Unity Care Group LLC Intake Information

Client Name:________________________ DOB:______________________ Today's Date_________________

Address:____ City:_________________ Zip:_____________

Phone: ________________________ Medicaid#: ________________________ SS# : _________________

Sex: M___ F___ Other___ Marital Status: S___ M___ D___W___ Guardian: Self______ Other______

Guardian Name :__________________________________ Address: ___________________________________

City: ______________________ Zip:_____________

Client Lives With: Family:__ Residential:__ Roomates:___ Independent/Own home/Apartment___

Residential Provider Name/Company Name: ____

Residential Contact Name:__________________________ Residential Contact #______________________

Primary Physician: __________________________ Primary Diagnosis:________________________________

Secondary Diagnosis:______________________ Medical Needs: ____________________________________

Team Member Name	Phone	Email Address

Medication	Dosage & Route	Reason	Taken While Attending Day Services?

Adaptive Equipment Used:

____

____

Eating Assistance Needed? Minimal: ___ Moderate: ___Total: ___ Independent: ___ Tube Feed ___

Personal Care Needs: Some Assistance: ___ Total Assistance:___ Independent: ___

1 Person Assist/Lift: ____ 2 Person Assist/Lift:____ Mechanical Lift:___

Any Behavioral Concerns?
Describe:____
____
____

Coping Activities/Behaviors?
____
____
____

Funding Source: IO Waiver___ Level One Waiver___ OHC___ Self___ Transition Supports___ FSS___

Private Pay___ Passport ___ HS Levy___ Other___ Source:_______________________

DODD Eligible? Y__ N__ Processing___ County: Montgomery __ Butler __ Warren __ Miami __

Other_______________

Acuity Score: _________ Alone Time: ________ Photo Release: Y__ N__

Transportation: Unity Care Group LLC __ Private Provider ___ Family ___ Project Mobility ___

Other_______________

Ethnicity: Black ___ White ___ Hispanic/Latinx ___ Native American ___ Other ______________

Religious Accommodations/Preferences? ____

Disabled Before Age 22: Y__ N__

Disability: Cerebral Palsy __ Down Syndrome __ ASD __ Muscular Dystrophy __ Visual Impairment __

Hearing Impairment __ Developmental Disability__ Developmental Delay __

Acquired Disability (after age 22) __ TBI __ Mental Health Diagnosis? Y__ N__ _______________

Referred By: County Board __ Family __ Friend __ Other __

Forms Required: HIPAA __ Medical Summary (signed by doctor, less than 12 months old) ___

Medication Order (if medication administered at UCG) ___ Photo Release ___ ISP __

Client Rights Signature Page __ Authorization of Release of Information Form ___

Emergency Contact Form ___ PRN Medication Form ___ Guardianship Document ___

FOR OFFICE USE ONLY:

Behavioral Concerns:

____

____

____

Medical Concerns:

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____

____

Staffing Concerns:

____

____

____

Transportation Concerns:

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____

____

Approval of Attendance by Admissions Team:

______________________Approve/Deny ______________________Approve/Deny

______________________Approve/Deny ______________________Approve/Deny

Reason for Denial: ____

Approval is Pending Awaiting:

Additional Information:

____

____

Medication/Medical Equipment:

____

____

Necessary Completed/Signed Forms:

____

____

CEO: ______________________ Program Director: ______________________

Unity Care Group LLC Day Services Medical Summary

Name ______________________ DOB __________ Medicaid # ______________

Diagnosis ______________________________ Date of Onset ________________

At Birth? (Circle One) Yes /No Did the disability occur before the age of 22? (Circle One) Yes /No

Will the disability continue indefinitely? (Circle One) Yes / No

Height __________ Weight ________ BP __________ Pulse _______ Vision _______

History of Seizures? (Circle One) Yes / No Date seizures began __________

Seizure Type (Circle) Focal Aware, Focal Impaired Awareness, Focal to bilateral tonic clonic, generalized onset, tonic clonic, tonic, atonic, myoclonic, absence, grand mal, petite mal

Seizure frequency

____

____

Seizure Triggers

____

____

Diet

____

____

Allergies____

____

Surgeries / Hospitalizations

____

____

____

Immunization History:

Type	Date	Date	Date	Date	Date
DTP					
DT					
Polio					
Polio Booster					
Rubeola					
Rubella					
Influenza					
Pneumonia					
Shingles					
Last Tetanus?					
TB Test					
TB Chest X-Ray					

Adaptive Equipment (please list)

____

____

____

Current Medications:

Name	Reason	Dose/Route	Freq/Time	Side Effects

Physical Assessment:

	Normal	Abnormal	List Findings:
General Appearance			
Skin			
Nose / Throat			
Eyes			
Ears			
Teeth			
Chest / Lungs			
Breast			
Heart			
Abdomen			
Spine / Skeletal			
Extremities			
Hernia			
Genito - Urinary			
Anorectal Exam			
Mental Health			
Intellectual/Emotional Status			

Urinalysis	Sugar	Albumin

Gynecological:	Pelvic:	Breast:	Pap Results:

Physical Limitations: (check if limitation is applicable)

Lifting: Very Light (10lbs) ____ Light (25lbs) _____ Moderate (40lbs) _____

Standing: Limited to 25% of time _____ Limited to 50% of time ____ Limited to 75% of time ____ No standing ____

Other: Walking ____ Bending ____ Bending & Lifting ____ Climbing ____

Limited/Restricted on: Left Side ____ Right Side ____ Both ____

Needs Close Supervision ____ Activity requiring manual dexterity ____ Activity above shoulder ____

Paced activity or nervous tension ____

Conditions to be avoided: Water on hands continually ____ Excessive temperature changes ____ Air Conditioning ____

Excess dust ____ Rubber gloves ____ Cotton gloves ____ Latex ____ Adhesives ____

Date_______________

Physician Name (Print) ____

Physician Signature ____

Unity Care Group LLC Day Services PRN Medication Authorization

Individual Name ______________________________ DOB______________

***Physician: Please check PRNs which have your approval**

***Medication Administration Certified Staff: Follow dosage instructions on medication label or container. Be sure to document on PRN medication sheet.**

___ Antacid

___ Antibiotic Ointment/Cream

___ Aspirin

___ Acetaminophen

___ Ibuprofen

___ Hydrocortisone Cream

___ Cough Medicine

___ Cold Medicine

___ Eye Drops

___ Nasal Spray

___ Sunscreen

___ Bug Repellant (DEET Free)

___ Other Physician approved PRN OTC medication:

____

____

____

Additional Comments / Instructions:

____

____

Physician Signature______________________________ Date ____________

HIPAA PRIVACY POLICY AND CONSENT

I understand I have certain rights to privacy regarding my health and medical information though the Health Insurance Portability and Accountability Act of 1999 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Program development based on my physical/developmental abilities.
- Communication with members of my team listed on my authorization release regarding information related to my disabilities.
- Day to day operation of day services.

I have also been informed I have the right to review and secure a copy of your Notice of Privacy Practices which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out programming, payment and health operations, but that you are not required to agree to these requested restrictions.

I understand that I may revoke this consent in writing at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Individual Signature ______________________________ Date ____________

Guardian/Authorized Rep.______________________________ Date____________

UNITY CARE GROUP LLC EMERGENCY CONTACT FORM

Individual Name: ______________________________ Date: ____________________________

*In the event of an emergency, the following information is required for each individual participating in UCG LLC Day Services:

Emergency Contact 1:______________________________ Phone # _____________________

Emergency Contact 2: ______________________________ Phone # _____________________

*By Signing this document, you authorize Unity Care Group LLC Day Services to make these contacts.

Individual Signature: ______________________________________

Guardian Signature : ______________________________________

Notice of Rights Distribution

Unity Care Group LLC Day Services has provided me with a copy of my rights as outlined in the Ohio Revised Code. I can request a copy of and/or have my rights explained to me at any time during day services or during my team/ISP meetings.

Individual Signature ______________________________ Date __________

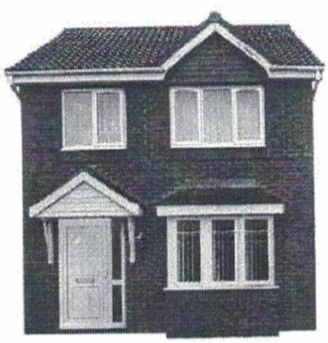
Guardian/Authorized Rep ______________________________ Date __________

Bill of Rights for People with Developmental Disabilities

An Easy Read Guide

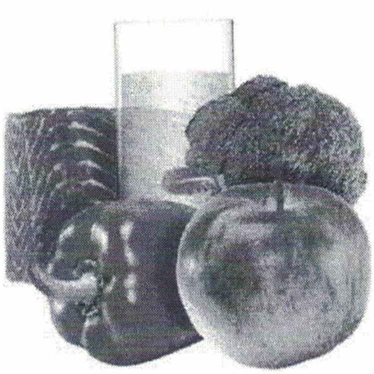
from Ohio Revised Code 5123.62

1. You have the right to be treated with respect.



2. You have the right to a clean, safe place to live.

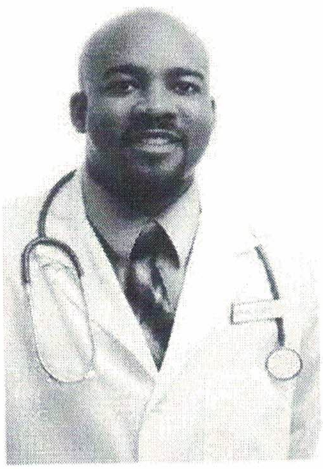
   And you have the right to a place to be alone.



3. You have the right to have food that is good for you.

4. You have the right to go to a church, synagogue or mosque if you want to.

   And you have the right not to go to one if you don't want to.

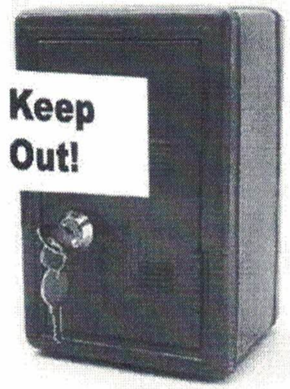


5. You have the right to go to a doctor or dentist when you need to.

6. You have the right to get other health care services, like speech therapy or physical therapy if you want to.

   And you have the right to get mental health services if you want to talk about your feelings.

7. You have the right to get these services in a way that makes you feel comfortable.



8. You have the right to be alone sometimes.

   And you have the right to keep some things private if you want to.

9. You have the right to talk to other people.

10. You have the right to have your own things.

    And you have the right to use your things.

11. You have the right to have men and women as friends.

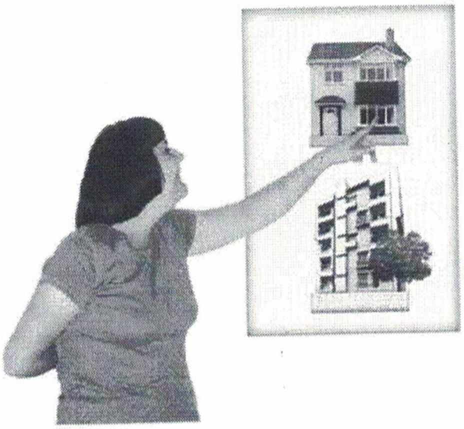
12. You have the right to do things that help you reach your goals.

13. You have the right to work and make money.

14. You have the right to be treated fairly.

15. You have the right to live without bullying or abuse.

16. You have the right to do things you enjoy.



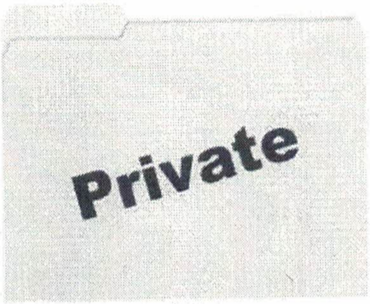
17. You have the right to help make decisions that affect your life.

18. You have the right to choose someone to help you make decisions.

19. You have the right to earn money and pay your bills.

You have the right to save your money and to spend your money.

And you have the right to choose someone to help you with your money.



20. You have the right to say who can see information about you and your disability.

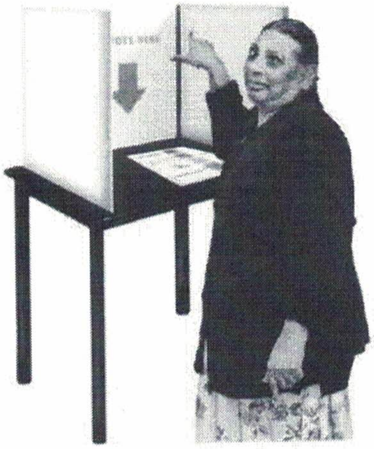
21. You have the right to ask for changes when you don't like something.

And you have the right to ask for changes without being afraid of getting into trouble.

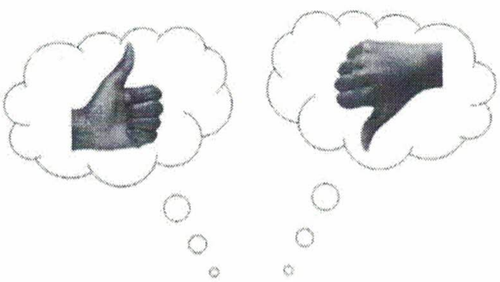
22. You have the right to refuse to take medicine you don't think you need.

You have the right to be in control of your own body.

You have the right not be held down if you are not hurting yourself or someone else.



23. You have the right to vote and to learn about laws.



24. You have the right to decide if you want to take part in a study or an experiment if someone asks you to.

You have the right to say no to taking part in a study or experiment.

Release of Information

Participant Name ______________________________________ DOB _________________________

I give UCG Day Services permission to communicate with the following individuals in order to provide continuity of care and share documents and pertinent information as needed:

SSA______________________________

Provider/Agency_________________________________

Family Member/Advocate_____________________________

Family Member/Advocate_____________________________

Physician_______________________________________

Physician_______________________________________

Other____

This release is good for one year from the date signed. At any time, the participant and/or guardian may decide they no longer want one or all of the entities to share information. At that time, the participant and/or guardian will provide written notice of the revocation.

Participant Signature____ Date ____________________

Guardian Signature ____ Date ____________________

This document grants Unity Care Group LLC Day Services authorization to use my likeness in a photo__, Video __, any UCG LLC publications including we based publications (UCG Facebook page, UCG website, etc.) __, without payment of other consideration.

I understand and agree that all photos will become the property of Unity Care Group LLC Day Services.

I authorize Unity Care Group LLC Day Services to edit, alter, copy, exhibit, publish or distribute these photos for any lawful purpose. I waive any right to inspect or approve the product where my likeness appears. I waive any right to royalties or other compensation arising from or relating to the use of these materials.

___ I do NOT authorize the use of my photos.

___ You must contact me to allow me to view the photo you want to use prior to posting or printing

I have read and understand the terms of this agreement. If I am not my own guardian, I understand my guardian must sign this document to authorize the above.

Individual Signature: ______________________________________ Date: ______________

Guardian Signature: ______________________________________ Date: ______________

Holidays

The Day Program will be closed on the following days:

New Year's Eve

New Year's Day

Memorial Day

Independence Day

Labor Day

Thanksgiving Day

Day after Thanksgiving

Christmas Eve

Christmas Day

UNITY CARE GROUP LLC DAY SERVICES

RIGHT TO WAIVE 30 DAY NOTICE

Unity Care Group LLC Day Services strives to provide a comfortable, peaceful and safe environment for the people we serve each day.

If your attendance in our facility becomes a health and safety issue for you or others we serve, we will communicate and/or meet with your team to brainstorm ways to improve your experience with us to make it as beneficial as possible for you and all of those in attendance.

However, if we find that it simply isn't safe or comfortable for you and others we serve for you to continue your attendance, we will ask that you and your team search for another day service that can better meet your needs.

By signing, you acknowledge you understand this policy and accept these terms.

Individual Signature ______________________________ Date ____________

Guardian/Authorized Rep______________________________ Date ____________

Unity Care Group LLC Day Services – Requirements to Begin Services

- Current Medical Summary (within one year)
- Current med orders signed by doctor (if medication taken at UCG)
- Completed intake packet/information
- Most current ISP
- Most current acuity assessment
- Any other pertinent information, assessments, etc.
- Transportation and/or home provider information (if different from UCG)
- Confirmation of UCG on the PAWS so billing is not delayed
- State ID
- Medicaid Card and other Insurance cards
- Guardianship information/documents