



Overnight Respite Application

ADAPT Community Network
Overnight Respite
Welcome

Once your loved one has been approved to attend the Respite Program, you will be contacted by one of the administrative staff to schedule a trial date. Prior to the trial, you will be invited for a tour of the facility. We encourage that you bring your loved one with you during the tour for a meet and greet. Our staff is fully trained in CPR/First Aid and medication administration.

Upon arrival, we will complete a thorough body check, where a nurse will be present; and, which we also encourage family members to be present as well. Their bags will be checked, and all clothing will be labeled, and medications will be verified, by medication order, for any prescriptions, which, you may have submitted to us prior to your loved one coming to our facility.

After your loved one has been admitted to our program as scheduled; if your loved one becomes ill/sick, we will notify a family member/legal guardian/or emergency contact listed on the application for your loved one to get picked up or transported home. This is to prevent anyone else at the Program from becoming infectious / contagious.

Our program only schedule three (3) months in advance in order to give all families an opportunity to utilize the program. Please keep in mind that we book on the first week of November for December, January, and February. The first week in February, we will book for March, April, and May. The first week of May, we will book for June, July, and August. The first week in August, we will book for September, October, and November. Please note there will be a yearly calendar mailed to all families with the actual date to call and book per borough. We will keep you informed of any changes regarding this schedule in the future.

We thank you and we welcome your loved one to our family.

Dear Parent/Guardian:

We would like to thank you and your family for using UCP/NYC Overnight Respite Services. This letter serves as a reminder of our Respite Intake process.

- ❖ Intakes are only done on Mondays and Fridays. There are no exceptions.
- ❖ Trials or new candidate to the program will also be admitted on Monday to Wednesday or Wednesday to Friday, based on the family's preference.
- ❖ Hours of arrival are between 8am and 12noon.
- ❖ Pick up times are also between 8am and 12noon. As you know, we provide transportation for all boroughs; with the exclusion to Bronx residents.
- ❖ There will only be arrival exceptions for individuals who attend our Day Habilitation Program on the Bronx Campus.
- ❖ If your son/daughter is coming in for a weekend visit and has to go to school on Monday morning, you may pick him/her up on Sunday afternoon; transportation will not be provided.
- ❖ If your son/daughter missed a day of school, we can provide a letter of excuse for the school.
- ❖ After your son/daughter has been checked into Respite (after medication check and body check), we kindly ask that you please leave the premises. As any place of business we want the most comfortable and secure stay for your child. We want to respect the privacy of all people supported utilizing our Respite Program.

If you have any questions, please feel free to contact us with any issues or suggestions at (718) 652-1902

We appreciate your time and cooperation.

Thank you.



Overnight Respite Application
ADAPT Community Network
Overnight Respite
Welcome

Dear Parent/Guardian:

Prior to your loved one coming to Bronx Overnight Respite Program, it is imperative that we receive all the documents listed below. All evaluations, permissions, and physician order forms must be current (within the present year). All documents requested, are important in order to expedite the application process. Please do not send any application without the required paperwork requested below.

- Completed Current Application (due annually)
- Consent for trips and pictures (due annually)
- Current Medical
- 2 Consecutive PPD readings (once submitted we will not request additional PPD)
- Current Medication/Feeding order including a required Tylenol order (as well as over the counter medications)
- Copy of all current prescriptions
- Most recent Psychological
- Most recent Psychosocial
- Current Life Plan (yearly)
- Current Life Plan Addendum (for the first-time applicants)
- LOC eligibility determination form (yearly)
- Waiver documents including NOD
- Copy of Medicaid or insurance card.
- Approved Service Amendment from OPWDD (completed by Care Manager)

Please note that an incomplete application will delay processing (that includes missing signatures)

All applications can be returned via the following methods

- **Shawn-Kay Gordon**
1822 Stillwell Avenue
Bronx, N.Y 10469
- **Via fax at 718-881-5823**

Feel free to email questions to:

Sgordon@ucpnyc.org, Aboissen@ucpnyc.org

Sincerely,

Shawna-Kay Gordon
Program Director
718-652-9790 Ext 6077

Overnight Respite Application

Applicant Name: _____ **Date:** _____
Date of Birth: _____ Male Female **Social Security #:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Cell Phone: _____ **Home Phone:** _____ **Email:** _____
Medicaid #: _____ **Medicare #:** _____ **Other insurance:** _____
Referring Coordinator: _____ **Agency:** _____
Telephone: _____ **Email:** _____

