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 Metro phone 952-852-0107 * Toll free 866-692-7400 *Fax: 952-852-0120

All parts of the application must be completed and mailed or faxed for registration in any Ventures Travel vacation. To assure the best possible experience, we need accurate information about each traveler, therefore, **complete all items**. Please include all personal information you feel will help us provide a safe and happy vacation experience. Thank you. **Date:** _____

Trips #'s/dates desired: 1st choice: _____ 2nd choice: _____
 3rd choice: _____ 4th choice: _____

I am registering for more than one trip, **explain:** _____

Full Legal Name _____

Full Legal Name as listed on photo ID: Last First Name (Nickname) Middle Initial

Address _____
 Street City State Zip

Telephone (_____) County of Birth _____ County of Residence _____

Age _____ Date of Birth _____ Male _____ Female _____ Email _____
DOB required for all flight/train/cruise trips

If applicant lives outside of private home, what is the staff/client ratio? 1:2 _____ 1:3 _____ 1:4 _____ 1:5 or higher _____

If 1:1, please explain: _____

Check type of living situation: Residential Facility _____ Foster Hm _____ Nursing Hm _____ SLS/SLA _____ SILS _____ Private Home/Apt _____

Residential Facility Name _____ Corporate Owner Name _____

Facility Address, if different from address above: _____

Facility Contact Person _____ Facility telephone (_____) _____

Facility email _____

Fax # (_____) _____ Facility Cell phone: (_____) _____

Trip information is sent out after traveler is registered for his/her vacation. I prefer info by email: Yes _____, No _____ OR This should be mailed to: parent _____ group home staff _____ traveler _____ guardian _____ other: _____

Religious preference _____ Race: White _____ African-Am _____ Native-Am _____ Asian _____ Hispanic _____

Is this traveler a child of a veteran? Yes _____ No _____ Parent's Post # _____

Is traveler covered under Medicare or MA? Yes _____ No _____ MA/Medicare # _____

Does traveler have *any other or additional* health insurance coverage? If so, name company: _____

Policy # _____ Policy holder's name _____

Emergency Contact Persons and/or Consultant: Please list two contacts to be reached in the event of medical care or other issue.

Name _____ Relationship to traveler _____

Home phone # (_____) _____ Cell # (_____) _____ Work # (_____) _____

Name _____ Relationship to traveler _____

Home phone # (_____) _____ Cell # (_____) _____ Work # (_____) _____

FOR OFFICE USE ONLY: Application received _____ Deposit received _____ By _____

WC SLW 1:2 1:3 1:4 1:5 or higher 1:1 staff needed OR PCA/volunteer going

Trips registered for: _____

Traveler's Name _____ Date of Birth _____ Age _____
Name of Person Completing Application _____

DISABILITY/OTHER CONDITIONS: Check one: _____ **with disability/other condition** _____ **without disability/other condition**
*Please check all boxes that apply. Conditions in bold print * require an additional questionnaire which our office will send you.*

_____ Ability Level is: _____ Mild _____ Moderate
_____ Asperger Syndrome
_____ Autism, type: _____
_____ Attention Deficit Disorder or _____ Attention Deficit Hyperactivity Disorder
_____ Alzheimer's or other Dementia (Beginning stages)
_____ Blind/Vision impaired: _____ Wears glasses _____ Uses cane
_____ Cerebral Palsy
_____ Deaf/hearing impaired: _____ wears hearing aid(s)
_____ Uses sign language (needs a staff proficient in sign language)
_____ Developmental/Cognitive or Intellectual Disability
_____ Down Syndrome
_____ Oppositional Defiant Disorder
_____ Pervasive Developmental Disorder
_____ Prader-Willi Syndrome
_____ Rett Syndrome
_____ Tourette Syndrome
_____ Traumatic Brain Injury
_____ Williams Syndrome
_____ Further explanation for any condition or other disorder, explain: _____

Other medical issues/items/notes:
_____ Allergies to _____

_____ Reaction: _____ Hives _____ Difficult breathing
_____ Anaphylaxis _____ Other _____

_____ Arthritis
_____ ***Catheter:** _____ intermittent _____ in-dwelling
_____ colostomy or ileo appliances
_____ ***Diabetes**, type _____
_____ **insulin dependent: traveler must be able to draw and administer own injections**
_____ ***Epilepsy/Seizures**, type & frequency: _____

