Elizabeth Richardson Center

ERC Enhancing lives Removing barriers Creating opportunities

ERC Adult Development Program Application for Admission

Please provide all critical health and safety information to provide an accurate picture of the individual being considered for admission. Withholding critical information may result in denial of services or discharge from services for the individual.

Your application is not complete until ERC receives the following:

Application and Service Needs Assessment form

A copy of your Medicaid, PASSE, Medicare and any private insurance cards (unless private pay)

ADDT Prescription for Services form signed by your physician

A physical examination completed within the last year (our form or doctor's office printout)

Psychological testing – IQ and/or adaptive behavior depending on developmental disability

A copy of your guardianship order or power of attorney, if applicable

A copy of your high school diploma if you are under 21

Submit all required information:

By mail or in person:

Elizabeth Richardson Center

ATTN: AD Case Manager

3917 S. Old Missouri Rd.

Springdale, AR 72764

By fax:

479-306-6819

ATTN: AD Case Manager

Direct questions to:

AD case managers at 479-365-6557 or 479-872-1800 (follow menu prompts for adult programs then case managers). You may also continue to contact a specific case manager directly if you have been speaking to one.

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ERC Adult Development Program Application and Service Needs Assessment

The Adult Development Program at ERC provides habilitation and pre-vocational skills training at our Life Skills facility to adults age 18 and over who have completed school. Individuals who are 25 or older, or who have met additional eligibility requirements may also receive training in our sheltered workshop, Richardson Industries.

We cannot provide Adult Development services to individuals under 18, but you can submit your application before turning 18. Admission is contingent on eligibility, funding, and ERC determination that we can meet the needs of the applicant. Approved applicants will be placed on a waiting list if space is not available at the time of approval. Additional information may be requested if ERC staff have additional questions or concerns about ERC's ability to serve the applicant. If you have questions or need assistance with the application, please call 479-872-1800 to speak to an adult case manager, or contact the case manager you have spoken to about services if known.

Your application is not complete until all required documents have been submitted.

Date of Application: _____

Applicant

Name: _____ Birthdate: _____ Age: _____

Address: _____ Phone number: _____

_____ Primary language: _____

APPLICANTS WHO ARE UNDER 21 MUST ATTACH A COPY OF A HIGH SCHOOL DIPLOMA OR OTHER PROOF OF COMPLETION OF SCHOOL.

Who should we contact concerning the application?

Name: _____ Relationship to applicant: _____

Phone number: _____ Email: _____

Alternate phone number: _____ Language if not English: _____

Preferred contact method: _____

Billing / Payment Information:

ERC must have complete information needed to bill for services prior to a new client beginning services. There is no charge for clients enrolled in a PASSE or with a category of Medicaid that covers services. ERC is not able to bill other insurance.

Clients may also private pay at a daily rate equivalent to the rate Medicaid pays for a day of service. Contact an AD Case Manager for the current daily rate.

Future services may be suspended if ERC is no longer able to bill due to an issue such as, but not limited to, the following:

- A problem within the Medicaid or PASSE computer systems
- Interruption of Medicaid eligibility due to the information requested for a reevaluation not being submitted to DHS or a problem with that information being processed by DHS
- Need to reapply for another Medicaid category due to a change in circumstances such as a change in SSI or type of Social Security benefits
- DHS determining the client is no longer eligible for Medicaid
- Failure to pay for services as agreed upon if private pay

Medicaid Number: _____

PASSE Provider: _____

PASSE Subscriber ID #: _____

PASSE Care Coordinator if known: _____

ERC must receive prior authorization to provide ADDT (Adult Development) services to clients enrolled in a PASSE.

Medicare Number: _____

Other Insurance: _____

ATTACH A COPY OF YOUR MEDICAID, PASSE, MEDICARE, AND ANY OTHER INSURANCE CARDS.

☐ I plan to private pay for services.

NOTE: Throughout the application, “you” and “your” refer to the applicant.

Demographic Information

Sex: ☐ Male ☐ Female

Social Security Number: _____

Marital Status: _____

Arkansas resident? ☐ Yes ☐ No

Race: _____

US Citizen? ☐ Yes ☐ No

Disability / Services Requested

Developmental Disability: ☐ Intellectual ☐ Autism ☐ Cerebral Palsy ☐ Epilepsy ☐ Down’s Syndrome

Other Disabilities: _____

_____

ATTACH A COPY OF A PSYCHOLOGICAL EVALUATION CONTAINING A FULL SCALE IQ OF 70 OR UNDER FOR INTELLECTUAL DISABILITY OR AN ADAPTIVE BEHAVIOR ASSESSMENT FOR OTHER DEVELOPMENTAL DISABILITIES.

