Adult Interim Home Care / Choices Westbrook
Admission Procedure

Main Number (800 Westbrook)	(937) 387-9983
Main Number (810 Westbrook)	(937) 387-6760
Fax	(937) 308-0005
Marvin Lewis, Senior Program Director	(937) 672-0129 mlewis@cicloh.com
Charlesa Gregory-Hutton, Home Manager	(419) 944-6074 cgregory-hutton@cicloh.com
Oriel Head, Assisting Manager	(937) 321-2448 ohead@cicloh.com
CICL Office and Emergency After Hours	(937) 898-2220

Side 1

800 Westbrook Rd

Dayton, OH 45415

Side 2

810 Westbrook Rd

Dayton, OH 45415

All admission to Adult Interim Care Home / Choices Main Street need approved by the director of Residential and Family Support.

Choices In Community Living

Westbrook Emergency Shelter / Adult Interim Care Home
Intake Policy & Procedure

1. Policy Statement & Objective

The purpose of this intake policy and procedure is to ensure a comprehensive, respectful, consistent and efficient process for admitting adults with developmental disabilities into any Choices emergency shelter / Adult Interim Care Home (AICH) (e.g. Westbrook). Choices is committed to delivering high quality services to all clients residing in any AICH it operates by providing individualized support tailored to each client's needs while adhering to all legal, ethical and regulatory standards.

2. Scope

This policy/procedure applies to all staff involved in the Westbrook intake process and all prospective clients seeking admission to the home.

3. Intake Procedure

I. **Initial Contact**

A. **Receipt of proposed referral**: The referring party (typically the incoming client's SSA) will contact one of the Westbrook managers (Marvin Lewis, Oriel Head or Charlesa Gregory-Hutton) by telephone or email to inform them of the proposed referral and arrival date. The notice may be verbal/informal, but a copy of the referring agency's written internal approval of the referral should be requested from the agency and included in the client's records. Most referrals come from the Montgomery County Board of Developmental Disability Services (MCBDDS).

B. **Request additional docs and info needed to make intake decision**: Westbrook managers will obtain from the referring party any documentation or information not already provided that is needed to make a decision on the referral. Note that some client documentation and information that is *not* needed in order to decide whether to accept the referral, but *is* needed later in the intake process (e.g., the client's ISP), may also be provided by the referring party at this stage.

II. **Screening and Acceptance of Referral**: Once all necessary information has been received Westbrook managers convene to discuss proposed referral and determine if individual meets eligibility criteria. Among other things, consideration should be given at this point to established criteria for *non*-admission (see Exhibit A – *Shelter Non-*

Admission Criteria) along with any other factors deemed relevant by managers. Any potential cultural or limited-English proficiency concerns about the client should also be considered, and if present, a strategy to address them must be devised. Westbrook management will then notify the referring party of its decision and, if referral is accepted, notify Westbrook staff about the incoming client and any preparations that need to be made.

III. **Add/Reactivate Client in Provide**: If the referred individual is a past Choices client, (s)he will be reactivated in Provide with the same consumer ID# used previously. If not, a member of the Westbrook management team will enter the individual as a new client in Provide as outlined below.

A. **Client Info**: the following are needed (any info not already received to be obtained from the referring party):

1. Client's legal name
2. Contact information
3. SSN
4. DOB
5. Medicaid/Medicare ID#
6. Consumer ID#

    a. Past clients: consumer ID# will be the same as previously used
    b. New clients: new consumer ID# will be requested from referring agency (e.g., for referrals from MCBDDS, request will be made by email to AICHAdmissions@mcbdds.org)

B. **Entering New Clients in Provide**

1. Login: Westbrook manager responsible for entering new client will log in to his/her Provide account.

2. Navigate to Consumer Section: Once logged in, find the section or tab labeled "Consumer."

3. Add New Client: Look for an option to add a new client. This could be a button labeled "Add New Consumer." Click on it to initiate the process of adding a new client.

4. Enter Client Details: Follow prompts to fill out various fields with the client's information. Contact the referring party for any necessary info not already provided.

5. Save Client Information: After entering all the required details, save the client's information. There's usually a "Save" or "Save Changes" button at the bottom of the page.

6. Review and Confirm: Double-check the entered information to ensure accuracy. Once you're satisfied, confirm the addition of the new client.

7. Confirmation: After successfully adding the client, you should see the new client listed in the consumer list.

IV. **Obtain Client's ISP (If Any)**: If the incoming client has an existing ISP and it has not already been provided, Westbrook manager will have the client's SSA or other referring party email the ISP to aich@cicloh.com. Westbrook manager will then print a copy of the ISA for inclusion in the new client's "client book." If no ISP exists or if existing ISP needs to be updated, client's SSA will work with client/client's guardian to develop/update one. If required, that process will be separate from but parallel with the intake process.

V. **Create Client Book**: Prior to or upon receipt of incoming client's ISP, or, in the case of a client arriving with no ISP, prior to or upon client's arrival, Westbrook manager will create the client's "client book" and, if the client has an ISP, add a copy thereof thereto. Other documents called for by the client book table of contents will be added as they become available.

VI. **Review of ISP by Westbrook Staff**: All Westbrook staff members expected to work with the incoming client are required to carefully review the client's ISP (if any) at their earliest opportunity. After doing so, each will sign a training acknowledgement for the ISP (see Exhibit B - *ISP Training Signature Sheet*). If at all possible, staff members should review the ISP and sign the acknowledgement before starting to work with the client.

VII. **Client's Arrival / Notice of Arrival**: Client's SSA or other referring party will arrange for client's transportation to the home. Client may be accompanied by its SSA and/or guardian on arrival. Once client has arrived, Westbrook manager will promptly send notice of arrival both to the referring agency (by email to AICHAdmissions@mcbdds.com, in the case of a referral from MCBDDS) and to the Choices intake team (by email to intake@cicloh.com).

VIII. **Additional Client Docs/Info**: Prior to or promptly after client arrives at the home, Westbrook manager will obtain from the referring party, the client and/or the client's guardian the following additional documents and info (if applicable to such client) and will scan and upload such items to client's profile in Provide. Photocopies of documents are acceptable in all cases, however originals are also acceptable but must be stored in the safe located behind the front desk in Choices' administrative offices at 1651 Needmore Road. Documents typically subject to expiration (e.g., powers of attorney, guardianship docs, insurance cards) should be checked carefully to ensure they are still in effect, and if they are not, currently effective versions should be obtained in their place. All insurance coverage must be verified.

A. State ID card
B. Social security card
C. Birth certificate

D. Medicaid and/or Medicare card
E. Private insurance card
F. Guardian paperwork
G. Client's parents' names, DOBs and SSNs
H. Social security and/or VA award letters
I. Psychiatric evaluations
J. Funeral plans
K. List of current medications and copies of current physician's orders
L. Copy of client's MAR (medication administration record)
M. List of client's current medical providers
N. List of scheduled medical appointments

IX. **Verification of Referral Details**: Source documents (e.g. social security card, birth certificate) received under Section VIII above should be used where possible to verify client information (e.g. SSN, legal name) initially obtained elsewhere.

X. **Intake Documentation (Medical)**: Prior to or as soon as possible after client's arrival, client, client's guardian and/or client's physician will complete and sign each of the following intake documents that apply to client:

A. *Psychotropic Medication Consent Form* (see Exhibit C): Needed for any client that will be taking psychotropic medication (e.g. anti-depressants, anti-anxiety meds, etc.) while at the home. Signed by the client/guardian and one witness.

B. *Physician Medication Order* (see Exhibit D): Incoming client's physician must complete this form for any client that will be taking prescription medications while at the home. All of client's active medications must be listed on the order.

C. *OTC Medication Order* (see Exhibit E): Complete for any client that might or is expected to take over-the-counter medications while at the home. Form signed by client's physician.

D. *Medication Intake Form* (see Exhibit F): Any clients bringing medication with them to the home must turn the medication over to Westbrook staff promptly upon arrival. Complete this form to document staff's receipt of such medications. Form is to be signed by client/guardian and initialed by staff member checking the meds in.

E. *Consent to Nursing Delegation* (see Exhibit G): Complete for all clients. Signed by nurse and by client/client's guardian.

F. *Medication Administration / HRA Delegation Form* (see Exhibit H): Complete if needed as determined by nursing staff. Signed by both trainer and staff trainee/designee.