_____ ***Orthopedic appliances**
_____ splints _____ braces _____ prosthesis
_____ ***Respiratory:** _____ C-pap/bi-pap _____ asthma
_____ other _____
_____ Heart problems, explain _____

Special Appliances/Ambulation

Does traveler use a wheelchair? _____ Yes _____ No (Ventures Travel does not provide wheelchairs. If needed, traveler must bring own chair.)
_____ wheelchair used for long distances only _____ wheelchair used full-time _____ Manual _____ Electric _____ Stroller
_____ traveler transfers self _____ traveler needs assistance to transfer _____ traveler can bear weight _____ traveler needs total assistance
Additional care instructions: _____
_____ traveler has range of motion exercises, how often? _____ **Please attach a copy of exercises.**
_____ traveler requires assistance in walking. Assistance is: _____ support from another person _____ cane _____ walker _____ crutches
Describe traveler's gait: _____ stable _____ unsteady _____ walks slowly _____ falls easily
Traveler wears: _____ **orthotics**, circle left or right _____ prosthesis, circle left or right _____ braces, circle daytime or nighttime
_____ shoe inserts, circle left or right

Sleeping

_____ traveler sleeps through the night _____ *traveler does not sleep through the night _____ *traveler has difficulty sleeping
*Explain: _____
Does traveler have any bedtime rituals that are important for us to know about? _____ Yes _____ No Please describe: _____

Eating

Traveler is _____ right-handed _____ left-handed Normal appetite is: _____ large _____ medium _____ small
Assistance level for eating: _____ No help _____ some help _____ all help, explain: _____
Traveler has food allergy to: _____
Reaction? _____ hives _____ difficulty breathing _____ nausea _____ other, explain _____
Is traveler on a special diet/restriction? _____ No _____ Yes, describe: _____

Does traveler have trouble: _____ swallowing _____ chewing _____ drinking liquids
Traveler uses: _____ special utensils (bring) _____ chopped food _____ dietary supplement (bring) _____ straw _____ **feeding tube**
Further instructions/information about eating or diet: _____

Personal Care

Traveler's current weight _____ current height _____ Traveler prefers: _____ baths _____ showers
Assistance level: _____ No help _____ *some help _____ *all help ***indicate areas where help is needed, check all that apply:**
_____ washing face and hands _____ mixing water for bath or shower _____ brushing teeth _____ washing hair _____ rinsing hair _____ shaving
_____ combing hair _____ menstrual care _____ washing body areas, explain: _____
_____ Traveler wears dentures _____ cares for dentures independently _____ takes dentures out at night _____ needs assistance in denture care
Further personal care instructions: _____

Traveler's Name _____ Date of Birth _____ Age _____
Name of Person Completing Application _____

Bathroom Use (Travelers with incontinence are required to pack plastic sheets/ depends/chuks or combination to protect hotel beds)

Traveler is: _____ independent in bathroom _____ needs reminders to use bathroom _____ *needs help in the bathroom _____ *is incontinent,
*explain: _____

Is traveler on a bathroom schedule? _____ Yes _____ No Please explain: _____

Does traveler use: (please bring all supplies) _____ *urinal _____ *adult depends or attends _____ *catheter or _____ **intermittent catheter**
_____ *colostomy or ileo appliances Explain any * items: _____

Communication

Traveler understands and responds to questions? _____ Yes _____ No Traveler is able to read: _____ Yes _____ No

Traveler communicates wants/needs: _____ Yes _____ No _____ Verbal _____ Non-verbal

If non-verbal, traveler communicates: _____ using sign language _____ using a communication board or book (please provide)

*If using sign language, traveler requires staff proficient in sign language: _____ Yes _____ No

*Traveler/family/group home can provide a staff proficient in sign: _____ Yes _____ No

Traveler is able to write: _____ Yes _____ No Any further explanation about communication: _____

Dressing

Traveler is: _____ independent in choosing/putting on clothes _____ needs assistance with choosing/putting on clothes _____ *needs total help

Traveler needs assistance with: _____ buttons _____ shoes _____ shoe laces _____ socks _____ fasteners _____ zippers _____ shirt _____ bra
_____ pants _____ reminders to wear clean clothes _____ separating clean and dirty clothes Any further explanation: _____

Social Interaction Skills: Check all that apply

_____ No unusual behavior _____ attaches to male staff _____ attaches to female staff _____ withdrawn or shy _____ *verbal aggression

_____ *self-injurious _____ *physically aggressive toward others _____ *physically aggressive toward objects _____ has temper tantrums

