JEREMY'S PLACE, INC.
4910 Jonesboro Road Bldg 200 Ste. 201 Union City, Ga 30291
770.969.9334 OFFICE | 770.969.9337 FAX

INTAKE APPLICATION

JEREMY'S PLACE, INC.

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INTAKE CHECK LIST

	Photo ID		Clinical Assessment
	Copy of Medicaid Card		Current Physical
	Guardianship Documents		Current TB Test or Chest X-Ray
	Admission Agreement		Eye Exam Report
	Transportation Authorization		Dental Exam Report
	YOU HAVE RIGHTS		Copy of Prescriptions
	Rights & Responsibility		Medication Profile w/Representative's Signature
	8-RIGHT OF MEDICATION		AIMS Report
	Assessment of Rights		Preventive Health Acknowledgment
	Notice of Privacy Practice		Self-Assessment of Personal Outcomes
	Confidentiality		
	Advance Directive		
	Consent for Services		
	(ROI) Release of Information		
	Grievance & Complaint		
	Behavioral Assessment		

Your prompt response to provide Jeremy's Place, Inc with all of the above documentation. The above information is required within 30 days of admission. Failure to comply will result in suspension of services. If at any time, you have any questions and/or concerns please fill free to contact our office.

Thank you in advance for your prompt response and welcome.

laTeisha Brown

LaTeisha Brown, CEO

_____ _____

Signature of Acknowledgment Date

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1. Biographical Information	**Date of Entry:**
Name	S.S.#:
Address:	Medicaid#
	Medicare#:
Phone:	

Region:	Gender: ■M ☐F	Date of Birth:

Race/Ethnicity (Please Check ☑)	**Language**	**Religious Affiliation (Optional)**
☐Native American ☐Black/African American ☐Caucasian ☐Hispanic/Latino ☐Asian ☐Other:	☐**English** ☐Spanish ☐Sign Language ☐Unknown ☐Other:	☐Catholic ☐Baptist ☐Methodist ☐Jewish ☐Protestant ☐Other:

2. **DIAGNOSIS:**

Primary/Secondary Diagnosis:

TYPE OF WAIVER SERVICES:	**Waiver Rate:**
NOW/COMP Waiver Services/Support Provider	Contact Name/ Phone
Residential/In Home:	
Day Habilitation/School:	
Supportive or Regular Employment:	
SvcM. or SvcC.:	

*** Are you currently being served by Jeremy's Place, Inc: yes ☐no ☐Program:**
*** Has Jeremy's Place, Inc, provided service to you in the past? yes ☐no ☐Program:**

3. FINANCIAL

Income Sources:
1. _____
2. _____

Amounts by Month
Amt: _____
Amt: _____

Private Insurance: (Yes) or (No)

If yes, Name:
Policy Coverage:

4. LEGAL GUARDIAN (Complete ONLY if person is a minor or has been adjudicated incompetent)

Legal Status: ☐Legally Competent ☐Unknown ☐ Minor under 18 years of age
☐Adjudicated Legally Incompetent
(Complete section below on legal guardian and attach documentation of guardianship)

Name of Legal; Guardian:	D.O.B	S.S.#:
Address:		
Home Phone:	Work Phone:	

If limited Guardianship, Describe Limitations:

5. PROFESSIONAL CONTACT

Name:	Telephone
1. (Support Coordinator)	
2. (Other):	

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INFORMATION CONSENT FORM

Name: _____ Soc. Sec. #: _____

Date of Birth: _____ MHID/CID#: _____

I, the above named person, hereby give permission to Jeremy's Place, Inc, and staff to be photographed of for identification purposes or to use my name, story, interview content and/or photographic image(s) in print, audio or other electronic forms for the purpose of marketing and promoting Jeremy's Place, Inc, This consent will remain effective until a written withdrawal is submitted to Jeremy's Place, Inc, Community Relations, at which time Jeremy's Place, Inc, will discontinue the use in all marketing and promotional materials produced in the future.

(Please Check) **Yes** ☐ **No** ☐

1. I, the above-named person, hereby give permission to Jeremy's Place, Inc, and staff to be videotaped, or recorded of for agency purposes.

   (Please Check) **Yes** ☐ **No** ☐

2. I, the above-named person, hereby authorize the release of medical records to the staff named below.

   (Please Check) **Yes** ☐ **No** ☐

3. I, the above-named person, hereby authorize Jeremy's Place, Inc, to release information pertaining to myself to the following named persons:

   (Please Check) **Fax** ☐ **Mail** ☐ **Other** ☐

- ❑ _____
- ❑ _____
- ❑ _____

For the following purpose(s): _____

_____

Individual/Resident /Parent/Guardian: _____
(Please Print)

Individual/Resident/Parent/Guardian: _____
(Signature)

Relationship to Individual/Resident: _____ Date: _____

Jeremy's Place, Inc, Staff Client: _____ Date: _____

Witness: _____ Date: _____

USE THIS SPACE ONLY IF THE PERSON/APPLICANT/GUARDIAN WITHDRAWS CONSENT

_____ _____
(Signature of person/Applicant/Guardian) (Date this Consent is revoked)

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"Lawful Presence in the United States Verification"
(Attachment A)

Documents that verify lawful presence in the United States must be "Originals" or "Certified" copies by issuing agency

Individual' Name: _____

Verification of Lawful Presence in the United States has been provided? ___Yes ___No

Copy of verification document is filed in Individual's record? ___ Yes ___No

If verification was not provided, are services required for an emergency ___Yes ___No___ NA situation?

