Lifetime Assistance Inc.

Thank you for your interest in Lifetime Assistance Self Directed Services! In addition to this letter is an application for our services. Before starting services, the enclosed application must be filled out completely. *In addition to the completed application*, we will also need the following information:

For applicants **New** to Self Direction:

- ☐ Most Recent Lifeplan with Lifetime FI and Broker (if applicable) listed as pending
- ☐ Current Level of Care (LCED)
- ☐ Psychological evaluation
- ☐ IPOP (if applicable)
- ☐ Behavior Support Plan w/ 1 years' worth of data (if applicable)
- ☐ Notice of Decision
- ☐ OPWDD Eligibility Letter
- ☐ Authorization for Self-Direction Services
- ☐ Attendance certificate from Self-Direction information session
- ☐ DDP-2 (computer-generated with ISPM score on last page)
- ☐ DDSO Risk Assessment (if applicable)
- ☐ Broker Name, Authorization Number, Phone Number, Email (if applicable)

For applicants who are **vendor changing** from another agency:

- ☐ Most Recent Lifeplan with LAI listed as service provider
- ☐ Current Level of Care (LCED)
- ☐ Psychological evaluation
- ☐ IPOP (if applicable)
- ☐ Behavior Support Plan w/ 1 years' worth of data (if applicable)
- ☐ Notice of Decision
- ☐ OPWDD Eligibility Letter
- ☐ Authorization for Self-Direction Services
- ☐ Attendance certificate from Self-Direction information session
- ☐ DDP-2 (computer-generated with ISPM score on last page)
- ☐ DDSO Risk Assessment (if applicable)
- ☐ Broker Name, Authorization Number, Phone Number, Email (if applicable)
- ☐ Staff Action Plan (if applicable)
- ☐ Signed FI Termination form
- ☐ Signed Broker termination form & new signed Broker Agreement
- ☐ Most Recent Expense Report
- ☐ Most Recent SD Budget

Please Note: The Intake Committee will accept the most recent assessments available for the purposes of Intake only. However, the agency requires more current assessments before placement in any Lifetime Assistance program.

Once you have gathered this information, please send it to:

Lifetime Assistance, Inc.
3315 Chili Ave Suite 200
Rochester, NY 14624
or via secure email: rachel.mason@lifetimeassistance.org
Attn: Rachel Mason, Senior Coordinator of Community Services

If you are interested in more information on our agency, please check out our website at www.lifetimeassistance.org. Thank you again for your interest in Lifetime Assistance!

LIFETIME ASSISTANCE, INC.

APPLICATION FOR SELF-DIRECTED SERVICES

Application Date:

Date Needed:

Received:

Services Requested (Check Desired Services)					
Fiscal Intermediary	☐	*OTPS*	☐	*Family Support Services*	☐
Broker Services	☐	*Housing Subsidy*	☐	*Family Reimbursed Respite*	☐
Self Hire Com Hab	☐	*Live in Care Giver*	☐	*Agency Supported Services*	☐
Self Hire Respite	☐	*IDGS*	☐		☐

Applicant Personal Information

Full Name: _____
Last *First, MI* *Male/Female*

Address: _____

Home Phone: _____ Alternate Phone: _____

Email: _____

Birth Date: _____ HSBC Waiver Enrolled? _____

Current Residence: ☐ Family Home ☐ Independent ☐ Certified: Agency: _____

ISPM SCORE: _____ TABS # _____ Attended Self-Direction Info. session: (Y/N) _____

Family /Advocate Information

Full Name: _____
Last *First, MI* *Relationship*

Address: _____

Home Phone: _____ Alternate Phone: _____

Email: _____

Court Appointed Guardian? _____ If yes, name: _____

Other Involved Family Members: _____

Care Coordinator Information

Full Name: _____
Last, First *Agency*

Agency Address: _____

Phone: _____ Alternate Phone: _____

Email: _____

Self-Directed Services Broker: Name/Agency/Phone: _____

Fiscal Intermediary: Name/Agency/Phone: _____

Applicant and family's attitude towards requested service:

_____

_____

Diagnoses

Psychiatric Diagnosis: _____

Medical Diagnosis: _____

Pica Diagnosis: Yes/No [ ] If yes, specify: _____

Living Skills Assessment – Supervision and Life Skills Support

Please indicate level of supervision (***Independent, Field of Vision, Range of Hearing, 1:1, etc.)***

At Home _____	In Community _____	While Eating _____
At Work/Program _____	Using Bathroom _____	

