agency for persons with disabilities
State of Florida

Area 4 Transitional Information Summary

Name _____
Last First Middle

Preferred Name to be called _____

Date of Birth _____

Height _____ Weight _____ lbs. Identifying Marks _____

Allergies _____

Record of Completion and Updates of Information (to be maintained by current provider)

Initial Date of Completion: _____ By: _____

Updated (date): _____ By: _____

Updated (date): _____ By: _____

Updated (date): _____ By: _____

Updated (date): _____ By: _____

Updated (date): _____ By: _____

Updated (date): By:

ATTACH RECENT COPY OF MEDICATION ADMINISTRATION RECORD (MAR)

Gynecologic: (women only)
Age menstruation started _____ stopped _____ still menstruating ☐ Yes ☐ No
Have you ever given birth to a child? ☐ Yes ☐ No
Date of last Pap smear _____
Any history of abnormal Pap smear? ☐ No ☐ Yes Explain: _____
Date of last mammogram _____ ☐ unknown ☐ never

Prior Evaluations

Date of last audiological exam _____	☐ unknown	☐ never
Date of last eye exam _____	☐ unknown	☐ never
Date of last bone densitometry _____	☐ unknown	☐ never
Date of sigmoidoscopy or colonoscopy _____	☐ unknown	☐ never
Date of last prostate cancer screening _____	☐ unknown	☐ never

Family History

Father: Deceased? Yes ☐ Age of death: _____ Cause of death: _____
No ☐ Current age: _____

Mother: Deceased? Yes ☐ Age of death: _____ Cause of death: _____
No ☐ Current age: _____

List all brothers/sisters with information about their age and health:

Is there any family history of:

Diabetes	☐ Unknown	☐ No	☐ Yes
High blood pressure	☐ Unknown	☐ No	☐ Yes
High cholesterol	☐ Unknown	☐ No	☐ Yes
Heart disease	☐ Unknown	☐ No	☐ Yes
Osteoporosis	☐ Unknown	☐ No	☐ Yes
Colon Polyps	☐ Unknown	☐ No	☐ Yes
Cancer	☐ Unknown	☐ No	☐ Yes

What type? _____

Are there any other diseases that "run in the family"?
☐ Unknown ☐ No ☐ Yes (give details below)

Has there been any genetic counseling in the family?
☐ Unknown ☐ No ☐ Yes (give details below)

Release of Information: I give my permission for this information to be released to a new agency or support person when I am requesting a new service or new service provider:

Signature of Individual: Date:

Signature of Guardian if a dependent minor: Date:

Immunizations _____ ☐Unknown ☐Allergic ☐Never

Date of Tetanus _____ ☐Unknown ☐Allergic ☐Never

Date of Flu shot _____ ☐Unknown ☐Allergic ☐Never

Date of Pneumovax _____ ☐Unknown ☐Allergic ☐Never

Date of Hepatitis B vaccine
Primary series (3 shots) _____ ☐Unknown ☐Allergic ☐Never

Booster _____ ☐Unknown ☐Allergic ☐Never

Date of Measles/Mumps/Rubella (MMR) _____ ☐Unknown ☐Allergic ☐Never

List any other vaccinations and dates (e.g.) Lyme, Hepatitis A, Varicella, etc)

Tuberculosis Skin Test (PPD) ☐Yes ☐No ☐Unsure
Have you ever had a positive skin test for tuberculosis? ☐Yes ☐No ☐Unsure
If yes, was any treatment given? (describe) _____
If untreated, explain (explain) _____
Date of last PPD _____

Medical History not released by parent/guardian ☐
For information contact:
Name _____ Relation _____
Address _____
Tel # _____

Surgical: List all previous surgeries and dates: (most recent first)

Any previous problem with anesthesia? ☐ No ☐ Yes Explain: _____
Physical: List any serious trauma or broken bones:

Medical: List all serious medical illnesses (pneumonia, heart attack, diabetes, high blood pressure, epilepsy):

