Address: 3451 E Copper point dr.
Meridian, ID 83642

Website: http://www.inclusionidaho.com

SERVICE APPLICATION-INTAKE PACKET

Revised: 5/26/17

INCLUSION
APPLICATION FOR SERVICES

1. GENERAL INFORMATION

APPLICANT FULL NAME: _____

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

PHYSICAL ADDRESS: _____

MAILING ADDRESS: _____

HOME TELEPHONE: _____ **WORK TELEPHONE**: _____

CELLULAR TELEPHONE: _____ **GENDER**: ☐ MALE ☐ FEMALE

SOCIAL SECURITY NUMBER: _____ **Age**: _____

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

GUARDIAN FULL NAME: ☐ SELF ☐ OTHER: _____

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

Name: _____

Address: _____
Street City State Zip

Responsible Person(s) Contact Information:

Name: _____

Address: _____
Street City State Zip

Applicant's Children: ☐ See below ☐ Not Applicable

Name: _____ Name: _____

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

Name: _____ Name: _____

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

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Applicants Sibling(s): ☐ See below ☐ Not Applicable

Name: _____ Name: _____

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

Name: _____ Name: _____

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

In Case of Emergency, Please Notify:

Primary Contact:

Name: _____ Relationship: _____

Address: _____
Street City State Zip

Telephone: _____ Secondary Telephone: _____

Secondary Contact:

Name: _____ Relationship: _____

Address: _____
Street City State Zip

Telephone: _____ Secondary Telephone: _____

INCLUSION
APPLICATION FOR SERVICES

2. Necessary Documentation

Please attach copies of the following documentation to service application:

☐ Initial intake packet filled out completely (including the rep payee page at the back if they choose to use Inclusion)

☐ Guardianship papers (if applicable)

☐ Participants ID and copy of social security card

☐ Copies of Medicaid and/or medicare cards

☐ Copy of any other insurance cards

☐ Psych eval

☐ Any other behavioral health documents

☐ History and physical

☐ Any other evaluations or medical assessments

☐ Med/Soc and SIBR

☐ Any programmatic documentation from previous placements

☐ Police records

☐ court records (if applicable)

☐ Probation/Parole documentation (if applicable)

INCLUSION
APPLICATION FOR SERVICES

3. Social History

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

Primary DX: _____

Secondary DX: _____

Current Living Arrangement:

☐ Family Residence	☐Institution or ICF-MR	☐Supported Living Arrangement
☐ Group Home	☐PCS Home	☐Foster Home
☐ Correction Facility	☐Nursing Home	☐Assisted Living
☐ Other:		

Marital Status: ☐Married ☐ Single ☐ Divorced ☐ Separated
☐Widowed ☐ Engaged ☐ Annulled ☐ Cohabitating

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

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

_____
_____
_____
_____

Are you currently on probation or parole? ☐ Yes ☐ No
If yes please explain: _____
_____
_____
_____

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

☐Depression ☐Stress/Anxiety ☐Drug-Alcohol ☐Employment-Career

☐Health issues ☐Sleep issues ☐Eating-diet ☐Interpersonal relationships

☐Family issues ☐Victimization ☐Sexual behaviors ☐Thoughts of harm to self

☐Thoughts of harm to others ☐Financial issues ☐OCD/compulsive disorders

☐Functional skill deficits/needs ☐Behavioral deficits/needs

☐Community access/Inclusion ☐Other (please specify):_____

4. Service History:

Have you received services from Inclusion Inc.. at any time in the past? ☐ Yes ☐ No
If so, please provide dates of service: _____
If so, please provide reason for initial discharge or termination of services:

_____
_____
_____

Have you received services from a different Supported Living-Residential Habilitation Agency; Developmental DisAbilities Agency; or CSE provider in the past?
☐ Yes ☐ No
If yes, please provide name of provider: _____

5. Service Needs:

Services Requested

What specific services are you requesting fromInclusion Inc..?

If you require information or definitions related to service(s) listed below,Inclusion Inc.. personnel can assist you in determining what services may meet the needs you express during the intake process:

☐ Residential Habilitation (Supported Living Model; Intense; HIGH; hourly)

☐ Community Supported Employment (CSE)

☐ Nursing Services

☐ Pharmacological Management via Psychiatrist (Dr. Banta)

Goals

Please list any goals, desires, or outcomes you'd like to achieve within the program you are requesting services from?

