EMERGENCY MEDICAL INFORMATION

Participant Name: _____ Date of birth: _____

Address: _____

Mother: _____ Cell #_____ Home #_____

Father: _____ Cell #_____ Home #_____

Guardian: _____ Cell #_____ Home #_____

In case neither parent/guardian can be located notify: _____

Relationship to Client: _____ Phone #_____

Preferred Physician: _____ Phone #_____

Preferred Dentist: _____ Phone #_____

Preferred Hospital: _____

EMERGENCY MEDICAL AUTHORIZATION

Purpose: To enable parents and guardians to authorize the emergency treatment for participants who become injured while under Charlene's Angels authority, when parents or guardians cannot be reached.
CONSENT MUST BE COMPLETED BEFORE PARTICIPANT IS ALLOWED TO PARTICIPATE.

GRANT CONSENT

In the event attempts to contact parents/guardian are unsuccessful I give my consent for: (1) any treatment deemed necessary by the preferred physician or preferred dentist or in the event my preferred physician/dentist is not available, by another licensed physician or dentist and (2) the transfer of the participant to the hospital. This authorization does not cover major surgery unless medical opinions of two other licensed physicians or dentists concur on the necessity of such surgery.

Parent/Guardian Name (printed) _____

Parent/Guardian Signature: _____ Date: _____

HEALTH PROBLEMS

Health Conditions: _____

_____

Allergies: _____

Current Medications: _____

_____

_____

Grievance Policy and Procedures

It is the policy of Charlene's Angels to protect and promote the rights of individuals with disabilities, to ensure that they are provided with humane care and protection from harm, and to ensure that the services they receive are in accordance with established standards of practice, as well as with the provision of the Individual Support Plan. Additionally, Charlene's Angels will comply with our "Code of Ethics" and any standards established by the BDDS (Bureau of Developmental Disabilities) for the provision services.

Reportable Incident: If an allegation of abuse, neglect, exploitation, mistreatment of an individual, or violation of an individual's rights is reported; Charlene's Angels will take all necessary steps to ensure the safety of the individual. He or she will ensure that Incident Reports are filed within 24 hours and will file all needed follow-up reports until the situation is resolved. Charlene's Angels will conduct or participate in an investigation as needed and will let the reporter and individual know of the final resolution in the individual's usual mode of communication.

Systemic Issues: Upon receipt of information, regarding ongoing, systemic behaviors on the part of the provider of service that are not in accordance with established standards of practice, Charlene's Angels will: first attempt to resolve the issue verbally with the person in question; if no resolution is made, will put the issue in writing to the person; bring the issue to the attention of the BDDS local representative to assist, if needed; and file an Incident Report to mediate for that issue.

Conflict Resolution: If the members are not able to come to a mutually satisfactory decision regarding support of an individual, Charlene's Angels will call upon the local BDDS representative to mediate for that issue.

Rights Violation: Upon receipt of a complaint of a rights violation from an individual or a reporter acting on an individual's behalf, Charlene's Angels will investigate and provide the individual and reporter with a determination of findings within two weeks of the date receipt of the complaint. That determination is to be provided in writing and in the individual's usual mode of communication.

Complaint against Charlene's Angels Staff: In the event of a complaint of an issue related to Charlene's Angels service, a company repetitive other than Charlene's Angels will investigate and provide the individual with a determination of the findings. The determination is to be provided in writing or the individual's usual mode of communication. If an Incident Report is appropriate follow up to the complaint, the company will report upon the receipt of resolution from BDDS.

Participant's Name _____ Date _____

Signature of Guardian or Representative _____ Date _____

_____ Med sheet

INFORMED CONSENT FOR MEDICATION MONITORING

Charlene's Angels, Inc. is committed to providing quality services and assistance to all participants involved in day and employment services and realizes that many participants may need medication to be monitored during the day. Medications may be monitored by trained Charlene's Angels, Inc. staff, but only upon the completion of this form by the participant or the participant's legal representative and under the following conditions:

*All medications must be in their original prescription containers.
*The prescription container includes the name of the medication, the dosage, the route, and the time it must be taken.
*Any change in medications requires an updated informed consent for medication monitoring to be submitted.
*All consent forms must be updated yearly.

PARTICIPANT'S NAME: _____

LIST MEDICATION ALLERGIES: _____

_____

REGARDLESS OF WHETHER OR NOT THE PARTICIPANT WILL TAKE MEDICATIONS AT CHARLENE'S ANGELS, WE REQUIRE A LIST OF THEIR CURRENT MEDICATIONS. In the event of an emergency, EMS will ask for a list of current medications. This will help give the participant the best emergency care and will help staff identify any adverse medication effects.

Please complete form below with ALL of the participant's current medications:

Medication Name	Dosage	Route of Administration (oral, rectal, topical, etc.)	Time Medication to be Taken	To be Taken While at Charlene's Angels, Inc.?
				YES NO
				YES NO
				YES NO
				YES NO
				YES NO
				YES NO
				YES NO
				YES NO
				YES NO
				YES NO
				YES NO
				YES NO
				YES NO
				YES NO
				YES NO
				YES NO
				YES NO

As the participant's legal guardian, I provide my consent to Charlene's Angels, Inc. to supervise participant's self-administration of the above medications marked "YES", prescribed to the participant by their health care provider.

