

## HABILITATION SERVICES APPLICATION

Please complete the Habilitation Services Application Packet and attach the necessary assessment, reports, etc. and return to the program. The Habilitation Services Interdisciplinary Team will review all of the information that is submitted for review. Determination for services is based on the Habilitation Services admission criteria and availability of service slots. Prospective participants are encouraged to visit the service and meet with the habilitation staff. Individuals applying for services will be notified as soon as possible regarding their status. Thank you for considering Rehabilitative Resources Inc. to provide services.

**Please Check Habilitation Services Applying for:**

- Habilitation Services/Medical Assistance Program (Medicaid)
- Habilitation Services/Alternative Funding

***Applicant:***

NAME:		MASS HEALTH CARD NUMBER:			DATE OF BIRTH:	
ADDRESS:		CITY:		STATE:	ZIP:	PHONE:
SOCIAL SECURITY NUMBER:	LANG. SPOKEN	HEIGHT	WEIGHT	EYE COLOR	HAIR COLOR	SEX: M    F
DISTINGUISHING MARKS		DMR	MASS. COMM. FOR BLIND			
		MEDICAID	PRIVATE	OTHER		
DMR SERVICE COORDINATOR					PHONE:	



**Assessments:**

PLEASE INDICATE IF THE FOLLOWING ASSESSMENTS HAVE BEEN PERFORMED PLEASE ATTACH REPORTS IF APPLICABLE			DATES:
Yes	No	Speech	_____
Yes	No	Psychological	_____
Yes	No	Occupational Therapy	_____
Yes	No	Physical Therapy	_____
Yes	No	Vocational	_____

LIST THE INTERESTS OR THINGS THE PERSON LIKES TO DO:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

PLEASE INDICATE IF THE FOLLOWING APPLY:				Comments
Yes	No	Partial	Able to feed self	_____
Yes	No	Partial	Incontinence	_____
Yes	No	Partial	Pedestrian Safety Knowledge	_____
Yes	No	Partial	Knowledge of Immediate Neighborhood	_____
Yes	No	Partial	Knowledge of Town/Community	_____
Yes	No	Partial	Response to Potentially Dangerous Situations	_____
Yes	No	Partial	Fire Safety Knowledge	_____
Yes	No	Partial	Telephoning	_____
Yes	No	Partial	Ability to Make Emergency Calls	_____
Yes	No	Partial	Verbal	_____
Yes	No	Partial	Ambulatory	_____
Yes	No	Partial	Able to make needs/wants known	_____

### ***Primary Care Physician***

NAME:	PHYSICIAN PROVIDER NUMBER:	PHONE:
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STREET:	CITY:	STATE:	ZIP:	# OF YRS WITH MD
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### ***Emergency Contact Person (s)***

PRIMARY EMERGENCY PERSON:	RELATIONSHIP:	DAYTIME PHONE:
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STREET:	CITY:	STATE:	ZIP:
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ALTERNATIVE EMERGENCY PERSON:	RELATIONSHIP:	DAYTIME PHONE:
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STREET:	CITY:	STATE:	ZIP:
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### ***Family History***

MOTHER'S NAME	PHONE
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STREET:	CITY:	STATE:	ZIP:
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FATHER'S NAME	PHONE
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STREET:	CITY:	STATE:	ZIP:
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DESCRIBE FAMILY INVOLVEMENT:
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LIST OTHER FAMILY MEMBERS, FRIENDS OR ADVOCATES:
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HAS A LEGAL GUARDIAN BEEN APPOINTED?  Yes                      No	IF YES, NAME OF GUARDIAN:
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STREET	CITY	STATE	ZIP	PHONE
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OTHER COMMENTS:
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SIGNATURE OF PERSON COMPLETING FORM:	DATE:
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**AUTHORIZATION FOR EMERGENCY MEDICAL CARE**

I, \_\_\_\_\_ hereby grant authorization to Rehabilitative Resources Inc. to take whatever measures that are necessary to provide hospitalization and medical care including surgery, in case of emergency for \_\_\_\_\_

\_\_\_\_\_/ Date of Birth \_\_\_\_\_ while

being served by Rehabilitative Resources Inc.

