Minding Miracles Learning Center, Inc.

Client Enrollment Information

Please fill out the following information in its entirety for Minding Miracles to attain pre-authorization and submit claims on your behalf. The following information must be complete and accurate. Any person who knowingly files false insurance information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

CLIENT DEMOGRAPHIC

Circle

Patient's Full Name: _____ **DOB**_____/_____/_____ **Gender:** ☐ ☐
Street Address: _____ **City, State, Zip:** _____
1) Parent/Guardian Full Name: _____ **Relationship:** _____
Street Address: _____ **City, State, Zip:** _____
Email: _____ **Phone#:** _____ **Alt Phone#:** _____
2) Parent/Guardian Full Name: _____ **Relationship:** _____
Street Address: _____ **City, State, Zip:** _____
Email: _____ **Phone#:** _____ **Alt Phone#:** _____

Emergency Contacts

#1 Full Name: _____ **Relationship:** _____ **Phone#:** _____
#2 Full Name: _____ **Relationship:** _____ **Phone#:** _____

INSURANCE AND DIAGNOSTIC

Date of last diagnostic evaluation: _____ **Performed by:** _____

Primary Insurance
Company Name: _____ **Effective Date:** ____/_____/_____ *Circle*
Policy Holder Full Name: _____ **DOB**_____/_____/_____ **Gender:** M / F
Policy Number: _____ **Group Number:** _____
Claims Address: _____ **Phone#:** _____

Is there a Secondary Insurance Plan? Yes / No **If so, please complete Secondary Insurance section**

Secondary Insurance
Company Name: _____ **Effective Date:** ____/_____/_____ *Circle*
Policy Holder Full Name: _____ **DOB**_____/_____/_____ **Gender:** M / F
Policy Number: _____ **Group Number:** _____
Claims Address: _____ **Phone#:** _____

MEDICAID DDD/DCF
Recipient ID#: _____ **Card Control #:** _____

Please provide the prescription for ABA services with any recent reports or evaluations that may be helpful to the patient's course of treatment. Please understand that Minding Miracles therapists are licensed professionals, not physicians. They cannot diagnose, alter, or change the diagnosis of any patient.

_____ _____ _____
Responsible Party Signature **Responsible Party Name (printed)** **Date**

****Please complete AND sign the reverse side of this form before submitting****
****Submit a copy of your child's Insurance Card(s) and diagnosis report with this form****

Minding Miracles Learning Center, Inc.

Client Financial Responsibility Statement:

When providing services for your child, Minding Miracles works within the specifications of our contract with your insurance company, New Jersey Medical Assistance Program-DXC Technology, the regulations of the NJ Department of Banking and Insurance and Federal/State laws. Therefore, the following financial responsibility statements must be agreed to, in order, to maintain services through Minding Miracles:

1. I understand that I am responsible for knowing the details of my insurance coverage. This includes my financial responsibility of copayments, deductibles, co-insurances, as well as referrals, etc. It is my responsibility to contact my insurance company to obtain this information.
2. I understand that for NJDDD and NJDCF, Respite care and Day Habilitation services:
    a. I am responsible for maintaining Medicaid Coverage and communication with my DDD Support Coordinator and/or DCF Perform Care to maintain approval for covered services.
3. I understand that if Minding Miracles is not participating or does not accept my insurance plan; if my plan does not have benefits for ABA services, or if I do not have insurance coverage, I will be responsible for all charges for services provided.
4. I understand that I am to pay the balance of any amount deemed as my financial responsibility, which may be referred as 'member or patient responsibility' from my insurance carrier (co-payments, deductibles, co-insurance, noncovered, etc.).
5. I understand that Copayments are due at the time of service and if not paid at the time of service Minding Miracles will issue a billing statement for my financial responsibility.
    a. Statements/invoices are issued by Minding Miracles monthly and the balance is due upon receipt. I understand that I am responsible to pay the full balance due or to contact MMLC to request a payment arrangement and if failed to do so, Minding Miracles reserves the right to suspend services and/or forward the account balance forwarded to a collection agency (additional fees apply).
    b. Minding Miracles is contractually obligated to collect copayments, coinsurance, and deductibles, etc., from our clientele. We cannot legally waive these fees. For clarification on your benefit coverage please contact your insurance plan. For questions on statements, please contact our billing office at 848-757-2123. **To request a payment arrangement, please submit your request in writing to Theresa.MMLC@gmail.com.**
6. I will provide all current information (including copies of both sides of my insurance card, updated address/contact information, or changes in coverage) before the date of said change.
7. I agree to immediately inform Minding Miracles billing department of **ANY** change in my insurance coverage (plan, policy #, group#, copay, etc.) and understand that failure to do so may result in me being responsible for the entire amount due for services rendered.
8. I agree to provide Minding Miracles administration with all required documentation including copies of my child's diagnosis letter, physician prescription for ABA services and any other documents required by my insurer.
9. I agree to respond to all inquiries made by my insurer within seven days of the request and to notify Minding Miracles main office of the request.
10. I understand I will be charged a $35.00 fee if my personal check is returned by my bank.

