WAIVER SERVICES APPLICATION PACKET

We appreciate your interest in Charlene's Angels! To begin the process of entering the program, we require the following information, which will help us meet your needs and provide the best possible services:

APPLICATION INFORMATION:

1. Completed Waiver Services Application
2. Indiana Medicaid card (Please provide a copy for our records)

PARTICIPANT HANDBOOK:

3. Acknowledgement of Receipt (Participant Handbook, Policies of Rights, Filing a Complaint, Notice of Privacy, and Infectious Parasites and Illness)

LEGAL CONSENTS & AUTHORIZATIONS:

4. Participant General Information
5. Participant Consent
6. Service Agreement
7. Informed Consent for Medication Monitoring
8. Consent for Emergency Treatment
9. Dual Guardianship Signature Agreement
10. Release/Authorization to Publish Images
11. Release/Authorize to Publish a Specific Image
12. Personal Health Info (PHI) Authorization & Release of Information (ROI)
13. Water Activities Waiver
14. Transportation Consent
15. Client AI Use Disclosure & Consent

All required forms listed above are included in this packet for your convenience and must be completed and returned to Charlene's Angels PRIOR to the start of service.

You may email them to mcox@charsangels.com or bring them to Charlene's Angels facility.

If you have any questions while completing the Application Packet, please call Charlene's Angels. We will gladly assist you through this process.

CHARLENE'S ANGELS

WAIVER SERVICES APPLICATION

Participant Name:	Nickname:
Phone Number:	Email Address:

Does the Applicant Have a Legal Guardian? ☐ YES ☐ NO

**If yes, please provide formal guardianship papers*

Name (s): _____

_____

Address: _____

Phone #: _____ Email: _____

Phone #: _____ Email: _____

Has the Applicant Ever Been Convicted of a Crime? ☐ YES ☐ NO

If YES, please include details below:

How did you hear about Charlene's Angels?

Desired Pathway(s):

☐ Facility Habilitation ☐ Community Habilitation

☐ PAC (Participant Assistance Care) ☐ RESPITE

ACKNOWLEDGEMENT OF RECEIPT

I understand and acknowledge that I received Charlene's Angels Participant Handbook and have reviewed its contents.

This includes:

- Program information and service expectations-I understand who I can talk to if I have a question or concern about my services.

- Participant rights and responsibilities, which include information about my rights and the process of filing a complaint. My rights have been explained to me, and I understand them. I also understand who I can talk to if I have a complaint or concern about my rights.

- Privacy practices, including how my information may be used and protected. (HIPPA safeguards, privacy rights)

If I have questions in the future about my rights or how I can file a complaint, I can contact:

Charlene Guthrie _____ 317-431-1484
Charlene's Angels supervisor's name Phone number

Signatures:

_____ _____
Individual/Legal Representative Date

_____ _____
Witness Date

Charlene's Angels
Participant General Information

Participant's Name:		**Date of Birth:**
Address:		
Home Phone:		**Cell #:**
Social Security # **(last 4 digits only)**	**Gender:** **Race:** **Religion:**	
1-Parent/Guardian Name **Phone #**		
2-Parent/Guardian Name **Phone #**		
1-Parent/Guardian Email Address		
2-Parent/Guardian Email Address		
Name of Case Management Company		
Case Manager's Name **Phone #**		
Case Manager's Email		
Residential Provider Company		
Residential Provider's Contact Name **Phone #**		
Does the participant have a Behavior Support Plan?	☐ **Yes** ☐ **No**	
Behavior Consultant Name **Phone #**		
Allergies	**Medication Allergies** _____ **Food Allergies** _____ **Environmental Allergies**_____ ☐**Gluten** ☐**Dairy** ☐**Bees** ☐**Seasonal** ☐**Animal** ☐**Latex**	

Charlene's Angels
Participant General Information

Seizures	☐Grand Mal ☐Petit Mal ☐Simple Partial ☐VNS (Date Implanted) _____ Emergency Medication: (Diastat, Valium, etc) _____
Pacemaker	☐Pacemaker ☐ICD (Implantable Cardioventricular Defibrillator
Diabetes	_____Type of diabetes (Type 1, Type 2, gestational, other) ☐Participant Self-Administers ☐Participant Requires assistance ☐Oral Medication ☐ Injectable Insulin is administered via: ☐ syringe ☐ insulin pump ☐pen
Asthma	☐Rescue inhaler (Inhaler must include name, dose, time to be given)
Incontinence	☐Bowel ☐Bladder ☐ Wears Depends
Communication Difficulty	Assistive Devices: (check box) ☐ Communication Device ☐ IPAD ☐ Sign Language ☐ Other
Fall Risk	☐ Yes ☐ No ☐ Assistive Device(s) _____
Dining Difficulty	☐ Choking Risk ☐ Aspiration Risk ☐ Chewing
Constipation	☐ Yes ☐ No
Dehydration	☐ Yes ☐ No
Wanders from the Group	☐ Yes ☐ No
Hearing Difficulty	Assistive Devices: (check box) ☐ Hearing Aides ☐ Amplifiers ☐Cochlear Implant
Vision Difficulty	☐ Wears Glasses ☐ Light Sensitivity ☐ Blind