Applicant Contact Information

Primary Guardian: _____ **Relationship:** _____
Home Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Cell Phone: _____ **Home Phone:** _____ **Email:** _____
Work Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Cell Phone: _____ **Home Phone:** _____ **Email:** _____
Alternative Guardian: _____ **Relationship:** _____
Work Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Cell Phone: _____ **Home Phone:** _____ **Email:** _____
Primary Care Provider (if different than family above) Relationship: _____
Name: _____ **Telephone:** _____
Home Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Members residing at home

Name: _____	Age: _____	Relationship: _____
Name: _____	Age: _____	Relationship: _____
Name: _____	Age: _____	Relationship: _____
Name: _____	Age: _____	Relationship: _____

**EMERGENCY CONTACT MUST BE A PERSON THAT CAN BE DEPEND UPON TO CONTACT AND/OR PICK UP YOUR CHILD
IN THE EVENT OF AN EMERGENCY**

1st Emergency Contact Name: _____ **Relationship:** _____
Cell Phone: _____ **Home Phone:** _____ **Email:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
2nd Emergency Contact Name: _____ **Relationship:** _____
Cell Phone: _____ **Home Phone:** _____ **Email:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Overnight Respite Application

Applicant Name: _____ **Date:** _____

Primary Medical Doctor: _____

Work Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____ Email: _____

Allergies to medication/food: _____

Vision: Impaired? Yes No Corrective Lenses

Hearing: Impaired? Yes No

Ambulatory: Walker Crutches Wheelchair Other, please explain: Ambulatory/Walk independently

Nutrition

Diet Content/Consistency: _____

Pureed Chopped Soft Regular Regular/cut-up Thickened liquids

Caloric Restriction No Yes, if yes please specify: _____

Special Considerations? Techniques/Feeding equipment: _____ n/a _____

Appetite: Excellent Good Poor

Favorite foods: _____

Least favorite foods: _____

Any problems with constipation? Yes (at times) No

Please provide psychological evaluation completed within the past three (if there was no changes) along with application.

Seizures: Yes No

Seizure Type: _____ Duration of Seizures: _____ Date of seizures this year: _____

Developmental Disability

Intellectual Disability Cerebral Palsy Developmental Disability Epilepsy

Autism Other Neurological Conditions: Please identify: Asperger Syndrome

Toileting

Toileting Assistance Needed? Yes No Diapers Yes No

Please describe the toileting plan: _____

Please send adequate amount of diapers, sanitary napkins, etc. for durations of stay

Skin integrity: Dry Normal Oily

Overnight Respite Application

Applicant Name: _____ Date: _____

Prone for rashes or breakdown? Yes No If Yes explain: _____

Special Care Needs: _____

Special equipment needed during shower? Yes No If yes, please specify: _____

Dressing: Complete help Partial Help Independent

Describe any special positioning or necessary equipment: _____

Behavior

Does applicant have a Behavior Plan? Yes No **Please attach formal behavioral plan.**

Self-injurious behavior Throws tantrums Scratches Hyperactive will strike out or attempt to hurt others bites Spitting Throws Objects Property Destruction

Others please describe:

How does the consumer let someone know that he or she is becoming upset, or doesn't like an activity?

What can lead to upsetting the consumer? And how do you calm him/her down?

Are there any physical or mechanical devices used to protect or restrain the individual? Yes No

If yes, please provide **script from doctor** and describe and provide a doctor's order for usage: _____

Communication

Verbal Non-Verbal Uses Gestures if yes, please describe: _____

Does he/she use a device to communicate? Yes No

If yes, please describe: _____

Overnight Respite Application

Applicant Name: _____

Date: _____

Sleeping

Usual Sleep time: _____ Awake time: _____

Please describe any sleep habits that we should be aware of: _____

Are there any special devices needed for protection while sleeping (bedrails, hospital bed, bumper, etc.)

Is there anything else UCP of NYC should know about your loved one to make their stay with us better?

Signature of person completing the form: _____

Date: _____

Once your loved one has been approved to attend the Respite Program, you will be contacted by one of the administrative staff to schedule a trial date. Prior to the trial, you will be invited for a tour of the facility. We encourage that you bring your loved one with you during the tour for a meet and greet. Our staff is fully trained in CPR/First Aid and medication administration.

Upon arrival, we will complete a thorough body check, where a nurse will be present; and, which we also encourage family members to be present as well. Their bags will be checked, and all clothing will be labeled, and medications will be verified, by medication order, for any prescriptions, which, you may have submitted to us prior to your loved one coming to our facility.

