
# Marion's Way Listening and Language Camp

## Summer 2025 Application

***Applications are due by April 1st 2025***

**Purpose and Philosophy:**
Marion's Way is an intensive summer language enrichment program for children who are deaf or hard of hearing incorporating a language-rich environment and instruction with a focus on developing listening and spoken language skills. Theme-based learning experiences incorporated into language, cognitive, and literacy activities for children will support social, emotional, and pre-academic development. Technology will optimize auditory access. Parent participation and education will support the carryover of these skills to home and family environments. Applications will be considered on a first come-first serve basis based on eligibility requirements.

**Eligible Students:**

- Ages 3-5
- Deaf or hard-of-hearing
- English spoken language levels of 2 years-5 years
- Participation is **required** for a speech/language, learning, and hearing assessments at the Marion Downs Center (MDC). This will include 1-2 clinic visits in early May.
- Parents must participate in all 3 parent information sessions
- Referral from parent, teacher, early intervention provider, speech-language pathologist, or audiologist
- Release of Information from clinical and school audiologist also needed

**Schedule and Location:**

- The 3-week program meets from 9:30-12:00 on Monday-Thursday from June 9th - June 26th.
- There will be a Parent Information/Welcome Session in person before June 9th and 2 additional parent education sessions will be on Zoom during the session (time to be arranged).
- Assessments are completed in early May at the MDC (4280 Hale Parkway, Denver 80220)
- Marion's Way Language Camp meets at the Anchor Center (2550 Roslyn Street, Denver 80238)

**Tuition and Scholarships:**

- Tuition is $500 and includes 3 weeks of intensive language learning and 3 parent information sessions.
- There is a non-refundable registration fee of $50
- Participation will not be limited by family's financial resources. Please contact us for a scholarship request form.

Today's date:
_____/_____/_____
month day year

**GENERAL INFORMATION:**

| | | | |
|---|---|---|---|
| Child's Name | | | |
| Birthdate (Month, Date, Year) | | | |
| Address | | City & Zip | |
| Parent 1 Name | | Parent 2 Name | |
| Phone (cell) | | Phone (home) | |
| Preferred Email | | | |

**With whom is the child currently living?**

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Both Parents | | Parent 1 | | Parent 2 | | Foster Parents/ Guardians | | Other | |

**Languages used at home: (Please check all that apply)**

| | | | |
|---|---|---|---|
| English | | Sign Language | |
| Spanish | | Other (specify) | |

**HEARING INFORMATION:**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| When was onset of Hearing Loss? | Present at birth | | Acquired after birth | | Don't know | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| If acquired, at what age? | Years | | Months | | Weeks | |
| Age at which hearing loss was confirmed by an audiologist | Years | | Months | | Weeks | |
| Age at which intervention first started | Years | | Months | | Weeks | |
| Age at which amplification was first received | Years | | Months | | Weeks | |

* Pick either months or weeks – whichever is applicable

**Type of amplification currently used:**

| | | | | | |
|---|---|---|---|---|---|
| None | | Hearing Aid(s) | | Osseointegrated device (Baha, Pronto, etc) | |
| FM System | | Cochlear Implant(s) | | | |

| | |
|---|---|
| Make and Model of Devices: | |

| | | | | |
|---|---|---|---|---|
| If your child has a cochlear implant | Date left ear implanted | | Date activated | |
| | Date right ear implanted | | Date activated | |

| | |
|---|---|
| Facility where hearing is tested | |
| Audiologist's Name | |

****Please attach a copy of current audiogram and most recent audiology report****

**CURRENT COMMUNICATION METHOD:**
Check the sentence that best describes how the child's primary caregiver (if not the mother or father) communicates with the child MOST of the time.

| | |
|---|---|
| | I speak to my child. I do not use sign language. |
| | I typically speak to my child. I occasionally use some sign language. |
| | I typically speak AND sign to my child. I try to sign most or all of the time when I talk. |
| | I typically sign to my child WITHOUT speaking. |
| | Other (specify) |

**CURRENT SCHOOL AND THERAPY IF APPLICABLE:**
NOTE: Answer each of the questions in this section in relation to the academic year your child just completed.

| | | | |
|---|---|---|---|
| Name of School | | School District | |
| Name of Classroom Teacher | | | |
| Name of Deaf Educator | | | |
| Name of Speech Pathologist | | | |
| Phone Number | | Email | |

**Please complete the following table indicating how many hours/minutes per week that your child is in each type of educational setting:**

| Type of Intervention | Hours | Minutes |
|---|---|---|
| Class primarily for deaf/hard-of-hearing children | | |
| Class for children with a variety of special needs | | |
| Class primarily for hearing children | | |
| Other, please describe: _____ | | |

