UCP United Cerebral Palsy
of Delaware, Inc.
Life without limits for people with disabilities

Camp Manito
700A River Road
Wilmington, DE 19809

Dear Parent/Guardian,

Thank you for your interest in United Cerebral Palsy of Delaware's Camp Manito! We are so excited that you are interested in attending Camp Manito. Enclosed you will find the camper application along with the essential information to provide you with a smooth registration process.

Due to the unprecedented events surrounding Covid-19, UCP will be hosting camp at a limited capacity.

This is what we will need from you before we can guarantee your camper's enrollment:

- Application
- A non-refundable $30 application fee – ($15 for each additional sibling)
- IEP and/or BEP
- Health Packet
- Completed CDBG Form
- Proof of Residency
- Proof of Annual Household Income
- Confirmation of Financial Responsibility
- **If any of the above documentation is missing or incomplete, the application will be put on hold. A spot will not be held.**

- **Camp Hours are 8:00am to 4:00pm, the fee is $200/week**
- **After Care is available from 4:00pm to 6:00pm, the fee is $50/week**

For your application to be reviewed, it must be complete, all required documentation must be submitted with the application, and your registration fee must be paid. Deadline for application and paperwork is **5/1/21**. This is not a guarantee of acceptance. Enrollment will be confirmed when completed documentation and application fee has been received and reviewed. You will be contacted if any forms are incomplete or missing. Missing information could only delay your camper being accepted.

Thank you again for your support, and we will see you this summer.

Kim

Kim Evans
Camp Administror
ucpdecamp@gmail.com
(o) 302-764-2400 (f) 302-764-8713

Revised 2/2021

United Cerebral Palsy of Delaware, Inc.'s Camp Manito

Date: July 5—August 13
Monday—Friday
Time: 8:00am—4:00pm $200/wk
After Care 4:00pm—6:00pm $50/wk

Location: United Cerebral Palsy of DE
700A River Road
Wilmington, DE 19809

Activities Include:
Arts & Crafts
Sports
Swimming (In-Pool Ramps)
Breakfast, Lunch & Snack Included

Accepting children ages:
3-21 with disabilities &
Children ages:
5-13 without disabilities

Volunteers Always Welcome!

Please Contact: Kim Evans
ucpdecamp@gmail.com
(302) 764-2400

Applications available
on website at:
www.ucpde.org

UCP United Cerebral Palsy
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Life without limits for people with disabilities

UNITED CEREBRAL PALSY OF DELAWARE, INC.
CAMP MANITO ~ CAMPER APPLICATION

700A RIVER ROAD WILMINGTON, DE 19809
Office 302-764-2400 Fax 302-764-8713

PLEASE TYPE OR PRINT CLEARLY Camper Name _____

Camper Information

Full Name: _____ Date of Application: _____

Nickname: _____ Date of Birth: _____/_____/_____ Age: _____

Gender (circle one) Female Male Race: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

E-Mail Address: _____

Please select how you plan to pay for camp ☐ DFS ☐ DDDS ☐ Self-Pay

☐ Other _____ Annual Household Income: _____

Camper's Health Information

Does the camper have a disability? ☐ Yes ☐ No If so, check all that apply

☐ Asperger's Syndrome
☐ Asthma
☐ ADD
☐ ADHD
☐ Autism
☐ Behavior Disorder
☐ Bleeding/Clotting Disorder
☐ Cerebral Palsy
☐ Cystic Fibrosis
☐ Diabetes
☐ Developmental Disorder
☐ Down Syndrome
☐ Epilepsy/Seizure Disorder
☐ Hearing Impaired
  ☐ Partial ☐ Total
☐ Heart, Circulatory, Respiratory Defect
☐ Intellectual Disabilities
  ☐Mild ☐ Moderate ☐Severe/Profound
☐ Learning Disability
☐ Muscular Dystrophy
☐ Psychosis
☐ Speech-Language/Voice Dysfunction
  ☐ Non Verbal
☐ Spina Bifida
☐ Spinal Cord Injury
  ☐ Quadriplegic ☐ Paraplegic ☐ Other
☐ Social/Psychological
☐ Visual Impairment
  ☐ Partial ☐ Total
☐ Other Disability (s) _____
_____
_____
_____

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CAMP MANITO ~ CAMPER APPLICATION

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Office 302-764-2400 Fax 302-764-8713