*I hereby give my consent to Minding Miracles to bill my insurance plan for the services rendered for the patient name listed and authorize insurance benefit payments to Minding Miracles Learning Center. In an event that the insurance plan issues payment to the member, I am responsible to send the endorsed check and Explanation of Benefits to Minding Miracles billing department for reimbursement.

In addition, I agree to pay my portion of financially responsibility in accordance to my benefit plan contract.

*I hereby give consent to Minding Miracles to release information necessary to process claims for services rendered with Minding Miracles Learning Center.

*I understand HIPAA privacy guidelines (copy provided upon initial enrollment) and a copy of the guidelines is available at my request.

*I authorize the release of information to my provider with Minding Miracles Learning Center.

I have read the above statements and fully understand and agree to these terms.

Patient's Full Name: _____ **DOB**_____/_____/_____

_____	_____	_____
Responsible Party Signature	**Responsible Party Name Printed**	**Date**

****Please read AND sign this form before submitting****

Form #7

State of New Jersey
Department of Human services
Division of Developmental Disabilities

EMERGENCY CONSENT FORM
ADULT DAY SERVICES

In my capacity as the legally appointed guardian of _____,
(Print Name)

I hereby consent to any and all medical or surgical treatment, including hospital admission, examinations and diagnostic procedures, anesthetics, transfusions and operations, which, in the event of an emergency are deemed necessary by competent medical clinicians to save the life or preserve the health of the above named individual. I also approve the release from the case records of any medical history or other medical data, which would be necessary for the physician and/or hospital to administer the treatment.

It is understood that general consent is only applicable specifically and exclusively to emergency situations. In each and every other instance of elective medical and/or surgical treatment recommended by medical professionals, an explicit, individual consent must be requested within a reasonable advance time period.

Emergency treatment should be followed by prompt notification of the guardian by the person(s) responsible for care of the individual.

_____ _____
Signature of Legal Guardian Date

_____
Print Name

Service Enrollment

Medical Disclaimer: In the event of a medical emergency, I give Minding Miracles personnel permission to apply first aid and secure necessary medical treatment for my child. Minding Miracles staff and corporation will not be held responsible or liable in any way as a result of seeking medical attention for our child. I (We) further agree to assume full financial responsibility for any medical or health care given to our child while under the care of Minding Miracles Learning Center, Inc.

Child Release Policy: The staff at Minding Miracles Learning Center can only release participants to parents, guardians orthose authorized by the parents or guardians. If you authorize individuals other than parents or emergency contacts to pick up your child from the center, please attach a separate sheet of paper including their name, phone number, relationship, and your signature. People who may not normally pick up your child will be asked to show identification.

Photo Release: Occasionally, when putting together advertisements, updating our website, giving presentations, posting on social media, or hosting trainings, our agency has the opportunity to display photos of our students in their learning process. No names will ever be used without first securing further permission. By initialing this section, you give permission for Minding the initial line.