_____
_____
_____
_____
_____
_____
_____
_____

If you have additional service requests, please let them below:

_____
_____
_____
_____
_____
_____

6. MEDICAL HISTORY

Medication	Dosage	Frequency/Time	AM/PM	Purpose
_____	_____	_____	**AM/PM**	_____
_____	_____	_____	**AM/PM**	_____
_____	_____	_____	**AM/PM**	_____
_____	_____	_____	**AM/PM**	_____
_____	_____	_____	**AM/PM**	_____
_____	_____	_____	**AM/PM**	_____
_____	_____	_____	**AM/PM**	_____
_____	_____	_____	**AM/PM**	_____
_____	_____	_____	**AM/PM**	_____
_____	_____	_____	**AM/PM**	_____

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

☐ Yes ☐ No

If so, what type?

☐Absence ☐Tonic clonic ☐Petite Mal ☐Complex partial ☐unknown
☐Clonic ☐Myoclonic ☐Grand Mal ☐atypical absence
☐Focal motor ☐Atonic ☐Simple partial ☐Secondary generalized

How frequent does the applicant experience seizure activity? _____

Date of most recent seizure activity? _____

Are seizures currently controlled by medication(s)? _____

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

_____
_____

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Please list any known allergies? _____

_____

Please list any recurring illnesses; or, injuries: _____

_____

Does the applicant require any specialized diet? _____

_____

Does the applicant require any specialized treatments? _____

_____

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APPLICATION FOR SERVICES

PROFESSIONAL-MEDICAL CONTACT INFORMATION:

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

Address: _____(Fax): _____

Name of Medication manager (if relevant): _____(Tel): _____

Address: _____(Fax): _____

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

Address: _____(Fax): _____

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

Address: _____(Fax): _____

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

Address: _____(Fax): _____

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

Address: _____(Fax): _____

Name of Dentist: _____(Tel): _____

Address: _____(Fax): _____

Name of Eye doctor: _____(Tel): _____

Address: _____(Fax): _____

Name of Other Specialist: _____(Tel): _____

Address: _____(Fax): _____

Name of Other Specialist: _____(Tel): _____

Address: _____(Fax): _____

Name of Other Specialist: _____(Tel): _____

Address: _____(Fax): _____

INCLUSION
APPLICATION FOR SERVICES

(RES HAB ONLY)

Representative Payee Support Program Availability and Choice

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

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

Explanation of Representative Payee Support Program:

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

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

Required Duties of a Representative Payee:

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

A Representative Payee cannot:

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

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APPLICATION FOR SERVICES

Reporting Responsibilities of the Representative Payee:

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

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

Additional events that you must report for SSI beneficiaries:

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

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

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

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

_____ _____

Signature of Participant, legal guardian, or authorized rep. Date

_____ _____

Inclusion Representative Date

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Informed Consent related to related to choice of accessingInclusion Inc.. as the Representative Payee:

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

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

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

_____ _____

Participant Signature — Date (Month-Date-Year)
Parent, Legal Guardian or Legally Authorized Representative

_____ _____

Inclusion Inc.. Representative — Date (Month-Date-Year)

INCLUSION
APPLICATION FOR SERVICES

Privacy Consent

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

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

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

1. Medical emergencies that require information only for handling the emergency.

2. Potential harm, danger, or threat of death to one's self or another person which require the police and/or intended victims to be notified.

3. Disclosure of abuse or neglect of a child, an aged person, or other vulnerable persons.

4. Records subpoenaed by the court.

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

_____ _____

Participant Signature — Date (Month-Date-Year)
Parent, Legal Guardian or Legally Authorized Representative

_____ _____

Inclusion Inc.. Representative — Date (Month-Date-Year)

INCLUSION
APPLICATION FOR SERVICES

SERVICES TO BE RECEIVED – EXPECTED BENEFITS AND ATTENDANT RISKS

Responsibility of the agency:

It is the responsibility of Inclusion to inform each participant and/or Legal guardian of the services to be received; as well as the expected benefits and risks of those services. This information must be provided by Inclusion with a written explanation of those risks and benefits which are associated with the services and treatment provided by the agency. The provision of the document must be maintained in the participant record.

Inclusion understands our personnel have a responsibility to our participants to explain the nature of all services provided via Inclusion. Inclusion will make every effort to inform participants about the purposes, goals, techniques, procedures, limitations, potential risks, and benefits of the services provided.

