Procedure No. 2-6-16

Revised: 09-10-21
Issued: 09-10-97

SUBJECT: Handbook for Individuals Served

PURPOSE: To assure individuals being served are informed of their rights, the organization's expectations and the procedures, rules, regulations and program definitions and to carry out the mandate of Habilitation Services Policy No. 2.

The following procedure will be followed to insure that individuals receiving services (hereafter referred to as the individual) through Woodhaven, their legal guardians, and Woodhaven staff are aware of the rights of the individuals being served as well as the expectations within the service delivery system of Woodhaven.

1. Prior to admission to Woodhaven, individuals and their families will be provided a handbook for individuals served, which will describe the various programs, applicable policies, procedures, rules and expectations of the organization, the rights of individuals served, organization commitments and annual consent forms.

   Upon admission, the Director of Residential and Community Services or designee, will thoroughly review the handbook with the individual, family members, guardians and assure that the contents of the Handbook are understood.

   The individual to be served, and/or their respective parent or guardians will be requested to sign a receipt of "Handbook for Individuals" form verifying that the material was reviewed with them and given to them. Applicable annual consents will be reviewed and signed at this time. The original consent forms and signed Handbook form will be placed in the individual's record and become a part of the permanent file.

2. The Program Manager ensures that a review of the handbook for individuals being served is completed annually at the person's Individual Plan Meeting. A receipt of Handbook for Individuals Served form will be signed, verifying that the material was reviewed and given to them. Applicable annual consent forms will be reviewed and signed at this time also. The original consent forms and signed Handbook form will be placed in the individual's record and become a part of the permanent file. If for some reason, the parent/guardian was unable to attend the IP meeting, a receipt form will be mailed to them along with a copy of the handbook and all applicable consents for their review and a request for the forms to be signed and returned to Woodhaven.

3. The Program Manager assigned will be responsible for coordinating this procedure.

Approved by:____
The Director of Residential and Community Services

Date:____

REQUEST/ RELEASE OF INFORMATION FORM (AS NEEDED)

I, ____, authorize Woodhaven to request/release a copy of my protected health information as identified below to: ____

____

Stated Reason for request or release: ____

____

____

By initialing the spaces below, I specifically authorize the request/release of the following health information and/or medical records:

_______Please send the entire medical record (all information) to the above-named recipient.

_______All facility records (including nursing Records and progress notes)

_______Transcribed reports

_______Medical records needed for continuity of care

_______Most recent five-year history

_______Emergency and urgent-care records

_______Dietary notes

_______Discharge summary

_______Clinician office chart notes

_______Dental records

_______Laboratory reports

_______Pathology reports

_______Diagnostic imaging reports

_______Billing statements

_______Activity notes

_______Care plans

_______Other:____

____

I understand that I may revoke this authorization in writing at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless revoked earlier, this authorization will expire one year from the date of signing or until (applicable date or event)______________________________

____ ___________________________

Signature of client, client's legal representative or guardian Date

____

Print client's name

(A copy of this signed form will be provided to the client)

WOODHAVEN

VISITATION CONSENT FORM

I, ____, give my permission for ________________________, to visit

(Parent or Guardian) (Name of Individual)

____.

(Name of person requesting visitation)

Date(s) of this visit:____.

Additional comments: (Describe activity):____

____

____

____

Date Parent or Guardian was called:____.

____ __________________________________

Person Giving Explanation Date

Attached to Procedure 2-6-16

WOODHAVEN
NEW PROGRAM PARTICIPANT ORIENTATION

Name:____Admission Date:_____________________

Program:____

Review of Handbook

- Mission and Services of Program
- List of Rights and Responsibilities of Person Served
- Grievance Procedure

Privacy Practices Notice (before the first day services are provided).

Annual Consents

Introductions to Staff

Review of Emergency Plans

Discussion of Community Activities

What to Expect in First 30 Days

- Program Manager will assist with scheduling Individual Plan meeting; invitations to meeting, assessment.
- Program Manager will assist with orientation to the community (i.e. introduction to neighbors, assist with learning bus schedule, etc.)