Psychiatric: List all major behavioral & psychiatric diagnoses (depression, schizophrenia, self injury, etc):

Vision
☐Normal
☐Low vision
☐Blind
☐Wears glasses

Hearing
☐Normal
☐Hard of hearing
☐Deaf
☐Hearing aid

Personal Hygiene
☐Independent
☐Needs assistance

Oral Hygiene
☐Independent
☐Needs assistance

Supported Devices
☐Padded side rails
☐Splints
☐Braces
☐Helmet
Head of bed elevated ☐yes ☐no

Toileting Ability
☐Continent
☐Incontinent
☐Needs assistance
☐Catheterized

Dining/Eating
☐ Independent
☐ Needs assistance
☐ Total assistance
☐ Fed through tube

Diet
☐Regular
☐Ground
☐Puree
☐Thicken liquid
☐Chopped

Living Status
☐Group home
☐Own family
☐Independent
☐Shared home
☐Other

Work/Day Status
☐Adult day training
☐Employment
☐School

Marital Status
☐Single
☐Married
☐Other

Nursing Supports
☐In home
☐Nursing coordination
☐In home 24 hours
☐Home health nurse
☐No nursing supports

Special Needs: Unusual Response to Medical Exams: ☐Cooperates ☐Partially cooperates ☐Resistant ☐ Fearful

☐Sedation for clinical exams Explain _____
☐Special positioning for examination? Explain _____
☐Double staffing required for exam Explain _____
☐Requires limited waiting periods for exams
☐Prefers early day appointments ☐Prefers late day appointments
☐Pain response ☐Normal ☐Unique Explain _____

Medical Providers

Primary Care
Name _____ tel. # _____
Address _____

Dental Care
Name _____ tel. # _____
Address _____

Eye Care
Name _____ tel. # _____
Address _____

Sub Specialist/Type
Name _____ tel. # _____
Address _____

Sub Specialist/Type
Name _____ tel. # _____
Address _____

Sub Specialist/Type
Name _____ tel. # _____
Address _____

Sub Specialist/Type
Name _____ tel. # _____
Address _____

Sub Specialist/Type
Name _____ tel. # _____
Address _____

Behavioral Information (refer to formal plan submitted by Waiver Support Coordinator)

a) Specific behavior concerns: _____

b) Formal Program? ☐ yes ☐ no _____

c) Reaction to hair cutting: _____

d) Reaction to dental care: _____

Sleeping Patterns

a) Sleep schedule: _____

b) Prefers to take nap or rest period? ☐ yes ☐ no

c) Sleeps with light ☐ on? ☐ Off? _____

d) Type of Bed: _____

e) Positions during sleep: _____

f) Sleep disturbances / problems: _____

g) Gets up 2 or more times to use restroom? _____

h) Preferred way to wake up: _____

Self Care

a) Assistance needed for bathing: ☐ independent ☐ verbal ☐ partial ☐ total care

b) Reaction to bathing? _____

c) Assistance needed for showering: ☐ independent ☐ verbal ☐ partial ☐ total care

d) Reaction to showers? _____

e) Assistance needed for tooth brushing: ☐ independent ☐ verbal ☐ partial ☐ total care

f) Reaction to tooth brushing: _____

g) Assistance needed for grooming : ☐ independent ☐ verbal ☐ partial ☐ total care

h) Reaction to grooming: _____

agency for persons with disabilities
State of Florida

Completed by: _____

Relationship to Person : _____

Date: _____

Area 4 Health Record
Adapted from Massachusetts DMR Health Care Record
(To be completed or updated at the Support Plan)

Name: _____ **Height:** _____ **Weight:** _____

Date of birth: _____ **Identifying Marks:**

Address: _____ **Health Insurance (type & numbers)**

_____ **Primary:** _____

Telephone: _____ **Secondary:** _____

Consent Status: Can give consent? ☐ Yes ☐ No **Agency Responsible for Providing Care** ☐ yes ☐ no