Confidentiality:

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

Inclusion defines the risks and benefits associated with our core services as follows:

Risks:

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

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

- Risks include, but may not be limited to:
- Risk of injury – Participants are often transported to and from appointments, community-based activities/settings, etc. – risk of injury in traffic-related accident(s) are possible. Other forms of injury may occur, which cannot be specified or predicted in advance.
- Loss of functional skill

- Increase in maladaptive behaviors
- Loss of meaningful relationships based on employee turnover; changes in environments; etc.

Benefits:

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

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

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

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

Participant/Guardian signature	Date
Inclusion Inc.. Representative	Date (Month-Date-Year)

INCLUSION

APPLICATION FOR SERVICES

Residential Habilitation Services

Service Information

(Medicaid Provider Agreement A-5.2)

Residential Habilitation is an intensive treatment program designed to provide adequate support to maintain community living placements for participants meeting ICF/MR level of care. Our goal, as a rehab treatment provider is to facilitate progress among our clients.

The agency's objective is to enable individuals with developmental disabilities to live rather than merely exist. The agency encourages its clients to be active participants rather than passive observers, to take risks, to learn from failures as well as successes, and to take pride and joy in their accomplishments

Emphasis:

1. Personal Development – It helps clients identify their natural abilities and interests through exposure to a variety of functional, behavioral, social, and recreational activities and programs. By broadening their horizons, participants have choices. Once interests/abilities are identified, the agency builds on them by implementing individual training programs.
2. Interpersonal Relationships – The agency recognizes the importance of social contact in every person's life. To that end, the agency encourages frequent contact with participants' biological families, as well as community members. The agency emphasizes the "team approach" between participants and staff and emphasizes the focus of participants in their homes. The agency also encourages relationships between participants, and it facilitates opportunities for them to meet with other people, both with and without developmental disabilities.

Principles:

1. Utilization of full human capacity.
2. Equipping people with skills (social, vocational, interpersonal and others).
3. People have the right and responsibility for self-determination
4. Services should be provided in as normalized environment as possible.
5. Differential needs and care.
6. Commitment from staff members.
7. Care is provided in an intimate environment without professional, authoritative shield and barriers.
8. Generalization.
9. No limits on participation.
10. There is an emphasis on a social, rehabilitative, and a medical model of care.
11. Emphasis is on the participant's strengths rather than on pathologies.
12. Emphasis is on the here and now rather than on problems from the past.
13. Flexibility of structure and service models.
14. Non-obligatory participation.
15. Support for mobility and choice of service options.
16. Active participant involvement in services.
17. Support for participant decision-making.
18. Concentration on quality of relationships and interactions between participants and staff.
19. Encouragement of peer support.
20. Responsiveness to participants' needs.
21. Utilization of a broad range of skills.
22. Active community education.
23. Active advocacy.
24. Cost-effectiveness: both operational and preventative.

Residential Habilitation: Residential habilitation services consist of an integrated array of individually-tailored

services and supports furnished to eligible participants which are designed to assist them to reside successfully in their own homes, with their families, or alternate family homes. The services and supports that may be furnished consist of the following:

a. Habilitation services aimed at assisting the individual to acquire, retain or improve his ability to reside as independently as possible in the community or maintain family unity. Habilitation services include training in one (1) or more of the following areas:
   - Self-direction, including the identification of and response to dangerous or threatening situations, making decisions and choices affecting the individual's life, and initiating changes in living arrangements or life activities;
   - Money management including training or assistance in handling personal finances, making purchases, and meeting personal financial obligations;
   - Daily living skills including training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hygiene, self-administration of medications, and other areas of daily living including proper use of adaptive and assistive devices, appliances, home safety, first aid, and emergency procedures;
   - Socialization including training or assistance in participation in general community activities and establishing relationships with peers with an emphasis on connecting the participant to his community. (Socialization training associated with participation in community activities includes assisting the participant to identify activities of interest, working out arrangements to participate in such activities and identifying specific training activities necessary to assist the participant to continue to participate in such activities on an on-going basis. Socialization training does not include participation in non-therapeutic activities which are merely diversional or recreational in nature);
   - Mobility, including training or assistance aimed at enhancing movement within the person's living arrangement, mastering the use of adaptive aids and equipment, accessing and using public transportation, independent travel, or movement within the community;
   - Behavior shaping and management includes training and assistance in appropriate expressions of emotions or desires, assertiveness, acquisition of socially appropriate behaviors; or extension of therapeutic services, which consist of reinforcing physical, occupational, speech and other therapeutic programs.