After your loved one has been admitted to our program as scheduled; if your loved one becomes ill/sick, we will notify a family member/legal guardian/or emergency contact listed on the application for your loved one to get picked up or transported home. This is to prevent anyone else at the Program from becoming infectious / contagious.

Our program only schedule three (3) months in advance in order to give all families an opportunity to utilize the program. Please keep in mind that we book on the first week of November for December, January, and February. The first week in February, we will book for March, April, and May. The first week of May, we will book for June, July, and August. The first week in August, we will book for September, October, and November. Please note there will be a yearly calendar mailed to all families with the actual date to call and book per borough. We will keep you informed of any changes regarding this schedule in the future.

We thank you and we welcome your loved one to our family.



Overnight Respite Application

Authorized/Permissions

Individual's Name: _____

Emergency permission: If my child becomes ill or injured and the physician cannot be reached, I hereby give my consent for medical treatment by an ADAPT Community Network physician or hospital emergency room accompanied by ADAPT Community Network staff and my child's medical/permission.

NO _____ YES _____

Signature Relationship Date

I give permission for the above named individual to participate in community activities.

NO _____ YES _____

Signature Relationship Date

I give permission for the above Individual to be photographed during his/her stay at Respite. This includes, but not limited to pictures of my child while out in the community on recreation, any injuries he or she may have upon arrival to Respite (during Intake Process), and thereafter during his/her stay at Respite.

NO _____ YES _____

Signature Relationship Date



The mission of ADAPT Community Network is empowering people through innovative solutions, one person at a time.

Overnight Respite Application

Consent form

Alternative Placement Agreement
Respite

Individual Name: _____

If in the judgment of the Director of the Respite Program, the above-mentioned Individual is unable to function adequately in the Program, the alternative placement person below agrees to be responsible for the Individual’s welfare while the Primary Caregivers is absent. If the Director of the Respite Program contacts the alternative placement person, he/she will provide transportation, as soon as possible, for the Individual to his/her home.

NAME OF ALTERNATIVE PLACEMENT PERSON

Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Work Phone: _____
Signature: _____ Date: _____

NAME OF ALTERNATIVE PLACEMENT PERSON

Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Work Phone: _____
Signature: _____ Date: _____



The mission of ADAPT Community Network is empowering people through innovative solutions, one person at a time.

Overnight Respite Application

**ORIENTATION
RECEIPT OF RIGHTS AND DUE PROCESS**

NAME: _____
Program: _____
DATE OF BIRTH: _____

I have been informed of the Due Process contracts and my/my child's rights and responsibilities at ADAPT Community Network. I have received a written copy of the Due Process contracts and my/ my child's rights and responsibilities. I know that if I have any questions, I can speak to a social worker, psychologist or case manager.

Signature: _____

Witness: _____

Date: _____



The mission of ADAPT Community Network is empowering people through innovative solutions, one person at a time

Annual Medical Examination

Patient Name: _____ D.O.B.: _____ Exam Date: _____

Patient escorted by/Residential facility: _____

Known Medical Diagnosis: _____

History of Present Illness: _____

Current Medication: _____

Allergies: _____ Diet: _____

Family History: _____

Tobacco: _____ Alcohol: _____ Drugs: _____

Surgery/Hospitalizations: _____

Immunizations (“+” for positive or immune/ “-“for negative or immune)

Measles _____ Mumps _____ Rubella _____ Varicella _____

Hep C. Antibody _____ Heb B Antigen _____ Heb B Antibody _____ Hep Bc Antibody _____

History of last PPD: Last Xray (date) _____ (results) _____ Treatment: _____

Last Td/TDaP: _____ Pneumovax: _____ Last influenza: _____

Recent tests (if applicable):

Last EKG: _____ Last dexa scan: _____

Last colonoscopy: _____ Last mammogram: _____

Last swallow study: _____ Last EEG: _____

Review of Systems: General _____

HEENT: _____ Neuro: _____

Cardio: _____ Orthopedic: _____

Repertory: _____ Neuro: _____

GI: _____ Skin: _____

GU/GYN: _____ Psych: _____

Annual Medical Examination

Patient Name: _____ **D.O.B.:** _____ **Exam Date:** _____

Sex: _____ **Height (Feet):** _____ **Weight (lbs):** _____ **Temp (F):** _____

BP: _____ **Resp. Rate:** _____ **Pulse:** _____ **BMI:** _____

General:	
Eyes:	
Ears:	
Nose:	
Mouth/Throat:	
Neck:	
Lungs:	
Heart:	
Breasts:	
Abdomen:	
Genitalia:	
Prostrate:	
Rectal:	
Extremities: <small>(Describe: Strength, contractures, asymmetry, atrophy, edema, etc.)</small>	
Neuro: <small>(Describe: Mental status, reflexes, gait, etc.)</small>	
Skin:	
Other:	