Program Participant:______________________________________ Date:______________________

Staff:____ Date:______________________

WOODHAVEN

AUTHORIZATION FOR SERVICES

Please check services applicable to individual served:

Residential Services _______

Personal, Social & Community Services _______

I, ____, hereby authorize Woodhaven to provide __________________ ____________________ services for ______________________________________.

(This consent (unless expressly revoked earlier) is valid for a period of one (1) year from the date of signature.

____ ____________________________

Resident or Legal Guardian Date

Attached to Procedure 2-6-16

WOODHAVEN

INFORMATION NOTIFICATION FORM

I, ____, have received and have had the opportunity to review Woodhaven's Handbook for Individuals Served on behalf of ______________________________________ who resides in ____________________________________, a facility operated by Woodhaven or who is served in Woodhaven's ____________________________________ Program.

____ ____________________________

Resident or Legal Guardian Date

____ ____________________________

Person Giving Explanation Date

Attached to Procedure 2-6-16

WOODHAVEN

EMERGENCY AUTHORIZATION

In the event that emergency treatment is required and I/we, are not available, I/we authorize Woodhaven's Program Manager, Health Services Manager, the Director of Programs or the Chief Executive Officer to authorize emergency procedures that may be necessary to insure the health and well-being of ____________________________.

(This consent (unless expressly revoked earlier) is valid for a period of one (1) year from the date of signature.

____ ____________________________

Resident or Legal Guardian Date

Attached to Procedure 2-6-16

WOODHAVEN

PHYSICAL AND DENTAL EXAMINATION FORM

I/We hereby authorize Woodhaven to seek routine physical examinations and dental examinations as may be necessary for ______________________________ and, in turn, authorize the examining agency to render services as sought by Woodhaven on his/her behalf.

(This consent (unless expressly revoked earlier) is valid for a period of one (1) year from the date of signature.

______________________________ ______________________
Resident or Legal Guardian Date

______________________________ ______________________
Person Giving Explanation Date

Attached to Procedure 2-6-16

WOODHAVEN

MEDICATION AUTHORIZATION

I/We hereby authorize Woodhaven personnel who are Level I Medication Aides or nurses, to administer medications, as prescribed by his/her physician to ____.

(This consent (unless expressly revoked earlier) is valid for a period of one (1) year from the date of signature.

______________________________ ______________________
Resident or Legal Guardian Date

______________________________ ______________________
Person Giving Explanation Date

Attached to Procedure 2-6-16

WOODHAVEN

CONSENT FOR PHOTOGRAPHY

I hereby agree and consent to the use of photographs or electronic recordings of:______________________ ______________________ (please print full name of client) and grant permission to Woodhaven to use said images for any and all purposes in promoting Woodhaven's programs. I understand that the photographs and/or electronic recordings may be included in video tapes, books, booklets, brochures, displays, and electronic media used in training or distributed to the general public. I further hereby waive my right to any and all compensation for such use.

______________________________ ______________________
Client or Legal Representative/Guardian Date

____
Address

Attached to Procedure 2-6-16
pc: Office of Development

WOODHAVEN
YEARLY PROGRAM ORIENTATION

Name:______________________________ Program:____________________________

Date:______________________________

Review of Mission, Services and Costs
Review of Rights and Responsibilities
Review of Grievance Procedure
Review of Privacy Practices Notice

Review of Individual Plan and how to change it

Review of role of Program Manager, Home Coordinator and Direct Support Professionals

Annual Consent for Photography

Authorization to Disclose Client Protected Health Information

Authorization of Methods Used When Disclosing Client Protected Health Information

Authorization To Use or Disclose Client Protected Health Information For The Purpose of Marketing or Fundraising Events

____ ____________________________
Program Participant Date

____ ____________________________
Staff Date

Attached to Procedure 2-6-16

Consent for Staff to Authorize Treatment and
Obtain Medical Information

I, ____, authorize the staff of Woodhaven to sign
Parent/Guardian
For Emergency room care, tests, treatments and procedures needed for
______________________________.
Client Name

I also give my authorization for the staff of Woodhaven to give and receive medical information regarding _____________________________ to/from any hospital or physician
Client Name
treating ___________________. I also authorize the staff of Woodhaven to sign for any home
Client Name

healthcare procedures needed.