Consent for Treatment: I now voluntarily consent to treatment or evaluation performed by clinicians with MMLC. This consent for treatment is valid for all care that is provided by Minding Miracles personnel. I understand that I can revoke this consent for treatment at any time in writing to the MMLC main office.

Communicable Illness: It is our first priority to maintain the health and wellness of all of our students and staff. In the event that the participant exhibits symptoms of communicable illness, he/she should not attend the center. Any individual who begins to exhibit symptoms while at the center will be separated from the group and you will be contacted to pick him/her up. For a complete list of symptoms, please see the center manager. Individuals must be symptom free for 24 hours before returning to the center.

Financial Responsibility: Minding Miracles assumes responsibility of submitting claims for services through designated agencies such as your insurer, DCFS or DDD. However, any requirements put in place by these entities in order to maintain the eligibility or authorization is the ultimate responsibility of the guardian. In the event that the parent/guardian does not comply with the requirements, financial responsibility will be assumed to fall on the parent. Hourly rates will be applied as of the last day that services were approved and parents will be responsible for payment in full. Any copay, deductible or overage charges not covered by the funding agency are the responsibility of the guardian.

Scheduling: Minding Miracles pays careful consideration to our staff ratios in order to provide a safe, effective and efficient program for all of our clients. In order to do so, clients must notify us of and adhere to a monthly schedule. Schedule changes are permitted with prior permission when logistically possible. Schedule changes, early drop-off and late-pickup are not permitted unless prior approval has been granted.

Privacy Policies: Minding Miracles is legally bound by the Health Insurance Portability and Accountability Act, which ensures the privacy of personal data and security provisions for safeguarding personal information. A copy of our HIPAA statement is attached to this packet for your information. By signing below, you acknowledge receipt of Minding Miracles' HIPAA privacy statement.

By signing below, you acknowledge receipt of the above-mentioned policies.

Client Name (print): _____

Client Representative (print): _____

Client/Representative Signature:_____ Date: _____

NEW JERSEY DEPARTMENT OF HUMAN SERVICES
Division of Developmental Disabilities

PARTICIPANT STATEMENT OF RIGHTS AND RESPONSIBILITIES

The rights and responsibilities of an individual with an intellectual or developmental disability receiving supports and services through the New Jersey Division of Developmental Disabilities (Division) include, but are not limited to, the following:

RIGHTS

I have the right to exercise my rights as a citizen.

I have the right to privacy and to be treated with dignity and respect.

I have the right to be believed to have the ability to make my own decisions.

I have the right to live as I choose, free from judgment, interference, or threat.

I have the right to protection from physical, verbal, psychological, or sexual abuse, neglect or punishment.

I have the right to equal employment opportunities, to work in the community and fair payment for my work.

I have the right to own, rent, or lease property.

I have the right to live and receive services/supports in the least restrictive environment and to be free from restraint.

I have the right to express human sexuality and receive appropriate training/education.

I have the right to marry and have children.

I have the right to presumption of legal competency in guardianship proceedings.

I have the right to be free from unnecessary and excessive medication.

I have the right to privacy during treatment and care of my personal needs.

I have the right to confidentiality/privacy of my information and medical records.

I have the right to access my personal resources and be free from personal and financial misuse/abuse.

I have the right to utilize my New Jersey Individualized Service Plan (NJISP) and budget to meet my needs within Waiver program guidelines.

I have the right to decide how to choose my services or to have someone I choose help me with decisions within the guidelines of the Waiver program.

I have the right to identify and invite who I want to participate in my service plan meetings.

I have the right to a fair hearing if for any reason my waiver services are denied, reduced, suspended or terminated. An initial appeal shall be made in writing to:

Division of Medical Assistance and Health Services (DMAHS) Fair Hearing Unit
PO Box 712
Trenton, NJ 08625

When living in a community residence licensed by the New Jersey Department of Human Services Office of Licensing, I have the right to have a key to lock/unlock my home and bedroom door, to have visitors of my choosing, make and receive phone calls, make my own schedule and access food at any time, unless otherwise determined in a documented person-centered process that I am a part of.

