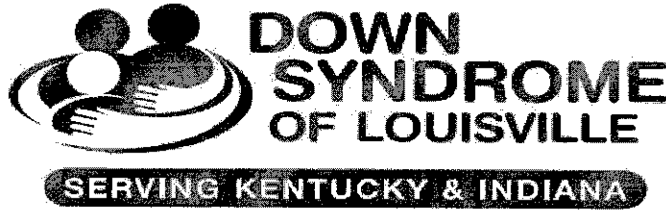
5001 S. Hurstbourne Pkwy.
Louisville, KY 40291
Phone: (502)-495-5088
Fax: (502)-495-5038



ENROLLMENT INFORMATION FORM

Member's name:	DOB:________ M/F:	Medicaid #:____________ SS #:	Date of application:

Case Manager:______________________ Waiver/Program:____________________ Phone:____________________________ Agency:___________________________ Agency address:____________________	Parent/Guardian:____________________ Phone:_____________________________ Address:___________________________ __________________________________
Member's address:__________________ __________________________________ Member's Phone:	Member's employer:__________________ __________________________________ __________________________________
Additional Diagnoses:________________ __________________________________	Member's school:____________________ __________________________________ Grade:
Mother's Email:____________________ Mother's Cell: ____________________ Mother's Employer:_________________	Father's Email:____________________ Father's Cell:_____________________ Father's Employer:_________________

The Following Information is Used for Grant Purpose Only

Income	Race/Ethnicity
Is the household Income Above or Below $23,850? (Circle One) Above Below	(Circle All that Apply) Caucasian Hawaiian/Pacific Islander African American Native American Hispanic Alaskan Native Asian Other______________

Community Contacts:	
Residential Provider: ______________________ Contact Name: ______________________ Phone:	Current Adult Day Provider: ______________ Contact Name: ______________________ Phone:
Behaviorist:______________________ Phone:______________________ Behavior Plan? Yes No	Psychologist:______________________ Phone:______________________
Physician:______________________ Phone:______________________ Specialty:	Physician:______________________ Phone: ______________________ Specialty:
Does the Member have any sensory issues that we should know about?	Answer:
What motivates the Member in an educational setting?	Answer:
What are 3 goals you would like the Member to accomplish by participating in Down Syndrome of Louisville programming?	Answer:

Does your son/daughter have behaviors or behavior concerns that need to be addressed? Would they need a behaviorist, or do they have a behavior plan already in place?	Answer:
Does your son/daughter have any toileting issues that need to be addressed?	Answer:
Does your son/daughter have any feeding issues that need to be addressed?	Answer:
Does your son/daughter have any elopement issues?	Answer:

Health, Safety or Welfare Concerns:

Issue:	Prevention:	Intervention:

Medication Administration:

(Can I take my medications independently? Do I take my medications whole with water? What procedure is used to hand these medications to me? Do I need to take my medications crushed and in a food product such as applesauce, pudding, or other products? What products are used for this? Do I pocket medication in my mouth instead of swallowing them? What do support staff do to help me take my medication? Do I require monitoring for medication side effects? What medications require monitoring and what side effects should staff watch for? Am I on any new medications? What possible reactions should staff watch for?)

Communication:

(Do I use words to communicate wants and needs? Do I use sentences, word combinations, or single words? Do I use gestures? What gestures do I use to let people know what I want? Do I use sign language? Is the sign language functional language or formalized sign language? Do I use vocalizations to express needs and desires? What types of vocalizations do I use? How do I communicate pain? How do I communicate sickness? How do I indicate what I like? How do I indicate what I do not like? How do I communicate affection? Do I have problems with people being in my personal space? What is the best way for staff to communicate with me? How will staff know I understand what is being communicated?):

Family Support/Situation:

Service Request:

_____ Adult Development Academy
_____ Behavior Supports
_____Book Club
_____College Connections
_____Boogie Down Crew
_____ First Steps DI
_____ Infant/Parent Class (Birth-18 months)
_____ Living and Learning
_____ Preschool Class
_____ School Age (Saturday)
_____ Social Events
_____ Speech Program
_____ Steps to Independence
_____ Supported Employment
_____ SEE/Respite
_____ Toddler Class (18 months – 3 years)
_____ Tutoring
_____ Other_____________________________

___ Referral accepted Date:	___ Referral denied Date:

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Consents and Notifications

Member name ______________________________ Date of birth ________________

Parent/Guardian ____________________________ Phone ____________________

Address ____

City/State/Zip code ____

Program ____

Consent to Programming

I, _________________________, the parent/guardian of _______________________, give consent for Down Syndrome of Louisville to evaluate, provide services, and conduct on-going assessments for program planning for,

____.

Consent to Photograph

I _____________________________, DO or DO NOT (Please Circle) authorize Down Syndrome of Louisville, Inc. to have photographs taken and/or videotapes made of _____________________________, of whom I am the parent/legal guardian.

