



Marion's Way Listening and Language Camp Summer 2026 Application

Applications are due by April 10th, 2026

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 starting early May.
- Parents must participate in 2 parent education 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 2-week program meets from 9:00-12:30 on Monday-Thursday from June 15th - June 25th.
- There will be 2 Parent Education workshops during the 2 weeks. (time to be arranged).
- Assessments are completed prior to the start of camp at the MDC (5570 DTC Pkwy Ste 200, Greenwood Village, 80111)
- Marion's Way Language Camp meets at the Anchor Center (2550 Roslyn Street, Denver 80238)

Tuition and Scholarships:

- Tuition is \$600 and includes 2 weeks of intensive language learning and 2 parent education 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	
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Languages used at home: (Please check all that apply)

English		Sign Language	
Spanish		Other (specify)	

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

When was onset of Hearing Loss?	Present at birth		Acquired after birth		Don't know	
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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, Ponto, etc)	
FM System		Cochlear Implant(s)			

Make and Model of Devices:	
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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	

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.

<input type="checkbox"/>	I speak to my child. I do not use sign language.
<input type="checkbox"/>	I typically speak to my child. I occasionally use some sign language.
<input type="checkbox"/>	I typically speak AND sign to my child. I try to sign most or all of the time when I talk.
<input type="checkbox"/>	I typically sign to my child WITHOUT speaking.
<input type="checkbox"/>	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.

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

Does your child receive speech or auditory therapy outside of school?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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):

<input type="checkbox"/>	Copy of Medical Records
<input type="checkbox"/>	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.
<input type="checkbox"/>	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.
<input type="checkbox"/>	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