RESPONSIBILITIES

I am responsible for maintaining/keeping Medicaid coverage to continue services on my Waiver program.

I am responsible for making sure that I can meet with my support coordinator and provide all information necessary to ensure that my NJISP can be created within 30 days of my support coordination agency selection.

I am responsible for participating in the development of my NJISP and sharing in any decision making associated with the plan.

I am responsible for what is included in my NJISP and for following my budget according to Waiver guidelines.

I am responsible for all required paperwork and following all Waiver program policies and procedures.

I am responsible to contact my support coordinator in the event that I want to change any of the service providers listed in my NJISP.

I am responsible to contact my support coordinator if anything changes in my life that may require a change to my NJISP or services that I receive.

I am responsible for participating in monthly phone contacts and quarterly face-to-face visits with my support coordinator. I understand these visits are mandatory and may occur in my home, day program or place of employment as agreed upon with my support coordinator. I understand that at least one of these face-to-face quarterly visits per year must take place inside my home.

I have read and /or understand these rights and responsibilities.

_____ _____

Participant/Representative Signature Date

Notice of Information Practices and Privacy Statement
For Minding Miracles, Inc. dba Beacon Achievement Center

This notice describes how your medical information may be used and disclosed (provided to others) and how you can get access to this information. Please review this notice carefully.

This Notice of Privacy Practices explains how Minding Miracles, Inc., its subsidiaries (Beacon Achievement Center), its staff members, contractors, employees, volunteers, and clinics may use and provide your Protected Health Information (called PHI) to others for treatment, payment, and health care "operations" as described below, and for other purposes allowed or required by law.

I. OUR RESPONSIBILITIES: Minding Miracles takes the privacy of our clients health information seriously. We are required by law to keep your health information private and provide you with this Notice of Privacy Practices. We will act according to the terms of this Notice. We reserve the right to change this Notice of Privacy Practices and to make any new practices effective for all Protected Health Information that we keep. Any changes made to the Notice of Privacy Practices will be posted in the Client Registration area and given to you at your next appointment.

II. WHAT IS "PROTECTED HEALTH INFORMATION" (PHI)? Protected Health Information (PHI) is information about a client's age, race, sex, and other personal health information that may identify the client. The information relates to the client's physical, behavioral or mental health in the past, present, or future, and to the care, treatment, and services needed by a client because of his or her health.

III. WHAT DOES "HEALTH CARE OPERATIONS" INCLUDE? "Health care operations" includes activities such as discussions between Minding Miracles staff, contractors, and other health care providers; evaluating and improving quality; making travel arrangements to and from Minding Miracles; reviewing the skills, competence, and performance of health care staff and contractors; training future health care staff; dealing with insurance companies; carrying out behavioral reviews and auditing; collecting and studying information that could be used in legal cases; and managing business functions.

IV. HOW IS MEDICAL INFORMATION USED? Minding Miracles uses medical records to record health information, to plan care and treatment, and to carry out routine health care functions. For example, your insurance company may need us to give them behavioral, skill performance, cognitive abilities and procedure/diagnosis information to bill for client treatment we provide. Other health care providers or health plans reviewing your records must follow the same privacy laws and rules that Minding Miracles is required to follow.

V. EXAMPLES OF HOW MEDICAL INFORMATION MAY BE USED FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

- Medical information may be used to show that a client needs certain care, treatment, and services.
- We will use medical information to plan treatment.
- We may disclose Protected Health Information to another provider for treatment (such as, referring doctors, specialists, and contractors to Minding Miracles).
- We may send claims to your insurance company containing medical information. We might also contact their utilization review department to receive precertification (approval for treatment in advance).
- We may use the emergency contact information you gave us to contact you if the address we have on record is no longer correct.