_____ Date_____
Signature of Participant (if able to sign)

_____ Date_____
Signature of Participant's Legal Guardian

_____
Printed Name of Participant's Legal Guardian

Charlene's Angels
5800 W. Smith Valley Road/Greenwood IN 46142
317-431-1484

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect January 2016, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, nursing students, or other staff who are involved in taking care of you. We may disclose health information about you to people outside of Charlene's Angels who may be involved in your care after you leave, such as family members, clergy, or others we use to provide services that are part of your care.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Medicaid Waiver: In accordance with state regulations, we are required to give copies of your Quarterly Progress Reports, Incident Reports and Risk Plans to the Bureau of Developmental Disabilities. To this end, these documents are uploaded to the BDDS Portal, and may be accessed by others on your Medicaid Waiver treatment team or other state agency staff.

Health Care Operations: We may use and disclose your health information in connection with our health care operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or health care operations, you may give us written authorization to use your health information to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Client Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose your health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up medications or other forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.c

Required by Law: We may use or disclose your health information when we are required to do so by law.
Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or the possible victim of other crimes. We may disclose to authorize your health information to the extent necessary to avert a threat to your health or safety of others.
National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials, health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.
Appointment Reminders: We may use or disclose your health information to provide you with meeting reminders (such as voicemail messages, postcards or letters).

CLIENT RIGHTS
Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot feasibly do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.10 (ten cents) for each page, $10.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.
Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not before January 2016. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.
Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).
Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location and provide a satisfactory explanation of how payments will be handled under the alternative means or location you request.
Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.
Electronic Notice: If you receive this Notice on our Website or by electronic mail (email), you are entitled to receive this notice in written form.

QUESTIONS AND COMPLAINTS
If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint with the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact: Charlene Guthrie
Address: 5800 W. Smith Valley Road
Greenwood, IN 46142

Telephone: 317-431-1484
Email: cguthrie@charsangels.com

Charlene's Angels

NOTICE OF PRIVACY

INFORMATION PRACTICES/HIPAA

ACKNOWLEDGEMENT OF RECEIPT

I hereby acknowledge that I have received a current copy of the "Notice of Privacy Information Practices" and consent to the use and disclosure of protected health information about the below named participant as outlined in the "Notice of Privacy" document.

Participant's Name: _____

Signature of Guardian or Representative: _____ Date: _____

Charlene's Angels Representative: _____ Date: _____

Charlene's Angels, Inc.

Photograph/Video Release Form

□ I, _____, hereby consent to and authorize the use
(Client's Name)
and reproduction of any and all photographs and video footage taken in which I may appear, for any purpose, without compensation to me.

I hereby release and discharge __Charlene's Angels_____ from any and all claims and demands ensuing from or in connection with the use of the photographs or video footage, including any and all claims for libel and invasion of privacy.

This authorization and release shall insure to the benefit of the legal representatives, licensees and assignees of ___Charlene's Angels_____ as well as the person(s) for whom appear in the photographs or video footage.

I hereby affirm that I am of full age and have the right to contract in my own name or on behalf of my minor child. I have read the foregoing and fully understand the contents hereof. This release shall be binding upon me and my heirs, legal representatives, and assignees.

□ I, _____, **do not** consent to or authorize the use and
(Client's Name)
reproduction of any and all photographs and video footage requested.

This release will expire on__12-31-2024__

_____ _____
Signature (Client or Legal Guardian) Date

Charlene's Angels
5800 W. Smith Valley Road/Greenwood IN 46142
317-431-1484

RELEASE FORM ACKNOWLEDGEMENT

Release Of Information Authorization

I give my authorization for release of the below named participant's medical/social information to Charlene's Angels. I further authorize Charlene's Angels to discuss or release information to physicians, appropriate social agency or any other facility/agency that would assist/enhance the care or management of the below named participant's particular medical or social service needs.

Emergency Treatment Protocol

In the event of an illness or injury requiring emergency treatment that may occur while the participant is participating at Charlene's Angels or with Charlene's Angels staff, I give Charlene's Angels my consent to administer first aid treatment as they deem necessary, to contact my personal physician, or to transport the participant to a hospital of their choice or any reasonably accessible hospital. I give Charlene's Angels permission to release any information concerning the participant's medical history (including medications, allergies, and physical conditions/diagnosis) to which a physician should be alerted.

Liability Release Form

Charlene's Angels will take all precautions to ensure the participant's welfare and will maintain a clean, safe, and well-supervised environment for each participant enrolled. However, in the event of accident, injury, or illness, I understand and agree that I will not hold Charlene's Angels or its staff, volunteers, or authorized representatives liable for any accident or injury/illness that the participant may incur during delivery of services. In consideration of the participant's participation, I hereby release Charlene's Angels and its staff, volunteers, and authorized representatives from liability for any damages or injuries incurred in performance of services with Charlene's Angels.

