HEARTZ 2 HEART DEVELOPMENTAL LIVING LLC

CLIENT ENROLLMENT, INTAKE, AND AUTHORIZATION PACKET

Welcome to Heartz 2 Heart Developmental Living LLC

Thank you for choosing **Heartz 2 Heart Developmental Living LLC**. Our mission is to provide person-centered services that promote independence, dignity, choice, and community inclusion. Please complete this packet as thoroughly as possible. All information collected is confidential and protected under HIPAA regulations.

SECTION 1: CLIENT INFORMATION

Personal Information

Client Name: _____

Preferred Name/Nickname: _____

Date of Birth: _____

Age: _____

Gender: _____

Social Security Number: _____

Medicaid Number: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone Number: _____

Email Address: _____

Preferred Language: _____

Marital Status:

☐ Single
☐ Married
☐ Divorced
☐ Widowed
☐ Other

Primary Diagnosis(es):

_____

_____

SECTION 2: LEGAL REPRESENTATIVE/GUARDIAN

Does the client have a legal guardian?

☐ Yes
☐ No

Guardian Name: _____

Relationship: _____

Phone Number: _____

Email: _____

Address: _____

Please provide guardianship documentation if applicable.

SECTION 3: EMERGENCY CONTACTS

Emergency Contact #1

Name: _____

Relationship: _____

Phone Number: _____

Alternate Number: _____

Address: _____

Emergency Contact #2

Name: _____

Relationship: _____

Phone Number: _____

Alternate Number: _____

Address: _____

SECTION 4: INSURANCE AND WAIVER INFORMATION

Medicaid

Medicaid Number: _____

CES Waiver

Does the client receive CES Waiver Services?

☐ Yes
☐ No

Support Coordinator: _____

Agency: _____

Phone: _____

Other Insurance

Primary Insurance Provider: _____

Policy Number: _____

Secondary Insurance: _____

Policy Number: _____

SECTION 5: SERVICES REQUESTED

Please check all services requested:

☐ Supportive Living
☐ Respite Services
☐ Environmental Modifications
☐ Supplemental Support Services
☐ Supported Employment
☐ Community Transition Services
☐ Transportation Assistance
☐ Community Integration
☐ Personal Assistance
☐ Life Skills Training

☐ Behavioral Support
☐ Other: _____

Reason for Referral:

_____

_____

SECTION 6: HOUSING INFORMATION

Current Living Situation:

☐ Own Home
☐ Family Home
☐ Apartment
☐ Foster Home
☐ Group Home
☐ Nursing Facility
☐ Hospital
☐ Other: _____

Current Address:

_____

Does the client require residential placement?

☐ Yes
☐ No

If yes, describe preferred placement needs:

_____

_____

SECTION 7: PROVIDER DIRECTORY

Primary Care Physician

Provider Name: _____

Phone: _____

Psychiatrist

Provider Name: _____

Phone: _____

Therapist

Provider Name: _____

Phone: _____

Dentist

Provider Name: _____

Phone: _____

Additional Providers

Provider Name: _____

Specialty: _____

Phone: _____

SECTION 8: PREFERRED PHARMACY

Pharmacy Name: _____

Address: _____

Phone Number: _____

Pharmacist Name (Optional): _____

SECTION 9: MEDICATION PROFILE

Medication	Dosage	Frequency	Prescribing Physician
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medication Allergies:

Does client self-administer medications?

☐ Yes
☐ No

Requires medication assistance?

☐ Yes
☐ No

SECTION 10: AREAS OF NEED

Please identify areas where support is needed:

☐ Bathing
☐ Dressing
☐ Grooming
☐ Toileting
☐ Meal Preparation
☐ Housekeeping
☐ Transportation
☐ Medication Management
☐ Budgeting
☐ Shopping
☐ Employment Support
☐ Community Participation
☐ Communication
☐ Behavior Support
☐ Mobility Assistance
☐ Safety Monitoring
☐ Social Skills
☐ Independent Living Skills
☐ Other: _____

SECTION 11: SOCIAL HISTORY

Highest Education Level: _____

Current Employment Status:

☐ Employed
☐ Unemployed
☐ Retired
☐ Student

Employer: _____

Military Service:

☐ Yes
☐ No

Religious Preference (Optional): _____

Community Activities:

Significant Life Experiences:

SECTION 12: INCOME INFORMATION

Income Source:

☐ SSI
☐ SSDI
☐ Employment
☐ Retirement
☐ Family Support
☐ Other: _____

Monthly Income: $_____

Representative Payee:

☐ Yes
☐ No

Name: _____

SECTION 13: PETS AND ANIMALS

Are there animals in the home?

☐ Yes
☐ No

Type: _____

Pet Name: _____

Temperament:

☐ Friendly
☐ Nervous
☐ Aggressive

Special Instructions:

SECTION 14: GETTING TO KNOW ME

Tell us about yourself:

What makes you happy?

What are your strengths?

What are your goals?

What would you like staff to know about you?

SECTION 15: MY LIKES AND DISLIKES

Things I Like

Favorite Foods: _____

Favorite Activities: _____

Favorite Music: _____

Favorite Movies/Shows: _____

Favorite Places: _____

Favorite Hobbies: _____

Things I Dislike

Foods I Dislike: _____

Activities I Dislike: _____

Things That Upset Me: _____

Sensory Triggers: _____

SECTION 16: PERSON-CENTERED PLANNING ASSESSMENT

My Goals for the Next Year:

_____

_____

Skills I Would Like to Learn:

_____

How I Want to Participate in My Community:

_____

Employment Goals:

_____

Housing Goals:

Health Goals:

How Staff Can Best Support Me:

HIPAA CONSENT FORM

I acknowledge that I have received information regarding my privacy rights under the Health Insurance Portability and Accountability Act (HIPAA).

I authorize **Heartz 2 Heart Developmental Living LLC** to use and disclose my protected health information as necessary for treatment, payment, healthcare operations, and coordination of services.

Client Signature: _____

Date: _____

Guardian Signature: _____

Date: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize **Heartz 2 Heart Developmental Living LLC** to obtain and release information to coordinate services with:

☐ Physicians
☐ Hospitals
☐ Therapists
☐ Support Coordinators

☐ Schools
☐ Insurance Providers
☐ Other: _____

This authorization remains in effect until revoked in writing.

Client Signature: _____

Date: _____

Guardian Signature: _____

Date: _____

EMERGENCY MEDICAL CONSENT

In the event of a medical emergency, I authorize **Heartz 2 Heart Developmental Living LLC** staff to obtain emergency medical treatment, transportation, and healthcare services as deemed necessary.

Preferred Hospital: _____

Primary Physician: _____

Client Signature: _____

Date: _____

Guardian Signature: _____

Date: _____

MEDICATION AUTHORIZATION

I authorize **Heartz 2 Heart Developmental Living LLC** staff, as permitted by state regulations and service plans, to assist with medication administration and medication reminders.

Client Signature: _____

Date: _____

Guardian Signature: _____

Date: _____

Physician Signature (if required): _____

Date: _____

CLIENT RIGHTS AND RESPONSIBILITIES

Client Rights

Every client has the right to:

- Be treated with dignity and respect.
- Receive services free from abuse, neglect, or exploitation.
- Participate in service planning.
- Make personal choices.
- Confidentiality and privacy.
- File grievances without retaliation.

Client Responsibilities

Clients are responsible for:

- Providing accurate information.
- Participating in service planning.
- Treating staff respectfully.
- Reporting concerns or changes in condition.

I acknowledge receipt of my rights and responsibilities.

Client Signature: _____

Date: _____

CLIENT GRIEVANCE PROCEDURE

If you have concerns regarding services:

Step 1: Contact your Program Manager.

Step 2: Submit a written grievance.

Step 3: Management will investigate within five business days.

Step 4: Written findings will be provided.

Step 5: Appeals may be submitted to the Executive Director.

Client Signature: _____

Date: _____

OFFICE USE ONLY

Referral Source: _____

Intake Coordinator: _____

Date Received: _____

Services Approved: _____

Program Assigned: _____

Start Date: _____

Case Manager: _____