VI. WHY MIGHT I HAVE TO SIGN A CONSENT FORM?

You may be asked to sign a consent form if it becomes necessary to share PHI for reasons other than listed above. For instance, before another professional will be permitted to observe a client, when reports or data collection is requested by professionals that are not-affiliated with Minding Miracles or when our agency requests the use of any identifying information for promotional purposes.

VII. CAN I CHANGE MY MIND AND WITHDRAW PERMISSION FOR MINDING MIRACLES TO DISCLOSE PHI?

You may change your mind and withdraw (revoke) permission, but we cannot take back information that has been released up to that point. Permission cannot be withdrawn if (1) the information is needed to maintain the integrity of the program, or (2) if the permission was originally given to obtain insurance coverage. All requests to withdraw permission for uses and disclosures of PHI should be made in writing. The request should be submitted to Minding Miracles' business office address, which will then forward this information to the Privacy Officer.

VIII. WHEN IS MY CONSENT *NOT* REQUIRED?

The law requires that some information may be disclosed without your permission during the following times:

- In an emergency
- When required by law
- When there are risks to public health
- To conduct health oversight activities
- To report suspected child abuse or neglect
- To certain government agencies who monitor activity
- In connection with court or government cases
- For law enforcement purposes
- To attain authorization from your designated insurance agency
- If health or safety is seriously threatened

IX. YOUR PRIVACY RIGHTS

The following explains your rights with respect to your Protected Health Information (called PHI) and a short description of how you may use these rights.

1. You have the right to review and to ask for a copy of your health information.
2. You have the right to request that access to your health information be limited.
3. You have the right to request to receive private communications in another way or at other locations.
4. You have the right to request changes to your health information.
5. You have the right to receive a record of when your health information has been disclosed by Minding Miracles.
6. You have the right to receive a paper copy of this Notice of Privacy Practices.

X. WHAT IF I HAVE A QUESTION OR COMPLAINT?

If you believe your privacy rights have been violated, you may file a complaint by contacting the Minding Miracles Privacy Officer at (732) 291-0810, or by e-mail at *mindingmiracles@aol.com* , or with the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint. Complaints can be filed through the following address:

Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F HHH Bldg.
Washington, D.C. 20201
www.hhs.gov/ocr/hipaa

STATE OF NEW JERSEY

DEPARTMENT OF HUMAN SERVICES - DIVISION OF DEVELOPMENTAL DISABILITIES

Medical Form for Adults

Name: _____ Age: _____ DOB: _____ ◯ Male ◯ Female

Health Insurance #: _____ SS#: _____ Exam Date: _____

A. HISTORY:

1) Indicate any present and past medical condition (include communicable disease history):

_____

_____

2) Previous hospitalizations/surgery: _____

_____

3) Immunizations:

Adult Diphtheria/Tetanus-Date: _____

(Document date of last booster OR administer if more than 10 years ago.)

Hepatitis B Immunization (if given) Date: [1] _____ [2] _____ [3] _____

B. LABORATORY TESTS:

1) **Mantoux Test yearly** if non-reactor or chest x-ray if indicated. Past or current results must be documented:

Results: _____ Date: _____

Tine test is not acceptable. Positive Mantoux reactor should never be retested.

2) Hepatitis B Profile: Initial (repeat at physician's discretion).

Results: _____ Date: _____

(Past or current results must be documented).

3) Lead Poisoning: Blood Lead Level is required:

a. For Individuals with known Pica behavior, test annually, or according to guidelines for elevated lead levels

b. Prior to discharge from development center (within 3 months of discharge).

c. For all new admissions to Divisional residential services (within 3 months prior to admission or within 10 days after admission).

