



Participant Information & Consent

Name: _____ Phone: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Date of birth: _____ Social Security number: _____ Medicaid Number: _____

Provider (or) Guardian name: _____ Relationship: _____

Mailing address: _____ City: _____ State: _____ Zip: _____

Work phone: _____ Cell phone: _____ Alternate phone: _____

E-mail address: _____

Please list at least two people we could contact in the event of an emergency if the caregiver cannot be reached. These phone numbers must be current; please let us know if any changes occur.

Name: _____ Relationship: _____ Phone: _____

Additional number(s) for this contact: _____

Name: _____ Relationship: _____ Phone: _____

Additional number(s) for this contact: _____

Participant's primary physician: _____ Phone: _____

Other physician (optional): _____ Phone: _____

Preferred Hospital (optional): _____

Number of days requesting attendance: _____

Non-Medical Transportation needed *Circle One* : (Yes) (No)

Please read the following statement, then sign and date below.

In the event of an emergency, I give permission for _____ to be transported to the nearest emergency room or to my preferred hospital (depending upon the nature of the emergency). I understand that I am responsible for all charges resulting from the emergency care, including ambulance or rescue squad charges. I also give permission for (ECS) staff to provide emergency medical personnel with any information which will assist them in treatment of the emergency.

Guardian signature: _____ Date: _____

Guardian name (printed): _____

***Please provide Empowered Community Services (ECS) with copies of the participant's Social Security card, photo I.D and insurance card(s) which we will keep on file in the event of an emergency.**



Medical History Form

The information you provide will help ensure that he/she is given appropriate care and services while in our care. This information will also serve in providing current medical history in the event of an emergency. Information provided on this form is confidential and will only be released with written authorization. Please attach any pertinent documentation to this form. Thank you for your assistance.

Participant name: _____ Date of birth: _____

Sex: _____ Street address: _____ City: _____ State: _____ Zip: _____

Does this person require (circle): *glasses* *hearing aid* *walker* *cane* *wheelchair*

DIAGNOSIS:

Primary: _____

Secondary: _____

ALLERGIES:

Food: _____

Medication: _____

Other: _____

PHYSICIAN'S ORDERS:

Medications: _____

Dietary Restrictions: _____

Physical limitations: _____

Recommendations /Comments: _____

Participant/Guardian Name: _____ **Date:** _____

Participant/Guardian Signature: _____ **Date:** _____

(ECS) representative signature: _____ **Date:** _____



Participant Prescription and Nonprescription Medication Form

Participant name: _____ **Date:** _____

1. medication: _____ dose/frequency: _____
specific time(s): _____ start date: _____ purpose: _____

2. medication: _____ dose/frequency: _____
specific time(s): _____ start date: _____ purpose: _____

3. medication: _____ dose/frequency: _____
specific time(s): _____ start date: _____ purpose: _____

4. medication: _____ dose/frequency: _____
specific time(s): _____ start date: _____ purpose: _____

5. medication: _____ dose/frequency: _____
specific time(s): _____ start date: _____ purpose: _____

6. medication: _____ dose/frequency: _____
specific time(s): _____ start date: _____ purpose: _____

7. medication: _____ dose/frequency: _____
specific time(s): _____ start date: _____ purpose: _____

8. medication: _____ dose/frequency: _____
specific time(s): _____ start date: _____ purpose: _____

9. medication: _____ dose/frequency: _____
specific time(s): _____ start date: _____ purpose: _____

10. medication: _____ dose/frequency: _____
specific time(s): _____ start date: _____ purpose: _____

11. medication: _____ dose/frequency: _____
specific time(s): _____ start date: _____ purpose: _____

12. medication: _____ dose/frequency: _____
specific time(s): _____ start date: _____ purpose: _____



Participant Prescription and Nonprescription Medication Form

13. medication: _____ dose/frequency: _____
specific time(s): _____ start date: _____ purpose: _____

14. medication: _____ dose/frequency: _____
specific time(s): _____ start date: _____ purpose: _____

15. medication: _____ dose/frequency: _____
specific time(s): _____ start date: _____ purpose: _____

16. medication: _____ dose/frequency: _____
specific time(s): _____ start date: _____ purpose: _____

17. medication: _____ dose/frequency: _____
specific time(s): _____ start date: _____ purpose: _____

18. medication: _____ dose/frequency: _____
specific time(s): _____ start date: _____ purpose: _____

19. medication: _____ dose/frequency: _____
specific time(s): _____ start date: _____ purpose: _____

20. medication: _____ dose/frequency: _____
specific time(s): _____ start date: _____ purpose: _____

21. medication: _____ dose/frequency: _____
specific time(s): _____ start date: _____ purpose: _____

22. medication: _____ dose/frequency: _____
specific time(s): _____ start date: _____ purpose: _____



PHOTO RELEASE FORM

Participant name: _____ **Date:** _____

I hereby give permission for the Empowered Community Services staff to:

(*check each box to which you agree)

- Be photographed
- Be videotaped
- Record voice
- Use of artwork (or a reproduction thereof)

Furthermore, I authorize the use and reproduction of these for publicity and/or educational and/or informational purposes without compensation. All copies and negatives shall be considered the property of Empowered Community Services (ECS).

