Venture
COMMUNITY SERVICES

# VENTURE COMMUNITY DAY PROGRAM SERVICES APPLICATION

Please complete the Day Program Services Application Packet and attach the necessary assessment, reports, etc. and return to the program. The Habilitation Services Interdisciplinary Team will review all of the information that is submitted for review. Determination for services is based on the Habilitation Services admission criteria and availability of service slots. Prospective participants are encouraged to visit the service and meet with the habilitation staff. Individuals applying for services will be notified as soon as possible regarding their status. Thank you for considering Venture Community Services, Inc. to provide services.

Please Check Habilitation Services Applying for:

☐ Habilitation Services/Medical Assistance Program (Medicaid)

☐ Habilitation Services/Alternative Funding

*Applicant:*

| NAME: | MASS HEALTH CARD NUMBER: | DATE OF BIRTH: |
|---|---|---|
| | | |

| ADDRESS: | CITY: | STATE: | ZIP: | PHONE: |
|---|---|---|---|---|
| | | | | |

| SOCIAL SECURITY NUMBER: | LANG. SPOKEN | HEIGHT | WEIGHT | EYE COLOR | HAIR COLOR | SEX: |
|---|---|---|---|---|---|---|
| | | | | | | □ M □ F |

| DISTINGUISHING MARKS | ☐ DDS ☐ MASS. COMM. FOR BLIND<br>☐ MEDICAID ☐ PRIVATE ☐ OTHER |
|---|---|
| | |

| DDS SERVICE COORDINATOR | PHONE: |
|---|---|
| | |

*Developmental History:*

PLEASE MARK PRIMARY DIAGNOSIS WITH A P AND SECONDARY DIAGNOSIS WITH AN S:

| | | |
|---|---|---|
| _____ Mental Retardation | _____ Visual Impairment | _____ Head Injured |
| _____ Cerebral Palsy | _____ Orthopedic Impairment | _____ Learning Disabled |
| _____ Autism | _____ Psychiatric Disorder | _____ Seizure Disorder |
| _____ Behavior Disorder | _____ Substance Abuse | _____ Other Disability |

PLEASE DESCRIBE

| WHEN WAS DIAGNOSIS FIRST MADE? | CAUSES IF KNOWN |
|---|---|
| | |

*Placement History:*

LIST SCHOOLS, PROGRAMS, INSTITUITIONS, ETC. IN WHICH THE PERSON WAS ENROLLED DATES

_____

_____

_____

_____

*Services the Person is Currently Receiving:*

| NAME OF ORGANIZATION | CONTACT PERSON |
|---|---|
| | |

| ADDRESS | CITY | STATE | ZIP | PHONE |
|---|---|---|---|---|
| | | | | |

| DESCRIPTION OF PROGRAM | HOURS |
|---|---|
| | |

| INDIVIDUAL'S ADJUSTMENT |
|---|
| |

| TRANSPORTATION | ADAPTIVE EQUIPMENT NEEDED | SPECIAL SERVICES/THERAPIES NEEDED |
|---|---|---|
| | | |

*Assessments:*

PLEASE INDICATE IF THE FOLLOWING ASSESSMENTS
HAVE BEEN PERFORMED. Please attach reports if applicable

DATES:

☐ Yes ☐ No Speech _____

☐ Yes ☐ No Psychological _____

☐ Yes ☐ No Occupational Therapy _____

☐ Yes ☐ No Physical Therapy _____

☐ Yes ☐ No Vocational _____

LIST THE INTERESTS OR THINGS THE PERSON LIKES TO DO:

_____

_____

_____

_____

_____

PLEASE INDICATE IF THE FOLLOWING APPLY:

| Yes | No | Partial | | Comments |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | Able to feed self | |
| ☐ | ☐ | ☐ | Incontinence | |
| ☐ | ☐ | ☐ | Pedestrian Safety Knowledge | |
| ☐ | ☐ | ☐ | Knowledge of Immediate Neighborhood | |
| ☐ | ☐ | ☐ | Knowledge of Town/Community | |
| ☐ | ☐ | ☐ | Response to Potentially Dangerous Situations | |
| ☐ | ☐ | ☐ | Fire Safety Knowledge | |
| ☐ | ☐ | ☐ | Telephoning | |
| ☐ | ☐ | ☐ | Ability to Make Emergency Calls | |
| ☐ | ☐ | ☐ | Verbal | |
| ☐ | ☐ | ☐ | Ambulatory | |
| ☐ | ☐ | ☐ | Able to make needs/wants known | |