Blood Level: _____ Date: _____

4) SMAC, initial (repeat at physician's discretion): _____

5) Complete Blood Count, initial (repeat at physician's discretion): _____

6) Urinalysis, initial (repeat at physician's discretion): _____

7) Serology, initial (repeat at physician's discretion): _____

8) Pap Smear (follow American Cancer Society guidelines): _____

9) EKG – initial at age 40 (repeat at physician's discretion): _____

C. OTHER MEDICAL CONDITIONS/NEEDS:

1) Seizures: { } Yes { } No Frequency & Type, if known: _____

_____

2) Special Dietary Needs: { } Yes { } No (Attach Prescription): _____

_____

3) Allergies, Sensitivities: (foods, drugs, others): _____

_____

4) Mental Health Problems (Behavioral/Psychiatric Disorders): _____

_____

UPDATE

D. MEDICATION:

Name: _____ Dosage: _____ Frequency: _____ Indication:_____
Name: _____ Dosage: _____ Frequency: _____ Indication:_____
Name: _____ Dosage: _____ Frequency: _____ Indication:_____
Name: _____ Dosage: _____ Frequency: _____ Indication:_____
Name: _____ Dosage: _____ Frequency: _____ Indication:_____

E. CLINICAL EXAMINATION:

1) Height: _____ Weight: _____ Temp.: _____ Pulse: _____ B.P.: _____
2) Sensory (Indicate any impairment and extent):
   Eyes: Vision (Glasses, etc.): _____
   Hearing: (Aids, etc.): _____
3) ENT: _____
4) Teeth & Gums: _____
5) Neck: _____
6) Breast (Follow American Cancer Society Guidelines for Mammography): _____
7) Lymphatic System: _____
8) Respiratory System: _____
9) Cardiovascular System: _____
10) Gastrointestinal System (Stool for occult blood after age 50): _____
11) Genitourinary System: _____
12) Prostate: _____
13) Muscular System: _____
14) Skeletal System: _____
15) Neurological System: _____

ADDITIONAL INFORMATION/RECOMMENDATIONS:

(Please indicate if there are limitations or restrictions regarding physical activities)

_____

_____

PLEASE ISSUE PRESCRIPTIONS FOR MEDICATION, DIET, ADAPTIVE EQUIPMENT, PROCEDURES AND THERAPIES. (Please Print or Type CLEARLY)

Physician's Name: _____ Date: _____

Address: _____ Phone #: _____

Physician's Signature: _____

PLEASE RETURN COMPLETED FORM TO:

NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

UPDATE

THANK YOU FOR YOUR COOPERATION

Minding Miracles Learning Center, Inc.

Please help us provide the best possible care by sharing the following information…

Participant's full name:	
Nickname:	Date of birth:
Siblings names & ages:	
Names and relationships of others in the home:	

Diagnostic Information

Diagnosis:	Date of Diagnosis:
Diagnosing physician:	
Current neurologist/developmental doctor:	
Primary care physician:	Contact info:
Has the participant ever been diagnosed with any other medical or learning conditions we should be aware of (aka, co-morbidity):	
Does the participant have a history of seizures?	
Does the participant have any allergies (including seasonal, food or medication)?	
Has the participant had any exposure to narcotics or alcohol?	
Does the participant regularly take medication? If so, Please explain reason, type & dosage:	

Service History

Has the participant ever received ABA services? Yes / No	Agency:	Date ended:
Does the participant receive any services other than DDD day habilitation?		
Where did you're the participant last attend school? Last date of attendance: What was their educational placement in school?		
Does your child have any sensory-related needs? If so, Please explain.		

Minding Miracles Learning Center, Inc.

Please help us provide the best possible care by sharing the following information…

Likes/Dislikes

Favorite foods:
Favorite TV shows/movies:
Dislikes:
Favorite Activities:
Favorite Songs:
Favorite Characters:
Other:

Personal Needs

Toilet use & level of assistance:
Mealtime assistance:
Fears & sensitivities:
Sensory related needs/Self-stimulatory behavior:
Sleep patterns:

Behavior

Does the participant engage in any of the following behaviors? (please circle all that apply) *Elopement* ☐ *Self-injury* ☐ *Aggressions toward others* ☐ *Stereotypy* ☐ *Repetitive Vocal Utterances* ☐ *Other:*
Please explain the behavior and the frequency usually observed:
How is the behavior usually addressed?
Is there currently a behavior plan in place for this behavior?

