mail (see right)

4) The Physical Exam Form (for the Doctor) will be mail later.

PLEASE FOLLOW THESE INSTRUCTIONS CARFEULLY. ALL SECTIONS OF BOTH FORMS MUST BE COMPLETED IN THEIR ENTIRETY. INCOMPLETE FORMS MAY NOT BE ACCEPTED AND WILL BE RETURNED WITH A REQUEST FOR ANY MISSING INFORMATION.

SECTION 1: PARTICIPANT INFORMATION

Participant name: _____

☐ Male ☐ Female Birth date: _____ Age on arrival at camp: _____

Participant home address: _____

City: _____ State: _____ Zip code: _____

SECTION 3: HEALTH INSURANCE

The participant is covered by health/hospital insurance: ☐ Yes ☐ No

Insurance company: _____ Subscriber: _____

Policy number: _____ Insurance company phone: _____

Include a copy of your insurance card if appropriate. Copy both sides of the card so information is readable.

SECTION 4: DIET/NUTRITION

☐ Eats a regular ☐ diet Eats a vegetarian diet ☐ Lactose intolerant ☐ Gluten intolerant ☐ Other (describe below)

Additional information regarding diet:

SECTION 5: ALLERGIES

☐ No known allergies ☐ The participant is allergic to the following:

Food	Medications	Environment	Other

Please describe below the reaction(s) seen and management of the reaction(s):

SECTION 6: LIMITATIONS/RESTRICTIONS

Do you feel that the participant will require limitations or restrictions to activity while at camp? Yes ☐ No ☐

If 'Yes,' please describe recommendations/adaptations below:

SECTION 7: GENERAL HEALTH HISTORY

Has/does the participant:

1. Ever been hospitalized? ..... ☐ Yes ☐ No
2. Ever had surgery? ..... ☐ Yes ☐ No
3. Have recurrent/chronic illnesses? .. ☐ Yes ☐ No
4. Had a recent infectious disease? .... ☐ Yes ☐ No
5. Had a recent injury? ..... ☐ Yes ☐ No
6. Ever had back/joint pain? ..... ☐ Yes ☐ No
7. Have diabetes? ..... ☐ Yes ☐ No
8. Had seizures? (see section 9) ..... ☐ Yes ☐ No
9. Had headaches? ..... ☐ Yes ☐ No
10. Had fainting or dizziness? ..... ☐ Yes ☐ No
11. Had asthma/wheezing/shortness of breath? ..... ☐ Yes ☐ No
12. Passed out/had chest pain during exercise? ..... ☐ Yes ☐ No
13. Had mononucleosis during the past 12 months? ..... ☐ Yes ☐ No
14. If female, have problems with menstruation? ..... ☐ Yes ☐ No
15. Have problems with falling asleep/sleepwalking? ..... ☐ Yes ☐ No
16. Have a history of bedwetting? ..... ☐ Yes ☐ No
17. Have problems with diarrhea/constipation? ..... ☐ Yes ☐ No
18. Have any skin problems? ..... ☐ Yes ☐ No
19. Wear glasses/contacts/protective eyewear? ..... ☐ Yes ☐ No
20. Traveled outside the country in the past 9 months? .. ☐ Yes ☐ No

Please explain 'Yes' answers below, noting the number of the question(s). For travel outside the country, please name countries visited and the dates of travel:

SECTION 8: MENTAL/EMOTIONAL/SOCIAL HEALTH

Has the participant:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder? ..... ☐ Yes ☐ No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder? ..... ☐ Yes ☐ No
3. During the last 12 months, seen a professional to address mental/emotional health concerns? ..... ☐ Yes ☐ No
4. Had a significant life event that continues to affect the participant's life? ..... ☐ Yes ☐ No
   (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, etc.)

Please explain 'Yes' answers below, noting the number of the question(s). The camp may contact you for further information:

SECTION 9: SEIZURES

Please complete this section if the participant is currently having seizures, or has a history of seizures.