*Primary Care Physician*

| NAME: | PHYSICIAN PROVIDER NUMBER: | PHONE: |
|---|---|---|

| STREET: | CITY: | STATE: | ZIP: | # OF YRS WITH MD |
|---|---|---|---|---|

*Emergency Contact Person (s)*

| PRIMARY EMERGENCY PERSON: | RELATIONSHIP: | DAYTIME PHONE: |
|---|---|---|

| STREET: | CITY: | STATE: | ZIP: |
|---|---|---|---|

| ALTERNATIVE EMERGENCY PERSON: | RELATIONSHIP: | DAYTIME PHONE: |
|---|---|---|

| STREET: | CITY: | STATE: | ZIP: |
|---|---|---|---|

*Family History*

| MOTHER'S NAME | PHONE |
|---|---|

| EMAIL ADDRESS: |
|---|

| STREET: | CITY: | STATE: | ZIP: |
|---|---|---|---|

| FATHER'S NAME | PHONE |
|---|---|

| EMAIL ADDRESS: |
|---|

| STREET: | CITY: | STATE: | ZIP: |
|---|---|---|---|

| DESCRIBE FAMILY INVOLVEMENT: |
|---|

| LIST OTHER FAMILY MEMBERS, FRIENDS OR ADVOCATES: |
|---|
| |

| HAS A LEGAL GUARDIAN BEEN APPOINTED?<br>☐ Yes ☐ No | IF YES, NAME OF GUARDIAN: |
|---|---|
| | |

| STREET | CITY | STATE | ZIP | PHONE |
|---|---|---|---|---|
| | | | | |

| EMAIL ADDRESS: |
|---|
| |

| OTHER COMMENTS: |
|---|
| |

| SIGNATURE OF PERSON COMPLETING FORM: | DATE: |
|---|---|
| | |

Venture
COMMUNITY SERVICES

# AUTHORIZATION FOR EMERGENCY MEDICAL CARE

I, _____ hereby grant authorization to Venture Community Services, Inc. to take whatever measures that are necessary to provide hospitalization and medical care including surgery, in case of emergency for _____/ Date of Birth _____
while being served by Venture Community Services, Inc.

This authorization is valid only in situations requiring emergency care as directed by a qualified physician.

This authorization is not to be construed as covering non-emergency surgery or hospitalization.

This authorization is valid for one year from the date indicated below.

Signed _____ Date _____

*Name*

Signed _____ Date _____

**Legal Guardian*

**Every reasonable effort will be made to contact the legal guardian in the case where an emergency medical care situation arises while a person is receiving services from Venture Community Services Inc.*

Venture
COMMUNITY SERVICES

## PHYSICIAN'S APPROVAL FOR ATTENDANCE

To: _____

Our records indicate that the following individual is currently under your care. Please complete the following information and return with a copy of the recent physical (less than one year old) as this is necessary for our records.

_____, DOB_____ has been accepted to our Community Day Program.

This program provides day services between the hours of 8:30 a.m. and 2:30 p.m., which includes Occupational, Physical and Speech Therapy as well as adult daily living skills.

Please check one of the following:

☐ This individual would benefit from Day Habilitation Services

☐ This individual would benefit from Day Habilitation Services with the following restrictions:

_____

_____

Please indicate diagnosis code:

☐ F70 Mild intellectual disabilities ☐ F71 Moderate intellectual disabilities

☐ F72 Severe intellectual disabilities ☐ F73 Profound intellectual disabilities

☐ Other (please indicate)_____

_____ _____ _____

Physician's Signature NPI Number Date

*Thank you in advance for your cooperation in this matter.*

Venture
COMMUNITY SERVICES

## ADMINISTRATION OF MEDICATIONS/TREATMENTS

Name: _____ Date of Birth: _____

Address: _____

_____

Telephone: _____

Physician's Name: _____

Address: _____

_____

Telephone: _____

| Medication | Dosage | Route/Time of Administration at Program |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

☐ May administer medication with food

Other medications currently being administered at home:

*This is to certify that the above medication orders are correct and current.*

Signature: _____ Date: _____

Venture
COMMUNITY SERVICES

# INDIVIDUALIZED SEIZURE PROTOCOL

NAME_____ DOB_____

TYPE OF SEIZURE_____ DURATION_____
LAST SEIZURE_____
DESCRIPTION_____
_____
_____
_____

## CALL EMS (911)

- If seizure last greater than _____minutes (Venture policy 5 minutes)
- If the individual has one seizure after another **yes** **no**
- If there is a CHANGE in a seizure pattern **yes** **no**
- If the individual has been injured **yes** **no**
- If individual has a seizure who has an INACTIVE pattern (greater than one year)
  **yes** **no**
- Other or any changes to the above statements
  _____
  _____