b. Personal Assistance Services necessary to assist the individual in daily living activities, household tasks, and such other routine activities as the participant or the participant's primary caregiver(s) are unable to accomplish on his own behalf.

c. Skills training to teach waiver participants, family members, alternative family caregiver(s), or a participant's roommate or neighbor to perform activities with greater independence and to carry out or reinforce Skills training is provided to encourage and accelerate development in independent daily living skills, self-direction, money management, socialization, mobility and other therapeutic programs.

By signing this form I verify that I have read, understood, received an explanation of the information listed above and provided copies of each. I verify that service information has been provided pertaining to residential habilitation services. This was done pursuant to relevant language in IDAPA Code and the Medicaid Provider Agreement.

_____ _____

Participant/Guardian Date

INCLUSION

APPLICATION FOR SERVICES

Residential Habilitation Services

Information Pertaining to Risk

(Medicaid Provider Agreement A-5.2)

Residential Habilitation is an intensive service designed to reduce the risk of institutionalization. Our goal, as a reshab treatment provider is to facilitate enough progress among our clients that we are no longer needed or services can be reduced.

Risks

Risks associate with services include, but are not limited to the following items. Remember, all services provided must be clinically appropriate in content, service location and duration.

- There are economic and interpersonal risks associated with obtaining your own residence.
- There are economic and interpersonal risks associated with residing with a roommate or care provider.
- There are functional, economic, behavioral, and medical risks associated with receiving services in the home or community.
- There are functional, interpersonal, behavioral, and medical risks associated with allowing a staff or care provider deliver services.
- There are functional, interpersonal, behavioral, and medical risks associated with having neighbors.
- There is a risk associated with transportation.
- Working with various therapists could be a source of frustration.
- Therapy is hard, but worth it!
- You might get worse before you get better.
- Our agency is here to support you, but hold you accountable to the goals you've helped develop.
- There are functional, interpersonal, behavioral, and medical risks associated with interacting with others in the community.
- There are functional, interpersonal, behavioral, and medical risks associated with developing new strengths and interests while addressing deficits.
- There are individualized risks unique to you.

We believe that assuming some of these risks will enable you to make the most progress in the shortest amount of time. We are committed to supporting to minimize the risk to you as you received services. Please actively participate with us in managing the risks. Remember, you are part of a team and we're all striving for the same goal!

By signing this form I verify that I have read, understood, received an explanation of the information listed above and provided copies of each and understand some of the risks associated with the services. I also agree that the risks associated with services are not limited to those identified in this document or in conversation with representatives of the agency.

_____ _____

Participant/Guardian Date

INCLUSION

APPLICATION FOR SERVICES

Residential Habilitation Services

Alternate Forms of Services Available

(Medicaid Provider Agreement A-5.2)

Residential Habilitation is an intensive treatment program designed to provide adequate support to maintain community living placements for participants meeting ICF/MR level of care. Our goal, as a rehab treatment provider is to facilitate progress among our clients.

We encourage, and will help you cultivate all of the supports you need to be successful and accomplish your goals. We will actively pursue unpaid service options to promote optimum independence.

The following service information pertains to DD Waiver Services available to participants who meet ICF/MR eligibility. The services may or not be available to participants through the agency. The procurement of needed services not available through the agency will be discussed with the service coordinator.

1. **Residential Habilitation**
2. **Chore Services**
3. **Respite**
4. **Supported Employment**
5. **Transportation**
6. **Environmental Accessibility Adaptations**
7. **Specialized Equipment and Supplies**
8. **Personal Emergency Response System**
9. **Home Delivered Meals**
10. **Skilled Nursing**
11. **Behavior Consultation/Crisis Management**
12. **Adult Day Care**
13. **Self-Directed Community Supports**

By signing this form I verify that I have read, understood, received an explanation of the information listed above, provided copies of each and understand the alternate forms of services and supports available to me. This was done pursuant to relevant language in IDAPA Code, the Medicaid Provider Agreement, and credentialing standards.