Annual Medical Examination

Patient Name: _____ D.O.B.: _____ Exam Date: _____

Assessment/Plan (include all ordered labs, tests, referrals, etc.):

Lined area for writing assessment and plan.

Return to clinic on _____ (Date)

_____, M.D./N.P. _____ (Stamp Name) (Signature) (Date)

Medication/Feeding Order

Name: _____ D.O.B: _____ Date: _____

In order for medication or GT/GB feeding to be administered here at Respite, we MUST have authorization form your doctor. The medication will be given by an approved supervised medication administration staff (AMAP) as prescribed by the doctor.

Please have your doctor complete the section below and return to the Respite program. Please include all PRN and Over the Counter medications as well.

Due to state regulations, we are not permitted to administer any medications including over the counter medications without written doctor's orders.

Name of Medication	Dosage Route	Frequency	Reason

GT/GB Feeding: _____

Formula: _____ Amount Prescribed (rate/per hr) _____

Bed Railings: During the night: Yes No

Medication must be prescribed by licensed practitioner

Effective Date: _____

Physician's Name (Print): _____

Phone: _____

Physician's Signature: _____

Date: _____

Physician's License #DEA/BNDD: _____

Parent/Guardian Signature: _____

Date: _____

This form MUST be submitted prior to any stay at ADAPT Community Network Respite Program

Medication/Feeding Order

TO BE COMPLETED BY A PHYSICIAN OVERNIGHT RESPITE DIETARY NUTRITION ORDERS

Name: _____

Nutrition/Caloric Intake: _____

Restrictions/Recommendations: (low fat/cholesterol; increased fiber, etc.) _____

Allergies: _____

Food Consistency-check one below

- WHOLE:** Food is prepared according to recipe and commonly served. This consistency is appropriate for individuals who independent with mealtime activities *i.e.: cut their food into appropriate pieces and eat at an appropriate pace.*

- 1" PIECES CUT TO SIZE:** Food is manually cut by staff into one inch pieces, approximately with width of a fork. This consistency is appropriate for individuals who require assistance with cutting their own food due to fine motor limitations or to aid in safe swallowing practices.

- 1/2" PIECES CUT TO SIZE:** Food is manually cut by staff into ½ inch pieces, approximately with width of a butter knife. *(Also known as LEVEL 3: Dysphagia advances or mechanical soft)*

- GROUND:** Prepared using a food processor. Food must be moist, cohesive mass with food particles no bigger than a grain of rice. Must be served with gravy, sauce, or condiment. *(Also known as a LEVEL 2: Dysphagia mechanically altered characteristics or chopped or moist)*

- PUREE:** Prepared using a food processor. Food must be smooth, pudding like consistency with NO lumps. Food is not sticky, pasty, or runny.

SOFTENED FOODS: Some individuals may require foods where minimal chewing is required. Examples of softened food include: scrambled eggs; cooked vegetables; canned fruit; fish; poultry; pancakes; soft cheese; potatoes without skin; pasta; hamburger; etc. Other foods may be softened with appropriate softeners. Some examples are broth, mayonnaise and ketchup.

Additional/Other individual considerations include: _____

Liquid Consistency (Choose ONLY one)

- Thin Liquids:** For those without swallowing difficulties: Liquids are served as usual
- Nectar/syrup:** Slightly thickened; it pours like syrup
- Honey:** thicker than a "syrup" consistency; it moved more slowly, but still pours
- Pudding:** "Mound" or "Plop- able" at room temperature (requires a spoon for feeding)

Physician Name: _____

Physician Signature: _____

Date: _____

License Number: _____



Medication/Feeding Order

TO BE COMPLETED BY A PHYSICIAN
OVERNIGHT RESPITE PRN ORDERS

Individual's Name: _____ D.O.B.: _____

Diagnosis: _____

Allergies: _____

The following may be used for 48 hours and/or one episode x5 doses, then consult MD for further orders. Medications to be given PO unless otherwise indicated.

