DEFINITIONS

BEHAVIORAL HEALTH SERVICES

Definition of Behavioral Health
"Behavioral health" as both acute and chronic psychiatric and substance use disorders as referenced in the most recent Diagnostic and Statistical Manual of Mental Disorders DSM and/or ICD of the American Psychiatric Association.
Accessible Intervention and Treatment our Organization promotes health screening for identification of behavioral health problems and patient education. We expected to:

• screen, evaluate, treat and/or refer (as medically appropriate), any behavioral health problem. We may treat for mental health and/or substance use disorders within the scope of our practice and bill using DSM and/or ICD codes.
• inform patients/family how and where we will provide behavioral health services
• understand that patient/family may self-refer to any behavioral health care provider without a referral from us

If we need to refer patients for further behavioral health care should contact their referral source. Our Organization continuously evaluates the patient's needs, by monitoring on-going behavioral health conditions, such as regular lab or ancillary medical tests and procedures.

BEHAVIORAL HEALTH DISCIPLINES:

BEHAVIOR ANALYSIS SERVICES

Behavior analysis services are provided to assist recipients to learn new, or increase existing, functionally equivalent replacement skills directly related to existing challenging behaviors. Challenging behaviors include those behaviors exhibited by the recipient that pose risk of harm to the recipient or others (i.e., aggression, self-injury, property destruction, behaviors that prevent inclusion in normal settings, or behaviors that the recipient does not exhibit with sufficient proficiency or skill to prevent harm to the recipient or others, including resisting basic hygiene, and refusal to take medications).

BEHAVIOR ANALYST

Provides consultation and intervention regarding behavior management, effective education and assessment of behavioral needs of clients with and without disabilities.

BEHAVIOR ASSISTANT SERVICES

The primary purpose of behavior assistant services (BAS) is to provide support in implementing the BASP created by the behavior analysis services provider.

BEHAVIORAL TECHNICIAN

The Registered Behavioral Technician will provide clinical skills instruction and behavior reduction protocols based upon the principles of Applied Behavior Analysis to children with Autism and related developmental disabilities in the home, community, and school settings. The RBT is primarily responsible for the direct implementation of behavior-analytic services.

TIPS FOR MAXIMAZE PATIENT'S INDEPENDENCE

Try to make at least minor decisions for yourself. Make sure that you know your rights as individuals such as when to bathe, eat, have visitors, etc. Try to do as much for yourself as possible when it comes to picking out clothes, deciding what activities to do and trying to dress yourself. Request to be looking as an individual...what you like and dislike, by allowing you to do as much as you can for yourself, always getting the staff/family to offer choice. Request to be allowed to speak and not be spoken over and respected for your possible different cultures and beliefs. Try reassessing guidelines for each of you on a regular basis to ensure any changes are monitored, example medication, etc as this can have an affect on you or your health. Try to participate in activities that you can carry out, like helping with the shopping, writing letters or making calls.
In many situations, mental health care are needed by clients who are receiving behavioral services. Our behavioral professional or technician may request orders for behavioral services to your program, physician, insurance, etc. In addition to these referrals, a request for behavioral services may be initiated by you or by another individual acting upon behalf of you. Services which will enable individuals to attain and/or maintain as good behavioral and mental health as possible; Services to encourage the development and maintenance of family and community interest and ties; Services to promote maximum independence in the management of their own affairs; Protective services, including evaluation of need for and arranging for guardianship; and Appropriate family planning services which include assisting the family in acquiring means, or other needed resources.

The presence of **AUTISM** in your life may grown your mind a thousand times over. So much of parenting children with autism is counter-intuitive. Here is a small list of techniques that we use daily that help reduce tantrums, increase understanding, direction following and happiness (theirs and mine). There is no one thing that works for all children, and there is no one quick fix, however, many of these techniques will work for many children. Whether or not they have autism.

1) Use Time to Decrease Transitional Tantrums

Many children have trouble leaving preferred places and activities. This is a BIG one for my 5 year old. There were times I wouldn't even take him to our neighborhood park because I was so scared of that awful moment when we had to leave. He was unpredictable and erratic. Sometimes he would scream and fall to the ground, or try to run into a busy street to get away from me, or lash out to hit me. It broke my heart and downright scared me.

One thing that has been life-changing for us is using Minute Warnings/Timers: Your child may need a 5 minute, 2 minute, or 1 minute warning before there is a change of activity. These warnings help the children prepare for the transition. They will begin to learn that the warning comes and then the change comes. Eventually, the minute warnings become routine, even if the next task is not.

2) FIRST/THEN

Many of our other tantrums are over wanting something they can't have at that moment. A toy, a snack, a trip somewhere RIGHT NOW. Or there is something they DON'T want to do. For many of these situations we use first/then. “First___, then____” statements are used to help a child finish a task before getting something motivating.

"First we finish our lunch, then we can go outside." "First we will clean up, then we can go to the park."

Depending on your needs and your child's skill set, you can either do this verbally, use pictures, or write items on a dry erase board.

Many children with autism think in pictures, so that is often the initial go to method.

It's a simple phrase that provides structure in a child's mind and helps them follow the directions at hand. It can help decrease a child's frustration because they can understand exactly what is expected of them.

3) Reward positive behavior

Reinforcing language identifies and affirms childrens' specific positive actions and encourages them to continue their appropriate behavior. For example, to a child that shared their swing at the park you might say, "I really like how you shared and played so nicely with that little boy at the park." It's especially important to recognize behaviors that a child usually struggles with- sharing, being quiet, following directions. With these words, the adult lets the children know that their positive behaviors were noticed.

4) Focus on what you want the child to do, not what you want them to STOP doing.

How many of you have screamed at your child, STOP SCREAMING?!!!! with crazed eyes and clinched fists? (Guilty). Minimize the use of ‘don’t’ and ‘stop.’ For example, ‘Walk on the sidewalk’ can be much more effective than ‘Don’t walk on the grass’ for a child who might not hear the ‘don’t’—or for one who isn’t sure where the acceptable place to walk might be. This lets the child know exactly what you WANT them to do. 'Stop screaming' becomes, 'Quiet please', 'Don't color on the table' becomes 'Only color on the paper'. It's counter-intuitive to the ways most of us usually parent but it works. There are times when there's NO WAY around a don't/stop statement. DON'T COLOR ON THE DOG. STOP HITTING YOUR BROTHER. Use your best judgement- you'll figure out when you need to lay down the DON'T law.

5) Remain Calm (YOU!)

1. This was a hard one for me to learn and is still a hard one for me to remember! This one is especially hard because what usually happens is your child goes out of control and then you quickly follow. It's exhausting, draining and frustrating. I take deep breaths and make sure my words sound calm, even if I'm not feeling it. I remind myself that I am the adult and if I expect my child to modify their behavior then I must too. Children don't always have the language to explain what they want and need and that can be extremely frustrating for them. I have had many, many more years of practice so I need to be much better at being kind, calm and patient while I lead by example.

Signs and Characteristics of Autism

Many parents struggle with uncertainty about how their child is progressing. They may notice unusual behaviors or their child's failure to reach certain developmental milestones. Concerned parents should schedule an assessment for their child to determine if there might be some degree of developmental delay or autism.

Signs of a possible development delay or autism include:

- Lack of eye contact at 3 months
- No big smiles or joyful expressions by 6 months
- No sharing of sounds, smiles, or facial expressions by 9 months
- No babbling by 12 months
- No gestures such as pointing, showing, reaching, or waving by 12 months
- No words by 16 months
- No response when the child's name is called by 10 months
- Any loss of speech, babbling, or social skills at any age
- Repetitive movements or postures (e.g., hand flapping)
- Strong devotion to specific nonfunctional routines or rituals
- Autism is a complex developmental disorder that typically appears during the first three years of life. Children diagnosed with autism often have difficulty with communication, social interactions, and play activities.

The good news is that with early intervention and therapy, it is often possible to get a child back on track and develop age-appropriate social and language skills. If you suspect a development delay in your child, you are encouraged to seek an assessment by a trained clinician and referral to a behavioral therapy service provider.

Safety Tips for Children with Autism

Your child's safety at home, at school, and elsewhere requires vigilance, continued attention, and skill building. Children with autism have special safety concerns. They may:

- Not respond to their name
- Escape from their house
- Wander away in the community
- Be too trusting of strangers

Here are some suggestions on how to keep your children safe:

- Teach Your Child to Swim: Drowning is the leading cause of death for individuals with autism. Children are often attracted to water and may wander away towards ponds, pools, or lakes.
- Provide Local First Responders with Information about your Child: If wandering is a concern, contact law enforcement, fire and ambulance agencies. Ask your local 911 call center to "red flag" this information in their 911 computer data base. Dispatchers can alert patrol officers about your concerns before they arrive.
- Get an ID Bracelet for Your Child : Include your name, address and phone number, and whether your child is non-verbal
- Secure Your Home: Install secure deadbolt locks, home security system, alarms on windows and doors, and place locks above your child's reach, fence your yard
- Notify Your Neighbors: Get to know your neighbors and let them know what characteristics or unusual behaviors your child might exhibit
- Teach Your Child Skills to Avoid Abuse or Abduction: Teach them not to approach or talk to strangers, teach them who it is OK to talk to ("community helpers" such as police officers, fire fighters, etc.), teach your child what to do if they get lost, and teach them what to do if a stranger approaches them in public (run away, say "no," report the stranger to a trusted adult).

Supporting Siblings of Children with Autism

It is not easy being a sibling of a child with autism. However, sibling relationships can be beneficial for developing social skills. Children with autism do best when they have a sibling who plays with them, helps them learn social skills, prompts them to use language, and is involved in all aspects of their Applied Behavior Analysis (ABA) program.
As a result, many families have high expectations for the typically developing siblings. These brothers and sisters need to understand that they play a very important role. Yet, a sibling's motivation and cooperation is only sustainable if parents provide them with confidence, self-esteem, independence, and support on their own journey to build a strong personal identity.

Here are some tips to help siblings cope with a sister or brother who has autism:

Talk about autism. Be open and honest in explaining autism and how it affects their brother or sister. Children will certainly have questions which you should be prepared for and feel comfortable answering. Include them in discussions about the child's programs, classrooms, and special needs, and encourage their comments and suggestions.

Show Praise and Gratitude. Having a sibling with autism is challenging. Praise your children and reward them for helping out. Their sibling will always require their patience and contribution. Let them know you are thankful for their efforts.

Focus on the Sibling. Set aside some "alone time" for you and the sibling on a regular basis. This is time for them to be a kid, and for you to enjoy their company and interests. Make this time fun and special, and allow the child to express his or her unique personality. Siblings should experience their own childhoods and enjoy separate sleepovers, play dates, and extracurricular activities that explore their individual talents and interests.

Communicate. Devote some regular quiet time just for talking. Create an atmosphere where your children feel safe expressing their emotions. Let them know you hear them, and that you know it is hard having so much attention and effort go to their sibling. Remind them of things that are special about them and ask if there are things you have neglected to acknowledge.

Selecting an Autism Therapy Service Provider

The choice of autism treatment can greatly impact a child's progress and future quality of life. It's critical to start the intervention early, as soon as there is any suspicion of developmental delay.
There are a number of therapeutic approaches to consider. Applied Behavior Analysis (ABA) is the most well-researched and scientifically-validated method. Look for service providers that use a blend of ABA-based strategies to ensure programs are collaborative, fun, and make measurable progress. These programs are often family-focused and incorporate everyday home routines.
It is also important to find an established agency with experienced and qualified staff members.
Staff members should:

- Make parents and the child feel comfortable
- Take an individualized and collaborative approach to treatment planning
- Provide honest and realistic feedback
- Parents should be encouraged to ask as many questions as they wish, such as:

Assessments

o Can you provide a basic developmental screening for autism?
o Does the assessment include a printed report, outlining the child's unique strengths/challenges?

Therapy

o Do you offer ABA-based therapy?
o What specific activities can be done at home to support the child's progress?
o Can you refer parents to other families you have worked with in the past?
o What happens during a typical treatment session?
o How involved will parents be in the day-to-day delivery of the child's program?
o How many hours of therapy per week will the child need?
o Do you provide weekly/monthly reports on the child's progress?
o Do you provide training or support for families?