**Check the sentence that best describes how the teacher communicates with your child MOST of the time.**

| | |
|---|---|
| | The teacher speaks to my child. She/He does not use sign language. |
| | The teacher speaks to my child. She/He occasionally uses a little bit of sign language. |
| | The teacher typically speaks AND signs to my child. She/He tries to sign most/all of the time when speaking. |
| | The teacher typically signs to my child WITHOUT speaking. |
| | Other (specify) |

| | | | | | |
|---|---|---|---|---|---|
| **Does your child receive speech or auditory therapy outside of school?** | | Yes | | No | |
| If YES, amount of time per week | | Therapist's Name(s) | | | |
| Phone Number | | Email: | | | |

**CHILD'S OTHER SPECIAL NEEDS/CONDITIONS:** (Please check all that apply.)

| | | | |
|---|---|---|---|
| | No other disabilities | | Vision problem/impairment |
| | Brain injury | | Seizures/Epilepsy |
| | Cerebral palsy (CP) | | Emotional/Behavioral problem |
| | Specific Learning disability (LD) | | Motor problem |
| | Developmental/Cognitive delay | | Central processing disorder |
| | Autism/PDD | | Cleft lip/palate |
| | Balance disorder | | Sensory/Motor integration problem |
| | Other disability (Please explain): | | |

| | | | | |
|---|---|---|---|---|
| Is your child receiving any intervention services for additional special needs/conditions (other than hearing loss)? | | Yes | | No |
| If Yes, name and type of program | | | | |
| Contact Person | | | | |
| Email Address | | Phone | | |

| | | | |
|---|---|---|---|
| Are you able to bring your child to the Marion Downs Center to do a speech/language/hearing/learning assessment? | Yes | | No |
| Will you be able to attend 2 parent information sessions during the program and participate in your child's intervention? | Yes | | No |

**What else would you like us to know about your child?**

Some audiology and speech language services are included as part of Marion's Way Summer Language Enrichment Program. Evaluations and some services will be billed to your insurance. If these are not benefits covered by your insurance, financial aid is available.

| | | | |
|---|---|---|---|
| Insurance Provider Company Name | | | |
| Medicaid ID # | | Policy Holder Name | |
| Who referred this child to Marion's Way Summer Language Enrichment Program? | | | |
| Name | | Phone Number: | |
| How did you hear about Marion's Way? | | | |
| | | | |

Please attach a copy of your child's most recent IEP documents, including testing results and audiogram.
** This information needs to be included with your application for it to be processed.
*** Please complete Release of Information included in this packet.

## AUTHORIZATION TO SECURE AND RELEASE STUDENT INFORMATION

| | | | | | |
|---|---|---|---|---|---|
| Today's Date | | | | | |
| Student Name | | Date of Birth | | | |
| Parent/Guardian Name | | Phone | | | |
| Street Address | | | | | |
| City | | State | | Zip Code | |

I, _____, authorize release of information specified below to/from The Marion Downs Center to allow inspection of records; exchange of treatment information; ongoing communication; and information by telephone. Any and all pertinent information includes, examination, diagnosis, history, treatment, and prognosis along with any other information you feel might be helpful.

**Specifically (check all that apply):**

| | |
|---|---|
| | Copy of Medical Records |
| | Evaluations and assessments, including cognitive assessments, psychological assessments, vision, hearing, or speech/language assessments, occupational or physical therapy assessments, social-emotional assessments, learning assessments, and any reports or recommendations pertaining thereto. |
| | Education records, including grades, test records, Individual Education Plans, assessments, discipline records, psychological records, attendance records, vocational assessments and data, social and emotional records, exclusion contracts and behavior management plans. |
| | Other records not specified above (please note): |

**INFORMATION TO BE OBTAINED FROM/OR RELEASED TO:**

| Name (Audiologist) | Phone | Address |
|---|---|---|
| | | |
| Name (Speech Pathologist) | Phone | Address |
| | | |
| Name (School) | Phone | Address |
| | | |
| Name (Physician) | Phone | Address |
| | | |

**REQUEST & AUTHORIZATION:** I hereby request and authorize the Marion Downs Center to secure and release information from the person or entity name above on this form. I understand that this information will be pertinent information concerning the student. I certify that this request has been made voluntarily and that the information described above is accurate, to the best of my knowledge. I understand that I may revoke the authorization at any time, except to the extent that action has already been taken to comply with it.

**Without my express written revocation, this consent will automatically expire under one or more of the following conditions:**
Upon receiving all requested information; if revoked in writing by the student or guardian; one year from the date of signature; or under the following conditions: _____
** I have been given the opportunity to read or obtain a copy of the Notice of Privacy Practices **

Signature of Patient/Guardian _____ Date _____
Signature of Witness _____ Date _____

**Please Return to:** The Marion Downs Center, 4280 Hale Parkway, Denver, CO 80220
Tel: 303-322-1871 Fax: 303-399-3411