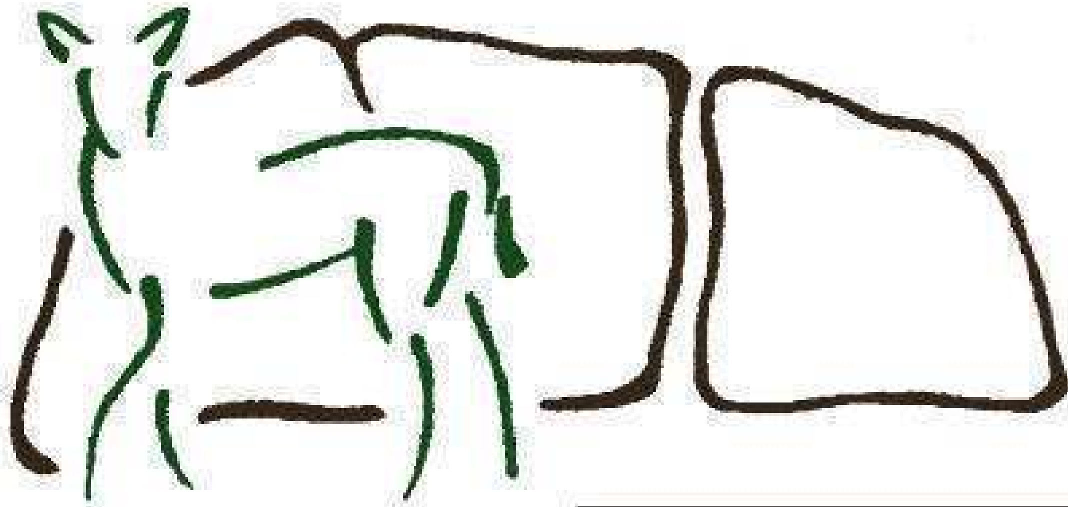

Pre-Admission Packet

DATE: ______________________

HINDS' FEET FARM MEMBERSHIP APPLICATION

MEMBER INFORMATION

Last Name:______________________ **First Name:**______________________ **Nickname:**______________________
Date of Birth: _____ /_____ /______ **Gender:** ☐ Male ☐ Female **Height:** ________ **Weight:** ______lbs.
Marital Status: ☐ Single ☐ Married ☐ Divorced **SS#:**_______-_______-_______
Street Address: ______________________
City:______________________ **County**______________________ **State:**________ **Zip Code:**________________
Home Phone:______________________ **Cell Phone:**______________________ **Work Phone:**______________________
Email:______________________

MEMBER'S LEGAL CAREGIVER CONTACT INFORMATION

Do you have a family caregiver or professional caregiver assisting you? ☐ Yes ☐ No
What agency is the professional caregiver from? ______________________
Name of person assisting with member? ______________________
Relationship to the member:______________________
Address:______________________
Home Phone:______________________ **Cell Phone:**______________________ **Work Phone:**______________________
Email:______________________

Do you have a legal guardian? ☐ Yes ☐ No **If "Yes", please have your legal guardian complete the information below:**
Last Name:______________________ **First Name:**______________________ **Relationship:**______________________
Address:______________________
Home Phone:______________________ **Cell Phone:**______________________ **Work Phone:**______________________
Email:______________________

EMERGENCY CONTACT INFORMATION

Who can Hinds' Feet Farm contact in case of an emergency? Please list two:

Primary Contact Name:______________________

Relationship to the Applicant:______________________

Address:______________________

Home Phone:______________________ **Work Phone:**______________________ **Cell Phone:**______________________

Secondary Contact Name:______________________

Relationship to the Applicant:______________________

Address:______________________

Home Phone:______________________ **Work Phone:**______________________ **Cell Phone:**______________________

EDUCATION INFORMATION

High School:		**Address:**	
From:	**To:**	**Did you graduate?** □ Yes □ No	**Degree:**
College:		**Address:**	
From:	**To:**	**Did you graduate?** □ Yes □ No	**Degree:**
Other:		**Address:**	
From:	**To:**	**Did you graduate?** □ Yes □ No	**Degree:**

AGENCY INVOLVEMENT

What agencies are you currently involved? Please list:

REHABILITATION INFORMATION

IMPORTANT: Please substantiate your brain injury, course of treatment and present condition with documentation from a health care professional. Please attach this information to the application.