Why do you want to participate in the Adult Development Program at ERC? _____

_____

_____

Do you need transportation? _____

Do you want services at Life Skills or Richardson Industries? Why that location? _____

_____

_____

IF YOU ARE UNDER 25 AND WANT SERVICES AT RICHARDSON INDUSTRIES WE MUST HAVE DOCUMENTATION THAT YOU ARE ELIGIBLE TO BE PAID SUB-MINIMUM WAGE.

Have you been in another day program within the last year? Which one, and why are you changing services? _____

_____

What would you like to achieve in the next year? _____

_____

_____

What would you like to achieve in the next 2-3 years? _____

_____

_____

Guardianship

Has a court appointed a legal guardian? ☐ Yes ☐ No

Guardian's Name: _____ Relationship: _____

Do you have a Power of Attorney? Who? _____

Do you have a Representative Payee to manage benefits? _____

Does someone help you with making decisions? Who? _____

ATTACH A COPY OF THE GUARDIANSHIP ORDER OR POWER OF ATTORNEY.

Communication

How do you communicate? ☐ Speaking ☐ Signing ☐ Gestures ☐ Other: _____

Do people who know you well have any trouble understanding you? ☐ Yes ☐ No ☐ Sometimes

Do people who don't know you well have trouble understanding you? ☐ Yes ☐ No ☐ Sometimes

How do you let people know what you want? _____

_____

How well do you understand what people say to you? _____

_____

What language is spoken at home? _____

How do people know you are happy? _____

How do people know you are unhappy? _____

Do you read and write? How well? _____

Background and Cultural Information

What is your living situation? Who lives in the home? _____

_____

If not living in the family home, do you see family? _____

_____

Are there difficulties at home? _____

_____

Who are the other important people in your life? _____

_____

Have you had any significant events/concerns in your past such as abuse/neglect, important changes in your family, serious medical conditions, etc.? _____

_____

_____

Is there anything we should know about your culture, religion, or family's traditions/beliefs? _____

_____

_____

Do you have any current or past legal issues? _____

_____

_____

Sensory Needs

Please describe your needs and sensitivities in the following areas:

Noise level - _____

_____

Lighting - _____

_____

Temperature - _____

_____

Personal space - _____

_____

Touch - _____

_____

Other - _____

_____

_____

Physical / Medical Needs

Do you see well? _____

Do you have any conditions that affect your vision (such as poor depth perception, color blindness, limited visual field)? _____

Do you use glasses or contacts? ☐ Glasses all day ☐ Glasses for some tasks ☐ Contacts

Is any assistance needed with glasses or contacts? _____

How well do you hear? _____

Do you use hearing aids? Is assistance needed? _____

Do you have any conditions that make it hard for you to hear (such as ringing in the ears, ear wax buildup, hearing over background noise)? _____

Do you walk by yourself? _____

Do you have any conditions that make it more difficult for you to walk (such as poor balance, vision problems, physical disability)? _____

Are you unsteady or do you fall often? _____

Do you need? ☐ Cane ☐ Walker ☐ Someone walking alongside ☐ Wheelchair ☐ Braces

What type of wheelchair? ☐ Manual ☐ Power For long distances only? ☐ Yes ☐ No

If you use a wheelchair, do you operate it yourself or need help? _____

_____

Do you have any physical limitations that aren't included above (such as weakness on one side or lifting restrictions)? _____

_____

_____

Name of primary care physician: _____

Name and type of specialists: _____

_____

_____

_____

_____

_____

Do you take medications? _____

What assistance do you need to take medications correctly? _____

_____

Would you need to take medication at Life Skills or Richardson Industries? What? _____

_____

ERC STAFF CANNOT ADMINISTER MEDICATIONS. WE CAN PROVIDE SUPPORTS SUCH AS REMINDERS ABOUT THE TIME TO TAKE MEDICATION, OPENING THE BOTTLE FOR PEOPLE WHO AREN'T PHYSICALLY ABLE TO, AND MONITORING WHILE THE CLIENT TAKES THE MEDICATION. A SINGLE DOSE MAY BE BROUGHT IN A CONTAINER WITH ALL PHARMACY/PACKAGE INFORMATION AND MUST BE TURNED IN TO STAFF FOR SECURE STORAGE.