XI. **Intake Documentation (Non-Medical)**: Upon or as soon as possible following client's arrival, Westbrook manager will work with client's SSA or other referring party and/or with the client or its guardian to complete each of the following additional intake

documents that apply to client:

A. *Lease Application* (see Exhibit I): Required for all clients. Signed by client/client's guardian. Staff should review the rules and disclosures contained in the INHC (Inclusive Neighborhoods Housing Corporation) lease cover page (see Exhibit J – *INHC Welcome Document*) with client/client's guardian at this time.

B. *Lease Agreement* (see Exhibit K: Required for all clients. Signed by client/client's guardian, by Miami Valley In-Ovations, Inc. (dba Inclusive Neighborhoods Housing Corp.), and by client's payee (if any).

C. *Consent To ROI By MCBDDS* (see Exhibit L): Required for all clients. This ROI authorizes releases of client's information (covers essentially any information connected with client's care) *by* MCBDDS *to* Choices. Signed by client/client's guardian.

D. *Consent To ROI To Choices* (see Exhibit M): Required for all clients. This authorizes releases of client's medical information *to* Choices. Signed by client/client's guardian.

E. *Consent To ROI By Choices* (see Exhibit N): Required for all clients. Authorizes releases of certain of client's information (including medical, biographical and for media purposes) *by* Choices. Signed by client/client's guardian, by Choices and by one witness.

F. *Generic Consent To ROI* (see Exhibit O): Required ONLY for additional releases of information not covered by any of the above releases. Signed by client/client's guardian and by one witness.

G. *Current Personal Summary* (see Exhibit P: Required for all clients.

H. *Intake Questionnaire* (see Exhibit Q): Required for all clients. Questions prompting for information already provided in other steps/documents under these procedures may be disregarded.

I. *Bed Bug Policy* (see Exhibit R: Required for all clients. Signed by client/client's guardian.

J. *AIHC Home Guidelines* (see Exhibit S): Required for all clients. Westbrook staff should review all guidelines with client/client's guardian to ensure client/guardian is aware of and understands them. Signed by client/client's guardian.

K. *Cash / Payment Cards Intake Log* (see Exhibit T): Required for clients who bring with them to the home (x) any cash in excess of the cash amount client is allowed to possess pursuant to its ISP or (y) any other form of payment, including credit/debit cards and checks/checkbooks, except for any form of payment client is allowed to possess pursuant to its ISP. Signed by client/client's guardian and by Westbrook staff member who checks these items in.

L. *Personal Property Inventory* (see Exhibit U: Required for all clients who bring with them to the home any personal property items with a value or purchase price of $50 or more. All such items must be listed. Inventory must also be updated on an ongoing basis to include any other ≥$50 items client may purchase while living at the home. Cash and other forms of payment in client's possession at the time of intake should NOT be listed on this inventory (those are covered in paragraph L above). Signed by Westbrook staff member who completes the list.

M. *Client Bill of Rights* (see Exhibit V): Must be provided to all incoming clients/client guardians. Westbrook staff should review list of client rights with client/client's guardian to ensure client/guardian is aware of and understands them.

XII. **Transportation Assessment**: Prior to or as soon as possible after client's arrival, Westbrook manager will work with client/client's guardian and/or SSA to assess the client's immediate transportation needs as a resident of the home and make appropriate arrangements to meet them.

XIII. **Fifth Day Meeting**: Westbrook managers and other appropriate staff will meet on or about the fifth (5th) business day following client's arrival to identify any outstanding items needed to complete client's intake and assign responsibility among the team for follow up on each.

XIV. **Upload All Intake Documents to Provide**: Copies of all documents related to any client received pursuant to this intake policy will be uploaded to client's Provide profile upon completion/receipt or as soon as possible thereafter.

4. Discharge Procedure

I. **Notification and Planning**: Westbrook management or the relevant county DDS agency (with notice to Westbrook management) makes determination that a current client will be discharged from the home. Westbrook staff will immediately notify the Choices intake team by sending an email to intake@cicloh.com specifying the client's name and scheduled exit date as well as the contact information for the new provider.

II. **Turnover of Client Documents**: Westbrook staff will turn over all client documents being held by Choices (including ID cards, social security card, insurance cards, etc.) to new provider. New provider must sign an itemized receipt for such items listing each one separately.

III. **Release of Cash and Medications**

A. *Cash / Other Means of Payment*: Any cash or other payment means being held on client's behalf will be released to the new provider. New provider must sign an

acknowledgement evidencing its receipt of the same (see Exhibit W – *Cash / Payment Cards Discharge Log*).

B. *Medications*: All client meds will be released to the new provider. New provider must sign a receipt acknowledgement evidencing its receipt of the same (see Exhibit X – *Medication Discharge Form*).

IV. **Discharge Summary** (see Exhibit Y – *Emergency Shelter Discharge Summary*): Westbrook staff will work with client/client's guardian, SSA and new provider to complete a discharge summary for the departing client substantially in the form attached hereto.

V. **Arrange Client Departure and Payment of Outstanding Invoices**: Westbrook manager will work cooperatively with the new provider to coordinate the move-out date and arrangements for the departing client.

VI. **Upload All Discharge Documents to Provide**: Copies of all discharge documents related to any client received pursuant to this policy will be uploaded to client's Provide profile upon completion/receipt or as soon as possible thereafter.

VII. **Terminate Client**: Westbrook manager will terminate client in Provide. This should not be done until AFTER all billing is completed and all discharge documentation is completed and uploaded to Provide.

VIII. **Forward Client Benefit Funds**: Forward any client benefit money to the new provider while the payee process is being established. The new provider becomes responsible for paying client's bills effective as of the move-out date.

5. Confidentiality/Privacy and Consent

All information collected during the intake process is confidential and will be shared only with authorized personnel for the purpose of providing services and only where appropriate releases of information from the client/client's guardian are in place. Unauthorized disclosure of confidential information is strictly prohibited and may result in disciplinary action.

6. Conflicts of Interest

All Westbrook staff must promptly disclose to a member of the Westbrook management team any actual or potential conflict of interest they become aware of at any point during the intake process. Conflicts of interest include any situations or circumstances as a result of which the personal interests of a staff member or any other party involved in providing services to the client might compromise the staff member's or other party's ability to act in the best interests of the client.

7. Training

All Westbrook managers will receive training in these procedures as part of their new managers training no later than 90 days after their hiring as a Westbrook manager, or their promotion or assignment to Westbrook management, as the case may be.

CHOICES WESTBROOK

EMERGENCY SHELTER INTAKE POLICY AND PROCEDURE

EXHIBITS

EXHIBIT A

SHELTER NON-ADMISSION CRITERIA

CRITERIA FOR NON-ADMISSION TO THE ADULT INTERIM CARE HOME

Consumers who have any of the following conditions will not be admitted to the Adult Interim Care Home:

1. Requires tube feeding.

2. Requires significant wound care.

3. Requites constant physical therapy unless adequate physical therapy services can be secured.

4. Consumers with unstable, chronic medical conditions will need a nursing assessment on an individual basis. Consumers with this condition will be considered only if they are able to self-assess and verbalize needs and help with any decisions regarding their health.

5. Acute medical conditions which have not been fully diagnosed or are in the process of treatment.

6. Having a tracheostomy.

7. Requires daily attention to Foley catheter or intermittent straight catheterization.

8. Consumers who have medications that require immediate dosage changes relative to the person's conditions will be assessed on an individual basis. Consumers with this situation will be considered only if dosage-change needs have clear, specific guidelines which are easily assessed.

9. Consumers requiring oxygen on a routine or supplemental basis will be assessed on an individual basis and will be considered only with clear, specific guidelines and a resident who can self-assess.

10. Consumers who need breathing or nebulizer treatments. This may be determined on an individual basis if the person can self-assess.

11. Requires ventilatory assistance.

12. Requires suctioning.

13. Requires injections unless self administered.

14. Insulin dependent diabetics. (Diet or oral med. controlled diabetics will be considered on an individual basis.)

15. Requires intravenous feeding or highly specialized diet.

16. Has extensive or decubitus skin problems, open or draining areas requiring extensive observation.

17. Requires dressing care using prescription medications and aseptic technique or skilled observation.

EXHIBIT B

ISP TRAINING SIGNATURE SHEET

ISP TRAINING SIGNATURE SHEET

Staff must read the ISP and sign below. Inform your supervisor of any questions concerning services and how to deliver them before you sign. Employees working with this person must complete this task before beginning work with this individual. Return to scanning when replaced with new signature sheet.

