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SERVICE APPLICATION-INTAKE PACKET

Revised June 8, 2009

INCLUSION, INC.

APPLICATION FOR SERVICES

1. GENERAL INFORMATION

APPLICANT FULL NAME: _____

APPLICATION DATE: _____ Date of Birth (DOB): _____

PHYSICAL ADDRESS: _____

MAILING ADDRESS: _____

HOME TELEPHONE: _____ WORK TELEPHONE: _____

CELLULAR TELEPHONE: _____ GENDER: MALE FEMALE

SOCIAL SECURITY NUMBER: _____ Age: _____

HEALTHY CONNECTIONS: YES NO MEDICAID #: _____
MEDICARE #: _____

GUARDIAN FULL NAME: SELF OTHER: _____

Guardian – Legally Authorized (Entity or Person) Contact Information:

Name: _____

Address: _____
Street City State Zip

Responsible Person(s) Contact Information:

Name: _____

Address: _____
Street City State Zip

Applicant's Children: See below Not Applicable

Name: _____ Name: _____

Age: _____ DOB: _____ Age: _____ DOB: _____

Name: _____ Name: _____

Age: _____ DOB: _____ Age: _____ DOB: _____

Applicants Sibling(s): See below

Not Applicable

Name: _____

Name: _____

Age: _____ DOB: _____

Age: _____ DOB: _____

Name: _____

Name: _____

Age: _____ DOB: _____

Age: _____ DOB: _____

Name: _____

Name: _____

Age: _____ DOB: _____

Age: _____ DOB: _____

Name: _____

Name: _____

Age: _____ DOB: _____

Age: _____ DOB: _____

In Case of Emergency, Please Notify:

Primary Contact:

Name: _____ Relationship: _____

Address: _____
Street City State Zip

Secondary Contact:

Telephone: _____ Secondary Telephone: _____

Name: _____ Relationship: _____

Address: _____
Street City State Zip

Telephone: _____ Secondary Telephone: _____

INCLUSION, INC.

APPLICATION FOR SERVICES

2. ADDITIONAL GENERAL INFORMATION

Please attach copies of the following documentation to service application:

- Medicaid Card (If Medicaid Eligible - Required)
- Medicare Card
- Other Insurance Card (If applicable)
- Guardianship Documentation (If relevant)
- Medical Documentation (including primary diagnosis, if available, may include, but not limited to: History and Physical; Psychological Evaluation; Medical Assessment or Evaluations; etc.)
- Current documentation, including, but not limited to: SIB-R, Individual Support Plan, other programmatic documentation

Primary and/or Secondary Diagnosis (please attach documentation verifying DX):

Primary DX: _____

Secondary DX: _____

Current Living Arrangement:

- | | | |
|--|--|---|
| <input type="checkbox"/> Family Residence | <input type="checkbox"/> Institution or ICF-MR | <input type="checkbox"/> Supported Living Arrangement |
| <input type="checkbox"/> Group Home | <input type="checkbox"/> PCS Home | <input type="checkbox"/> Foster Home |
| <input type="checkbox"/> Correction Facility | <input type="checkbox"/> Nursing Home | <input type="checkbox"/> Assisted Living |
| <input type="checkbox"/> Other: _____ | | |

- Marital Status:
- | | | | |
|-----------------------------------|----------------------------------|-----------------------------------|-------------------------------------|
| <input type="checkbox"/> Married | <input type="checkbox"/> Single | <input type="checkbox"/> Divorced | <input type="checkbox"/> Separated |
| <input type="checkbox"/> Widowed | <input type="checkbox"/> Engaged | <input type="checkbox"/> Annulled | <input type="checkbox"/> Cohabiting |
| <input type="checkbox"/> Deceased | | | |

Are you presently taking any **prescription** or **non-prescription medication(s)** – if so, please list:

Medication(s):	Dosage	Frequency/Time	Purpose
_____	_____	_____ <input type="checkbox"/> AM <input type="checkbox"/> PM	_____
_____	_____	_____ <input type="checkbox"/> AM <input type="checkbox"/> PM	_____
_____	_____	_____ <input type="checkbox"/> AM <input type="checkbox"/> PM	_____
_____	_____	_____ <input type="checkbox"/> AM <input type="checkbox"/> PM	_____
_____	_____	_____ <input type="checkbox"/> AM <input type="checkbox"/> PM	_____
_____	_____	_____ <input type="checkbox"/> AM <input type="checkbox"/> PM	_____
_____	_____	_____ <input type="checkbox"/> AM <input type="checkbox"/> PM	_____
_____	_____	_____ <input type="checkbox"/> AM <input type="checkbox"/> PM	_____
_____	_____	_____ <input type="checkbox"/> AM <input type="checkbox"/> PM	_____
_____	_____	_____ <input type="checkbox"/> AM <input type="checkbox"/> PM	_____
_____	_____	_____ <input type="checkbox"/> AM <input type="checkbox"/> PM	_____
_____	_____	_____ <input type="checkbox"/> AM <input type="checkbox"/> PM	_____
_____	_____	_____ <input type="checkbox"/> AM <input type="checkbox"/> PM	_____
_____	_____	_____ <input type="checkbox"/> AM <input type="checkbox"/> PM	_____
_____	_____	_____ <input type="checkbox"/> AM <input type="checkbox"/> PM	_____

Have you ever been hospitalized due to mental health issues? Yes No

If yes, please provide information related to hospitalization (i.e. dates, frequency; reason(s)):

Are you currently on probation or parole? Yes No

Service History:

Have you received services from Inclusion, Inc. at any time in the past? Yes No

If so, please provide dates of service: _____

If so, please provide reason for initial discharge or termination of services:

Have you received services from a different Supported Living-Residential Habilitation Agency; Developmental DisAbilities Agency; or CSE provider in the past?