PHYSICIANS MUST INDICARE WITH "X" WHICH ORDERS APPLY:

- Ibuprofen 200mg two tablets PO qhs for pain, headache or fever of 101°.
- Robitussin DM 5cc PO qhs for cough with cold symptoms
- Diaper rash cream apply thin layer to red areas on perianal area PRN and after every diaper change
- Fleet Enema one per rectum PRN if no BM x3days, may repeat x1
- Bacitracin ointment for minor cuts or skin abrasions
- Benadryl 25mg tab or 12.5mg per 5ml, give 10ml TID PRN for rash or persistent itch
- Benadryl/Caladryl lotion sparingly to area of bug bite, rash, or minor skin irritation TID PRN
- Imodium 2mg give 2 tabs after first loose BM then 1 tab after subsequent BMs up to 4 tabs in 24 hours.

Physician Signature: _____

Date: _____

License Number: _____

If no PRN orders are applicable, please sign below

Physician Signature: _____

Date: _____

License Number: _____



NOTICE OF PRIVACY PRACTICES

ADAPT COMMUNITY NETWORK

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAYBE USED AND DISCLOSED TO OTHERS AND HOW TO GET ACCESS TO THIS INFORMATION.

PLEASE READ IT CAREFULLY

EFFECTIVE DATE: _____

If you have any questions or request contact

_____ Phone # _____

IMPORTANT SUMMARY INFORMATION

INTRODUCTION

ADAPT Community Network has a legal duty to protect health information about you. This privacy notice tells you how medical information about you and other Individuals may be used and disclosed (given) to others. This notice also tells you, your guardians and /or personal representatives how you can get access to this information.

Guardians and personal representatives need to be aware that the word “you” in this Notice refers to the Individual, not the guardian. (TO DO: research this distinction).

We are required by law to protect the privacy of health information that may reveal your identity, and to provide you with a copy of this notice which describes the health information privacy practices of our agency list staff and affiliated health care providers that jointly provide treatment and perform payment activities and business operations with our agency. A copy of our current notice will always be posted in our reception area. You will also be able to obtain a copy by accessing our website at Adaptcommunitynetwork.org, calling 718-652-1902, or asking for one at the time of your next visit.

QUESTIONS

If you have any questions about this notice or would like further information, please contact us at Bronx Overnight Respite at 718-652-1902.

REQUIREMENTS FOR WRITTEN AUTHORIZATION

We will generally obtain your written authorization before using your health information or sharing it with others outside the agency. You may also initial the transfer of your records to another person by completing an authorization form. If you provide us with written authorization, you may revoke that authorization at any time, except to the extent that we have already relied upon it. To revoke an authorization, please write to Bronx Overnight Respite.

HOW TO KEEP TRACK OF THE WAYS HEALTH INFORMATION HAS BEEN SHARED WITH OTHERS

You have the right to receive a list from us, called the “accounting list,” which provides information about when and how we have disclosed your health information to outside persons or organizations. Many routine disclosures we make will not be included on this accounting list but the accounting will identify non-routine disclosures of your information. For more information please see page 12 of this notice.

HOW TO REQUEST ADDITIONAL PRIVACY PROTECTIONS

You have the right to request further restrictions on the way we use your health information or share it with others. We are not required to agree to the restriction you request but if we do we will bound by our agreement. For more information please see page 13 of this notice.

HOW TO REQUEST CONFIDENTIAL COMMUNICATIONS

You have the right to request that we contact you in a way that more confidential for you such as at work instead of at home. We will try to accommodate all reasonable requests. For more information please see page 13 of this notice.

HOW SOMEONE MAY ACT ON YOUR BEHALF

You have the right to name a persona representative who may act on your behalf to control the privacy of your health information. Parents and guardians will generally have the right to control the privacy of health information about minors unless the minors are permitted by law to act on their own behalf.

HOW TO LEARN ABOUT SPECIAL PROTECTIONS FOR HIV, ALCOHOL AND SUBSTANCE ABUSE, MENTAL HEALTH AND GENETIC INFORMATION

Special privacy protections apply to HIV related information alcohol and substance abuse treatment information, mental health information and genetic information. Some parts of this general Notice of Privacy may not apply to these types of information. If your treatment involves this information you will be provided with separate notices explaining how the information will be protected. To request copies of these other notices now please contact ADAPT Community Network at 212-683-6700.