_____ _____

Participant/Guardian Date

INCLUSION
APPLICATION FOR SERVICES

REFUSAL OF SERVICES

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

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

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

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

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

_____ _____

Participant Signature
Parent, Legal Guardian or Foster Parent

Date (Month-Date-Year)

_____ _____

Inclusion Inc.. Representative

Date (Month-Date-Year)

INCLUSION
APPLICATION FOR SERVICES

CHOICE OF SERVICE PROVIDERS

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

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

CHOICE OF SERVICE PROVIDERS - DEVELOPMENTAL AND CULTURAL SENSITIVITY

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

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

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

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

_____ _____

Participant Signature
Parent, Legal Guardian or Foster Parent

Date (Month-Date-Year)

_____ _____

Inclusion Inc.. Representative

Date (Month-Date-Year)

INCLUSION
APPLICATION FOR SERVICES
Participant Rights and Informed Consent

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

THE RIGHT TO RECEIVE HUMANE CARE AND TREATMENT
You have the right to receive humane care and treatment while receiving services from Inclusion Inc..

THE RIGHT NOT TO BE PUT IN ISOLATION
You have the right not to be placed in isolation.

THE RIGHT TO BE FREE FROM MECHANICAL RESTRAINTS, UNLESS NECESSARY FOR THE SAFETY OF THAT PERSON OR FOR THE SAFETY OF OTHERS
You have the right to not be physically restrained you (hold you down or keep you from moving). If you are in danger of harming yourself or others law enforcement assistance will be sought.

THE RIGHT TO BE FREE FROM MENTAL, PHYSICAL, SEXUAL ABUSE, OR RETALIATORY BEHAVIOR
You have the right to not be abused. Retaliation for filing a grievance or making a complaint are prohibited.

THE RIGHT TO PRACTICE YOUR OWN RELIGION OR ABSTAIN FROM RELIGIOUS PRACTICE
INCLUSION INC.. will not interfere with your right to practice your religion and spiritual beliefs.

THE RIGHT TO WEAR YOUR OWN CLOTHING AND TO RETAIN AND USE PERSONAL POSSESSIONS
INCLUSION INC.. will not interfere with your choices to wear your own clothing and use your own personal possessions.

THE RIGHT TO BE INFORMED OF YOUR MEDICAL AND HABILITATIVE CONDITION AND SERVICES AVAILABLE VIAInclusion Inc..
You have the right to be involved in your individualized Individual Support Plan and control your health-related (medical and non-medical) services.

THE RIGHT TO REASONABLE ACCESS TO ALL RECORDS CONCERNING YOURSELF
You may request access to your records at any time. The request will be granted in a manner as timely as possible and in a way that is consistent with our HIPAA Notice of Privacy Practices.

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

THE RIGHT TO EXERCISE ALL CIVIL RIGHTS, UNLESS LIMITED BY PRIOR COURT ORDER
INCLUSION INC.. will not interfere with your right to exercise all other rights guaranteed to you under the Constitution of the United States, unless limited by a prior court order.

THE RIGHT TO PRIVACY AND CONFIDENTIALITY
The services that you receive at Inclusion Inc.. are confidential as defined in our HIPPA Notice of Privacy Practices. The staff of Inclusion Inc.. are trained to protect your privacy and confidentiality.

THE RIGHT TO BE TREATED IN A COURTEOUS MANNER

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

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

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

THE RIGHT TO ALL OTHER RIGHTS ESTABLISHED BY LAW

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

THE RIGHT TO BE PROTECTED FROM HARM

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

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

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

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

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

THE RIGHT TO REFUSE TO PERFORM SERVICES FOR THE AGENCY.

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

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

_____ _____

Participant Signature — Date (Month-Date-Year)
Parent, Legal Guardian or Foster Parent

_____ _____

Inclusion Inc.. Representative — Date (Month-Date-Year)

INCLUSION
APPLICATION FOR SERVICES

Residential Habilitation

Residential Habilitation

Participant Rights Information

(**16.04.17.300.09***)*

PARTICIPANT RIGHTS.