Yes No

If yes, please provide name of provider: _____

Service Needs:

Current Issues/Concerns (please identify any and all current issues and/or concerns):

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Stress/Anxiety | <input type="checkbox"/> Drug-Alcohol | <input type="checkbox"/> Employment-Career |
| <input type="checkbox"/> Health | <input type="checkbox"/> Sleep Disturbances | | <input type="checkbox"/> Eating-Diet |
| <input type="checkbox"/> Interpersonal Relationships | | <input type="checkbox"/> Thoughts of Harm to Self | |
| <input type="checkbox"/> Thoughts of Harm to Others | | <input type="checkbox"/> Family Issues | <input type="checkbox"/> Victimization |
| <input type="checkbox"/> Financial | <input type="checkbox"/> OCD | <input type="checkbox"/> Sexual Behavior(s) | |
| <input type="checkbox"/> Functional Skill Deficits or Needs | | <input type="checkbox"/> General Behavioral Deficits or Needs | |
| <input type="checkbox"/> Community Access or Inclusion | | <input type="checkbox"/> | |
| <input type="checkbox"/> Other (please specify): | _____ | | |

INCLUSION, INC.

APPLICATION FOR SERVICES

3. MEDICAL HISTORY

Has the applicant had or does he/she currently suffer from epilepsy; or, seizure disorder(s)?

Yes No

If so, what type?

- | | | | | |
|--|---|---|--|--------------------------------|
| <input type="checkbox"/> Absence | <input type="checkbox"/> Atypical absence | <input type="checkbox"/> Myoclonic | <input type="checkbox"/> Atonic | <input type="checkbox"/> Tonic |
| <input type="checkbox"/> Clonic | <input type="checkbox"/> Tonic-Clonic | <input type="checkbox"/> Simple Partial | <input type="checkbox"/> Complex Partial | |
| <input type="checkbox"/> Secondarily Generalized | | <input type="checkbox"/> Petite Mal | <input type="checkbox"/> Grand Mal | |
| <input type="checkbox"/> Focal Motor | | <input type="checkbox"/> Unknown | | |

How frequent does the applicant experience seizure activity? _____

Date of most recent seizure activity? _____

Are seizures currently controlled by medication(s)? _____

Does the applicant suffer from any chronic medical conditions; if so, please list:

Please list any known allergies? _____

Please list any recurring illnesses; or, injuries: _____

Does the applicant require any specialized diet? _____

Does the applicant require any specialized treatments? _____

INCLUSION, INC.

APPLICATION FOR SERVICES

PROFESSIONAL-MEDICAL CONTACT INFORMATION:

Name of Primary Care Physician: _____ (Tel): _____

Address: _____ (Fax): _____

Name of Caseworker (if relevant): _____ (Tel): _____

Address: _____ (Fax): _____

Name of TSC Agency (if relevant): _____ (Tel): _____

Address: _____ (Fax): _____

Name of PSR Agency (if relevant): _____ (Tel): _____

Address: _____ (Fax): _____

Name of Counselor-Therapist (if other): _____ (Tel): _____

Address: _____ (Fax): _____

Name of Psychiatrist (if relevant): _____ (Tel): _____

Address: _____ (Fax): _____

Name of Other Specialist: _____ (Tel): _____

Address: _____ (Fax): _____

Name of Other Specialist: _____ (Tel): _____

Address: _____ (Fax): _____

Name of Other Specialist: _____ (Tel): _____

Address: _____ (Fax): _____

INCLUSION, INC.

APPLICATION FOR SERVICES

Representative Payee Support Program Availability and Choice

Inclusion, Inc. offers Representative Payee supports to participant(s) accessing our Residential Habilitation-Supported Living Program services. Inclusion, Inc. provides this support at no cost to the participant; or, an insurance carrier – therefore, the support provided by Inclusion, Inc. is offered at no cost to any party, but Inclusion, Inc.

Please understand - if the participant does not access services within our Residential Habilitation-Supported Living Program, Inclusion, Inc. is unable to provide Representative Payee support.

Explanation of Representative Payee Support Program:

A Representative Payee is an individual; or, in this case, an organization (Inclusion, Inc.), that receives Social Security and/or SSI payments for someone (a participant) who cannot manage or direct the management of his/her money. Payees should use the funds for the current and foreseeable needs of the beneficiary and save any remaining funds for the beneficiary's future use.

A payee acts on behalf of the beneficiary (participant). A payee is responsible for everything related to benefits that a capable beneficiary would do for himself or herself. SSA encourages payees to go beyond just managing finances and to be actively involved in the beneficiary's life. The following lists the required duties of a payee.

Required Duties of a Representative Payee:

- Determine the beneficiary's needs and use his or her payments to meet those needs;
- Save any money left after meeting the beneficiary's current needs in an interest bearing account or savings bonds for the beneficiary's future needs;
- Report any changes or events which could affect the beneficiary's eligibility for benefits or payment amount;
- Keep records of all payments received and how they are spent and/or saved;
- Provide benefit information to social service agencies or medical facilities that serve the beneficiary;
- Help the beneficiary get medical treatment when necessary;
- Notify SSA of any changes in your (the payee's) circumstances that would affect your performance or continuing as payee;
- Complete written reports accounting for the use of funds; and
- Return any payments to which the beneficiary is not entitled to SSA.

A Representative Payee cannot:

- Sign legal documents, other than Social Security documents, on behalf of a beneficiary.
- Have legal authority over earned income, pensions, or any income from sources other than Social Security or SSI.
- Use a beneficiary's money for the payee's personal expenses, or spend funds in a way that would leave the beneficiary without necessary items or services (housing, food, medical care).
- Put a beneficiary's Social Security or SSI funds in their or another person's account.
- Use a child beneficiary's "dedicated account" funds for basic living expenses. This only applies to disabled/blind SSI beneficiaries under age 18.
- Keep conserved funds once you are no longer the payee.
- Charge the beneficiary for services unless authorized by SSA to do so.

Reporting Responsibilities of the Representative Payee:

A Representative Payee must report the following events as soon as possible, by calling SSA at 1-800-772-1213, or contacting the local SSA office. Note that there are additional reporting requirements for SSI beneficiaries at the end of the list.