Verification Reviewed by: _____Date: _____

Title: _____

"Affidavit of Lawful Presence in the United States"
(Attachment B)

State of Georgia
County of_____

Personally appeared before the undersigned officer, duly authorized by law to administer oaths in the State of Georgia (Individual's name) _____,
Who after being duly sworn, deposes and states from his/her own personal knowledge as follows:

I hereby do swear or affirm that I am: Please initial One

_____ a United States citizen or legal permanent resident 18 years of age or older,
OR
_____ a qualified alien or non-immigrant under the federal Immigration and Nationality Act Lawfully Present in the United States, and I am 18 years of age or older. Further affiant sayeth naught.

_____ _____
Signature Printed Name

Sworn to and sub scribed before me this _____Day _____, 20_____

Notary Public_____ (Notary seal) _____
My commission expires:

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Authorization for Use or Disclosure of Protected Health Information

I, _____, authorized the Georgia Department of Human Resources, Department of Behavioral Health and Developmental Disabilities, provider Jeremy's Place, Inc and its administrative and support staff to:

(**Check all that apply**)

- ☐ Use the following protected health information
- ☐ Disclose the following protected health information to Jeremy's Place, Inc, ONLY.
- ☐ I authorize the disclosure of alcohol and drug abuse information, (if Any).
- ☐ I authorize the disclosure of any information concerning testing for HIV (human immunodeficiency virus) and/or treatment for HIV or AIDS (acquired immune deficiency syndrome) and any related conditions, (if any).

The authorization shall be in force and effect Either thirty (30) days after I no longer receive services from this Department of Human Resources provider, or for one year from the date this is signed, whichever is shorter, at which time this authorization expires. I understand that I have the right to revoke the authorization, in writing, at any time by sending such written notification to the:

Department's Privacy Officer:
404.656.4421 Phone/404.657.1123 Fax
Two Peachtree Street, NW
Room 22.240
Atlanta, GA 30303-3142

OR

Divisions Privacy Coordinator
404.657.6423 Phone/404.657.6424 Fax
Two Peachtree Street, NW
Room 29.210
Atlanta, GA 30303-3142

Or to the Staff of my service provider.

The Department of Human Resource and its provider will not condition my treatment, payment, or eligibility for any applicable benefits on whether I provide authorization for the requested use or disclosure.

_____ / / _____ / /
Signature of Person or (Person Legally Authorized to sign on his/her behalf.) Date Signature of Witness/Title Date

_____
Description of Legally Authorized Person's Authority

(Use this space only if individual/resident withdraws authorization)

_____ _____
Date Authorization is withdrawn Signature of Individual/Resident

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AUTHORIZATION TO TRANSPORT

(Personal Vehicle)

I _____hereby request and authorize, authorized Jeremy's Place, Inc, Employee's the authority to transport my individual/resident to and from any planned activities. I understand that this authorization will remain in effect for our term with Jeremy's Place, Inc, as our providing agency.

☐ Ninety (90) days unless otherwise specified: __/__/__
☐ One (1) year

I understand that this action has been taken which was based on my consent; I may withdraw this consent at any time.

_____
Individual/Resident Signature Date
(Parent/Guardian)

_____
Coordinator Signature Date

_____
Program Director/Mgr. Signature Date

Jeremy's Place, Inc, employees have submitted the following items:

Proof of Insurance
7yr-Motor Vehicle Report (MVR)
Valid Georgia Driver's License.

Under no circumstance are employees allowed to use a cellular phone while driving. If the Jeremy's Place, Inc, employee needs to make a call or respond to a call while on company time, the employee must drive to a safe location and park the vehicle.

Use this space only if Parent/Guardian withdraws consent.

_____
Signature of Parent/Guardian Date this consent is revoked

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PLACE PHOTO HERE

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EMERGENCY CONTACT FORM

Name of Individual: _____SSN: _____		
Address:		Medicaid#
		Medicare#:
Phone:		
Ethnicity:	Gender: __M __F	Date of Birth:
Parent/Guardian/Representative:		
EMERGENCY /FAMILY CONTACT		
Name:		Name:
Relationship: __Parent __Sibling __Relative __Other (Specify)_____		Relationship: __Parent __Sibling __Relative __Other (Specify)_____
Address:		Address:
Employer:		Employer:
Phone: Work_____Home_____ Cell_____		Phone: Work_____Home_____ Cell_____
Medical Information		
Allergies: Allergies: (Y) or (N) *If yes specify:*		Seizures: Allergies: (Y) or (N) *If yes specify:*
None		
Diagnosis:		
Adaptive Equipment:		
Other Medication (By Permission) (For Example: Over the Counter Medication)		
Physicians and Other Important Contacts	**Contact:**	**Address:** **Phone#:**
Primary Doctor:		
Dentist:		
Hospital Preference:		
Pharmacy:		
Other/Private Insurance: Yes/ No (Please Circle One)		

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Individual Rights

Day Program,

Dear _____,
As a person receiving services, you have rights, which are guaranteed by your provider. It is your provider's job to make sure you understand your rights and that your rights are protected. Your provider will explain your rights to you and give examples to help you understand them.