This authorization is valid only in situations requiring emergency care as directed by a qualified physician.

This authorization is not to be construed as covering non-emergency surgery or hospitalization.

This authorization is valid for one year from the date indicated below.

Signed \_\_\_\_\_ Date \_\_\_\_\_  
Name

Signed \_\_\_\_\_ Date \_\_\_\_\_  
\*Legal Guardian

\*Every reasonable effort will be made to contact the legal guardian in the case where an emergency medical care situation arises while a person is receiving services from Rehabilitative Resources Inc.

**PHYSICIAN'S APPROVAL FOR ATTENDANCE**

To: \_\_\_\_\_

Our records indicate that the following individual is currently under your care. Please complete the following information and return with a copy of the recent physical (less than one year old) as this is necessary for our records.

\_\_\_\_\_, DOB \_\_\_\_\_  
has been accepted to our Habilitations Services Program.

This program provides day services between the hours of 9:00 a.m. and 3:00 p.m., which includes Occupational, Physical and Speech Therapy as well as adult daily living skills.

Please check one of the following:

- This individual would benefit from Day Habilitation Services
- This individual would benefit from Day Habilitation Services with the following restrictions:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

Thank you in advance for your cooperation in this matter.

**ADMINISTRATION OF MEDICATIONS/TREATMENTS**

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

<b>Medication</b>	<b>Dosage</b>	<b>Route/Time of Administration at Program</b>

? May administer medication with food

Other medications currently being administered at home:

This is to certify that the above medication orders are correct and current.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

## **STATEMENT OF CONFIDENTIALITY**

It is the policy of Rehabilitative Resources Inc. to ensure that all information relating to the personal facts, records, data, behaviors, disability or any other information including lists of names, addresses, records and agency evaluations are considered confidential. Such information shall also be held to be private property of Rehabilitative Resources Inc.

The use of such information and records is limited to purposes directly connected with the administration of the service and shall not be disclosed directly or indirectly other than in the administration of the program and then only in accordance with the agency's policy regarding release of such information. To obtain or disclose information or records it is necessary to obtain informed consent from the participant and guardian where applicable.

I have read and understand the above statement of confidentiality.

\_\_\_\_\_  
Signature of RRI Employee, Student,  
Volunteer or other Agency  
Representative

\_\_\_\_\_  
Date

**INFORMED AND VOLUNTARY CONSENT FOR PUBLIC IDENTIFICATION TO PUBLICIZE AND PROMOTE REHABILITATIVES RESOURCES INC.**

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

I give permission and authorize Rehabilitative Resources Inc. to photograph and/or video \_\_\_\_\_

\_\_\_\_\_ (Person's Name) for the purpose of publicizing and promoting Rehabilitative Resources Inc.'s mission, purpose, and services in the following ways:

- \_\_\_\_\_ Newsletters
- \_\_\_\_\_ Annual Appeals
- \_\_\_\_\_ Annual Reports
- \_\_\_\_\_ Brochures and Promotional Publications
- \_\_\_\_\_ Fundraising Materials
- \_\_\_\_\_ Fundraising Events
- \_\_\_\_\_ Grant Applications
- \_\_\_\_\_ Rehabilitative Resources Inc. Website
- \_\_\_\_\_ Holiday Cards
- \_\_\_\_\_ Newspaper, Magazine and other Advertising
- \_\_\_\_\_ Newspaper, Magazine and other Articles/Stories

**I consent to my photograph/video being taken and/or used to publicize or demonstrate the nature and scope of Rehabilitative Resources Inc. as described above.**

**I understand that for each instance of public identification, I will be contacted for my approval verbally.**

**This consent is in effect for one year from the date it is signed. I understand that I may withdraw my consent at any time without fear of punishment.**