Participant/Guardian Name: _____ **Date:** _____

Participant/Guardian Signature: _____ **Date:** _____

(ECS) representative signature: _____ **Date:** _____

***Please note:** Failure to agree to any other items on this release form WILL NOT affect participation in the program.



Consent to Services

Participant name: _____ **Date:** _____

I hereby give permission for _____ to participate in the (ECS) activities described below. (please check all that apply):

- Participation of daily services and scheduled activities provided at the Empowered Community Service's center.
YES __ NO __
- NMT transportation provided by (ECS) to and from any scheduled community engagement activities / opportunities during program hours.
YES __ NO __
- NMT transportation by (ECS) providing pick up and drop off services.
YES __ NO __
- Administration of prescription medication by certified (ECS) staff as prescribed by the participant's physician (medications must be brought to the center in a labeled, duplicate prescription bottle or container.)
YES __ NO __

Participant/Guardian Name: _____ **Date:** _____

Participant/Guardian Signature: _____ **Date:** _____

(ECS) representative signature: _____ **Date:** _____



Participant Activities of Daily Living

Participant name: _____ Date: _____

| ACTIVITY | INDEPENDENT | NEEDS HELP | UNABLE TO DO |
|--------------------------|--------------------------|--------------------------|--------------------------|
| <i>Dressing</i> | | | |
| tie shoes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| slip-on shoes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| socks/stockings | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| buttons | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| zippers | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>Personal Hygiene</i> | | | |
| bathing him/herself | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| teeth/denture cleaning | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| brushing/combing hair | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| shaving | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| toileting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>Movement</i> | | | |
| in and out of car | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| rising from chair | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| walking on level surface | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| stairs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>Eating</i> | | | |
| feeds him/herself | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| cuts meat | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| knows utensils | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| prepares a sandwich | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| ACTIVITY | NEVER | SOMETIMES | ALWAYS |
|----------------------------|--------------------------|--------------------------|--------------------------|
| sleeping problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| wandering | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| suspiciousness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| confusion | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| repetitious questions | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| disorientation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| agitation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| aggressiveness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| follows simple instruction | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| takes medications readily | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| ABILITY | NO LOSS | NORMAL LOSS | MODERATE LOSS | SEVERE LOSS |
|----------------|--------------------------|--------------------------|--------------------------|--------------------------|
| hearing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| vision | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| reading skills | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| writing skills | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| speech | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |



Medical Release of Information

By way of my signature, I provide Empowered Community Services (ECS) with my authorization and consent to use and disclose protected information for the purpose of adult day services and / or treatment.

I, _____, authorize Empowered Community Services (ECS) to do the following to release _____ personal information. This authorization is valid for no more than one year from signature date.

PLEASE CIRCLE YOUR CHOICE(S) BELOW:

1. (ECS) **may / may not** release the participant's information to authorized physicians.
2. (ECS) **may / may not** release the participant's information to the following person(s) or organizations: _____

Participant/Guardian Name: _____ **Date:** _____

Participant/Guardian Signature: _____ **Date:** _____

(ECS) representative signature: _____ **Date:** _____



Grievance Policy Agreement

Participant name: _____ Date: _____

The Empowered Community Service's team is committed to providing the highest quality of care and services to our participants, and their families. In the event any aspect of our care has been less than satisfactory, we want to know. We encourage the family, the participants supporting team or the participant themselves to tell us if he or she are dissatisfied with our service.

If in the event you have a complaint, please inform the (ECS) Chief Executive Officer:

(Joseph Kowalski)

Email: JKowalski@pickempowered.com Phone: (937) 205 - 5220

A verbal response from management will occur within 24 hours of a received complaint. A written response is available upon request.

If you observe any employee engaging in any activity which you consider to be illegal, improper, or wasteful, please call the immediate contacts listed below:

Branch Manager: Dustin Knight (937) 204 - 0056

Chief Executive Officer: Joseph Kowalski (937) 205 - 5220

County Support Administrator: _____ ()

I have read, understood, and agreed to the above (ECS) policy:

Guardian name (printed): _____ **Date:** _____

Guardian signature: _____ **Date:** _____



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Participant name: _____ Date: _____

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County Support Administrator: _____ ()

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Guardian name (printed): _____ **Date:** _____

