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**Main Office/Headquarters:** 6350 Indian Chief Road; Eden Prairie, MN 55346-1619  
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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:** \_\_\_\_\_

Trip #'s/dates desired: 1<sup>st</sup> choice: \_\_\_\_\_ 2<sup>nd</sup> choice: \_\_\_\_\_  
 3<sup>rd</sup> choice: \_\_\_\_\_ 4<sup>th</sup> choice: \_\_\_\_\_

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

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 \_\_\_\_\_ !:3 \_\_\_\_\_ 1:4 \_\_\_\_\_ 1:5 or higher \_\_\_\_\_  
**If 1:1, please explain:** \_\_\_\_\_

**Check type of living situation:** Residential Facility \_\_\_\_\_ Foster Home \_\_\_\_\_ Nursing Home \_\_\_\_\_ SLS/SLA \_\_\_\_\_ SILS \_\_\_\_\_ Private Home \_\_\_\_\_

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 \_\_\_\_\_  
 Record # \_\_\_\_\_ 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 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? \_\_\_\_\_

How did you hear about Ventures Travel? \_\_\_\_\_ internet search \_\_\_\_\_ social worker \_\_\_\_\_ teacher \_\_\_\_\_ friend/family \_\_\_\_\_ Arc \_\_\_\_\_ DSAM  
\_\_\_\_\_ AUMN \_\_\_\_\_ other support organization

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 2<sup>nd</sup> day without BM \_\_\_\_\_ Fleets enema if no results from suppository \_\_\_\_\_ Bisacodyl Suppository 3<sup>rd</sup> 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: \_\_\_\_\_

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 \$ \_\_\_\_\_. (You will receive a monthly bill each month until balance is paid.)

\_\_\_\_\_ 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.)

**Note: Due to timing of when invoices are sent and payments are received, it may take 30-60 days for payments to be reflected on the billing invoice.**

\_\_\_\_\_ 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: \$ \_\_\_\_\_