If you need to take medication at Life Skills or Richardson Industries, does the medication have special storage requirements? _____

_____

Do you have any medication allergies? _____

Are you able to feed yourself? _____

Do you choke easily? When? _____

_____

Must foods be cut in to smaller pieces for you? _____

Is the consistency of your food or beverages changed? _____

_____

Do you have any food allergies? _____

Do you have any other nutritional / feeding needs? _____

_____

_____

Do you need monitoring or accommodations due to your health that are not covered above? _____

_____

_____

Toileting/Assistance in the Restroom

Please check all of the areas below where assistance is needed and provide an explanation as requested. ERC will assess its ability to provide assistance with personal care based on the needs you have identified. **We may not be able to accommodate additional needs that come up or current needs that are not discussed prior to admission.**

☐ The applicant does not need any assistance in the restroom – **NO** supports or assistance will be provided

☐ Reminders to wash hands

☐ Reminders to go to the restroom – How often? What type of prompt? _____

_____

☐ Supervision to use the toilet correctly (such as using too much toilet paper, flushing items that aren't intended to be flushed)

☐ Assistance changing menstrual or incontinence pad – How often? _____

☐ Has occasional "accidents" (not due to unexpected illness) – How often? What assistance is needed? _____

☐ Assistance with clothing – Can you stand while clothing is pulled up or down? _____

_____

☐ Assistance turning around to sit on the toilet, or assistance sitting down – Please describe the amount of assistance that is needed: _____

_____

☐ Needs close supervision while sitting on the toilet – Why? _____

_____

☐ Assistance with wiping – After urinating or bowel movement? How is this done at home? _____

_____

☐ Uses a portable urinal or similar device – What assistance is needed? _____

_____

☐ Inappropriate behavior such as playing in or smearing feces: _____

_____

Explain any special urinary or bowel needs: _____

_____

_____

_____

_____

For Applicants Who Must Transfer from a Wheelchair for Personal Care

☐ Transfer to and from the toilet or a toilet chair

☐ Support all of your own weight during transfer. Another person may help guide or balance but doesn't support you – What bars (including the type) or other supports are used? _____

_____

_____

☐ Another person supports part or all of your weight during a transfer – How many people assist? How is this done at home? _____

_____

_____

☐ A lift or other equipment is used to transfer – What type? _____

☐ Transfer to a bed, table, or other surface – Describe how personal care is done: _____

_____

_____

_____

Are there other personal care needs we should be aware of? _____

_____

_____

_____

Behavioral Needs and Supports:

Behavioral issues will not automatically disqualify you, but ERC needs to understand your behavioral issues so we know the best way to support you. The more information we have, the better we can plan supports.

Please check all behaviors below that have occurred within the last year and tell us when the behavior is most likely to happen (such as when you don't get what you want), who it involves (such as hitting mother), what reduces or stops the behavior, and any services/supports that have been used within the past two years. **Withholding information regarding behaviors or behavioral services and supports could result in discharge.**

☐ Have not had any of the behaviors listed below within the last year.

☐ Have not used any of the services or supports listed below within the last two years.

☐ Behavior that could harm yourself (hitting, biting, pinching, picking, etc., including attempts):

_____

_____

☐ Behavior that could harm other people (hitting, kicking, biting, pinching, etc., including attempts):

_____

_____

☐ Screaming, yelling, cussing, calling people names: _____

_____

_____

☐ Lying, false accusations, “making up stories”, repeating hurtful gossip: _____

_____

_____

☐ Excessive worrying or crying, hallucinations or delusions: _____

_____

_____

☐ Obsessive or compulsive behavior: _____

_____

_____

☐ Repetitive words or noises: _____

_____

☐ Frequent noncompliance or ignoring: _____

_____

_____

☐ Leaving home, school or another facility without permission: _____

_____

_____

☐ Removing clothing, sexual actions (even if not intended sexually), sexual comments or innuendo:

_____

_____

☐ Intentional incontinence or vomiting: _____

_____

_____

☐ Actual or likely property destruction or intentionally causing something to malfunction: _____

_____

_____

☐ Taking other people's food, money or personal belongings without permission: _____

_____

_____

☐ Eating trash or inedible substances or objects: _____

_____

_____

Have you been suspended or discharged from school or an adult program due to behavior within the last 2 years? Please explain: _____

_____

_____

Have you been moved to another classroom or area due to behavior in the last 2 years? Please explain:

_____

_____

_____

Have you had a behavior management plan within the last 2 years? Please explain: _____

_____

_____

Have you taken medication due to a mental health diagnosis or to help you control some type of behavior within the last 2 years? Please explain: _____

_____

_____

Have you received individual, group or family counseling or therapy within the last 2 years? Please explain: _____

_____

_____

Remember to complete and submit:

Application and Service Needs Assessment form

A copy of your Medicaid and PASSE cards

Have your physician sign and return the ADDT Prescription for Services form in this packet (on the next page)

A physical examination completed within the last year (our form or a doctor's office printout)

Psychological testing – IQ and/or adaptive behavior depending on development disability

A copy of your guardianship order or power of attorney, if applicable

A copy of your high school diploma if you are under 21

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ADDT Prescription for Services

Client's Name	Date of Birth	Client's Medicaid Number

I prescribe the following services and certify that these services are/continue to be medically necessary to promote this individual's development.

____ **Adult Developmental Day Treatment** – includes habilitation training for adults with Developmental Disabilities in life skills areas such as pre-vocational, self help, socialization, communication, etc. Habilitation training will enable the person to gain independent living skills.

____ **Medicaid Transportation to/from the Elizabeth Richardson Center**

Physician's Signature	Date

Print Physician's Name

Please return by fax to 479-306-6819 or mail to:

Name:_____, ERC Adult Case Manager
3917 S. Old Missouri Rd, Springdale, AR 72764

ERC FORM – Physician's Prescription for Services (Revised **5/2019**)

This Physical Examination Form is to be completed by your **Primary Care Physician**.

Patient's Name: _____ Date of Examination: _____
Name of parent(s) or legal guardian: _____
Patient's address: _____
Street City State Zip Code

PHYSICAL EXAMINATION

General appearance: _____
Height: _____ Weight: _____ Pulse: _____ Resp.: _____ BP: _____

Check normal findings with "O". Check abnormal findings with "X". Describe abnormal findings in the spaces to the right.

_____ Posture _____
_____ Musculature _____
_____ Nutrition _____
_____ Skin and hair _____
_____ Upper extremities _____
_____ Lower extremities _____
_____ Eyes (including vision as best as can be determined) _____
_____
_____ Ears (including hearing as best as can be determined) _____
_____
_____ Nose _____
_____ Mouth _____
_____ Teeth _____
_____ Throat _____
_____ Neck _____
_____ Chest and lungs _____
_____ Heart _____
_____ Abdomen _____
_____ Genitalia & rectum _____

Neurological
_____ Cranial _____
_____ Cerebellum _____
_____ Sensory _____
_____ Motor _____
_____ Operations _____
_____ Other findings _____

Impressions

Diagnosis: _____

_____

Physical Conditions: _____

_____

Mental Conditions: _____

_____

Placement in any of ERC's programs may involve physical/recreational activities, meal preparation, and dining in local restaurants w/o dietary restrictions. Based on your examination, are there any restrictions or contraindications for such activities? Please explain. _____

_____

Physical exertion

_____ less than 1 hour
_____ 1 to 2 hours
_____ 2 to 3 hours
_____ 3 to 4 hours

Dietary

_____ regular
_____ low fat/low cholesterol
_____ NCS
_____ bland

Lifting and Bending

_____ less than 5 pounds
_____ less than 10 pounds
_____ less than 25 pounds
_____ less than 50 pounds
_____ over 50 pounds

Current Medications

Medication	Dosage	Time Taken	Reason

_____ _____

Physician's Signature Date

Your Information.
Your Rights.
Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information

Please Review It Carefully.

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or send mail to a different address. • We will say "yes" to all reasonable requests.

Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
	  ○ We are not required to agree to your request, and we may say "no" if it would affect your care.
	• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
	  ○ We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights were violated	• You can complain if you feel we have violated your rights by contacting us using the information on the back page. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W. Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care. • Share information in a disaster relief situation. • Include your information in a facility directory. *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we never share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.

	Example: A case manager in one program asks a case manager in another program about goals you are working on.
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities. *Example: We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues	• We can share health information about you for certain situations, such as: ○ Preventing disease ○ Helping with product recalls ○ Reporting adverse reactions to medications ○ Reporting suspected abuse, neglect, or domestic violence ○ Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: ○ For workers' compensation claims ○ For law enforcement purposes or with a law enforcement official ○ With health oversight agencies for activities authorized by law ○ For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticeapp.html.

Change to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Elizabeth Richardson Center, Inc.
Cathy Obana, Corporate Compliance Officer
10 S. College Ave.
Fayetteville, AR 72701
(479)872-1800
Email: cobana@ercinc.org

NOTICE OF PRIVACY PRACTICES
ELIZABETH RICHARDSON CENTER, INC.
Effective September 2013

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This is to acknowledge my receipt of ERC's Notice of Privacy Practices (effective date September, 2013) on the date stated below.

Date of Individual's or Personal Representative's Signature

Signature of Individual or Personal Representative

Individual's Name (Please print)

Individual's Address

Name of Personal Representative (If applicable)

Description of Representative's Authority to Act for the Individual (If applicable)