Please describe the cause of the brain injury: ______

What was the date of the injury? ______

Have you participated in rehabilitation activities in the past? ☐ Yes ☐ No

What rehabilitation activities are you currently involved in now? Please list:

MEDICAL/MENTAL HEALTH/COURT INFORMATION

Do you have any known allergies (i.e.: food, insect, bees, etc.)? ☐ Yes ☐ No

If "Yes", please list:______

Do you have any Epi-Pen? ☐ Yes ☐ No If "Yes", please list dosage:______

Do you have chronic illnesses (i.e. diabetes, asthma, etc.)? ☐ Yes ☐ No

If "Yes", please list:______

Do you have assistive/adaptive equipment? ☐ Yes ☐ No

If "Yes", please list:______

Do you have a mental health treatment background, in the past or currently? ☐ Yes ☐ No

If "Yes", please list:______

Do you have a substance abuse treatment background, in the past or currently? ☐ Yes ☐ No

If "Yes", please list:______

Do you have seizure disorder? ☐ Yes ☐ No

If "Yes", please identify the following:

What type of seizures does the member have? ______

What is the typical motor activity during a seizure? ______

What is the average frequency of the seizures?______

How long does the seizure(s) last?______

What would you like us to do if a seizure occurs? ______

Is there anything else that we need to know about the seizure disorder? ______

Advanced Directives:______

Healthcare Power of Attorney : ______ Code Status: ______

Does member have a criminal record? ☐ Yes ☐ No If "Yes", please explain below:

Offenses	**Conviction Dates**

Are there any pending charges? ☐ Yes ☐ No If "Yes", please list: ______

Are you currently on Probation? ☐ Yes ☐ No

Is placement court ordered? ☐ Yes ☐ No (If "Yes", please attach copy of the court order document)

RESIDUAL CHALLENGES/FUNCTIONAL IMPACT/ADAPTIVE STRATEGIES

What specific residual challenges (difficulties/problems/concerns) do you currently encounter following your brain injury and how do they impact your day to day functioning in life? Please list:

What adaptive or coping strategies assist you in compensating for your residual challenges? Please list:

What are your strengths that you can count on following your brain injury? Please list:

PERSONS/STAFF MEMBERS AUTHORIZED TO PICK UP & TRANSPORT MEMBERS

(PHOTO I.D. IS REQUIRED BY ALL PERSONS TO PICKUP OR TRANSPORT MEMBERS)

Name: ______ **Phone:** ______
Relationship to Member: ______ **Phone:** ______
Name: ______ **Phone:** ______
Relationship to Member: ______ **Phone:** ______
Name: ______ **Phone:** ______
Relationship to Member: ______ **Phone:** ______
Name: ______ **Phone:** ______
Relationship to Member: ______ **Phone:** ______
Name: ______ **Phone:** ______
Relationship to Member: ______ **Phone:** ______
Name: ______ **Phone:** ______
Relationship to Member: ______ **Phone:** ______

BILLING & INSURANCE INFORMATION

Is the Member on a Private Pay/Sliding Scale Fee Plan? YES or NO

Billing Rate: $______ **Frequency:** ______ **Billing Code:** ______

Name of Primary Insurance or LME: ______ **Phone:** ______
Policy Number: ______ **Group:** ______
Address: ______
Secondary Insurance Name: ______ **Phone:** ______
Policy Number: ______ **Group:** ______
Address: ______
Tertiary Insurance Name: ______ **Phone:** ______
Policy Number: ______ **Group:** ______
Address: ______
Nurse Case Manager (if applicable): ______ **Phone:** ______
Address: ______ **Cell:** ______
Email Address: ______ **Fax:** ______
Attorney (if applicable) ______ **Phone:** ______
Address: ______ **Cell:** ______
Email Address: ______ **Fax:** ______