To facilitate new resident's adjustment to his/her individual program a new residence orientation session will be held to familiarize both staff and residents of their individual/resident rights. This ensures the guarantee of residences to provide the rights of the staff and the residents

You can expect to be treated with dignity and respect at all times by your provider and any staff who works with you. If you feel you are not being treated with dignity and respect, or if you think your rights have been violated, you should immediately tell someone. No one will be angry or punish you for reporting that you believe your rights have been violated.

All individual/resident will be treated with upmost respect and under no circumstances will the following occur:

a) Threats (over or implied):
b) Corporal punishment;
c) Fear-eliciting procedures;
d) Abuse or Neglect of any kind;
e) Withholding nutrition or nutritional care; or
f) Withholding of any basic necessity such as clothing, shelter, rest or sleep.

As a Person receiving services, you have the following rights:

- The right to receive services that protect your health and safety.
- The right to receive services that respect your dignity and honors your choices.
- The right to actively pursue your own goals, interests, dreams and aspirations, and to receive support in doing so.
- The right to actively participate in the planning of your services including any changes made to the services you receive; the right to refuse services; the right to select those outcomes that are most important to you.
- The right to be informed of the benefits and risks of your services and your choices.
- The right to full confidentiality of your records, as well as information regarding your services and care.
- The right to exercise all civil, political, personal, and property rights to which you are entitled as a citizen, including your right to vote, and the assurance of support in exercising those rights, including obtaining legal counsel or an advocate if needed.
- The right, if you have been ruled incompetent, to appeal or contest this ruling.
- The right to be free from mental, physical, sexual, or verbal abuse, neglect, or exploitation.
- The right to be fully informed of any charges for services.
- The right to be free from discrimination based upon your age, gender, race, religion, sexual orientation, national origin, marital status, physical or mental disability, or the source of payment for your services.
- The right to exercise your rights and to file a grievance if you feel your rights have violated, without fear of retaliation.
- The right to have an advocate independent of the service system to help you raise issues, complaints, grievances, or recommendations.
- The right to obtain a copy of your provider's most recent licensure, certification or inspection reports.
- If you are receiving residential services, your provider will ensure that you have the following rights protected:
- The right to make personal decisions which affect your life including: where and with whom you will live; how you will spend your days; who you will share information with; how you will use your personal money.
- The right to stay in contact with your family and friends, and to receive support in doing so.
- The right to select your physician, dentist, and other professional caregivers; the right to refuse medical services unless a physician or licensed psychologist feels that refusal would be unsafe for you or others.

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- The right to have privacy in your room, to receive visitors, to converse privately, to have access to a telephone, to send and receive unopened mail, to retain your personal belongings, and to have your personal property treated with respect.
- The right to remain free of personal restraints, physical restraints, or time-out procedures, unless such measures are required to protect your safety or the safety of others.
- The right to be free from chemical restraint and from isolation, physical punishment, or punishment that involves loss of rights or interferes with activities of daily living.
- The right to practice the religion of your choice, without having the religious belief or practice of others imposed on you.
- The right to have your residence and personal belongings protected at all times.

RESPONSIBILITIES You Have:

- You have the responsibility to inform staff when you do not understand.
- You have the responsibility to say "NO" and report any words or actions you feel are not appropriate to you.
- You have the responsibility to understand services and the consequences that might occur due to your choice.
- You have the responsibility to contact or have someone contact a Medical Doctor, Dentist or licensed Psychologist for you, when you are in need of their assistance.
- You have the responsibility to act in a respectful manner towards your peers.
- You have the responsibility to ask for a copy of your written plan if you want your own copy.
- You have the responsibility to report your concerns when you have something that bothers you.
- You have the right to know that staff has been trained to know how you communicate to express a need or want, and to use the least restrictive way of helping you.

- If you feel your rights have been violated, you should tell one of these people within your provider agency:
- Your Support staff person
- Service Support Coordinator
- The Support Director
-

Individual/Residents who feel that his/her rights have been violated, may also contact the DBHDD Office of External Affairs at any time.

Developmental Disabilities Human Rights Coordinator
2 Peachtree Street NW, Suite 22-412
Atlanta, GA 30303 3
404/657-5964
Email: DBHDDconstituentservices@dhr.state.ga.us

Individual/Residents who feel that his/her rights concerning the community ombudsman program have been violated, may also contact their State or Community Ombudsman Representative

State: 404-656-0798 Community: 404-371-3800

Depending on the nature of your call, this may be escalated to the Program Director or the Executive Director and then, if appropriate, to the Jeremy's Place, Inc, Quality Assurance for investigation. Rights are in compliance with the Rules of the Department of Human Resources Mental Health, Georgia Department of Behavioral Health and Developmental Disabilities, Chapter 290-4-9.

ACKNOWLEDGMENT:
I have received a copy of my rights and they have been explained to me.