PARTICIPANT CONSENT

I have applied to Charlene's Angels program for facility and community-based services. Charlene's Angels includes opportunities for learning and assistance in the areas of self-care, sensory/motor development, socialization, daily living skills, communication, community living, and social skills.

I believe I would benefit from participation in Charlene's Angels services and agree to attend on the days I am scheduled. While participating with Charlene's Angels, I also agree to respect the privacy of other people who are enrolled in the program and to follow the Participant Code of Conduct.

_____ _____

Participant/Legal Representative Date

_____ _____

Witness Date

cc: Charlene's Angels file
Individual and/or legal representative

SERVICE AGREEMENT

Individual's Printed Name: _____

Charlene's Angels agrees to provide Medicaid Waiver Services to the above named individual in accordance with the services authorized on the individual's Service Authorization.

Service Agreement Signatures:

By signing this document, you are acknowledging that you understand and agree to the terms of this Service Agreement.

_____ _____

Individual/Legal Representative Date

_____ _____

Witness Date

cc: Charlene's Angels file
Individual and/or legal representative

_____ 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
				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

CONSENT FOR EMERGENCY TREATMENT

Individual's Printed Name: _____

I hereby give permission for this individual to be given emergency treatment (first aid and CPR) by a qualified Charlene's Angels staff member. I also give my permission for this individual to be transported by ambulance or staff car to an emergency center for treatment. In the event that I cannot be contacted, I further consent to the medical, surgical, and hospital care treatment and procedures to be performed for this individual by a licensed physician or hospital when deemed immediately necessary or advisable by the physician to safeguard the individual's health.

LEGAL STATUS	
☐ Individual is an emancipated adult	Primary emergency contact:
☐ Individual is an adult with a legal representative. Circle: Legal Guardian, POA, Healthcare Rep	Name and contact information of legal representative:
☐ Individual is a minor child.	Name and contact information of parent/legal guardian:

MEDICAL INFORMATION	
Individual's primary care physician:	
Physician's address:	
Physician's phone number:	
Allergies/Health Issues:	
Preferred hospital:	
Hospital address:	
Hospital phone number:	
Medical insurance:	
Insurance numbers:	
Date of last tetanus (or DPT):	

SIGNATURES	
Individual/legal representative signature:	Date:
Witness:	Date:

DUAL GUARDIANSHIP SIGNATURE AGREEMENT

Participant Name: _____

The participant's co-guardians agree that:

Both signatures are necessary on **ALL** paperwork that requires guardian signatures.

_____ _____
Legal Guardian's Signature Date

_____ _____
Legal Guardian's Signature Date

OR

One signature is all that is necessary on **ALL** paperwork that requires guardian signatures.

_____ _____
Legal Guardian's Signature Date

_____ _____
Legal Guardian's Signature Date

cc: Charlene's Angels file
Individual and/or legal representative

RELEASE/AUTHORIZATION TO PUBLISH IMAGES

☐ I DO NOT GIVE CONSENT for Charlene's Angels to use images of me

☐ I DO GIVE CONSENT for Charlene's Angels to use images of me

I hereby give Charlene's Angels full, unrestricted rights to publish, distribute electronically and/or use any still or motion pictures of me for use in Charlene's Angels' printed publications and websites.

I hereby release and hold harmless the above named, its successors, employees, agents, and assigns from any liability or claims of damage whatsoever in connection with said use of my likeness. I waive the right to inspect and approve final use of materials covered hereunder. I have read and understand this Release, and certify that the information provided is true and accurate.

_____ _____

Individual/Legal Representative Date

_____ _____

Witness Date

RELEASE/AUTHORIZATION TO PUBLISH A SPECIFIC IMAGE

Individual Printed Name: _____

☐ **I DO GIVE CONSENT** for Charlene's Angels to use the attached image of me.