FINANCIAL INFORMATION	
What is your present average monthly income after taxes? Please specify:	
Employment	$
Unemployment Benefits	$
Workers' Compensation	$
Rental Income	$
Trust or Interest Income	$
Retirement Income	$
Child Support	$
Medicaid – specify (i.e. Standard, CAP Services)	$
Medicare – specify	$
SSDI SSI SSA (please circle if applicable)	$
Food Stamps	$
Fuel Assistance	$
VA Disability	$
HUD Housing	$
Other (please specify)	$
Other (please specify)	$
Other (please specify)	$
TOTAL MONTHLY INCOME	$

Who else contributes to the household income?

NAME	SOURCE OF INCOME	MONTHLY AMOUNT
		$
		$
		$
TOTAL MONTHLY HOUSEHOLD INCOME		$

ASSETS: Please list your own and your household's savings and assets:

ASSET	AMOUNT or VALUE	IN WHOSE NAME
Savings	$	
Checking	$	
CD (Maturity date)	$	
IRA (Maturity date)	$	
Other (please specify)	$	
TOTAL HOUSEHOLD ASSETS	$	

I certify that the information in this application is true and accurate and I agree to notify Hinds' Feet Farm, in writing, of any changes in my medical, emergency contact, and financial information. I understand that unless Hinds' Feet Farm receives written notice of any changes, they will assume that all of my medical, emergency contact and financial information is unchanged.

____________________	____________
Name & Signature	**Date**
____________________	____________
Guardian's Name & Signature (if applicable)	**Date**
____________________	____________
Hinds' Feet Farm Staff Name & Signature	**Date**

This application contains information that is confidential and/or legally privileged. It is intended only for the use of the individual(s) and Hinds' Feet Farm named as recipient. The information cannot be disclosed without prior written authorization, except as other wise provided by law.

FOR OFFICE USE ONLY:

Hinds' Feet Farm's Admissions Committee has reviewed this individuals needs and feels that they are appropriate for Hinds' Feet Farm's ______________________________ programs.

____________________	____________
Program Director Signature	*Date*
____________________	____________
Coordinator Signature	*Date*

Residential Services Agreement

This Residential Services Agreement is a binding legal document between Hinds' Feet Farm (provider) and ______________________________________(payor) on behalf of __________________________________ (resident).

The (provider) agrees to provide residential services for (resident) in Puddin's Place, a 6-bed long-term care home, located at 14645 Black Farms Road, Huntersville, North Carolina 28078. This residence is operated by Hinds' Feet Farm, Inc., a non-profit corporation with a principal address of 14625 Black Farms Road, Huntersville, North Carolina 28078.

Services to be provided within the scope of Residential Service Agreement:

- One private bedroom with walk-in closet
- Shared bathroom with private personal toiletry locker
- Open communal living spaces (living room, dining room, kitchen, etc.)
- Board, to include (3) three meals daily that meet the nutritional and dietary requirements of (resident)
- (24) Twenty-four hour professional care staff and supervision, 365 days per year.
- Care staff will provide daily living care for (resident) per the resident's care plan and person centered plan (see attached Residential Care Plan)
- Laundry services
- Bed linens and bath towels
- Transportation to and from routine and local medical appointments, not to exceed (4) four times per month
- Medication administration by trained care staff
- Transportation with other residents and staff on community outings (shopping, movies, restaurants, etc.)
- Access to phone, internet, and television in common areas
- Membership in the Hinds' Feet Farm Day Program is included
- Bi-lingual staff (Spanish only)

Services NOT to be included within the scope of Residential Service Agreement:

