

Personal Information

Name of Person Served: _____ Preferred name or nickname: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Pager Number: _____ Cellular Phone: _____

Email address: _____ Gender: _____

Date of Birth: _____ Social Security #: _____

Do you have interest in receiving general emails about community activities or resources related to your needs: Y or N

Family &/ or Legal Guardian Contacts

Parent/ Guardian Name: _____ Home Phone: _____

Parent/ Guardian Street Address: _____ City: _____ State: _____ Zip: _____

Work Phone: _____ Pager/ Cellular: _____

Email address: _____

Do you have interest in receiving general emails about community activities or resources related to your needs: Y or N

Additional Parent/ Guardian Name: _____ Home Phone: _____

Additional Parent/ Guardian Street Address: _____ City: _____ State: _____ Zip: _____

Work Phone: _____ Pager/ Cellular: _____

Email address: _____

Do you have interest in receiving general emails about community activities or resources related to your needs: Y or N

Educational Contacts

Presently attending school: No ___ Yes ___ If yes, please complete the following:

School Attending: _____ Local School District: _____

Present Grade Level: _____ Teacher of Record: _____

If not currently attending, last school attended _____ When? _____

May we contact your school and/ or teacher for coordination of services? No ___ Yes ___

Health &/ or Medical Care Contacts

General Physician: _____ Phone: _____

Primary Psychiatrist: _____ Phone: _____

Preferred Hospital: _____ Phone: _____

Dentist: _____ Phone: _____

Primary Insurance: _____ Policy #: _____

Secondary Insurance: _____ Policy #: _____

Medical Diagnosis: _____

Allergies: _____ Last Tetanus Immunization: _____

Other Individuals Involved in the Care of Person Served

(ie: case managers, therapists, physicians, employers, friends, extended family, neighbors, etc.)

Name: _____ Relationship to Person Served: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Pager: _____

Cellular Phone: _____ Email address: _____

Name: _____ Relationship to Person Served: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Pager: _____

Cellular Phone: _____ Email address: _____

Name: _____ Relationship to Person Served: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Pager: _____

Cellular Phone: _____ Email address: _____

Consent for Services: As part of informed consent, the terms of services have been explained to me and I agree to them as a client receiving support services from Connections. I have also been made aware that other providers of similar services exist in my community and have, with this knowledge, made an informed choice of Connections, Inc. to provide for my service needs.

Please check if: Accepted: _____ or Declined: _____ Initials: _____

Agreement for Medication Administration: I authorize the staff of Connections, Inc. to administer prescribed medications to the named individual in accordance with the written orders of the prescribing physician. I understand that a written order from the physician must be provided in order for medications to be given by a Connections employee or agent. I further agree to utilize the preferred pharmacy services of Connections, Inc. to fill my prescription order if any Connections employees or agents are to administer medications to the named individual.

Please check if: Accepted: _____ or Declined: _____ Initials: _____

Consent for Personal Health Care Assistance: In the case of an emergency or as required for daily routine health care, I give Connections, Inc. permission to assist with physical care for the purposes of providing quality supports and assuring good health and hygiene. I understand that, at times, Connections, Inc. staff may be required to provide physically invasive care in the following areas: bowel, bladder, genital, dental, hair, and nail care; as well as, general bathing. As such, I agree to the rendering of these services as needed for acceptable health care.

Please check if: Accepted: _____ or Declined: _____ Initials: _____

Consent for Emergency Treatment: In case of an emergency, if I can not be reached and the emergency persons named above can not be contacted, I hereby give my permission for Connections, Inc. staff to secure medical treatment and/ or hospitalize _____. Connections, Inc. staff is relieved of all legal liability which may result from such services. Expenses for medical services will be the responsibility of the client served and/ or parent/ guardian or their health insurance company. Furthermore, I understand it is the policy of Connections, Inc. to provide life-prolonging medical treatments until the proper medical personnel arrived. In the event an Advance Directive is in place and attached to this consent, the Advanced Directive will be given to the emergency medical personnel.