Consent from guardian ☐ Yes ☐ No Agency _____ Tel. # _____

Name of guardian _____ Tel. # _____ Primary contact Person _____

Unable to give own consent and has no guardian ☐ Yes ☐ No

Resuscitation Status: ☐ DNR ☐ Full Resuscitation **Health Care Proxy** ☐ Yes ☐ No

Emergency contacts

#1 Name _____

Telephone _____

#2 Name _____

Telephone _____

Allergic to: **Type of Reaction:**

☐ Medications: _____

☐ Food: _____

☐ Environmental: _____

Medical Diagnoses:

Medications: ☐ MAR attached ☐ List attached

Pharmacy: Name _____

Address _____

Tel. # _____

Current Medical Problems

Communication

☐ Able to communicate
☐ Uses verbalizations
☐ Uses gestures
☐ Uses sign language
☐ Unable to express needs
☐ Only understands foreign language
☐ Special communication device/ method

Medication Administration

☐ Independent/Self medicates
☐ Administered by staff
☐ Supervised by staff

Ambulation

☐ Dependent ☐ Steady ☐ Unsteady
☐ Needs Assistance
☐ 1 person ☐ 2 people
☐ Aids
☐ Crutches ☐ Walker ☐ Cane
☐ Uses wheelchair ☐ Owns wheelchair
☐ Non ambulatory

Release of Participant's Portrait & Video Image

For Facility Newsletters, Online Activity Posting, & Community Media

Facility: _____

I, _____, am aware that staff or visiting photographers and/or videographers will be capturing audio and photo or video footage at this facility during participant activities and special events. By allowing the photographers or media to capture my image / my family member's image, I am granting permission to the facility, and it's visiting service and activity providers to use my image / my family member's image to promote the facility, healthy activities, the activity service providers, and any of the associated events. I must inform the media manager if I do not wish myself or my family member to be photographed or audio/video recorded, and must then refrain from being included in such media.

I, _____, understand that any media images which may be taken and shared are in the utmost respect for myself / my family member, and are meant to represent all those involved in the most positive manner. I understand that <u>at no time</u> will this be in attempt to invade any privacy, or share my detailed personal/medical information, or the personal/medical information of my family member; with the public or any business or soliciting entity. I hereby release and hold harmless in all media and legacy; this facility, the organizers, sponsors, affiliated service providers, visiting entertainers, activity service agents and any supervisors of this media recording effort, from any and all ties of personal copyright or gains or from media ownership of my image or my family member's image.

Participant Name _____ Date _____

Usable Media First Name / Nickname "_____"

Responsible Party Name _____ Date _____

<u>Optional Contact Information for Photo Prints / Media Viewing Updates:</u>

Phone _____

E-Mail _____

Street Mailing Address _____

_____

PRINCIPLES OF CHOICE

- All people have the right to make choices.
- People have the right to learn about choices through exposure to natural life experiences, making mistakes, naturally occurring consequences, training and through seeking advice from others.
- All people with disabilities have the right to receive impartial information concerning choices. Undue, imbalanced or self-serving influence is not acceptable
- Factors that limit choices for people with disabilities should not differ from those for people without disabilities.
- People have the right to choose from a variety of supports and services and make changes based on their individual needs.
- People should be offered options which are free from threats to their immediate health and safety or the immediate health and safety of others.
- Consistent with other principles of choice, people have the right to make an informed choice of any qualified provider of any needed service or support.
- The choices people make do not diminish the obligation to act in a responsible manner and to accept the consequences of their choices.

Applicant Initial_____

Community Participation and Involvement

Name:_____ Service:_____

Mark all of the kinds of community and leisure activities that you participate in now or desire to do.