- The beneficiary dies;
- The beneficiary moves;
- The beneficiary marries;
- The beneficiary starts or stops working, even if the earnings are small;
- A disabled beneficiary's condition improves;
- The beneficiary starts receiving another government benefit, or the amount of that benefit changes;
- The beneficiary plans to leave the U.S. for 30 days or more;
- The beneficiary is imprisoned for a crime that carries a sentence of over one month;
- The beneficiary is committed to an institution by court order for a crime committed because of mental impairment;
- Custody of a child beneficiary changes or a child is adopted;
- The beneficiary is a child (including a stepchild), and the parents' divorce;
- You can no longer be payee; or
- The beneficiary no longer needs a payee.

Additional events that you must report for SSI beneficiaries:

- The beneficiary moves to or from a hospital, nursing home, or other institution;
- A married beneficiary separates from his or her spouse, or they begin living together after a separation;
- Somebody moves into or out of the beneficiary's household;
- The beneficiary has any change in income or resources (i.e., a child's SSI benefit check may change if there are any changes in the family income or resources); or
- Resources that exceed \$2000.

Inclusion, Inc. may only operate as the Representative Payee after our agency has received a formal, written notification from the Social Security Administration notifying us that we have been officially identified as the responsible party to manage the participant's funds. Therefore, the previous Representative Payee or responsible party will need to continue to manage the participant's funds until Inclusion, Inc. has received official notice of responsibility. Therefore, if you are choosing to request Inclusion, Inc. to act as the Representative Payee of the participant – it is vital that the paperwork process required by the Social Security Administration be activated as soon as possible.

Informed Consent related to provision of information related to choice of accessing Inclusion, Inc. as the Representative Payee:

By signing below, you are indicating the above information related to Representative Payee supports was provided by INCLUSION, INC. representative(s) and reviewed with you by INCLUSION, INC. personnel; and, that you have received the information in written terms, as well as, verbally; and, that you adequately understand and comprehend the information provided; and, agree to consent.

Participant Signature
Parent, Legal Guardian or Legally Authorized Representative

Date (Month-Date-Year)

Inclusion, Inc. Representative

Date (Month-Date-Year)

Informed Consent related to related to choice of accessing Inclusion, Inc. as the Representative Payee:

By indicating and signing below, you are either formally choosing to request Inclusion, Inc. to act as Representative Payee for the participant; or, formally indicating that Inclusion, Inc.'s support program has been offered, but refused:

Based on this consent document, I choose to formally *request* Inclusion, Inc. to act as Representative Payee on behalf of the participant.

Based on this consent document, I choose to formally *decline* Inclusion, Inc.'s offer to act as Representative Payee on behalf of the participant.

Participant Signature
Parent, Legal Guardian or Legally Authorized Representative

Date (Month-Date-Year)

Inclusion, Inc. Representative

Date (Month-Date-Year)

INCLUSION, INC.

APPLICATION FOR SERVICES

Informed Consent

The adopted Inclusion, Inc. Code of Ethics, as well as, State Laws require personal information discussed with any Inclusion, Inc. employee or contractor, or provided via Claim Questionnaires, be kept confidential. This means information about you may be shared among Inclusion, Inc. personnel only for professional purposes; it is not revealed to other persons, providers, agencies, or entities without your clear and specific permission. Protecting your privacy and confidence is of highest importance to us at Inclusion, Inc.

Inclusion, Inc. understands Informed Consent is an ongoing part of the therapeutic or professional relationship; therefore, Inclusion, Inc. personnel may revisit and document discussions related to informed consent during the therapeutic relationship and professional processes, as well.

PRIVACY EXCEPTIONS – Inclusion, Inc. personnel are legally required to report the following situations:

1. Medical emergencies that require information only for handling the emergency.
2. Potential harm, danger, or threat of death to one's self or another person which require the police and/or intended victims to be notified.
3. Disclosure of abuse or neglect of a child, an aged person, or other vulnerable persons.
4. Records subpoenaed by the court.

By signing below, you are indicating the above information related to privacy exceptions and notices was reviewed with you by Inclusion, Inc. personnel; that you have received the information in written terms, as well as, verbally; and, that you adequately understand and comprehend the information provided; and, agree to consent.

Participant Signature
Parent, Legal Guardian or Legally Authorized Representative

Date (Month-Date-Year)

Inclusion, Inc. Representative

Date (Month-Date-Year)

INCLUSION, INC.

APPLICATION FOR SERVICES

SERVICES TO BE RECEIVED – EXPECTED BENEFITS AND ATTENDANT RISKS

It is the responsibility of INCLUSION, INC. to inform each participant (or, legal guardian) of the services to be received; as well as, the expected benefits and risks of those services.

Inclusion, Inc. must provide participant's with a written explanation of risks and benefits associated with services and treatment provided by the agency. The provision of this documentation must be maintained in the Participant Record.

INCLUSION, INC. understands our personnel have a responsibility to our participants to explain the nature of all services provided via INCLUSION, INC. INCLUSION, INC. will make every effort to inform participants about the purposes, goals, techniques, procedures, limitations, potential risks, and benefits of services; as well as, the therapist's qualifications, credentials, and relevant experience; continuation of services upon the incapacitation or death of a responsible professional; and, other pertinent types of information. Inclusion, Inc. will also take appropriate steps to provide participant's detailed information related to diagnosis; condition, programming (functional; behavioral); uses of tests or reports, fees, billing arrangements.

You have a right to confidentiality – and, INCLUSION, INC. personnel make efforts to protect your privacy; however, you must also understand our professionals work within an interdisciplinary team; and, a Person-Centered Planning (PCP) team; and, information about you and your services may be shared with supervisors or contracted consultants, including, but not limited to, psychiatrist and physician. The purpose of this information sharing involves training, consultation, recommendations and professional and agency oversight requirements.

You also have the right to be involved in the development and implementation of your individualized service plan, as well as, to choose others to be involved in the development of the internal service planning; and, Individual Support Plan (ISP).

Inclusion, Inc. defines the risks and benefits associated with our core services, as such:

Risks:

Often services and programs provided by Inclusion, Inc. require addressing, recalling and talking about unpleasant aspects of your history or your present situation, which can bring to the surface extremely uncomfortable feelings such as sadness, anger, frustration, shame, etc. Although it may be necessary to talk, process, or address painful or embarrassing subjects, the process often assists the participant to address issues within his or her PCP team.

