CHOICES IN COMMUNITY LIVING

# New Client Move-in Checklist

Client Name: _____

Address: _____

Move in date: _____

Consumer #/Client ID: _____

## Docs Needed:

- ❑ State ID
- ❑ Social Security Card
- ❑ Birth Certificate
- ❑ Food Stamp Card
- ❑ Medicaid Card
- ❑ Medicare Card
- ❑ Guardian paperwork
- ❑ Trust information
- ❑ Pre-need Docs
- ❑ Previous payee and/or Provider
- ❑ Parents name, DOB, and social if possible
- ❑ VA Benefit information
- ❑ Award Letters for SS and/or VA benefits
- ❑ Employment information
- ❑ ISP (15 days Prior to move in)
- ❑ Start- up funds?
- ❑ Current Signed Lease
- ❑ Authorized Rep Medicaid Forms

Ohio Department of Medicaid

# Designation of Authorized Representative

**Section 1** *(Please Print)*

| Name of Applicant/Recipient | Medicaid Billing Number or SSN | County | |
|---|---|---|---|
| Street Address *(include Apt #)* | City | State | Zip |

**I hereby authorize the following person or entity to act as my representative.**

This authority lasts until *(specify a date or event)*, or until it is revoked by me in writing.

| Name of Representative | Title | Company | |
|---|---|---|---|
| Home Phone | Work Phone | Email Address | |
| Mailing Address | City | State | Zip |

**I authorize my representative to do the following on my behalf:**

☐ Act on my behalf in all matters with the agency ["agency" includes the County Department of Job and Family Services (CDJFS), the Ohio Department of Medicaid (ODM), and ODM's contracted designees].

**OR only the specific actions selected below:**

☐ Assist with my application/renewal for benefits
☐ Represent me at a state hearing
☐ Provide verifications to the CDJFS on my behalf
☐ Receive and respond to copies of all correspondence
☐ Discuss and receive information regarding my financial and medical information including protected health information (PHI)*
☐ Other *(please specify)*

***NOTE** *You must complete Section 2 of this form if this authorization is intended to allow the use or disclosure of PHI.*

***While this authorization is in effect, all notices sent by the CDJFS and/or ODM will also be sent to your authorized representative.***

**Signatures.** This form has no effect unless signed by both the person granting authority and by the authorized representative. By signing below, the authorized representative agrees to maintain the confidentiality of any information regarding the applicant/recipient provided by the agency. If the authorized representative is a provider, staff member or volunteer of an organization, then the authorized representative also agrees to adhere to the regulations cited in 42 C.F.R. 435.923(e).

| Signature of Person Granting Authority *(Applicant/Recipient or Parent/Guardian)* | | Date |
|---|---|---|
| Signature of Authorized Representative | Title *(if employee of an organization)* | Date |

## Section 2

### Authorization for the Use and Disclosure of Protected Health Information

| Name of Applicant/Recipient | Case Number/Medicaid ID | | Date of Birth |
|---|---|---|---|
| Address | City | State | Zip Code |

The County Department of Job and Family Services (CDJFS), the Ohio Department of Medicaid (ODM) and ODM's contracted designees *(including Medicaid managed care plans)* are authorized to disclose my protected health information (PHI) to my authorized representative designated in Section 1 of this form.

**I hereby authorize the use or disclosure of my protected health information (PHI) as described below.** I understand PHI can include the following types of information, and authorize its disclosure: medical records; substance abuse care; vision care; reproductive care; mental health; communicable disease; pharmacy; HIV/AIDS; dental records; and psychiatric care.

This protected health information may be disclosed:

The information is being released for the following purpose(s)

**Terms and Conditions**

By signing below, I hereby authorize the disclosure of my PHI by the agency. I understand that:

- This authorization expires on the following date or event , or upon revocation by me in writing, whichever occurs first.
- I may revoke this authorization at any time. If I revoke this authorization, the revocation is not effective for the use or for the disclosure of my information that has already occurred.
- Any information used or disclosed pursuant to this authorization could be re-disclosed by the person or entity receiving the information, and will likely no longer be protected by federal privacy regulations.
- This authorization is voluntary and that I may refuse to sign it. The provision of treatment, payment, enrollment in a health plan, or eligibility for benefits cannot be conditioned on the signing of this authorization, unless the authorization is necessary for determining eligibility for the program or enrollment in the program.
- In the event my records contain psychotherapy notes, a separate authorization may be required for the release of any psychotherapy notes.
- This authorization permits the use and/or disclosure of information related to HIV testing or the treatment of AIDS or AIDS related conditions, drug or alcohol abuse, psychiatric conditions (excluding psychotherapy notes) unless specifically excluded above.

*By signing below, I confirm that I have read and understand the contents of this authorization, and confirm that the contents are consistent with my direction to the entity releasing my information.*

| **Signature of Applicant/Recipient** | **Date** |
|---|---|
| | |

If this form is signed by someone other than the Applicant/Recipient, please describe the authority to act on the individual's behalf (*such as Power of Attorney or Legal Guardian*). If not already on record with the agency, please provide legal documentation showing this authority.

Transfer of Representative Payee Responsibilities/Authorized Representative

Date: _____

Client Name: _____

Social Security Number: _____

This letter will serve to notify that I, _____ will be transferring Representative Payeeship and Authorized Representative for

_____ to Choices In Community Living Inc. I have been made aware of how Choices In Community Living Inc. handles client funds and Representative Payee matters. Choices In Community Living will be responsible for notifying the Social Security Administration, Job and Family Services and all government/non-government entities of any housing, income, or status changes once the Representative Payee transfer has been established. I also understand that upon my request I can inquire about the funds of the clients and how his/her money is being dispersed. I understand that until Choices In Community Living is made payee, I will forward all government funds (Social Security, VA, Pension etc.) for

_____ to Choices In Community Living Inc. Client banking no later than the fifth of every month. I understand this will be used to pay all of his/her living expenses. I further understand that it can take up 120 days for Choices In Community Living to become payee.

Previous Payee Print Name _____

Previous Payee Signature _____

Payee Address _____

_____

Payee Phone Number _____

# Release of Information

**For**_____

**(name)**

## Financial

**1. I give my OK for Choices In Community Living to release all necessary information requested by agencies that may provide me with financial assistance.**

**□ Yes □ No**

## Documentation/Information

**2. I give my OK for Choices In Community Living to release insurance information, social histories, any and all medical information, incident reports, biographical data and other programmatic information to:**

- **□ CICL Nursing (for the purposes of continuity of care, delegated medication administration, and health related activities).**
- **□ Adult Services**
- **□ County Board of Developmental Disabilities**
- **□ School**
- **□ Other**_____

## Transportation

**3. I give my OK to ride in a vehicle driven by an employee or volunteer of Choices In Community Living.**

**□ Yes □ No**

## Media

**4. I give my OK for my full name, photo and other identifying information to be used in print or other media as identified below. All pictures will be uploaded to a secure email and then deleted from personal devices.**

- **□ Within Choices In Community Living**
- **□ "Choices Voices" newsletter (distributed through database and online on Partners For Community Living website)**
- **□ Feature story or news release to area media, public presentations**

**□ Name and/or photo on Partners website (other than newsletter) and/or other social media, i.e. Facebook**
**□Name and/or photo for fundraising and/or solicitation for CICL and/or Partners For Community Living**
**□Can use quotes for CICL/Partners print or media**
**□I DO NOT give permission to use my picture for any reason**
**□I DO NOT give permission to use quotes**

## Healthcare

5. **I give my OK for Choices In Community Living to release all necessary information requested by healthcare professionals as needed for medical treatment.**

   **□ Yes □ No**

6. **I give my OK for Choices In Community Living to assist me in obtaining routine and emergency medical care.**

   **□ Yes □ No**

7. **I give my OK for Choices In Community Living to assist me in selecting healthcare professionals. My preferences, if any, are:**

| | | | |
|---|---|---|---|
| **Primary Doctor** | | **Vision** | |
| **Dentist** | | **Hospital** | |
| **Hearing** | | | |
| **Psychiatrist** | | | |
| **Neurologist** | | | |

**Signature of Individual or Legal Guardian** **Date**

**Signature of Witness/Relationship of Individual** **Date**

**Choices Representative** **Date**

Under the Law all Choices In Community Living Clients are protected through HIPAA.
By signing this form today, I understand that per HIPAA, no individual's personal or medical information will be shared with anyone outside of their team under any circumstances, due to HIPAA laws.
Please refer all questions or concerns to the Home Manager. You can also contact our HIPAA Compliance Officer, Chasity Cook, at (937) 898-2220.