Leisure/Community Involvement Activities	Now	Desire
Library		
Shopping		
To the Bank		
Community dances		
To the Post Office		
Church		
Movies		
Attend sporting events		
Attend a health club		
A park		
A community center		
Favorite restaurant		
Volunteer work		
Attend a class		
Go to the beach		
Use public transportation		
Rent a movie		
Attend a concert/play		
skating		
bowling		
Lessons		
Volunteer at a nursing home		
Volunteer at an animal shelter		
Community cleanup		
Fitness activities		
Other		
Other		
Other		
Other		

RIGHTS AND RESPONSIBILITIES OF INDIVIDUALS RECEIVING SERVICES

(Standard 1.A.2 Cite, 1,2,7,8/C.A)

Support Services, LLC is committed to promoting the rights and protecting the health and safety of the individuals served by this agency. We will abide by and adhere to Chapter 393 of the Florida Statutes, which ensures the following individual rights for individuals with developmental disabilities:

- Dignity, privacy and humane care
- Religious freedom and practice
- Services provided in the least restrictive environment
- Quality education and training, within available resources, including sex education, marriage and family planning
- Social interaction and participation in community activities
- Physical exercise and recreation
- Freedom from harm, including unnecessary physical, chemical or mechanical restraints, isolation, excessive medication, abuse or neglect.
- The right to refuse treatment
- Be excluded from participation in any program or activity receiving public funds
- To vote
- Unrestricted right to communication
- Possession and use of his/her own clothing and personal effects
- Prompt and appropriate medical treatment
- Access to individual storage space
- Humane discipline
- Examination by a physician prior to behavioral programming
- Fair Labor Practices
- To a central record
- Opportunity to have a copy of these rights and an explanation of them in a format understood by the individual.

In addition, any restriction of client rights will be made in accordance with state statute and regulations. Individuals have a right to be treated with respect, and to be included in decisions regarding their life (with assistance from their guardian if applicable.) Food/drink may not be withheld for punishment and the individual has a right to freedom of movement. Any restriction of movement will be limited to those indicated in an approved behavioral plan.
We will keep sufficient records to account for how money is being used if I assist individuals with handling their money.

We want to provide the best service possible to the individuals. To that end, if individuals are dissatisfied with my services for any reason, they have a responsibility to discuss these concerns with me so that, together, we can attempt to resolve the issues.
These rights and the individual's responsibilities will be discussed with the person on an annual basis.

This confirms that my rights and responsibilities have been explained to me.

Individual / Guardian *(if applicable)* _____ Date _____

GRIEVANCE PROCEDURE
FOR PARENTS/GUARDIANS AND
PERSON RECEIVING SERVICES/CAREGIVERS

Every person receiving services, caregiver, parent and/or guardian has a right to express a grievance to the center staff. The staff member shall attempt to address the problem.

If the grievance is not addressed to the satisfaction of the person receiving services/caregiver/parent/guardian, he/she may take the complaint to the Program Director.

A grievance form should be filed at this time.

The Program Director shall have 7 days to respond to the filed grievance.

If the grievance is still not resolved to the satisfaction of the person receiving services/caregiver/parent/guardian, he/she may make an appointment to meet with the Program Director.

The Director shall have 20 days to resolve the complaint.

If the grievance is not addressed to the satisfaction of the person receiving services/caregiver/parent/guardian he/she shall then request an appointment with Support Coordinator/Case Manager and/or Liaison, Director; owner/operator. The owner/operator shall have 10 days to resolve this complaint and the decision shall be final.

This form will be reviewed annually

_____ _____

Caregiver signature Date

_____ _____

Director signature Date

Applicant Initial_____

Informed Consent

Section 393.506, Florida Statutes, authorizes an independent direct service provider (including a direct service provider employee) not licensed to practice nursing or medicine to administer medication or supervise the self-administration of medication following completion of medication administration training and current annual competency validation by a licensed registered nurse or physician. This form authorizes medication assistance by a trained, validated provider.

I, _____, as the below-named client or client's legal
(Printed name of client or client's representative)

representative, contingent upon the authorization of my health care provider,

provide my consent to _____ to:
(Printed name of validated medication assistance provider)

_____ Administer medications prescribed for me by my professional health care provider; *or*

_____ Supervise my self-administration medications prescribed for me by my professional health care provider.

_____ _____
Signature of Client or Client's Legal Representative *Date*

_____ _____
Printed name of person signing *Date*

(NOTE: A validated unlicensed direct service provider cannot consent as the client's legal representative.)