Client Name_____

ISP Date_____

Revision Date_____

Revision Details_____

Date	Staff Signature

EXHIBIT C

PSYCHOTROPIC MEDICATION CONSENT FORM

MEDICATION CONSENT FORM

(for psychotropic medication)

UPDATE ANNUALLY OR AS CHANGES OCCUR

I, _____, have been made aware of the possible side effects of the following psychotropic medications prescribed by my doctor.

Name of Medication(s): _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I give my informed consent to take these medications.

_____ _____

Individual Date

_____ _____

Legal Guardian Date

_____ _____

Witness Date

6/00

EXHIBIT D

PHYSICIAN MEDICATION ORDER

MONTGOMERY COUNTY BOARD OF DEVELOPMENTAL DISABILITIES SERVICES

PHYSICIAN MEDICATION ORDERS

Name: _____ DOB: _____

PHYSICIAN TO COMPLETE:

Please list all medications to be given under Board of DD Services Adult Interim Care Home supervision.

1. _____
   Medication Dosage Route Frequency

2. _____
   Medication Dosage Route Frequency

3. _____
   Medication Dosage Route Frequency

4. _____
   Medication Dosage Route Frequency

5. _____
   Medication Dosage Route Frequency

6. _____
   Medication Dosage Route Frequency

7. _____
   Medication Dosage Route Frequency

Reactions to medications that should be reported. Special instructions:

_____

_____

Physician Signature: _____ Date: _____

Physician Name _____

Address: _____
Street City State/ Zip

Phone : _____ Emergency Phone: _____

EXHIBIT E

OTC MEDICATION ORDER

Name:_____ Date:_____

Check which over the counter medication this individual may use as needed:

Please make changes as needed:

Pain or Temperature

_____ **Tylenol (Acetaminophen)** take two 325mg tablets, by mouth, every 4 hours, not to exceed 12 tablets in 24 hours, as needed, for general pain (not including stomach pains), headache, or temperature over 100 degrees Fahrenheit taken by an oral or temporal device

_____ **Other** (describe)_____

Laxative

_____ **Milk of Magnesia** 30ml by mouth at bedtime, as needed, not to exceed 60cc in 24 hours, give after three days of no bowel movements, to produce a bowel movement. Call RN if medicine does not produce a bowel movement.

_____**Other**_____

Cough

_____**Robitussin DM**, 10ml, by mouth, every 4 hours, as needed, for non-productive cough, not to exceed 6 doses in 24 hours, if cough persists for 5 days, without a fever, call MD to make appointment.

_____**Other**_____

Diarrhea

_____**Imodium AD** 2mg tablets, take 2 tablets (4mg), by mouth, after first loose watery stool then, one tablet (2mg) after each subsequent loose stool, as needed for loose watery stools, not to exceed 4 tablets in 24 hours. If loose watery stools continue despite medication, call MD for appointment.

Other:

_____May use **Triple Antibiotic Cream/Ointment** apply to affected area(s) topically three times a day, as needed, for areas of broken skin, If not improved in 7 days call doctor for appointment

Caffeine and Alcohol

_____Individual may consume beverages and/or items containing caffeine.

_____Individual may consume beverages containing alcohol.

_____Additional Information:_____

____**Other**_____

Dietary Guidelines:_____

_____

Work Limitations:_____

_____

Physician's Signature:_____Date:_____

EXHIBIT F

MEDICATION INTAKE FORM

Choices Westbrook - Medication Intake Form

Client Information:

- **Full Name:** _____
- **Date of Birth:** _____
- **Consumer ID#:** _____
- **Date of Admission:** _____
- **Name of Facility:** Choices Westbrook - Adult Interim Care Home

Medications Brought by Client:

Using the table on the following page, please list all medications client is taking that are being brought with client today. This includes prescription medications, over-the-counter drugs, supplements, vitamins, and any other medications. If you need more space, please use the back of this form or provide a separate list.

Medication Name	Dosageand # of doses	Frequency (how often you take it)	Reason for Medication	Any Special Instructions (e.g., take with food)?

Important Information:

- Please make sure to bring all medications in their original containers or with clear labeling.
- If any medication requires refrigeration, please inform the facility staff upon check-in.
- If you have any allergies to medications or any adverse reactions to any drugs, please list them here:
- If you are bringing in any controlled substances (e.g., narcotics, stimulants), please inform the staff immediately.

Acknowledgment:

By signing below, you acknowledge that the above list is accurate to the best of your knowledge and that you have informed the facility of any special instructions or concerns regarding your medications.

Client/Guardian Signature: _____

Date: _____

Facility Staff Use Only:

- Medications Checked by: _____
- Date/Time Checked: _____
- Additional Notes: _____

EXHIBIT G

CONSENT TO NURSING DELEGATION

Choices in Community Living, Inc. - Westbrook
Consent to Delegation of Nursing Tasks

Client Information:

- Full Name: _____
- Date of Birth: _____
- Consumer ID: _____

Client Address:

800 / 810 Westbrook Road, Dayton, OH, 45415
(circle one)

Task to Be Delegated: Administering Medication (including all routes); Vital Signs, Treatments and Health-Related Activities.

Nursing Assessment: Does not indicate any concerns about utilization of delegated nursing for medication administration or nursing tasks and activities to be performed by trained unlicensed personnel.

Delegating Nurse Information:

- Name: Dawn Wissel, RN
- Signature: _____ Date: _____

Client Consent: By signing below, I, the undersigned, consent for the unlicensed, non-nursing staff in this home to administer medications and/or perform other health-related activities as delegated by a nurse. I understand that I can revoke this consent at any time.

- Client or Guardian Signature: _____ Date: _____
    - Name: _____

EXHIBIT H

MEDICATION ADMINISTRATION / HRA DELEGATION FORM

Medication Administration / HRA Delegation Form

Form to be reviewed with each certified DD personnel **BEFORE** administration of medication or HRA, updated when a new route of medication is received.

Client Name:_____ Identified by: Name Picture Other:_____

Address or Facility:_____

Diagnosis/Health Care Information:_____

_____

Drug/Food Allergies:_____

Special Instructions – attach additional documentation as needed (where and how meds taken, task performed i.e. meds taken with beverage or BP taken in left arm only):_____

_____

_____

_____

_____

_____

Emergency Meds: __Diastat __Epi-Pen __Glucagon __Other:_____

Emergency Medication Instruction (if applicable):_____

_____

Medication Routes or HRA's performed (check all that apply) or Other:_____

__Oral	__Inhaler	__Oxygen	__Ostomy Care	__Glucometer
__Rectal	__Nebulizer	__Pulse Ox	__Urine Drainage	__Insulin Injected
__Vaginal	__Nasal	__CPap/BiPap	__External Urinary Cath Care	__Insulin Inhaled
__Sublingual/Buccal	__Vital Signs	__Cough Assist	__I&O	__Insulin Pump
__Eye (R or L)	__Diastat	__Percussion Vest	__Specimen Collection	__Glucagon
__Ear (R or L)	__Epi-Pen	__Oral Suction	__Simple Dressing	__G/J Tube
__Topical	__OTC Musculoskeletal		__Compression Hose	__Non Insulin Injectables

Date	Staff Name	Staff Initials	Trainer Name	Trainer Initials	Updates (specify)	Updates (trainer/staff initials)

**Trainer and staff must also initial Updates column if changes are made. Signatures indicate observation was completed by trainer.