DETAILED INFORMATION ABOUT THIS PRIVACY NOTICE

REQUIREMENT FOR WRITTEN AUTHORIZATION

We will generally obtain your written authorization before using your health information or sharing it with others outside of the agency. You may also initiate the transfer of your records to another person by completing an authorization form. If you provide us with written authorization you revoke that authorization at any time except to the extent that we have already relied upon it. To revoke any authorizations please write to ADAPT Community Network Bronx Overnight Respite.

WHAT HEALTH INFORMATION IS PROTECTED

We are committed to protecting the privacy of information we gather about you while providing health related services. Some examples of protected health information are:

- The fact that you are a participant at or receiving treatment or health related services from our agency.
- Information about your health condition (such as a disease you may have).
- Information about health care products or services you have received or may receive in the future (such as medication or treatment); or
- Information about your healthcare benefits under an insurance plan (such as whether a prescription is covered).

When combined with:

- Geographic information (such as where you live or work).
- Demographic information (such as your race, gender, ethnicity or marital status).
- Unique numbers that may identify you (such as your social security number, your phone number or your driver's license); and
- Other types of information that may identify who you are.

1. The company also protects the privacy of your health information. Finally, we may share your health information with other providers and payers' for certain of their business operations if that other party also has or had a treatment or payment relationship with you and in that event we will only share information that pertains to that relationship.

Appointment Reminders, Treatment Alternatives, Benefits and Services. We may use your health information when we contact you with a reminder that you have an appointment for treatment or services at our facility. We may also use your health-related benefits and services that maybe of interest to you.

Fundraising (We may use demographic information about you, including information about your age and gender, and where you live or work, and the dates that you received treatment, in order to contact you to raise money to help us operate. We may also share this information with a charitable foundation that will contact you to raise money on our behalf. If you do not want to be contacted for these fundraising efforts, please write to ADAPT Community Network at 212-683-6700.

FACILITY DIRECTORY / FRIENDS AND FAMILY

2. We may use your health information and disclose it from our Facility Directory or share it with friends and family involved in your care without your written authorization or other written permission. We will always give you an opportunity to object unless there is insufficient time because of a medical emergency (In which case we will discuss your preferences with you as soon as the emergency is over). We will follow your wishes unless we are required by law to do otherwise.

Agency Directory unless you object we will include your name, [your location in our facility, your general condition (e.g. fair, stable, critical, etc.) and your religious affiliation] in our Agency Directory while you are an Individual at our facility. This directory information except for your religious affiliation may be released to people who ask for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or rabbi even if he or she doesn't ask for you by name.

Friends and family involved in your care. If you do not object, we may share your health information with a family member, relatives or close personal friend who is involved in your care. We may also notify a family member personal representative or another person responsible for your location and general condition here at our facility, or about the unfortunate event of your death. In some cases, we may need to share your information with a disaster relief organization what will help us notify these persons.

Product Monitoring, Repair and Recall: We may disclose your health information to a person or company that is required by the Food and Drug Administration to (1) report of track product defects or problems; (2) repair, replace, or recall defective or dangerous products; or (3) monitor the performance of a product after it has been approved for use by the general public.

Lawsuits and Disputes: We may disclose your health information if we are ordered to do so by a court or administrative tribunal that is handling a lawsuit of other dispute Law Enforcement. We may disclose your health information to law enforcement officials for the following reasons:

- To comply with court orders or laws that we are required to follow
- To assist law enforcement officers with identifying or locating a suspect, fugitive, witness, or missing person
- If you have been a victim of a crime and we determine that (1) we have been unable to obtain your consent because of an emergency or your incapacity; (2) law enforcement officials need this information immediately to carry out their law enforcement duties; and (3) in our professional judgment disclosure to these officials in your best interests
- If we suspect that your death resulted from criminal conduct
- If necessary to report a crime that occurred on our property; or
- If necessary to report a crime discovered during an offsite medical emergency (for example, by emergency medical technicians at the scene of a crime).

To Avert a Serious Threat to Health or Safety: We may use your health information or share it with others when necessary to prevent a serious threat to your health or safety or the health or safety of another person or the public. In such case we will only share your information with someone able to help prevent the threat. We may also disclose your health information to law enforcement officers if you tell us that you participated in a violent crime that may cause serious physical harm to another person (unless you admitted that fact while in counseling), or if we determine that you escaped from lawful custody (such as prison or mental health institution).

National Security and Intelligence Activities or Protective Services: We may disclose your health information to authorized federal officials who are conducting national security and intelligence activities or providing protective services to the President or other important officials.