Each agency must develop and implement written policies that include a clear definition of personal, civil, and human rights. Upon initiation of services, the agency must provide each participant and guardian, if applicable, with written and verbal information outlining participant rights. This information must be in easily understood terms. The policy and procedure must include the following rights:

a. Humane care and treatment;

b. Not be put in isolation;

c. Be free of restraints, unless necessary for the safety of that person or for the safety of others;

d. Be free of mental and physical abuse;

e. Voice grievances and recommend changes in policies or services being offered;

f. Have the opportunity to participate in social, religious, and community activities of his choice;

g. Wear his own clothing and retain and use personal possessions;

h. Be informed of his habilitative condition, services available at the agency;

i. Reasonable access to all records concerning himself;

j. Choose or refuse services;

k. Exercise all civil rights, unless limited by prior court order;

l. Privacy and confidentiality;

m. Receive courteous treatment;

n. Receive a response from the agency to any request made within (14) business days;

o. Receive services that enhance the participant's personal competencies and, whenever possible, promote inclusion in the community;

p. Refuse to perform services for the agency. If the participant is hired to perform services for the agency, the wage paid must be consistent with state and federal law;

q. Review the results of the most recent survey conducted by the Department and the accompanying plan of correction;

r. All other rights established by law;

s. Be protected from harm;

t. Choose one's roommate;

u. Reside in the environment or setting that is least restrictive of personal liberties in which appropriate treatment can be provided;

v. Communicate by sealed mail, telephone, or otherwise with persons inside or outside of their residence, to have access to reasonable amounts of letter writing material and postage and to have access to private areas to make telephone calls and receive visitors;

w. Receive visitors at all reasonable times and to associate freely with persons of his own choice;

x. Keep and be allowed to spend a reasonable sum of his own money for personal expenses and small purchases, and have access to individual storage space for his or her own use; and

y. Unless limited to prior court order, exercise all civil rights, including the right to dispose of property, execute instruments, make purchases, enter into contractual arrangements, and vote.

By signing this form I verify that I have read, understood, received an explanation of the information listed above and provided copies of each. This was done pursuant to relevant language in IDAPA Code and the Medicaid Provider Agreement.

_____ _____

Participant/Guardian signature Date

INCLUSION
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Inclusion Inc..

VERIFICATION OF RECEIPT OF Participant Rights Agreement (IDAPA 16.03.21.905.03.a and c)

I have read, reviewed, understood and received a copy of my rights and responsibilities as a participant receiving services fromInclusion Inc.. if necessary, these have been provided to the participant and/or guardian; representative verbally.

Participant Full Name (PRINT): _____

Participant/Guardian Signature: _____

AuthorizedInclusion Inc.. Representative: _____

Date: _____

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Participant Choice and Informed Consent

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

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

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

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

Inability to Provide Consent

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

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

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

_____ _____

Participant Signature
Parent, Legal Guardian or Foster Parent

Date (Month-Date-Year)

_____ _____

Inclusion Inc.. Representative

Date (Month-Date-Year)

INCLUSION
APPLICATION FOR SERVICES
Acknowledgement Receipt Form

Verification of Receipt of Participant's Rights Agreement (16.04.17.402 RH)

_____ I have read, understood, received a verbal explanation of, and received a copy of my rights as a participant receiving developmental services from the agency.

Verification of Receipt of Names, Addresses, Telephone Numbers of Protection and Advocacy Services (Medicaid Provider Agreement A-5.9)

_____ I have read, understood, received a verbal explanation of, and received a copy of the names, addresses, and advocacy services in my region from the agency.

Verification of Receipt of Alternate Service Available (Medicaid Provider Agreement A-5.2)

_____ I have read, understood, received a verbal explanation of, and received a copy of the agency's grievance procedure.

Verification of Receipt of Information on Risks (Medicaid Provider Agreement A-5.2)

_____ I have read, understood, received a verbal explanation of, and received a copy of the agency's grievance procedure.

Verification of Receipt of Service Information (Medicaid Provider Agreement A-5.2)

_____ I have read, understood, received a verbal explanation of, and received a copy of the agency's grievance procedure.

By signing this form I acknowledge that I have read, understood, received an explanation of the information listed above and provided copies of each. This was done pursuant to relevant language in IDAPA Code.

_____ _____

Participant/Guardian Date

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HIPAA Notice of Privacy Practices

Information and Consent Form

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

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

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

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

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

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

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

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

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

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

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

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

YOUR RIGHTS AS RELATED TO HIPAA

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

YOU HAVE THE RIGHT TO INSPECT AND COPY YOUR PHI IN A DESIGNATED RECORD SET.
For certain reasons we may deny access to certain records under specific circumstances. Under certain circumstances you may ask that the decision to deny be reviewed by another health care provider.