_____ _____
Individual/Legal Guardian Date

_____ _____
Witness Date

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ANNUAL PHYSICAL

Name: _____ D.O.B._____
Diagnosis: _____
Allergies:_____
_____
Seizures: _____

Height	Weight	B.P.	Pulse	Resp.

(Please Check ☑)

Vision	[ ] Adequate	[ ] Impaired	[ ] Legally Blind	[ ] Undetermined
Hearing	[ ] Adequate	Impaired { [ ] Mild [ ] Mod. [ ] Sev. }		[ ] Uses Appliance

EENT:_____
MOUTH:_____
LUNGS & CHEST:_____
HEART:_____
ABDOMEN:_____
GENITALS:_____
HERNIA:_____
GYNECOLOGIAL:_____ BREAST _____
PAP SMEAR_____ RECTAL_____
BONES, JOINTS, MUSCLES_____

ACTIVITY RESTRICTIONS: _____
_____
_____
_____
_____
_____

Recommendations and Treatment Plan:_____
_____
_____
_____
_____
_____
_____

Time: _____
Date: _____

_____
Must be signed by a Medical Doctor

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FREEDOM OF CHOICE

(Statement of Informed Consent)

It is the policy of the State of Georgia that services are delivered in the least restrictive manner that addresses the service needs of the individual/resident while enhancing the promotion of social integration. Further, it is the policy of the state to recognize the recipients' full citizenship and individual/resident dignity; providing safeguards to protect rights, health, and the welfare of recipients.

Based on these beliefs the State of Georgia assures that potential recipients and their authorized representatives will be afforded an opportunity to make an informed choice concerning services. Once a receipt is determined to be likely to require the level of care provided in an SNF, ICF, or ICF/MR the recipient and his/her authorized representative will be (1) informed of any feasible alternatives available under the waiver, the (2) given the choice of either institutional or home and community based services, and (3) that the substance of the information provided will make one reasonably familiar with service options, their alternatives, and possible benefits and hazards, and (4) the disclosure of said information is designed to be fully understood and appears to be fully understood.

Verification

I have verified that the recipient and his/her authorized representative have been informed about their choices in the manner outlined above.

_____ _____

Clinical Evaluation and Support Services Team Coordinator Or Authorized Designee — Date

Acceptance

I and/or my authorized representative have been informed of my choices and have chosen to accept the program described in the attached Plan of Care Voucher (ISP Summary).

_____ _____ _____ _____

Recipient — Date — Authorized Representative — Date

_____ _____ _____ _____

Recipient — Date

REFUSAL

I and/or my authorized representative have been informed of my choices and have chosen to refuse waiver services.

_____ _____ _____ _____

Recipient — Date — Authorized Representative — Date

_____ _____ _____ _____

Recipient — Date

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GRIEVANCE/COMPLAINT

The purpose of this document is to ensure that persons receiving supports and services with complaint/grievances, regarding acts committed by any staff, residents, day program participants, or guest in a respite or crisis respite setting, that are inconsistent with Jeremy's Place, Inc's policies of residences or program/services are addressed in a timely and accurate manner.

If you have a concern or a situation occurs of being abused verbally, physically, sexual or financial exploited, involved in an accident, received injuries, or changes in your health or safety you should follow the procedures below.

Procedure:

1. If you have a complaint regarding an act or situation that occurred between you and another resident, day program participant or respite guest, you should tell the staff that is present immediately. The staff is responsible for contacting their supervisor of the residence, day program or respite services and following the Jeremy's Place, Inc, Complaint Policy and procedure, for the reporting and responding of complaints/grievances.

2. If you observe a situation in the residence, day program, or respite setting that is of concern to you, you should tell the staff that is present immediately. The staff is responsible for contacting their supervisor of the home and following the Jeremy's Place, Inc, Complaint Policy and procedure, for the reporting and responding of complaints/grievances.

3. If you have a complaint regarding an act or situation that occurred with your staff, you should tell:
   a. **Day program:** The manager of the program or the director of the program, if the manager is not present. The manager or director is responsible for following the Jeremy's Place, Inc, Complaint Policy and procedure for the reporting and responding of complaints/grievances.

   d. **Family support (In Personal Residence):** The supervisor assigned to your personal residence. The supervisor is the Jeremy's Place, Inc, Coordinator. (Be sure to get a contact number for the supervisor or your residence). The supervisor is responsible for contacting the Director of the program/service and following the Jeremy's Place, Inc, Complaint Policy and procedure for the reporting and responding of complaints/grievances.

Your complaint will be address as stated in the Jeremy's Place, Inc, Reporting and Responding of Complaints/Grievances policy and procedure.

For concerns involving verbal & physical abuse, sexual or financial exploitation, accidents, injuries, or changes in your health and safety, the complaint will be followed through by the Critical Incident Reporting and Investigation policy and procedures.

At any time during this process, if you are still unsatisfied with the resolution to your grievance/complaint, we recommend that you contact your local DD/AD Regional Board.