Type: _____

Frequency: _____ Duration: _____

Triggers: _____

Date of last seizure: _____ Are the seizures currently under control? ☐ Yes ☐ No

SECTION 10: IMMUNIZATION HISTORY

Please provide the month and year for each immunization. Starred (★) immunizations must include the date to meet ACA standards. Copies of immunization records from healthcare providers or state or local government are acceptable. Please attach them to

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diphtheria, tetanus, pertussis (DTaP/TdaP)						
Mumps, measles, rubella (MMR)						
Polio (IPV)						
Haemophilus influenzae type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox)						
Meningococcal meningitis (MCV4)						

Has the participant had chicken pox? Yes ☐ No ☐ If 'Yes,' date of chicken pox:_____

Date of last tuberculosis (TB) test: _____ Result: ☐ Negative ☐ Positive

★ Date of last tetanus booster (dT or TdaP – **MUST PROVIDE**): _____

SECTION 11: IMMUNIZATION RELEASE

If you are unable to provide sufficient/complete immunization records and/or the participant has not been fully immunized, please sign the following statement/release:

I UNDERSTAND AND ACCEPT THE RISKS TO THE PARTICIPANT FROM NOT BEING FULLY IMMUNIZED.

Signature: _____ Relationship: _____ Date: _____

SECTION 12: HEALTHCARE PROVIDERS

Name of participant's primary doctor(s): _____ Phone: _____

Name of dentist(s): _____ Phone: _____

SECTION 13: ADDITIONAL INFORMATION

Please provide in the space below any additional information about the participant's health that you think important, or that may affect their ability to fully participate in the camp program:

PRESCRITION MEDICATION REMINDER

All prescribed medications must be in their original bottle or blister pack from pharmacy with the original script from the prescribing physician. All over the counter medications must be brought to camp in their original bottles. Any altered prescription label will not be accepted. The dosage and schedule on the pharmacy label must match the information on the health form signed by the physician. Camp Fairlee staff will not accept pre-poured medication or anything

SECTION 14: PERMISSION TO TREAT PARTICIPANT/PARENT/GUARDIAN AUTHORIZATION

This health history is correct and accurately reflects the health status of the participant to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I hereby give permission to the medical personnel selected by Easterseals to order x-rays, routine tests and treatment related to the health of the participant for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the medical personnel selected by Easterseals to hospitalize, secure and administer treatment for, and order injection, anesthesia or surgery for the participant. I give permission to Easterseals staff to provide or arrange any necessary related transportation for the participant. I give permission for the release of any records necessary for insurance purposes. I understand that the information on this form will be shared on a 'need to know' basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of the participant's health record from providers who treat them. These providers may talk with the program's staff about the participant's health status.

Signature of participant (if over 18 years of age): _____ Date: _____

Signature of parent/guardian: _____ Date: _____

LETTER OF INTENT FOR FUNDING

INSTRUCTIONS FOR FAMILIES AND CARE PROVIDERS

If you are requesting funding from an agency or organization, this form must be completed and returned to the administrative coordinator at Easterseals Camp Fairlee as soon as possible, in order to secure a place and official enrollment at camp.

Complete **Section One** and contact your community agency/organization/community navigator providing funding towards your fee, before sending this form to the appropriate contact person, who will complete **Section Two**.

Your agency/organization may return the form to you or send it directly to camp. If it is returned to you, please ensure you send the form back to the administrative coordinator at Easterseals Camp Fairlee.

SECTION ONE (to be completed by family/care provider)			
Name of participant requesting funding:			
Address:			
Camp session dates:		**Funding requested:**	**$**
PLEASE NOTE: THE DEPOSIT OR ANY REMAINING BALANCE OF THE OVERALL FEE, WHICH WILL NOT BE COVERED BY THE AGENCY/ ORGANIZATION, MUST BE PAID **NO LATER THAN JUNE 1ST**. FAILURE TO PAY THE REMAINING BALANCE (IF ANY) WILL RESULT IN THE LOSS OF YOUR PLACE AT CAMP.			

INSTRUCTIONS FOR AGENCIES AND ORGANIZATIONS

In order for the participant to secure a place and official enrollment at camp, this form must be completed. By doing so, your agency or organization is agreeing to provide funding for the participant named above, who is scheduled to attend Easterseals Camp Fairlee during the time frame listed.

SECTION TWO (to be completed by agency/organization authorizing payment)			
Agency/Organization:		**Funding authorized:**	**$**
Address:			
Contact person:		**Phone:**	
Signature		**Date:**	

PLEASE NOTE: PAYMENT FROM THE AGENCY/ORGANIZATION MAY BE RECEIVED AFTER THE SERVICE, PROVIDED THAT THE LETTER OF INTENT FOR FUNDING IS ON FILE. THIS MUST BE COMPLETED AND SIGNED AS AN AUTHORIZATION OF PAYMENT.

☐ Payment is enclosed ☐ Please send invoice before session ☐ Please send invoice after session

Checks can be made payable to:
Easterseals of Delaware and Maryland's Eastern Shore