Please check if: Accepted: _____ or Declined: _____ Initials: _____

I attest the proceeding information is complete and accurate:

Person to be served (print full legal name) _____ Date: _____

Person Served/ Parent/ or Legal Guardian Signature: _____ Date: _____

Connections Witness Signature: _____ Date: _____

Acknowledgement of Confidentiality Rights: I have been informed that the confidentiality of all client records maintained by Connections, Inc. is protected by State and Federal law which prohibits disclosure of any information with the following exceptions: written consent of the client or guardian, court order, information about suspected abuse or neglect of a minor child or dependent adult, information about the client threatening to harm self or others. I have also received a statement of my privacy rights as required by the Health Insurance Privacy Portability Act.

Please check if: Accepted: _____ or Declined: _____ Initials: _____

Acknowledgment of Individual Rights: I have been presented with the Notice of Individual Rights concerning the services I am to receive from Connections, Inc. I understand that any questions or concerns I may have about these notices can be directed to the appropriate staff or leadership of Connections, Inc.

Please check if: Accepted: _____ or Declined: _____ Initials: _____

Agreement for Financial Responsibility: I authorize Connections, Inc. to release any information necessary to process my insurance and/ or third party claims and benefits. I authorize payment directly to Connections for these benefits. I further understand I am responsible for any co-pays, deductibles, non-allowed, or non-covered services which I authorize. In addition, I authorize Connections, Inc. to utilize and release information for third party payer purposes and audit as required.

Please check if: Accepted: _____ or Declined: _____ Initials: _____

Agreement for Transportation: I authorize Connections, Inc. to transport the named individual in a privately owned vehicle during hours of service. I understand a Bureau of Motor Vehicles driving record check is mandatory for all Connections, Inc. staff authorized to drive upon hire.

Please check if: Accepted: _____ or Declined: _____ Initials: _____

I attest the proceeding information is complete and accurate:

Person to be served (print full legal name) _____ Date: _____

Person Served/ Parent/ or Legal Guardian Signature: _____ Date: _____

Connections Witness Signature: _____ Date: _____

The following rights are provided to all persons served and/ or their legal representatives in accordance with all Federal, State, and local regulations governing our services:

1. **You have the rights guaranteed by the Constitution of the United States and the Constitution of the State of Indiana:** As a participating member of our community, persons served shall have all rights afforded them under local, State, and Federal laws and regulations.
2. **You have the right to individual support services in the least restrictive setting:** All services rendered by Connections, Inc. will be provided with the personal needs of those served as our primary consideration. As directed in our mission statement, our services will be provided in natural, community based settings as allowed by our regulatory authorities and your financial support mechanisms.
3. **You have the right to respect, dignity, and individuality:** All persons supported by Connections, Inc. shall have impartial access to appropriate service regardless of race, religion, gender, ethnicity, age, ability, or sexual preference. Each person has the right to be treated with consideration and respect in full recognition and appreciation of their dignity.
4. **You have the right to privacy and confidentiality:** The privacy of each person served is protected in accordance with our agency privacy policies. Copies of our policy are provided to you upon enrollment. Additional copies are available at all times upon request.
5. **You have the right to be safe, receive humane care, and protection from harm:** Persons served by Connections, Inc. shall be free from mental, verbal, and physical abuse at all times. Physical and chemical restraints will be strongly avoided except as specified in emergencies, ordered by a physician, or as determined to be a component of a necessary care plan to protect the person served from injury to self or others.
6. **You have the right to assume appropriate risks:** Each person served by Connections, Inc. has the right to assume age appropriate risks to improve their quality of life. We will support individual choice and expression as long as persons served do so safely, legally, and with respect for others who may be involved.
7. **You have the right to receive services consistent with standards of professional practice:** Our agency continually strives to provide ethical, responsible care to those served at all times in support of industry and therapeutic best practices. We also commit to remaining in full compliance with our local, State, and Federal regulatory agencies and funding mechanisms as we deliver the best possible care to those served.
8. **You have the right to provide informed consent and to receive appropriate care:** Each person served is informed of their rights and responsibility in their care planning. Persons served have the right to refuse treatment or give informed consent at any time during this process.
9. **You have the right to information about services offered in your community:** Connections, Inc. maintains contact information about other care providers providing similar services to ours in the community and still others who can offer financial resources to assist you or your family. Your case manager or the Chief Operations Officer within our agency can link you to these supports upon request.
10. **You have the right to information about other services offered by Connections, Inc.:** In order to assure persons served are able to make informed health care decisions, you will be informed of all services offered by Connections, Inc. upon request.
11. **You have the right to refuse treatment & services:** Persons served have a right to the extent permitted by law, to refuse care, treatment, or therapeutic interventions at any time. To assure your own, and community safety, Connections, Inc. reserves the right to responsibly seek appropriate legal alternatives or involuntary hospitalization if you become an immediate threat of harm to yourself or others. We may also seek, in accordance with professional standards of care, to terminate our relationship with the person served as a result.