I hereby give Charlene's Angels full, unrestricted rights to use the attached image of me for the following purpose(s):

- ☐ Charlene's Angels website
- ☐ Charlene's Angels Social Media (specify: _____)
- ☐ Charlene's Angels Newsletter (newsletters are emailed, handed out to employees and staff, and published on the Charlene's Angels website and Facebook page)
- ☐ Charlene's Angels Brochure
- ☐ Charlene's Angels Marketing Display
- ☐ Charlene's Angels Office Location Display (specify the office location: _____)
- ☐ Other (specify:

_____)

I hereby release and hold harmless the above-named, its successors, employees, agents, and assigns from any liability or claims of damage whatsoever in connection with said use of my likeness. I waive the right to inspect and approve the final use of materials covered hereunder. I have read and understand this Release and certify that the information provided is true and accurate.

☐ **I DO NOT GIVE CONSENT** for Charlene's Angels to use the attached image of me.

_____ _____

Individual/Legal Representative Signature Date

CHARLENE'S ANGELS

PROTECTED HEALTH INFORMATION (PHI) AUTHORIZATION & RELEASE OF INFORMATION (ROI)

Participant Name: _____

Date of Birth: _____ **Medicaid Number:** _____

Purpose of This Authorization

This document authorizes Charlene's Angels to use and disclose Protected Health Information (PHI) as required for the coordination, delivery, and billing of waiver services, and—if selected—authorizes a specific release of information to a designated individual or organization.

PHI includes any information that identifies the Participant and relates to their health status, medical history, diagnoses, medications, treatment, or services received.

SECTION 1 — GENERAL PHI AUTHORIZATION (Required for Services)

Information That May Be Used or Disclosed

Charlene's Angels may use or disclose the following PHI as needed for service provision and compliance:

- Medical history, diagnoses, and treatment information
- Medication lists, MARs, and physician orders
- Behavioral support plans, risk plans, and safety plans
- Emergency contacts and medical emergency information
- Service notes, progress notes, and quarterly summaries
- Information required for BDS, Medicaid, or case management
- Any additional information necessary to ensure health, safety, and service coordination

Who May Receive This Information

PHI may be shared with:

- BDS
- Case Managers and Support Coordinators
- Medicaid and Medicaid Waiver oversight entities
- Physicians, nurses, and other healthcare providers
- Emergency medical personnel
- Legal guardians or authorized representatives
- Other providers involved in the Participant's care (e.g., therapies, respite, PAC)

Purpose of Disclosure

PHI may be used or disclosed for:

- Service planning and coordination
- Health and safety monitoring
- Medication management
- Emergency treatment
- Billing and claims processing
- Compliance with state and federal regulations

- Communication with guardians and authorized representatives

Method of Disclosure

Charlene's Angels may disclose PHI through:

- **Written documents** (plans, summaries, reports)
- **Electronic communication** (encrypted email, secure portals, BDS systems)
- **Verbal communication** (phone, in-person, care coordination meetings)
- **Emergency disclosure** to medical personnel
- **Secure electronic transmission** required by oversight entities

Reasonable safeguards will be used regardless of method.

SECTION 2 — INDIVIDUAL RIGHTS & ACKNOWLEDGEMENTS

By signing this authorization, the Participant or Guardian acknowledges the following rights:

Right to Refuse Authorization

- Signing is voluntary, but refusal may limit the ability to provide services requiring PHI.

Right to Revoke Authorization

- May be revoked at any time by submitting a written request.
- Revocation does not apply to PHI already used or disclosed.

Right to Inspect or Request Copies of PHI

- Copies of PHI may be requested in writing.

Right to Request Restrictions

- Restrictions may be requested; Charlene's Angels may decline if they interfere with service delivery or compliance.

Right to Confidential Communication

- Alternative communication methods or locations may be requested.

Right to Receive a Copy of This Authorization

- A copy will be provided upon request.

Acknowledgement of Potential Re-Disclosure

- PHI disclosed to another entity may no longer be protected by HIPAA if that entity is not bound by HIPAA regulations.

SECTION 3 — EXPIRATION OF AUTHORIZATION

This authorization remains in effect:

- **For the duration of active services**, OR
- **Until revoked in writing**, OR

- **One year after service discharge** for billing, audit, and compliance purposes.

After expiration, PHI remains protected under Charlene's Angels' confidentiality and record-retention policies.

SECTION 4 — OPTIONAL RELEASE OF INFORMATION (ROI)

(Complete this section only if requesting a specific release of records.)