\_\_\_\_\_  
Signature of Person Granting Consent

\_\_\_\_\_  
Date

\_\_\_\_\_  
If Appropriate, Signature of Legal Guardian

\_\_\_\_\_  
Date

**VERBAL INFORMED CONSENT FOR PUBLIC IDENTIFICATION TO  
PUBLICIZE AND PROMOTE REHABILITATIVE RESOURCES INC. LOG**

Name: \_\_\_\_\_

<b>Person Contacted (Person and/or Legal Guardian)</b>	<b>Date</b>	<b>Approval Yes or No</b>	<b>Description of Public Identification* Consent is Given for this Instance Only</b>

\* Newsletters, Annual Appeals, Annual Reports, Brochures and Promotional Publications, Fundraising Materials, Fundraising Events, Grant Applications, Rehabilitative Resources Inc. Website, Holiday Cards, Newspaper, Magazine and other Advertising, Newspaper, Magazine and other Articles/Stories



## **NOTICE OF PRIVACY PRACTICES**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT PERSONS RECEIVING SERVICES FROM RRI MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. **What this Is**

This Notice describes the privacy practices of Rehabilitative Resources Inc.

2. **Our Privacy Obligations**

We are required by law to maintain the privacy of medical and health information about the people RRI serves (“Protected Health Information” or “PHI”) and to provide you with this Notice of our legal duties and privacy practices with respect to PHI. When we use or disclose PHI, we are required to abide by the terms of the Health Insurance Portability and Accountability Act (HIPAA) or other notice in effect at the time of the use or disclosure.

## **Acknowledgement Receipt of RRI's Privacy Protection Policies and Procedures**

Person Served by RRI \_\_\_\_\_ Date \_\_\_\_\_

### **ACKNOWLEDGEMENT OF RECEIPT OF REHABILITATIVE RESOURCES INC.'S NOTICE OF PRIVACY PRACTICES:**

By my signature below, I hereby acknowledge that I have received a copy of Rehabilitative Resources Inc. "Notice of Privacy Practices".

\_\_\_\_\_  
Signature of Person Served by RRI Date

\_\_\_\_\_  
Signature of Legal Guardian, If Appropriate Date

The signed Acknowledgement will be maintained in the individual's case record.

**POLICY NUMBER: 6**

**TITLE: Informed Consent**

It will be the policy of RRI to enforce the individual's rights regarding informed consent in accordance with the following requirements in accordance with 115 CMR 5.08.

1. The informed and voluntary consent of the person served or legal guardian will be required in the following circumstances:
  - a) Prior to admission to a facility;
  - b) Emergency medical treatment;
  - c) Prior to medical or other treatment, in accordance with the requirements of 115 CMR 5.15 (medication);
  - d) Prior to the initiation of a formal behavior plan
  - e) Annually for the instance of public identification (TV, newspaper, video, etc.)
  - f) When access to a person's record is requested by persons other than authorized RRI employees or a request for record access is made from this agency to another
2. Informed Consent means the knowing consent voluntarily given by a person served or their legal guardian who can understand and weigh the risks and benefits involved in the particular decision or matter.
3. Whenever the informed consent of the individual or guardian is required, the following criteria will apply;
  - a) The consent of the person served or guardian will be in writing and filed in the individual's record;
  - b) The written consent shall be dated and shall expire upon completion of the specific procedure for which it applies; in any event an informed consent shall expire one year after it is signed;
  - c) No coercion or overbearing inducement will be utilized to obtain consent;
  - d) A written record will be made which;
    1. details the procedure utilized to obtain the consent;
    2. identifies the name, position, and affiliation of the individual securing the consent;