- All charges associated with medical appointments. Charges for these services will be billed separately to the (payor), Medicaid/Medicare or other private insurance as appropriate by the medical professional
- All prescription medication and related medical supplies. Charges for prescription medication will be billed separately to the (payor), Medicaid/Medicare or other private insurance as appropriate by the pharmacy
- Any additional therapy such as but not limited to physical therapy, occupational therapy, speech therapy, psychotherapy, etc**.** Charges for these services will be billed separately to the (payor) , Medicaid/Medicare or other private insurance as appropriate by the medical professional providing such services
- Clothing, toiletries, and personal care/hygiene products (toothbrush, soap, shampoo, razors, etc.)
- Bedroom furniture (bed, mattress, night stand, etc.)
- Incontinence related products such as adult diapers
- Transportation to private medical/therapy appointments in excess of (4) four times per month
- Private phone (in resident's bedroom)
- Private television and cable (in resident's bedroom)
- Private computer / internet access (in resident's bedroom)
    - If private computer / internet access is needed, resident or payor must provide an appropriate computer with wireless capability to connect to the residential home's wireless network
- Interpretation and translation services for languages other than English and Spanish.
- Durable medical equipment as needed for resident's specific needs (wheelchair, walker, standing frame, etc.)
- Personal spending money

Miscellaneous

(Resident) is required to abide by the rules and regulations outlined in the Membership Criteria, Rights, Responsibilities, and Program Rules (attached).

(Resident) agrees to comply with the goals and plans outlined in the Residential Care Plan and Person Centered Plan. These plans will be updated/revised at least annually but may be updated more frequently if required.

(Resident) may choose to bring and/or purchase his/her own furniture. For safety purposes (per the Division of Health Service Regulation and the Local Health Department) all furniture must be approved by the (provider) before it can be placed in the resident's bed room.

Furniture may be purchased by (payor) on behalf of (resident) as necessary. (Payor) and (resident) may choose from one of several bedroom furniture options to be provided by

(provider) upon request. This furniture may be purchased for one-time fee and will become the property of the (resident).

Minimum furnishings for (resident) bedroom must include: bed, bedding, pillow, bedside table and storage for personal belongings per the Division of Health Service Regulation for Mental Health/Developmental Disability/Substance Abuse Services 10A North Carolina Administrative Code 27G.0304.

A private phone, television with cable access, and/or computer with wireless internet access may be purchased for the (resident) by the (resident) or (payor) upon request. These items may be purchased for a one-time installation fee and ongoing monthly service charge.

(Resident) may choose a different color of wall paint for his/her own bedroom upon request. The (resident)'s bedroom will be painted by the (provider). There will be a one-time fee assessed to repaint the (resident's) bedroom.

It is anticipated that the (residents) and staff will be out in the community often. Therefore, family members are encourage to call the residence at (704) 992 -5762 to arrange a visit. For security purposes, all visitors must to sign in and out on the Visitor Log located in the residence.

Residential Services Rate Summary

Residential Rate $ _________ (per day)

Day Program Membership (Included)

Non-Refundable Damage Deposit $ _________ (one-time fee)

Other Agreed Upon Services:

Description________________________________ Rate $ ________ ( )

Description________________________________ Rate $ ________ ( )

Description________________________________ Rate $ ________ ( )

Description________________________________ Rate $ ________ ( )

Description________________________________ Rate $ ________ ( )

Residential Services Terms

The (payor) agrees to pay the first month and the last month's services to (provider) in upon admission. The payment for the last month's services may be applied to the balance due, prorated and/or refunded upon termination of services.

The first (90) ninety days of residence will be considered a trial placement period. During this time, the (provider) will perform a complete assessment of the (resident)'s needs, challenges and strengths to determine whether or not the (resident) is appropriate for regular placement and is not beyond the (provider)'s ability to provide safe and effective care for all residents. Should the (resident) not be appropriate, all parties shall be informed and the (resident) will be discharged in accordance with Hinds' Feet Farm's Residential Discharge Policy and Procedure.