An additional risk of accessing services with Inclusion, Inc. is referred to as "life-change"; our mental and emotional health affects how we act, react, and how other people (especially people who are close to you) act and react to us. Therefore, as we grow or change perspectives – or, changes in environments, such as leaving a family home to live in the community can upset the delicate balances within our relationships. Our friends and family are used to us behaving in certain ways in specific environments...changing those patterns, motives, behaviors, etc. promotes risk of changing various relationships and responses.

- Risks include, but may not be limited to:

- Risk of injury – Participants are often transported to and from appointments, community-based activities/settings, etc. – risk of injury in traffic-related accident(s) are possible. Other forms of injury may occur, which cannot be specified or predicted in advance.
- Loss of functional skill
- Increase in maladaptive behaviors
- Loss of meaningful relationships based on employee turnover; changes in environments; etc.

Benefits:

A number of benefits are available from participating in informal and formal programming within Inclusion, Inc.'s services and supports. The benefits you obtain from services are, in part, dependent on participant's willingness, capabilities, and, energies a participant is willing to bring forth to engage in therapeutic services; as well as, willingness and capabilities to engage in non-Inclusion, Inc. services, supports, activities, etc. – identified within the service plan. The benefits available may include, but is not limited, to the following:

- Attaining a better understanding of yourself and your personal goals and values, developing functional skills for improving your relationships; developing and maintaining general daily living skills; etc.
- Acquiring Functional Skills
- Community Access
- Community Inclusion
- Decreasing Maladaptive Behaviors
- Residing in a Community-Based Setting
- Finding resolution to issues or concerns

There are no guarantees about what outcomes Inclusion, Inc. programs and services will have for each participant. Some people find that participating in our services and programs result in changes that were not expected or intended at the outset.

By signing below, you are indicating the above information related to benefits and risks associated with services provided by INCLUSION, INC. was reviewed with you by INCLUSION, INC. personnel; that you have received the information in written terms, as well as, verbally; and, that you adequately understand and comprehend the information provided; and, agree to consent.

Participant Signature
Parent, Legal Guardian or Foster Parent

Date (Month-Date-Year)

Inclusion, Inc. Representative

Date (Month-Date-Year)

INCLUSION, INC.

APPLICATION FOR SERVICES

REFUSAL OF SERVICES

Inclusion, Inc. must ensure participants receiving services from the agency have obtained informed consent from the participant or their legal guardian related to the participant's right to refuse services offered by the agency.

It is your right to refuse services provided by INCLUSION, INC. at any point in time. Participants have the right to refuse treatment at any time. A participant's right to refuse treatment or services from the agency is fundamental and reflects our respect for the autonomy of the individual. Informed consent related to the right to refuse treatment is ethically imperative and promotes self-determination. INCLUSION, INC. personnel will respect the right to refuse treatment.

Please note, if you refuse recommended services or treatment, agency personnel are required to document the refusal of services or treatment in your record.

You have been provided with written and verbal explanation of their right to refuse treatment or services during the intake process.

By signing below, you are indicating the above information related to your right to refuse services was reviewed with you by INCLUSION, INC. personnel; that you have received the information in written terms, as well as, verbally; and, that you adequately understand and comprehend the information provided; and, agree to consent.

Participant Signature
Parent, Legal Guardian or Foster Parent

Date (Month-Date-Year)

Inclusion, Inc. Representative

Date (Month-Date-Year)

INCLUSION, INC.

APPLICATION FOR SERVICES

CHOICE OF SERVICE PROVIDERS

You must be allowed the right to choose to, or refuse, to receive services and supports from INCLUSION, INC. in order to assist you in accomplishing objectives to be identified within your Individual Support Plan (ISP). Please indicate whether you choose to receive services and supports with Inclusion, Inc below.

Further, INCLUSION, INC. provides participants with a list of alternative service providers. Attached to this packet is a listing of alternative service providers – INCLUSION, INC. cannot guarantee if the listing provided is current and accurate.

CHOICE OF SERVICE PROVIDERS - DEVELOPMENTAL AND CULTURAL SENSITIVITY

INCLUSION, INC. strives to provide quality services to a variety of populations. We understand our personnel may be required to communicate information in a variety of formats that are developmentally and culturally appropriate. Our personnel will strive to provide information in clear, concise text or language when discussing issues related to informed consent. If you require a translator or interpreter, INCLUSION, INC. will make every effort to provide this service.

In instances when participants are not literate; lack cognitive abilities to understand or comprehend written communications; or, have difficulty understanding the primary language used in the practice setting, personnel should take steps to ensure participants' comprehension, when applicable. This may include providing participants with a detailed verbal explanation or arranging for a qualified interpreter or translator whenever possible.

INCLUSION, INC. personnel also understand we should be providing services within the context of our individual qualifications; and, therefore, will make formal referrals to alternate professionals, or providers, when appropriate.

By signing below, you are indicating the above information related to your choice to choose a service provider was reviewed with you by INCLUSION, INC. personnel; that you have received the information in written terms, as well as, verbally; and, that you adequately understand and comprehend the information provided; and, agree to consent.

Participant Signature
Parent, Legal Guardian or Foster Parent

Date (Month-Date-Year)

Inclusion, Inc. Representative

Date (Month-Date-Year)

INCLUSION, INC.

APPLICATION FOR SERVICES

PARTICIPANT RIGHTS

Inclusion, Inc. ensures all additional rights of the participants we serve are upheld, including, human and civil rights.

Inclusion, Inc. will ensure each participant receiving services will be informed of their participant rights, as follows; and, as identified by specific rights listed below:

- Upon initiation of service(s), each participant and guardian, where applicable, must be provided a packet of information outlining participant rights; access to grievance procedures; and, names, addresses, and telephone numbers of protection and advocacy services. The packet will be distributed in easily understood written terms. Inclusion, Inc. representatives will read and explain the participant rights and responsibilities, as needed. Follow-up questions and clarification may be provided to explain the information. An interpreter may be utilized if necessary to ensure the highest level of understanding for participants, families, and relevant others.
- Each participant and guardian, where applicable, must be provided a verbal explanation of their rights in a manner that will best promote individual understanding of these rights.
- Inclusion, Inc. will ensure all personnel are made aware of, and understand, the policies of non-discrimination, respect for human rights; as well as, participant rights; and, participant choice during the initial orientation training; and, ongoing, as needed.