3. summarizes the information provided to the person from whom consent is secured
- e) The person securing the consent shall;
1. explain the intended outcome, nature, and procedures involved in the proposed treatment or activity;
  2. explain the risks, including side effects, of the proposed treatment or activity, as well as the risks of not proceeding;
  3. explain the alternatives to the proposed treatment or activity, particularly alternatives offering less risk or other adverse effects; and
  4. explain that consent may be withheld or withdrawn at any time, with no punitive action taken against individual;
  5. present the foregoing information in a manner which can be understood by the person served, or guardian, where appropriate;
  6. offer to answer questions that the person served or guardian may have regarding the matter for which consent is being sought;
- f) The appropriateness of the consent shall be reviewed as part of the annual review of the ISP and DHSP

**POLICY NUMBER: 7**

**TITLE:** Confidentiality and Protection of Privacy

It is the policy of RRI that all information regarding personal facts, records, or any other case information of the persons served by RRI is to be held confidential and private at all times.

*All RRI employees, volunteers, students/interns, sign the Statement of Confidentiality, upon hire, which is placed in their personnel file. Each person served by RRI and their family or legal representative will be notified of RRI's privacy practices prior to the initiation of services; the signed Acknowledgement Form will be maintained in the individual's file.*

**Maintenance of Records**

All case records are maintained in a locked cabinet on site. The Case Manager oversees the process of materials to be filed, and ensures that the files are present and locked at the end of each day. Any person authorized to access the records must sign in. If a record should need to be purged, this will be done by the Case Manager and any information purged will remain in a locked cabinet.

**Access**

Persons served and/or their legal representative may submit a written request to inspect or obtain a copy of the person's case record using the "Access Request Form". An oral request is also acceptable. RRI shall act on the request within 30 days of receiving the request. Authorized RRI professional personnel, upon request of the person served or legal guardians, may provide explanations and interpretation of material contained within.

The scope of an employee's access is limited to that amount of information necessary to accomplish their job.

Students, interns, and volunteers, as a general rule, will not have access to the case record except under special circumstances as deemed appropriated by the Program Director and authorized by the person served.

"Business Associates" pursuant to the Health Care Insurance Portability and Accountability Act are required to sign an agreement regarding the protection of health care information that they may have access to in the course of doing business with RRI. For example, an accreditation or licensing agency, an accounting or auditing firm or legal counsel.

**Release of Information**

The person served and/or the legal guardian may authorize the review or release of information contained in the case recorded, to any person or agency not affiliated with RRI, upon RRI's

receipt of the Release of Information Form signed by the person served and/or legal guardian, as appropriate.

All releases must indicate the person or agency representative who will review the information, the type of information requested, the date of access and the expiration of the release of information, the purpose for which the information is used and the extent of any further released information.

### **Content of Information**

The case record will include all information pertinent to services for and individual. The case record includes the official documents reflecting the individual choices and decisions, needs, and current status of each person served by RRI. The case record is kept current, complete, and accurate.

### **Amendment of the Case Record at the Person's Served and/or Legal Guardian's Request**

All persons served and/or legal guardian, as applicable, may request in writing, that information contained within the file be amended if they believe that the information is inaccurate, misleading, or in violation of the person's rights. Requests will be submitted on the "Request for Amendment Form" to the Program Director. The request will be acted upon within 60 days of receipt of the request. The CEO will make the final decision.

If the record is amended, the original record will not be erased or altered. Instead, a new page will be inserted which is dated, initialed by the CEO and labeled as an amendment. The original sections should be marked with the phrase "DO NOT COPY".

If RRI believes that the record is accurate and complete and the decision is made not to amend the information in question, the person requesting the amendment will be notified in writing, of the decision and will be advised of his/her rights to a hearing through a written outline of the complaint procedure.

A complaint may also be filed with the Department of Mental Retardation and a copy sent to the RRI Human Rights Committee.

### **Verbal Exchange of Information**

Individual person's status or needs are to be discussed with directly involved service staff and/or other appropriate team members only in order to perform their jobs.

It is the responsibility of all staff to be aware of where such discussions are held and that all such conversations are private and out of "ear shot" of other persons served.