_____ wanders unintentionally (distracted) _____ wanders or runs away intentionally _____ other _____

_____ *traveler is on a **behavior modification or management plan** (explain below and *send copies if expected to comply on vacation*)

_____ traveler has been away from home before _____ *traveler experiences homesickness _____ *traveler has fears that will impact vacation

Explain any checked behaviors (and those with *), their frequency and suggested method of dealing with behavior: _____

Personal Information

We continually evaluate giving every traveler their own bed. This means increased numbers of hotel rooms or larger vacation homes which are difficult to find. In order to maximize staff supervision, accommodations are based on sleeping arrangements which require sharing double / queen/king size beds. **Traveler will share a bed _____ OR Traveler will pay \$25/night extra for own bed _____** (add'l fees are added to bill)

Is there a traveler on this vacation they would feel comfortable sharing a bed with? Name of traveler: _____

Travelers may go to a social function/restaurant where alcohol is served. May traveler have alcohol? _____ Yes _____ No. If yes, what type of alcoholic beverage may be chosen? _____ Beer _____ Wine _____ Liquor Suggested drink limit? _____

Traveler: _____ manages spending money independently _____ will check spending money in with staff. Explain any other money management concerns: _____

Traveler: _____ takes medications independently _____ needs some staff supervision to ensure meds taken _____ needs staff to administer meds

Traveler smokes: _____ Yes _____ No If a smoker, traveler manages cigarettes: _____ Yes _____ No *Staff hold cigarettes: _____ Yes

*Traveler on cigarette limit: _____ Yes, how many and how often? _____

Traveler enjoys swimming _____ Yes _____ No Traveler rides a _____ 2-wheeler w/ helmet _____ 3-wheeler w/ helmet _____ No bike riding

Traveler has: _____ attended a Ventures Travel trip _____ traveled w/ a similar company—which company? _____

Additional information regarding activities enjoyed, likes, dislikes, fears or activity restrictions which may be helpful to our staff: _____

Each traveler sends a post card to a family member/friend/coworker/housemate. Please identify a person (and their relationship) and provide a complete mailing address: _____

Traveler's Name: _____ Date of Birth: ____/____/____ Age: _____

HEALTH HISTORY-LIST OF MEDICATIONS

This Health History Form may be completed by the traveler (if own guardian), parent, legal guardian or facility personnel. It **does not** require a physician signature. We need to receive it for registration in any Ventures Travel, LLC trip. PLEASE SEND PHOTOCOPIES (fronts & backs) OF ALL INSURANCE, MA & MEDICARE CARDS.

Doctor: _____ (____) _____
 Name Address City/State/Zip Phone
 MA # _____ Medicare # _____

Special Medical Needs: You may be sent a questionnaire requesting more information. Complete and return to our office at least 2 weeks prior to check-in. **Please check all that apply:** _____ Asthma _____ Nebulizer _____ Tracheostomy _____ Seizures
 _____ Orthopedic Appliances _____ Gastrostomy (Feeding Tube) _____ Receives care from licensed nurse on a daily basis
 _____ Diabetes: _____ Insulin Dependent (traveler must be able to draw/administer insulin or administer from pre-drawn syringes)
 _____ Diabetes controlled by diet _____ Blood sugar testing required _____ Colostomy / Ileostomy
 _____ Catheter: Type _____ Other _____

MEDICATIONS: All medications MUST BE RECEIVED IN AN ORIGINAL CONTAINER, BUBBLE PACK OR PILL DISPENSER AND PROPERLY LABELED with person's name, medication, dosage and times of administration. NOTE: Non-prescription over-the-counter meds, vitamin or herbal supplements must come in a container that has written instructions and dosage information. If prescribed by a medical doctor or doctor of osteopathy, send in a prescription-labeled bottle from the pharmacy. **We encourage leaving at home any unnecessary medications.**

Oral Medications	mg. per tablet	# tablets/dose	frequency	8:00A	Noon	4:00P	9:00P	Special Instructions (before, with or in food)

Please check all that apply: _____ swallows meds _____ crush meds _____ meds are in liquid form _____ other (explain in *exceptions below) For insulin: _____ syringes (pre-drawn or traveler is able to set up) OR _____ dial-up insulin pen

Topical Medications and Treatments: (Please state specific instructions for use of drops, ointments, dressings, treatments, etc.)