12. **You have the right to transfer care providers or request a discharge from our agency:** Persons served have the right to voluntarily terminate services with Connections, Inc. at any time. However, we respectfully request 30 days notice of this action. Persons who are mandated by a judicial court to receive our services are advised we are required to advise the court of your decision. We can assist you in identifying other care providers upon your request.
13. **You have the right of representation, personal advocacy, and grievance:** All persons served by Connections, Inc. may have access to their personal advocate, attorney, guardian, or advocacy organization at any time. Persons served who feel they could benefit from an advocate independent of our agency but does not know of one will be referred to Indiana Protection and Advocacy for assistance. All persons served have a right to initiate a complaint or grievance. You are encouraged to file them either verbally or in written form with our Chief Executive Officer and/ or Chief Operations Officer for their assistance with resolution. All requests received will be responded to within five business days of the inquiry.
14. **You have the right to individual records and to allow access of them to others:** Connections, Inc. will maintain individual records for persons served to document the nature of their services, treatment or service plans, and other relevant information. These records will be maintained for a period of seven years and are the property of Connections, Inc. They are your confidential, protected records and may only be accessed by you, your legal representatives or to individuals or organizations to whom you release these records in writing.
15. **You have the right to participate in research projects:** Persons served by Connections, Inc. have the right to participate in any research projects. We do however reserve the right to refuse to participate in the projects if we believe they compromise our ability to provide therapeutically appropriate and professional services to you.
16. **You have the right to your personal possessions and choice of dress:** Each person served has the right to live in a normal, comfortable, hygienic, and safe environment. Individuals served shall be allowed to retain and use personal possessions as space permits. Persons served shall have the right to dress appropriately in their own chosen clothing. Any restrictions or limitations to this right will be identified in the support plan.
17. **You have the right to work in your preferred setting:** Each individual served by Connections, inc. shall have the right to maintain employment. Persons receiving financial management assistance from Connections will, however, be required to submit a copy of their pay stubs for State and Federally mandated monitoring of wages.
18. **You have the right to visit with others:** Persons served by Connections, Inc. have a right to visit with others privately or refuse their visit to the extent as allowed by legal authorities and/ or their care plans.
19. **You have the right as a citizen to vote:** Persons served by Connections, Inc. are encouraged to exercise their right to vote. Upon request, we will assist you in registering to vote and provide assistance in reporting to the polls on election days.
20. **You have the right to manage your personal finances:** Persons served by Connections have the right to manage their personal financial affairs or elect to receive assistance in managing them as necessary. For those receiving assistance, our agency will maintain a transaction history of all items for your review upon request.
21. **You have the right to determine your health care:** Persons served by Connections will receive support as needed to access appropriate physical and mental health care. You will be encouraged to attend all recommended appointments and follow your physician's orders. However, we will respect your right to determine your personal health care needs and refuse treatments, medications, and dietary recommendations.
22. **You have the right to practice the religion or faith of your personal choice:** Each person served by Connections, Inc. may practice a religion or faith of personal choice or decline to practice any religion. We respect your right to practice as you choose. As appropriate and requested by you, our agency will link you to a faith based organization of your choice.

