

SWCARC, Inc.
P.O. Box 66
Southbridge, MA 01550
508-764-4085

Program Admission Agreement

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(program site)

hereby agree to the following terms and agreements.

Obligations of the SWCARC Programs

Day Habilitation _____

1. To provide individuals with medical and developmental disabilities with challenging, supportive and individually driven skills training programs, with the goal of helping each individual achieve their highest level of independence.
2. To provide each program member with individualized skills training programs in a supportive, therapeutic setting.
3. Day Habilitation will strive to meet the needs of each individual served, through skills training services, restorative services, nursing care and assistance in daily living; focusing on the interest, preferences and goals of each person served.
4. Day Habilitation will provide individual supports in the following skills training areas:
 - Self Monitoring of Health and Nutritional Status
 - Self Help Development
 - Sensorimotor Development
 - Communication
 - Social Development
 - Independent Living Skills
 - Safety Skills for Home, Work and Community
 - Use of Community Resources
 - Affective Development
 - Behavior Development
5. Each individual will receive supports and services tailored to their specific needs, interests and abilities.
6. Support Services will include Restorative Services (Physical Therapy, Occupational Therapy, Speech Therapy) as well as Behavior Modification Supports, Nursing Supports, Health and Nutritional Programming and Case management Services.

VOCATIONAL _____

1. To provide employment opportunities, both paid and volunteer
2. To provide training opportunities to better enhance individual's job readiness skills and employability.
3. To provide support, Case Management and Job Coaching supports, both in the program and community.
4. To provide support and training to assist each individual in developing safety skills, social skills, and marketable employment skills.

GENERAL:

- 1. To promote the rights and dignity of all persons with disabilities to lead meaningful lives as valued members of their community.
- 2. To provide the supports in the areas of self-advocacy, human rights, and growth and independence.

CONFIDENTIALITY CLAUSE:

- 1. SWCARC will adhere to confidentiality policies as required by HIPAA. (See attached Privacy notice)
- 2. SWCARC will limit access to program member's records to individuals employed by the organization and the required accreditation entities. Any other release of information will require approval from the program member and/or his/her guardian.

Obligations of the Participant and/ or Responsible Party

- 1. To provide personal clothing and items as needed.
- 2. To provide the agency with required documentation upon request.
- 3. To supply an updated physical annually.
- 4. To communicate any changes in physical, emotional, home status.
- 5. To notify individual programs of medication changes, if appropriate.
- 6. In the event of an emergency, SWCARC is authorized to take such action with respect to the participant as is deemed best under the circumstances of unavailability of both physician and responsible party.

I take responsibility for the above listed obligations that are designated our responsibility in the Admission Agreement.

Participant's Signature: _____

Guardian's Signature: _____

Date: _____

Person securing Consent: _____

Please retain for your records

Southern Worcester County ARC, Inc.

Privacy Notice

Protecting the personal information of the individuals this agency serves is something we at SWCARC, Inc. and all of its programs take very seriously. This privacy notice explains how we handle the personal information about you that we collect and may disclose. It also tells you how you can limit our disclosure of personal information about you. This notice applies to current and former clients. We may amend this notice from time to time.

Our Privacy Promise

- We will safeguard, according to strict standards of security and confidentiality, any information you share with us.
- We will limit the information about you that we share by asking you to authorize disclosure of personal health information to any entity who is:
 - Not an employee of the agency
 - Not an employee of the funding source which has financial responsibility for your services through SWCARC, Inc.
 - Not an affiliated partner in treatment (Dept. of Mental Retardation, Department of Mental Health, Division of Medical Assistance, Massachusetts Rehabilitation Commission, School or Private Organization whom you are affiliated with)
- We will not reveal your personal health information to any external organization unless we have previously informed you in disclosures or agreements, have been authorized by you, or are required by law.
- We will permit only authorized employees, who are trained in the proper handling of client information to have access to that information. Employees who violate our privacy policies will be subject to agency disciplinary process.
- We will not provide information about you for the purposes of research, marketing or publication, without explicit approval and authorization from you
- If you are under guardianship, we will follow all regulatory procedures regarding seeking approval from your guardian for any disclosure about you or your personal health information and must seek guardian approval for any distribution of your name or information about you for any research, marketing or publication.
- Whenever we hire consultants or other entities to assist in your care and treatment, these consultants will be bound by the same privacy policies as our agency staff.
- We will not share, internally or externally, personal identifiable medical information for any purpose other than your care and treatment, unless so authorized by you.
- We will attempt to keep client records complete, up-to-date, accurate and secure.
- We will share your personal information with you (review or make copies from your record) at your written request, or that of your guardian. If you are unable to complete a written request, staff assistance to do so will be provided.
- If you feel a portion of your record contains incorrect information, you may dispute the content of the record in writing to The Director of Programs, SWCARC, Inc., PO Box 66 Southbridge, Ma. 01550. If you are unable to complete a written request, staff assistance to do so will be provided.

