March 10, 2026

Dear Applicant:

Thank you for applying for the **Hawwa-Chamoun Camp Leadership Program** at Camp *WANNAGOAGAIN!* Camp will be moving to a new location this year! Buck Hill Scout Reservation is located at **422 Croff Rd, Pascoag, RI 02859**. The camp is beautiful and a good fit for our camp too.

This program has been successful for many years now and we look forward to you joining us! It is our goal to offer campers the opportunity to be a leader at camp, to learn important job skills and most importantly, to have fun!

Important job skills are those you need to get a job. So, we ask that ***you*** complete an application and then we will call to schedule an interview with you. This is a time for us to get to know you and for you to ask any questions you might have about the program.

Attached is the CLT Application. This year the Camp Leadership program will run for week one of camp. The deadline to return your application to The Autism Project is June 5, 2026.

We know that not everyone has had previous work or volunteer experience. These are NOT required to be a part of the program. You can leave those areas blank if you don't have any experience.

Please return your application to me at The Autism Project.

Catherine Young
Camp Director
401-785-2666 ext. 76787
Camp *WANNAGOAGAIN!* 2025
catherine.young@brownhealth.org

Hawwa-Chamoun Camp *WANNAGOAGAIN!*
Camp Leadership Program Application (CLT)

Registration deadline is June 5, 2026

Camper's First Name:		Camper's Last Name:	
☐New Camper ☐Returning Camper		Preferred Pronouns: ☐She/Her ☐He/Him ☐They/them	
DOB:	Age:	Grade:	Sex:
Address:		City:	State:
T-Shirt Size **Youth**: ☐XS ☐S ☐M ☐L ☐XL		**Adult**: ☐S ☐M ☐L ☐XL ☐XXL ☐other_____	
Camper's Preferred Language:			

Camper Information For new campers or if we do not have an updated ICD-10 form, please have a physician complete the ICD-10 verification on page 9 and fax to (401)785-2272.

Diagnosis: 1:	Diagnosis 2:
Additional related diagnoses:	

Name(s) of Parent(s)/Caregiver(s):		
Address:	City:	State:
Home Phone:	Cell Phone:	Zip:
Email:		
Preferred Language:	Translator Needed: ☐ Yes ☐ No	

Preferred method of contact: ☐ E-mail ☐ Phone Call-voicemails ok ☐ Phone Call – no voicemails ☐ Text*
*please note, text is not available for all contact

Please complete the following information, in case an emergency arises, and we must contact you. Include information about how to reach you or another designated person during camp hours.

Emergency Contact Name	Relationship	Daytime Phone	Cell Phone

Does the camper receive one-to-one support in the classroom or at home? ☐ Yes ☐ No

Camp Leadership Training Program

CAMPER PROFILE

Please include photo here or send a digital photo for use in verification of identification during medical care

Camper Name:	

Please complete the following sections and provide as much detail as possible. This information will help us create a successful experience for each camper.
Please check all items that apply to camper's present health and thoroughly explain checked answers.
ALLERGIES (list below): ☐No known allergies
☐Food (include any dietary restrictions):
☐Insects/Plants:
☐Medicine Allergies:
Treatment for any of the above that The Autism Project may need to perform.
☐ Epi Pen ****Doctor's order required**** ☐ Other:
Please check box and include any details and protocols for the following:
☐ Seizures ☐ G-Tube
Medications Please list all medications below and indicate if a medication must be administered at camp.
☐Admin at camp Time:
☐Admin at camp Time:
☐Admin at camp Time:
☐Admin at camp Time:
Doctor's Order Required for all medications and protocols - have the doctor fax orders to 401-785-2272
****ALL MEDICATION MUST BE CLEARLY LABELLED IN PRESCRIPTION PACKAGING****
Physical limitations: ☐No ☐Yes If yes, please explain:
Recent history of hospitalization or other **important information for Camp Nurse** to know:
Emergency Medical Information
Name of Physician: **Phone:**
Hospital of Choice:
In case of emergency, I understand that every effort will be made to contact me, or the emergency contacts provided. If I cannot be reached, I understand that staff will use a standard 911 protocol.
Signature of parent/guardian:
Printed name of parent/guardian:

Education & Training

High School: _____ Address: _____

From: _____ To: _____ Did you graduate? YES ☐ NO ☐ Degree: _____

College: _____ Address: _____

From: _____ To: _____ Did you graduate? YES ☐ NO ☐ Degree: _____

Other: _____ Address: _____

From: _____ To: _____ Did you graduate? YES ☐ NO ☐ Degree: _____

References

Please list three personal or professional references.