Participant's Name: _____

Guardian/Representative's Signature: _____

Date: _____

Charlene's Angels Adult Day Center

RIGHTS AND RESPONSIBILITIES OF ADULT DAY CENTER PARTICIPANTS

Families, participants, and staff recognize that to have an effective service, the effort must be a partnership, working together to provide quality care.

Your Responsibilities as a Participant

1. You have the responsibility to provide information about your medical and social history, present health status, medications, and other matters relating to your health to the best of your ability.
2. You have the responsibility to cooperate with all personnel to treat them with consideration and respect.
3. You have the responsibility to be respectful of other's property and privacy.
4. You have the responsibility to make suggestions concerning services and programs that would enrich your experience.
5. You have the responsibility to Charlene's Angels as soon as you know of anticipated absences or to telephone in the event of unanticipated absences.
6. You have the responsibility to be prompt in payment of services and prompt in asking questions about billing which you do not understand. We reserve the right to discontinue services if payment isn't received in a timely manner.
7. You have the responsibility to inform Charlene's Angels director promptly, if you believe any of your rights have been violated.

Your Rights as a Participant

1. You have the right to considerate and respectful care regardless of sex, gender, race, religion, or national origin.
2. You have the opportunity to self-determine within the setting, including the opportunity to:
   a. Decide whether or not to participate in any given activity
   b. Be involved to the extent possible in program planning and operation
   c. End services at any time
3. You have the right to confidentiality and the requirement for written consent for release of information to persons not authorized under law to receive it.
4. You have the right to voice grievances about care, without discrimination or reprisal, to staff or the local ombudsman.
5. You have the right to be free from harm, including unnecessary physical or chemical restraint, isolation, excessive medication, abuse, or neglect.
6. You have the right to a safe physical environment with appropriate handicap access to building and restrooms.
7. You have the right to services that includes current event discussions, crafts, spiritual support and appropriate stimulation and exercise of body and mind.
8. You have the right to healthy snacks with special diet modifications as prescribed by your physician.
9. You have the right to assistance as needed with medications prescribed by your physician and ongoing instruction in action, side effects, dosage, and proper monitoring to maximize the effect of your medicines.
10. You have the right to have a service animal, consistent with the "reasonable accommodations" clause of the Fair Housing Act.
11. You have the right to participate in the planning of activities and the right to choose not to participate in activities offered.
12. You have the right to adequate rest time.
13. You have the right to prompt billing and to have guidance in inquiring into financial assistance, if needed.
14. You have the right to access or review your file at any given time.

I have received, read, and understood a copy of the "Rights and Responsibilities of Participants" as provided by Charlene's Angels.

Name of Client _____ Signature (Participant or Representative) _____ Date _____

PARTICIPATION INFORMATION/INTAKE FORM

Participant Full Name		Date of Birth
Address		
Home Phone #	Cell #	
Medicaid #	Social Security #	
Gender	Race	Religion
Does the Participant have a Criminal History?	___NO	___YES (please provide documentation detailing criminal history)
Does the Participant have a Legal Guardian?		
1-Parent/Guardian Name	Phone #	
Parent/Guardian Email		
2-Parent/Guardian Name	Phone #	
Parent/Guardian Email		
Referred By		
Case Manager/Provider		
Case Manager Phone #		
Case Manager's Email		
Residential Provider	Phone #	
Residential Program Director	Phone #	
Primary Staff	Phone #	
Residential Director Email		
Does Participant have a Behavior Support Plan?		
Is Participant Physically Aggressive? (Please explain)		
Behavior Consultant & Provider		
Behavior Consultant Phone #	Email	

PARTICIPANT'S NAME

PARTICIPANT HEALTH INFORMATION

Allergies	Medication _____ Food _____ Environmental _____ ___Gluten ___Dairy ___Bees ___Latex ___Seasonal ___Animal _____
	EpiPen (dose, when to be given)
Seizures	___Grand Mal ___Petit Mal ___Simple Partial ___VNS (date implanted) _____ Emergency Medication? (Diastat, Valium, etc.)
Pacemaker	___Pacemaker ___ICD (Implantable Cardioventricular Defibrillator)
Diabetes	___Insulin Pump
Asthma	___Rescue Inhaler: (Name, dose, time to be given)
Incontinence	___Bowel ___Bladder
Communication Difficulty	Assistive Devices: (circle: Communication Device, iPad, Sign Language, other)
Fall Risk	Assistive Devices: (circle: Wheelchair, walker, cane, AFOs)
Dining Difficulty	___Choking Risk ___Aspiration Risk
Constipation	___YES ___NO
Dehydration	___YES ___NO
Wanders from Group	___YES ___NO
Hearing Difficulty	Assistive Devices: (circle: Hearing Aides, Amplifier, Cochlear Implant)
Vision Difficulty	___Wears Glasses ___Blind