Staff Qualifications

o What are the qualifications of your therapists regarding Applied Behavior Analysis?
o Will the child's program be supervised by a Master's level staff member?

Helping Children Cope with Parent Separations

Having a parent travel or live away from home is difficult for any child, but especially for a child with autism. Children with autism rely on predictability and are comforted by familiar routines. Helping children prepare for significant changes prior to the departure and prior to the return will help make things more comfortable for everyone. Here are some tips for helping your child adjust:

Make the transitions as predictable as possible, and establish expectations for what the change and separation will be like. Allow time for your child to understand what is ahead.

Set the Expectation

• Social stories are helpful in providing an expectation of what is to come.

• Write a simple narrative that explains when the change will occur, what it will be like, and what may seem different in the home.

• Read the same story every day for at least two weeks prior to the event.

• Use a calendar or other visual device to "countdown" to the big day. Do not present the situation as a bad thing.

Create Predictable Routines

• It is important for your family to have reliable routines. Children - especially those with autism - rely on predictable daily and weekly events for keeping stress low.

• Create daily routines for chores, TV time, and homework, and be sure to set aside some special time with mommy or daddy.

• Create routines that help you!

When you are parenting alone, it is easy to lose sight of just how much stress you are under. Taking care of yourself is just as important as taking care of your child.

Find Support

• Join or create a support group. Gathering a small group of parents together who are dealing with parenting issues on their own can be an enormous help. Having a shared focus helps you accomplish the specific goals you need to address to relieve stress.

• Sign your child up for activities outside the home. Help your child develop personal interests by enrolling him or her in one of the three C's — classes, clubs, or camps — to increase the probability of making friends, finding a new hobby, becoming more independent, and trying new things.

Back to School Tips

Getting ready for the new school year can be a hectic and exciting time. However, for children with autism, all this change can feel overwhelming. Here are some suggestions for how to help ease your child's back-to-school anxieties:

Scope out the school and classroom in advance. If your child is going into a new classroom, visit it at least once before the first day of school. If transition has been a struggle in the past, consider taking as much time as your child needs to explore the classroom. Make it as much fun as possible, playing in each of the new areas.

Check out seat assignments. For older children, ask the teacher if a seat assignment has been made. Do some enjoyable activities in that seat. If familiar classmates will be in the room, show where they will be sitting, too.

Rehearse new activities. Find out from the teacher what new activities are planned. Then, prepare your child by performing, practicing, and talking about them. This rehearsal will reduce anxiety when the new activities come up in the first week of school.

Anticipate sensory overload. The noise and chaos of a typical classroom can sometimes be a bit much to handle. Establish a plan for what to do in this situation – perhaps there is a quiet room where your child can "take a break" for a short time.

Volunteer in the classroom. Most teachers welcome assistance from parents. Your presence may be a source of comfort to your child during those challenging first weeks.

Going to school can pose many challenges for children with autism, as well as countless opportunities for building crucial social, language, and academic skills. Be positive and encouraging, and your child will be off to a great year!

Preparing for a Special Education IEP Meeting Child with Autism

An Individual Education Plan (IEP) is developed for every child eligible for special education. This plan contains a statement of a child's present level in terms of performance, educational needs, goals, levels of service, and measurable outcomes. An IEP meeting can be held after a formal assessment; if a child demonstrates a lack of progress; or if a parent or teacher requests a meeting to develop/review/revise a child's current IEP.

Here are some suggestions to make the most of this important planning session:

Prepare supplemental materials. Gather reports or other documentation for the school district to consider at the IEP meeting and provide to the district one week in advance. Ask members of your "team" for their opinion of your child's progress/needs. Consider: Where is your child now, in terms of progress/goals? What current goals would you like your child to continue to work on? Where do you want your child to be one year from now?

Write the school district. Request all assessments, progress reports, and proposed goals in advance of the meeting.

Have a basic understanding of key terms. Some common IEP terms include: Present Level of Performance - summary of strengths/needs Objectives – skills a child needs to develop/achieve specific IEP goal(s) Benchmarks – the mastery level a child is expected to meet.

Plan who to bring. Determine if there is another person – such as a current service provider – who you'd like to have at the IEP meeting. You may consider contacting a lawyer or advocate if you need assistance/support beyond the IEP team.

Evaluate goals. Determine if baselines are accurate, objective and meaningful; if areas of need are addressed; and if goals are objective, measurable and appropriate.

Document. Note the date, time, who said what, and what was said in the meeting.

Potential Placements. The team will determine which learning environment will allow the IEP to be best implemented. Observe initial sessions to ensure the placement is a good fit for your child. **Carefully review the IEP**. Make sure to read the complete IEP, and ensure that all of your questions have been asked and answered about the IEP.

Planning Play Dates

Play dates are a great way to help your child practice social skills, play skills, and communication skills with peers in a safe and structured setting. Preparing for a play date and having it go as planned can be difficult for many families with a child with autism. Here are some tips for a successful play date.

Select peers carefully. Choose a child who is close to your child's age and displays age appropriate communication, social, and play skills. The peer should be able to play cooperatively and be flexible. It helps to have a peer who enjoys giving lots of help and suggestions to friends. Your child's school, neighbors, or members of your religious congregation may be able to connect you with peers.

Plan the activities ahead of time. Choose activities which both children will enjoy. They should be structured, organized and should require some level of cooperation. Make the play date fun and special.

Pre-teach the activities to your child. Prepare your child for the play date by practicing the planned activities in advance. Try role playing and pretend to be the other child.

Know what you want your child to learn during play dates. Having clear goals will increase the likelihood that specific skills will be learned during play dates. This time is too valuable to simply hope that something is learned. Have two or three specific goals (e.g. taking turns, asking questions, responding to questions, changing play activities appropriately), and take notes on how your child did on each goal.

Keep it short. You may want to stick to 30 minutes for first few play dates. The 30 minutes can be further broken down into several 10-15 minute activities. Make sure transitions between activities are short and smooth.

Facilitate the play and provide reinforcement. Encourage cooperative play and guide the children to interact with each other. Provide frequent treats and praise as reinforcement for positive interactions.

Play date ideas. Consider activities where the children need to work together, problem solve, and share the same materials. Treasure hunts are great activities - hide toys and treats around the house and give the children a map to the treasures. Art projects are also fun with friends - make a collage, paint a poster or mural. Yard games to try are Freeze Tag, Hide and Seek, Red light Green Light.

Have fun!

Toy Recommendations

Top Toys for Young Children with Autism Selecting suitable toys for a child's holiday or birthday gifts can be challenging, especially when the recipient is a child with autism. This handy list includes a number of popular, age-appropriate toys for children up to five years of age. Parents should keep in mind, however, that every child is unique and will respond differently to certain toys and teaching materials. You can check with your child's therapist or teacher to determine what's most appropriate for your child's needs and interests.

Children under three:

- Shape sorters
- Puzzles (wooden with handles for each piece; suggested brand: Melissa and Doug)
- Board books
- Stacking blocks and cups
- Cause-and-effect toys with lights, sounds and/or music (e.g., Pop Up Pals, Fisher-Price Sing-Along activity Barn, Wiggles products) Plush toys and animals
- Dolls and large action figures

For children age three – five:

- Games (e.g., Candy Land, Chutes and Ladders, Don't Break the Ice, Connect Four, Hi-Ho Cherry-O, Cariboo, Hullabaloo, Lucky Ducks)
- Puzzles with up to 25 pieces (suggested brand: Melissa & Doug)
- Action figures/dolls and related accessories
- Play sets (e.g., kitchen, construction)
- Dress up items and beads
- Puppets
- Story books with large pictures
- Art supplies (markers, crayons, construction paper, glue, clay)
- Small building blocks (e.g., LEGOS)
- Trucks and cars
- Sorting items (counting sets such as fruit and animals, stacking shapes, peg boards)

For both groups (children five and under):

- Large building blocks (suggested brands: Mega Blocks or Duplo)
- Electronic learning toys (suggested brands: Leap Frog, V Tech)
- Fisher-Price Little People sets (e.g., houses, farms)
- Magna-Doodle

Reducing Holiday Stress

Holidays can be stressful and over-stimulating for anyone, but particularly so for children with autism. Here are some helpful strategies to lessen your child's anxiety and increase your family's enjoyment of the holiday season:

Decorating

- Decorate in gradual stages, rather than changing everything at once.
- Allow your child to interact with the decorations and help put them in place.
- Flashing lights or musical decorations can disturb some children. To see how your child will respond, experience these items in a store or someone else's home first.

Shopping

- Last minute holiday shopping can be stressful for children who rely on routines.
- If you do take your child shopping, allow enough time to gradually adapt to the intense holiday stimuli that stores exhibit this time of year.

Family Routines

- Meet as a family to discuss how to minimize disruptions to established routines and how to support positive behavior when disruptions are inevitable.
- Continue using behavior support strategies during the holidays. Try social stories to help your child cope with changes in routine, and visual supports to help prepare for more complicated days.
- Try using a visual schedule if you are celebrating the holidays on more than one day (e.g., Hanukah) to show when there will be parties/gifts and when there will not.

NEW HOPE CASE MANAGEMENT SERVICES, INC.

CLIENT'S BILL OF RIGHTS

AS OUR CLIENT YOU HAVE THE RIGHT TO: Considerate and respectful care.*to expect reasonable continuity care.* to request from your physician complete current information concerning your diagnosis, prognosis and treatment in terms you can reasonably understand.*to expect that all communication and records pertaining to your care be treated as confidential. *To every consideration of your privacy concerning your own medical program, case discussion, consultations and treatments are confidential and should be conducted discretely.*Those not directly involved in your care must have your permission to be present.*To know the name of the responsible person coordinating and supervising your Case Management and the manner in which that person may be contacted during regular working hours.*To know the name and professional relationship of those individuals involved in your care.*To refuse any segment of treatment to the extent permitted by the law without relinquishing other segments of the treatment plan. You have the right to be informed of the medical consequences of your action.*to the extend that is reasonably possible to be involved in the planning and implementation of the Case Management Plan of Care and its expected outcome.* to be informed of the policy and procedure for registering formal complaint about the services being provided. You have the right to be informed that the Case Management Services will not be disrupted as a result of filing a complaint.*to expect that within its capacity the Organization must make a reasonable response to your request for services.*To receive and examine an explanation of our bill regardless of source of payment.*To know what Organization rules and expectations apply to your conduct as a client.*To be informed of the Plan of Care *To have a copy of the Plan of Care if requested.*Be informed of the right to formulate and Advance Directive and/or Do not resuscitate (DNR) order.*To have the pain evaluated and intensity controlled.*Be free of physical and mental abuse/neglect and/or exploitation. Be informed of the availability to report **Abuse, Neglect or exploitation: 1-800-962-2873.***To have your property treated with respect.*To voice grievance regarding services furnished, or regarding lack of respect for property by anyone who is furnishing services on behalf of the Organization, and must not be subjected to discrimination or reprisal for doing so.

YOUR RIGHTS AS A CLIENT TO PRIVACY OF YOUR HEALTH AND MENTAL INFORMATION

RIGHT TO REQUEST RESTRICTIONS You have the right to request restrictions on our use and disclosures of your health and mental information, however we may refuse to accept the restriction.***RIGHT TO REQUEST CONDIFENTIAL COMMUNICATIONS** You have the right to request that we communicate with your confidentially, for example to speak with you only in private; to send mail to an address you designate; or to telephone you at a number you designate. We will make every attempt to honor your request**.*RIGHT TO REQUEST ACCESS TO YIOUR HEALTH INFORMATION** you have the right to request access to your health information in order to inspect or copy it. Your request must be in writing. We may deny your request and, if so, you may request a review if the denial. However, we will make every attempt to honor your request**.*RIGHT TO REQUEST AN AMENDAMENT OF YOUR HEALTH INFORMATION** you have the right to request an amendment to your health information. Your request must be in writing and must provide a reason for the amendment. We may deny your request and, if so, you may submit a statement of disagreement. However, we will make every attempt to honor your request.***RIGHT TO REQUEST AN ACCOUNTING OF DISCLOSURES OF YOUR HEALTH NFORMATION** you have the right to request an accounting of our disclosures of your health information for purpose other than treatment , payment m, and case management operations. We will make every attempt to honor your request. We are not required to provide an accounting for disclosures for more than 6 years prior to the date or your request.***RIGHT TO OBTAIN A PAPER COPY OF THE PRIVACY NOTICE** If you received the Privacy Notice electronically, you have the right receive a paper copy. To exercise any of these rights please write of telephone to our Organization.