Guardian signature: _____ **Date:** _____

(Participant) Copy



Rights of Individuals with Developmental Disabilities

- ✓ ***The right to be treated at all times with courtesy, respect and with full recognition of their dignity and Individuality.***
- ✓ ***The right to an appropriate, safe, and sanitary living environment that complies with local, state, and federal standards and recognizes the persons' need for privacy and independence.***
- ✓ ***The right to food adequate to meet accepted standards of nutrition.***
- ✓ ***The right to practice the religion of their choice or to abstain from the practice of religion.***
- ✓ ***The right of timely access to appropriate medical or dental treatment.***
- ✓ ***The right of access to necessary ancillary services, including, but not limited to, occupational therapy, physical therapy, speech therapy, and behavior modification and other psychological services.***
- ✓ ***The right to receive appropriate care and treatment in the least intrusive manner.***
- ✓ ***The right to privacy, including both periods of privacy and places of privacy.***
- ✓ ***The right to communicate freely with persons of their choice in any reasonable manner they choose.***
- ✓ ***The right to ownership, use of personal possessions so as to maintain individuality and personal dignity.***
- ✓ ***The right to social interaction with members of either sex.***
- ✓ ***The right of access to opportunities that enable individuals to develop their full human potential.***
- ✓ ***The right to pursue vocational opportunities that will promote and enhance economic independence.***
- ✓ ***The right to be treated equally as citizens under the law.***
- ✓ ***The right to be free from emotional, psychological, and physical abuse.***
- ✓ ***The right to participate in appropriate programs of education, training, social development, and habilitation and in programs of reasonable recreation.***
- ✓ ***The right to participate in decisions that affect their lives.***
- ✓ ***The right to select a parent or advocate to act on their behalf.***
- ✓ ***The right to manage their personal financial affairs, based on individual ability to do so.***
- ✓ ***The right to confidential treatment of all information in their personal and medical records, except to the extent that disclosure or release of records is permitted under sections 5123.89 and 5126.044 of the Revised Code.***
- ✓ ***The right to voice grievances and recommend changes in policies and services without restraint, interference, coercion, discrimination, or reprisal.***
- ✓ ***The right to be free from unnecessary chemical or physical restraints.***
- ✓ ***The right to participate in the political process.***
- ✓ ***The right to refuse to participate in medical, psychological, or other research or experiments.***

Participant name: _____ **Date:** _____



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Policies and Admissions Agreement

Participant name: _____ Date: _____

1. Hours to be spent at the Center will be based upon the participant's agreed / approved service authorization.
2. Center hours of operation will be between the hours of 8:00 a.m. to 3:00 p.m. Monday thru Friday (with some exceptions).
3. (ECS) must have *two* current emergency numbers on file at all times.
4. Transportation to the Center is provided by (ECS) per the participant's agreed / approved service authorization.
5. Prescription medications must be brought to or kept at the center in a duplicate prescription bottle. Nonprescription medications must be in their original container. Medications will be stored in a locked secure area unless otherwise specified in individuals plan.
6. Appropriate notice of (***24-hours***) shall be given to (ECS) if the participant is unable to attend on a scheduled day, at which time an alternate day may be scheduled. Please call: () -
7. Participants may be disallowed from attending the program for: (1) behavior which is severely disruptive to the activities of others; (2) behavior which place other persons served, staff members, or others in danger; (3) change in health status which cannot be managed by Empowered; (4) transporting pests such as lice or bed bugs.
8. Participants with acute infectious diseases symptoms (such as vomiting, diarrhea and unusually high temperature) may be disallowed from attending the program. Reasonable efforts must be made by families or residential providers for early dismissal for anyone who becomes ill while at the Center. A physician's release may be requested prior to the individuals resuming scheduled days
9. All scheduled and unscheduled program delays or closures will be be posted on our website pickempowered.com , local television (Channel 7) and radio as well as Facebook.

I have read, understood, and agree to the above policies:

Participant/Guardian Name: _____ **Date:** _____

Participant/Guardian Signature: _____ **Date:** _____

(ECS) representative signature: _____ **Date:** _____



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I have read, understood, and agree to the above policies:

Participant/Guardian Name: _____ **Date:** _____

Participant/Guardian Signature: _____ **Date:** _____

(ECS) representative signature: _____ **Date:** _____



In addition to all of the required paperwork, we please ask that you also bring any of the needed items below:

- A complete change of clothing (pants, shirt, underwear, socks, etc.) that can be left here for emergencies.
 - Any type of protective garment if required by participant (optional).
 - Please ensure we have a current copy of your Social Security card, photo I.D and insurance cards (any that you would present upon hospital admission) of which we will make a copy and keep on file.
 - Any legal document that you would present upon hospital admission – Power of Attorney, Healthcare Power of Attorney, Living Will, specific “Do Not Resuscitate” order. We will make copies of these as well.
 - If we are to give any prescription or PRN medications during the day, we require that the medicines be in their original containers. Pharmacies are very willing to give a second bottle with the prescription on it if you ask.
- **Friendly reminder:** *All scheduled and unscheduled program delays or closures will be posted on our website www.pickempowered.com, local television (Channel 7) and radio as well as Facebook.*
- *We invite you to download our communications application, to receive updated information on our weekly, monthly and daily activities along with enabling immediate communication with our management team.*

