INTAKE APPLICATION:

1945 Cliff Valley Way, STE 220, Atlanta GA 30329
(404) 634-4222

Georgia Community Support and Solutions
1945 Cliff Valley Way, STE 220, Atlanta, GA 30329
404-634-4222

Listed below are the documents required for admission.

Documents needed from: Family/Guardian/Advocate:

- Current Photo
- Copy of Medicaid Card
- Copy of Social Security Card
- Copy of Birth Certificate
- Citizenship Verification Form
- Copy of Annual Physical and Immunization Forms
- Copy of Private INS., Card (If Applicable)
- Current PPD test (T.B. skin test) due at time of admission
- Copy of Most current Psychological Assessment
- Most Recent Social Security Award Letter or Income Statement
- Copy of Most Current ISP/IEP

Thank you,

Denise Urgent

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INTAKE FORM

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 GCSS: yes ☐no ☐Program:**
*** Has GCSS 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, hereb give permission to GCSS 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 GCSS. This consent will remain effective until a written withdrawal is submitted to GCSS Community Relations, at which time GCSS 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 GCSS and staff to be video taped, 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 GCSS to release information pertaining to myself to the following named persons:

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

   - ☐ ___________________________
   - ☐ ___________________________
   - ☐ ___________________________

For the following purpose(s): _____

____

I understand that unless otherwise limited by state or federal regulation and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time. All information authorize to be obtained from this agency will be held strictly confidential and cannot be released by the recipient with out my consent. I understand that this authorization will remain in effect for 1 year unless otherwise stated. All information will be held confidential

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

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

Relationship to Individual/Resident:________________________________ Date:______________

GCSS Staff Member:____ Date:______________

Witness:____ Date:______________

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

___________________________ ___________________________

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

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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: ____________________________________

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"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 Georgia Community Support and Solutions, 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 GCSS 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 GCSS 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 GCSS 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

GCSS Employee's have submitted the following items:

Proof of Insurance
Motor Vehicle Report (MVR)
Valid Georgia Drivers License.

Under no circumstance are employees allowed to use a cellular phone while driving. If the GCSS 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

Residential, Day Programs, Crisis Support Services, Respite, Emergency Respite, Supported Employment, In- Home Supports and Temporary Immediate Supports

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 residents 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.

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.

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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

All of whom can be reached by calling the main line at 404-634-4222.

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

Department of Behavioral Health & Developmental Disabilities
Office of External Affairs
2 Peachtree St. NW, 24nd Floor
Atlanta, GA 30303
404/657-5964
Email: DBHDDconstituentservices@dbhdd.ga.gov

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 GCSS 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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Mental Retardation Waiver Program

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 Date
Or Authorized Designee

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 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 GCSS'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 accidents, 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 GCSS 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 GCSS 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. **Resident:** The supervisor assigned to your residence. The supervisor is the GCSS Coordinator for your residence. (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 GCSS Complaint Policy and procedure, for the reporting and responding of complaints/grievances.

   b. **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 GCSS Complaint Policy and procedure for the reporting and responding of complaints/grievances.

   c. **Respite:** 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 GCSS 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 GCSS 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 GCSS Complaint Policy and procedure for the reporting and responding of complaints/grievances.

Your complaint will be address as stated in the GCSS Reporting and Responding of Complaints/Grievances policy and procedure AG26.

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 AG07.

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

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Department of Behavioral Health and Developmental Disabilities Regional Boards

Region 1 REGION ONE DBHDD OFFICE 705 North Division Street Rome, Georgia 30165 Phone: (706) 802-5272 or 1-800-646-7721 Fax: (706) 802-5280	**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 100 Crescent Centre Parkway Suite 900 Tucker, Georgia 30084 Phone: (770) 414-3052 Fax: (770) 414-3048	**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) 351-6577 (912) 351-6421 Fax: (912) 351-6309	**Region 6** REGION SIX DBHDD OFFICE **REGIONAL OPERATIONS** 3000 Schatulga Road Building 4 Columbus, Georgia 31907 Phone: (706) 565-4138 Fax: (706) 568-2128

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 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 <u>only</u> 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 individuals/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 GCSS, 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 Georgia Community Support and Solutions 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?
(*Please* **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?
(*Please* **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
(*Please* **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

(*Please* **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

(*Please* **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:_____________
____

Georgia Community Support and Solutions
1945 Cliff Valley Way, STE 220, Atlanta, GA 30329
404-634-4222

Feeding Difficulties
(*Please 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 GCSS AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. This notice is effective September 1, 2011. It is provided to you under the Health Insurance Portability and Accountability Act of 1996 and related federal regulations (HIPAA). If you have questions about this Notice please contact your Treatment Provider or GCSS, or the Department's Privacy Officer at the address below.

Georgia Community Support and Solutions, 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. GCSS must comply with those laws. For situations where stricter disclosure requirements do not apply, this Notice of Privacy Practices describes how GCSS 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. GCSS 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 GCSS maintains at the time of issuance. GCSS 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 GCSS Privacy Officer (Quality Assurance), or in person at any facility where you receive services from GCSS.

1. Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by GCSS, 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: GCSS may use or disclose your protected health information to support the business activities of GCSS, 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 GCSS 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, GCSS 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 GCSS, 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, GCSS will not disclose AIDS confidential information without your authorization. GCSS may disclose this information in certain circumstances to protect persons at risk of infection by you, including your family and health care providers. GCSS 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: GCSS 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, GCSS 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 GCSS'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 GCSS maintains the protected health information. This information includes medical and billing records and other records GCSS 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 GCSS 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 members 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. GCSS is not required to agree to a restriction you request, and if GCSS 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 GCSS does agree to the requested restriction, GCSS 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, GCSS 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. GCSS will not request an explanation from you as to the basis for the request.

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d. You may have the right to request amendment of your protected health information: If GCSS created your protected health information, you may request an amendment of that information for as long as it is maintained by GCSS. GCSS 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 GCSS made to you, to family members 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 GCSS 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: 404- 634-4222, Fax: 404-634-1324, or by mail to Georgia Community Support and Solutions, Inc. Attn: Quality Assurance – Privacy Officer, 1945 Cliff Valley Way Suite 220, Atlanta, Georgia 30329.** You must state the basis for your complaint.

GCSS 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**

Reference DBHDD Policy 23-100 and 23-101