BEHAVIORAL SERVICE AGREEMENT *(Spanish Translation in the back)*

NEW HOPE CASE MANAGEMENT SERVICES, INC.

Client: _____

Medical Record: _____

VOLUNTARY ADMISSION: I VOLUNTARILY CONSENT TO ADMISSION TO THE ORGANIZATION, AND TO TREATMENT THAT MAY BE ADVISED AND OR RECOMMENDED BY MY PHYSICIAN AND/OR PROGRAM TREATMENT TEAM.
I REQUEST A COPY OF THE PLAN OF TREATMENT: Y_____ N_____

CONSENT TO RECEIVE BEHAVIORAL SERVICES: I HEREBY AUTHORIZE THE ORGANIZATION, TO RENDER APPROPRIATE BEHAVIORAL SERVICES AS PRESCRIBED BY MY PHYSICIAN AND/OR PROGRAM COORDINATOR, OR BY ANY OTHER PROGRAM WHO MAY BE SERVING ME, INCLUDING ALL DIAGNOSTIC AND THERAPEUTIC TREATMENT THAT MAY BE CONSIDERED ADVISABLE OR NECESSARY IN THE JUDGMENT OF THE PHYSICIAN. THE GOAL OF THE ASSESSMENT PROCESS IS TO DETERMINE THE BEST COURSE OF TREATMENT FOR YOU. THE TYPE AND EXTENT OF SERVICES THAT YOU WILL RECEIVE WILL BE DETERMINED FOLLOWING THE ASSESSMENT AND DISCUSSION WITH YOUR BEHAVIOR ANALYST . THE TREATMENT PLAN MAY INCLUDE: GROUP OR WORKSHOP, INDIVIDUAL BRIEF THERAPY AT HOME, THERAPIST ASSISTED ON-LINE (TAO), PSYCHIATRY SERVICES, CASE MANAGEMENT, REFERRALS FOR LONGER TERM THERAPY OR SPECIALIZED TREATMENT WITH A COMMUNITY PROVIDER, AND/OR REFERRALS TO OTHER HEALTH RESOURCES.

EMERGENCY MEDICAL SERVICES: I UNDERSTAND THAT DURING THE COURSE OF MY TREATMENT THE NEED FOR EMERGENCY TREATMENT AND/OR TREATMENT AND/OR TRANSFER TO A HOSPITAL MAY BECOME NECESSARY AND APPROPRIATE. I UNDERSTAND THAT THE ORGANIZATION DOES NOT PROVIDE EMERGENCY MEDICAL CARE AND THEREFORE SHOULD THE NEED FOR SUCH TREATMENT AND/OR TRANSFER MAY BE DEEMED NECESSARY AND APPROPRIATE, THE ORGANIZATION STAFF WILL CALL **911**. I CONSENT TO SUCH EMERGENCY TREATMENT AND/OR TRANSFER TO A HOSPITAL AND HEREBY INDEMNIFY THE ORGANIZATION FROM SUCH EMERGENCY TREATMENT AND/OR TRANSFER. I AGREE TO ASSUME SOLE RESPONSIBILITY FOR ALL CHARGES INCURRED FOR SUCH TREATMENT.

ADVANCE DIRECTIVE AND LIVING WILLS: I HAVE RECEIVED WRITTEN INFORMATION REGARDING MY RIGHTS TO MAKE DECISIONS CONCERNING MEDICAL CARE, INCLUDING THE RIGHT TO ACCEPT OR REFUSE MEDICAL OR MENTAL TREATMENT AND THE RIGHT TO FORMULATE ADVANCE DIRECTIVES UNDER STATE LAW.
I HAVE AN ADVANCE DIRECTIVE: ___ YES ___ NO.
I HAVE A LIVING WILL: ___ YES ___NO. IF YES, LOCATION OF LIVING WILL:_____
I HAVE A PATIENT ADVOCATE/PROXY:___YES___NO: MY PATIENT ADVOCATE/PROXY IS: Name: _____
_____ADDRESS:_____PHONE:_____
I WANT TO USE THE **DNR ORDER** ___ Y ___ N (If yes, complete the official Legal Form)

SECTION ONE
INSURANCE BENEFITS AND PAYMENT: I HEREBY AUTHORIZE MY INSURANCE CARRIER TO PAY INSURANCE BENEFITS TO THE ORGANIZATION, AND AGREE TO THE RELEASE OF ALL MEDICAL INFORMATION TO MY INSURANCE CARRIER IF SHOULD BE REQUIRED BY ANY PROGRAM

☐ I HAVE BEEN ADMITTED THROUGH PROGRAM: _____
_____
_____
_____
_____

☐ I HAVE BEEN ADMITTED THROUGH **MEDICAID** AND MY RESPONSIBILITY IS $ 2.00 CO-PAY PER VISIT WITH A MAXIMUM OF ONE CO-PAYMENT PER DAY.

☐ I HAVE BEEN ADMITTED THROUGH _____HMO, _____COMMERCIAL INSURANCE,_____. The charges will be determined through third party contracts.

☐ I HAVE BEEN ADMITTED THROUGH **PRIVATE PAY** AND THE CHARGES ARE SPECIFIED IN THE SECTION TWO OF THE AGREEMENT.

I CERTIFY THAT THE FINANCIAL INFORMATION INDICATED ABOVE, RELATED TO THE PAYMENTS MADE BY INSURER OR THIRD PARTY PAYER, THE SCOPE AND INTENT OF COVERAGE, AND THE CHARGES FOR NON-COVERED SERVICE CHARGES, HAS BEEN EXPLAINED AND UNDERSTOOD.

SECTION TWO
HOME HEALTH SERVICES TO BE FURNISHED, FREQUENCY AND CHARGES:
BEHAVIORAL ANALYST_____ BEHAVIORAL ASSISTANT_____
TARGETED CASE MANAGER_____ BEHAVIORAL TECHNICIAN _____
OTHER:_____
ALSO I AUTHORIZE THE AGENCY'S TO PERFORM NEEDED VISIT OF **SUPERVISIONS**.

NEW HOPE CASE MANAGEMENT SERVICES, INC.

Client: _____

Medical Record: _____

STATEMENT OF PATIENT RIGHTS, RESPONSIBILITY AND ABUSE REGISTRY: I CERTIFY THAT I HAVE READ, UNDERSTOOD AND RECEIVED A COPY OF THE STATEMENT OF PATIENT RIGHTS AND RESPONSIBILITY WHICH HAS BEEN EXPLAINED TO ME VERBALLY BY A REPRESENTATIVE OF THE ORGANIZATION I RECEIVED ALL ADMISSION DOCUMENTS (GRIEVANCE PROCEDURE, EMERGENCY INFO, ETC) I UNDERSTAND THE POLICY AND HAVE RECEIVED A COPY WITH THE TOLL FREE ABUSE PHONE NUMBER (1-800-962-2873), AND HOTLINE (1-888-419-3456).

HIPAA: NOTICE OF PRIVACY PRACTICES/CONFIDENTIALITY/PHI: I HAVE RECEIVED A COPY OF THE AGENCY'S NOTICE OF PRIVACY PRACTICES, I DISCUSS AND RECEIVE A COPY OF THE CLIENT INFORMATION HANDBOOK.

THE PURPOSE OF MEETING WITH A BEHAVIORAL COUNSELOR OR THERAPIST IS TO GET HELP WITH PROBLEMS IN YOUR LIFE THAT ARE BOTHERING YOU OR THAT ARE KEEPING YOU FROM BEING SUCCESSFUL IN IMPORTANT AREAS OF YOUR LIFE. YOU MAY BE HERE BECAUSE YOU WANTED TO TALK TO A COUNSELOR OR THERAPIST ABOUT THESE PROBLEMS. WHEN WE MEET, WE WILL DISCUSS THESE PROBLEMS. WE WILL ASK QUESTIONS, LISTEN TO YOU AND SUGGEST A PLAN FOR IMPROVING THESE PROBLEMS. IT IS IMPORTANT THAT YOU FEEL COMFORTABLE TALKING TO US ABOUT THE ISSUES THAT ARE BOTHERING YOU. AS A GENERAL RULE, WE WILL KEEP THE INFORMATION YOU SHARE WITH US IN OUR SESSIONS **CONFIDENTIAL**, UNLESS I HAVE YOUR WRITTEN CONSENT TO DISCLOSE CERTAIN INFORMATION. THERE ARE, HOWEVER, IMPORTANT EXCEPTIONS TO THIS RULE THAT ARE IMPORTANT FOR YOU TO UNDERSTAND BEFORE YOU SHARE PERSONAL INFORMATION WITH US IN A THERAPY SESSION. IN SOME SITUATIONS, WE ARE REQUIRED BY LAW OR BY THE GUIDELINES OF OUR PROFESSION TO DISCLOSE INFORMATION WHETHER OR NOT WE HAVE YOUR PERMISSION, SUCH AS: YOU TELL US YOU PLAN TO CAUSE SERIOUS HARM OR DEATH TO YOURSELF, YOU TELL US YOU PLAN TO CAUSE SERIOUS HARM OR DEATH TO SOMEONE ELSE WHO CAN BE IDENTIFIED, YOU ARE DOING THINGS THAT COULD CAUSE SERIOUS HARM TO YOU OR SOMEONE ELSE, YOU TELL ME YOU ARE BEING ABUSED-PHYSICALLY, SEXUALLY OR EMOTIONALLY-OR THAT YOU HAVE BEEN ABUSED IN THE PAST, YOU ARE INVOLVED IN A COURT CASE AND A LEGAL REQUEST IS MADE FOR INFORMATION ABOUT YOUR COUNSELING OR THERAPY.

MINOR CLIENTS: YOU MAY BE HERE BECAUSE YOUR PARENT, GUARDIAN, DOCTOR OR TEACHER HAD CONCERNS ABOUT YOU. EXCEPT FOR SITUATIONS SUCH AS THOSE MENTIONED ABOVE, WE WILL NOT TELL YOUR PARENT OR GUARDIAN SPECIFIC THINGS YOU SHARE WITH ME IN OUR PRIVATE THERAPY SESSIONS. THIS INCLUDES ACTIVITIES AND BEHAVIOR THAT YOUR PARENT/GUARDIAN WOULD NOT APPROVE OF — OR WOULD BE UPSET BY — BUT THAT DO NOT PUT YOU AT RISK OF SERIOUS AND IMMEDIATE HARM. HOWEVER, IF YOUR RISK-TAKING BEHAVIOR BECOMES MORE SERIOUS, THEN I WILL NEED TO USE MY PROFESSIONAL JUDGMENT TO DECIDE WHETHER YOU ARE IN SERIOUS AND IMMEDIATE DANGER OF BEING HARMED. IF WE FEEL THAT YOU ARE IN SUCH DANGER, WE WILL COMMUNICATE THIS INFORMATION TO YOUR PARENT OR GUARDIAN.

Adolescent therapy client: Signing below indicates that you have reviewed the policies described above and understand the limits to confidentiality. If you have any questions as we progress with therapy, you can ask your therapist at any time. **___ N/A**

Minor's Signature _____ Date_____

Parent/Guardian: Check boxes and sign below indicating your agreement to respect your adolescent's privacy: **___ N/A**

___/ I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed.

___/ Although I know I have the legal right to request written records/session notes since my child is a minor, I agree NOT to request these records in order to respect the confidentiality of my adolescent's treatment.

___/ I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment and may sometimes be made in confidential consultation with her consultant/supervisor.

PATIENT SERVICE AGREEMENT: I HAVE RECEIVED A COPY OF THE AGENCY'S CLIENT SERVICE AGREEMENT AND HAVE ALL QUESTIONS AND CONCERNS ANSWERED TO MY SATISFACTION. ALSO I AUTHORIZE TO _____, (RELATION TO PATIENT _____) **TO SIGN ALL DOCUMENTS**, BECAUSE I'M UNABLE TO DO SO. REASON UNABLE TO SIGN: _____

⇨

_____ _____ _____

SIGNATURE OF CLIENT OR AUTHORIZED REPRESENTATIVE RELATIONSHIP DATE

_____ _____

SIGNATURE OF AGENCY'S REPRESENTATIVE DATE

NEW HOPE CASE MANAGEMENT SERVICES, INC.
CONSENT TO SHARE BEHAVIORAL HEALTH INFORMATION FOR CARE COORDINATION PURPOSES

First Name	Middle Initial	Last Name	Date of Birth	Individual's ID Number (Medicaid ID, Last 4 digits of SSN, other)

Under the Health Insurance Portability and Accountability Act (HIPAA), a health care provider or agency can use and share most of your health information in order to provide you with treatment, receive payment for your care, and manage and coordinate your care. However, your consent is needed to share certain types of health information. This form allows you to provide consent to share the following types of information.

- Behavioral and mental health services
- Referrals and treatment for an alcohol or substance abuse disorder

This information will be shared to help diagnose, treat, manage and get payment for your health needs. You can consent to share all of this information or just some information.

I. I consent to share my information among:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

II. I consent to share:

☐ All of my behavioral health and/or substance use disorder information

☐ All of my behavioral health and/or substance use disorder information except: (List types of health information you do not want to share below)

_____

I understand that HIPAA allows providers and other agencies to use and share much of my health information without my consent in order to provide me with treatment, receive payment for my care, and to manage and coordinate my care.

III. By signing this form I understand:

- I am giving consent to share my behavioral health and substance use disorder information. Behavioral health and substance use disorder information includes, but is not limited to, referrals and services for alcohol and substance use disorders.
- My information may be shared among each agency and person listed above.
- My information will be shared to help diagnose, treat, manage and pay for my health needs.
- My consent is voluntary and will not affect my ability to obtain mental health or medical treatment, payment for medical treatment, health insurance or benefits.
- My health information may be shared electronically.
- Other types of my information may be shared with my behavioral health and substance use disorder information. HIPAA allows my providers and other agencies to use and share most of my health information without my consent in order to provide me with treatment, receive payment for my care, and to manage and coordinate my care.
- The sharing of my health information will follow state and federal laws and regulations.
- This form does not give my consent to share psychotherapy notes as defined by federal law.
- I can withdraw my consent at any time; however, any information shared with or in reliance upon my consent cannot be taken back.
- I should tell all agencies and people listed on this form when I withdraw my consent.
- I can have a copy of this form.
- My consent will expire on the following date, event or condition unless I withdraw my consent. (If expiration date is left blank or is longer than one year, the consent will expire 1 year from the signature date.)

  Expiration Date: _____

I have read this form or have had it read to me in a language I can understand. I have had my questions about this form answered.

Signature of person giving consent or legal representative	Date

Relationship to individual

☐ Self ☐ Parent ☐ Guardian ☐ Authorized Representative

MEDICATION SCHEDULE*

Patient's Name: _____ MR Number_____

Pharmacy Name:_____ Phcy Phone:_____ Date: _____

Address: _____ Primary MD Name: _____ MD ph:_____

DO NOT USE ABBREVIATION: U, IU, QD, Q.D., qd, q.d., QOD, Q.O.D., qod, q.o.d., >, <, @, cc, µg, MS, MSO_4, $MgSO_4$, trailing zero: X.0 mg, .X mg

N C O	**Date Ordered** *Fecha*	**Medications** **Dose, Route, Frequency** *Medicinas, Dosis, Ruta, Frecuencia*	**Breakfast** *Desayuno*	**Lunch** *Almuerzo*	**Dinner** *Comida*	**Bedtime** *Acostarse*	**Clasification** *Clasificación*	**Side Effects** *Efectos Secundarios*	MD Ordering Full Name *Doctor que ordena*	Level of Understanding Good Fair Poor	**D/C Date** *Alta*

Key To Side Effects/*Guía de Efectos Secundarios*

A-Nausea/Vomiting *Vómito*
B- Constipation *Estreñimiento*
C- Diarrhea *Diarrhea*
D- Hypertension *Presión Alta*
E- Hypotension *Presión Baja*
F- Skin Rash/Urticaria *Erupción de la piel*
G- Headaches *Dolor de Cabeza*
H- Dizziness *Mareos*
I- Hypoglycemia *Hypoglicemia*
J- Hyperglycemia *Hiperglicemia*
K- Edema *Edema*
L- Diaphoresis *Sudoración*
M-Hemorrhage *Hemorrageas*
N- Hematuria *Hematuria*
O- Dry Mouth Thirst/*Sed Boca Seca*
P- Bradycardia *Bradicardia*
Q- Tachycardia *Taquicardia*
R- Tremors *Temblores*
S- Tinitus *Zumbidos en oidos*
T- Fluid/Electrolyte Imbalance *Desbalance líquido*
U- Anorexia
V- Malaise *Malestar*
W- Dyspnea *Falta de Aire*
X- Confusion
Y- Flushing/Blurred Vision *Enrojecimiento/Visión borrosa*
Z. Other_____ *Otros*

Allergies: _____ *Alergías*

Firma Enfermera/Fecha
Nurse Signature/Date:_____

Reconciliation
Update on: _____ By: _____
Actualizado en *Por*

Reconciliation
Update on: _____ By: _____

Reconciliation
Update on: _____ By: _____

NEW HOPE CASE MANAGEMENT SERVICES, INC.

** Part of Emergency/Disaster Plan*

Rev. Date: 09/7/2011

DRUG CLASSIFICATIONS

NOTE: CLASSIFICATIONS ARE NOT INCLUSIVE OF ALL SIDE EFFECTS

#	CLASS	SIDE EFFECTS
1	ANALGESICS / NARCOTIC	SEDATION / CONSTIPATION
2	ANALGESICS / NON-NARCOTIC	WELL TOLERATED
3	ANALGESICS / NSAIDS / ANTINFLAMMATORY	GI DISTRESS / DROWSINESS
4	ANTIBIOTICS	GI DISTRESS / ANAPHYLAXIS
5	ANTICOAGULANTS / ANTIPLATELETS	DIARRHEA / RASH / FEVER / BLEEDING
6	ANTICONVULSANTS	GI DISTRESS / ATAXIA / CONFUSION
7	ANTIDEMENTIA / CEREBRAL METABOLIC / ENHANCERS	GI DISTRESS / DIZZY / HA / INSOMNIA
8	ANTIDOTE	GI DISTRESS / TACHYCARDIA / HTN
9	ANTIFUNGAL	GI DISTRESS / HA / CHILLS
10	ANTIHYPERLIPIDEMICS	GI DISTRESS / DIZZY / MUSCLE PAIN
11	ANTIMPOTENCE	HA / DIZZY / FLUSHING
12	ANTIMIGRAINE	DIZZY / TINGLING / SEDATION
13	ANTIPARASITIC	DIZZY / LOCAL IRRITATION
14	ANTITUBERCULAR	GI DISTRESS / RASH
15	ANTIVIRAL / ANTIRETROVIRAL	GI DISTRESS / HA / FUNGAL INFECTION
16	BLOOD / BLOOD DERIVATIVES	ANAPHYLAXIS / RASH / FEVER
17	BPH	DIZZY / HA
18	CANCER / CHEMOTHERAPEUTIC / ANTINEOPLASTICS	GI DISTRESS / BLOOD DYSCRASIA / ALOPECIA
19	CARDIAC / ANGINA / CAD / ASCVD	DIZZY / LOW BP / EDEMA / ^K+
20	CARDIAC / CHF / CARDIOMYOPATHY	DIZZY / LOW BP / EDEMA / ^K+
21	CARDIAC / DYSRHYTHMIA	LOW BP / LOW PULSE / EDEMA / ^K+
22	CARDIAC / HTN / ASHD	DIZZY / LOW PULSE / EDEMA / ^K+
23	CNS STIMULANT	INSOMNIA / NERVOUSNESS
24	CORTICOSTEROID ANTINFLMMATORY	GI DISTRESS / EDEMA / ^BS / EUPHORIA
25	DERMATOLOGIALS MISC	RASH / LOCAL IRRITATION / BURNING
26	DIABETES	LOW BS / ANAPHYLAXIS / HEPATOTOXICITY
27	DIETARY SUPPLEMENTS	GI DISTRESS / RASH
28	DIGESTANTS / GI ENZYMES	GI DISTRESS
29	DIURETICS	ELECTROLYTE DISTURBANCES / LOW BP
30	ELECTROLYTES	GI DISTRESS
31	GI / ANTIACIDS	CONSTIPATION / DIARRHEA / FLATULENCE
32	GI / ANTIDIARRHEAL / ANTISPASMODIC	CONSTIPATION / DRY MOUTH / URINARY RETENTION
33	GI / GASTRITIS / ULCER / REFLUX	GI DISTRESS / CONFUSION / HA
34	GI / LAXATIVES	GI DISTRESS / DEPENDENCE DIARRHEA
35	GI / NAUSEA / VOMITING	SEDATION / DRY MOUTH / BLURRED VISION
36	GLAUCOMA	HA / NAUSEA
37	GOUT / URICOSURIC	GI DISTRESS
38	HEMATINIC	GI DISTRESS / BLACK STOOLS
39	HEMATOPOIETIC	BONE PAIN / HTN
40	HEMOSTATIC	GI DISTRESS
41	HERBAL	GI DISTRESS / RASH
42	HORMONES	HOT FLASHES / BOATING / DEPRESSION
43	IMMUNOLOGIC / IMMUNOSUPRESSANTS	HA / TREMORS / CANDIDA INFECTION
44	IV FLUSH	BURNING
45	MUSCLE RELAXERS	DROWSINESS / DRY MOUTH
46	OPTHALMIC LUBRICANTS	REDNESS / IRRITATION
47	OSTEOPOROSIS	GI DISTRESS / LOCAL IRRITATION
48	OXYGEN	NASAL IRRITATION
49	PARKINSONS	LOW BP / DYSKINESIA / HALLUCINATIONS
50	PLASMA VOLUME EXPANDERS	EDEMA / ANAPHYLAXIS
51	PSYCHIATRIC / ANTIANXIETY / ANTIDEPRESSANTS	DIZZY / DROWSINESS / DRY MOUTH
52	PSYCHIATRIC / ANTIPSYCHOTICS / ANTIMANICS	EPS / DROWSINESS / DRY MOUTH
53	RESPIRATORY / ANTIHISTAMINES / DECONGESTANTS / ANTIALLERGY	DIZZY / DROWSINESS / DRY MOUTH
54	RESPIRATORY / ANTITUSSIVES / EXPECTORANTS	SEDATION
55	RESPIRATORY / BRONCHODILATORS	TACHYCARDIA / TREMORS / NERVOUSNESS / HA
56	SALICYLATES	GI DISTRESS / TINNITUS
57	SEDATIVES / HYPNOTICS	SEDATION / CONFUSION
58	THYROID	TACHYCARDIA / TREMORS / INSOMNIA
59	URINARY ANTISPAMODICS	LOW BP / URINARY RETENTION / DIZZY
60	VERTIGO / SYNCOPE	DRY MOUTH / DROWSINESS
61	VITAMINS / MINERALS	GI DISTRESS / ANAPHYLAXIS
62	OTHER	

NEW HOPE CASE MANAGEMENT SERVICES, INC.

PERSONAL INFORMATION SHEET

Name:_____ Date:_____
Nombre Fecha

Address:_____ Zip _____
Dirección Código Postal

Telephone: _____ Sex: _____ Marital Status:_____ Legal Status: _____
Teléfono Sexo Estado Civil Estado legal

SS#: _____ Date of Birth: _____ Age: _____ Place of birth: _____
No. de SS Fecha de Nacimiento Edad Lugar de Nacimiento

Medicare # _____ Medicaid #_____
No. de Medicare No. de Medicaid

EMERGENCY CONTACT (Contacto de Emergencia):

Name (Nombre): _____ Relationship: _____
Relación

Address:_____ Phone:_____
Dirección Teléfono

Name (Nombre): _____ Relationship: _____
Relación

Address:_____ Phone:_____
Dirección Teléfono

LEGAL GUARDIAN _____ Relationship: _____
Tutor Relación

Address:_____ Phone:_____
Dirección Teléfono

MEDICATION'S LIST: (Lista de Medicinas): _____
_____
_____
_____
_____
_____

DOCTOR'S INFORMATION (Información de los doctores):

PCP (Médico Primario) : _____
Name, address and telephone (Nombre, dirección y teléfono)

PSYCHIATRIST (Psiquiatra): _____
Name, address and telephone (Nombre, dirección y teléfono)

ALLERGIES: _____
Alergias

_____ _____
Client's Signature (Firma del Cliente) Date (Fecha)

_____ _____
Legal Guardian's Signature (Firma del tutor) Date (Fecha)

NEW HOPE CASE MANAGEMENT SERVICES, INC.

TARGETED CASE MANAGEMENT Organization

CLIENT NUMBER: _____ **TIME IN:** _____AM PM **TIME OUT:** _____ AM PM **UNITS**: _____

CASE MANAGEMENT ASSESSMENT

The primary goal of mental health targeted case management is to optimize the functioning of recipients who have complex needs by coordinating the provision of quality treatment and support services in the most efficient and effective manner.

Client's Full Name:		Date:
Social Security No.:	DOB:	Age:
Place of Birth:	Primary Language:	
Residential Status:	Referral Date (referral form must be previously completed):	
Marital Status (If married, divorced, widow, separated, how time ago):		

I. SOURCES OF INFORMATION

Client's Report		Client's legal guardian (attach copy of court disposition)	
Client's family and friends		Agency who referred the client	
School		Other previous treating providers	

Other source (specify):

II. PRESENTING PROBLEMS (Diagnosis, Current symptoms, Treatment Compliance, Decompensation, client's own appraisal of his/her situation)

DIAGNOSIS (Specify DSM IV Number and Name):

CURRENT SYMPTOMS (Select all that apply)

Depression		Nervousness		Restlessness she couldn't sit still	
Anxiety		Lack of motivation		Lost or gained weight without trying	
Sadness/blue		Spells of terror or panic		Fear to go out of your home alone	
Fearfulness		Tension		Fear in open spaces or on the streets	
Worthlessness		Confusions		Being suddenly scared for no reason	
Loneliness		Hopelessness		Hallucinations (verbal or auditory)	
Lack of energy		Helplessness		Disorientation:(Time/ Place/ Person)	

Other Symptoms:

Client's own appraisal of his/her situation:

What were the major problems that have distressed client during the last seven days? :

Family's assessment/Legal representative's assessment of client's situation (if applicable):

Is client being attended by a psychiatrist at moment? (If yes, include doctor's name and how long time client is being receiving psychiatrist care with this doctor. If not, explain reasons):

III. PSYCHIATRIC HISTORY (Onset of mental illness (include approximate date) and significant events that have triggered , previous hospitalizations, Baker Act, history of psychiatrist care and treatment. If client has been hospitalized in the last 12 months, please document the dates, hospitals, and circumstances):

Suicidal Ideation/Suicidal attempts:

Homicidal Ideation/Homicidal attempts:

If client refers suicidal/homicidal ideations, planning or attempt at interview time or during the last six months, please contact Supervisor and Crisis Team if required

IV. MEDICAL HISTORY (Include all physical illness client's suffers, injuries, surgeries and hospitalizations)

Is client being attended by a Primary Physician at moment? (If yes, include doctor's name and how long time client is being receiving medical care with this doctor. If not, explain reasons):

Allergies or intolerance:

Current Medications (Please include medication's name, dosage and side effects. Please include any OTC medicine being taking by client at moment):

V. RESOURCES AVAILABLE TO THE CLIENT

(Please include information about all resources available in client's case- Psychiatrist, Therapist, Primary Care Physician, Specialists, Home Health Services, Legal guardian, Care Worker, DCF Case Worker, Probation officers, Housing program representative/manager, others. Please, include Effectiveness rating of current services).

Agency Name	**Services provided**	**Contact Person** (Include name, address and phone/fax)	**Effectiveness rating of current services** (Specify if Non Effective, Somewhat Effective or Highly Effective).

COMMENTS (Include any comment about areas from I to V):

Strengths and Needs of the client and Support System

Please select N for needs identified, S for Client's strengths and N/A if applicable.

VI. Psychological and Social Area

1. Substance Abuse History (List types of substances, duration of use and any treatment received) N ☐ S ☐ N/A ☐

2. Physical or Emotional Abuse/Domestic Violence (perpetrator's data, times, dates, and whether reported) N ☐ S ☐ N/A ☐

3. General Level of Performance before the Onset of the Illness: N ☐ S ☐ N/A ☐

4. Intellectual Functioning (memory, concentration , ability to perform and understand tasks) N ☐ S ☐ N/A ☐

MMSE Score: Date:

5. Relationship with Others (ability to trust in others, ability to socialize, cooperativeness with others) N ☐ S ☐ N/A ☐

6. Social Support Network (support from friends, acquaintances, peers, neighbors, coworkers or others) N ☐ S ☐ N/A ☐

7. Family Support (communication with family, type of support received, effectiveness) N ☐ S ☐ N/A ☐

8. Leisure activities/Interests/Skills and talents (specify kind and how it contribute to client's recovery) N ☐ S ☐ N/A ☐

9. Employment concern. Desire to work. N ☐ S ☐ N/A ☐

10. Level of Education. Vocational Trainings. School concern. Desire to learn. N ☐ S ☐ N/A ☐

11. Beliefs and Cultural Traditions (beliefs and spiritual practices, and how it assist client in dealing with stressors) N ☐ S ☐ N/A ☐

12. Stability/Maturity. Behavior during interview (Term of relationships, frequency of moving/changes) N ☐ S ☐ N/A ☐

13. Level of Functioning. Ability to perform ADL's and IADL's (include level of assistance required, if any) N ☐ S ☐ N/A ☐

Level of functioning (Write The GAF score at the time of assessment):

14. Awareness and insight. Compliance with appointments and treatments N ☐ S ☐ N/A ☐

15. Financial resources (Specify amount of income and source. Specify economical condition as referred by client) N ☐ S ☐ N/A ☐

(Please include also information about food, clothing, housing):

16. Transportation Means (Means of transportation, ability to use private/public transportation) N ☐ S ☐ N/A ☐

COMMENTS (Include any comment about Psychological and Social Area):

VII. Legal Area

1. Legal History (delinquency, antisocial behavior. Specify charges, dates, convictions and incarcerations): N ☐ S ☐ N/A ☐

2. Legal status (Client's current legal status, if legal documentation is updated) N ☐ S ☐ N/A ☐

3. Legal guardian or proxy (Client has a legal guardian or needs one. Communication with guardian). N ☐ S ☐ N/A ☐

Please, attach a copy of the court disposition in case client has a legal guardian.

COMMENTS (Include any comment about Legal Area):

VIII. Physical Area

1. Physical Health (Specify if client's health interfere with day-to-day functioning, if is required medical care continuity) N ☐ S ☐ N/A ☐

(Please, include medical services required by client as per his/her report: Dentist, specialist, therapy, diagnostic test or others):

2. Personal hygiene/Dressing N ☐ S ☐ N/A ☐

3. Nutrition (Client's appetite, meals per day, if special diet is required. Be specific) N ☐ S ☐ N/A ☐

4. Age-Appearance (Specify if level of functioning and appearance is in accordance with chronological age) N ☐ S ☐ N/A ☐

COMMENTS (Include any comment about Physical Area):

IX. HOME VISIT (The case manager must conduct a home visit prior to completion of the assessment, if the case manager is unable to complete a home visit, a face-to-face interview must be conducted in another setting).

Was a home visit conducted prior to the completion of Assessment: Yes: No:

Was the home visit conducted in the setting in which the client resides: Yes: No:

If home visit cannot be performed, please explain reasons (explanation must be signed by TCM and Supervisor)

TCM's Signature: _____ Supervisor's Signature: _____

Address:	**Date of Home Visit:**

Description of the house (House's location, neighborhood (rural/urban, crime level). Physical condition of the house, number of bedrooms, living and sleeping arrangements, low income housing program if applies.)

Description of appliances, roof, floor, sanitary condition, accessibility (Please describe potential safety or accessibility problems)

Indirect signs of abuse, violence and/ or drug use

Amount of rent and monthly utilities (specify, who is responsible for monthly payments)

X. Recommended Service Coordination

Each Mental Health Targeted Case Management's client must receive a thorough assessment, which will serve as the basis for the development of his/her Service Plan.

	Behavioral		Mental Health/Substance Abuse Services
	ADL/IADL Training		Medical and dental services
	Education		Assistance with employment opportunities
	Recreational activities		Living Environment/Housing
	Economical/Financial Assistance		Environmental support (peers groups)
	Legal Assistance		Family/Caregiver support and education
	Vocational or job training		Transportation
	Others:		

Other/Comments regarding recommended services :

XI. SIGNATURES I certify that I have provided the service(s) documented above in accordance with all applicable regulations.

_____	_____	_____
Case Manager's Name	Case Manager's Signature and credentials	Date
_____	_____	_____
Supervisor's Name	Supervisor's Signature and credentials	Date

NEW HOPE CASE MANAGEMENT SERVICES, INC.

MONTHLY CALENDAR

Year: _____

JANUARY □	FEBRUARY □	MARCH □	APRIL □	MAY □	JUNE□
JULY□	AUGUST □	SEPTEMBER □	OCTOBER □	NOVEMBER □	DECEMBER □

Patient's Name: _____ Client Record #: _____

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

NEW HOPE CASE MANAGEMENT SERVICES, INC.

NOTES: (For your records)

HOSPITALIZATIONS:

Admitted: ____/ ___/ _____ Discharge: ___/ ___/ _____
Admitido *Alta*
Hospital: _____
Reason / Razón: _____

- -

Admitted: ____/ ___/ _____ Discharge: ___/ ___/ _____
Admitido *Alta*
Hospital: _____
Reason / Razón: _____

- -

MD VISITS / *VISITAS AL DOCTOR*

Date	Physician/Doctor Name/Phone	Reason

Notes:

NEW HOPE CASE MANAGEMENT SERVICES, INC.

INITIAL SERVICE PLAN

Date: _____Time IN: _____ OUT: _____Units: _____

Section I:

Client's Name: _____ Client's Number: _____

Diagnosis (DSM IV Number and Name): _____

Section II: Strengths and Weakness

Strengths: _____

Weakness: _____

Section III: Long Term View *(The long term view is both the focus and foundation of the Service planning process for each client. The long term view is an optimistic, yet realistic, narrative describing what the client would like to happen, with whom and where. This section reflects the expectations and desires of the client, where the client "sees" him or herself in the future. It is written in the first person by the client with help and support from the Case Manager).*

What I would like to happen: _____

What I want to accomplish regards with specific domains included in my Service Plan: _____

What I need to accomplish this: _____

Client's Name: _____ Client's Number: _____

Section IV: Needs *(The following goals and objectives describe the client's service needs and the activity that the Mental Health Targeted Case Manager will undertake in partnership with the client)*

Domain's Legend: **1** -Behavioral **2**-Daily Living Skills **3**-Educational **4**-Substance Abuse **5**- Social Relationships **6**- Economical **7**- Legal **8**-Family **9**- Mental Health **10**-Physical Health **11**-Employment **12**-Living Environment **13**- Leisure Time **14**- Vocational **15**-Transportation

SERVICE AREA NEEDS *(Please include all needs identified, the date needs were identified and domain)*

Identified Need Goals Objective	**Tasks: Who will do what**		**Date Identified** Completion Attained	**Domain** (Name & number)	**Mark**
	Client will:	**Case Manager will:**			
					□ New Goal □ Addendum □ Ongoing
					□ New Goal □ Addendum □ Ongoing
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					□ New Goal □ Addendum □ Ongoing

This Service Plan was developed in conjunction with the client, parent or legal guardian and was discussed and explained to client in terms he/she understands. This Service Plan is based on client's service needs and according with previous assessment completed in client's case.

Client's Name: _____ Client's Number: _____

Section IV: Needs *(The following goals and objectives describe the client's service needs and the activity that the Mental Health Targeted Case Manager will undertake in partnership with the client)*

Domain's Legend: **1** -Behavioral **2**-Daily Living Skills **3**-Educational **4**-Substance Abuse **5**- Social Relationships
6- Economical **7**- Legal **8**-Family **9**- Mental Health **10**-Physical Health
11-Employment **12**-Living Environment **13**- Leisure Time **14**- Vocational **15**-Transportation

SERVICE AREA NEEDS *(Please include all needs identified, the date needs were identified and domain)*

Identified Need Goals Objective	**Tasks: Who will do what**		**Date Identified** Completion Attained	**Domain** (Name & number)	**Mark**
	Client will:	**Case Manager will:**			
					□ New Goal □ Addendum □ Ongoing
					□ New Goal □ Addendum □ Ongoing
					□ New Goal □ Addendum □ Ongoing
					□ New Goal □ Addendum □ Ongoing
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_____ _____ _____ _____
Client Signature Date Parent, Guardian or Surrogate Date

_____ _____
Case Manager Name, Signature and Credential Date

_____ _____
Supervisor Name, Signature and Credential Date

Client's Name: _____ Client's Number: _____

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_____ _____ _____ _____
Client Signature Date Parent, Guardian or Surrogate Date

_____ _____
Case Manager Name, Signature and Credential Date

_____ _____
Supervisor Name, Signature and Credential Date

EMERGENCY/DISASTER PLAN FOR HOME HEALTH CARE PATIENTS

(Keep this plan where it can be easily located)

PLAN DE EMERGENCIA/DESASTRE PARA PACIENTES EN SU CASA

NEW HOPE CASE MANAGEMENT SERVICES, INC. *(Mantenga este plan en un lugar accesible)*

Date/*Fecha*: _____ **Client:** _____ **MR:**_____

Information obtained by: ☐ **Client/Patient** *(Cliente/Paciente)* ☐ **Caregiver** *(Familiar/persona Encargada)*

If caregiver, relationship to patient/*Relación*: _____

The Emergency Medical Service dispatcher will need to know (caregiver):

El operador del Servicio de Emergencia Médica necesita conocer (Responsable)

Name/*Nombre*: _____ Phone: _____

Address/*Dirección*:_____

CLIENT's EMERGENCY CLASSIFICATION (circle one): D1 D2 D3 D4 ***(see back for instructions)***

CLASIFICACION DE EMERGENCIA DEL CLIENTE

Patient's Data/*Datos del Paciente*:

Allergies: ☐ NKA ☐ Penicillin ☐ Sulfa ☐ Aspirin ☐ Pollen ☐ Iodine **Special needs:**_____

Alergias: ☐ Other: _____ *Necesidades especiales:*_____

Medications ☐ See medication scheduled *(part of Emergency plan)* *(Ver el registro de medicinas, parte del Plan de Emergencia)*

Comments _____

Comentarios _____

Supplies/DME: ☐ Walker ☐ W/C ☐ Cane ☐ Commode ☐ Hoyerlift ☐ O_2 concentrator ☐ Gloves ☐ Alcohol Pads

Equipos médicos: ☐ Hospital Bed ☐ Sharp Container ☐ 4x4 Gauze ☐ Other: _____

Pharmacy/Phone/Farmacia/teléfono: _____

Address/*Dirección:*_____

Doctor: _____ **phone**: _____

(IN CASE OF MEDICAL EMERGENCY DIAL 911) *EN CASO DE EMERGENCIA MEDICA LLAMAR AL **911**.*

IN CASE OF NURSING OR RELATED PROBLEM CALL THE AGENCY AT PHONE IN THE COVER

(EN CASO DE PROBLEMA CON EL SERVICIO O SI QUIERE COMUNICARSE LLAME A LA AGENCIA AL TELEFONO EN EL COVER)

To contact your nurse directly you may call her/him at:_____

(Puede llamar a su enfermera/ro al teléfono) (24 hrs a day, 7 days a week, 24 hrs/día, 7 días/semana)

Name/*Nombre*: _____ _____

IN CASE OF EMERGENCY NOTIFY TO: *EN CASO DE EMERGENCIA NOTIFICAR A:*

Name/Nombre: _____ Phone: _____

Address/Dirección:_____

Service Provided: ☐ Skilled Services ☐ Non-Skilled Services (Personal Care only)

IN THE EVENT OF A HURRICANE (OTHER NATURAL DISASTER) I WILL:

EN CASO DE UN HURACAN (U OTRO DESASTRE NATURAL) YO:

☐ **Stay at home**/*Me quedaré en casa.*Who will help with meds/*Quién le ayudará con medicinas*_____

☐ **Stay with family** *(voy con familiares)* – Name/address/telephone:_____

☐ **Go to shelter** *(voy a Refugio)*_____

Shelter address/*Dirección*

☐ **Go to a hospital, if medically necessary**_____

Voy a un hospital, si es medicamente necesario **Hospital Name**/*Nombre*

Type of Transportation/*Tipo de tranporte:* _____

PLEASE CONTACT OUR AGENCY FOR ALTERNATE SERVICE OPTIONS IN CASE OF DISASTER.

POR FAVOR CONTACTAR NUESTRA AGENCIA PARA OPCIONES EN SERVICIOS ALTERNOS O EN CASO DE DESASTRE.

_____ _____ _____ _____

Signature of Client/*Firma del Paciente* **Date**/*Fecha* **Signature of Nurse**/*Firma* **Date**/*Fecha*

GENERAL INSTRUCTIONS TO CLIENT ON USE OF THIS FORM:

This information is provided to you as a quick reference source in case any emergency occurs. Keep this document where it can easily be found. Inform other persons close to you (relative, neighbor, etc.) of its location.

1. **Our Agency has a nurse on call 24 hours a day. You can reach the nurse through our phone number (in the cover of the book), After office hours and on weekends an answering service will reach the nurse and he/she will return your call and come to see the client if necessary, or simply answer any questions you may have.**
2. **In case of a serious medical emergency, the client should be taken to the hospital. Our Agency does not operate as an emergency service, therefore valuable time may be lost by contacting the Agency for a serious emergency such as diabetic coma, severe chest pain, unconsciousness, etc.**
3. **Ambulance service number is 911.**

CLASSIFICATION

(Please circle the correct classification for client)

Dl- Category 1

Clients who cannot safely forgo care: highly unstable clients with high probability of inpatient admissions if home care is not provided: IV therapy, highly skilled wound care, with no family/caregiver, life sustaining medication or equipment.

D2-Category 2

Client whose condition recently worsened: moderate level of skilled care. That should be provided that day, but could postpone visit until emergency situation improves. Client with untrained families/caregivers who could provide basic care in an emergency.

D3-Category 3

Client who can safely forgo care or a scheduled visit including Home Health Aide visits, Clients receiving routine supervisory visit, evaluation visits. Client with 1 or 2 visits/ week, or Clients who have a competent family/caregiver.

D4-Category 4

Patient who refused information, or signed the registration release form releasing the Agency from evacuation responsibilities.

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*INFORMACIÓN GENERAL PARA EL PACIENTE SOBRE ESTE FORMULARIO. Esta información es en **caso de una Emergencia**. Deben de dejar este formulario en un lugar rápido de encontrar,(Dígale a su familia, Vecinos, etc) donde se encuenta este formulario.*

1. *Nuestra Agencia tiene un Representante en servicios las 24 hora al día. Usted se puede comunicar con la agencia llamando a nuestro número de teléfono (en la cubierta del libro), después de hora o fin de semana, la agencia llamará a la persona que se encuentre "ON CALL" (de guardia), Esta persona le devolverá la llamada.*
2. *En caso de una EMERGENCIA, el paciente debe ser llevado(a) al hospital más cercano. Nuestra Agencia No opera como un servicio de Emergencia.*
3. *Para llamar a a una AMBULANCIA, deben marcar el 911.*

CLASIFICACION

(favor de circular la clasificación del paciente)

D1 (category 1)

Paciente que no se puede dejar sin servicio, muy inestable, con gran probabilidad de Ingreso si el cuidado en la casa no es proveido: terapia IV, cuidado de ulceras, sin familiar/encargado, medicación o equipos de por vida.

D2 (category 2)

Pacientes cuyas condiciones empeoraron recientemente, moderado nivel de cuidado, que debe darse según calendario, pero puede posponerse hasta que la situación de emergencia mejore. Pacientes con familiares/encargados no entrenados, pero que pueden dar cuidados básicos en emergencias.

D3 (categoria 3)

Pacientes que de una forma segura se puede dejar de visitar, incluyendo la assistente de enfermera, clientes reciviendo rutinarias visitas de supervisión, evaluación. Clientes con 1 a 2 visitas por semana, o clientes que tienen familiares/encargados entrenados y competentes.

D4 (Categoria 4)

Rehusó dar información, o liberó a la Agencia de Responsabilidades de Evacuación.

Understand What Having an In-Home Program Means

. The way that most ABA agencies operate is that a child is assigned a certified program manager/behavioral consultant/specialist/supervisor (different terms are used by agencies) who assesses your child's needs, develops and oversees the program. Behavior techs or aides (different terms are used for the staff who work in your home) are the ones who work in your home with you and your child in the implementation of the program. Some agencies provide their own trained behavior techs while others do not and parents must find their own.

It is an adjustment having people in your home and figuring out your relationship with them. It is an unusual and sensitive one by definition. There is perhaps no other relationship quite like this where someone has close access to your child as well as to siblings, other relatives and to your entire home, including parts of the home considered personal and private like bedrooms and bathrooms.

While staff are employees of the agency you are working with, you are their direct contact in your home and it is your responsibility to be an active participant in your child's program. You will interview prospective staff and decide if you think that it is a good fit for your child and your family. You will also give feedback on the job they are doing and in determining the effectiveness of their work.

Prepare for the Interview

You have done the necessary research and you now know that the practitioners have the requisite certifications. Whether the agency provides line staff or you do your own hiring, you will be the one to train on the specifics of your home and your child.

What questions should you ask? What qualities should you look for? The following is a list of questions I have used in my own interviews.

. Have you worked with primarily younger or older children?

. Was your experience in the home, school, community or combination?

. Did you work on skill acquisition or challenging behavior or both?

. Are there any behaviors that you feel you cannot handle or work with?

. How many families are you currently working with?

. What is your availability? Be specific and firm with what you need. Lots of staff work evening and early morning shifts today so go with what you really need – not what is convenient to them.

. How do you view your relationship with the rest of the family? Siblings? Parents?

. Do you have a cell phone and email? What is the best way to reach you?

. How will you keep me updated on my child's progress and needs?

. If there are parts of your home that are off limits to your child and/or staff, make sure you say this. Keep in mind that boundaries will blur as the program progresses to include the parts that your child naturally uses, i.e. bathrooms, bedrooms, dining area and play areas. I have returned home often to find my son and aide in my bedroom or my personal bathroom. If it is an area that he is allowed in without the in-home support then it naturally follows that he may wander in there when I am not there.

. Emergency preparation – how do you handle unforeseen problems? Can you call on colleagues or supervisors for back-up support?

. Privacy: How will you assure that my family's identity and information are respected and protected?

. Religion/Culture: How will you make sure that my family's religious preferences and culture are respected and adhered to?

. Do you have any local references of parents that I can call?

Once you have conducted your interviews, I strongly advise contacting references. In that conversation you should determine whether family is happy with service provided and why. How long has the family worked with them and what have they been working on. You should try to compare apples to apples, younger children to younger, teen to teen, etc. You should also ask if there have been any issues or problems in the home.

We hope this primer on starting an in-home ABA program is helpful. Parents, what other words of wisdom mighty you offer for parents new to this? Share your ideas with us

HOURS OF OPERATION AND EMERGENCY SERVICES

All clients/caregivers will be provided with the information regarding service hours of the Organization (see Inside Front Cover) and access to staff for emergencies. Organization will provide adequate, qualified staff for emergency response and troubleshooting related to any services provided to client/caregiver. **Emergency Response:**

1. On initial visit, client/caregiver will be provided with an Organization business card and telephone number, and will be educated on the organization's twenty-four (24) hours, seven (7) days per week, availability of Behavioral Care staff.
2. Phone calls may be made to the Organization during the office regular business hours Monday-Friday to reach the office staff.

a) Emergency calls may be handled after office hours and on weekends by dialing the office number.
   1. Notify the answering service of your name/phone number and a representative will contact you ASAP.
   2. If caller chooses only to leave a message, the Organization staff will follow up the call on the next business day.
   3. Emergency Services are available after office hours, including weekends and on holidays.
   4. All clients/caregivers are instructed on admission to contact **911** in the event of a life threatening emergency.

b) On-call representatives will handle all problems, or will contact the Organization for any issues.

c) The On-Call staff is responsible for determining the necessity for a client visit, notifying the program, physician and/or taking other appropriate actions.

3. The on-call representative will keep a log of all calls and actions taken.

INFORMATION TO PERSONS WITH SENSORY IMPAIRMENTS

Our Organization will take steps as necessary to ensure that qualified persons with disabilities, including those with impaired sensory or speaking skills, receive effective notice concerning benefits of services or written material concerning waivers of rights or consent to treatment. All aids needed to provide this notice are provided without cost to the person being served. The identification of special needs and disabilities are a part of the referral process. Information regarding special services will be posted and presented to individuals upon admission.

For Persons With Hearing Impairments: The Organization will make a maximum effort to contract a qualified sign-language interpreter for persons who are deaf/hearing impaired and who use sign-language as their primary means of communication. The following Organization offers the needed services:

The Florida Coordinating Council for the Deaf and Hard of Hearing: 4052 Esplanade Way, Bin #A06. Tallahassee, FL 32399 Voice: 850-245-4913 Toll Free Voice: 866-602-3275 TTY: 850-245-4914 Toll Free TTY: 866-602-3276

For Persons With Visual Impairments: Staff communicate the content of written materials concerning the benefits, services, waivers of rights, and consent to treatment forms by reading them out loud to visually impaired persons. Large print, taped and braille materials are available upon request. Please contact the Director of Social Services for these materials.

For Persons With Speech Impairments: Writing materials, TDD, computers, and communication boards are available to facilitate communication concerning program services and benefits, waivers of rights and consent to treatment forms.

ETHICS ISSUES

All of our staff will provide care and services to our clients within the Ethical framework established by the home health care standards, professional requirements and the law during the performance of their duties.

NON-DISCRIMINATION POLICY

Our Organization does not exclude, deny benefits to or otherwise discriminate against any person on the grounds of race, color, national origin, disability or age in admission to, participation in, or receipt of the services and benefits of any of its programs and activities or in employment therein, whether carried out by our Organization directly or through a contractor or any other entity with which our Organization arranges to carry out its programs and activities. This statement is in accordance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Regulations of the U.S. Department of Health and Human Services issued pursuant to the Acts, Title 45 Code of Federal Regulations Part 80, 84, and 91. (Other Federal Laws and Regulations provide similar protection against discrimination on grounds of sex and creed.)
In case of question please contact the Organization Section 504 Coordinator, (Agency's information in the cover of the book).

CONFIDENTIALITY

All information received by persons employed by or providing services to the Organization and/or received by the Organization through reports or inspections shall be deemed privileged and confidential, and shall be stored and maintained in such a manner as to maintain the confidentiality of same, following **HIPAA guidelines**. The above information shall include, but not be limited to, client records as well as personnel records. Accessibility to information shall be limited to authorized personnel within the Organization. Information shall not be disclosed without the written consent of the client/guardian and/or employee. Release of information shall be accomplished only upon the approval of the Organization Administrator and/or Designee. At the start of employment all employees shall be instructed in the confidentiality policy of the Organization, and will read and sign a "Confidentiality Statement". This shall become part of the employee's personnel record. Breach of confidentiality may be grounds for immediate termination of employment.

DIMINISHED VISION REHABILITATION

Diminished vision is a visual deterioration not correctable by standard eye glasses, contact lenses, medicine, or surgery that interferes with a person's ability to perform everyday activities.
What Causes Diminished Vision? Impaired vision can result from a variety of diseases and injuries that affect the eye. Many people with impaired vision have age related diabetic retinopathy, macular degeneration, glaucoma or cataract.
How Does Diminished Vision Affect People's Lives? People with diminished vision experience physical, financial, and psychological changes that reduces their quality of life. Without proper assistance and training, patients may have difficulty using magnifying devices and completing necessary activities of daily living tasks such as: Meal preparation, Reading, Financial management, Home maintenance, Grooming, Shopping, Community and leisure activities An insurance beneficary with impaired vision may be eligible for rehabilitation services designed to improve functioning, by therapy, to improve performance of activities of daily living including self-care and management skills in a home setting

PATIENT'S RIGHTS, COMPLAINTS, GRIEVANCE

Our clients/caregivers have the option to exercise their rights, participate in their care plan, voice grievance/complaints and recommend changes in our policy and procedures without fear of reprisal or discrimination. Any complaint/concern brought to us (preferably to our administrator) will be thoroughly investigated, responded to in writing, including a corrective action plan if needed.

PATIENT RESPONSIBILITY

As a behavioral care client you have the responsibility to: Give accurate and complete health information concerning your past illness, hospitalization, medications, allergies, and other pertinent items, Assist in developing and maintaining a safe environment, Inform the Organization when you will not be able to keep a care visit, Participate in the development and update of your behavioral care plan and comply with prescribed medical regimen, Adhere to your developed (updated behavioral care plan), Request further information concerning anything you do not understand, Give information regarding concerns and problems you have to a home health care Organization staff member. Agree to accept all care givers without regard to race, color, religion, sex, age, gender, preference, handicap, or national origin and provide a safe environment for our staff including pets (dogs, snakes, etc) and any kind of fire arms, remain under a physicians care while receiving behavioral services, Provide the Organization with all requested insurance and financial records, Signs required consents and release forms, Accept the responsibility of any refusal of treatment, reviewed and understand your responsibilities as described above.

LANGUAGE ASSISTANCE SERVICES

You are entitled to care in your preferred language. This service is provided at no charge to you, our agency's staff will make every attempt to meet your language needs. If you require additional assistance, please contact our office.

TECHNIQUES TO BATTLE DEPRESSION

Research it. Find out as much as you can about depression, its causes, signs and symptoms, what conventional treatments are available. The more you know and understand about depression, the better prepared you will be to beat it. **Talk to someone about it.** A problem shared is a problem solved. Have you ever felt better by getting something off your chest? Of course you have. Did talking about a problem in the past help to put it into perspective and perhaps make it easier to deal with. **Don't be afraid to try new things.** Everyone is different and some people respond better to some things than others. **Keep a Depression Diary.** This can also help you unload your problems, thoughts and feelings but this time onto paper instead of to a real person. **Improve your diet.** I'm sure you will agree that many of us should try this whether we have depression or not. In relation to depression improving your diet can help improve your shape, appearance and fitness which in turn can help with self esteem.

MINIMUM CHARGES FOR OUR SERVICES

Charge are per visits: Behavioral Services: $100.00, Aide care: $65.00
This rate may vary according to Private Insurance, Co-payments or Self Pay option (Ask our Admission staff to explain to you the Section One and Two of our Service Agreement for more information about charges)

CLIENTS SAFETY GOALS

* Identify patients correctly * Use medicines safely * Prevent crisis * Prevent patients from falling *Identify patient safety risks

FRAUD PREVENTION

Key ways to protect yourself from fraud: * Review your claims summaries thoroughly to ensure you received each service listed and that all the details are correct. * Never share (or allow to use for other person) your Insurance Number, except with your doctors or other healthcare providers. Guard your social security/Insurance number. * Report suspected fraud by calling our Organization, or your Insurance carrier. The sooner you see and report errors, the sooner authorities/ Insurance can investigate and stop the fraud.

SERVICES

This Organization can provide a single service or a combination of services in your home, school, all under the direction of a physician, program. Working with your doctor, our qualified staff will plan, coordinate and provide care tailored to your needs. Our services may include: Behavioral Analyst, Behavioral Assistance, Behavioral Technician, Personal Care and Companion Services, etc.

ELIGIBILITY CRITERIA FOR ADMISSION

Admission to this Organization can only be made under the directions of a physician, program, based upon the patient's identified care needs, and the type of services required that we can provide directly or through coordination with other organizations. If we cannot meet your needs, either directly by our Organization or indirectly through service agreement with other providers, we will not admit you or will not continue to provide services to you.

10 COMMON FLU MYTHS

1. You can get the flu from the immunization. The influenza vaccine is made from inactivated virus and can't transmit infection. **2. I had the flu even though I was immunized, so the influenza vaccine didn't work.** Influenza vaccine is designed to cover the top 3 viruses, but a person may get a different influenza virus that is not included in the vaccine. **3. Healthy people don't need immunizations.** Current recommendations include one seasonal annual immunization for everyone over 6 months of age. Also, caregivers and health care workers need immunized to avoid spreading the influenza virus. **4. Influenza vaccine is not safe for pregnant women.** Pregnant women should receive influenza vaccine because there is a reduction in the immune system and a high proportionate death rate during pregnancy. **5. Influenza immunizations are not needed every year.** The influenza viruses change and mutate each year. **6. It is better to wait and get the influenza immunization later in flu season.** Immunity from the influenza vaccine lasts the entire flu season. It's best to receive the immunization early in the fall since the flu season is fall and winter (up through May) with the peak usually late November – March. **7. Influenza is the same as a "bad cold."** The flu may cause "bad cold" symptoms, but a significant number of people are hospitalized or die from the flu every year. **8. You can't spread the flu if you feel well.** 20% -30% of people with the flu are asymptomatic. A person is infectious 1 day prior to s/s of flu to 5 – 7 days after onset of s/s. **9. You can catch influenza from going out in the cold and not wearing a coat/ hat or going out with wet hair, etc.** The influenza viruses are only spread with direct contact with people who sneeze, cough, or talk closely to you. **10. Antibiotics are necessary with the flu.** Antibiotics do not work against viruses.

WHAT I HAVE TO KNOW ABOUT MEDICATION SAFETY

What is the name of each medicine? * What is it for? * What time should I take it? * How much of it should I take each time? * How should I take it? * Should I take it with food? * How long should I take it? * What should I do if I miss a dose? * Are there any side effects? What should I do if I have any? * Is it safe to combine the medicines that I am taking, including over-the-counter medicine, vitamins or herbals? * What food, drink or activities should I avoid while taking it?

WHO IS RESPONSIBLE FOR YOUR MEDICINES?

A lot of people-including you!
Doctors check all of your medicines to make sure they are OK to take together.
Pharmacists will check your new medicines to see if there are other medicines, foods or drinks you should not take with your new medicines.
Nurses and other caregivers may prepare medicines or give them to you.
What if you forget the instructions for taking a medicine or are not sure about taking it? Call your doctor or pharmacist. Don't be afraid to ask questions about any of your medicines.

PRECAUTIONS TO PREVENT FALLS

Many falls can be prevented. By making some changes, you can lower your chances of falling.
Four things YOU can do to prevent falls: ❶ Begin a regular exercise program Exercise is one of the most important ways to lower your chances of falling. It makes you stronger and helps you feel better. Lack of exercise leads to weakness and increases your chances of falling. Ask your doctor or health care provider about the best type of exercise program for you.
❷ Have your health care provider review your medicines Have your doctor or pharmacist review all the medicines you take, even over-the-counter medicines. As you get older, the way medicines work in your body can change. Some medicines, or combinations of medicines, can make you sleepy or dizzy and can cause you to fall.
❸Have your vision checked **❹ Make your home safer** Remove things you can trip over (like papers, books, clothes, and shoes) from stairs and places where you walk. Remove small throw rugs or use double-sided tape to keep the rugs from slipping. Keep items you use often in cabinets you can reach easily without using a step stool. Have grab bars put in next to your toilet and in the tub or shower. Use non-slip mats in the bathtub and on shower floors. Improve the lighting in your home. As you get older, you need brighter lights to see well. Hang light-weight curtains or shades to reduce glare. Have handrails and lights put in on all staircases. Wear shoes both inside and outside the house. Avoid going barefoot or wearing slippers.

HELP PREVENT ERRORS IN YOUR CARE, BE INVOLVED

Everyone has a role in making health care safe. That includes family members, caregivers, doctors and health care professionals. Health care organizations all across the country are working to make health care safe. As the patient, you can make your care safer by being an active, involved and informed member of your health care team. Speak up if you have questions or concerns. If you still don't understand, ask again. It's your body and you have a right to know. Pay attention to the care you get. Make sure you get the right treatments and medicines by the right home care professional. Don't assume anything. Educate yourself about your condition. Learn about the home care services you will get. Learn about your care plan. Ask a trusted family member or friend to be your advocate (advisor or supporter). Know what medicines you take. Know why you take them. Medicine errors are the most common health care mistakes. Use a home care organization that has been carefully checked out. Participate in all decisions about your treatment and the home care services you receive. You are the center of the health care team.

GET VACCINATION TO AVOID DISEASES AND FIGHT THE SPREAD OF INFECTIONS

Make sure that your vaccinations are current, even for adults.
Check with your doctor about what you may need. **Vaccinations** are available to prevent these diseases:
• Chicken pox • Mumps • Measles • Diphtheria • Tetanus • Hepatitis • Shingles • Meningitis
• Flu (also known as influenza) • Whooping cough • German measles (also known as Rubella)
• Pneumonia • Human papillomavirus (HPV)

BASIC SAFETY GUIDELINES: HOME ENVIRONMENT

Many accidents can be prevented in the home by following a few basic suggestions. Because we are concerned for your health and safety, we offer the following recommendations: Remove scattered rugs to avoid falls. Be sure there are no frayed edges on carpeting, Keep all pathways clear and uncluttered to prevent falls and avoid the risk of fire hazard. Do not overload electrical outlets, and do not hide cords under carpeting, All stairs/ramps should have hand rails and non-skid surface, In the kitchen, avoid loose-fitting clothing when using stove; use pot-holders or insulated kitchen mitts to handle hot items. Keep cooking utensils within easy reach; whenever possible, sit while doing kitchen chores to prevent falls caused by becoming over-tired. In the bathroom, use non-slip rugs or carpeting to prevent falling on wet floors; use non-slip strips or mats in the tub. Always test water temperature before entering tub or shower. Water temperature should be 120 degrees or less. Use grab bars, shower chairs and/or raised toilet seats for client who is very ill, weak, and/or tires easily. At night, use a night light to prevent falling in the dark. Keep telephone and other items that may be needed during the night on a bedside stand, within easy reach. Install smoke detectors on all home levels; keep a fire extinguisher in home; learn how to use it properly. Plan a fire emergency escape route, and practice leaving your home by that route to avoid unnecessary loss of time and unnecessary stress should a real fire emergency occur. If use of oxygen is necessary in the home, be sure you are instructed as to what to do during an emergency situation.
POST FIRE AND OTHER EMERGENCY NUMBERS ON OR BY THE TELEPHONE

HOME SAFETY AND EMERGENCY EXIT PLAN

RECOMMENDATIONS: In case of fire, do you have an emergency exit plan and an alternate exit plan?

* Once a fire starts, it spreads quickly and there may be a great deal of confusion, it is important for everyone to know what to do.
* Develop an emergency exit plan *Choose a meeting place outside your home to be sure everyone has exited safely. * Practice the plan to ensure that everyone can escape quickly and safely. **ALL HOME AREAS:** Check all areas of your home for any frayed cords, check all electrical and telephone cords; remove rugs, runners and mats which can cause falls. Check all smoke detectors, electrical outlets and switches to ensure they are in good working condition. Practice your emergency exit plan with all members of your household. **RECOMMENDATIONS**: * Arrange furniture so that outlets are near lamps & appliances. * Minimize the use of extension cords. If used, extension cords/telephone cords should always be placed on floor against wall to avoid tripping over them. Furniture resting on cords, nails and staples can cause damage and create fire and shock hazards. Electric cords which run under carpeting may cause a fire. Remove cords, nails and staples from under furniture and carpeting, check for damaged wiring. Use tape to attach cords to walls/floors. * If an extension cord is needed, use one having sufficient amp or wattage rating.
* If the rating on a cord is exceeded because of the power requirements of one/more appliances being used on the cord, change cord to higher rated one or unplug some appliances. *DO NOT USE FRAYED CORDS!* **BEDROOM AREAS:**
RECOMMENDATIONS: Are lamps/switches within reach of each bed? * Lamps/switches should be located close to people during periods of darkness to see where they are going. * Rearrange furniture so that lamps/switches are closer to beds * Install night lights. Are cigarettes, ashtrays, and lighters located away from beds/bedding? * Burns are a leading cause of death, smoking in bed is a major potential fire source (hot plates, teapots, etc. are major contributors to this problem).
*Never smoke in bed. * Remove any possible source of heat/flames from areas around beds.
SMOKE DETECTORS QUESTIONS Are smoke detectors properly located? **RECOMMENDATIONS:** There should be a smoke detector located on every floor of your home. Follow manufacturer's instructions/advice for the best place to install your device. Place detectors near ceiling or 6-12 inches below ceiling on the wall. Smoke detectors should be placed away from air vents. Fire injuries and deaths are often caused by smoke and toxic gases, rather than by the fire itself. Smoke detectors provide early warning in the event of a fire. If you are unable to purchase a fire detector, some fire departments and/or local governments will provide assistance in acquiring and installing smoke detectors. Purchase a smoke detector if you do not have one, or call your local fire department for further information. Check and replace batteries and bulbs as directed by manufacturer. Replace any detector that can not be repaired. Vacuum the grillwork of your smoke detector.

NOTICE OF PRIVACY PRACTICES (HIPAA)

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

Our Organization is providing this Notice of Privacy Practices because the privacy of your health information is very important to you and to us, and in compliance with federal regulations. By "your health information" we mean the information that we maintain that specifically identifies you and your health status.

Your Rights: You have the right to: Get a copy of your paper or electronic medical record, Correct your paper or electronic medical record, Request confidential communication, Ask us to limit the information we share, Get a list of those with whom we've shared your information, Get a copy of this privacy notice, Choose someone to act for you, File a complaint if you believe your privacy rights have been violated

Your Choices: You have some choices in the way that we use and share information as we: Tell family and friends about your condition, Provide disaster relief, Include you in a hospital directory, Provide mental health care, Market our services and sell your information, a Raise funds.

Our Uses and Disclosures: We may use and share your information as we: Treat you, Run our organization, Bill for your services, Help with public health and safety issues, Do research, Comply with the law Respond to organ and tissue donation requests, Work with a medical examiner or funeral director, Address workers' compensation, law enforcement, and other government requests, Respond to lawsuits and legal actions.

Your Rights: When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record: You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record: You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may deny your request, but we'll notify you why in writing within 60 days.

Request confidential communications: You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will agree to all reasonable requests.

Ask us to limit what we use or share: You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may disagree if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will agree unless a law requires us to share that information.

Get a list of those with whom we've shared information: You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice: You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you: If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated: You can complain if you feel we have violated your rights by contacting us.

You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.**

Your Choices: For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to: Share information with your family, close friends, or others involved in your care, Share information in a disaster relief situation. Include your information in a hospital/Organization directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission: Marketing purposes, Sale of your information, Most sharing of psychotherapy notes. In the case of fundraising: We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures: How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you: We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization: We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*

Bill for your services: We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?: We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.

NOTICE OF PRIVACY PRACTICES (HIPAA) *(continuation)*

Help with public health and safety issues: We can share health information about you for certain situations such as: Preventing disease, Helping with product recalls, Reporting adverse reactions to medications, Reporting suspected abuse, neglect, or domestic violence, and preventing or reducing a serious threat to anyone's health or safety.
Do research: We can use or share your information for health research.
Comply with the law: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests: We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director: We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests: We can use or share health information about you: For workers' compensation claims, For law enforcement purposes or with a law enforcement official, With health oversight agencies for activities authorized by law, For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions: We can share health information about you in response to a court or administrative order, or in response to a subpoena.
Our Responsibilities: We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.
Changes to the Terms of this Notice: We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you. Notice Effective Date: 03/26/2013

HOSPITALIZATION RISK MANAGEMENT

Our Organization is in a position to respond to patient and family needs by implementing strategies targeted to reduce avoidable hospitalizations. Our Organization can identify patients who are at higher risk of hospitalization. Our field staff can partner with these patients to implement strategies, which reduce risk. Patients partnering with our field staff can learn to manage their own health. Our experience shows that when we partner with patients and physicians, acute care hospitalizations can be reduced. Specific interventions are implemented for those patients rated as high-risk to reduce the potential of unplanned hospitalization. A dialogue with the patient and family is necessary to determine their wishes, goals and desires to be met by the interdisciplinary team. The team's responsibility is to commit to achieving the patient's stated goals.
It is the responsibility of our home care nurse to accurately complete the hospitalization risk assessment in a timely manner (as needed) and to then communicate the high-risk status of patients to appropriate managers, other disciplines, and oncall staff. Our home care nurse is also responsible for the selection of appropriate individualized interventions that may be used to assist in reducing avoidable acute care hospitalizations. Examples of interventions that an Organization may offer include: Patient emergency planning, Medication management, Front-loading visits, Phone monitoring, Telemonitoring, Teletriage, Fall prevention, Immunization, Patient self-management, Disease/case management. Our nurses are able to correctly, effectively, and efficiently communicate his/her risk assessment findings to physicians to obtain necessary orders.

UNDERSTAND YOUR DOCTOR AND OTHER CAREGIVERS

It can be difficult to understand what your doctors and other caregivers are telling you about your care and treatment. This section has questions and answers to help you understand caregivers.
Questions to ask your caregivers: ■ Is there someone who can help you understand your doctor, nurse, and other caregivers? ■ Is there someone who can help you understand how to take your medicine? ■ Is there any written information in your language? ■ Is there any written information in your language that is easy to read? ■ Is there someone who speaks your language who can help you talk to caregivers? ■ Is there a support group for people like you? For people with your illness or condition? ■ Are there other resources for you?
What can you do if you don't understand what your caregiver is saying? Tell them you don't understand. Use body language. If you don't understand shake your head to show that "No, I don't understand." Ask lots of questions. By asking questions you're helping them understand what you need.
What can you do if they explain and you still don't understand? Tell them you still don't understand. Try to be as clear as possible about what you do not understand. Caregivers have a duty to help you understand. They should not leave until you understand what to do and what is happening to you.
What if the caregiver is rushed and doesn't have time to answer your questions? Ask them if you can schedule another appointment when they can answer your questions.
What can you do if you speak another language? Ask for someone who speaks your language. This person can help you talk to caregivers. This person should work for the Organization. Their job is to help people who speak other languages. This person may not be in the office. He or she may be on the telephone. You have the right to get free help from someone who speaks your language. Ask if there is paper work in your language.
What can you do if you have trouble reading? Or if you cannot read? Don't be embarrassed. Tell your caregivers. They can help you. They can explain paper work to you. They may even have paper work that is easy to read and understand.
Your doctor's instructions are not clear. Should you try to figure it out yourself? No. Instructions from your doctor or others are important. Tell them what you think the instructions are. Tell them if they need to write down the instructions. Tell them if you have a family member or friend who helps you take your medicine. Ask the doctor to have someone talk to your family member or friend, too.
What if you don't understand written instructions? Tell your caregivers. Tell them that you need to have the instructions read to you. Tell them you need instructions that are easy to read. Or that you need instructions in your language.

NEW HOPE CASE MANAGEMENT SERVICES, INC.

GRIEVANCE PROCEDURES

1. Any person, who believes he or she has been subjected to discrimination, or otherwise denied equitable and fair treatment, may file a grievance under these procedures. The Organization will not retaliate against anyone solely for filing a grievance or cooperation in the investigation of a grievance.

2. Grievances must be submitted to the Organization within thirty (30) days of the date the person filing the grievance becomes aware of the action.

3. A complaint should be in writing/phone, containing the name and address of the person filing it. The complaint must state the problem or action alleged to have occurred and the remedy or relief sought by the grievant.

4. The Director of Nursing or Administrator shall conduct an investigation of the complaint to determine its validity. This investigation may be informal, but it has to be thorough, affording all interested persons the ability to submit evidence relevant to the complaint

5. The Director of Nursing will maintain the files and records of the Organization relating to such grievance.

6. The Director of Nursing will issue a written decision on the grievance no later than thirty (30) days after its filing.

7. The grievant may appeal the decision of the Director of Nursing by filing an appeal in writing to the Administrator of the Home Health Organization within fifteen (15) days of receiving the Director of Nursing's decision.

8. The Administrator shall issue a written decision in response to the appeal no later than thirty (30) days after filing.

9. The availability and use of the grievance procedure does not preclude a person pursuing other remedies accorded by local, State and Federal laws and regulations.