Military and Veterans: If you are in the Armed Forces we may disclose health information about you to appropriate military command authorities for activities they deem necessary to carry out their military mission. We may also release health information about foreign military personnel to the appropriate foreign military authority.

Right to Inspect and Copy Records

You have the right to inspect and obtain a copy of any of your health information that may be used to make decisions about you and your treatment for as long as we maintain this information in our records. This includes medical and billing records. To inspect or obtain a copy of your health information, please submit your request in writing to the person responsible for the department. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies we use to fulfill your request. The standard fee is \$0.75 per page and must generally be paid before or at the time we give the copies to you.

We will respond to requests for copies within 30 days if the information is located in our facility and within 60 days if it is located off site at another facility. If we need additional time to respond to a request for copies, we will notify you in writing within the time frame above to explain the reason for the delay and when you can expect to have a final answer to your request.

Under certain very limited circumstances, we may deny your request to inspect or obtain a copy of your information. If we do, we will provide you with a summary of the information instead. We will also provide a written notice that explains our reasons for providing only a summary, and a complete description of your rights to have that decision reviewed and how you can exercise those rights. The notice will also include information on how to file a complaint about these issues with us or with the Secretary of the Department of Health and Human Services. If we have reason to deny only part of your request, we will provide complete access to the remaining parts after excluding the information we cannot let you inspect or copy.

Right to Request Amendment of Records

If you believe that the health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept in our records. To request an amendment, please write to the person responsible for the department. Your request should include the reasons why you think we should make the amendment. Ordinarily, we will respond to your request within 60 days. If we need additional time to respond, we will notify you in writing within 60 days to explain the reason for the delay and when you can expect to have that answer to your request.

If we deny part or all of your request, we will provide a written notice that explains our reasons for doing so. You will have the right to certain information related to your requested amendment included in your records. For example, if you disagree with our decision, you will have an opportunity to submit a statement explaining your disagreement which we will include in your records. We will also include information on

Right to Request Additional Privacy Protections

You have the right to request that we further restrict the way we use and disclose your health information to treat your condition, collect payment for that treatment, or run our agency's normal business operations. You may also request that we limit how we disclose information about you to family and friends involved in your care. For example, you could request that we not disclose information about a surgery you had. To request restrictions, please write to the person responsible for the department. Your request should include (1) what information you want to limit; (2) whether you want to limit how we use the information, how we share it with others, or both; (3) to whom you want the limits to apply.

We are not required to agree to your request for a restriction and in some cases; the restriction you request may not be permitted under law. However, if we do agree, we will be bound by our agreement unless the information is needed to provide you with emergency treatment or comply with the law. Once we have agreed to a restriction, you have the right to revoke the restriction at any time. Under some circumstances, we will also have the right to revoke the restrictions as long as we notify you before doing so; in other cases, we will your permission before we can revoke the restriction.

Right to Request Confidential Communications

You have the right to request that we communicate with you about your medical matters. In a more confidential way by requesting that we communicated with you by alternative means at alternative locations. For example, you may ask that we contact you by fax instead of by mail, or at work instead of at home. To request more confidential communications, please write to the person of the department. We will not ask you the reason for your request, and we will try to accommodate all responsible requests. Please specify in your request how or where you wish to be contacted and how payment of your health care will be handled. We will communicate with you through this alternative method or location.

January 1995

ADAPT Community Network

RIGHTS

BILL OF RIGHTS

POLICY

ADAPT Community Network respects the rights of the people who are served. The agency expects the administration, staff, consultants, volunteers and vendors to encourage the expression of these rights. If any staff, consultants or volunteers violate the rights of the individuals receiving services, it is cause for disciplinary action including dismissal.

The rights are being denied or abridged on the basis of severity of the disability, race, religion, national origin, creed, age, gender, ethnic background, sexual orientation, or health condition.

Rights may be limited for therapeutic purposes, but not for disciplinary reasons or the convenience of staff. For example, the rights of an individual may need to be limited in consideration of the rights of others (see ADAPT Community Network 2.7 Privacy). If there are any limitations on rights the must be:

1. On the individual basis
2. For a specific period of time
3. Only for clinical purposes
4. With full documentations in the person's individuals program plan (IPP) record
5. Approved by program planning team (PPT)

RIGHTS

The agency provides an environment that implements and enhances the following rights for the people served:

1. To be treated with respect as an individual and provided opportunities and rights as described by all state and federal constitutions and laws.
2. To be provided a program that offers the means of achieving optimal growth and productivity by building upon competencies. The program leads to positive interaction with his or her environment and maximum independence.
3. To be provided meaningful, productive activities and recreation which recognize personal interests and abilities and facilitate community, integration and contact with persons without disabilities.