During the first (30) thirty days of residence, the (provider) will create a complete Residential Care Plan which will outline the specific care needs of the (resident). The Residential Care Plan will be updated on at least an annual basis, but may be changed at any time based on the (resident)'s needs.

During the first (30) thirty days of residence, the (provider) will create a complete Person Centered Plan (PCP) which will outline the specific challenges and goals of the (resident). The Person Centered Plan will be updated on at least an annual basis, but may be changed at any time based on the (resident)'s needs.

The (provider) will invoice the (payor) the last week of each month for the services provided. Invoice terms are net (30) unless alternative terms are agreed upon. A service charge of 1.5% will be charged per month for invoices over 30 days past due.

The (provider) agrees to provide the (payor) with detailed documentation of the services provided to the (resident) on behalf of the (payor) in a mutually agreed upon format.

The damage deposit is due upon admission and is non-refundable.

In the event of the termination of residential services with (provider), any furniture and/or belonging to the (resident) or purchased by the (payor) on behalf of the (resident) may be removed by the (resident), (payor) or agents of the (resident/payor). (Provider) will not provide storage or moving services for the (resident). All belongings and/or furniture must be removed from the residence within (15) fifteen days of discharge.

The (payor) agrees to provide the (provider) with at least (30) thirty day notice in the event the (resident) decides to seek alternative residential placement.

The (provider) agrees to provide (payor and/or guardian) with at least (60) sixty day notice in the event of an involuntary discharge. An involuntary discharge will occur when the (provider) has determined that (resident) is inappropriate for the (provider)'s services and the (provider) is unable to safely accommodate and provide appropriate services for the (resident). The (resident) may be discharged by the (provider) on an emergency

discharge basis when a significant incident has occurred that poses a clear risk of mental, sexual, and physical harm to the (resident), other residents, and/or staff. Emergency discharges are effective immediately.

Should the (payor) become (90) ninety days past due in invoices for the services provided to the (resident) by the (provider), alternative living placement must be sought out by the (payor and/or legal guardian) and the (resident) will be discharged to that alternative living placement. Any costs associated with such placement are the responsibility of the (payor).

Invoices should be sent to:

Contact Person: ____

Address: ____

Phone: ____

Fax: ____

Email:____

Question concerning any invoices may be directed to:

Hinds' Feet Farm
Attn: Office Manager
PO Box 2842
Huntersville NC 28070
Office: (704) 992 - 1424
Fax: (704) 992 – 1423

Authorized Signatures

For (provider)

Signature ________________________ Print ___________________ Date __________

Authorized (payor)

Signature ________________________ Print ___________________ Date __________

(Resident) and/or legal guardian

Signature ________________________ Print ___________________ Date __________

Residential Care Plan

I. Resident Information

Client Name: ____ D.O.B.__________________

Address: ____

Phone: ____ Sex: _____ M _____ F

Diagnosis:

____

Allergies: Yes or No (if yes, complete Allergy section)

Seizures: Yes or No (if yes, complete Seizure section)

Primary Health Insurance Provider:

____

Secondary Health Insurance Provider:

____

Tertiary Health Insurance Provider:

____

Hospital of Choice: ____

Please list the name, specialty, address, phone number, and frequency of visit for all current healthcare professionals:

Name	Specialty	Address	Phone	Frequency of Visit

Name	Specialty	Address	Phone	Frequency of Visit

Primary Emergency Contact (Name, address, phone):

____

Legal Guardian (Name, address, phone):

____

Nurse Case Manager/Social Worker (Name, address, phone):

____

Attorney (Name, address, phone):

____

II. Services Received

Describe all other services the client receives regularly (provide contact name, description of service, and phone number):

____

____

____

____

____

III. Summary of Client Condition

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

IV. General Assessment Information

Verbal Communication (including use of call system):

____

Hearing: ____

Vision: ____

Orientation (defined as the awareness of an individual to his/her present environment in relation to person, place, and time):

____

____

____

V. Activities of Daily Living

INSTRUCTIONS: For use of the tasks listed, check the level of assistance needed from the Personal Care Assistant and/or describe the procedure.