Please check all that apply and bring the medications below which will be administered as needed.
 _____ MOM 2nd day without BM _____ Fleets enema if no results from suppository _____ Bisacodyl Suppository 3rd day without BM
 _____ Bowel Movement Program Not Applicable _____ Other: _____

Check if traveler is subject to the following: _____ sunburn _____ frequent colds _____ dizziness/fainting spells
 _____ constipation _____ menstrual problems _____ frostbite _____ bronchitis _____ ear infection(s)
 _____ diarrhea _____ vaginal infections _____ sore throat _____ pneumonia _____ sinus infection
 _____ nausea/vomiting _____ urinary infections _____ skin rash _____ hernia _____ must not get water in ears
 _____ stay out of water _____ other _____ Explain checked items: _____

***This Health History is correct so far as I know** and the person described has permission to engage in all activities except as noted.

*Exceptions: _____

 Signature of person who completed this form Date

TO SHORTEN YOUR CHECK-IN TIME:

1. **THIS FORM MUST BE COMPLETED AS PART OF THE APPLICATION FOR REGISTRATION ON ANY VENTURES TRAVEL, LLC VACATION.**

 2. *If there is a change in the traveler's health or medication(s), please call the Program Coordinator at (952) 852-0107, ext. 6. Keep us updated with any medical changes or conditions!*

 3. We must be notified of anyone who has had surgery within 3 weeks prior to departure date. Call the Program Coordinator at (952) 852-0107, ext. 6 to determine continued eligibility. Thank you.

 4. **PRESCRIBED MEDICATIONS MUST BE PROPERLY LABELED IN AN ORIGINAL CONTAINER, BUBBLE PACK OR PILL DISPENSER.**
- ****NOTE: Any non-prescription, over-the-counter, vitamin or herbal supplement must come in a container that has written instructions and dosage information. Bottles purchased from Target, Wal-Mart, etc. are perfectly acceptable if they have clear instructions and dosage information. If prescribed by a medical doctor (M.D.) or doctor of osteopathy (DO), send in a prescription-labeled bottle from the pharmacy. *******
5. **Any person bringing the traveler to check-in must be able to answer questions regarding the applicant's:**
 - A. Dietary Needs
 - B. General health and medication(s)
 - C. Special appliances and/or other medical needs
 - D. Wheelchair use and transfer techniques
 - E. Emergency contact information

THANK YOU!

Traveler's Name: _____

PAYMENT AGREEMENT: Please read carefully. I/We agree to pay for the services provided by Ventures Travel, LLC. I/We understand that the cost of service includes: staff supervision, accommodations (single bed/room fees are extra), attractions, method of travel, and most of the meals. I/We understand that the spending money I bring will cover the cost for a small number of meals while on vacation and all souvenirs. If this page is not completed, I/we understand that Ventures Travel, LLC will assume I am paying the actual cost.

Check all that apply.

I will pay the actual cost of trip _____ I will pay discount fee _____ Full payment is enclosed _____ Deposit only enclosed _____

Would you like to receive your invoice via email? Yes _____ No _____

Email address: _____

Invoice should be sent to: Name: _____

Address: _____

City/State/Zip: _____

Please note: Invoices are automatically printed and sent each month. Sometimes payments are received very close to that time and may not be reflected in your most current statement. It may take 30-60 days for payments to be reflected on the invoice. You will receive a monthly bill each month until the balance is paid.

I cannot pay for my trip all at once. Here is my plan for payments: **Check all that apply**

_____ I will pay balance within 30 days of completing the trip.

_____ I will make monthly payments in the amount of \$ _____.

_____ I will pay by credit card. Bill \$ _____ to my: Master Card _____ Visa _____

Card # _____ Printed name on Card: _____

Expiration Date: _____ CVV# (3 digits on back): _____

Signature: _____

Billing Address of credit card: _____

Cardholder's telephone number (in case of questions): (_____) _____

(Your credit card statement will list GIVEDIRECT as the payee, not Ventures Travel, LLC.)

_____ I will have help paying for my vacation. Payments will come from these sources:

\$ _____	_____	_____	_____	_____	_____
Amount	Name of person or organization	Address	City	State	Zip

\$ _____	_____	_____	_____	_____	_____
Amount	Name of person or organization	Address	City	State	Zip

Is applicant eligible to receive Waiver Service Funds? Yes _____ No _____ **If yes, please check the waiver that applies:**

Consumer Directed MR/RC CADI MR/RC TBI ISP/CSP Other _____

I want to contribute to the "Scholarship Fund" to help another person take a Ventures Travel, LLC vacation. Amount donated: \$ _____

