Consumer Intake & Establishing Eligibility

Date________ Consumer: ____ Birth Date: _____________

Telephone Numbers:____________________and/or__________________________County:____________

Physical Address: __________________________________Mailing Address:_______________________
(Street) (Street)

__________________________________ ______________________
(City, State, Zip) (City, State, Zip)

E-mail Address:______________________________ Race:____________ Gender: Male or Female

Marital Status: ____________ Registered Voter? YES or NO Veteran? YES or NO

Education Level: ____Program:_______________________

Guardian? YES or NO If Yes, Name:______________________________ Relationship:_____________

Telephone Numbers:________________________________and/or_________________________

SS#:______________________ Medicaid:_____________________ Medicare #__________________

Monthly Income: ________________Do you have a Spenddown? ____ Yes/Amt $______ No _______

Has this Consumer relocated from a Nursing Home Facility back into the community? _______________

If no, has this Consumer continued to live in the community of his/her choice?________________

*** This consumer is **eligible / ineligible** (circle one) for services from Access II, ILC because of*:

Please list the Consumer's disability(s) below:

Date Began Disability Type Specific Disability

Independent Living Plan

Goal Type Set Date Target Date Completed Description

Sign Here *ONLY* If I choose to *WAIVE* my Independent Living Plan: ________________________________

Alternate Contact **Name:** ________________________________**Relationship:**__________________

Address:____

Telephone: ___________________________**Alternate Phone:**_______________

Establishing Eligibility

Check any that apply

- Currently Employed (16 + hours) — Employer: ______________________________
- Hired to Begin Working — Date: ______________________
- Seeking Employment
- In School — At: ____________________________________
- Live Independently, Not Employed

Check all that apply

- Private Home
- Apartment
- Group Home
- Nursing Home
- Special Housing
- Live Alone
- Live with Attendant
- Live with Spouse and Children
- Live with Parents and Other Family
- Live with Other Adults

List names and relationships of adult family members who live with you:

____

Do you plan to change your living situation in the near future? Yes No
If Yes, please explain:____

Are you currently using Consumer Directed Services (CDS) ? Yes No
If yes, please explain:____

Are you currently receiving services through Department of Health & Senior Services (DHSS), or have you in the past? Yes No

VR Office____
Mental Health____
DHSS____
Other____

____
Staff Signature Date

____
Consumer / Guardian Signature Date

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
DIVISION OF SENIOR AND DISABILITY SERVICES

HOME AND COMMUNITY BASED SERVICES REFERRAL

DATE

PERSON BEING REFERRED (LAST, FIRST, MI)	DCN	RACE	SEX	DOB (MM/DD/YYYY)

PHYSICAL ADDRESS (STREET, CITY, ZIP)	MAILING ADDRESS (STREET, CITY, ZIP)	COUNTY	PRIMARY PHONE NUMBER	OTHER PHONE

MARITAL STATUS/LIVING ARRANGEMENTS	PRIMARY LANGUAGE	SPECIAL COMMUNICATION NEEDS

REPORTED HEALTH CONDITION

NAME OF PERSON MAKING REFERRAL	AGENCY NAME	PHONE NUMBER(S)

ADDRESS (STREET, CITY, ZIP)

OTHER PERSONS INVOLVED	ROLE	ADDRESS	PHONE
	Physician		
	Other Responsible Party		
	Other		

REASON FOR REFERRAL	☐ PERSONAL CARE ASSISTANCE (CONSUMER-DIRECTED MODEL) ☐ HOMEMAKER ☐ RESPITE CARE ☐ PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY ☐ ADULT DAY CARE ☐ HOME DELIVERED MEALS ☐ PERSONAL CARE ☐ ADVANCED PERSONAL CARE ☐ AUTHORIZED NURSE VISITS ☐ PERSONAL CARE RCF/ALF
SAFETY CONCERNS	☐ NO KNOWN CONCERNS ☐ DANGEROUS NEIGHBORHOOD ☐ ILLEGAL DRUG ACTIVITY ☐ CONTAGIOUS/ INFECTIOUS DISEASE ☐ STRUCTURALLY UNSAFE HOME OR ACCESS TO HOME ☐ WEAPONS IN THE HOME ☐ PEST INFESTATION ☐ HISTORY OF VIOLENT BEHAVIOR ☐ OTHER: EXPLAIN
MEDICAID STATUS	☐ ACTIVE ☐ SPENDDOWN (CHECKED CYBERACCESS WEBTOOL, MEDICAID CURRENTLY ACTIVE? – ☐ YES ☐ NO)