### **Informed Consent**

It is RRI's policy to obtain informed and voluntary consent from the individuals RRI serves and where appropriate, an individual's legal guardian, whenever access to the case record is requested.

### **Right to Receive an Accounting of Disclosures**

Upon written request, a person served by RRI and/or their legal guardian may obtain an accounting of disclosures.

### **Permissible Uses and Disclosures not Requiring Consent or Authorization**

As authorized by state and federal laws: Payment for services rendered from Medicaid, the Department of Mental Retardation, etc., public health activities, health oversight activities, judicial and administrative proceeding in response to a legal order, law enforcement officials, health and safety emergencies, and any other instances when required to do so by any other law not already referred to in this policy.

- Purging files – The Manager or their Designee is responsible for the upkeep of the files, and will purge the files on an annual basis. Purged material will be stored under lock in a designated area.

### **3. Access**

Persons served and/or their legal representative may submit a written request to inspect or obtain a copy of the person's case record using the "Access Request Form." An oral request is also acceptable. RRI shall act on the request within 30 days of receiving the request. Authorized Rehabilitative Resources Inc. professional personnel upon request of the person served or legal guardians may provide explanations and interpretation of material contained within.

In all other instances, the Manager authorized access to an individual's case record. The scope of an employee's access is limited to that amount of information necessary to accomplish their job.

Students, interns and volunteers as a general rule will not have access to the case record except under special circumstances as deemed appropriate by the Manager and authorized by the person served.

“Business Associates” pursuant to the Health Care Insurance Portability and Accountability Act are required to sign an agreement regarding the protection of health care information that they may have access to in the course of doing business with RRI. For example, an accreditation or licensing agency, an accounting or auditing firm or legal counsel.

#### 4. **Release of Information**

The person served and/or the legal guardian may authorize the review or release of information contained in the case record, to any person or agency not affiliated with Rehabilitative Resources Inc., upon RRI’s receipt of the *Release of Information Form* signed by the person served and/or legal guardian as appropriate.

All releases must indicate the person or agency representative who will review the information, the type of information requested, the date of access and the expiration of the release of information, the purpose for which the information is used and the extent of any further released information.

**REPORT/RECORD REQUESTED FROM:** the Department of Mental Retardation

       MEDICAL

       PSYCHOLOGICAL

       DENTAL

       HOSPITALIZATIONS

       OPHTHALMOLOGICAL

       PROGRAM/EDUCATION

       AUDIOLOGICAL

       EMPLOYMENT/TRAINING.

       FAMILY, SOCIAL HISTORY

       TREATMENT HISTORY

       TERMINATION SUMMARY

       OTHER, PLEASE SPECIFY

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Requested by:

NAME: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

AGENCY:   RRI  

POSITION: \_\_\_\_\_

**PLEASE PRINT, COMPLETE & INSERT RRI PHYSICAL EXAM FORM**

## MEMORANDUM

TO: INDIVIDUALS AND THEIR FAMILIES WHO RECEIVE SERVICES FROM RRI

FROM: BONNIE KEEFE-LAYDEN, CEO, RRI

DATE: March 7, 2006

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This packet of information is being sent to you in compliance with the federal law, the *HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)*. The purpose in sending you this information is to provide you with RRI's policies and procedures regarding confidentiality, and the protection of privacy for each person served by RRI, pursuant to the regulations.

We would appreciate it if you would read through this important material; then sign and return the Acknowledgement Form at your earliest convenience for our records to comply with the HIPAA Regulations.

If you have any questions or concerns, please feel free to contact us.

Thank you for your time.

**RRI HABILITATION SERVICES**

**LEGAL GUARDIAN AUTHORIZATION FOR  
ADMINISTRATION OF MEDICATIONS/TREATMENTS**

Participant's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Medication	Dosage	Route of Administration

I hereby consent to the RRI Habilitative Services certified staff to administer this medication/treatment for above named participant.

Date \_\_\_\_\_ Signature \_\_\_\_\_

Legal Guardian