_____ _____ _____
Signature of Witness No. 1 *Printed Name of Witness No. 1* *Date*

_____ _____ _____
Signature of Witness No. 2 *Printed name of Witness No. 2* *Date*

This document remains effective until _____, unless I
(Twelve months from signature date)

elect to withdraw my consent.

As always, you are encouraged to review the Discovery Review tools (including protocols) for all services plus the administrative requirements.

These can be found online at this website:
https://florida.qlarant.com/PublicL2/resourceCenter/providers/discoveryReviewTools/index.html

Please make sure to include a coversheet identifying my name and your provider name with the documentation you submit. Also, include the number of pages submitted in order to verify that I have received the entire package. Make sure you only submit copies since the documentation will not be returned to you.

Program Policies

1. Hours of operation

The program is open from 8:00 am to 3:00 pm, Monday through Friday. Closing will occur promptly at 3:00 pm. A late fee will be assessed for individuals not picked up by 3:00 pm with a charge of $10.00 every 15 minutes. Transportation of individuals through transportation companies is coordinated by staff through the family and funding source.

2. Incontinence

Protective undergarments are acceptable for loss of bladder control. Please send in at least two extra per day.

3. Special Assistance

The staff is always available to provide assistance to clients. Persons regularly requiring the simultaneous assistance of more than one staff person are considered on an individual basis.

4. Hygienic Standards

It is very important that all clients have good hygiene. Good hygiene means a clean body (including mouth and hair) and clothes. In case of poor hygiene, staff will advise the client and/or caregiver and assist with helping to solve the problem through referrals and/or education and/or individual attention.

Applicant Initial___ _____

5. Medicines

5. Medicines

Administer medication to the client in accordance with the following criteria:

-Medication prescribed for administration during the day care hours of service must be properly labeled with name of medication, pharmacy number, prescribing physician, dosage, and times of administration. Medication should also come in a bottle directly from the pharmacy.

-Medication to be administered will remain on premises for duration of client's participation in the program.

-Medication renewals will be the responsibility of client or responsible party.

-If the client refuses medication, the responsible party will be notified.

6. Bed Rest

A day bed is available for clients who become ill and need to lie down. Otherwise, comfortable easy chairs, couches, and recliners, are available for reclining.

7. Activities

A variety of activities are scheduled and all clients are encouraged to participate.

8. Wandering

To ensure clients' reasonable safety, determination of the appropriateness of clients who are prone to wandering will be made on an individual basis. Alarms and fences are in place.

9. Combative Behavior

The participation of persons who are routinely hostile, combative, or verbally abusive to others (clients or staff) will be terminated. The client will be allowed to remain as a client if behavior problems can be controlled by mediations or behavior management.

10. Termination from the Program

These policies and standards were developed to ensure a healthy, pleasant, stimulating environment for all clients and staff. A client who does not meet these standards will be re-evaluated to determine cause for termination from the program. In such situations, an individual conference with the client, caregiver, and/or case manager may be scheduled to assess the situation. In all cases, the client and/or caregiver will be given a minimum of one week of prior notice to the termination date. When safety is an issue due to progression of symptoms, these clients will be dealt with on a one to one basis.

11. Volunteers

Adult daycare utilizes volunteers from the community, local schools, and universities. There are many volunteer opportunities.

12. The client or Responsible Party agrees to:

-Complete or provide all necessary client-related forms prior to admission.
-Notify the daycare at least seven (7) days prior to client's intended date of discontinuance in the program
-Provide changes of labeled clothing and undergarments to be stored at the center.
If client uses incontinence diaper, an adequate supply should be provided for each day.