PLEASE TYPE OR PRINT CLEARLY

Camper Name _____

Parent/Caregiver Information

1. Custodial Parent/Guardian: _____

Relation to Camper: _____ Home #: _____

E-Mail Address: _____

Employer: _____ Work#: _____ Cell#: _____

Street Address: _____

City: _____ State: _____ Zip: _____

2. Custodial Parent/Guardian: _____

Relation to Camper: _____ Home #: _____

E-Mail Address: _____

Employer: _____ Work#: _____ Cell#: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Additional Contact Information

Emergency Contact #1: _____

Relation to Camper: _____ Phone #: _____

Emergency Contact #2: _____

Relation to Camper: _____ Phone #: _____

Referral Information

Has camper ever attended UCP of DE's Camp Manito before? ☐ Yes ☐ No

If yes, please list the year (s) camper attended _____

If no, please tell us how the camper found UCP of DE's Camp Manito:

☐ Family Member _____ ☐ Other Camper _____
☐ Camp Fair _____ ☐ School _____
☐ Website _____ ☐ Social Service Agency _____
☐ Other _____

UNITED CEREBRAL PALSY OF DELAWARE, INC.
CAMP MANITO ~ CAMPER APPLICATION

700A RIVER ROAD WILMINGTON, DE 19809
Office 302-764-2400 Fax 302-764-8713

PLEASE TYPE OR PRINT CLEARLY Camper Name _____

Additional Camper Information

Mobility ☐ Walks ☐Walker ☐ Wheelchair ☐ Can propel/drive self

Transfers ☐ No assistance needed ☐ Needs Assistance (explain) _____

Assistive Devices ☐None ☐ AFO's ☐Glasses ☐Hearing Aid

☐Helmet ☐Other _____

Communication ☐ No serious difficulties expressing thoughts or wants

☐ Has difficulties (explain) _____

☐ Uses sign language ☐ Uses a communication device (what kind?) _____

Eating ☐No assistance Needed ☐Needs assistance (explain) _____

Diet ☐Normal ☐Blended/Pureed ☐Diabetic ☐Gluten Free ☐Feeding Tube

☐Food Allergies (list) _____

Bowel Control ☐No assistance Needed ☐Incontinent

☐ Needs Assistance (explain) _____

Bladder Control ☐No assistance Needed ☐Incontinent

☐ Needs Assistance (explain) _____

☐Catheter ☐Urinal ☐Disposable Undergarments ☐Other

Dressing ☐Assistance Needed ☐No Assistance Needed

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CAMP MANITO ~ CAMPER APPLICATION

700A RIVER ROAD WILMINGTON, DE 19809
Office 302-764-2400 Fax 302-764-8713

PLEASE TYPE OR PRINT CLEARLY Camper Name _____

Camper's Social Background

School/Employer: _____

Grade: _____ School Phone Number: _____

Does your Child have a State Case Worker? ☐ Yes ☐No

Case Worker: _____ Phone #: _____

Can the camper read? ☐Yes ☐No Write? ☐Yes ☐No

Does the camper have any special behavior or sensory challenges? ☐Yes ☐No

If yes, please describe:

_____

_____

When do behavior problems occur?

_____

_____

Describe effective methods to redirect or prevent behaviors:

_____

_____

Does the camper have a Behavior Intervention Plan (BIP)? ☐ Yes or ☐ No
Does the camper have an Individualized Education Program (IEP) at school? ☐ Yes ☐ No
(If yes, please submit a copy of the BIP and/or IEP to UCP)

Does the camper have temper tantrums that will intensify into aggressive and destructive behavior? ☐ Yes ☐ No if yes, how do you help him/her de-escalate?

_____

_____

Please list any fears the camper may have: _____

Please list any activities the camper dislikes: _____

Is your camper able to participate in the camp swimming program: ☐Yes ☐ No

If yes, any pool restrictions? _____

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CAMP MANITO ~ CAMPER APPLICATION

700A RIVER ROAD WILMINGTON, DE 19809
Office 302-764-2400 Fax 302-764-8713

PLEASE TYPE OR PRINT CLEARLY Camper Name _____

Payment & Financial Information

CAMP FEES

- $200/week - this covers the camp day of 8am – 4pm
- A non-refundable application fee is DUE with the application
  - $30 for first application and $15 per additional application
- After care is available from 4pm – 6pm. The fee is $50 per week.
- Late pick up fees:
  - If camper is picked up between 6:01pm – 6:14pm a payment of $20 is due
  - Starting at 6:15pm, it is an additional $1 per minute
  - These fees are per camper and due at time of pick up
  - 3 late pick-ups will result in termination
- Tuition is due Monday morning of each week by 9:30am. Late fees will be assessed starting the next day (Tuesday). A daily late fee will be applied in the amount of $20/day. If not paid by Wednesday of that week, camper will not be permitted to return.

Please circle a T-shirt size for camper:

Youth S M L Adult S M L XL 2XL

If you are unable to afford the full cost of camp, you may request a campership.

Please indicate your need for a campership. ☐ YES ☐ NO

****** If yes, please provide the following with your application

- A personal statement explaining the reason you need a campership,
- A list of all members living in the household,
- Three most recent paystubs from each household earner,
- Documentation for all other income (child support, alimony, benefits, etc.) or a statement that you do not receive additional income.

Signature: _____ Date: _____

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UNITED CEREBRAL PALSY OF DELAWARE, INC.
CAMP MANITO ~ CAMPER APPLICATION

700A RIVER ROAD WILMINGTON, DE 19809
Office 302-764-2400 Fax 302-764-8713

PLEASE TYPE OR PRINT CLEARLY Camper Name _____

Waivers & Releases

(1) **Approval, Waiver, and Activity Consent:** This application has my approval. While UCP of DE's, Camp Manito will take every precaution, it is agreed that UCP of DE's, Camp Manito is not legally responsible for any accidents, incidents, or injuries that may occur during camp session, assumes no responsibility for applicant's personal property and is released from liability for any accident, incident, or injury except that may be covered by camper's insurance. Applicant has my permission to engage in all camp activities, except noted by myself or physician.

(2) Medical Treatment: The undersigned hereby authorizes and grants permission to any licensed/certified medical or professional designated by UCP of DE's, Camp Manito to provide routine medical care and administer medications or to perform any emergency procedures on the camper that would be jeopardized by any delay in providing such treatment or performing such procedures.

(3) Media Release: I, the undersigned, hereby authorize UCP of DE's, Camp Manito, its employees, agents, and assigns to release any pictures or photography taken of the above-named camper for publication for purposes of conveying information concerning the named individual and/or UCP of DE's, Camp Manito. The undersigned hereby agrees also to hold UCP of DE's, Camp Manito harmless of liability should such pictures or photographs either accompanied or unaccompanied by printed material, appear in other publications by whomsoever published, circulated, or distributed. I understand that these materials may be published on UCP of DE's, Camp Manito's network, web sites, and social media.

I attest that all information provided in this application, materials, medical examination summary, and any supplemental items attached are true and correct to the best of my knowledge.

Signature of Legal Guardian/Adult Camper: _____

Date: _____ Printed Name: _____

Please note that many community organizations require UCP to release to them the name, address, and in some cases the phone number for any child who receives a campership. The information is for the community organization's records and will be kept confidential.

I give United Cerebral Palsy of DE, Inc., permission to release my name, address, and phone number to the organization that provides the campership for my child (ren).

Signature: _____ Date: _____

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Life without limits for people with disabilities

UCP United Cerebral Palsy of Delaware, Inc.
Life without limits for people with disabilities

700A River Road Wilmington, DE 19809

Camper Name: _____

Weekly Camp Fee is $200 which covers camp day 8am – 4pm
After Care Weekly Fee is $50 which covers 4pm – 6pm

Please enter drop off time and pick up time on each date. If camper is not attending a specific date, place an "X" on that date.

July 5	July 6	July 7	July 8	July 9	TOTAL DUE (this will be completed by camp)
July 12	July 13	July 14	July 15	July 16	TOTAL DUE (this will be completed by camp)
July 19	July 20	July 21	July 22	July 23	TOTAL DUE (this will be completed by camp)
July 26	July 27	July 28	July 29	July 30	TOTAL DUE (this will be completed by camp)
August 2	August 3	August 4	August 5	August 6	TOTAL DUE (this will be completed by camp)
August 9	August 10	August 11	August 12	August 13	TOTAL DUE (this will be completed by camp)

Revised 2/2021

Summer 2021 Attendance Calendar – CAMP MANITO

UCP United Cerebral Palsy of Delaware, Inc.
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Camp Manito Health Form 2021

To Parent(s)/Guardian(s):
1. Please complete the first three pages of this form in their entirety then bring the fourth page to your Health Care Provider to be completed and signed.
2. Make sure to attach a copy of your camper's immunization record, or further information if applicable.