Dressing:
Level of Assistance:

( ) Can dress with no help
( ) Needs minimal supervision or reminding
( ) Needs help to put on clothing
( ) Is dressed by another person
( ) Is never dressed

Describe procedure: ____

____

( ) Check here if client's behavior complicates completion of task.

Range of Motion (ROM):

Describe Procedure**:** ____

____

____

( ) Check if client's behavior complicates completion of task.

Application of Prosthetics/Orthotics:

Describe Procedure:____

____

____

____

( ) Check here if client's behavior complicates completion of task.

Grooming:

Level of Assistance

( ) Grooms self with no help
( ) Needs supervision or reminding
( ) Needs daily help from another person
( ) Is completely groomed by another person

Describe Procedure: ____

____

( ) Check here if client's behavior complicates completion of task.

Bathing:

Level of Assistance

( ) Bathes without help of any kind
( ) Needs minimal supervision and reminding
( ) Needs supervision only
( ) Needs help getting in and out of tub
( ) Needs help washing and/or drying body
( ) Is completely bathed by another person

Describe Procedure: ____

____

____

____

____

____

( ) Check here if client's behavior complicates completion of task.

Skin Care:

Describe Procedure: ____

____

____

____

____

( ) Check here if client's behavior complicates completion of task.

Eating:

Level of Assistance

( ) Feeds self without help of any kind
( ) Needs minimal Supervision and reminding
( ) Needs help cutting food, buttering bread, etc.
( ) Needs partial feeding from another person (needs observation for choking or inappropriate behavior)
( ) Needs total feeding from another person

Describe procedure: ____

____

____

____

( ) Check here if client's behavior complicates completion of task.

Special Diet/Concerns: ____

____

Meal Preparation:

____

____

Does Client require assistance with grocery shopping? Yes or No

Type of Assistance:____

Transfers:

Level of Assistance

( ) Transfers without help of any kind
( ) Needs guidance only by presence of another person
( ) Needs assistance of one person or two as needed
( ) Needs mechanical aid (hoyer lift, etc.)
( ) Remains in bed

Describe Procedure: ____

____

____

____

( ) Check here if client’s behavior complicates completion of task.

Mobility:

Level of Assistance

( ) Walks without assistance of any kind
( ) Needs help of a device (cane, walker, etc.)
( ) Needs help of one person
( ) Needs help of two people
( ) Not able to walk

Describe Procedure: ____

____

____

____

( ) Check here if client's behavior complicates completion of task.

Positioning:

Level of Assistance:

( ) Moves self in bed without any help
( ) Needs occasional help from another to sit up
( ) Always needs help from another person to sit up
( ) Needs help in turning and positioning

Describe Procedure: ____

____

____

____

( ) Check here if client's behavior complicates completion of task.

Toileting:

Level of assistance

( ) Uses toilet without help
( ) Needs help to toilet, not incontinent
( ) Occasional incontinence, not more than once a week
( ) Incontinent at night
( ) Incontinent bladder, more than once a week
( ) Incontinent bowel, more than once a week
( ) Incontinent bowel and bladder.

Describe Procedure: ____

____

____

____

( ) Check here if client's behavior complicates completion of task.

VI. Medications & Medical Equipment

Does the client need assistance with medications: Yes or No

Describe type of assistance needed: ____

____

____

List of Medications:

Medication	Frequency/Dosage	Route

Allergies and Allergic Reactions:

____

____

____

____

Special Instructions: ____

____

Does a Personal Care Assistant need to accompany the client to medical appointments?

Yes or No

Special Instructions: ____

____

____

( ) Check here if client's behavior complicates completion of task.