Specify other supervision needs:

Please indicate level of supervision ***(Please mark "Total Support", "Physical Assistance", "Verbal Prompting", or "Independent".)***

Food Prep _____	Housekeeping _____	Toileting _____
Shopping _____	Money Management _____	Dressing _____
Cooking _____	Telephone Usage _____	Eating _____
Laundry _____	Self-Care _____	Bathing _____
Grooming _____	Menses Care _____	Brushing Teeth _____

Regulates Water Temperatures (Y/N):

Fire Evacuation Ability

How many minutes for exiting?					
Will respond to fire alarm (Y/N)		Leaves House Independently (Y/N)			
Needs: Verbal prompts (Y/N)		Physical Assistance (Y/N)		Total Assistance (Y/N)	

Transportation Ability

Public Transportation (Y/N)		Family Transports (Y/N)		Drives Car (Y/N)	
RTS Access (Y/N)		Medi Cab Transportation (Y/N)		Other:	
Behavioral concerns during transport:					
Special equipment needed during transport:					

Mobility Status (Check all that apply)

Ambulatory	☐	Manual Wheelchair	☐	Requires Use of Lift	☐
Can Negotiate Stairs	☐	Power Wheelchair	☐	Can be Transported in Car	☐
Can Bear Weight	☐	One Person Transfer	☐	Requires Vehicle with Lift	☐
Uses Cane or Walker	☐	Multi Person Transfer	☐	Special Positioning Needed	☐
Uses Gait Belt	☐			Specify:	

Physical Health

Describe: _____

Seizure Disorder (Y/N)		Frequency and description of seizure?			
Are you a smoker? (Y/N)		If yes, how many per day:		Allergies:	
Visual Impairment (Y/N)		Deaf (Y/N)		Diabetic (Y/N)	
Wears Glasses (Y/N)		Hearing Impairment (Y/N)			
Legally Blind (Y/N)		Wears Hearing Aids (Y/N)			

Special Needs (Check all that apply)

Suctioning	☐	Equipment Needed at Bedtime:	☐	Other:	
Dressing/Wound Care	☐	C-Pap Machine	☐		
Injections	☐	Hospital Bed	☐		
Oxygen	☐	Bed Rails	☐		
Respiratory Therapy	☐	Lifts and Transfers required	☐		
Capable of Self-Medicating (Y/N)					
Support required for taking medications:					
Special considerations during mealtime:					
Special Diet:					
Gastrostomy Tube Feeding (Y/N)		Use Adaptive Feeding Equip (Y/N)		Describe:	

Communication

Primary Language:				Verbal (Y/N):
Communication Device (Y/N)		Specify:		
Sign Language (Y/N)				
Comments:				

Behavioral Supports Summary (Check behaviors that have occurred within the last 12 months)

Tantrums/Emotional Outburst	☐	Damages own or others property	☐	Physically assaults others	☐
Disrupts other activities	☐	Verbally/Gesturally Aggressive	☐	Self-Injurious	☐
Teases/Harass Peers	☐	Resists Supervision	☐	Runs or Wanders Away	☐
Steals	☐	Displays Sexually Inappropriate Behavior	☐	Eats Inedible Objects	☐
Smears Feces	☐	Other (Specify):			

Describe any sexuality issues or concerns and how they are managed:	
Does the applicant have a Behavior Support Plan or guidelines (Y/N) If yes, attach a copy of the plan and 12 months of data.	
Does the applicant have a history of starting fires? (Y/N)	
Has the applicant been through the DDRO's At Risk Committee? (Y/N). If yes, include risk assessment.	
Has the applicant ever been convicted of a felony or misdemeanor (Y/N) If yes, please explain:	

Relationship to Lifetime Assistance, Inc.

Does the applicant for services have any family members currently **receiving services** from LAI (Y/N)	
If yes, please list family members name, relationship, and services received:	
Does the applicant for services have any family members who are currently **employed** with LAI? (Y/N)	
If yes, please list the family member's name, relationship to applicant, and location:	

Acknowledgement

By signing below, I am verifying that the information provided within is accurate to the best of my knowledge. I understand that knowingly withholding necessary information may affect intake or placement decisions.

Signature of Applicant and Date
Signature of Referring Person and Date
Signature of Family or Guardian and Date

CONSENT FOR RELEASE OF INFORMATION

I _____ hereby authorize the release of information to Lifetime Assistance Incorporated.