I authorize Charlene's Angels to release the following information:

☐ Entire record ☐ Medical Information ☐ Medication records / MARs ☐ Behavioral plans / Risk plans ☐ Service notes / Quarterly summaries ☐ Emergency information ☐ Other (specify):_____

Date Range of Records (optional):

From: _____ To: _____

Information To Be Released To:

Name/Organization: _____

Address: _____ Phone: _____

Email: _____

Purpose of Release:

☐ Continuity of care ☐ Legal/guardianship ☐ Medical provider request ☐ Personal use
☐ Other: _____

Type of Release:

☐ **One-time release only** ☐ **Ongoing release for the duration of services** *(Guardian may revoke at any time.)*

SECTION 5 — SIGNATURES

Participant or Legal Guardian:

Name: _____ Signature: _____

Date: _____

Charlene's Angels Representative:

Name: _____ Signature: _____

Date: _____

TRANSPORTATION CONSENT FOR COMMUNITY OUTINGS

As part of Charlene's Angels Day Habilitation, Respite, and PAC services, individuals may regularly participate in community outings and community-based activities that support inclusion, independence, safety, and personal goals. These activities may require transportation provided by Charlene's Angels staff during authorized service hours. By signing this form, you authorize Charlene's Angels to transport the individual to and from community outings while receiving Day Habilitation, Respite, or PAC services.

Participant's Name: _____

Participant's Signature: _____ Date: _____

Legal Guardian(s) (if applicable):

Name: _____

Signature: _____ Date: _____

Name: _____

Signature: _____ Date: _____

CHARLENE'S ANGELS
Client AI Use Disclosure & Consent

Organization Name: __Charlene's Angels_____
Client Name: _____ **Date:** _____

How We Use AI
Our organization uses limited forms of **artificial or augmented intelligence (AI)** to support—never replace—human staff. AI may help with scheduling, communication, documentation, or analyzing health information to improve service quality. All final decisions are made by qualified staff.

AI in Service Delivery
AI may assist with:

- Automated reminders or messaging
- Tools that help staff assess needs or risks
- Systems that organize or summarize information

You may ask at any time whether AI was used in your services.

AI in Health Data Analysis
Some of your health information may be processed by AI to identify trends or support staff decision-making. AI does **not** make independent clinical decisions; staff reviews all AI-generated insights.

Privacy & Sensitive Data Protection
We follow all federal and state privacy laws, including HIPAA. We ensure:

- Only necessary information is used
- Data is encrypted and securely stored
- Access is limited to authorized staff
- AI tools meet strict privacy and security standards

Human Oversight
AI never replaces human judgment. Staff monitor AI tools for accuracy, fairness, and safety, and remain fully responsible for all decisions affecting your care.

Incident Notification
We will notify you if:

- Your information is involved in an AI-related incident
- An AI tool error may have affected your services
- A breach requires legal notification

Policy Review
Our AI policies are reviewed **at least annually** and updated as needed.

Client Acknowledgment & Consent
I acknowledge that I have been informed about the organization's use of AI as described above and have had the opportunity to ask questions.

☐ I consent to the use of AI as described. ☐ I do NOT consent to the use of AI in my services.

Client Signature: _____ **Date:** _____

Parent/Guardian (if applicable): _____ **Date:** _____

Staff Signature: _____ **Date:** _____

CHARLENE'S ANGELS
WATER ACTIVITIES WAIVER

Individual's Printed Name: _____

☐ **Individual is an emancipated adult.** (Sign below)

I understand that I can participate in water activities when there is a trained lifeguard on duty. If I want to participate in water activities when a lifeguard is not present, I understand that there must be documented agreement from my Individualized Support Team (IST) within the ISP, including any associated risks and any safety measures required such as life jackets or other water safety devices.

I understand the risks associated with these activities and still choose to participate. The Water Activities policy & procedure has been explained to me, and I understand that although Charlene's Angels employees may accompany me during water activities, they shall not act in the capacity of lifeguard or other emergency/safety personnel.

_____ _____
Individual Date

_____ _____
Witness Date

☐ **Individual is an adult with a legal representative.** Circle: Legal Guardian, POA

☐ I do not authorize water activities.

☐ I authorize the individual to participate in water activities with a lifeguard present.

Specific activities authorized (swimming, wading, fishing, etc.):
_____
_____

Special considerations (life jacket, depth of water, etc.):
_____
_____

☐ I authorize the individual to participate in the following water activities without a lifeguard:

Specific activities authorized (swimming, wading, fishing, etc.):
_____
_____

Special considerations (life jacket, depth of water, etc.):
_____
_____

I understand the risks associated with these activities and still choose for this individual to participate. The Water Activities policy & procedure has been explained to me, and I understand that although Charlene's Angels employees may accompany the individual during the activities listed above, they shall not act in the capacity of lifeguard or other emergency/safety personnel.

_____ _____
Legal Representative Date

_____ _____
Witness Date