CONNECTIONS, INC.: NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW THERAPEUTIC INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice describes privacy practices of Connections, Inc. and their affiliates, including: any health care professional authorized to enter information into your health/medical records; all employees, staff, trainees, departments and units of Connections, Inc. whom we allow to help you while you are receiving care;

I. Our Duty to Safeguard Your Protected Health Information: Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for your health care is considered "Protected Health Information" ("PHI"). We understand that medical information about you and your health is personal and we are committed to protecting medical information about you. We are required by law to make sure that your PHI is kept private and to give you this Notice about our legal duties and privacy practices, that explains how, when and why we may use or disclose your PHI. Except in specified circumstances, we must use or disclose only the minimum necessary PHI to accomplish the purpose of the use or disclosure.

We must follow the privacy practices described in this Notice, though we reserve the right to change the terms of this Notice at any time. We reserve the right to make new Notice provisions effective for all PHI we currently maintain or that we receive in the future. If we change this Notice, we will notify you in writing of the changes at your current address on file.

II. How We May Use and Disclose Your Protected Health Information: We use and disclose PHI for a variety of reasons. For certain uses/disclosures, we must get your written authorization. However, the law provides that we may make some uses/disclosures without your authorization. The following section offers more description and examples of our potential uses/disclosures of your PHI.

• **Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations.** Generally, we may use/disclose your PHI:

For treatment: We may disclose your PHI to doctors, nurses, and other health care personnel who are involved in providing your health care. For example, your PHI will be shared among members of your treatment team, our pharmacy partner, or with a specialist to whom you have been referred. We may also share PHI with health care provider licensing bodies like the Indiana State Department of Health.

To obtain payment: We may use/disclose your PHI in order to bill and collect payment for your health care services. For example, we may release portions of your PHI to Medicare/Medicaid, a private insurer or group health plan to get paid for services that we delivered to you. Release of your PHI to the state Medicaid agency might also be necessary to determine your eligibility for publicly funded services.

For health care operations: We may use/disclose your PHI in the course of our operations. For example, we may use your PHI or your answers to a patient satisfaction survey in evaluating the quality of services provided by our staff, or disclose your PHI to our auditors or attorneys for audit or legal purposes.

Appointment reminders: Unless you provide us with alternative instructions, we may send appointment reminders and other similar materials to your home. We may also call your home and leave a message on your answering machine or voice mail. (See Section III about confidential communication.)

Treatment or service alternatives: We may contact you about possible treatment options or alternatives, or other health-related benefits or services that may interest you. We may contact you by phone, email, or postal mail regarding other activities or programs offered at Connections, Inc.

• **Uses and Disclosures Requiring Authorization:** For uses and disclosures other than treatment, payment and operations purposes, we are required to have your written authorization, unless the use or disclosure falls within one of the exceptions described below. You may revoke an authorization, in writing, any time to stop future uses/disclosures. If you revoke your authorization, we will stop using/disclosing your PHI for the purposes or reasons covered by your written authorization. You understand that we are unable to take back disclosures we have already made with your permission and that we are required to keep our records of the care we provided to you.

• **Uses and Disclosures Not Requiring Authorization:** The law provides that we may use/disclose your PHI without your authorization in the following circumstances:

When required by law: We may disclose PHI when a law requires that we report information about suspected abuse, neglect or domestic violence, or relating to suspected criminal activity, for FDA-regulated products or activities, or in response to a court order. We must also disclose PHI to authorities that monitor compliance with these privacy requirements.

For public health activities: We may disclose PHI when we are required to collect information about disease or injury, or to report vital statistics to the public health authority, such as reports of tuberculosis cases or births and deaths.

For health oversight activities: We may disclose PHI to the Indiana State Department of Health or other agencies responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.

Relating to decedents: We may disclose PHI relating to an individual's death to coroners, medical examiners or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.

To avert threat to health or safety: In order to avoid a serious threat to health or safety, we may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.

Law enforcement: We may disclose PHI to a law enforcement official in circumstances such as: in response to a court order; to identify a suspect, witness or missing person; about crime victims; about a death that we may suspect is the result of criminal conduct; or criminal conduct at the hospital or health care facility.

For specific government functions: We may disclose PHI of military personnel and veterans in certain situations; to correctional facilities in certain situations; and for national security and intelligence reasons.

