Participant Information & Consent

Name: _____ Phone: _____

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

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

Location Request: Englewood Springboro

Requested Days of Services: (Mon) (Tue) (Wed) (Thur) (Fri) (Sat)

Door to Door Transportation: (Yes) (No)

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: _____

Support Administrator: _____ Phone:_____

Support Administrator Supervisor: _____ Phone:_____

Waiver Coordintor/Budget Authority: _____ Phone:_____

Span Start Date:_____

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.**

EMPOWERED
COMMUNITY SERVICES

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*

Participant's primary physician: _____ Phone:_____ Other physician (optional): _____ Phone:_____ Preferred Hospital (optional): _____

DIAGNOSIS:

Primary: _____

Secondary: _____

ALLERGIES:

Food: _____

Medication: _____

Other:_____

DELEGATION:

Are Delegated Nursing necessary while being served by Empowered Community Services: (Yes) (No)

If yes please complete prescription medication form. If no delegation needed please skip medication form.

Medication Administration:_____

G/J-Tube Administration:_____

Insulin Monitoring or Administration:_____

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

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

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

EMPOWERED
COMMUNITY SERVICES

Participant Prescription and Nonprescription Medication Form

Participant name: _____ **Date:** _____

PHYSICIAN'S ORDERS:

Dietary Restrictions: _____

Physical limitations: _____

Recommendations /Comments: _____

_____

See Below For Medications List - P/O must also be submitted/attached.

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: _____

Primary Care Physician: _____ ***Phone#: (____)_____Date:_____***

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

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

EMPOWERED
COMMUNITY SERVICES

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.

EMPOWERED
COMMUNITY SERVICES

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:*** _____

EMPOWERED
COMMUNITY SERVICES

Participant Activities of Daily Living

Participant name: _____ Date: _____

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

ACTIVITY	NEVER	SOMETIMES	ALWAYS
sleeping problems	❑	❑	❑
wandering	❑	❑	❑
suspiciousness	❑	❑	❑
confusion	❑	❑	❑
repetitious questions	❑	❑	❑
disorientation	❑	❑	❑
agitation	❑	❑	❑
aggressiveness	❑	❑	❑
follows simple instruction	❑	❑	❑
takes medications readily	❑	❑	❑

ABILITY	ABOVE AVERAGE	AVERAGE	BELOW AVERAGE	N/A
hearing	❑	❑	❑	❑
vision	❑	❑	❑	❑
reading skills	❑	❑	❑	❑
writing skills	❑	❑	❑	❑
speech	❑	❑	❑	❑

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.

In the event you have a complaint, please inform Branch Management

Englewood Springboro

Dustin Knight : 937.204.0056 Karen Miracle : 513.780.6138

A verbal response from management will occur within 48 hours of a received complaint. A written response is available upon request.

In the event response from Branch Management isn't prompt or satisfactory feel free to contact Empowered Community Services CEO

Joe Kowalski : jkowalski@pickempowered.com

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

Guardian name (printed): _____ Date: _____

Guardian signature: _____ Date: _____

(ECS) Copy

Grievance Policy Agreement

Participant name: _____ Date: _____

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Joe Kowalski : jkowalski@pickempowered.com

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

Guardian name (printed): _____ Date: _____

Guardian signature: _____ Date: _____

(Participant) Copy

EMPOWERED
COMMUNITY SERVICES

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:** _____

(ECS) Copy

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EMPOWERED
COMMUNITY SERVICES

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 8:30 a.m. to 3:30 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 approved and have a physicians order form to be brought to or kept at the center. All medications should be in a duplicate prescription bottle or pack provided by the pharmacy. Nonprescription (PRN) 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 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 through our ***Remind*** App, the website *pickempowered.com* , local television (Channel 2) and on Facebook.

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

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

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

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

(ECS) Copy

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COMMUNITY SERVICES

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

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

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

Participant Copy

EMPOWERED
COMMUNITY SERVICES

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. (If required or requested))

- 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.

- Friendly reminder: *All scheduled and unscheduled program delays or closures will be be posted on our website www.pickempowered.com, local television (Channel 2), Facebook and the Remind app.*

- *We invite you to download our communications application *Remind*, to receive updated information on our weekly, monthly and daily activities along with enabling immediate communication with our management team. Please ask your Branch Manager for more details.*

(Participant) Copy