Participant Rights and Informed Consent

The following Participant Rights will be provided to participant's during intake process. The rights will be made available in a manner in which the participant(s) will understand and comprehend. The Participant Rights will be posted in the facility, as follows:

THE RIGHT TO RECEIVE HUMANE CARE AND TREATMENT

You have the right to receive humane care and treatment while receiving services from INCLUSION, INC.

THE RIGHT NOT TO BE PUT IN ISOLATION

You have the right not to be placed in isolation.

THE RIGHT TO BE FREE FROM MECHANICAL RESTRAINTS, UNLESS NECESSARY FOR THE SAFETY OF THAT PERSON OR FOR THE SAFETY OF OTHERS

You have the right to not be physically restrained you (hold you down or keep you from moving). If you are in danger of harming yourself or others law enforcement assistance will be sought.

THE RIGHT TO BE FREE FROM MENTAL, PHYSICAL, SEXUAL ABUSE, OR RETALIATORY BEHAVIOR

You have the right to not be abused. Retaliation for filing a grievance or making a complaint are prohibited.

THE RIGHT TO PRACTICE YOUR OWN RELIGION OR ABSTAIN FROM RELIGIOUS PRACTICE

INCLUSION, INC. will not interfere with your right to practice your religion and spiritual beliefs.

THE RIGHT TO WEAR YOUR OWN CLOTHING AND TO RETAIN AND USE PERSONAL POSSESSIONS

INCLUSION, INC. will not interfere with your choices to wear your own clothing and use your own personal possessions.

THE RIGHT TO BE INFORMED OF YOUR MEDICAL AND HABILITATIVE CONDITION AND SERVICES AVAILABLE VIA INCLUSION, INC.

You have the right to be involved in your individualized Individual Support Plan and control your health-related (medical and non-medical) services.

THE RIGHT TO REASONABLE ACCESS TO ALL RECORDS CONCERNING YOURSELF

You may request access to your records at any time. The request will be granted in a manner as timely as possible and in a way that is consistent with our HIPAA Notice of Privacy Practices.

THE RIGHT TO REFUSE SERVICES

INCLUSION, INC. offers voluntary services. You will be involved in your service plan development. If you have a guardian, they will be involved as well. You have the right to receive services you wish to participate in; and, should not be receiving any services you do not wish to receive. You have the right to refuse any services. This refusal will be documented in your record.

THE RIGHT TO EXERCISE ALL CIVIL RIGHTS, UNLESS LIMITED BY PRIOR COURT ORDER

INCLUSION, INC. will not interfere with your right to exercise all other rights guaranteed to you under the Constitution of the United States, unless limited by a prior court order.

THE RIGHT TO PRIVACY AND CONFIDENTIALITY

The services that you receive at INCLUSION, INC. are confidential as defined in our HIPAA Notice of Privacy Practices. The staff of INCLUSION, INC. are trained to protect your privacy and confidentiality.

THE RIGHT TO BE TREATED IN A COURTEOUS MANNER

INCLUSION, INC. personnel will treat you with respect and dignity. You have the right to be treated in a courteous manner at all times.

THE RIGHT TO RECEIVE A RESPONSE FROM THE AGENCY TO ANY REQUEST MADE WITHIN A REASONABLE TIME FRAME

INCLUSION, INC. will make all reasonable attempts to respond to your requests in a timely manner.

THE RIGHT TO ALL OTHER RIGHTS ESTABLISHED BY LAW

INCLUSION, INC. will not interfere with your right to exercise all other rights established by law.

THE RIGHT TO BE PROTECTED FROM HARM

INCLUSION, INC. takes steps to ensure individuals hired do not have a conviction or prior employment history of child or participant abuse, neglect, mistreatment, or exploitation. All confirmed or suspected incidents of mistreatment, neglect, exploitation or abuse of participants will be reported to the Department of Health and Welfare and/or the appropriate authorities.

THE RIGHT TO VOICE GRIEVANCES AND TO RECOMMEND CHANGES IN POLICIES AND/OR SERVICES BEING OFFERED

If you feel that any of your rights outlined above, or otherwise, have been violated or you have complaints or suggestions regarding your program, please follow the grievance procedure outlined in the intake packet. If you need assistance following this procedure, you can request the assistance from INCLUSION, INC. personnel.

THE RIGHT TO RECEIVE SERVICES WHICH ENHANCE THE PARTICIPANT'S SOCIAL IMAGE AND PERSONAL COMPETENCIES AND WHENEVER POSSIBLE PROMOTE INCLUSION IN THE COMMUNITY

The services provided by INCLUSION, INC. are intended to assist participants to enhance their social image and personal competencies – and, promote successful outcomes in the lives of our participants.

THE RIGHT TO REFUSE TO PERFORM SERVICES FOR THE AGENCY.

If the participant is hired to perform services for the agency the wage paid shall be consistent with state and federal law, and

By signing below, you are indicating the above information related to participant rights was reviewed with you by INCLUSION, INC. personnel; that you have received the information in written terms, as well as, verbally; and, that you adequately understand and comprehend the information provided; and, agree to consent.

Participant Signature
Parent, Legal Guardian or Foster Parent

Date (Month-Date-Year)

Inclusion, Inc. Representative

Date (Month-Date-Year)

INCLUSION, INC.

APPLICATION FOR SERVICES

Participant Choice and Informed Consent

INCLUSION, INC. qualified personnel shall support a participant in self-determination to the maximum extent possible and shall assist the participant in making decision(s) through informed consent. Personnel must support a participant's informed choice regarding life, liberty, and the pursuit of health and happiness, unless the participant's actions or decisions put other persons at risk of significant harm. When a participant is capable of making informed choices, he-she has the right to be involved in decisions about the type, frequency, amount of services he-she will receive. The participant has the right receive services under conditions of acceptable risk in which the participant assumes the risk associated with decisions which he-she makes under conditions of informed consent.