Receipt of Family Handbook

I, _________________________, parent/guardian of _______________________, acknowledge that I have reviewed and understand the policies and practices described in the Family Handbook for the Down Syndrome of Louisville Lifelong Learning Center. My signature below confirms that I agree to adhere to the policies and practices included in the Family Handbook.

Parent / Guardian Signature ____________________________ Date __________

DSL Staff Signature ___________________________________ Date __________

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HIPAA

The signature below confirms that ________________________, the parent/guardian of ______________________________, has received a copy of Down Syndrome of Louisville's Privacy Practices under HIPAA.

______________________________ ______________
Parent/guardian signature Date

______________________________ ______________
DSL Witness signature Date

Under HIPAA, we are not allowed to leave messages, or speak with anyone other than a member (if an adult) or the member's parent/guardian. With written permission from the member's parent/guardian, we can do otherwise. Please complete this form so we may serve you more efficiently.

Please circle YES or NO on every line.

May we leave a message on your home/cell/work phone?	YES	NO
May we mail information to the address provided on the enrollment form?	YES	NO
May we discuss the member's progress with anyone other than you?	YES	NO

If YES, please indicate who Down Syndrome of Louisville may contact and what information should be available to them. List name, relationship to the member (i.e. aunt, teacher, neighbor, etc.), a phone number and what information may be shared.

	Name	Phone	Relationship
1.			
2.			
3.			

Parent/Guardian Signature ______________________________ Date __________

DSL Staff Signature ______________________________ Date __________

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KEEP AT HOME FOR YOUR RECORDS!

NOTICE OF PRIVACY PRACTICES UNDER HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABLITY ACT, 1996)

THIS NOTICE DESCRIBES INFORMATION WE COLLECT, HOW WE USE THAT INFORMATION AND WHEN AND TO WHOM WE MAY DISCLOSE IT. ***PLEASE REVIEW THIS DOCUMENT CAREFULLY.***

Types of Information We Collect and How We Collect It

Down Syndrome of Louisville will gather personal, health and financial information about the waiver participant and family. This information is sometimes referred to as *protected health information* or *personal health information (PHI)*. This information is typically gathered by the administrative staff at Down Syndrome of Louisville.

Protected/Personal Health Information (PHI) Includes and Relates to:
- past, present, and future physical, medical or mental health conditions;
- past, present, or future payment for the care or services received; and
- care and services provided.

Down Syndrome of Louisville is required by law to maintain the privacy of health information and to inform you of its duties and privacy practices. This notice describes some of the ways in which Down Syndrome of Louisville may use or disclose personal health information and the rights concerning the health information.

Effective Date and Changes to the Privacy Notice

This Practice went into effect on **April 14, 2003**. Down Syndrome of Louisville is required to follow the terms of this Notice until the Notice is revised. Down Syndrome of Louisville may revise or change the contents of this Notice at any time. If it does so, the new notice will be made available within 30 days after the effective date of the change.

Use or disclosure of Personal Health Information

Most of the purposes for which Down Syndrome of Louisville routinely uses or discloses health information are described in other consent forms that you sign. This Notice of Privacy Practices **DOES NOT** replace those consent forms. Down Syndrome of Louisville will continue to seek your consent to use or disclose health information as described in those consent forms and as required by the privacy provisions of the Individuals with Disabilities Education Improvement Act.

A. USES OR DISCLOSURES WITH PRIOR CONSENT

Down Syndrome of Louisville will continue to obtain your consent for most uses and disclosures, including the following:

Treatment: Down Syndrome of Louisville will obtain your consent before disclosing health information to a provider for treatment. For example, Down Syndrome of Louisville will obtain consent before providing an occupational therapist with the health or developmental information in a personal health record.

KEEP AT HOME FOR YOUR RECORDS!

Payment: Down Syndrome of Louisville will obtain your consent before disclosing health information for the purposes of payment.

Health Care Operations: Down Syndrome of Louisville will continue to obtain your consent before using or disclosing health information to conduct most health care operations. For example, Down Syndrome of Louisville will continue to obtain your consent to disclose health information to physician specialists or pediatric subspecialists.