## CALL NEUROLOGIST

- If the individual experiences _____seizures in 24 hour period
  *(Number)*
- If the individual experiences _____seizures in a week
  *(Number)*

- If the seizure last longer than _____minutes
- If the individual has a seizure who has an INACTIVE pattern ( greater than one year)
  **yes** **no**
- If post seizure behavior ( confusion, agitation, decrease in activity etc.) continues longer than 30 minutes **yes** **no**

Additional
Information_____
_____

Date_____ HCP Signature _____

Venture
COMMUNITY SERVICES

# RELEASE OF INFORMATION CONSENT FORM

Name: _____ Date of Birth: _____

I, (Person Giving Consent): _____,

hereby authorize the release of information relevant to my ongoing care and treatment, to my health care and or service provider (s) as specifically described here:

DDS Doctor_____

Harrington Hospital

I understand that I am able to exercise the following rights:

1) To have my personal data maintained in an accurate, complete, timely and relevant manner.
2) Not to have my personal data disclosed without my consent or consent from my legal guardian.
3) To contest the accuracy, timeliness and relevance of my records.
4) My consent may be withheld or withdrawn at any time with no punitive actions taken against me.

This consent is updated annually, and unless earlier revoked in writing is in effect from:

Date:_____ to _____.

I, _____, hereby give my informed and voluntary consent.

_____ _____

Signature Date Legal Guardian Date

_____ _____

Signature of Securer and Position Date

# NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT PERSONS RECEIVING SERVICES FROM VENTURE MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. What this is: This Notice describes the privacy practices of Venture Community Services Inc.

2. Our Privacy Obligations: We are required by law to maintain the privacy of medical and health information about the people Venture Community Services Inc. serves ("Protected Health Information" or "PHI") and to provide you with this Notice of our legal duties and privacy practices with respect to PHI. When we use or disclose PHI, we are required to abide by the terms of the Health Insurance Portability and Accountability Act (HIPAA) or other notice in effect at the time of the use or disclosure.

Venture
COMMUNITY SERVICES

# Acknowledgement Receipt of Venture's Privacy Protection Policies and Procedures

Person Served by Venture _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT OF VENTURE COMMUNITY SERVICES INC.'S NOTICE OF PRIVACY PRACTICES:

By my signature below, I hereby acknowledge that I have received a copy of Venture Community Services Inc. "Notice of Privacy Practices".

_____

Signature of Person Served by Venture Date

_____

Signature of Legal Guardian, If Appropriate Date

The signed Acknowledgement will be maintained in the individual's case record.

**POLICY NUMBER: 6**

**TITLE:** Informed Consent

**POLICY:** It is the policy of Venture Community Services Inc. to obtain and document informed and voluntary consent from the individuals Venture serves, and where appropriate, an individual's guardian, relative to the following areas:

- Emergency Medical Treatment
- Prior to Routine or Preventative Medical Care
- For each instance of public identification (TV, newspaper, video, etc.)
- When access to a person's record is requested by persons other than authorized Venture employees or a request for record access is made from this agency to another
- Prior to the initiation of a Formal Behavior Plan

**PERSONS RESPONSIBLE:** Chief Executive Officer or their Designee

**REVISED DATE:** March 2, 2006

**PROCEDURE:**

1. Prior to the initiation of Venture services, individuals served by Venture, and their legal guardian, will be asked to give their consent to the following:

   - Authorization for Emergency Medical Care
   - Authorization for Routine or Preventative Medical Care

2. A. Consent for Public Identification:
   Informed consent must be obtained and documented for the individual and his/her legal guardian where appropriate, for each instance of public identification that is requested by an organization other than Venture.

   B. Informed Consent for Public Identification to Publicize and Promote Venture Community Services, Inc.:
   Informed consent must be obtained from the individual and his/her legal guardian where appropriate, on an annual basis for public identification to publicize and promote Venture's mission, purposes and services (i.e. newsletters, annual appeals,
   grant presentations, annual reports, brochures and promotional publications, Venture website, Christmas cards, etc.) which is authorized by Venture

C. Documented Verbal Consent:

In addition, throughout the year, for each instance of public identification, verbal consent is obtained from the individual and their legal guardian as appropriate and documented in the individual's case record.