-Absolve the daycare of liability for any loss or damage to the client's personal property or valuables to fire, theft, or other mishaps.
-Absolve Infinity Care , Inc.'s officials, employees, and/or any other person, firm, or corporation charged or chargeable with responsibility or liability from any and all claims, damages, costs, expenses, loss of services, actions, and cause of action, which could arise out of any occurrence, and particularly on account of personal injury, sustained by the said participant, while the participant is on the vehicles arranged/owned by the daycare.
-Authorize the daycare to transport the client off the premises for planned outings, neighborhood walks, or community events, etc. as part of the therapeutic programming.
-Accept the decision of the daycare regarding discharge of the client due to concerns for his/her safety or that of others.

13. Authorize the daycare to:

-Use pictures or identifying information regarding the client for publicity purposes or use in an emergency.
-Release information regarding the client for publicity purposes or use in an emergency.
-Transport clients to the nearest emergency facility in the event of an acute illness if family or responsible persons cannot be reached.

14. a. Pay the daycare the daily rate 10hr at the beginning of the week or month, plus transportation.
b. Allow the daycare to submit third party billings monthly for services rendered, if necessary, if covered.
c. Infinity Care! hours are from 8:00am to 3:00 pm.
d. A late fee of $10.00 will be charged for each fifteen minutes past 5:30 pm, or agreed time for client to be picked up.
e. Client will attend daycare _____ per week on the following days _____.

15. All employees and participants receive training on preventing, recognizing and reporting abuse, neglect and exploitation on an annual basis. This training is tailored for recipients and questions are encouraged to ensure an understanding is met. The procedure for each abuse, neglect and exploitation is explained and the registry/abuse number is located in several spots around the center. Abuse, neglect and exploitation are all very serious offences and are taken very seriously in our center. The staff are trained and policies are in place to protect against abuse, neglect and exploitation. If at any time you have concerns in this area please report to the center director.

I have read and understand the above items and agree to abide by them.

_____ _____

Legal Caregiver/ Participant Date

Applicant Initial____ __

If transportation is provided by a transportation company for your family member, it is of utmost importance that you or someone at your home assists the driver in loading the individual from the vehicle. Transportation company drivers maintain a very tight schedule and are on a very tight time limit when providing this service to you and your loved one. Any assistance you provide will allow them to be more accurate on their arrival times.

Transportation must be provided personally or by a transportation company, if so chosen.

If using a transportation company is the means of transportation for your loved one please follow the following:

1. Be ready 20-30 minutes before estimated pick-up time.
2. Have individual dressed, groomed, and toileted before pick-up.
3. Driver is only able to wait 5 minutes for passenger to leave the house.
4. Be prepared for a delay due to traffic or weather.
5. If they have not arrived by the estimated pick-up or drop-off time, please call and we can check on estimated arrival time or you may call your transportation company.

Your cooperation in this matter would be greatly appreciated.

Applicant Initial____ _____

RATE AGREEMENT

Daily charges will be based on the contracted rate with the funding source. The private pay rate is $70.00 for up to 8 hours daily. The drop-in rate is $10.00 per hour plus $4.00 meals. Individuals funded by outside sources, subject to contract agreement. Scholarships may be available for non-funded clients.
Payment is required at the beginning of the week and/or month. Funded clients must have current service authorizations on file.

If you know that the client will not be attending on a regularly scheduled day, to avoid being charged for that day, twenty-four (24) hours notice must be given.

Refund policy: Since payment is made at the beginning of the week/month, any excess payment will be credited toward the following week.

DATE: _____

DAILY RATE: _____

I have received a copy of Infinity Care. policies. I hereby agree to comply with the stated policies and procedures and to respect the personal rights and private property of the other participants.

_____

Participant's/Guardian's Signature

_____

Director's Signature

Applicant Initial_ ____ ___

Information Form

Personal Information:

Last Name:_____ First Name: _____

Address: _____

_____

Telephone:_____Cell:_____

Date of Birth:_____ _____ _____

Person to notify in case of emergency:

Name:_____Relationship:_____

Telephone:_____Cell: _

Additional Comments:

_____

_____

Date:_____Signature:_____

_____Start Date: _____