The purpose of this disclosure is referral for services. I understand that this authorization covers the information listed below and any additional information necessary for the purpose of assessing eligibility for services. Lifetime Assistance Incorporated will maintain the confidentiality of this information. Lifetime Assistance Incorporated will not release this information.

Information to be released: (Please check all that are available and if attached)

	Date:	**Attached:**
Lifetime Assistance Application for Services	_____	☐Yes ☐No
Psychological Assessment	_____	☐Yes ☐No
Physical Exam	_____	☐Yes ☐No
Current Life Plan:	_____	☐Yes ☐No
Behavior Support Plan With Data:	_____	☐Yes ☐No
DDSO Risk Assessment (if applicable):	_____	☐Yes ☐No
Notice of Decision and OPWDD Eligibility	_____	☐Yes ☐No
LCED:	_____	☐Yes ☐No
IPOP (Day and/or Residential)	_____	☐Yes ☐No
DDP-2	_____	☐Yes ☐No
Other	_____	☐Yes ☐No

In addition, I authorize representatives of Lifetime Assistance Incorporated to make inquiries and/or visits to current service providers in order to make an informed determination regarding placement.

_____	_____
Applicant's Signature	**Advocate / Legal Guardian**
_____	_____
Date	**Date**
_____	_____
Applicant's Address	**Relationship**

PENALTIES FOR MISUSING THIS CONSENT:

Title 18, Section 1001 of the U.S. Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department of the United States Government. HUD and any owner (or any employee of HUD or the owner) may be subject to penalties for unauthorized disclosures or improper uses of information collected based on the consent form. Use of the information collected based on this verification form is restricted to the purposes cited above. Any person who knowingly or willingly requests, obtains, or discloses any information under false pretenses concerning an applicant or participant may be subject to a misdemeanor and fined not more than $5,000. Any applicant or participant affected by negligent disclosure of information may bring civil action for damages and seek other relief, as may be appropriate, against the officer or employee of HUD or the owner responsible for the unauthorized disclosure or improper use. Penalty provisions for misusing the social security number are contained in the Social Security Act at **208 (a) (6), (7) and (8).** Violations of these provisions are cited as violations of 42 USC **408 (a) (6), (7) and (8).**

NOTE: ***THIS CONSENT MAY BE REVOKED AT ANY TIME BY PUTTING SUCH REQUEST IN WRITING.***

Dear Friend –

Attached is the Lifetime Assistance Inc. Notice of Privacy Practices. After reviewing this notice, please sign on the signature line below and return this page along with the Self Direction intake application. If you have any questions regarding this notice, you may contact us at 585-426-4120.

Sincerely,

Lifetime Assistance, Inc. Quality Assurance & Corporate Compliance Team

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I have reviewed the Lifetime Assistance Inc. Notice of Privacy Practices and acknowledge the receipt of this information.

_____ _____

Name (please print) Date

_____

Name (please sign)

LIFETIME ASSISTANCE INCORPORATED AGENCY POLICIES AND PROCEDURES MANUAL	DATE ISSUED 9/23/2013	PAGE 1 of 5	TOPIC NO. 1.8.2
	FUNCTION HIPAA COMPLIANCE		
	SUBJECT PRIVACY		
SOURCE/REFERENCE 164.42(a)(1)	TOPIC Privacy Practices		

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

This policy is effective as of September 23, 2013. If you have any questions about this notice, please contact our Corporate Compliance/Privacy Officer at 585-426-4120, ext. 3116.

Our Privacy Commitment to You

At Lifetime Assistance, Inc. we understand that information about you and your family is personal. We are committed to protecting your privacy and sharing information only with those who need to know and are allowed to see the information about you. This policy tells you how Lifetime Assistance, Inc. uses and discloses information about you. It describes your rights and what our responsibilities are concerning information about you.

1. Who will follow this policy:
   All people who work for Lifetime Assistance, Inc. will follow this policy. This includes **employees,** persons we contract with (**contractors**) who are authorized to enter information in your clinical record or need to review your record to provide services to you, and **volunteers** that we allow to assist you.

2. What information is protected:
   All information we create or keep that relates to your health care and treatment, or the billing or payment for such services, including your name, address, birth date, social security number, your medical information, your individualized service plan, and other information about your care in our programs.

Your Health/Clinical Information Rights

You have the following rights concerning your health/clinical information. When we use the word “you” in this notice, we also mean your personal representative. Depending on your circumstances and in accordance with state law, this may be your guardian, involved parent, spouse, or adult child, or your advocate.

- You have a right to see or inspect your health/clinical information and obtain a copy. Some exceptions apply, such as psychotherapy notes, certain records regarding incident reports and investigations, and information compiled for use in court or administrative proceedings.
- If we deny your request to see your health/clinical information, you have the right to request a review of that denial. A professional chosen by Lifetime Assistance, Inc. who was not involved in denying your request, will review the record and decide if you may have access to the record. You may also have an opportunity for further review at the State level.
- You have the right to ask Lifetime Assistance, Inc. to change or amend your health/clinical information that you believe is incorrect or incomplete. We may deny your request in some cases, for example, if the record was not created by Lifetime Assistance, Inc. of if after reviewing your request, we believe the record is accurate and complete.
- You have the right to request a list of the disclosures Lifetime Assistance, Inc. has made of your health/clinical information with certain exceptions depending upon how the information is maintained.
- You have the right to request a restriction on uses or disclosures of your health information related to treatment, payment, health care operations and disclosures to involved family. Lifetime Assistance, Inc., however, is not required to agree to your request, except we must agree to your request to restrict the information we provide to

your health plan if the disclosure is not required by law and the information relates to health care being paid in full by someone other than the health plan.
- You have the right to request that Lifetime Assistance, Inc. communicates with you in a way that will help keep your information confidential.
- You have the right to receive a paper copy of this notice. You may ask Lifetime Assistance, Inc. staff to give you another copy. To request access to your health/clinical information or to request any of the rights listed here, you may contact our Corporate Compliance Officer at 585-426-4120, extension 3116.

Lifetime Assistance, Inc. Responsibilities for Your Health Information

Lifetime Assistance, Inc. is required by law to:

- Maintain the privacy of your information.
- Notify you following a breach of unsecured health information.
- Give you this policy of our legal duties and practices concerning the health information we have about you.
- Follow the rules in this policy. Lifetime Assistance, Inc. will use or share information about you only with your permission except for the reasons explained in this notice. Any new notice will be posted on our website at www.lifetimeassistance.org and in our facilities.

How Lifetime Assistance, Inc. Uses and Discloses Health Care Information

Lifetime Assistance, Inc. may use and disclose health/clinical information without your permission for the purposes described below. For each of the categories of uses and disclosures, we explain what we mean and offer an example. Not every use of disclosure is described, but all of the ways we will use or disclose information will fall within these categories.

- **Treatment:**
  Lifetime Assistance, Inc. will use your health/clinical information to provide you with treatment and services. We may disclose health/clinical information to doctors, nurses, psychologists, social workers, qualified mental retardation professionals (QMRPs), developmental aides, and other Lifetime Assistance, Inc. personnel, volunteers or interns who are involved in providing you care. For example, involved staff may discuss your health/clinical information to develop and carry out your individualized service plan (ISP). Other Lifetime Assistance, Inc. staff may share your health/clinical information to coordinate different services you need, such as medical tests, respite care, transportation, etc. We may also need to disclose your health/clinical information to your service coordinator and other providers outside of Lifetime Assistance, Inc. who are responsible for providing you with the services identified in your ISP or to obtain new services for you.

- **Appointment Reminder:**
  Lifetime Assistance, Inc. may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or services at one of our programs.

- **Payment:**
  Lifetime Assistance, Inc. will use your health/clinical information so that we can bill and collect payment from you, a third party, an insurance company, Medicare or Medicaid or other government agencies. For example, we may need to provide the NYS Department of Health (Medicaid) with information about the services you received in our facility or through one of our HCBS waiver programs so they will pay us for the services. In addition, we may disclose your health/clinical information to receive prior approval for payment for services you may need. Also, we may disclose your health/clinical information to the US Social Security Administration, or

the Department of Health to determine your eligibility for coverage or your ability to pay for services.

- **Health Care Operations:**
  Lifetime Assistance, Inc. will use health/clinical information for administrative operations. These uses and disclosures are necessary to operate our programs and residences and to make sure all consumers receive appropriate, quality care. For example, we may use health/clinical information for quality improvement to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also disclose information to clinicians and other personnel for on-the-job training. We will share your health/clinical information with other Lifetime Assistance, Inc. staff, for the purposes of obtaining legal services through our agency attorney, conducting fiscal audits, and for fraud and abuse detection and compliance. We will also share your health/clinical information with Lifetime Assistance, Inc. staff to resolve complaints to our business associates who need access to the information to perform administrative or professional services on our behalf.

Fundraising

To support our business operations, we may use certain information about you when deciding whether to contact you or your personal representative to raise money to help us operate. We may also share this information with a charitable foundation that will contact you or your personal representative to raise money on our behalf. You have a right to opt out of receiving such communications by contacting the Privacy Officer.

Business Associates

We may disclose your health information to contractors, agents and other business associates who need the information in order to assist us with obtaining payment or carrying out our business operations. For example, we may share your health information with an accounting firm or law firm that provides professional advice to us about how to improve our health care services and comply with the law. If we do disclose your health information to a business associate, we will have a written contract to ensure that our business associate also protects the privacy of your health information.

Other Uses and Disclosures that Do Not Require your Permission

In addition to the above, Lifetime Assistance, Inc. will use your health/clinical information without your permission for the following reasons:

- When we are **required to do so by federal or state law**;
- For **public health reasons**, including prevention and control of disease, injury or disability, reporting births and deaths, reporting child abuse or neglect, reporting reactions to medication or problems with products, and to notify people who may have been exposed to a disease or are at risk of spreading the disease;
- To report **domestic violence and adult abuse or neglect** to government authorities if you agree or if necessary to prevent serious harm;
- For **health oversight activities**, including audits, investigations, surveys and inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws. Health oversight activities do not include investigations that are not related to the receipt of health care or receipt of government benefits in which you are the subject;
- For **judicial and administrative proceedings**, including hearings and disputes. If you are involved in a court or administrative proceeding we will disclose health/clinical information if the judge or presiding officer orders us to share the information;
- For **law enforcement purposes**, in response to a subpoena, or other legal process, to identify a suspect or witness or missing person, regarding a victim of a crime, a death, criminal conduct at the facility, and in emergency circumstances to report a crime;
- Upon your death, to **coroners or medical examiners** for identification purposes or to determine cause of death, and to **funeral directors** to allow them to carry out their duties;

- To organ procurement organizations to accomplish cadaver, eye, tissue, or **organ donations** in compliance with state law;
- For **research** purposes, when you have agreed to participate in the research and an Institutional Review Board or Privacy Committee has approved the use of the health/clinical information for the research purposes;
- To **prevent or lessen a serious and imminent threat** to your health and safety or someone else's;
- To **correctional institutions or law enforcement officials** if you are an inmate and the information is necessary to provide you with health care, protect your health and safety or that of others, or for the safety of the correctional institution; and
- To **governmental agencies that administer public benefits** if necessary to coordinate the covered functions of the programs.

Uses and Disclosures that Require Your Agreement or Authorization

Lifetime Assistance, Inc. may disclose health/clinical information to the following persons if we tell you we are going to use or disclose it and you agree or do not object:

- To **family members and personal representatives** who are involved in your care if the information is relevant to their involvement and to notify them of your condition and location; or
- To **disaster relief organizations** that need to notify your family about your condition and locations should a disaster occur.

Authorization Required For All Other Uses and Disclosures

- For all other types of uses and disclosures not described in this Notice, Lifetime Assistance, Inc. will use or disclose health/clinical information only with a written authorization signed by you that states who may receive the information, what information is to be shared, the purpose of the use or disclosure and an expiration for the authorization. Written authorizations are always required for use and disclosure of psychotherapy notes, for marketing purposes and involving the sale of protected health information. **Note**: If you cannot give permission due to an emergency, Lifetime Assistance, Inc. may release health/clinical information in your best interest. We must tell you as soon as possible after releasing the information.

  You may revoke your authorization at any time. If you revoke your authorization in writing, we will no longer use or disclose your health/clinical information for the reasons stated in your authorization. We cannot, however, take back disclosures we made before you revoked and we must retain health/clinical information that indicates the services we have provided to you.

Changes to this Policy

We reserve the right to change this policy. We reserve the right to make changes to terms described in this policy and to make the new policy terms effective to all health/clinical information that Lifetime Assistance, Inc. maintains. We will post the new policy with the effective date on our website at www.lifetimeassistance.org and in our facilities.

Complaints

If you believe your privacy rights have been violated:

You may file a complaint with our Corporate Compliance/Privacy Officer at 425 Paul Rd., Rochester N.Y. 14624, 585-426-4120, ext. 3116. Or, you may contact the Office of Civil Rights, US Department of Health and Human Services, Jacob Javits Federal Building, 26 Federal Plaza, Suite 3312, New York, New York 10279. Phone number: (800) 368-1019. TDD