4. To be provided services, assistance and guidance from staff who are well trained, humane and skillful.
5. To jointly develop and implement a written IPP and case management services. To choose to involve family or other advocates in the program planning process.
6. To receive information on or prior to admission concerning these rights and all aspects of the service to be provided. (See ADAPT Community Network 3.1, Admission).
7. To learn and practice choice and decision making including choice of personnel (within the staffing constraints of the program), choice of service from persons outside the agency and opportunity to obtain a second medical opinion.
8. To learn and practice self-advocacy to act as an active partner with staff in program plan development, implementation and revision; to play active and informed role in all levels of policy and programmatic decision making.
9. To give or deny informed consent for any aspect of the IPP which presents a risk (see ADAPT Community Network 2.13, Informed Consent and 2.14 Consent for Medical Treatment).
10. To have direct communication with the staff, including freedom of convey ideas and questions, disagreements and the implementation of these rights without fear of reprisal. The communication includes program planning, prompt, accurate answers to questions, and appointments with staff for Individuals or families.
11. To receive assistance from staff when requested in conveying information, ideas requests, alterations in the program or residential settings and other topics.
12. To object to any portion of the IPP and its implementation through informal means and the due process procedure.
13. To register and vote, and to participate in civic organizations and responsibilities.
14. To choose and develop stable nurturing relationships outside and within the family and agency.
15. To have freedom or sexual expression.
16. To enjoy a safe, sanitary and accessible environment.

17. To receive balanced and nutritious meals at appropriate times in a normal manner with assistance as needed. If not provided by the agency, the agency advocates for such meals. Meals are not denied or altered for behavior management or disciplinary purposes.
18. To have freedom from abuse or neglect and freedom from corporal punishment.
19. To have freedom from unnecessary, excessive or undocumented use of medication, mechanical or chemical restraining devices and to access active treatment to reduce dependency on drugs or physical restraints.
20. To be protected from commercial or other exploitation or from participation in research without informed consent (see ADAPT Community Network 2.7 Privacy).
21. To have privacy, confidentiality of information and the rights to have visitors.
22. To have freedom of religion with personal choices about observance and participation to be respected by staff.
23. To won appropriate personal clothing, grooming, and personal hygiene supplies. To have a reasonable amount and quality of personal storage space.
24. To be taught to manage personal finances and earn income according to one's ability and for those sums managed by the agency, to have those finances kept separate from other agency funds and to have completed standard and open accounting.
25. To have the opportunity to make an informed decision regarding cardiopulmonary resuscitation, Do Not resuscitate Orders and Health Care Proxy/
26. To be free from discrimination based upon HIV test or status.

In addition, the agency advocates in collaboration with its Individuals for the government and broaden community to implement the above rights for all people with disabilities.

IMPLEMENTATION

All new staff receives orientation and training in the rights of the Individuals served with regular on-going training for all staff. Program Directors regularly address rights topics in staff meetings. Staff learns how to practically implement the rights.

UNDERSTANDING AND MANAGEMENT OF RIGHTS CONTACTS

ADAPT Community Network Administration

Dahlia Porter
Senior Vice President of Adult Services



80 Maiden Lane - 8th Floor
New York, NY 10038
212-683-6700

Linda B. Laul
Chief Operating Officer
80 Maiden Lane - 8th Floor
New York, NY 10038
212-683-6700 Ext. 1370

Edward R. Matthews
Chief Executive Officer
80 Maiden Lane # 8th Floor
New York, NY 10038
212-683-6700 Ext. 1280

Outside Contacts

Director of your OMRDD Borough Developmental Services Office

Bronx DDRO
Mildred Ramos
2400 Halsey Street
Bronx, NY 10461
718-430-0700

Queens DDRO
Jeff Levi
P.O. Box 2080507
Queens Village, NY 11427
718-217-6485

Brooklyn DDRO
Janet Strauss
888 Fountain Avenue
Brooklyn, NY 11208
718-642-8629

Staten Island DDRO
John Winne
1150 Forest Hills road
Staten Island, NY 10314
718-982-1931

Manhattan DDRO
Marynelly Rodriguez
75 Morton Street
New York, NY 10014
646-766-3293