EXHIBIT I

WESTBROOK LEASE APPLICATION

INHC
Inclusive Neighborhoods Housing Corporation

PO Box 115, Englewood, Ohio 4322
Email – carri@inhcmc.org
kathleen@inhcmc.org

SHORT TERM/ RESPITE LEASE APPLICATION

APPLICANT INFORMATION		
LAST NAME FIRST NAME		BIRTH DATE
PHONE NUMBER	EMAIL	

CURRENT ADDRESS			
STREET ADDRESS CITY STATE ZIP			
LIVES With:	RELATIONSHIP	PHONE	

ACCESSIBILITY NEEDS / HOUSING PREFERENCES	
1	3
2	4

SELF PRESERVATION	
Definition of Incapable of Self Preservation (OBS Chapter 2) - Persons who, because of age, physical limitations, mental limitations, chemical dependency, or medical treatment, cannot respond as an individual to an emergency situation to complete a building evacuation. Please note 1. If a person in a wheelchair can operate their chair to assist in their evacuation then they are considered capable of self-preservation, even if assistance is needed transferring into their wheelchair. 2. If a person is capable of assisting with the completion of the evacuation, even if it slows their evacuation time, they are still capable of self-preservation.	
By definition of Incapable of Self Preservation, Is the applicant Incapable of Self-Preservation?	Yes or No

INCOME	
AMOUNT	SOURCE
PAYEE NAME	PAYEE PHONE NUMBER

PAYEE EMAIL ADDRESS	

GUARDIAN CONTACT		
LAST NAME	FIRST NAME	RELATIONSHIP
EMAIL		PHONE NUMBER

EMERGENCY CONTACT		
LAST NAME	FIRST NAME	RELATIONSHIP
EMAIL		PHONE NUMBER

MCBDDS	
CURRENT SSA	PHONE NUMBER

RELEASE OF INFORMATION

I/we, the undersigned, authorize Miami Valley In-Ovations, Inc. (Landlord) and its agents to obtain and verify my employment, criminal history, income, rental and residence history, and behavior history as it relates to violence and property damage. I, hereby release all sources, their officers, agents, and employees from liability of any nature, whether caused by negligence or otherwise, which may result from the answering of questions concerning my past.

_____ _____

Signed Applicant Date

EXHIBIT J

INHC WELCOME DOCUMENT

WELCOME

INHC is happy to provide safe, affordable, and accessible housing to you during your housing transition or temporary respite.

In order to provide this important housing, the cost to stay at INHC's Adult Interim Care Home is **$15.00 per night**. Your stay is **NOT** free. You must pay rent for your stay as a condition of your short term lease agreement.

For your protection and insurance compliance, a signed short term lease is required. Just as a hotel, AIRBNB or hospital stay would require a signed agreement outlining your stay, cost, and expectations.

INHC **DOES NOT** allow for long term or permanent leases. Your stay is intended to last no more than 90 days. Your stay may be extended based upon your available housing options. Approval from INHC is **required** to extend stay beyond 90 days.

Short term lease holders are required to participate in the housing search process to support a timely and successful transition to community housing.

INHC

Inclusive Neighborhoods Housing Corporation

RULES for Safety in Shared Living

Overnight visitors are not permitted.

Handguns or Weapons are not permitted on the property.

Smoking is not permitted within INHC properties

Physical violence, fighting or threats of violence is not permitted.

Illegal activity, including drug-related illegal sell, distribute, or use of a controlled substance prohibited.

EXHIBIT K

WESTBROOK LEASE AGREEMENT

SHORT TERM/ RESPITE LEASE AGREEMENT

INCLUSIVE NEIGHBORHOODS HOUSING CORPORATION

800-810 WESTBROOK RD LEASE AGREEMENT

PARTIES:

LANDLORD: Inclusive Neighborhoods Housing Corp.
PO Box 115
Englewood, Ohio 45322

TENANT (YOU): _____

TENANT'S GUARDIAN: _____
(IF APPLICABLE)

1. **AGREEMENT TO LEASE: PROPERTY DESCRIPTION**

INHC as Landlord, leases to **You**, as a tenant, a house at

☐ 800 Westbrook Rd., Dayton, Ohio 45415
Or
☐ 810 Westbrook Rd., Dayton, Ohio 45415

in which **You** agree to share the home with other tenants and also receives support services and has a binding agreement with Miami Valley In-Ovations, Inc. dba, Inclusive Neighborhoods Housing Corp. (INHC).

2. **TERM OF LEASE**

This Lease will commence on _____ and starting the next day will be a day to day lease subject to tenant cancellation with 24 hour notice.

This is a **short term/ respite** lease agreement. Short term lease agreements are intended to terminate within 90 days of entering into agreement. Leases beyond 180 days are not permitted.

This short term lease agreement requires **You** and/ or your representative to actively participate in the housing search process to include pursuing all suitable, safe, and affordable housing options within Montgomery County that are available during your short term stay. Refusal to participate in the housing search process is grounds for lease termination.

It is recognized by and between the parties to this Lease that INHC owns this property for the purpose of making it available to persons qualified to receive services under the Supported Living Program provided through the Montgomery County Board Developmental Disabilities Services. No person may reside in this property who is not qualified to receive such Supported Living services.

Participation in Supported Living Program is required for INHC housing eligibility. If **You** are dispelled from the Supported Living Program with cause (level of care, provider termination, etc.), **Your** lease is subject to immediate termination.

4. **RENT**

You agree to pay for your short term stay at 800-810 Westbrook Rd., Dayton, Ohio 45415. INHC will not have to ask for or send **You** a bill for payment of rent.

You agree to remit rent payments to the Montgomery County Board of Developmental Disability Services (MCBDDS) upon invoicing and MCBDDS will remit payments to INHC on your behalf.

Your rent $15.00 per night or $450.00 per 30 days/ month.

5. **TERMINATION OF LEASE**

INHC may terminate this Lease without cause by giving thirty (30) days prior written notice to **You**, but no termination by **You** without cause may take effect without 24 hour notice (1 day) written notice.

6. **RENT INCREASE**

INHC may increase the monthly rent or change the terms of this Lease on written notice to **You** given at least thirty (30) days in advance of the first (1st) day of the month in which the increase in rent or change in lease terms is effective.

7. **LEASE RENEWAL**

This Lease shall continue under the same terms and conditions as stated herein unless either party shall give notice in writing to the other party at least thirty (30) days prior to the end of this Lease of his intention to terminate the Lease agreement or continue same under changed terms and conditions.

8. **UTILITIES AND SERVICES**

INHC agrees to pay the cost of utilities services for and during the term of the lease as follows:

__X__ Electricity and gas
__X__ Water and sewer
__X__ Trash collection
__X__ Furnished

You agree that INHC has the right temporarily to stop the service of electricity, gas or water in the event of an accident affecting the same to facilitate repairs or alterations made on the premises or elsewhere in MVIO's property.

You agree to not bring outside furniture into the property to limit the exposure to bed bugs or other pests.

9. **BREACH OF THIS LEASE BY YOU**

If **You** shall fail to pay rent, or any other sum, to INHC when due, or within sixty (60) days thereof, or shall default in any other provisions of this Lease and said default shall not be cured within thirty (30) days of written notice thereof by INHC to **You**, or shall abandon the premises and move or attempt to remove **Your** possessions from the premises, INHC, in addition to all other remedies provided by law, may void and terminate this Lease, re-enter into possession of the premises, sue for and recover all rent earned up to the date of such entry; or INHC may, without terminating this Lease, terminate **Your** right of possession, reenter and resume possession of the premises, and re-let the same for the remainder of the term, at the best rent it can obtain, for **Your** account, who shall make good any deficiency. **You** hereby expressly waive the service of notice of such intention to reenter, or of the institution of legal proceedings to that end.

10. **USE OF PROPERTY/ DAMAGE TO PROPERTY**

You agree to use the premises only as **Your** temporary residence and shall not assign this Lease or sublet the premises. **You** agree not to do or permit any act or practice injurious to the building, or which may be unreasonably disturbing to other residents, or which may affect the insurance risk factor on the building.

You agree to use and occupy the premises in careful, safe, lawful and proper manner, without waste, and to give notice to INHC of the need for repair, and to pay for all repairs to the premises, its contents, and to all other parts of INHC's property which are necessitated by the lack of care on **Your** part, or **Your** family, agents, support staff, or visitors. INHC agrees to provide normal repair and preventive maintenance services.

You agree to reimburse INHC actual costs incurred for excessive/abnormal damage including, but not limited to, broken glass, toilet stoppage, excessive wall

damage, damage to appliances and like items, within thirty (30) days of **Your** receiving an invoice of the cost thereof from INHC. Excessive, abnormal damages to INHC property, equipment and appliances due to tenant's negligence will be repaired by INHC and **You** will be billed and responsible to pay for the actual costs incurred.

11. **RIGHT TO ENTER THE PROPERTY**

INHC may enter the Property without **Your** consent in case of emergency. INHC may enter the Property giving **You** 24 hours oral or written notice. Such entries may be made to inspect the Property, or to make necessary repairs. **You** will not unreasonably withhold **Your** consent to such entries. INHC will not be responsible for any damage from such entries, except damage caused by its own negligence.