INCLUSION, INC. Personnel should consult their direct supervisor if a person is making choices or decisions which place the participant or others at risk of significant harm.

If the qualified personnel question the participant's ability to understand the consequences of decisions or choices; and, to give informed consent, qualified personnel should assess the status of the participant or arrange for prompt assessment of the participant's mental status, by qualified professionals, to determine if the individual's ability to provide informed consent is substantially impaired and if the health and welfare of the participant or others is at risk.

Participants will be provided with written and verbal explanation of their right to make choices or decisions related to their services or treatment during the intake process. Participants will be notified they have the right and option to refuse services or treatment; or, make decisions related to choosing alternative services, treatment options, or providers without explanation.

Inability to Provide Consent

When providing services to minors or persons unable to provide voluntary, informed consent, INCLUSION, INC. personnel will require consent from legal guardians; or, other persons with legal responsibility for the participant. INCLUSION, INC. personnel recognize the rights of those unable to provide consent in the treatment process; or, relationship, and will strive to include their input and decisions in treatment planning and interventions – but, also recognize the balance between their capacity to provide informed consent and parental, familial, or legal guardianship rights and responsibilities to protect these participants.

If you do not have the legal authority to provide consent – please understand, informed consent must be gained by your legal guardian or representative prior to service provision. INCLUSION, INC. professionals will make every effort to explain the extent and limitations of your ability to consent on an individual basis during the intake process.

By signing below, you are indicating the above information related to participant choice and informed consent, as well as, inability to provide consent, was reviewed with you by INCLUSION, INC. personnel; that you have received the information in written terms, as well as, verbally; and, that you adequately understand and comprehend the information provided; and, agree to consent.

Participant Signature
Parent, Legal Guardian or Foster Parent

Date (Month-Date-Year)

Inclusion, Inc. Representative

Date (Month-Date-Year)

INCLUSION, INC.

HIPAA Notice of Privacy Practices

Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. However, this form is a "friendly" version.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations and for the purposes that permitted or required by law. This notice also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition, as well as, related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION:

Your protected health information may be used and disclosed by Inclusion, Inc. professional(s) or our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of INCLUSION, INC.'s practice, and any other use required by law.

The agency utilizes various contractors and other entities to conduct business. These contractors or entities may have access to PHI, but must agree to abide by the confidentiality rules of HIPAA.

The participant's confidential information will not be used for the purposes of marketing or advertising services.

TREATMENT:

INCLUSION, INC. will utilize and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes coordination and management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to your physician's office that provides health care services to you. Or, another example might be disclosing protected health information to a physician to who you have been referred to ensure that the physician has the necessary information to diagnose and treat you.

PAYMENT:

Your protected health information will be utilized, as needed, to obtain payment for your health care services. For example, obtaining approval for specific services to be rendered by INCLUSION, INC. may require that your relevant protected health information be disclosed to the insurance carrier or health plan to obtain approval for provision of the service.

HEALTHCARE OPERATIONS:

INCLUSION, INC. may utilize or disclose, as-needed, your protected health information in order to support the business activities of INCLUSION, INC. These activities include, but are not limited to, quality assessment and assurance activities, employee and contractor review activities, training of therapists and office employees or contractors, credentialing or accreditation activities, and conducting or arranging other business related activities. We may participants other communications informing the participant of changes to agency policies or procedures that the participant might find valuable.

Participant information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, health insurance payers as is necessary and appropriate for your care. Participant files will be filed in locked files. The normal course of providing participant care means that such records may be left, at least temporarily, in administrative areas such as the front office, or therapy rooms, etc. Those records will not be available to persons other than qualified personnel having a need to access records. The participant must agree to the normal procedures utilized within the office for handling participant records, charts, PHI and other documentation or information.

WE ARE PERMITTED AND MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION IN THE FOLLOWING SITUATIONS WITHOUT YOUR AUTHORIZATION. THESE SITUATIONS INCLUDE: AS REQUIRED BY LAW; PUBLIC HEALTH ISSUES AS REQUIRED BY LAW; PREVENTING-CONTROLLING COMMUNICABLE DISEASES; HEALTH OVERSIGHT; ABUSE OR NEGLECT; FOOD AND DRUG ADMINISTRATION REQUIREMENTS; LEGAL PROCEEDINGS; LAW ENFORCEMENT; CORONERS; FUNERAL DIRECTORS; AND ORGAN DONATION; RESEARCH; CRIMINAL ACTIVITY; MILITARY ACTIVITY AND NATIONAL SECURITY; WORKER'S COMPENSATION; INMATES; DEPARTMENT OF HEALTH AND WELFARE AND MEDICAID; REQUIRED USE AND DISCLOSURES; AND UNDER THE LAW, WE MUST MAKE DISCLOSURES TO YOU AND WHEN REQUIRED BY THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO INVESTIGATE OR DETERMINE OUR COMPLIANCE WITH THE PRIVACY RULE.

- The participant must understand and agree to inspections of the agency and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

- We are permitted to disclose your PHI to family members and friends who are involved in your treatment and payment of your care as long as we give you the opportunity to object.
- In emergencies and for disaster relief we may use professional judgment to disclose your PHI. Other disclosures will be made only with your authorization unless required by law.
- You may revoke an Authorization, at any time, in writing, except to the extent that your therapist or INCLUSION, INC. has already relied on the Authorization in the use or disclosure of your PHI. Each participant has the right to request restrictions in the use of your protected health information and to request change in certain policies used within the agency concerning the participant's PHI. However, we are not obligated to alter internal policies to conform to participant request.
- Inclusion, Inc. agrees to provide participants with access to their records in accordance with state and federal laws.
- The participant must agree to bring any concerns or complaints regarding privacy to the attention of the Office Manager or the Administrator.
- Inclusion, Inc. may change, add, delete or modify any of these provisions to better serve the needs of both the agency and our clientele.