Camper Name: _____

Camper Address: _____
Street Address **City** **State** **Zip**

Camper DOB: _____ **Camper Gender:** ☐ **Male** ☐ **Female**

Emergency Contacts/Authorized for Pick Up:

Name (please print)	Pick-Up?	Relationship to Camper	Cell Phone	Work Phone/Other
1.	☐Yes ☐ No			
2.	☐Yes ☐ No			
3.	☐Yes ☐ No			

Allergies: ☐ No Known Allergies
This camper is allergic to: ☐ Food ☐ Medicine ☐ The environment (insect stings, hay fever, etc.) ☐ Other
(please describe what the camper is allergic to, include the reaction, medication needed, dosage, and application)

Diet/Nutrition: ☐ This camper has a regular diet ☐ This camper has a special diet or restrictions **(please describe below)**

Restrictions: ☐ Full activities, no restrictions: ☐ Restrictions (please describe restrictions)

Parent/Guardian Authorization for Health Care:

The health history is correct and accurately reflects the health status of the camper it pertains to. The person described has permission to participate in all camp activities except as noted by me and/or examining physician. If I cannot be reached in an emergency, I hereby authorize and grant permission to any licensed/certified medical professional designated by UCP of DE to provide medical care, including but not limited to, X-rays, routine tests, and treatment. I hereby give permission for emergency transportation, hospitalization, medication, anesthesia, and/or surgery.

Signature of Parent/Guardian _____ Date _____ Relationship to Camper _____

******Please provide a photo copy of insurance card FRONT and BACK********

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To Parent(s)/Guardian(s):
1. Please complete the first three pages of this form in their entirety then bring the fourth page to your Health Care Provider to be completed and signed.
2. Make sure to attach a copy of your camper's immunization record, or further information if applicable.

Camper Name: _____

General Health History: Please place an **"X"** next to each question that applies to your camper.

Has or does your camper:

_____ have any skin problems
_____ ever had surgery
_____ have recurrent/chronic illness
_____ had a recent infectious disease
_____ had a recent injury
_____ had asthma/shortness of breath
_____ Wear glasses/contacts/eyewear
_____ had fainting or dizziness
_____ have diabetes
_____ ever had back or joint problems
_____ had seizures
_____ had headaches
_____ ever been hospitalized
_____ Behavior Problem
_____ Speech/Vision/Hearing difficulty
_____ had mononucleosis during the past 12 months
_____ passed out/had chest paid during exercise
_____ traveled outside of the country in the past 9 months
_____ visited the hospital for anaphylaxis
_____ have problems with diarrhea/constipation
_____ have problems with periods/menstruation

Please explain any questions you marked with an "X" below:

Camp First Aid

The following non-prescription medications are supplied by camp and are used on an **as needed basis** to manage illness and injury. Please circle the medications the camper is allowed to receive.

Acetaminophen (Tylenol)
Aloe
Bismuth subsalicylate (Pepto-Bismol)
Calamine Lotion
Cough Drops
Diphenhydramine (Benadryl)
Hydrocortisone 1% Cream
Ibuprofen (Advil, Motrin)
Topical antibiotic cream

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1. Please complete the first three pages of this form in their entirety then bring the fourth page to your Health Care Provider to be completed and signed.
2. Make sure to attach a copy of your camper's immunization record, or further information if applicable.

Camper Name: _____

Mental, Emotional, and Social Health: Check "yes" or "no" for each statement.

Has the camper:

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

Please explain "YES" answers in the space below, noting the number of the questions. The camp may contact you for additional information.

6. Does your camper currently have (or had in the past) any major or minor behavioral concerns, such as issues with aggression, control, anxiety, or attachment? ☐ Yes ☐ No
Please explain concerns in the space below:

What Have We Forgotten to Ask? Please provide in the space below any additional information about the camper's health (medical, emotional, or mental) that you think is important or may affect the camper's ability to fully participate in the camp program. **Attach additional information if needed.**

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To Parent(s)/Guardian(s):
1. Please complete the first three pages of this form in their entirety then bring the fourth page to your Health Care Provider to be completed and signed.
2. Make sure to attach a copy of your camper's immunization record, or further information if applicable.

PARENT/GUARDIAN: COMPLETE THIS SECTION AND GIVE THIS PAGE TO YOUR HEALTH CARE PROVIDER TO BE COMPLETED.

Camper Name: _____
First Middle Last

☐ Male ☐ Female Birth Date _____
Month/Day/Year

Physical completed today: ☐ Yes ☐ No (if "No", date of last physical: _____)
Month/Day/Year

Weight: _____lbs. Height: _____ft._____in Blood Pressure _____/_____

The camper is undergoing treatment at this time for the following conditions: (describe below) ☐ None

CODE: **X** - Within Normal Limits **O** - See Remarks Below

_____ Scalp/Skin _____ Heart _____ Vision _____ Ear/Nose _____ Lungs _____ Hearing _____ Throat

_____ Abdomen _____ Blood Pressure _____ Eyes _____ Teeth _____ Extremities _____ Neck/Glands

_____ Nervous System

REMARKS AND RECOMMENDATIONS:

IS CHILD PROGRESSING NORMALLY FOR AGE GROUP? ☐ Yes ☐ No

Do you feel that the camper will require limitations or restrictions to activity while at camp? ☐ Yes ☐ No (please provide additional documentation if you answered "yes"

I have reviewed the Health Form and have discussed the camp program with the camper's parent/guardian. It is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above).

_____ _____
Printed Name of Licensed Provider Signature of Licensed Provider/Date

_____
Office Phone Number

Please attach a copy of current immunization record.
This completed form may be returned via fax 302-764-8713, email ucpdecamp@gmail.com, or mail to UCPDE, 700A River Road, Wilmington, DE 19809.
Any questions, please call Kim at 302-764-2400.

Application Checklist

Please present to applicants: the Agency application** (if applicable), **the Client Reporting Form and this checklist to obtain the information below.

New Castle County (NCC) receives Federal Community Development Block Grant (CDBG) and/or Emergency Solutions Grants (ESG) to operate this program. In order to process your application, we'll need the following information to verify household income and residency. Income information must be provided for all adults living in the household. *If you have any questions concerning the information requested, please contact Nicole Waters with the Department of Community Services at 302-395-5644.*

- ○ **Completed Agency Application/Intake Form & the New Castle County CDBG Client Reporting Form** **(complete entire form, sign & date)**
- ○ **Picture ID & Proof of Address**
- ○ **Proof of all Earned and Unearned Income:** ***Excludes Presumed Benefit Activities***
    - ○ Last three (3) consecutive paystubs or letter from employer detailing annual salary
    - ○ Copy of Social Security/Disability Benefits (letter from Social Security)
    - ○ Copy of current State Temporary Assistance for Needy Families (TANF), General Assistance (GA) or any other State assistance in the form of the benefit letter or letter from agency case manager detailing monthly award amount
    - ○ Copy of Unemployment Checks
    - ○ Copy of Child Support Payments or Order
    - ○ Notarized Statement of any family income not listed above
    - ○ Notarized Statement of Zero income (last resort only)

CLIENT REPORTING FORM

NEW CASTLE COUNTY BENEFICIARY INFORMATION

SELF-CERTIFICATION OF INCOME, RACE, AND ETHNICITY

For CDBG Programs Requiring Information on Income by Family Size

Applicants should provide proof of income in accordance with New Castle County's two acceptable forms of income first (Part 5 Annual Income or IRS Form 1040). Head of Household must complete this entire form.

NUMBER OF FAMILY/HOUSEHOLD MEMBERS _____ * ANNUAL FAMILY/HOUSEHOLD INCOME _____

For each member over the age of 18 attach income documentation or a notarized letter certifying zero income.

Name:	Over 18	Race:	Ethnicity:	Name:	Over 18	Race:	Ethnicity:

RACE AND ETHNICITY:

This information contained herein is CONFIDENTIAL and will be used only for the purpose as stated below. This information is requested by the Government SOLELY for the purpose of monitoring compliance with Federal anti-discrimination statutes. It is a HUD requirement we collect this information for statistical reporting purposes.

Please use the codes below to record Race & Ethnicity Data in box above for ENTIRE HOUSEHOLD...

Household Race:

11 – White
12 – Black or African American
13 – Asian
14 – American Indian or Alaska Native
15 – Native Hawaiian or Other Pacific Islander
16 – American Indian or Alaska Native & White
17 – Asian & White
18 – Black or African American & White
19 – American Indian or Alaska Native & Black or African American
20 – Other Multi Racial
21- Hispanic Ethnicity
22- Non-Hispanic Ethnicity

Address:

_____

_____

_____

Agency: Remember to perform parcel search of address www/nccde.org/parcelview & attach results

Female Head of Household: ☐ Yes ☐ No
Handicapped Status: ☐ Yes ☐ No

(Handicapped households are those headed by a person who is handicapped. Also included are handicapped persons who are members of non-handicapped households. "Handicapped person" means any person who (I) has a physical or mental impairment which substantially limits one or more major life activities, (II) has a record of such impairment, or (III) is regarded as having such an impairment.)

Under penalty of perjury, I certify that the information presented in this certification is true to the best of my knowledge. I further understand that providing false information on this page constitutes an act of fraud. False, misleading or incomplete information may result in termination of assistance.

_____ _____ _____

Signature of Applicant Printed Name of Applicant Date

For Agency Office Use Only (Please remember to complete this section):

_____ 0% - <30% of median _____ 31% - <50% of median _____ 51% - <80% of median ___ Over 80% of median

Date of Income Guidelines Used _____