12. **REDUCTION OR ABATEMENT OF RENT; INTERRUPTION OF SERVICES**

You will not be entitled to any reduction or abatement of rent or other compensation when services or utilities are interrupted by causes beyond the control of INHC or by repairs, alterations or improvements to the Property. Such interruptions will not be considered constructive evictions.

13. **TERMINATION OF LEASE**

You will leave the Property promptly at the end of the term or on the earlier termination of this Lease. **You** will leave the Property in good condition, room clean, reasonable wear and tear expected. **You** will repair any damages caused by **You**, restoring the Property to its condition at the starting date of this Lease. **You** will clean, scrub, and polish all fixtures, appliances, and apartment surfaces prior to surrender.

14. **DAMAGE TO PROPERTY**

If the property is damaged by fire or other cause, where applicable, INHC will repair the property, to the extent of insurance. INHC will repair the damage as quickly as is reasonably possible after receipt of notice of the damage. **You** will notify INHC of any such damage. The time for making repairs will be extended by any time lost due to adjustment of insurance of INHC claims, labor disputes, or causes beyond control. If the damage is so extensive as to render the Property untenantable, then **You** will not be required to pay rent from the time of the damage until the property has been restored to a tenantable condition.

15. **MULTI UNIT BUILDING**

In the event that this Lease pertains to a unit in a duplex or multiple unit building then this Lease confers no rights upon **You** to use for any purpose any other property of INHC other than the interior of the unit, and its part of the grounds if any, except the walks and roadways giving access thereto and such other areas, if any, as INHC may designate for the use of residents. When the use by **You** or any other portion of INHC property is permitted it shall be subject to the rules and regulations established by INHC. When **You** enter any other units **You** shall do so by permission of the Lessee of the other unit and **You** shall be considered a visitor in accordance with the terms of that Lessee's Lease.

16. **ASSIGNMENT, SUBLET**

You will not assign this Lease, sublet, or permit anyone else to live in any portion of the Property other than **You**, without INHC's prior written consent, which may be withheld in absolute discretion.

17. **RENT COLLECTION**

If INHC accepts partial payment of rent, it will not constitute a waiver of its right to full payment. No endorsement on a check or letter accompanying a partial payment of rent will be a waiver of the right to full payment or will be an accord and satisfaction. Rent is due by the 1st day of each month.

18. **WAIVER**

If either party does not insist on strict performance of the promises in this lease, it is not a waiver. Either party may insist on strict performance if the Lease is breached again in the same manner.

19. **CHANGES**

Any changes of this Lease must be in writing, signed by INHC and by **You**.

20. **ENTIRE AGREEMENT**

This lease is the entire agreement between INHC and **You**. It supersedes all previous discussions and agreements whether written or oral.

21. **NOTICES**

Notices must be in writing and must be mailed or hand delivered to INHC or to **You** at the addresses shown in Section 1 and to **You** at **Your** property.

22. **ALTERATIONS**

You will make no alterations, additions or improvements to the property without prior, written approval. If approved, **You** will use only contractors or mechanics acceptable to INHC. INHC must also approve the time and manner of performing the work. **You** will keep the Property free of mechanics' liens resulting from the work. **You** will promptly remove any such liens that attach to the Property. Any alterations or improvements that are attached to the building or grounds so that they cannot be removed without injury to the building or grounds will be the property of INHC.

23. **SEVERABILITY**

If any portion of this Lease is found to be void, unenforceable, or against public policy, the remaining portions of this Lease will not be affected.

24. **TRANSFER OF PROPERTY**

The term "INHC" as used in this Lease so far as covenants or obligations on the part of INHC are concerned, shall be limited to mean and include only the Owner, at the time in question, of the fee of the premises. In the event of any transfer or transfers of the title to such fee, INHC herein named (and in case of subsequent transfers or conveyances) the then Grantor shall be freed and relieved from and after the date of such transfers any conveyances of all liability with respect to the performance of any covenants or obligations on the part of INHC contained in this LEASE thereafter to be performed. Without further agreement, the transferee of such title shall be deemed to have assumed agreed to observe and perform any and all obligations of said Lease. INHC may transfer its interest in the premises without **Your** consent and such transfer or subsequent transfer shall not be deemed a violation upon INHC's part of any of the terms and conditions of this Lease. INHC or transferor shall remain and continue liable for any performance or payment which shall have accrued or become owing during INHC's or transferor's tenure as Lessor or transferor hereunder.

25. **APPLIANCES**

INHC shall provide said premises with the following: __X__ Washer; __X__ Dryer; __X__ Refrigerator; __X__ Cooking Stove; __X__ Dishwasher; __X__ Garbage Disposal.

These shall be in good working order and shall be maintained by INHC during the term of the Lease and any extension hereof subject to the responsibilities of **You** under paragraph 11 of the Lease. The provision of and maintenance for all other furnishings needed or desired by **You** shall be **Your** responsibility and at **Your** expense.

26. **LEAD BASED PAINT**

If the Premises was built before 1978, You hereby acknowledge that it may contain lead based paint.

27. **JOINT LIABILITY**

The term "**You**" used herein shall refer collectively to all persons named above, and signing this Lease as Lessee, and the liability of each such person shall be joint and several. Notice given by INHC to any person named as Lessee, or by any such person to INHC shall bind all persons signing this Lease as Lessee.

28. **SERVICES PROVIDER LIABILITY**

It is understood by **You** that keys to the premises may be requested by persons/agencies who provide services to **You**. INHC hereby agrees to provide a key to **Your** "Providers" upon the request of **Your** Advisors and/or Sponsors. However, **You** jointly and severally, agree that INHC shall have no responsibility and/or liability for the activities of said Providers while on **Your** premises and **You**, jointly and severally, agree to indemnify and hold INHC harmless from any liability resulting from the activities of said Providers while on INHC property.

29. **LAWN CARE/SNOW REMOVAL**

INHC will be responsible for lawn and garden care as may be required.

INHC will be responsible for snow removal of driveways.

It is understood by **YOU** that Providers will be responsible for snow removal and salting of sidewalks and steps and that it is not the responsibility of INHC.

It is understood by **YOU** that Providers will be responsible for snow removal and salting driveways, sidewalks and steps when the snow/ salt **accumulation is less than 2 inches.**

30. **RULES**

Apartment Rules and Regulations are like all basic rules between good neighbors, based on common courtesy. These rules help to maintain the proper operation and appearance of the property, and provide you and your fellow tenants with the comfort and convenience that you expect in your home environment. We hope that you will feel that compliance with these rules will accomplish our mutual objectives. **Violation of the above provisions shall be a material violation of the lease and good cause for termination of tenancy.**

You will comply with the following rules which may be modified or supplemented by INHC from time to time. Any new or modified rules will not

substantially alter the terms of this Lease. **You** will be notified in writing of any changes in the rules. **Please read the rules carefully, they are part of your lease.**

a. Your will have 24 hours access to the property.

b. INHC will retain a pass key to the Property for immediate entry in emergency situations and entry for general repair purposes on 24 hour notice. No new locks may be installed or existing locks altered without consent.

c. Roomers and boarders are prohibited.

d. **You** or your guest shall not engage in illegal activity, including drug-related illegal sell, distribute, or use of a controlled substance.

e. Overnight guests are not permitted

f. The garbage disposal will be used only for food waste.

g. INHC will provide light bulbs at the start of the Lease. **You** will replace all light bulbs that burn while **You** live in the house.

h. Nothing will be fastened to any part of the Property. No holes will be drilled or nails or screws inserted in any structure, and no interior surfaces will be decorated or covered, without prior written consent, other than normal picture hooks.

i. Toilets, sinks, faucets, and other water equipment will be used only for the purposes for which they are intended. No improper articles may be thrown into them. Damage caused by the misuse of water equipment will be borne by **You**, if it is caused by **You** or occurs on the Property.

j. All noise will be held to reasonable levels at all times. During the time from 11:00 p.m. to 7:00 a.m. no noise will be heard outside the Property.

k. Nothing may be done or kept in the property which will increase the rate of insurance of the building or the contents thereof beyond the rates applicable for residential housing without prior written consent of INHC.

l. Pets are forbidden unless it's a "service or companion animal covered under the Americans with Disabilities Amendments Act of 2008 (ADAAA), Section 504 of the Rehabilitation Act of 1973 ("Section 504"), the Fair Housing Act, the Individuals with Disabilities Education Improvement Act (IDEA), the Air Carrier Access Act of 1986, the Ohio Revised Code, and the Ohio Administrative Code" and/or a licensed professional.

m. A smoke detector is installed, and operative, in the Property. **You** must assure that a fully charged battery is in the smoke detector at all times.

n. **You** will be responsible for cleaning and/or replacing the furnace filter at regular intervals.

o. Naphtha, benzene, bensole, gasoline, benzene-varnish, gunpowder, fireworks, nitroglycerin, phosphorus, saltpeter, nitrate of soda, camphene, spirit-gas, or any flammable fluid or oil, shall not be allowed or used on the Premises without written permission of INHC.

p. Handguns or Weapons are not permitted on the property.

q. Smoking of cigarettes/ tobacco products is not permitted within INHC properties. Smoking, the use of any tobacco products, and vaping are not permitted in any INHC Property, except outside away from the front entrance and sidewalks. Smoking of marijuana and the cultivation/growing of marijuana is not permitted in INHC properties or on the grounds of INHC properties. All tenant guests must comply with all smoking/tobacco/vaping-related regulations.

r. Physical violence, fighting or threats of violence is not permitted.

s. **You** are responsible to comply with Rules and Procedures outlined in INHC Home Guide for Tenants and Providers.

32. **PROVIDER SERVICE TO TENANT**

Service providers must receive prior authorization from INHC to provide services in INHC properties. Additional or change in providers is prohibited without written permission.

33. **SPECIAL TERMS**

Special terms of this Lease are _____ attached _____ not attached.

SPACE INTENDED TO BE BLANK

33. **BINDING EFFECT**

This Lease is binding on **You** and INHC, if applicable.

MIAMI VALLEY IN-OVATIONS, INC.

By: C Rauchal

Date: _____

TENANT

By: _____

Date: _____

GUARDIAN ADDENDUM:

As guardian of the person identified as Tenant, I am aware of and consent to their residential placement at 800 -810 Westbrook Rd. Dayton, Ohio 45415. Guardian is not assuming any financial responsibility, on behalf of the guardian or Tenant, for payment of rent or any other expenses or fees as required by the lease agreement.

TENANT'S GUARDIAN/AGENT (IF APPLICABLE)

Signature _____

Guardian of the person of _____

Date: _____

PAYEE ADDENDUM:

As payee of the person identified as Tenant, I acknowledge tenant's fiduciary responsibility to pay the security deposit, rent and utilities.
_____ (Individual/Company) agree to pay tenant's security deposit, rent, utilities, and lease related expenses in compliance with the lease for the duration of the lease.

_____ _____

Company Name Authorized representative

Date: _____

EXHIBIT L

CONSENT TO ROI (RELEASES *BY* MCBDDS)

Montgomery County Board of Developmental Disabilities
Authorization for Release of Confidential Information

Name of Individual Served: _____ Date of birth: _____

I authorize MCBDDS to Release to (name and address):

Choices In Community Living
1651 Needmore Road
Dayton, Ohio 45414

The following information:

☒	Assessments (DINA, C/OEDI etc)	☒	Photograph
☒	Individual Plan (ISP, IFSP, etc)	☒	HIV/AIDS status information or treatment records
☒	Collateral (Social history, Medical summary, etc)	☒	Identifying information (copy of SS card, birth certificate, state ID, etc)
☒	Psychological evaluation	☒	Other: All information necessary to assist with respite or emergency service delivery by Choices In Community Living in their role as the provider at the Adult Interim Care Home
☒	Eligibility information (FED, grandfather statement)		
☒	Intellectual Property (artwork, written work, etc)		

Obtain from (name and address):

The following information:

☐	Medical records (immunizations, etc)	☐	Assessments
☐	School records (including IEP, ETR)	☐	Eligibility information
☐	Benefits information (SS award letter, insurance information, etc)	☐	Other:

The purpose of this disclosure is:

☒	Coordination of Care	☒	Requested by individual, guardian/parent
☐	Other: All information necessary to assist with respite or emergency service delivery by Choices In Community Living in their role as the provider at the Adult Interim Care Home		

1) I understand that I may revoke this authorization at any time by submitting a written request, unless records have already been released.
2) I understand that the party receiving my information might not be subject to HIPAA, FERPA or Ohio confidentiality laws and might be allowed to disclose this information.
3) The MCBDDS does not require that I sign this authorization to receive services.

Expiration date: _____
-Not to exceed one year from the date of authorization unless otherwise specified as less. If no date is specified, the release will be valid for 1 year.

Approved by: _____ **Date:** _____
(Individual or guardian's signature)

Print Name: _____

Please return to your contact person or to Lauren Fritz at 5450 Salem Ave. Dayton OH 45426.

EXHIBIT M

CONSENT TO ROI (RELEASES *TO* CHOICES)

AUTHORIZATION FOR RELEASE OF INFORMATION

Concerning (individual):_____ Social Security #: _____

I, _____, do hereby authorize the release of information noted below.
(individual/legal guardian)

Name of individual or agency authorized to release information:_____

_____

Name of individual or agency to whom information is to be released: (1) Dawn N. Wissel, RN and (2) Choices in Community Living, Inc. (CICL) and its employees and representatives

Information to be released: Any and all of the above-named individual's medical information

_____

For the purpose of: Continuity of care; provision of medical care; delegation of medication administration and health-related activities

It is understood that the information released will be for the express purpose noted above and will not be used for any other purpose.

This authorization to release information is to be updated annually. It may be revoked at any time by making written note of revocation on this release.

_____ _____

Signature of Individual / Legal Guardian Signature of Witness

_____ _____

Name and date Name and date

EXHIBIT N

CONSENT TO ROI (RELEASES *BY* CHOICES)

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.

EXHIBIT O

GENERIC CONSENT TO ROI

Authorization for Release of Information (ROI)

1. Client/Individual

- **Full Name:** _____
- **Date of Birth:** _____
- **SSN:**_____

2. Information to Be Released

- **Information / Type of Information to Be Released (Specify):**
  _____
  _____
  _____

- **Date(s) of Information to Be Released (if applicable):**
  - From: _____ To: _____

3. Purpose of Release

- Continuity of Care
- Personal Use
- Legal
- Insurance
- Other (please specify): _____

4. Recipient Information

- **Name of Recipient/Organization:** _____
- **Address:** _____

- **Phone Number:** _____
- **Fax Number (if applicable):** _____
- **Email Address (if applicable):** _____

5. Authorization and Acknowledgments

- I authorize the release of the information described above to the recipient listed.
- I understand that the information released may contain sensitive information, including but not limited to medical records, mental health records, and substance use disorder treatment records, which are protected by privacy laws.
- I understand that I may revoke this authorization at any time by submitting a written request to the organization, except to the extent that action has already been taken based on this authorization.
- I understand that the release of information may not be conditioned on signing this authorization, and I have the right to refuse to sign.

Expiration of Authorization:

This authorization will expire on (choose one):

- When the information is released
- On (specific date): _____
- No expiration

6. Signature of Client/Individual or Authorized Representative

- **Signature:** _____
- **Printed Name:** _____
- **Date:** _____

7. Signature of Witness

- **Signature:** _____
- **Printed Name:** _____
- **Date:** _____

EXHIBIT P

CURRENT PERSONAL SUMMARY

CURRENT PERSONAL SUMMARY

Date: _____

NAME: _____ Likes to be called: _____ D.O.B. _____
Address: _____ Home Phone: _____
Primary Contact Name and Phone: _____
Emergency Contact Information: _____
Guardian Info: _____
Primary Physician and Phone: _____
SS#: _____ Medicare #: _____
Medicaid #: _____ Other
Insurance: _____
Ht____ Wt____ Blood Type____ **ALLERGIES or SENSITIVITIES: NO_ YES_ Specify:**

_____

_____

_____

Chronic Diagnoses: _____

_____

Level of mental retardation: Mild ☐ Moderate ☐ Severe ☐ Profound ☐ Other DD:_____

Functional Status: Impaired Vision ☐ Blind ☐ Impaired Hearing ☐ Deaf ☐ Other: _____

Communication: Easily Understood ☐ · Difficult to Understand ☐ · Nonverbal but understands some ☐
Signs with Standard Sign Language ☐ Signs -Uses Own Gestures ☐ No Receptive or Expressive language ☐

Residential Supervision: ☐24 HR ☐ Specify number of staffing hours per **Day** ☐_____ or ☐**Week**_____

Care Limitations (includes ability to take meds): _____
Self-Administering Meds ☐ _____
Assistance w/Self Administering Meds ☐_____
Medication Provided by Unlicensed Worker ☐ _____

Assistance with daily needs: Meds ☐ Eating ☐ Dressing ☐ Toileting ☐ Bathing ☐ Dental Care ☐

Adaptive Equipment: Glasses ☐ Hearing Aid ☐ Trach ☐ G/J Tube ☐ Oxygen ☐ Cane ☐
Walker ☐ Prosthesis ☐ Wheelchair ☐ Communication Device ☐ Other:

Seizures: **NO** ☐ **YES** ☐ **Specify Frequency/Severity:** _____

Behavioral Issues:

_____

CURRENT PERSONAL SUMMARY

Social History:

Tobacco	☐YES ☐NO	PPD: _____	# Yrs: ___	
Alcohol	☐YES ☐NO	Drinks/week	_____	
Caffeine	☐YES ☐NO	CPD:	_____	
Illicit Drugs	☐YES ☐NO	Type:	_____	

Last time you had any of the following vaccines: (list year)

flu vaccine	_____	rubella	_____
hepatitis	_____	haemophilus Influenza HIB	_____
pneumococcal	_____	chicken pox	_____
oral polio	_____	measles-mumps-rubella	_____
TB	_____	Other	_____

PPD= Packs Per Day; Cups Per Day=CPD

Last time you had a: (list year)

Pneumonia Shot	_____	Tetanus shot	_____		
Stool Blood Test	_____	TB Skin Test	_____	For Women Only	
Sigmoid exam	_____	Rectal exam	_____	Age of onset of menstrual period	____
Hearing Test	_____	Eye exam	_____	Year of last: Breast exam_____	☐ Normal ☐ Abnormal
Cholesterol Test	_____	PT evaluation	_____	Mammogram:_____	☐ Normal ☐ Abnormal
Dental Exam	_____	Prostate test (PSA)	_____	Pap test:_____	☐ Normal ☐ Abnormal

**If needed, information about sexual activity, birth control use, pregnancies, sexually transmitted disease, AIDS, and HIV status will need to be obtained from the individual during the health care encounter.*

Food allergies / dietary restrictions (list all):

_____

_____

_____

_____

_____

_____

Past Medical History: (Have you ever had the following? Check "YES" and "NO". Leave blank if uncertain. If you answered yes to any question then indicate in the comments section approximately when or how long.)

Measles	☐YES ☐NO	Migraine	☐YES ☐NO	Hives or Eczema	☐YES ☐NO
Mumps	☐YES ☐NO	Tuberculosis	☐YES ☐NO	Bladder Infections	☐YES ☐NO
Chicken Pox	☐YES ☐NO	Diabetes	☐YES ☐NO	Infectious Mono	☐YES ☐NO
Whooping Cough	☐YES ☐NO	Cancer	☐YES ☐NO	Bronchitis	☐YES ☐NO
Scarlet Fever	☐YES ☐NO	Glaucoma	☐YES ☐NO	Mitral Valve Prolapse	☐YES ☐NO
Diptheria	☐YES ☐NO	Polio	☐YES ☐NO	Stroke	☐YES ☐NO
Smallpox	☐YES ☐NO	Hernia	☐YES ☐NO	Hepatitis	☐YES ☐NO
Pneumonia	☐YES ☐NO	Stomach Ulcer	☐YES ☐NO	Blood Transfusion	☐YES ☐NO
Pheumatic fever	☐YES ☐NO	Back Trouble	☐YES ☐NO	Kidney Disease	☐YES ☐NO
Arthritis	☐YES ☐NO	Hemorrhoids	☐YES ☐NO	Bleeding Tendencies	☐YES ☐NO
Anemia	☐YES ☐NO	Epilepsy	☐YES ☐NO	Other:	☐YES ☐NO

List any other diseases:

CURRENT PERSONAL SUMMARY

Comments:

Hospitalizations:

Year	Illness/Operation	

Previous Diagnostics (attach results, if available)		
EKG	☐YES ☐ NO	Date
EEG	☐YES ☐ NO	
Brain CT scan	☐YES ☐ NO	
Brain MRI	☐YES ☐ NO	
Echocardiogram	☐YES ☐ NO	

Schools Attended:

School	Location/City	Dates Attended	Graduated?

Work History:

Employer	Location/City	Dates Worked	Tasks Performed	Work Limitations

EXHIBIT Q

WESTBROOK INTAKE QUESTIONNAIRE

INTAKE QUESTIONS

What are individuals likes

What are dislikes or things that are bothersome?

Are there dietary concerns

Are there allergies

How independent is person in daily living skills

Does person prefer bath or shower?

What day program does person attend?

Do they carry a packed lunch?

Do we have a medical summary current with in year?

We need doctor orders for all prescribed meds

We need PRN sheet for over the counter meds

We need copies of insurance cards

Has person been away from home before?

Will there be visitors and can they leave with them

While in community will person wander off or try to runaway

Make transportation arrangements for programming

Are there other things we haven't asked that we might need to know?

What are the emergency contact numbers?

EXHIBIT R

BED BUG POLICY

Date Adopted	3/15	Section	Program and Services
Date Revised		Subject	Bed Bug Policy
Rule Referenced			

Bed Bug Policy

It is the policy of Choices In Community Living to be proactive in the control of bed bugs in any program setting, including residential settings, day programs, transportation, and temporary living arrangements.

When an individual comes to a residential location to stay overnight or longer, the following steps will occur prior to them entering the home:

1 All items/personal belongings will be placed in the two brown totes outside in front of the building.

2 The individual will be asked to shower so their clothes that they currently have on can be placed in the washer, dryer, and/or heater.

3 The individual will be given temporary clothing such as; a set of socks and a pair of sweats along with a tee-shirt until their clothes have been washed and dried and/or heated to kill possible bed bugs.

4 The items in the totes will be inspected for bed bugs, washed, dried and/or heated and then inventoried prior to placing them in the individual's room.

5 If bed bugs are discovered CICL will determine at that time if they can be treated effectively. There is some possibility that some items may need to be disposed of. This will only occur with the approval of the individual and their ISP team.

6 AT THE MAIN STREET LOCATION – it is important to understand that this residential setting is a temporary living arrangement. As such, it has an obligation to manage bed bugs in a proactive manner, being mindful of each individual's rights yet also expecting adherence to the steps noted above so that the other parties living at this home will not be bothered with bed bugs.

Signed _____ date_____

Signed_____ date_____

A signed copy of this policy should be kept in each individual's file:

EXHIBIT S

WESTBROOK/AIHC HOME GUIDELINES

Adult Interim Care Home

Welcome to the Adult Interim Care Home! We are happy that you have chosen us to support you during your respite stay. While you are staying with us, you will be provided with a safe place to live, healthy meals and your own bedroom. Staff will be on-site 24/7 to assist you during your stay with us.

To help ensure that your stay at the Adult Interim Care Home is a positive experience, the following guidelines have been established:

AICH guidelines:

1. Before leaving the Adult Interim Care Home you must let staff know that you are leaving and when you expect to return. Also, in the event staff would need to contact you, please let them know where you are going and a good phone number where you can be reached. If you are going to be late please contact staff at (937) 454-3652 to let them know when you will be returning.
2. Everyone, residents and visitors, must use the sign in sheets when they leave and when they return.
3. The Adult Interim Care Home is locked from 11:00 PM to 7:00 AM to ensure everyone's safety. If you are out after 11:00 PM, the doors will be locked and it will be necessary for you to call staff at (937) 454-3652 to be admitted.

Personal guidelines:

1. Each person will be responsible for the maintenance of his or her own personal possessions and personal space (bedroom) and is expected to assist in typical day-to-day "household maintenance" activities. *(Everyone is expected to contribute based on ability.)*
2. Each person is responsible for maintaining his or her own personal hygiene. Staff is available to assist.
3. In an effort to maintain your employment and/or your education, if you are enrolled in school, employed or attend day programming you are expected to continue to attend.