B. **USES OR DISCLOSURES WITHOUT PRIOR CONSENT**

Down Syndrome of Louisville may use health information without consent for the following purposes:

Health Care Operations: Down Syndrome of Louisville may use or disclose health information as required for certain health care operations. For example, Down Syndrome of Louisville may use your health information to conduct quality assurance and/or monitoring activities.

When Required by Law: Down Syndrome of Louisville may disclose health information as required by federal, state or local laws. For example, Down Syndrome of Louisville may disclose information pursuant to a Federal Grand Jury subpoena.

Government Benefit Programs: Down Syndrome of Louisville may use or disclose health information as needed for the administration of a government benefit program such as Medicaid.

Federal Oversight and Monitoring: Down Syndrome of Louisville may disclose health information to an office or agency of the federal government in connection with the federal government's oversight or monitoring activities.

Emergencies: Down Syndrome of Louisville may disclose health information to medical or law enforcement personnel if the information is needed to prevent immediate harm.

Other Uses of Information /Revocation Rights: Other uses and disclosures of health information not covered by this notice or the laws that apply to Down Syndrome of Louisville will be made only with your written authorization. If you provide Down Syndrome of Louisville with permission to use or disclose health information, you may revoke that authorization in writing at any time. Should you revoke the authorization, Down Syndrome of Louisville will no longer use or disclose health information for any reasons that require your written authorization. **NOTE**: Down Syndrome of Louisville may not take back any disclosures it has already made prior to processing the revocation request.

Your Rights Regarding Health Information

Right to Inspect and Copy: You have the right to inspect and receive a copy of the health information that Down Syndrome of Louisville has as it pertains only to the individual. This includes medical and billing records. You must submit a request in writing to Down Syndrome of Louisville and include a time period for which you wish to receive your records. You may be charged a reasonable fee, unless such a fee would prevent you from exercising this right.

Right to Request Amendment: You have a right to ask Down Syndrome of Louisville to amend the health information it has collected or maintains, if you feel it is incorrect or incomplete. If your request is approved, your

request and the amendment will become part of your permanent record. You must submit your request in writing to Down Syndrome of Louisville. You must state the reason you are requesting an amendment.

Right to a List of Types and Locations: You have a right to request a list of the types and locations of health information collected, used or maintained by Down Syndrome of Louisville. This request must be submitted in writing to Down Syndrome of Louisville.

Right to Receive an Accounting of Disclosures: You have a right to request a list of each time Down Syndrome of Louisville has disclosed personal health information, on or after April 14, 2003, for reasons other than treatment, payment or health care operations, or certain other reasons as provided by law. You must submit your request in writing to Down Syndrome of Louisville. Your request must state a time period that may not be longer than six years. Please note that you may be charged a reasonable fee, unless such a fee would prevent you from exercising this right.

Right to Request Restrictions: You have the right to request a restriction or limitation on the health information that Down Syndrome of Louisville uses or discloses for treatment, payment and health care operations. You must submit your request in writing to Down Syndrome of Louisville, and indicate what information you want limited and to whom the limits apply. **NOTE**: Down Syndrome of Louisville is not required to agree to your request.

Right to Request Communication Methods: You have a right to request that Down Syndrome of Louisville communicate with you in confidence about personal health information in a different means or at a different location. For example you may request that Down Syndrome of Louisville contact you with confidential information only at work or by mail, or communicate with you in your own language if you are non-English speaking.

Right to Receive Additional Copies of this Notice: You have a right to receive additional copies of this Notice upon request. To request additional copies, please contact Down Syndrome of Louisville.

Right to File a Complaint: If you believe your privacy rights have been violated by Down Syndrome of Louisville, you have the right to complain to Privacy Office listed below. Down Syndrome of Louisville will not retaliate against you if you file a complaint.

PRIVACY OFFICER

To receive additional information or to file a complaint with Down Syndrome of Louisville, please contact the U.S. Department of Health and Human Services:

Region IV – Atlanta
Roosevelt Freeman, Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services
Atlanta Federal Center, Suite 3B70
61 Forsyth Street, S.W.
Atlanta, GA 30303-8909

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AUTHORIZATION TO DISCLOSE INFORMATION

Member Name____ Date of Birth _____________

Parent/Guardian Name _________________________________ Relationship ______________

Home address ___________________________________ City _____________ State____ Zip________

I authorize Down Syndrome of Louisville, Inc.