The Manager or Designee is responsible for obtaining written consent using the Informed and Voluntary Consent for Public Identification Form or the Informed and Voluntary Consent for Public Identification to Publicize and Promote Venture, along with documenting verbal consent for each instance of public identification in the individual's case record using the Verbal Consent Log.

- This same process is followed when a request is made from this agency to another, seeking record access.

3. Informed consent must be obtained when access to an individual's record is requested by persons other than authorized Venture employees. Before informed consent is given, the individual and legal guardian where appropriate, will be provided with the opportunity, if they so choose, to examine the records to be released, and shall be provided with the name of the recipient, what specific information will be released, the date on which consent will expire, the intended use of the information and possible risks, benefits and alternatives to disclosure. The Release of Information Consent Form shall be used by the person seeking consent.

4. An individual and the legal guardian, if appropriate, are requested to sign all Level 1 Behavior Plans. Also signing this document is the Venture Human Committee Chairperson, the Director, the Manager of the service and the Behavior Specialist.

All Informed Consent documents that are signed by an individual, and legal guardian where appropriate, shall be placed in the individual's permanent file.

**POLICY NUMBER: 7**

**TITLE:** Confidentiality and Protection of Privacy

**POLICY:** It is the policy of Venture Community Services Inc. that all information as to the personal facts, records or any case information regarding a person served by Venture is to be held confidential and private at all times.

**PURPOSE:** To assure the confidentiality of all personal facts, records and information regarding persons served by Venture and to comply with the Health Insurance Portability and Accountability Act [HIPAA] Regulation

**PERSONS RESPONSIBLE:** All employees, volunteers and students/interns

**REVISED DATE:** March 2, 2006

**PROCEDURE:** *All Venture employees, volunteers, student/interns sign the Statement of Confidentiality, which is placed in their personnel file. Each person served by Venture and their family or legal representative will be notified of Venture's privacy practices prior to the initiation of services; the signed Acknowledgement Form will be maintained in the individual's file. Venture's practices are available upon request and are displayed in a prominent location.*

1. **Location of Records:** Case Records are maintained in a locked cabinet at 1 Picker Rd.

2. **Maintenance of Records:**

    a. Material to be filed – The Manager oversees this process.
    b. Locking files – All files are maintained in a locking cabinet (s). The Manager or their Designee is responsible for ensuring that all files are in place and that cabinets are locked at the end of each day.
    c. Sign-in, Sign-out sheet – Any person who is authorized to access a file must sign the record in and out specifying the reason for accessing the file in the purpose column.
    d. Returning the records – It is the responsibility of the person who signs out the record to put the file back as soon as possible and to insure the
        - Confidentiality of the file at all times. All records are to be locked by the end of the day.
    e. Purging files – The Manager or their Designee is responsible for the upkeep of the files, and will purge the files on an annual basis. Purged material will be stored under lock in a designated area

## 3. Access

a. Persons served and/or their legal representative may submit a written request to inspect or obtain a copy of the person's case record using the "Access Request Form." An oral request is also acceptable. Venture shall act on the request within 30 days of receiving the request. Authorized Venture Community Services Inc. professional personnel upon request of the person served or legal guardians may provide explanations and interpretation of material contained within.

b. In all other instances, the Manager authorized access to an individual's case record. The scope of an employee's access is limited to that amount of information necessary to accomplish their job.

c. Students, interns and volunteers as a general rule will not have access to the case record except under special circumstances as deemed appropriate by the Manager and authorized by the person served.

d. "Business Associates" pursuant to the Health Care Insurance Portability and Accountability Act are required to sign an agreement regarding the protection of health care information that they may have access to in the course of doing business with Venture. For example, an accreditation or licensing agency, an accounting or auditing firm or legal counsel.

## 4. Release of Information

a. The person served and/or the legal guardian may authorize the review or release of information contained in the case record, to any person or agency not affiliated with Venture Community Services Inc., upon Venture's receipt of the *Release of Information Form* signed by the person served and/or legal guardian as appropriate.

b. All releases must indicate the person or agency representative who will review the information, the type of information requested, the date of access and the expiration of the release of information, the purpose for which the information is used and the extent of any further released information.

## 5. Content of Information

a. The case record will include all information pertinent to services for an individual. The case record includes the official documents reflecting the individual choices and decisions, needs, and current status of each person served by Venture Community Services Inc. The case record is kept current, complete and accurate.