General home guidelines:

1. To allow everyone to maintain contact with friends and/or family, please limit phone calls to 15 minutes per call. Please contact staff if you need assistance. (Due to the nature of the home, emergency situations may come up during which staff must have access to the phones. Once the situation is resolved then phones will be made available to everyone.)
2. Alcoholic beverages and illegal or non-prescribed drug usage are not permitted.
3. Sexual activity is not permitted.
4. No weapons are allowed.
5. To respect the rights of all, media (audio, video, print, web-based) containing profanity, pornography, sexual innuendo, excessive violence, objectification of women or men, or racial or ethnic slurs will be reviewed on an individual basis. If the activity is disruptive to the Adult Interim Care Home, it will be addressed.
6. To respect the rights of all, media will be played at a reasonable volume.
7. To respect the rights of all, profanity, referring to individuals in derogatory "street terms" or mockery of individuals' disability, ethnicity, culture, national origin or medical condition(s) is forbidden.
8. Video games of a violent or sexual orientation will be reviewed on an individual basis. If the activity is disruptive to the Adult Interim Care Home, it will be addressed.
9. Fighting and threatening or acts of verbal or physical intimidation are not allowed.
10. Destruction of the Adult Interim Care Home or another individual's property is forbidden.

Failure to follow the aforementioned rules may result in law enforcement intervention or placement in a community-based homeless shelter.

_____ _____

Consumer's Signature Date

_____ _____

Caregiver's Signature Date

EXHIBIT T

CASH / PAYMENT CARDS INTAKE LOG

Choices Westbrook Emergency Shelter / AICH

Client Cash / Payment Cards Intake Log

Client Name: _____ **Admission Date:** _____

Customer ID#: _____

Client Guardian:_____ **Checked-In By (Staff Member):**

_____

Client's Cash & Other Forms of Payment Logged In:

Date	Payment Type	Amount	Currency/Medium (e.g., cash, check, credit card, etc.)	Received By (Staff Member)	Notes/ Remarks
____	_____	_____	_____	_____	_____
____	_____	_____	_____	_____	_____
____	_____	_____	_____	_____	_____
____	_____	_____	_____	_____	_____

Acknowledgments and Staff Verification

Client's/Guardian's Signature: _____ **| Date:** _____

(Client/guardian acknowledges that all forms of payment are being handed over to the facility for safekeeping except as otherwise contemplated by the client's ISP.)

Staff Member Signature: _____ **| Date:** _____

EXHIBIT U

PERSONAL PROPERTY INVENTORY

INVENTORY RECORD

Name of Individual: _____ Name of Program: _____ Month/Day/Year _____

Please record any item with the purchase price of $50 or more: (O.A.C. 5123:2-3-12 (C) (4)

Article	# of Items	Date of Purchase	All Ready Have Please Put a X	Date of Disposal/ Lost	Staff Initials	Why	Date Client/Guardian Notified
Bathing Suit							
Bathrobe							
Boots							
Dress Shoes							
Every Day Shoes							
Jerseys (baseball, basketball, football,etc)							
Jogging Suit							
Lightweight Jacket							
Pants							
Suits							
Sweaters							
Tennis Shoes							
Winter Coat							

Article	# of Items	Date of Purchase	All Ready Have Please put a x	Date of Disposal/ Lost	Staff Initials	Why	Date Client/Guardian Notified
Air Conditioner (window)							
Bed							
Box Springs & Matress Set							
Camera							
Carpet Shampooer							
Cell Phone							
Chair/Couch							
Computer (lap top or desk top)							
Dresser							
Dryer							
DVD Player							
Flat Screen TV							
Grill (charcoal or gas)							
I-Pod/I-Pad							
Lawn Mower							
Microwave							
MP3 Player							
Night Stand							
Patio Furniture							
Pots & Pans (set)							

Article	# of Items	Date of Purchase	All Ready Have Please Put a X	Date of Disposal/ Lost	Staff Initials	Why	Date Client/Guardian Notified
Refrigerator							
Snow Blower							
Stove							
Table & Chairs							
TV Stand							
TV Wall Mount							
Vacuum							
Video Camera							
Video Game System							
Video Games							
Washer							

1. Items should not be discarded without the consent of the individual or guardian.
2. Inventory record must be updated annually (OAC 5123:2-3-12 (C) (3).
3. Use a new sheet every year and don't forget to carry over the purchase date.

Staff Signature: _____ Date: _____

 Notes:

EXHIBIT V

CLIENT BILL OF RIGHTS

CLIENT BILL OF RIGHTS

Every person has the right to:

- Be treated nicely and as a person at all times
- Have a clean safe place to live and a place to be alone
- Have food that is good for you
- Go to any church, temple, mosque or other place of worship, if you want
- Go to a doctor or dentist when you want
- Have help with the way you walk, talk, act, feel or do things with your hands, if you need it
- Have people help and teach you if you want
- Have time and a place to be by yourself
- Call, write letters, emails or texts, or talk to anyone you want about anything you want
- Have your own things and be able to use them
- Have men and women as friends
- Join in activities and do things that will help you grow to be the best person you can be
- Work and make money
- Be treated like everyone else
- Be treated with respect (not be hit, yelled at, cursed, or called names that hurt you)
- Learn new things, make friends, have activities to do, and go out in your community
- Tell people what you want and be part of making plans or decisions about your life
- Ask someone you want to help you or let others know how you feel or what you want
- Use your money to pay for things you need and want, with help if you need it
- Say yes or no before people talk to you about what you do at work or home or look at your file
- Disagree and ask for changes if you do not like something without getting into trouble
- Refuse medication that you do not need and not be held down unless you are hurting yourself or others
- Vote and learn about laws and your community
- Say yes or no to being part of a study or experiment

EXHIBIT W

CASH / PAYMENT CARDS DISCHARGE LOG

Choices Westbrook Emergency Shelter / AICH

Client Cash / Payment Cards Discharge Log

Client Name: _____

Customer ID#: _____

Client Guardian:_____

Discharge Date: _____

Released By (Staff Member):

_____

Released To (New Provider):

_____

Client's Cash & Other Forms of Payment Released:

Date	Payment Type	Amount	Currency/Medium (e.g., cash, check, credit card, etc.)	Notes/ Remarks
____	_____	_____	_____	_____
____	_____	_____	_____	_____
____	_____	_____	_____	_____
____	_____	_____	_____	_____

Receipt Acknowledgment

On behalf of the new provider/agency named above, recipient hereby acknowledges that the above list is complete and accurate and that all items listed have been received.

Recipient Name: _____

Recipient Signature: _____

Date: _____

Choices Staff Member Signature: _____ | **Date:** _____

EXHIBIT X

MEDICATION DISCHARGE FORM

Choices Westbrook - Medication Discharge Form

Client Information:

- **Full Name:** _____
- **Date of Birth:** _____
- **Consumer ID#:** _____
- **Date of Admission:** _____
- **Name of Facility:** Choices Westbrook - Adult Interim Care Home

Client Medications Transferred to New Provider/Agency:

Using the table on the following page, please list all client medications that are being transferred to new provider/agency upon client discharge. This includes prescription medications, over-the-counter drugs, supplements, vitamins, and any other medications. If you need more space, please use the back of this form or provide a separate list.

Important Information:

- Please transfer all medications in their original containers or with clear labeling.
- If any medication requires refrigeration, please note in below table

Medication Name	Dosage and Pill/Dose Count	Notes

Acknowledgment:

Recipient hereby acknowledges that the above list is complete and accurate and that all listed medications have been received.

Recipient Signature: _____

Date: _____

Facility Staff Use Only:

- Medication Release/Transfer Performed by: _____
- Date/Time: _____
- Additional Notes: _____

EXHIBIT Y

EMERGENCY SHELTER DISCHARGE SUMMARY

EMERGENCY SHELTER DISCHARGE SUMMARY

CLIENT NAME:	DATE OF ADMISSION:	DATE OF DISCHARGE:
NAME OF NEW PROVIDER/AGENCY:		PHONE: FAX: EMAIL:
CLIENT NEW ADDRESS:		
WHO WILL CONDUCT MOVE OF CLIENT AND CLIENT PROPERTY?		

DOCUMENTS RECEIVED BY NEW PROVIDER/AGENCY:

__Physician Orders
__Appointment List
__Birth Certificate
__Social Security Card
__Guardianship Paperwork
__Insurance Card
__Medicaid Card
__Medicare Card
__Identification Card
__Food Stamp Card
__Other(s) (specify):_____ _____

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

The above Information is complete and correct to the best of my knowledge. I have transferred/received the Client's documentation identified above.*

*Transferor (Choices representative):

PRINT NAME:	SIGNATURE:	DATE:

*Recipient (New provider/agency representative):

PRINT NAME:	SIGNATURE:	DATE: