

Georgia Community Support and Solutions

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

Welcome

Thank you for your interest in Georgia Community Support and Solutions. We look forward to working with you as we try to enrich the lives of people with disabilities and their families by providing information, advocacy, and supports to expand their choices in the community. You have in your hands a copy of our Intake Packet. It must be completed when applying for either Waivered or Private Pay Services.

Please note that we are excited for the opportunity to work with you as a service provider and our goal is to provide the highest level of service possible as we work to impact the lives of individuals with disabilities. While completing the intake packet please think over the following questions:

What kind of support is the family/person looking for specifically?

If there are behaviors, is there a Behavior Support Plan?

Once a **COMPLETE** intake packet is received the Intake Coordinator will schedule an intake interview with the individual and family, guardian, PLA, SSSC, or support coordination. At least one of the preceding individuals must be in attendance for the interview.

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URGENT!!!

Listed below are the documents REQUIRED for admission.

Documents needed from: Family/guardian/advocate:

- Current Photo
- Copy Of Medicaid Card
- Copy Social Security Card
- Copy of Birth Certificate
- Copy of Immunization or Tetanus Shot no more than 45 days prior to admission
- Copy of Physical Form
- Copy of Private INS., Card (If Applicable)
- Current PPD test (T.B. Test) due at time of admission

Documents needed from: Support Coordination Team:

- Copy of Most current Psychological Assessment
- Copy of Most current Nursing or Physicians Assessment
- Copy of Most current Social Work or Social History Assessment
- Copy of Current DMA-6
- Copy of Most Current ISP/IEP
- Copy of Medicaid Waiver Application

Once a **COMPLETE** intake packet is received the Intake Coordinator will schedule an intake interview with the individual and family, guardian, PLA, SSSC, or support coordination. At least one of the preceding individuals must be in attendance for the interview.

APPLICATIONS ARE PROCESSED WITHIN 30 DAYS OF RECEIPT OF ALL DOCUMENTATION!!!

Thank you,

Ranardia Gaillard

Ranardia Gaillard, MS
Intake Coordinator

Updated July 17, 2010

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INTAKE FORM			
1. Biographical Information		Date of Entry: _____	
Name:		S.S.#:	
Address:		Medicaid#	
Phone:		Medicare#:	
Region:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth:	
Race/Ethnicity (Please Check <input checked="" type="checkbox"/>) <input type="checkbox"/> Native American <input type="checkbox"/> Black/African American <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian <input type="checkbox"/> Other	Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Sign Language <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____	Religious Affiliation (Optional) <input type="checkbox"/> Catholic <input type="checkbox"/> Baptist <input type="checkbox"/> Methodist <input type="checkbox"/> Jewish <input type="checkbox"/> Protestant <input type="checkbox"/> 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:		(Amounts by Month)	
1. _____		Amt: _____	
2. _____		Amt: _____	
Private Insurance: (Y) or (N)			
If yes, Name: _____			
Policy Coverage:			

4. Legal Guardian			
Legal Status: <input type="checkbox"/> Legally Competent <input type="checkbox"/> Unknown <input type="checkbox"/> Minor under 18 years of age			
<input type="checkbox"/> Adjudicated Legally Incompetent <input type="checkbox"/> D.A.I. Score Comments: _____			
(Complete section below on legal guardian and attach documentation of guardianship)			
Legal Guardian (Complete ONLY if person is a minor or has been adjudicated incompetent)			
Name of Legal Guardian:		D.O.B	S.S.#:
Address:			
Home Phone:		Work Phone:	
If limited Guardianship, Describe Limitations:			
5. Required Signatures			Date:
1. (Intake Coordinator)			
2. (Support Coordinator)			

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Emergency Contact Form

Name: _____		SSN: _____	
Address: _____		Medicaid# _____	
_____		Medicare#: _____	
Phone: _____		_____	
Ethnicity: _____	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth: _____	
Parent/Guardian/Representative: _____			
EMERGENCY /FAMILY CONTACT			
Name: _____		Name: _____	
Relationship: <input type="checkbox"/> Parent <input type="checkbox"/> Sibling <input type="checkbox"/> Relative <input type="checkbox"/> Other (Specify) _____		Relationship: <input type="checkbox"/> Parent <input type="checkbox"/> Sibling <input type="checkbox"/> Relative <input type="checkbox"/> Other (Specify) _____	
Address: _____		Address: _____	
Employer: _____		Employer: _____	
Phone: _____ Work _____ Home _____ _____ Pager _____ Cell _____		Phone: _____ Work _____ Home _____ _____ Pager _____ Cell _____	
Medical Information			
Allergies: Allergies: (Y) or (N) <i>If yes specify:</i> _____		Seizures: (Y) or (N) <i>If yes specify:</i> _____	
_____		_____	
Diagnosis: _____			
Present Prescribed Meds/Dosage/Frequency: _____			

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: (Y) or (N)			

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Information Consent Form

Name: _____ Soc. Sec. #: _____

Date of Birth: _____ MHID/CID#: _____

1. I, the above named person, hereby 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 Circle)

Yes	No
-----	----

2. I, the above named person, hereby give permission to GCSS and staff to be video taped, or recorded of for agency purposes.

(Please Circle)

Yes	No
-----	----

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

(Please Circle)

Yes	No
-----	----

4. I, the above named person, hereby authorize GCSS to release information pertaining to myself to the following named persons:

(Please Circle)

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 revoked)

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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? _____

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

Hygiene

(Please check all that apply).

- Prefers Shower () Bath ()
Washes Independently ()

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When is nap time? _____

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 ()

- Cannot Wash Self ()
- Needs Assistance ()
- Shampoos Hair independently ()
- Needs Assistance ()
- Brushes/Combs Hair ()
- Cannot brush/comb hair ()
- Brush/Comb Hair w/ assistance ()
- Brushes Teeth independently ()
- Cannot Brush Teeth ()
- Brushes Teeth w/ assistance ()
- Shaving (if applicable) ()
- Shaving w/ assistance ()
- Menstruation ()
- Needs assistance ()

FEEDING

- Eats Independently ()
- Drinks Independently ()
- Bottle Fed ()
- Blended Diet ()
- Special Diet ()

Feeding

- G Tube Fed ()
- NG Tube Fed ()
- J Tube Fed ()
- Choking/gag reflux ()
- Must Have Food Cut ()
- Needs assistance w/utensils ()

Toileting

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

(Schedule) _____

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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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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 right of those at risk of being infected is 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 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.

Updated July 17, 2010

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NOW/COMP 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
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 and have chosen to refuse waiver services.

Recipient

Date

Authorized Representative

Date

Recipient

Date

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ANNUAL PHYSICAL

Name: _____ D.O.B. _____

Diagnosis: _____

Allergies: _____

Seizures: _____

Height	Weight	B.P.	Pulse	Resp.

(Please Check)

Vision	<input type="checkbox"/> Adequate	<input type="checkbox"/> Impaired	<input type="checkbox"/> Legally Blind	<input type="checkbox"/> Undetermined
Hearing	<input type="checkbox"/> Adequate	Impaired { <input type="checkbox"/> Mild <input type="checkbox"/> Mod. <input type="checkbox"/> Sev. }	<input type="checkbox"/> 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: _____

(Medical Doctor Signature)

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice is effective April 14, 2003. It is provided to you pursuant to provisions of the Health Insurance Portability and Accountability Act of 1996 and related federal regulations. If you have questions about this notice please contact the Department's Privacy Officer or Divisions Coordinator at the address below.

The Department of Human Resources is an agency of the State of Georgia responsible for numerous programs that deal with medical and other confidential information. Both federal and state laws establish strict requirements for most programs regarding the disclosure of confidential information, and the Department must comply with those laws. For situations where stricter disclosure requirements do not apply, this Notice of Privacy Practices describes how the department 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 to access and control your protected health information, and provides information about your right to make a complaint if you believe the Department has improperly identify you and relates your "protected health information." Protected health information is information that may personally identify you and relates to you past, present, and future physical or mental health or condition and related health care services. The Department is required to abide by the terms of this Notice of Privacy Practices, and may change the terms of this notice, at any time. A new notice will be effective for all protected health information that the Department maintains at the time of issuance. Upon request, the Department will provide you with a revised Notice of Privacy Practices by posting copies at its facilities, publication on the Department's website, in response to a telephone or facsimile request to the Privacy Office, or in person at any facility where you receive services from the department.

1. Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by the department, its administration and clinical staff and others involved in your care and treated 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, and 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:** The Department may use or disclose your protected health information to support the business activities of the Department, including, for example but not limited to, quality assessment activities, employee review activities of the Department, including, for example, but not limited to, quality assessments 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 used to contact you about appointments or for to there 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, except as permitted or required by law as described below. Generally, if there is protected health information that identifies you as a person who has applied for or received substance abuse services, that information will not be disclosed without your consent unless the law allows or requires such a disclosure. The Department may use and disclose your

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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, the Department may use and disclose certain protected health information to your representative, as that is defined in the Georgia Mental Health Code, upon your admission or discharge; you may be giving a chance to object to certain other disclosures to your representative.