Inmates: An inmate does not have rights listed in this Notice of Privacy Practices. The rights listed in this notice will not apply to inmates of a correctional institution.

• **Uses and Disclosures Requiring You to Have an Opportunity to Object:** In the following situations, we may disclose your PHI if we inform you about the disclosure in advance and you have the opportunity to agree to or prohibit or restrict the disclosure. However, if there is an emergency situation and you cannot be given the opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and the disclosure is determined to be in your best interests. You must be informed and given an opportunity to object to further disclosure as soon as you are able to do so.

To families, friends or others involved in your care: We may share with these people information directly related to your family, friend's or other person's involvement in your care, or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or death.

Disaster relief: We may release your PHI to a public or private relief agency for purposes of coordinating notifying your family and friends of your location, condition or death in the event of a disaster.

III. Your Rights Regarding Your Protected Health Information: You have the following rights relating to your protected health information:

To request restrictions on uses/disclosures: You have the right to ask that we limit how we use or disclose your PHI. You must make your request in writing. We will consider your request, but are not legally bound to agree to the restriction. To the extent that we do agree to any restrictions on our use/disclosure of your PHI, we will put the agreement in writing and abide by it except in emergency situations. If agreed upon, these restrictions will only apply to Connections, Inc.. You understand that we are not able to take back disclosures already made. We cannot agree to limit uses/disclosures that are required by law.

To request confidential communication: You have the right to ask that we send you information at an alternative address or by an alternative means, such as contacting you only at work. You must make your request in writing. We must agree to your request as long as it is reasonably easy for us to do so.

To inspect and copy your PHI: Unless your access is restricted for clear and documented treatment reasons, you have a right to see your protected health information if you put your request in writing. We will respond to your request within 30 days. If we deny your access, we will give you written reasons for the denial and explain any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed. You have a right to choose what portions of your information you want copied and to have information on the cost of copying in advance.

To request amendment of your PHI: If you believe that there is a mistake or missing information in our record of your PHI, you may request, in writing, that we correct or add to the record. Written requests must include a reason that supports your request. We will respond within 60 days of receiving your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. We may also deny your request if we determine that the PHI is: (1) correct and complete; (2) not created by us and/or not part of our records, or; (3) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial reviewed, along with any statement in response that you provide, appended to your PHI. If we approve the request for amendment, we will change the PHI and so inform you, and tell others that need to know about the change in the PHI.

To find out what disclosures have been made: You have a right to get a list of when, to whom, for what purpose, and what content of your PHI has been released other than instances of disclosure for which you gave your written authorization. (This is called an accounting of disclosures.) Your request can relate to disclosures going as far back as six years. The list will not include any disclosures made before April 14, 2003; for national security purposes; for treatment, payment or operations purposes; through a facility directory; or to law enforcement officials or correctional facilities. Your request must be in writing. We will respond to your written request for such a list within 60 days of receiving it. There will be no charge for the first list requested each year. There may be a charge for subsequent requests.

To receive a paper copy of this Notice: You have a right to receive a paper copy of this Notice and/or an electronic copy by email upon request. To obtain a copy of this Notice, contact our office at 317.423.1000.

IV. How to Complain about our Privacy Practices: If you think we may have violated your privacy rights, or if you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed in Section V. below. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services. You will not be penalized if you file a complaint.

V. Contact Person for Information or to Submit a Complaint: If you have questions about this Notice or any complaints about our privacy practices, please contact: Jenifer Asher, Chief Executive Officer, Connections, Inc., 711 S. East St. Indianapolis, IN 46225, E-mail: jasher@connections-inc.net.

VI. Instructions for Revoking an Authorization: You may revoke an authorization to use or disclose your PHI, in writing, except: 1) to the extent that action has been taken in reliance on the authorization, or 2) if the authorization was obtained as a condition of obtaining insurance coverage and other law provides the insurer with the right to contest a claim under the policy. Your written revocation must include the date of the authorization, the name of the person or organization authorized to receive the PHI, your signature and the date you signed the revocation, addressed to the contact person listed on your original authorization.