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Department of Behavioral Health and Developmental Disabilities
Regional Boards

Region 1 REGION ONE DBHDD OFFICE 1230 Bald Ridge Marina Road Suite 800 Cumming, Ga 30041 Phone: (678) 947-2818 or 1-877-217-4462	**Region 2** REGION TWO DBHDD OFFICE 3405 Mike Padgett Highway Building 3 Augusta, Georgia 30906 Phone: (706) 792-7733 or 1-866-380-4835 Fax: (706) 792-7740
Region 3 REGION THREE DBHDD OFFICE 3073 Panthersville Rd Bldg. 10 Decatur, Ga 30034 Phone: (404) 244-5050 Fax: (404) 244-5179	**Region 4** REGION FOUR DBHDD OFFICE 400S. Pinetree Boulevard (PO Box 1378 Thomasville, GA 31799) Thomasville, Georgia 31792 Phone: (229) 225-5099 Fax: (229) 227-2918
Region 5 REGION FIVE DBHDD OFFICE Georgia Regional Hospital at Savannah 1915 Eisenhower Drive, Building TWO Savannah, Georgia 31406 Phone: (912) 303-1670 Fax: (912) 303-1681	**Region 6** REGION SIX DBHDD OFFICE **REGIONAL OPERATIONS** 3000 Schatulga Road Building 4 Columbus, Georgia 31907 Phone: (706) 565-7835

This policy and process has been explained to me and I have received a copy of this letter.

Signature of Person of Receiving Services or Family/Legal Guardian/Date

Witness Signature/Date

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COMMUNICABLE DISEASE

In accordance with founding and continuing philosophies of Georgia Community Support & Solutions the following policy on communicable disease was established to better serve our individual/residents.

Today the climate and wellness of the society demands that special attention and careful guidance be given to all communicable diseases, including HIV/AIDS.

Careful thought and realistic action will be promptly implemented to ensure a safe and healthy environment for all individuals/residents and employees. The rights of those infected and the rights of those at risk of being infected are to be protected and dignified in a manner that is inherent with the mission and goals of this organization.

The guidelines and recommendations set forth by the Georgia Department of Public Health, and appropriate federal agencies, regarding communicable diseases will be strictly adhered to under this policy. Infection control practices will be taught and implemented in all facilities under the auspices of this organization following established guidelines. An environment will be created to motivate employees and individuals/residents to use good hygiene techniques. Step-by-step hygiene techniques/instructions will be frequently reinforced for staff. Curriculum, including signs, will be reinforced to better serve our non-readers.

The following policy statements must be considered whenever an individual/resident or employee is identified as having any communicable disease:

- ✓ Prospective individuals/residents, currently enrolled individuals/residents, and current employees have the right to remain in their status according to present policy and procedure only so long as their participation does not violate the rights, safety, or health of other individuals/residents or employees.

- ✓ Prospective and current parents/legal guardians have the right to be informed of this policy. Written documentation will be maintained in the individual's/residents files showing when parents/legal guardian were made aware of the policy.

- ✓ Employees have the right to be informed of this policy. Written documentation will be maintained in personnel files indicating date reviewed.

- ✓ Up-to-date information, instructions, and training will be made available to the employees regarding communicable disease.

- ✓ Subject to the guidelines of the Georgia Department of Public Health, the CDC, and Jeremy's Place, Inc, admissions of an infected individual, including one who is HIV positive, is not in and of itself sufficient cause for refusal of services. Decisions regarding the most appropriate learning environment for those individuals/residents shall be determined on an individual basis.

I have read and understand the Jeremy's Place, Inc policy on "Communicable Disease".

_____	_____	_____
Individual/Resident	Parent/ Guardian Signature	Date

It is a requirement that Georgia Community Support & Solutions inform all parents/guardians about the policy on Communicable Disease. Please sign this form for the agency records.

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Demographic Information

COMMUNICATION

How does the participant communicate?
(*Pleas***e** *check* ☑ *all that apply***).**

Can talk without difficulty □
Can talk with some difficulty □
Makes sounds that are understandable to the parent □
Uses Sign Language □
Uses communication device □

Signboard □
Augmentative Communication □

Other: (Please List) □
_____

_____

Communicates with facial expressions □
Does not communicate □
Other: _____ □
_____

How well does the participant understand what is said to him/her?
(*Pleas***e** *check* ☑ *all that apply***).**

Has no problem with understanding □
Requires simple one or two step instructions □
Needs gestures to understand □
Doesn't understand language □
Uses facial expression to understand □
Other means of understanding:
_____

_____

Sleep Habits

When is wake up time? _____
When is bed time? _____
When is nap time? _____

Sleeping Arrangements
(*Pleas***e** *check* ☑ *all that apply***).**

Sleeps in a regular bed □
Sleeps in a crib □
Sleeps in a bed w/ rails □
Sleeps in a hospital bed □
Other (please describe) □
_____
_____

PARTICIPANT PREFERENCES

Does the participant have a certain schedule of activities? If yes, please list times and activities.
_____

_____

_____

Does the participant have favorite activities? Please list.
_____

_____

Does the participant have favorite foods? Please list
_____

_____

Are there certain foods or activities to avoid? Please list
_____

_____

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Does the participant have specific fears that staff or care providers should know about (e.g. dogs, loud noises)
_____

_____

_____

Are there any specific house rules or other: requirements to be enforced by the respite care provider/agency?
_____

_____

_____

PERSONAL CARE NEEDS

(*Pleas*e *check* ☑ *all that apply*).