____________________________________ ________________________
Parent/Guardian Signature Date

Explained By:____

Attached to Procedure 2-6-16

WOODHAVEN

IMMUNIZATION PERMISSION FORM

I hereby give my permission for any immunization and/or boosters deemed necessary by the attending physician, to be administered by the Health Services staff while ______________________________ is receiving services from
(Clients Name)
Woodhaven.

(This consent (unless expressly revoked earlier) is valid for a period of one (1) year from the date of signature.

Signed: ____ Date: ____________________

If ______________________________(Clients Name) has ever had any adverse reactions to any immunization, please indicate the type of immunization and describe the reaction:

____

____

____

____

____

Attached to Procedure 2-6-16

WOODHAVEN

FINANCIAL CONSENT FORM

I, ____________________________________, give permission for staff at Woodhaven to assist ____________________________________(Client Name) in managing his/her finances. This assistance may include the depositing and expenditure of ________________________‘s funds to and from a bank account maintained specifically for persons being served by Woodhaven. The account will be interest bearing and will be managed in a fiduciary manner in accordance with good business practices. Expenditures on behalf of the individual will be in accordance with written procedures. As ____________________________becomes independent with all or part of his/her financial management skills, the assistance will be faded.

______________________________ ____________________

Individual or Legal Guardian Date

______________________________ ____________________

Person Giving Explanation Date

AUTHORIZATION TO USE OR DISCLOSE CLIENT PROTECTED HEALTH INFORMATION FOR THE PURPOSE OF MARKETING OR FUNDRAISING EVENTS

Listed below are ways that Woodhaven may use or share client PHI (Protected Health Information) when communicating for marketing purposes or fundraising events. Please check below which methods you authorize Woodhaven to use:

_______**Agency Newsletters** – Distributed quarterly to Woodhaven donors, prospective donors, churches, businesses and foundations. Information includes pictures of clients with first names only, activities, employment and basic information on meeting the challenges associated with their disability. *For example: (Joe, who is in a wheel chair, has been living at Kathy House for just a few months and attends a Bible study class despite the fact that he is blind).*

_______**Fundraising Events** – May consist of a video or computer presentations which include client photos with first name only and information on the types of activities or programs clients participate in. Video or computer presentations would be presented at fundraising dinners, to churches, Sunday School Classes or other church groups.

_______**Agency Brochures** – Distributed to Woodhaven donors, prospective donors, churches and new client referrals who request general information about our services. Brochure are also made available at all fundraising events and Regional Assemblies of the First Christian Church, Disciples of Christ. Photos would be the ONLY client PHI shared through brochures.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to receive services from Woodhaven.

I understand that I may revoke this authorization in writing at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless revoked earlier, this authorization will expire one year from the date of signing or until (applicable date or event) ______________________________.

____ ____________________________
Signature of client, client's legal representative or guardian Date

____
Print client's name

Attached to Procedure 2-6-16

RIGHTS OF INDIVIDUALS RECEIVING SUPPORT FROM WOODHAVEN

You shall be entitled to the following without limitation:

To have human care and treatment;

To the extent that the facilities, equipment and personnel are available, to medical care and treatment in accordance with the highest standards accepted in medical practice;

To have safe and clean housing;

To attend religious services of your choice;

To receive prompt evaluation and care, treatment, habilitation or rehabilitation;

To be treated with respect;

To be the subject of an experiment only with your consent or the consent of the person legally authorized to act for you;

To have your private doctor examine you at your own expense;

To be evaluated and cared for in the least restrictive environment;