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

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

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

YOU HAVE THE RIGHT TO REQUESTInclusion Inc.. AMEND YOUR PHI.
If we deny your request for amendment, you have the right to file a statement or written disagreement withInclusion Inc.. Inclusion Inc.. may prepare a rebuttal to your statement and will provide you a copy of any such rebuttal.

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

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

COMPLAINTS.
If you believe your privacy rights have been violated, you have the right to file a complaint with our office at:
3451 e copper point dr
Meridian, Id 83642

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

HIPAA Violation and Participant Complaint Process:

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

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

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

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

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

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

_____ _____

Participant Signature
Parent, Legal Guardian or Foster Parent

Date (Month-Date-Year)

_____ _____

Inclusion Inc.. Representative

Date (Month-Date-Year)

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Inclusion Inc.

Grievance Procedure (IDAPA 16.03.21.905.03.a; 16.03.21.101.02.q; and, IDAPA 05.01.05.244.01-02)

In accordance with Inclusion Inc.'s Participant Rights Statement, participants and their families are offered the opportunity to exercise their rights. The right to file a grievance is outlined below:

- If any individual or their guardian, representative, advocate is dissatisfied with services or treatment provided by Inclusion Inc.., these concerns should be expressed.
- The **OPERATIONS DIRECTOR** is to be notified immediately by telephone at **208.888.1758**; or, in writing at **3451 E. Copper Point Drive, Meridian, Idaho 83642**. The **OPERATIONS DIRECTOR** will respond by telephone and/or in writing to the grievance. If satisfactory resolution cannot be found, the **OPERATIONS DIRECTOR** will assist the individual, their guardian, advocate or representative to find other appropriate services, if necessary.
- If the Direct Care staff person is notified of a concern, they will be responsible to notify the **OPERATIONS DIRECTOR** and alert the individual, their guardian, advocate or representative they have completed this action.
- If you do not receive response, The Protection/Advocacy Agency, Disability Rights of Idaho can be reached at the following:

  Telephone: 1-866-262-3462 (toll-free)

  Email: info@disabilityrightsidaho.org

  Boise Office:
  4477 Emerald Street, Suite B-100
  Boise, Idaho 83706
  208-336-5353
  208-336-5396 (fax)
  800-632-5125 (toll-free)

  Pocatello Office:
  845 West Center Street, C-107
  Pocatello, Idaho 83204
  208-232-0922
  208-232-0938 (fax)
  866-309-1589 (toll-free)

  Moscow Office:
  200 S. Almon
  Moscow, Idaho 83204
  208-882-0962
  208-883-4241 (fax)
  877-654-2178 (toll-free)

Participant Full Name (PRINT): _____

Participant/Guardian Signature: _____

Authorized Inclusion Inc.. Representative: _____

Inclusion Inc..

VERIFICATION OF RECEIPT OF Grievance Procedure

(IDAPA 16.03.21.905.03.a; 16.03.21.101.02.q; and, IDAPA 05.01.05.244.01-02)

I have read, reviewed, understood and received a copy of Inclusion Inc.'s Grievance Procedure; if necessary, these have been provided to the participant and/or guardian; representative verbally.

Participant Full Name (PRINT): _____

Participant/Guardian Signature: _____

Authorized Inclusion Inc.. Representative: _____

Date: _____

Protection and Advocacy Information-Region 3 and 4

Residential Habilitation

Protection and Advocacy Information
(*Medicaid Provider Agreement A-5.9)*

In accordance with the method of informing participants of their rights described in the Medicaid Provider Agreement, the agency provides participants and their family's information pertaining to protection and advocacy services.

REGIONAL OFFICES

Regional Medicaid Services reg. 4
1720 Westgate Drive
Boise, Idaho 83704
208-334-0940

Regional Medicaid Services reg. 3
3402 Franklin Rd.
Caldwell, ID 83605
208-455-7150

ADULT PROTECTION

Adult protection services
125 E 50th st
Boise, ID 83714
208-489-6909

DISABILITY RIGHTS OFFICES

Disability Rights Idaho
Corporate Office (Boise):
4477 Emerald Street, Suite B-100
Boise, Idaho 83706
208-336-5353 (TDD/Voice)
208-336-5396 (fax)
800-632-5125 (toll-free)
www.disabilityrightsidaho.org

Disability Rights Idaho
Pocatello Office:
1246 Yellowstone Avenue, Suite A-3
Pocatello, Idaho 83201-4374
208-232-0922
208-232-0938 (fax)
866-309-1589 (toll-free)
www.disabilityrightsidaho.org

Participant/Guardian _____ Date _____

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VERIFICATION OF RECEIPT OF

Names, Addresses, Telephone Numbers of Protection and Advocacy Services (16.03.21.905.03.a)

I have read, reviewed, understood and received a copy of the Names, Addresses, and Advocacy services in my Region from Inclusion Inc.. if necessary, these have been provided to the participant and/or guardian; representative verbally.