COMMENTS

DIRECTIONS TO PARTICIPANT ADDRESS

Demographics / About Our Services

Date: ____________________ Consumer Name: ____

DOB: ____________________ Access II Staff: ____

Disability: ____ Ethnicity: ____________________

Address: ____ City: ____________________ MO

Zip: ______________ County: ____________________ Phone: ____________________ Gender: _____

Living Arrangements: ______________________________ Referral: ____________________

"X" each item as it is discussed with you. Initial any items you are interested in learning more about.

Intake Information

- Client Assistance Program (CAP) (Federally mandated)
- Consumer Directed Program Overview (IL Philosophy)
- Voter's Rights and Registration
- Organizational Information

Access II Independent Living Center, Inc Services

Five Core Services

-Information and Referral
-Advocacy
-Peer Support
-Transitions
-Independent Living Skills Training

- Consumer Directed Services (CDS)
- Accessibility Services
- TAP- Telephone (Telecommunications Access Program)
- Benefits Counseling
- Circuit Breaker MO PTC
- Assistive Technology
- Equipment Loan Program
- Consumer Assistance Fund Request
- Nursing Home Transitioning
- Alternative Format
- Transportation
- disAbility Awareness Program
- IEP (Individualized Education Programs) Assistance
- Youth Services
- Universal Design Program
- Prescription Drug Assistance Program
- AgrAbility
- Low-Vision Equipment
- Food Pantry
- Other Services: ____

Please continue on other side…..

Skills I possess and am willing to teach and/or share with others…….

- ASL (American Sign Language)
- Computer
- Budgeting
- Shopping Comparison
- Cooking
- Cleaning
- Companionship
- Leadership
- Tutoring
- Lobbying
- disAbility Awareness
- Other… Please specify____

I am interested in volunteering at Access II. My area(s) of ability are…..

- Secretarial duties (copying, faxing, reception, etc)
- Newsletter Articles
- Read/Compile disability related newspaper clippings
- Office Organization
- Ramps and Home Modifications
- Recreation
- Provide Transportation
- Events Coordinator
- On-Site Consumer Assistance
- Advisory council to the Board of Directors
- Other… Please specify____

I have been offered information on Voter Registration: ☐ YES ☐ NO

I understand that Access II's 5 core services are provided to me at no charge and that I must qualify financially to participate in certain services that have been explained to me. I acknowledge that I have received information and a brochure on the Client Assistance Program (CAP).

____ ____________________
Consumer Signature Date

____ ____________________
Access II Staff Signature Date

Consumer Information Acknowledgement Form

I acknowledge that I have:

1) Received, reviewed, and understand information about rights available to me through Missouri's federally funded Client Assistance Program (CAP) and have been provided literature describing the program:

   Missouri Protection & Advocacy Services (MOPAS)
   Main Office: 925 South Country Club Drive
   Jefferson City, MO 65109
   Phone 573-893-3333 or 1-800-392-8667 Toll Free
   Fax 573-896-42312 or 1-800-735-2966 TDD

2) Received an orientation on the agency and an Access II Independent Living Center, Inc brochure;

3) Received an explanation of the purpose of an Independent Living Center (ILC) and have had an opportunity to discuss services offered by the Independent Living Specialist (ILS);

4) Met and/or spoken with the ILS who will be working with me as a guide and/or advocate, and we have discussed their professional relationship with me;

5) Expressed my expectations to the ILS and my expectations of the agency;

6) Been given an explanation of Access II-Independent Living Center, Inc's expectations of me;

7) Reviewed literature on "Authorization for Release and/or Request of Information" forms;

8) Received and discussed any financial arrangements needed for services related to my program;

9) Made an informed choice to either develop and Independent Living Plan (ILP) and pursuing a plan of action as described in the Independent Living Plan or signed an Independent Living Waiver;

10) I have access to Access II-Independent Living Center, Inc's grievance procedure in the event that I am dissatisfied with any action or inaction by Access II-Independent Living Center, Inc in connection with the provision of its services to me. Under the procedure:
    a) I first discuss my concerns with the Access II, Inc Certified Manager
    b) If I am dissatisfied, or it is impractical for me to discuss my dissatisfaction with the Certified Manager, I may submit a written grievance to Access II Independent Living Center, Inc Executive Director. The grievance is to be submitted within 10 working days after the action or inaction of the complaint
    c) If I am still dissatisfied, within 30 days after submitting the grievance to the Executive Director, I may submit a written grievance to the President of the Board of Directors for Access II Independent Living Center, Inc. The written decision of the Board of Directors about my grievance ends the grievance process.

11) Access II Independent Living Center, Inc is authorized and required to release statistical information concerning Access II's services to agencies, institutions, organizations, and others who fund, contribute, or otherwise support Access II's goals.

This information may also be included in Access II publications and/or other materials accessible to the public that Access II may publish;

12) Access II Independent Living Center, Inc is required by federal, state, and/or local laws to make its services available without discrimination based on race, gender (sex), religion, veteran status, disability, age, sexual orientation, and national origin.

☐ **I am an individual with a disability who:**

*has a physical, mental, cognitive or sensory impairment that substantially limits one or more of my major life activities;

*has a record of such an impairment; or

*is regarded as having such an impairment.

☐ **I am an individual with a significant disability** who has a severe physical, mental, cognitive or sensory impairment that substantially limits my ability to function independently in the family or community to obtain, maintain, or advance in employment.

Consumer / Guardian Signature ______________________ Date ______________

Access II Staff Signature ______________________ Date ______________

STATE OF MISSOURI

AUTHORIZATION FOR DISCLOSURE OF CONSUMER MEDICAL/HEALTH INFORMATION

I, ______________________________ authorize and request
(NAME OF CONSUMER, PARENT, GUARDIAN/LEGAL REPRESENTATIVE)

Check all that apply:

☒ Department of Mental Health (DMH) ☒ Department of Health and Senior Services (DHSS)

☒ Department of Social Services (DSS) ☒ Department of Elementary and Secondary Education (DESE)

☒ any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility or other health care provider that has provided payment, treatment or services to me or on my behalf.

☒ Other ______________________________
(NAME OF FACILITY, AGENCY, MENTAL HEALTH CENTER, PERSON)

to **disclose/release** the below specified information of:

NAME	DCN	DATE OF BIRTH	SOCIAL SECURITY NUMBER

WHO RECEIVED SERVICES ON (DATES)

To: **(check all that apply)**

☐ Department of Mental Health (DMH) ☐ Department of Health and Senior Services (DHSS)

☐ Department of Social Services (DSS) ☐ Department of Elementary and Secondary Education (DESE)

☒ Other Access II Independent Living Center, Inc
(NAME OF FACILITY, AGENCY, MENTAL HEALTH CENTER, PERSON)

101 Industrial Parkway, Gallatin MO 64640
(ADDRESS, CITY, STATE, ZIP)

THE PURPOSE OF THIS DISCLOSURE IS (CHECK ALL THAT APPLY)

☒ Eligibility Determination ☒ Assessment ☐ Aftercare

☐ Placement ☐ Transfer/Treatment ☐ Treatment Planning

☒ Continuity of Services/Care ☐ Conditional/Unconditional Release Hearing ☒ At Consumer's Request

☒ To share or refer my information to other Missouri state agencies (such as DMH, DHSS, DSS, DESE, DOC, MVC, etc.) to obtain services consistent with the Independent Living Services program (please complete the name of the program in which you want to participate)

☐ Other (specify) ______________________________

☐ Do a general medical evaluation, psychological evaluation, orthopedic evaluation, or ______________ evaluation, and, if applicable, complete the enclosed IM-60A. The examination may include test(s) which are indicated by the patient's complaints and are necessary before you can reach a decision on his/her employability. The examination is scheduled for ______________ at __________. The Family Support Division will honor a physician's usual and customary charges, up to but not exceeding our professional reimbursement schedule. If, in your opinion, the patient must be hospitalized in order for you to complete this medical report, Prior Written Authorization by the State Medical Review Team must be given before payment will be made by the Family Support Division.

THE SPECIFIC INFORMATION TO BE DISCLOSED IS (CHECK ALL THAT APPLY)

☐ Discharge Summary ☐ Progress Notes ☐ Treatment Plan and/or Review

☐ Social Service Assessment ☐ Educational testing, IEP, transcript, and/or grading reports protected by 34 CFR Part 99

☐ Medical/Psychiatric Assessment(s), and, if applicable, complete the certification section of the enclosed IM-60A.

☐ Psychometric testing, including intelligence quotient (IQ) results, neurological testing, or other developmental test results.

☒ Other Any information that may be pertinent with my enrollment in Independent Living

☐ Hospital's Pertinent data: History and Physical, Discharge Summary, Consultative Exams, Lab Reports, Radiology Reports including MRI and CT Scans, Cardiology Records, Operative Reports, Pathology Reports, and Emergency Room Records

1. **READ CAREFULLY:** I understand that my medical/health information records are confidential. I understand that by signing this authorization, I am allowing the release of any and all of my medical/health information whether past, present or created in the future up to the expiration or revocation date of this authorization, unless otherwise indicated. The protected health information (PHI) in my medical record includes mental/behavioral health information. In addition, it may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), and/or other communicable diseases or environmental diseases and conditions.
2. This authorization includes both information presently compiled and information to be compiled during the course of treatment at the above-named facility or agency paying for services, during the specified time frame.
3. Unless otherwise indicated, this authorization become effective on the date of signature below and will expire one year from that date.
4. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so **IN WRITING** and present my written revocation to the health information management department (medical records) or client information center at this facility. I further understand that actions already taken based on this authorization, prior to revocation, will **NOT** be affected.
5. I understand that I have the right to receive a copy of this authorization. **A photographic copy of this authorization is as valid as the original.**
6. I understand that authorizing the disclosure of this medical/health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may request to inspect or request a copy of information to be used or disclosed, as provided in 45 CFR Section 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my medical/health information, I can contact the health information management director (medical records director) or client information center, or designee, or the Privacy Officer for this covered entity.

MY SIGNATURE BELOW ACKNOWLEDGES THAT I HAVE READ, UNDERSTAND, AND AUTHORIZE THE RELEASE OF MY PHI.

SIGNATURE OF CONSUMER	DATE
WITNESS	DATE
SIGNATURE OF PARENT/LEGAL GUARDIAN/REPRESENTATIVE	

(Please include a Description of Authority to Act on Consumer's Behalf and attach a copy of the Document Granting Authority, where applicable)

AUTHORIZATION TO DISCLOSE SUBSTANCE ABUSE TREATMENT INFORMATION

Alcohol and drug abuse treatment records are specifically protected by federal regulations (42 CFR Part 2) and by signing in the block below, I am allowing the release of any alcohol and/or drug information records (if any) that I may have to the agency or person specified on this form. Prohibition of Redisclosure: Federal regulations (42 CFR Part 2) prohibit the recipient of substance abuse treatment records from making further disclosure of those records without the specific written authorization of the person to whom those records pertain, or as otherwise specified by such regulation. A general authorization for disclosure of medical or other information is NOT sufficient for this purpose. Sign below **if you wish to authorize** the release of **alcohol and drug abuse information.**

SIGNATURE OF CONSUMER	DATE

NOTICE OF REVOCATION

DATE

I, ______________________________ , (Consumer) hereby revoke my authorization of this disclosure of information to the agency/person listed above. This revocation effectively makes null and void any permission for disclosure of information expressly given by the above authorization. I understand that any actions based on this authorization, prior to revocation, will not be affected.

SIGNATURE OF CONSUMER	DATE
WITNESS	DATE
SIGNATURE OF PARENT/LEGAL GUARDIAN/REPRESENTATIVE	DATE

If you choose to revoke your authorization, please provide a copy of the completed revocation to the health information management director (medical records director), or the client information center, or to the Privacy Officer of this facility.