Full Name: _____ Relationship: _____

Company: _____ Phone: **( )** _____

Address: _____

Full Name: _____ Relationship: _____

Company: _____ Phone: **( )** _____

Address: _____

Full Name: _____ Relationship: _____

Company: _____ Phone: **( )** _____

Address: _____

Previous Employment or Volunteer Experiences

Agency: _____ Phone: **( )** _____

Address: _____ Supervisor: _____

Job Title: _____

Responsibilities: _____

May we contact your previous supervisor for a reference? YES ☐ NO ☐

Agency: _____ Phone: **( )** _____

Address: _____ Supervisor: _____

Job Title: _____

Responsibilities: _____

From: _____ To: _____ Reason for Leaving: _____

May we contact your previous supervisor for a reference? YES ☐ NO ☐

Interest & Experiences

Please tell us about any previous experience and/or expertise you have that could be used in our program:

Camp Leadership Training Program Policies

- The Autism Project monitors and evaluates every Camp Leadership Camper to provide feedback and to develop leadership skills.
- CLTs must review the Program Procedures Manual and the Employee Handbook as part of the orientation process which include employee procedures that volunteers must also follow (e.g., health & safety, confidentiality, dress code, attendance, etc.).
- CLTs are encouraged to discuss issues they may have with their mentor at camp. Successful working conditions and relationships depend upon successful communication. The Autism Project welcomes questions, ideas, and suggestions. We will provide as much support and training as possible to ensure that your experience is positive.

Disclaimer and Signature

I certify that my answers are true and complete to the best of my knowledge. I further understand that volunteer positions require the completion of a criminal background checks (if over 18) and other onboarding requirements.

Signature: _____ Date: _____

Signature of Parent Guardian (if volunteer is under 18): _____ Date: _____

Camp Leadership Training Program
Personal Reflections

1. Tell us three things about you that make you a good candidate for the CLT Program.

2. Tell us one thing you want to learn as a member of the Camp Leadership Training Program?

CONFIDENTIALITY AGREEMENT

The Autism Project is a non-profit organization dedicated to empowering professionals and parents to educate and support individuals with autism. Our mission is to develop a comprehensive coordinated system of services and resources that meets the needs of people with an Autism Spectrum Disorder (ASD) and their families. The Autism Project requires that all staff, consultants, and volunteers maintain the confidentiality of information collected, stored, or shared as part of its operations. Confidential information includes any information that may be used to identify an individual child, program, school, or organization and that is not a matter of public record.

All information regarding individuals, their diagnoses, and other medical information, academic records, assessments, and program placement is confidential. This information will only be shared with staff, consultants, and volunteers on a "need to know" basis. Furthermore, any documents containing such information will be handled prudently. Such documents will bear the stamp "CONFIDENTIAL," be retained for as brief a timeframe as necessary, and then shredded through a professional service.

The Autism Project requires all staff, consultants, and volunteers to submit a signed Agreement as part of its Confidentiality Policy. Please sign this form for our records. Thank you for your cooperation and for your efforts to safeguard any and all confidential information you may come in contact within your work with The Autism Project.

I have reviewed the above Confidentiality Policy and agree to maintain the confidentiality of information as required.

Printed Name:
Signature: Date:
Program:

BROWNHealth UNIVERSITY

☐ RIH ☐ TMH ☐ HC ☐ BH ☐ NH ☐ BHMG ☐ GH

O Interview O Video O Photography O Broadcast

Date_____

Authorization and Release
For Photography/Audio and Videotaping/Broadcasting/Interviewing
(When Protected Health Information is Involved)

Brown Health Staff Name _____Initial use_____
name of brochure, ad, event, etc

Patient description _____
use if multiple patients photographed for initial use, ex. yellow shirt, tall, etc.

Patient Name (please print_____

Patient Address (city/state/zip):_____

Patient Date of Birth:_____ Patient Phone #: _____ Patient Email: _____

As applicable and as further described below, I **authorize** Brown University Health and its affiliates to photograph, video and/or audiotape, and/or interview me, or I agree to take part in any radio or TV programs (the "Permitted Interaction"). Describe nature of Permitted Interaction (i.e. context of interview, event at which photos are to be taken, etc.) and nature of protected health information to be gathered about patient:

_____

_____

_____

_____

I **authorize** the Brown University Health Marketing and Communications department to (1) identify me by name in any photographs, videos and/or audio tapes, interviews, broadcasts and/or news stories, generated from the Permitted Interaction, and (2) to use or disclose such materials (along with my name) for display in print, radio, TV or internet media or other form of media for advertising, marketing, fundraising, promotional and educational purposes (the "Permitted Use"), and (3) to use and disclose such materials as necessary to effectuate the Permitted Use (i.e. to employees of newspapers or radio stations).

I **authorize** Brown University Health to copyright any photographs, videos and/or audiotapes, interviews, broadcasts and/or news stories, generated from the Permitted Interaction.

I **understand** that, to the extent the content of the Permitted Interaction contains my protected health information, this information is protected under the federal privacy laws and regulations and under the General Laws of Rhode Island, and cannot be disclosed without my written consent except as otherwise specifically provided by law.

I **understand** that if the person or entity that receives my protected health information (as applicable) is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and is no longer protected by those regulations. Therefore, I release Brown University Health from all liability arising from this disclosure of my health information.

I **understand** this authorization will expire ten (10) years from the date signed below. Prior to the expiration date, I understand I may revoke this authorization by notifying, in writing:

Brown University Health Marketing and Communications, 117 Ellenfield Street, Suite 100, Providence, Rhode Island 02905

I **understand** that any previously disclosed information would not be subject to my revocation request.

I **understand** that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits at Brown University Health.

This form must be fully complete before signing.

_____ _____
Signature of Patient or Patient's Legal Representative Date

_____
Print Signer's Name

_____ _____
Print Name of Legal Representative (if applicable) Relationship to Patient

(A copy of this signed form will be provided to the patient).

BUH0325

Camp Leader Name:	DOB:
Parent(s)/Guardian:	
Address:	Phone:

Please complete the following information if someone other than yourself may pick up the camper from Camp. You must notify us in advance of who will be picking up the camper. Please note that we ask that person to present valid identification to verify his/her identity before releasing the camper to him/her.

Name	Address	Relationship	Phone #

Signature of parent/guardian:	**Date:**
Printed name of parent/guardian:	

Please provide a unique **CODEWORD** to utilize upon pick-up from camp/bus: _____
Please provide this unique **CODEWORD** to persons picking up the camper from Camp. They will be asked for this codeword (by staff) to further verify identification before releasing the camper.

Camp Transportation Agreement:

☐ I will provide transportation to and from Camp *WANNAGOAGAIN!*

☐ **I would like to have transportation, provided by the Autism Project, to Camp WANNAGOAGAIN from the Johnston High School parking lot (345 Cherry Hill Road, Johnston, RI 02919) and back. I understand that the camper will ride in a large bus or van. I agree to pay the $100 transportation fee for the week.**

Transportation Waiver:

I, on behalf of myself and the participant, hereby release, indemnify, quit and hold harmless, and forever discharge The Autism Project and its affiliates and its and their respective governors, directors, officers, employees, and agents from and against any and all liabilities, obligations, damages, penalties, claims, actions, causes of action, demands, judgments, executions, costs (including reasonable attorneys fees), charges, loss of services, expenses, compensation, and any and all other claims whatsoever, both at law and in equity, which I may incur or may assert in connection with bus/van transportation as described herein.

_____ **(initial here)**

I hereby authorize, acknowledge, and accept the risks involved in transporting the camper to and from Camp WANNAGOAGAIN (422 Croff Rd, Pascoag, RI 02859) in a van or bus.

_____ **(initial here)**

I understand that drop off will be at 8:00am Monday-Friday in Johnston High School Parking Lot. I further understand that pick up will be at the same location, at 3:30pm Monday-Thursday, and at 1:30pm on Friday.

_____**(initial here)**

Signature of Parent/Guardian: Date:

Printed Name: Phone #:

ICD-10 Clinical Diagnosis Form

Please bring this page to the physician or clinician and ask them to complete the form. The completed form can be faxed to The Autism Project at 401-785-2272. If you have submitted this form in the past 2 years, you do not need to resubmit.

Dear Physicians and Clinicians,
Please list your patient's diagnosis and the relevant ICD-10 Codes. This is required for insurance.
Please complete the information below & fax to: 401-785-2272 ATTN: Manisha Negi

Date:	
Patient Name:	
ICD-10 code(s) / Diagnosis:	
Physician/Clinician Printed Name:	
Physician/Clinician Signature:	
Credentials:	

Summer Camp 2026
PAYMENT INFORMATION (Confidential)

Camper Leader Name: ***(Required)***			**SS#:**
Parent Name:			**Medicaid ID#:**
Billing Address:			
City:	**State:**	**Zip:**	

Party responsible for payment: ☐ Self/Parent ☐ School/Agency

If school/agency is paying, name of school/agency and contact person:

Address:	City:	State:	Zip:
Office Phone:	Email:		

PLEASE NOTE: ALL CREDIT CARD PAYMENTS WILL SHOW ON YOUR STATEMENT AS PAYPAL.

We do not have a card reader, and process all payments through PayPal.

$75 registration fee will be processed upon receipt, remaining tuition will be processed following placement.

Registration Fee ($75.00) *<u>Fee must be paid to process registration</u>*

☐Check ☐Money Order ☐ Visa/MasterCard/Discover ☐School Paying

Method of payment for Camp Tuition: $475.00 (after $75 Reg. Fee is paid) Total: $550.00

☐Check ☐Money Order ☐ Visa/MasterCard/Discover ☐School Paying

One-to-one support (if not covered by Medicaid) $750.00 or $1000.00 with bus transportation

☐Check ☐Money Order ☐ Visa/MasterCard/Discover ☐School Paying

Transportation $100 (includes pick-up and drop off from Johnston High School, 345 Cherry Hill Road)

☐Check ☐Money Order ☐ Visa/MasterCard/Discover ☐School Paying

Card #	Exp. Date:
Cardholder's Name:	*Security Code:
Cardholder's Billing Address:	
City: State: Zip:	

I authorize The Autism Project to process my payment as indicated above.

Parent/Guardian Signature: Date:

☐Campership Program

Camperships are available on a sliding scale. You may request an application which you will submit with income verification (2025 W2, or 2025 tax return).

Please contact Manisha Negi at 401-785-2666 ext. 76797 for a Campership application. A limited number of scholarships are available.

FOR OFFICE USE ONLY

Payment Received:__/__/__ $_____ Initials: _____ Campership award:_____

Registration and/or Total Tuition (circle) Check#: _____ Parent Portion:_____

SUMMER CAMP DEADLINE INFORMATION

Please keep this page for future reference

JUNE 5, 2026 DEADLINE FOR ALL CAMP REGISTRATIONS

JUNE 19, 2026 LETTERS CONFIRMING PLACEMENT MAILED

JULY 10, 2026 TOTAL CAMP PAYMENT DUE

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CAMP SESSION ONE:
July 20th-July 24th
Monday – Thursday from 9am – 3pm, Friday from 9am – 1pm

CAMP SESSION TWO:
July 27th- July 31st
Monday – Thursday from 9am – 3pm, Friday from 9am – 1pm

CAMP SESSION THREE:
August 3rd-August 7th
Monday – Thursday from 9am – 3pm, Friday from 9am – 1pm

Registrations that are received after the above deadline or without the $75.00 registration fee will result in the camper being placed on a waitlist for an appropriate opening based on age and ability. We appreciate your understanding.

Please Note: All camp groups and times will be determined according to the deadline schedule. Week one is geared towards campers who exhibit more independence. Week two is for campers who may need more support. Week three is for campers 18+ years of age. Due to the number of applicants, session dates cannot be chosen by families, but will be determined based on children's ages and abilities. Thank you for understanding.

We look forward to a fun summer at Camp *WANNAGOAGAIN 2026!*