Mobility

Walks independently □
Crawls □
Uses walker or crutches □
Walks w/ assistance □
Uses wheelchair independently □
Can sit w/out wheelchair □
Uses wheelchair w/assistance □
Requires transfers □
Uses stroller/travel chair □

TOILETING

Independent □
Bladder Control □
Bowel Control □
Needs assistance □
Wears diapers/attends □
Toilets on a schedule □
(Schedule)_____
Needs enema □
Requires catheterization □

HYGIENE

(*Pleas*e *check* ☑ *all that apply*).

Prefers: Shower □ Bath □
Washes independently □
Cannot wash self □
Needs assistance □
Please explain: _____
_____

Shampoos hair □
Cannot Shampoo hair □
Needs assistance □
Brushes/combs hair □
Cannot brush/comb hair □
Needs assistance □
Brushes teeth □
Cannot brush teeth □
Needs assistance □
Please explain: _____
_____

Shaving □

Needs assistance □
Menstruation □
Needs assistance □

FEEDING

Eats independently □
Drinks independently □
Bottle fed □
Blended or special diet □
G, J, or NG tube fed □
Feeds self w/ spoon □
Feeds self w/ fork □
Must have food cut □

Needs assistance with w/ utensils □
Needs other assistance □
Please explain: _____
_____

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FEEDING DIFFICULTIES
(*Pleas***e** *check* ☑ *all that apply***).**

Tongue thrust □
Gag reflex □
Swallowing difficulties □
Difficulty chewing □
Other □
Explain: _____
_____

DRESSING

Dresses independently □
Needs assistance □
Please explain: _____
_____

OTHER NEEDS

BEHAVIOR
Hitting, biting, or fighting □
Self-abusive behavior □
Running away □
Hyper/Overactive behaviors □
Other □
Please explain: _____
_____

MEDICAL NEEDS

Has a G-tube □
Has a J-tube □
Has a NG-tube □
Is on a apnea monitor □
Has a tracheotomy □
Requires shallow suction □
Requires deep suction □
Oxygen dependent □
Ventilator dependent □
Requires injections □
Other □
Please explain: _____
_____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY THE DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES (DBHDD) AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. This notice is effective November 10, 2015. It is provided to you under the Health Insurance Portability and Accountability Act of 1996 and related federal regulations (together referred to as "HIPAA") and provides some additional information about other federal and state confidentiality protections.
If you have questions about this Notice please contact the facility where you receive services (your treatment provider or services provider) or DBHDD's Privacy Officer at the address below

Jeremy's Place, Inc. operate with the Department of Behavioral Health and Developmental Disabilities (DBHDD) by contract or letter of agreement responsible for providing supports and services to individuals. Both federal and state laws establish strict requirements regarding the disclosure of medical and other confidential information. Jeremy's Place, Inc, must comply with those laws. For situations where stricter disclosure requirements do not apply, this Notice of Privacy Practices describes how Jeremy's Place, Inc, may use and disclose your "protected health information" for treatment, payment, health care operations, and for certain other purposes. This notice also describes your rights regarding your protected health information. **Protected health information** is information that may personally identify you and relates to your past, present or future physical or mental health or condition and related health care services. Jeremy's Place, Inc, is required to provide you this Notice of Privacy Practices, and to abide by its terms, and may change the terms of this notice at any time. A new notice will be effective for all protected health information that Jeremy's Place, Inc, maintains at the time of issuance. Jeremy's Place, Inc, will provide you with any revised Notice of Privacy Practices by posting copies at its facilities and through each program department, in response to a telephone or fax request to the Jeremy's Place, Inc, Privacy Officer (Quality Assurance), or in person at any facility where you receive services from Jeremy's Place, Inc.

1. Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by Jeremy's Place, Inc, its administrative and clinical staff and others involved in your care and treatment for the purpose of providing health care services to you, and to assist in obtaining payment of your health care bills.

a. Treatment: Your protected health information may be used to provide, coordinate, or manage your health care and any related services, including coordination of your health care with a third party that has your permission to have access to your protected health information, such as, for example, a health care professional who may be treating you, or to another health care provider such as a specialist or laboratory.

b. Payment: Your protected health information may be used to obtain payment for your health care services. For example, this may include activities that a health insurance plan requires before it approves or pays for health care services such as: making a determination of eligibility or coverage, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

c. Health Care Operations: Jeremy's Place, Inc, may use or disclose your protected health information to support the business activities of Jeremy's Place, Inc, including, for example, but not limited to, quality assessment activities, employee review activities, training, licensing, and other business activities. Your protected health information may be used to contact you about appointments or for other operational reasons. Your protected health information may be shared with third party "business associates" who perform various activities that assist us in the provision of your services.