## 6. Amendment of the Case Record at the Person's Served and/or Legal Guardian's Request

a. All persons served and/or legal representative, as applicable, may request in writing that information contained within the file be amended if the above-mentioned persons believe that the information is inaccurate, misleading or in violation of the person's rights. Requests will be submitted on the "Request for Amendment Form" to the Manager. The Request will be acted upon within 60 days of receipt of the Request. The Director of the service will make the final decision.

b. If the record is amended, the original record will not be erased or altered. Instead, a new page will be inserted which is dated, initialed by the Director and labeled as an amendment. The original sections should be marked with the phrase "do not copy."

c. If Venture Community Services Inc. believes that the record is accurate and complete and the decision is made not to amend the information in question, the person requesting the amendment will be notified in writing of the decision and will be advised of his/her rights to a hearing through a written outline of the complaint procedure.

d. A complaint may also be filed with the Department of Developmental Services and a copy sent to the Venture Human Rights Committee.

**7. Verbal Exchange of Information**

a. Individual person's status or needs are to be discussed with directly involved service staff and/or other appropriate team members only in order to perform their jobs.
b. It is the responsibility of all staff to be aware of where such discussions are held and that all such conversations are private and out of "ear shot" of other persons served.

**8. Informed Consent (Refer to Venture Policy Number 6 for the Policy in its entirety)**

a. It is Venture's policy to obtain informed and voluntary consent from the individuals Venture serves and where appropriate, an individual's legal guardian, whenever access to the case record is requested.

**9. Right to Receive an Accounting of Disclosures**

a. Upon written request, a person served by Venture and/or their legal representative may obtain an accounting of disclosures.

**10. Permissible Uses and Disclosures Not Requiring Consent or Authorization**

a. As authorized by state and federal laws: Payment for services rendered from Medicaid, the Department of Mental Retardation, etc., public health activities, health oversight activities, judicial and administrative proceeding in response to a legal order, law enforcement officials, health or safety emergency, and any other instances when required to do so by any other law not already referred to in this policy.

**REPORT/RECORD REQUESTED FROM:** the Department of Developmental Services

| | |
|---|---|
| _____MEDICAL | _____PSYCHOLOGICAL |
| _____DENTAL | _____HOSPITALIZATIONS |
| _____OPHTHALMOLOGICAL | _____PROGRAM/EDUCATION |
| _____AUDIOLOGICAL | _____EMPLOYMENT/TRAINING. |
| _____FAMILY, SOCIAL HISTORY | _____TREATMENT HISTORY |
| _____TERMINATION SUMMARY | _____OTHER, PLEASE SPECIFY |

_____

_____

_____

*Requested by:*

AGENCY: Venture Community Services, Inc.

NAME:_____ POSITION:_____

SIGNATURE:_____

# MEMORANDUM

TO: INDIVIDUALS AND THEIR FAMILIES WHO RECEIVE SERVICES FROM VENTURE

---

This packet of information is being sent to you in compliance with the federal law, the *HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA).* The purpose in sending you this information is to provide you with Venture's policies and procedures regarding confidentiality, and the protection of privacy for each person served by Venture, pursuant to the regulations.

We would appreciate it if you would read through this important material; then sign and return the Acknowledgement Form at your earliest convenience for our records to comply with the HIPAA Regulations. If you have any questions or concerns, please feel free to contact us.

Thank you for your time.

**VENTURE COMMUNITY DAY SERVICES**

**LEGAL GUARDIAN AUTHORIZATION FOR ADMINISTRATION OF MEDICATIONS/TREATMENTS**

Name: _____ Date of Birth: _____

Address: _____

_____

Telephone: _____

Physician's Name: _____

Address: _____

_____

Telephone: _____

| Medication | Dosage | Route/Time of Administration at Program |
|---|---|---|
| Acetaminophen<br>*For fever over 100 or discomfort* | 1000mg | P.O / PRN q6 |
| Mylanta<br>*For upset stomach* | 30 cc | P.O / PRN q4 |
| Triple Antibiotic Ointment<br>*For minor scrapes/abrasions after cleaning* | Small Amount | Topical / PRN q4 |
| Hydrocortisone Cream 1%<br>*For rash/itchy skin areas* | Small Amount | Topical / PRN q4 |
| | | |

*I hereby consent to the Venture Community Day Services certified staff to administer this medication/treatment for above named participant.*

Legal Guardian Name: _____

Legal Guardian Signature: _____ Date: _____