To refuse hazardous treatment or surgery unless ordered by a court;

To request and have a second opinion before hazardous treatment or irreversible surgery, except in emergencies;

To have nourishing, well-balanced meals;

To not work unless part of your treatment, rehabilitation or habilitation plan;

To be free from abuse of any kind;

To have your records kept confidential;

To correspond by sealed mail with officials of the Department of Mental Health, your lawyer or a court;

Unless otherwise stated by law, to have the same legal rights and responsibilities as any other individual;

To receive an impartial review of alleged violations of the rights listed above and any also otherwise assured under law;

To wear your own clothes and to keep and use your personal possessions;

To keep and spend a reasonable amount of your own money;

To receive visitors of your own choosing at reasonable times;

To have access to your medical and service records;

To use a telephone in private to make and receive confidential calls;

To exercise physically and be able to pursue outdoor recreation;

To have access to current newspapers, magazines, radio and television programs.

Attached to Procedure 2-6-7 and 2-6-16

AUTHORIZATION TO DISCLOSE CLIENT PROTECTED HEALTH INFORMATION (PHI)

I (guardian/name of client), ________________________ authorize Woodhaven to use or disclose a copy of (my/client's) ____________________ protected health information (PHI) to the following family members or friends who may be involved in (my/client's)______________________________ Healthcare who are not (my/client's)________________________ guardian:

By checking the box below, I authorize Woodhaven to use or disclose the following client PHI. In the right hand column also include the name of those individuals, family members or friends who are involved in the clients' care to which you wish the information to be released to:

Information I want released:	**To whom you want information released to:**
_______Medical History	______________________
_______Current Physical	______________________
_______Individual Plans	______________________
_______Behavior Issues	______________________
_______Employment Information	______________________
_______Community Activities	______________________
_______All of the above	______________________

If there is any specific information you do not want released, please indicate:______________________

____

Finally, I understand that I may revoke this authorization in writing at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless revoked earlier, this authorization will expire one year from the date of signing or until (applicable date or event)______________________.

______________________________ ______________________
Signature of client, client's legal representative or guardian Date

____
Print Client's name

______________________________ ______________________
Print name of legal representative or guardian (if applicable) Relationship to client

Attached to Procedure 2-6-16

AUTHORIZATION OF METHODS USED WHEN DISCLOSING CLIENT PROTECTED HEALTH INFORMATION

There are different ways of communication that Woodhaven has used in the past. You will find a detailed list of these methods below that also includes a detailed description of what information could be disclosed. Before HIPAA went into effect, Program Managers and/or Home Coordinators had also been communicating to guardians and/or other family members who were involved in the clients' healthcare via emails, faxes and/or leaving messages on answering machines. We can no longer communicate to you or your family by these methods unless we have your authorization to do so. Please review the list below and indicate by checking which methods you authorize Woodhaven to communicate to you or other family members by:

_______**E-Mail** – Communication from Program staff for the sole purpose of communicating to the guardian and/or family members about client behaviors, health and safety issues, community access, employment, programming issues and/or concerns they may have.

_______**Fax** – Communication by Program Managers/Home Coordinators to family members and/or guardians regarding client IP's. This method of communication will only be used when the fax is located in the homes of the guardians and/or family members.

_______**Telephone Answering Machine** – Communication from Program managers for the sole purpose of setting up client IP dates. This method of communication will only be used when the answering machine is located in the homes of the guardians and/or family members.

_______**Regular Mail** – This method of communication will be used by Program Managers and/or Home Coordinators when there is no other means of communicating to guardians and/or family members.

I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the federal substance abuse confidentiality requirements.

I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization.

Finally, I understand that I may revoke this authorization in writing at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless revoked earlier, this authorization will expire one year from the date of signing or until (applicable date or event) ____________________________.

______________________________________ ______________________

Signature of client, client's legal representative or guardian Date

____

Print Client's name

Print name of legal representative or guardian (if applicable) | Relationship to client

A copy of this signed form will be provided to the client