2. Other Permitted or Required Uses and Disclosures with Your Authorization or Opportunity to Object: Other uses and disclosures of your protected health information will be made only with your written authorization, which you may revoke at any time to the extent that Jeremy's Place, Inc, has not acted upon your authorization, **except** as permitted or required by law as described below. The Department may use and disclose your protected health information when you authorize in writing such use or disclosure of all or part of your protected health information. If you are hospitalized, Jeremy's Place, Inc, may use and disclose certain protected health information to your representative, as that term is defined in the Georgia Mental Health Code, upon your admission or discharge; you may be given a chance to object to certain other disclosures to your representative.

a. Confidentiality of Alcohol and Drug Abuse Patient Records: The confidentiality of patient records which disclose any information identifying you as an alcohol or drug abuser is protected by federal law and regulations. This information generally will not be disclosed unless you consent in writing, the disclosure is allowed by a court order, or the disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation. Violation of these federal laws and regulations by the facility, treatment or Jeremy's Place, Inc, is a crime. You may report violations to appropriate authorities in accordance with the federal regulations. Federal regulations do not protect any information about a crime committed by you either at a facility or program or against any person who works at a facility or program or about any threat to commit such a crime. Federal regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

b. AIDS confidential information: AIDS confidential information, including HIV status or testing information, is confidential under state law. Generally, Jeremy's Place, Inc, will not disclose AIDS confidential information without your authorization. Jeremy's Place, Inc, may disclose this information in certain circumstances to protect persons at risk of infection by you, including your family and health care providers. Jeremy's Place, Inc, may disclose AIDS confidential information in certain circumstances as part of your mental health commitment or by other legal procedures.

3. Permitted or Required Uses and Disclosures without Your Authorization or Opportunity to Object: Jeremy's Place, Inc, may use or disclose your protected health information without your authorization for continuity of your care or for your treatment in an emergency or when clinically required; when required to do so by law; for public health purposes; to a person who may be at risk of contracting a communicable disease; to a health oversight agency; to an authority authorized to receive reports of abuse or neglect; in certain legal proceedings, such as hearings regarding your hospitalization or commitment or to comply with workers' compensation laws; and for certain law enforcement purposes. Protected health information may also be disclosed without your authorization to a coroner or medical examiner, and to the legal representative of your estate.

4. Required Uses and Disclosures: Under the law, Jeremy's Place, Inc, must make certain disclosures to you, and to the Secretary of the United States Department of Health and Human Services when required to investigate or determine Jeremy's Place, Inc's compliance with the requirements of HIPAA regulations beginning at 45 CFR Section 164.500.

5. Your Rights: The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

a. You have the right to inspect and copy your protected health information: You may inspect and obtain a copy of protected health information about you for as long as Jeremy's Place, Inc, maintains the protected health information. This information includes medical and billing records and other records Jeremy's Place, Inc, uses for making medical and other decisions about you. A reasonable, cost-based fee for copying, postage and labor expense may apply. Under federal law you may not inspect or copy psychotherapy notes; information compiled in anticipation of, or for use in, a civil, criminal, or administrative proceeding, or protected health information that is subject to a federal or state law prohibiting access to such information. While you are hospitalized, your physician may restrict your right to review your records if it would be harmful to your physical or mental health.

b. You have the right to request restriction of your protected health information: You may ask Jeremy's Place, Inc, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations, and not to disclose protected health information to family clients or friends who may be involved in your care. Such a request must state the specific restriction requested and to whom you want the restriction to apply. Jeremy's Place, Inc, is not required to agree to a restriction you request, and if Jeremy's Place, Inc, believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted, except as required by law. If Jeremy's Place, Inc, does agree to the requested restriction, Jeremy's Place, Inc, may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment.

c. You have the right to request to receive confidential communications from us by alternative means or at an alternative location: Upon written request to a person listed in section 6 below, Jeremy's Place, Inc, will accommodate reasonable requests for alternative means for the communication of confidential information with you, but may condition this accommodation upon your provision of an alternative address or other method of contact. Jeremy's Place, Inc, will not request an explanation from you as to the basis for the request.

d. You may have the right to request amendment of your protected health information: If Jeremy's Place, Inc, created your protected health information, you may request an amendment of that information for as long as it is maintained by Jeremy's Place, Inc, Jeremy's Place, Inc, may deny your request for an amendment, and if it does so will provide information as to any further rights you may have with respect to such denial. Please contact one of the persons listed in section 6 below if you have questions about amending your protected health information.

e. You have the right to receive an accounting of certain disclosures the Department has made of your protected health information: This right applies only to disclosures for purposes other than treatment, payment or healthcare operations, and does not apply to any disclosures Jeremy's Place, Inc, made to you, to family clients or friends or representatives, as defined

in the Georgia Mental Health Code, who are involved in your care, or for national security, intelligence or notification purposes. You have the right to receive legally specified information regarding disclosures occurring in the six (6) years before your request, subject to certain exceptions, restrictions and limitations.

f. You have the right to obtain a paper copy of this notice from the Department, upon request.

6. Complaints: You may complain to us and to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint in writing with Jeremy's Place, Inc, provider of support and services, under contract or agreement with the Department of Behavioral Health and Developmental Disabilities (DBHDD) which maintains your protected health information at **telephone: 770-716-2233, Fax: 844-270-7142, or by mail to Jeremy's Place, Inc, Attn: Quality Assurance – Privacy Officer, 4910 Jonesboro Rd Bldg 200 Ste. 201 Union City, GA 30291.**

You must state the basis for your complaint.

Jeremy's Place, Inc, will not retaliate against you for filing a complaint.

You may also contact the **Department's Privacy Officer by telephone at (404) 657-2282, facsimile (404) 657-2173, or by mail to 2 Peachtree Street NW, Room 22.240, and Atlanta, Georgia 30303-3142,** for further information about the complaint process or this notice.

Please sign a copy of this Notice of Privacy Practices for your records.

I have received a copy of this Notice on the date indicated below.

_____ _____

Signature of Individual **Date**

_____ _____

Signature of Legal Guardian/If Applicable **Date**

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CONFIDENTIALITY AGREEMENT

I, _____the undersigned, understand and agree that during my tour at Jeremy's Place, Inc, any medical or personal information learned by me about any person who is an individual at Jeremy's Place, Inc or any family member of an individual, is privileged information and subject to all state and federal laws, which protect the rights of the individual in Day Habitation Center.

I understand that the information learned by me about any individual(s) will not be discussed with anyone except authorized personnel of Jeremy's Place, Inc unless otherwise authorized by policy or state or federal laws.

I have read and understand this agreement.

_____
Printed Name

_____
Signature

_____
Date

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AUTHORIZATION TO PICK-UP

Name: _____
DOB: _____

I am the ☐ Individual ☐ Parent ☐ Legal Guardian ☐ CAG Provider of the person named above.

Please list below all persons, besides parents and/or legal guardians, who are authorized to pick up the individual listed above from JEREMY'S PLACE, INC

Note: For the individual's safety, all authorized persons will be asked for photo identification. Please inform the person listed below in advance on this precautionary measure. Persons may be added to the list or removed at any time, just inform office of any changes to this form.

AUTHORIZED TO PICK- UP

Name	Relation	ID Number	Phone #

NOT AUTHORIZED TO PICK- UP

Name	Do they know they cannot pick up the individual listed?	Comments

Please initial all that apply below:

_____ I may occasionally send an employee or relative to pick up the individual listed above. If so, I will notify the office by phone or in writing on the day of the change.

NOTE: The individual being served WILL NOT be released to anyone who is not authorized. Authorization will be determined based on this form submitted by the individual, parent, legal guardian and/or care provider. It is the individual, parent, legal guardian and/or care provider responsibility to keep this information current.

_____ _____ _____
Individual's Signature Date Provider's Signature Date

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Name of Facility: _____
Address: _____
Phone: _____ Fax: _____
Website: _____
Email: _____

To Whom It May Concern:

Your patient, _____ DOB: _____ S.S#: XXX-XX-_____

Has chosen to apply for ☐ CCSP, ☐ SOURCE: a long-term Medicaid Waiver Program. The patient will benefit from a CNA or PCA who will come to their home and assist with their daily needs. In order for us to facilitate the process, please provide us with the following:

_____ A current copy of the patient's Medication List, Diagnosis and two most recent office visits.
_____ The most recent 2-years of pertinent information (chart notes, labs, x-ray and/or test results
_____ All medical records
_____ Specific Information (please specify):
_____

1. I understand that the information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state or federal laws (except as set forth in paragraph 2below).
2. I understand that, pursuant to 42 C.F.R Part 2, alcohol and drug abuse records that I authorize to be disclosed pursuant to this document may not be further re-disclosed without my written consent, except by a court order that complies with the preconditions set forth at 42 C.F.R. 2.61 et seq., or the other limited circumstances specifically permitted by 42 C.F.R. Part 2. Any individual that makes such a disclosure in violation of these provisions may be reported to the United States Attorney and be subject to criminal penalties.
3. I understand that the Department or my healthcare provider will not condition my treatment, payment, or eligibility for any applicable benefits on whether I provide authorization for the requested release of information.
4. I intend this document to be a valid authorization conforming to all requirements of the Privacy Rule and State law, and understand that my authorization will remain in effect for: (PLEASE CHECK ONE)
   ☐ one (1) year OR ☐ the period necessary to complete all transactions on matters related to services provided to me.

I understand that unless otherwise limited by state or federal regulation, and except to the extent that action has been taken based upon it, I may revoke this authorization at any time as shown in the space below.

PATIENT AUTHORIZATION:
I consent to the release of information and/or disclosure to **Jeremy's Place, Inc**., all and/or any part of my health information by any physician, hospital, or other facility of which I have been a client/patient.

Patient Name (Print) **Patient Signature** **Date**

Authorized Representative Name (Print) **Authorized Representative Signature** **Date**

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AGREEMENT OF PAYMENT

These are of the payment plans that you may select from. Please review these plans and select one by filling out the bottom portion of this form.

1. MEDICAID — COMP WAIVER ONLY JEREMY'S PLACE will bill accordingly
2. PRIVATE PAY — At the beginning of the service month.
3. PRIVATE PAY — Discount payment due at the beginning of service NON-REFUNDABLE
4. SUB-CONTRACT — Payment due _____

I _____, selected to the payment plan option _____.
Representative's Name (Print)

I AGREE TO THE ARRANGEMENTS OF THE PLAN 1 SELECTED

_____ _____
Patient Name (Print) **Patient Signature** **Date**

_____ _____
Authorized Representative Name (Print) **Authorized Representative Signature** **Date**