Maintenance Exercises Other Than Range of Motion (Ambulatory, Standing Table, etc.):

Describe Procedure: ____

____

____

Clean/Maintain Medical Equipment

Check equipment used by the client:

( ) Manual Wheelchair
( ) Electric Wheelchair
( ) Motorized scooter
( ) Communication System
( ) Standing Frame
( ) Walker
( ) Splints
( ) Crutches
( ) Hospital Bed
( ) Other ____________________________
( ) Cane
( ) Braces
( ) Ted Socks
( ) Commode

Describe Procedure: ____

____

____

____

VII. Seizures

Does the client have a seizure disorder? Yes or No

Describe the type of seizures: ____

____

____

____

Describe seizure triggers (if known):

____

____

Describe the client's typical motor activity during a seizure:

____

____

____

Frequency of Seizures: ____

Duration of Seizures: ____

Specific seizure first aid and other instructions for this client:

____

____

____

____

____

VIII. Behaviors

( ) Socially offensive
( ) Withdrawn
( ) Sexually uninhibited
( ) Unusual/repetitive habits
( ) Needs prompts/assistance to initiate task
( ) Needs intermittent prompts/assistance during a task
( ) Needs ongoing prompts/assistance during task

Describe behaviors: ____

____

____

____

____

____

____

____

Describe Appropriate Procedures or Plan: ______________________________

____

____

____

____

____

____

____

____

Does the client have a substance abuse treatment background, in the past or currently?
Yes or No

Describe:

____

____

____

____

Does the client have a criminal record? Yes or No

Offenses	Conviction Dates

Does the client have any pending charges? Yes or No

Is the client currently on probation? Yes or No

IX. Independent Living Skills

Describes the type of assistance required, frequency, and other supports this client receives:

Nutritional Management/Cooking:

____

____

____

House Hold Management:

____

____

____

Community Orientation and Mobility:

____

____

____

Interpersonal Relationships/Communication: ____________________________________

____

____

Safety and Self Defense:____

____

____

Working With Staff: ____

____

____

Time and Schedule Management: ____

____

____

Knowledge of Resources: ____

____

X. Additional Information/Special Concerns

____

____

____

____

XI. Individuals & Entities Authorized to Transport Individual

Name	Phone

XII. Signatures

Client Signature____ Date: ________________

Print Name ____

Legal Guardian Signature____________________________________ Date: ________________

Print Name ____

Staff Signature: ____ Date: _________________

Print Name ____

HINDS' FEET FARM
SUBSTANCE ABUSE CONTRACT

The goal at Hinds' Feet Farm program is to maximize member's physical and mental potential with integrated, unique and holistic programs; allowing them to pursue meaningful activities while developing a sense of belonging at home and in the surrounding communities. Current research findings in the field of brain injury indicate that the use of alcohol, nonprescription, and abuse of prescription drugs can adversely affect a person living with brain injury's quality of life.

Therefore, the use of alcohol, nonprescription, and abuse of prescription drugs are not allowed during Hinds' Feet Farm's program hours, any social event at Hinds' Feet Farm and/or during any outings in the community with Hinds' Feet Farm staff. Members that use nonprescription drugs and/or abuse of prescription drugs may be suspended from services with Hinds' Feet Farm. All new members must be drug free for a period of 90 days prior to admission of the residential or day program.

All participation at Hinds' Feet Farm is voluntary. In order to participate at Hinds' Feet Farm, you are required to sign the below Substance Abuse contract form.

I, ____________________, agree to the following while participating at Hinds' Feet Farm effective as of today.

1. I will not use alcohol or other prescription or nonprescription drugs not prescribed to me by my physician during program hours, any social event at Hinds' Feet Farm and/or during any outings in the community with Hinds' Feet Farm staff.
2. I will undergo an alcohol and drug screen if deemed necessary by Hinds' Feet Farm staff.
3. If my alcohol or drug screen is positive, I may immediately be suspended from Hinds' Feet Farm programs and/or referred for a detoxification treatment program.
4. I attest that I have not used nonprescription drugs and/or abused prescription drugs within 90 days prior to admission to the residential and/or day program.

______________________________ ______________
Name & Signature **Date**

______________________________ ______________
Guardian's Name & Signature (if applicable) **Date**

______________________________ ______________
Hinds' Feet Farm Staff Name & Signature **Date**

FOR OFFICE USE ONLY	
Member Name:	**DOB:**
HFF ID #:	
Medicaid ID #:	

HINDS' FEET FARM MEMBERSHIP CRITERIA,PROGRAM RULES, RIGHTS &RESPONSIBILITIES

This information is given to all Hinds' Feet Farm (HFF) members, staff, community volunteers, student interns, and visitors. Members of HFF have a right to receive service information, including their rights and responsibilities.

RESIDENTIAL MEMBERSHIP CRITERIA
In order to become a member a person must be: ▪ Must be at least 18 years of age. Minors will not be served regardless whether consent is given by parent/guardian. ▪ Must have an established traumatic brain injury (TBI) or acquired brain injury (ABI) diagnosis and be in need of placement. ▪ Must be medically stable and not requiring a level of medical care beyond the management and training of our staff. ▪ Must be at Level VI or higher on the Ranchos Los Amigos Scale. ▪ Must need moderate to maximum assistance with activities of daily living (ADLs). ADLs will be assessed by Hinds' Feet Farm QP staff initially and are subject to ongoing assessment as needed. ▪ Must not be a danger to self or others. ▪ Must not have severe behavioral issues that are beyond the capacity and level of care of Hinds' Feet Farm's staff. ▪ Must not be an active drug user and must be willing to comply with the rules of our drug, alcohol, and tobacco free home. ▪ Must be willing to live in a communal environment without physical restraints. ▪ Must be a legal U.S. citizen. ▪ Must have a combination of fiscal resources sufficient to meet the room and board rate. ▪ Must have a secured source of funding to pay for all costs related to medical care and medications.

DEFINITIONS

What is a right?
Something you can do by law.

What is a rule?
Something set up by a program or Area Program or the State so things will run smoothly.

What is a responsibility?
Something you agree to do to the best of your ability.

WHAT ARE RIGHTS AND RESTRICTIONS?

"Rights restrictions" limit or take away a person's right to do something. Your rights cannot be taken away without safeguards in place to protect you. Your rights may be limited if you might harm yourself or other persons and could involve an involuntary commitment.

A very specific change to your person-centered plan must be approved by your team before your rights are limited in any way. A human rights committee may need to approve some restrictions. You or your guardian will participate in making these decisions.

A person's rights cannot be taken away because of the way others behave, because of staffing problems, because it is easier for staff or because it will make your home, work, or community operate more smoothly.

For minors under age 18, a parent or legal guardian makes treatment and service decisions for you or with you.

If you feel your rights are being violated, you have the right to contact Disability Rights North Carolina (formerly the Governor's Advocacy Council) at 1-919-856-2195.

If you have any concerns that we have not been able to correct, please contact the Department of Health and Human Services Client Complaint Hotline at 1-800-624-3004.

MEMBERS' BILL OF RIGHTS

Members have the right to:

1. Be treated with respect, dignity, and integrity.
2. Be empowered, self-determined, and person-centered with free-choice in a welcoming, belonging, community and clubhouse program.
3. Be self-governing through the fluidity of the program and will have opportunities to participate in person-centered planning, and to engage in reestablishing and empowering occupation or meaning in life.
4. Be a part of Hinds' Feet Farm's holistic health and wellness, and empowerment philosophy.
5. Know the membership criteria and program rules.
6. Be free from sexual harassment, physically or mentally abused or exploited.
7. Privacy and confidentiality; and have confidential records that cannot be released without the individual's or guardian's written permission.
8. Voice their opinions, needs, improvements, contributions, grievances, and other thoughts to HFF program staff.
9. A smoke free environment, except in designated smoking areas.
10. