Lifetime Assistance

Referral Form for Self-Directed Services

Thank you for your interest in Lifetime Assistance Self Directed-Services! Please return this form and all required documentation to Rachel.Mason@lifetimeassistance.org

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!

Applicant Personal Information

Full Name:	Date of Birth:
Address:	
Phone:	
Email:	

Current Living arrangements:
☐ Independent /Alone
☐ With Family / Friends
☐ Certified/Supportive Setting Agency Name:

Who is the applicant's guardian:
☐ Self
☐ Parent(s)/Family Name:
☐ Other Name:

Primary Contact, if not the applicant:
Relation to the person:
Address:
Phone:
Email:

Care Coordinator Contact

Care Coordination Agency:
Care Coordinator Name:
Phone:
Email:

Broker Contact

Agency Name or Independent:		
Name:		
Phone:		
Email:		
Would like a Lifetime Assistance Agency Broker	☐ Yes	☐ No

1. **Does the applicant have an active self-direction budget?** ☐ Yes ☐ No
   - If Yes, please provide the additional information:
     - o Provide the name of the current FI agency:
     - o Would you like to switch to Lifetime Assistance? ☐ Yes ☐ No
     - o If yes, please provide information below on why you would like to change from your current FI:

     - o Does the applicant have staff that work for another agency? ☐ Yes ☐ No

2. **Does the applicant/family have access to a computer or smart phone?** ☐ Yes ☐ No
   - Please note, we use an electronic database for all submission of reimbursement.

3. **Does the applicant want to self-hire staff?** ☐ Yes ☐ No ☐ Undecided
   - What services would you like to self-hire? ☐ Community Hab ☐ Respite
   - Do you already have a staff identified? ☐ Yes ☐ No

4. What is the applicant looking for from their self-directed budget?

5. Has the applicant/family attended an OPWDD Self-Direction Information Session? ☐ Yes ☐ No
   - Date of Attendance:

6. Does the applicant have any behavioral concerns?

7. Does the applicant have any personal care or medical needs?

8. Are there any legal matters or issues/concerns that we should be aware of (parole, probation, custody arrangements, etc.)?

9. Does the person currently have an ISS Housing Subsidy? ☐ Yes ☐ No
   - If yes, which agency provides the subsidy?

Required Documentation					
Life Plan	☐	Letter of guardianship (if applicable)	☐	SD Authorization Letter	☐
NOD (Notice of Decision)	☐	LCED	☐	CR4	☐
Behavior plan (if applicable)	☐	DDP2	☐	Acknowledgement (signatures required)	☐
Notice of Privacy Practices (signatures required)	☐	Consent to Release (signatures required)	☐		☐

Relationship to Lifetime Assistance, Inc.	
Does the applicant for services have any family members currently **receiving services** from LAI ☐ Yes ☐ No	
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? ☐ Yes ☐ No	
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): Notice of Decision and OPWDD Eligibility LCED:	_____	☐ Yes ☐ No
IPOP (Day and/or Residential)	_____	☐ Yes ☐ No
DDP-2	_____	☐ Yes ☐ No
Other	_____	☐ Yes ☐ No
	_____	☐ Yes ☐ No
In addition, I authorize representatives of Lifetime Assistance Incorporated to make inquiries and/or visits to current serviceproviders in order to make an informed determination regarding placement.	_____	☐ Yes ☐ No

_____	_____
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)

NOTICE OF PRIVACY PRACTICES

THIS NOTICE 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 notice is effective as of 1/20/2017 and was updated in March 2021. If you have any questions about this notice, please contact our Corporate Compliance and Privacy Officer at 585-426-4120, ext. 3118.

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 notice 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 notice. 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 or Lifetime Assistance, 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, medical information, 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, adult child, or your advocate.

You have a right to see or inspect your health/clinical information and obtain a copy. Some exceptions apply.

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., or 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 and depending upon how the information is maintained.

You have the right to request a restriction on the uses or disclosures of your health information related to treatment, payment, health care operations and disclosures to involved family members. 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 and Privacy Officer at 585-784-3118.

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 notice regarding our legal duties and practices concerning the health information we have about you.

Follow the rules in this notice. 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 Intellectual Disability Professionals (QIDPs), Direct Support Professionals, and other Lifetime Assistance, Inc. personnel, volunteers, or interns who are involved in providing your care. For example, involved staff may discuss your health/clinical information to develop and carry out your individualized service plan (ISP) or Life Plan. 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 Care Manager and other providers outside of Lifetime Assistance, Inc. who are responsible for providing you with the services identified in your ISP or Life Plan or obtaining 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 and 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 Development Office at 585-784-5006.

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 processes, 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 expiration for the authorization. Written authorizations are always required for use and disclosure 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 Notice

We reserve the right to change this notice. We reserve the right to make changes to the terms described in this notice and to make the new notice terms effective to all health/clinical information that Lifetime Assistance, Inc. maintains. We will post the new notice 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 and Privacy Officer at 425 Paul Rd., Rochester N.Y. 14624, 585-784-3118. 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: (800) 537-7697. Fax: (212) 264-3039.

You may file a grievance with the Office of Civil Rights by calling (866) OCR PRIV or (866) 627-7748 or (886) 788-4989 (TTY).

All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.