___to obtain information from ___ to release information to

____

____

____

medical, psychological, educational and social information for the purpose of

____ Individualized Family Service Plan (IFSP) development
____ Individualized Education Plan (IEP) development
____ Program Planning
____ Assessment
____Vocation Rehabilitation Service Plan development
____SCL/MPW Service Plan development
____ Other (please specify) ____

Specific information requested: ____
____

Time Limitation: This authorization expires one year from the date of signature or sooner. This release is subject to revocation at any time except to the extent that the program which is to make disclosure has already taken action in reliance on it.

_______________________________________ ________________
Parent/Guardian Signature Date

_______________________________________ ________________
DSL service provider Date

_______________________________________ ________________
Revoction Signature Date

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Individual Grievance Policy

If a DSL member or his or her parent/guardian has concerns that need to be resolved, the following procedures need to be followed:

I. Communicate concerns with the involved service provider.
II. If the concerns cannot be addressed with the involved service provider, communicate concerns with the provider's direct supervisor.
III. If the concerns cannot be addressed sufficiently by the service provider's direct supervisor, communicate concerns with the Executive Director/ Program Director.
IV. If the concerns involve the Executive Director/Program Director, the Board of Trustee's for Down Syndrome of Louisville should be contacted.
V. The Executive Director/Program Director/Board of Trustees will communicate with the member and parent/guardian regarding the resolution of the concerns. At that time, the member and parent/guardian will be informed of their rights of due process external to the agency, as appropriate for Kentucky and Indiana:

Kentucky

a.	Ombudsman	(502) 564-5080
b.	Protection and Advocacy	1-800-372-2988
c.	DCBS	(502) 633-1892

Indiana

a.	Ombudsman	1-800-662-4484
b.	Protection and Advocacy	1-800-662-4845
c.	FSSA	1-800-545-7763
d.	DDRS	(317) 232-7842

If the member and parent/guardian would like to report a formal complaint about a service provider or Down Syndrome of Louisville, they must do so in writing and submit it to the Executive Director/Program Director. The Executive Director/Program Director will meet with the person issuing the complaint within seven (7) business days and address the complaint and resolution of the issue.

I have read the above Individual Grievance Policy and Procedure for reporting complaints within Down Syndrome of Louisville.

_______________________________ _______________

Parent/Guardian Signature Date

_______________________________ _______________

DSL Staff Signature Date

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Member Rights

The participant and parent/guardian rights as recognized by Down Syndrome of Louisville Shall include:

1. The right to access accurate and easy-to-read information.
2. The right to be treated with dignity and respect and to maintain one's dignity and individuality.
3. The right to voice grievances and complaints regarding services and supports that are furnished, without fear of retaliation, discrimination, coercion, or reprisal.
4. The right to choice of approved service provider(s).
5. The right to accept or refuse services.
6. The right to be informed of and participate in preparing the Person Centered Plan of Care any changes in the plans of care and services provided.
7. The right to be advised of the provider(s) who will furnish services and the frequency and duration of services.
8. The right to confidential treatment of all information, including information in the participant's record(s).
9. The right to receive services in accordance with current Person Centered Plan of Care.
10. The right to be informed of the name, business, telephone number, and business address of the person supervising the services and how to contact the person.
11. The right to have property and residence treated with respect.
12. The right to be informed of any cost share liability and any consequences if any cost share is not paid.
13. The right to review the individual participant's records upon request.
14. The right to receive adequate and appropriate services without discrimination.
15. The right to be free from mental, verbal, sexual, and physical abuse, neglect, exploitation, isolation, corporal or unusual punishment, including interference with daily functions of living.
16. The right to be free from mechanical, chemical or physical restraints.
17. The right to live and work in and integrated setting.
18. The right to time, space and opportunity for personal privacy.
19. The rights to communicate, associate, and meet privately with the person of choice.
20. The right to send and receive unopened mail.
21. The right to retain and use personal possessions, including clothing and personal articles.
22. The right to private, accessible use of a telephone or cell phone.

I acknowledge that the above rights have been reviewed and explained to me and that I understand these rights.

_______________________________ _______________

Parent/Guardian signature Date

_______________________________ _______________

DSL Staff Signature Date

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EMERGENCY TREATMENT CONSENT AND CONTACTS

In case of an emergency or when medical treatment is necessitated, DSL will provide First Aide, CPR, and/or contact Emergency Medical Services. I would like to have ________________________ transported to the following Hospital if there is a need for emergency medical services:

Hospital Name : ______________________________

In case of an emergency, the DSL member's parent or guardian will be called first, unless otherwise directed in writing.