YOUR RIGHTS AS RELATED TO HIPAA

YOUR RIGHTS:

The following is a statement of your rights with respect to your protected health information.

YOU HAVE THE RIGHT TO INSPECT AND COPY YOUR PHI IN A DESIGNATED RECORD SET.

For certain reasons we may deny access to certain records under specific circumstances. Under certain circumstances you may ask that the decision to deny be reviewed by another health care provider.

YOU HAVE THE RIGHT TO REQUEST A RESTRICTION OF YOUR PHI.

This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Forms are available upon request.

INCLUSION, INC. is not required to agree to a restriction that you may request. INCLUSION, INC. will be bound by the restrictions you outline only if we agree to those restrictions. If INCLUSION, INC. believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to choose and utilize another provider.

YOU HAVE THE RIGHT TO REQUEST TO RECEIVE CONFIDENTIAL COMMUNICATIONS FROM US BY ALTERNATIVE MEANS OR AT AN ALTERNATIVE LOCATION. YOU HAVE THE RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE FROM INCLUSION, INC., upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

YOU HAVE THE RIGHT TO REQUEST INCLUSION, INC. AMEND YOUR PHI.

If we deny your request for amendment, you have the right to file a statement or written disagreement with INCLUSION, INC. INCLUSION, INC. may prepare a rebuttal to your statement and will provide you a copy of any such rebuttal.

YOU HAVE THE RIGHT TO REQUEST AN ACCOUNTING OF CERTAIN DISCLOSURE INCLUSION, INC. HAS MADE, IF ANY, OF YOU PHI upon request (after April 14, 2003), the first accounting within a 12 month period will be provided at no charge. Reasonable charges may apply for more frequent requests.

CHANGES TO THIS NOTICE.

INCLUSION, INC. reserve the right to make revisions to our Notice of Privacy Practices which will apply to all PHI created or received prior to issuing this revision. We will provide you with the revised Notice at your first visit following the revision of the Notice. You can always request a copy of the current Notice by writing us or callus at the physical address or telephone number listed below.

COMPLAINTS.

If you believe your privacy rights have been violated, you have the right to file a complaint with our office at:

If you have any additional concerns, please contact our Operations Director:

HIPAA Violation and Participant Complaint Process:

Inclusion, Inc. will strive to adhere to HIPAA Privacy Rule. If a participant believes HIPAA violations have occurred, the participant must have the right and ability to report the violation.

Inclusion, Inc. will provide participant's with a written privacy notice during the intake process; as well as, information on how to file a complaint if the participant believes their privacy or rights have been violated under HIPAA Privacy Rule. The information will include the following:

- *A copy of the US Department of Health and Human Services FACT Sheet, which outlines the process for filing of formal complaint.*

INCLUSION, INC. will not deny treatment or services because a participant files a complaint. Information related to the complaint process is posted in the facility.

These HIPAA-related policies must be provided to each participant in written terms, as well as, verbally provided during the intake process; and, documentation of their receipt, as well as, understanding of these policies must be maintained in the participant's record.

Signing below indicates the participant has received a hardcopy of the information above; and, has received a verbal explanation of the information, if necessary, to comprehend and understand the content of the document; and, agree to the above written information.

Participant Signature
Parent, Legal Guardian or Foster Parent

Date (Month-Date-Year)

Inclusion, Inc. Representative

Date (Month-Date-Year)



PHARMACY SERVICES PROVIDER AGREEMENT

Named Patient: _____ Room# (if applicable) _____

I, _____, authorize Heartland Pharmacy, and any other pharmacies owned by PharmEase, LLC to provide medications and associated products and services to the above named Resident. I certify that I have the legal authority to sign this agreement on behalf of said Resident. As the Financial Responsible Party for the same Resident, I accept responsibility and agree to pay for all products and services provided by Heartland Pharmacy. Furthermore, I agree to pay Heartland Pharmacy their usual and customary fee for service for the provision of products to the above-named Resident. For residents receiving support from a third-party payer, I am aware that certain medications may not be paid for and that co-payments may apply, and I will be responsible for payment for said medications and other products. Heartland Pharmacy will bill the Responsible Party on a monthly basis for all items not covered by a third-party. I agree to pay Heartland Pharmacy within 30 days of the billing date. In the event said bill is not paid within thirty (30) days, I agree to pay a past due interest fee of 1.5% per month. If said bills are not paid within sixty (60) days, Heartland Pharmacy may not provide additional products or services to the above-named Resident. I agree to pay reasonable attorney and collection agency fees and costs incurred in collecting any amounts due and owing hereunder. In the absence of specific written instructions by the Financial Responsible Party, Heartland Pharmacy will act at the direction of the facility administration and staff and attending physician(s). I agree to pay for medications and services provided by Heartland Pharmacy at the direction of the facility administration and staff unless I instruct otherwise in writing. Should I arrange for home health and/or hospice services and supplies, I understand that Medicare will not reimburse me or my supplier and I will be responsible for their cost.

Signature of Financial Responsible Party _____ Date _____

Financial Responsible Party (please print): _____
Address: _____ Phone #: _____
Other Phone #: _____
Relation to Resident: _____

Resident Information

Name: _____ Date of Admission: _____
Physician(s): _____ Date of Birth: _____
Social Security Number: _____
Primary Insurance Carrier: _____ Policy & Group # _____
Secondary Insurance Carrier: _____ Policy & Group # _____
Allergies: _____
Diagnosis: _____

PLEASE ATTACH COPIES OF FRONT AND BACK OF RESIDENT'S INSURANCE CARDS

ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES (HIPAA)

I acknowledge that I have received a copy of Heartland Pharmacy's Notice of Privacy Practices: _____

In the event that the Notice of Privacy Practices was not received, Heartland Pharmacy made a good faith effort to obtain a written acknowledgment of the Resident's receipt of the Notice, but a written acknowledgment was not received for the following reason:

- Individual refused to sign
Individual was not able to sign (please specify): _____

Please list other individuals who are authorized to discuss your health information: _____

ASSIGNMENT OF BENEFITS (Complete Assignment of Benefits section only if Resident has Medicare and/or Medicaid)

I hereby request that payment of authorized insurance benefits be made on my behalf to Heartland Pharmacy for equipment and/or services furnished to me by the aforementioned supplier. I authorize any holder of medical information about me to release to the center for Medicare and Medicaid Services, health insurances, or their agents any information needed to determine these benefits.

Signature of Beneficiary _____ Date _____

I hereby acknowledge that I have received a copy of the CMS Medicare DMEPOS Supplier Standards (See reverse of this page).

Signature of Beneficiary _____ Date _____

CMS Medicare DMEPOS Supplier Standards

[Social Security Act §1834(j); 42 U.S.C. §1395m(j); 65 Fed. Reg. 60,366 (2000) (to be codified at 42 C.F.R. pt. 424.57)]

Following are the new supplier standards as they appear in the Federal Register.

The supplier:

1. Operates its business and furnishes Medicare-covered items in compliance with all applicable Federal and State licensure and regulatory requirements;
2. Has not made, or caused to be made, any false statement or misrepresentation of a material fact on its application for billing privileges. The supplier must provide complete and accurate information in response to questions on its application for billing privileges. The supplier must report to CMS any changes in information supplied on the application within 30 days of the change.;
3. Must have the application for billing privileges signed by an individual whose signature binds a supplier;
4. Fills orders, fabricates, or fits items from its own inventory or by contracting with other companies for the purchase of items necessary to fill the order. If it does, it must provide, upon request, copies of contracts or other documentation showing compliance with this standard. A supplier may not contract with any entity that is currently excluded from the Medicare program, any State health care programs, or from any other Federal Government Executive Branch procurement or nonprocurement program or activity;
5. Advises beneficiaries that they may either rent or purchase inexpensive or routinely purchased durable medical equipment, and of the purchase option for capped rental durable medical equipment, as defined in § 414.220(a) of this subchapter. (The supplier must provide, upon request, documentation that it has provided beneficiaries with this information, in the form of copies of letters, logs, or signed notices.);
6. Honors all warranties expressed and implied under applicable State law. A supplier must not charge the beneficiary or the Medicare program for the repair or replacement of Medicare covered items or for services covered under warranty. This standard applies to all purchased and rented items, including capped rental items, as described in § 414.229 of this subchapter. The supplier must provide, upon request, documentation that it has provided beneficiaries with information about Medicare covered items covered under warranty, in the form of copies of letters, logs, or signed notices;
7. Maintains a physical facility on an appropriate site. The physical facility must contain space for storing business records including the supplier's delivery, maintenance, and beneficiary communication records. For purposes of this standard, a post office box or commercial mailbox is not considered a physical facility. In the case of a multi-site supplier, records may be maintained at a centralized location;
8. Permits CMS, or its agents to conduct on-site inspections to ascertain supplier compliance with the requirements of this section. The supplier location must be accessible during reasonable business hours to beneficiaries and to CMS, and must maintain a visible sign and posted hours of operation;
9. Maintains a primary business telephone listed under the name of the business locally or toll-free for beneficiaries. The supplier must furnish information to beneficiaries at the time of delivery of items on how the beneficiary can contact the supplier by telephone. The exclusive use of a beeper number, answering service, pager, facsimile machine, car phone, or an answering machine may not be used as the primary business telephone for purposes of this regulation;
10. Has a comprehensive liability insurance policy in the amount of at least \$300,000 that covers both the supplier's place of business and all customers and employees of the supplier. In the case of a supplier that manufactures its own items, this insurance must also cover product liability and completed operations. Failure to maintain required insurance at all times will result in revocation of the supplier's billing privileges retroactive to the date the insurance lapsed;
11. Must agree not to contact a beneficiary by telephone when supplying a Medicare-covered item unless one of the following applies:
 - i. The individual has given written permission to the supplier to contact them by telephone concerning the furnishing of a Medicare-covered item that is to be rented or purchased.
 - ii. The supplier has furnished a Medicare-covered item to the individual and the supplier is contacting the individual to coordinate the delivery of the item.
 - iii. If the contact concerns the furnishing of a Medicare-covered item other than a covered item already furnished to the individual, the supplier has furnished at least one covered item to the individual during the 15-month period preceding the date on which the supplier makes such contact.
12. Must be responsible for the delivery of Medicare covered items to beneficiaries and maintain proof of delivery. (The supplier must document that it or another qualified party has at an appropriate time, provided beneficiaries with necessary information and instructions on how to use Medicare-covered items safely and effectively);
13. Must answer questions and respond to complaints a beneficiary has about the Medicare-covered item that was sold or rented. A supplier must refer beneficiaries with Medicare questions to the appropriate carrier. A supplier must maintain documentation of contacts with beneficiaries regarding complaints or questions;
14. Must maintain and replace at no charge or repair directly, or through a service contract with another company, Medicare-covered items it has rented to beneficiaries. The item must function as required and intended after being repaired or replaced;
15. Must accept returns from beneficiaries of substandard (less than full quality for the particular item or unsuitable items, inappropriate for the beneficiary at the time it was fitted and rented or sold);
16. Must disclose these supplier standards to each beneficiary to whom it supplies a Medicare-covered item;
17. Must comply with the disclosure provisions in § 420.206 of this subchapter;
18. Must not convey or reassign a supplier number;
19. Must have a complaint resolution protocol to address beneficiary complaints that relate to supplier standards in paragraph (c) of this section and keep written complaints, related correspondence and any notes of actions taken in response to written and oral complaints. Failure to maintain such information may be considered evidence that supplier standards have not been met. (This information must be kept at its physical facility and made available to CMS, upon request.);
20. Must maintain the following information on all written and oral beneficiary complaints, including telephone complaints, it receives:
 - i. The name, address, telephone number, and health insurance claim number of the beneficiary.
 - ii. A summary of the complaint, the date it was received, the name of the person receiving the complaint, and a summary of actions taken to resolve the complaint.
 - iii. If an investigation was not conducted, the name of the person making the decision and the reason for the decision.
21. Provides to CMS, upon request, any information required by the Medicare statute and implementing regulations.