3. Permitted or Reported Uses and Disclosures without Your Authorization or Opportunity to Object

The Department 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 a 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; 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 representatives of your estate.

4. Required Uses and Disclosures: Under the law, the Department must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine the Department's compliance with the requirement of the Privacy Rule at 45 CFR Sections 164.500 et seq.

5. Your Rights: The following is a statement of your rights with respect to your protected health information and 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 the Department maintains the protected health information. This information includes medical and billing records and other records the department 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.
- b. **You have the right to request restrictions of your protected health information.** You may ask the Department not to use or disclose any part of your protected health information for the purpose 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 restrictions to apply. The Department is not required to agree to a restriction requested, and if the Department 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 the Department does agree to the requested restriction, the Department 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 communication from us by alternative means or at an alternative location.** Upon written request to a person listed in section 6 below, the department will accommodate reasonable requests for alternative means of communication of confidential information, but may condition this accommodation upon your provision of an alternative address or other method of contact. The department will not request an explanation from you as to the basis for the request.
- d. **You have the right to request an amendment of your protected health information.** If the Department created your protected health information, you may request an amendment of that information for as long as the Department maintains it. The Department 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 medical information.

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- e. **You have a 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, excluding any disclosures the Department made to you, to family members or friends involved in your care, or for national security, intelligence or notification of purposes. You have the right to receive legally specified information regarding disclosures occurring after 14, 2003, 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 by notifying the Department's Privacy Officer of the bases for your complaint. The Department will not retaliate against you for filing a complaint.

**You may contact the Department's Privacy Officer:
Georgia Department of Behavioral Health and Developmental Disabilities**

404.656.4421 Phone 404.657.1123 Fax
2 Peachtree Street, NW
Room 29.210
Atlanta, GA 30303-3142

OR

The Divisions Privacy Coordinator

404.657.6423 Phone 404.657.6424 Fax
2 Peachtree Street, NW
Room 22.240
Atlanta, GA 30303-3142

OR

To the staff of your provider for further information about the complaint process or this notice.

Please sign a copy of this notice of Privacy Practices for the Department's Records.

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

Signature of Individual/Resident or legally Authorized Person

Date

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Individual/Resident Rights

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.

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.

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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.

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 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 Human Rights Committee.

Rights are in compliance with the Rules of the Department of Human Resources Mental Health, Mental Retardation and Substance Abuse, Chapter 290-4-9.

ACKNOWLEDGMENT:

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

Name

Date

Witness

Date

Updated July 17, 2010

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(404) 634-4222

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.

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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 DBHDD Regional Board.

Department of Behavioral Health and Developmental Disabilities Regional Boards

Region 1 DBHDD REGION ONE OFFICE 1305 Redmond Circle Building 401 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	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 Receiving Service or Family/Legal Guardian/Date

Witness Signature/Date

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Authorization for Use or Disclosure of Protected Health Information

I, _____, authorize the Georgia Department of Behavior Health and Developmental Disabilities provider Georgia Community Support and Solutions, Inc, and it's administrative and support staff to:

(Check all that apply):den

_____ use the following protected health information

_____ disclose the following protected health information to:

The protected health information authorized to be used or disclosed includes:

_____ 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 protected health information authorized to be used or disclosed for the following purposes:

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
2 Peachtree Street, NW
Room 22.240
Atlanta, GA 30303-3142

OR

Divisions Privacy Coordinator

404.657.6423 Phone/404.657.6424 Fax
2 Peachtree Street, NW
Room 29.210
Atlanta, GA 30303-3142

Or to the Staff of my service provider.

The Department of Human Recourses 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

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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WAIT!!!!

Before Returning Your Packet:

Please Make Sure You Have Signed & Completed ALL Forms in the Attached Application to the Best of Your Ability.

PLEASE NOTE:

1. When you return an application **INCOMPLETE:** It slows the process!!!
2. If you have a Support Coordinator or Planning List Administrator assigned to your case make sure you have informed them of your choices and also their obligations to assist with the process.
3. Applications are processed within **(30) thirty days** of receipt of a fully completed application/intake packet. All documentation must be in before application is processed.

~Thanks You~