Participant Full Name (PRINT): _____

Participant/Guardian Signature: _____

Authorized Inclusion Inc.. Representative: _____

Date: _____

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Inclusion Inc..
3451 E Copper Point Dr
Meridian, ID 83642
Phone: 208-888-1758 Fax: 208-888-5520

Release of Records Exchange
REQUEST FOR AND AUTHORIZATION TO RELEASE RECORDS OR HEALTH INFORMATION

By my signature below, I _____, authorize Inclusion Inc. to release; and/or, obtain personal health information (written-verbal) to/from:

Provider Name: _____

Address: _____

Telephone: _____

Facsimile: _____

And have access to; or, release the following records: _____

- ☐ Current or Historical Medical Information and/or Medical Records
- ☐ Evaluation, Assessment, or Diagnostic Reports or Documentation
- ☐ Treatment Plan(s); or, Update, Addenda to Treatment Plan(s)
- ☐ Individual Support Plan; or, Addenda
- ☐ IEP or school-related reports
- ☐ Progress Notations
- ☐ Programmatic Documentation
- ☐ Nursing Documentation
- ☐ Other (please specify): _____

For the purpose(s) OR need: _____

For (Participants full name) _____ (DOB; _____)

AUTHORIZATION STATEMENT:

I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by Inclusion, Inc. Re-disclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, this written authorization will have an expiration date of one (1) calendar year from the authorized signature below.

Inclusion Inc.. may only use or disclose your personal health information for purposes as required by law or regulations and will continue to protect your personally identifiable health information as described in the Informed Consent form(s) provided.

With my signature below, I understand what this document states and authorize release of my personal health information as stated above. I understand I will be given a signed copy of this Authorization for my records, if requested.

_____ _____
Participant Signature (if applicable) Month/Date/Year

_____
Print Participant Name

_____ _____
Signature of Legally Authorized Representative or Guardian (if applicable) Month/Date/Year

_____
Print Legally Authorized Representative Name

_____ _____
Representative, Inclusion Inc.. Month/Date/Year

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ADDITIONAL INFORMATION REGARDING DISCLOSURE OF PARTICIPANT-CLIENT MEDICAL OR HEALTH-RELATED INFORMATION

INCLUSION INC.. honors a participant's right to confidentiality of medical or health-related information as provided under federal and state law. Please read the following guidelines before signing this authorization.

No Obligation to Sign. You are under no obligation to sign this form, and you may refuse to do so. Except as permitted under applicable law, INCLUSION may not refuse to provide you treatment or other health care services if you refuse to sign this form.

Revocation. You have the right to revoke this authorization, in writing, at any time before it expires. However, your written revocation will not affect any disclosures of your medical information that the person(s) and/or organization(s) listed on the reverse side of this form have already made, in reliance on this authorization, before the time you revoke it. In addition, if this authorization was obtained for the purpose of insurance coverage, your revocation may not be effective in certain circumstances where the insurer is contesting a claim. Your revocation must be made in writing and addressed to:

Inclusion Inc..
3451 E. Copper Point Drive, Meridian, ID 83642

Re-release. If the person(s) and/or organization(s) authorized by this form to receive your medical information are not health care providers or other people who are subject to federal health privacy laws, the medical information they receive may lose its protection under federal health privacy laws, and those people may be permitted to re-release your medical information without your prior permission.

Right to Inspect. You have the right to inspect or copy the medical information whose disclosure you are authorizing, with certain exceptions provided under state and federal law. If you would like to inspect your records, contact INCLUSION for further information.

Signatures. Generally, if you are 18 years of age or older, you are the only person who is permitted to sign a form to authorize the disclosure of your medical information. If you are under the age of 18, your parent or guardian must sign this form for you. However, there are many situations in which this general rule does not apply. For more information regarding who is authorized to sign this form, contact INCLUSION representatives.

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Remove this page and attach the new Heartland/Reliant agreement, the rep payee signature form, the functional assessment and the separate rights packet.