Member's name ______________________________

Parent/guardian name ______________________________

Phone (cell preferably) ______________________________

Please list three people with relationship to member, in the order they should be called, if the parents or guardians are not reachable in an emergency situation:

1. ______________________________ Phone ________________

2. ______________________________ Phone ________________

3. ______________________________ Phone ________________

The signature below indicates this information has been provided by the parent/guardian of the DSL member listed above and gives consent to allow DSL to provide First Aide/CPR treatment and seek Emergency Medical Services as necessary.

______________________________ ________________
Parent/guardian signature Date

______________________________ ________________
DSL Staff Signature Date

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Medical Health Information

Member Name ______________________ Age __________ Date __________

Completed By ______________________ Relationship to member __________

Please list any doctors providing care to the member and Medications the member takes.

Doctor ______________________ Specialty __________ Last seen __________
Doctor ______________________ Specialty __________ Last seen __________
Doctor ______________________ Specialty __________ Last seen __________

Medication ______________________ Dosage __________ Frequency taken __________
Medication ______________________ Dosage __________ Frequency taken __________
Medication ______________________ Dosage __________ Frequency taken __________

Allergies to Medication ☐No ☐Yes ______________________
Other Allergies ☐No ☐Yes ______________________

Has the member ever had a problem with or been treated for: (Check All That Apply)

☐No ☐Yes – Heart Disease__________
☐No ☐Yes – Blood Pressure__________
☐No ☐Yes – Respiratory/Lung__________
☐No ☐Yes – Muscular/Skeletal__________
☐No ☐Yes – Spasms__________
☐No ☐Yes – Head Injury__________
☐No ☐Yes – Stomach/Bowel__________
☐No ☐Yes – Neurological/Seizure__________
☐No ☐Yes – Previous Surgeries__________
☐No ☐Yes – Anemia/Blood Disorder__________
☐No ☐Yes – Endocrine/Thyroid__________
☐No ☐Yes – Liver Problems__________
☐No ☐Yes – Eye/Visual Functioning__________
☐No ☐Yes – Hearing Functioning__________
☐No ☐Yes – Speech/Language Functioning__________
☐No ☐Yes – Growth/Development__________
☐No ☐Yes – Circulation__________
☐No ☐Yes – Diabetes__________
☐No ☐Yes – Caner__________
☐No ☐Yes – Skin__________
☐No ☐Yes – Kidney/Bladder__________
☐No ☐Yes – Gyn/Prostate__________

Nutrition Status

Current Weight __________ ☐Actual ☐Stated

☐ No weight changes in the past 3 months.
☐ Gained _______lbs. in the past 3 months.
☐ Lost _______ lbs. in the past 3 months.

Current Height __________ ☐Actual ☐Stated

How would you describe the member's appetite? ☐Good ☐Fair ☐Poor __________
Does the member have problems with Cholesterol or blood sugar? ☐Yes ☐No __________
Is the member on a special diet? ☐Yes ☐No __________

In case of medical emergency, 911 will be called. Parent/guardians will be called as well. To which hospital should the DSL member be taken by ambulance? ______________________

This Form must be completed annually

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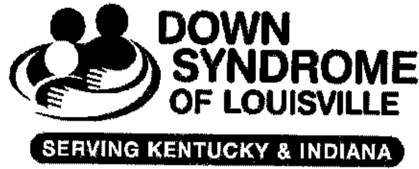

Allergy From

Member's name ____

(Check One)

______ Has no known allergies

______ is allergic to:

____

____

____

____

____

In case of an allergic reaction, the DSL staff member should: ____________________

____

____

____

______________________________ ______________________
Parent/guardian signature Date

______________________________ ______________________
DSL Staff Signature Date

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Email Communication Authorization

Participant Name: ____

Email Address:____

I authorize Down Syndrome of Louisville and MOU (Memorandum of understanding) contracted entities to use the above listed email address for sending information necessary to support services and personal health information regarding the above named participant.

I understand the by supplying my email address I am consenting to receiving emails and materials to the above stated address.

I understand that it is my responsibility to check my email account, and the Down Syndrome of Louisville and MOU contracted entities cannot be held responsible for emails that do not reach my above address.

I understand that email communication is not secure and that other members of the household with shared email accounts may view my personal information, Including attachments to emails.

I understand that electronic transmission of information by email is not secure and that personal information could be viewed by unauthorized parties.

I understand that I may reverse this authorization by contacting Down Syndrome of Louisville or MOU contracted entities at any time.

Guardian Signature ______________________________ Date __________

DSL Staff Signature ______________________________ Date __________