Language

What language is predominantly spoken within the home?
Participant's primary means of communication: *Expressive language* ☐ *Gestures* ☐ *Sign language* ☐ *Augmentative device* ☐

Please list any additional information that may be helpful to a smooth transition on the reverse of this page.

Minding Miracles Learning Center, Inc.

Transportation Permission

Participant's Full Name:_____

Parent/Guardian Name:_____

Parent/Guardian Contact Information: _____

I hereby give permission for Minding Miracles/Beacon Achievement Center staff to transport the above-named individual for the following reasons:

_____ Transportation to/from the center for program participation

_____To/from center-sponsored community outings

_____To/from a third-party location: (please list address) _____

I relieve Minding Miracles and its employees of all liability beyond that of normal supervision and protection. In the event of an emergency, I give permission for the above-named participant to receive the necessary medical treatment.

Parent/Guardian Signature _____ Date_____

Vehicle Emergency Information:

In the case of emergency, please contact:

Primary contact: _____ _____ _____
(name) (phone) (relationship)

Secondary contact: _____ _____ _____
(name) (phone) (relationship)

Participant's home address: _____

Pertinent Medical Information: Diagnosis: _____

Allergies: _____

Current Medication: _____

Other medical conditions: _____

Emergency Card

Last Name	First Name	DOB	Age	Phone
Address				
DDD ID	Case manager	Agency		Phone

Residential Contact Name		☐Parent ☐Other family ☐Residential program staff ☐Sponsor ☐Other	
Home phone	Cell phone	Work phone	Other
Legal Guardian Name:		Address	
Home phone	Cell phone	Work phone	Other phone

Other persons who are authorized to act in an emergency and are authorized to pick up or receive drop off of individual.

(1)Name	Address		Relationship to individual
Home phone	Cell phone	Work phone	Other phone
(2)Name	Address		Relationship to individual
Home phone	Cell phone	Work phone	Other phone

Background information

Diagnosis	Seizures yes ◯ no ◯	Allergies yes ◯ no ◯ Specify:	
Other health conditions:		Preferred hospital:	
General physician name:		Address	Phone
TB test date:	***Result: negative ◯ positive ◯ Chest xray date/results:***		
Hepatitis B status :	***Date:***	***Date of last tetanus vaccination:***	

Medicaid number:		Medicaid HMO *(if applicable):*
Medicare number:		Medicare HMO *(if applicable):*
Other medical insurance carrier:	ID number:	Group #:
Prescription drug insurance company:		ID#:

UPDATE

_____***Signature of home representative*** _____***Date***

Emergency Card

Medication Information as of _______________(date) ***Must be complete despite whether or not the individual is receiving meds while at program

Medication name	Dose	Medication	Dose	Medication	Dose

Medication Information as of _______________(date) ***Must be complete despite whether or not the individual is receiving meds while at program

Medication name	Dose	Medication	Dose	Medication	Dose

Medication Information as of _______________(date) ***Must be complete despite whether or not the individual is receiving meds while at program

Medication name	Dose	Medication	Dose	Medication	Dose

Medication Information as of _______________(date) ***Must be complete despite whether or not the individual is receiving meds while at program

Medication name	Dose	Medication	Dose	Medication	Dose

UPDATE

Department of Human Services

Division of Developmental Disabilities - Community Services		
Over-the-Counter Medication Orders for Use as Needed		
Name	Date (good for one year)	Doctor's Signature
Allergies		

Symptom	**Medication**	**Dosage**	**Frequency**	**Maximum Amount In 24 Hours**
Headache				
Menstrual Cramps				
Diarrhea If more than five times/day see doctor.				
Constipation If three days or longer, see doctor.				
Cold Symptoms Including Coughs – If cough lasts longer than three days, see doctor.				
Sinusitis				
Fever under 101°F If more than 101°F, see doctor				
Other: Nausea/vomiting/indigestion				
Any medications that should never be given.				

Check this box if you do not want us to administer OTC medications ☐