Complaints:

If you believe your privacy rights have been violated, you may file a complaint with us. All complaints must be filed in writing, however, if you are unable to file a complaint in writing, staff assistance will be provided to help you do so.

Complaints must be filed with: The Privacy Officer
SWCARC, Inc.
PO Box 66
Southbridge, MA. 01550

For further information about matters covered by this notice, please contact The Privacy Officer at the above address or call (508) 764-4085.

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508-764-4085

Programmatic Release Form

I hereby authorize _____ to:
(individual to attend)

1. Participate in any programs conducted by Southern Worcester County ARC including (but not limited to) community access trips and recreational activities that may be conducted at places other than this program but approved by this program.
2. Be transported to any of the above by staff or volunteers of the agency and hold the operator of any agency owned vehicle harmless.
3. Be transported by means other than agency owned vehicles when necessary and approved by Southern Worcester County ARC, and hold the operator of any such vehicle harmless.
4. I will allow the Southern Worcester County ARC staff to provide emergency first aide and if necessary, transport the individual to the emergency room, or contact an ambulance if needed.

I understand that in the case of an emergency, all efforts will be made by SWCARC staff to contact the Guardian and the emergency contact person listed with the agency.

Participant Signature: _____

Guardian Signature: _____

Date: _____

I affirm that my consent was not obtained under coercion or undue influence, and that it may be withdrawn at anytime without fear of consequences.

Participant's Name Participant's signature Date

Guardian's Name Guardian's signature Date

Person Securing Consent: _____ Position: _____

This consent must be reauthorized annually. Consent may be withdrawn at any time by the program participant / guardian by notifying Southern Worcester County ARC, Inc. in writing.

Signature of Participant/ Responsible Party / Guardian (circle one) Date

*In case of an emergency, or in the event that I cannot be contacted, please contact one of the following persons:

1. NAME í .

ADDRESS í .

PHONE í .

2. NAME í ..

ADDRESS í .

PHONE í .

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Annual Photo Consent Form

1. I, _____, grant permission to Southern Worcester County ARC to videotape / photograph me when at work or when participating in activities within the program or in the community for use in the program site or agency only.

_____initial

2. I, _____, grant permission to Southern Worcester County Arc to use my photo image for publication in SWCARC Center of Hope use and promotional materials such as brochures, video, and the website.

_____initial

I understand that staff will respect my privacy and will not videotape/photograph me when I ask them not to.

I understand that staff will respect my privacy and will not videotape/photograph me in embarrassing situations.

I affirm that my consent was not obtained under coercion or undue influence and that it may be withdrawn as specified without fear of consequences.

I understand that if a photo, video or other personal information is to be used in a public manner (Display board for Legislative breakfast/ newspaper article, video to be shown publicly) I (or if applicable, my Guardian) will be asked to sign a "Use Specific Release" prior to the use of my image in a public manner.

Participant's Signature: _____

Person securing Consent: _____ Date: _____

____ Check if under Guardianship

Guardian's Signature: _____ Date: _____

This consent must be reauthorized annually.

Consent may be withdrawn at any time by the program participant / guardian by notifying Southern Worcester County ARC, Inc. in writing or by calling Rachel Reyes, Director of Programs at 508-764-4085.

If a photo is to be used outside of the agency, or in any public manner, the individual and his or her guardian will be required to sign an additional consent at that time.

SWCARC, Inc. revised 12/06, 6/07, 1/08, 10/08

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Guardian Request for Information

Individual Served: _____

Program: _____

I would like to receive information regarding documented incidents in the following manner:

- _____ Phone call
- _____ Mailed copy of report
- _____ Faxed copy of report
(Fax #: _____)
- _____ Phone call and copy of report
- _____ Annual assessment

Guardian Signature: _____

Date: _____

SWCARC, Inc. 10/04, 6/07, 1/08, 10/08

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CONSENT TO CONTACT

I, _____ hereby authorize SWCARC Center of Hope to contact my Family / Care Provider / Residential staff to discuss:

- _____ my participation in the program
- _____ social interactions between myself and peers / staff
- _____ behavioral incidents that occur involving me
- _____ any other issue that staff feel should be relayed to my Family / Care Provider / Residential staff

I attest that I was not coerced into consenting.

I understand at any time that I can withdraw my consent.

This form must be updated annually.

Participant's signature: _____

Person securing consent: _____

Date: _____

SWCARC, Inc. 2/06, 6/07, 1/08, 10/08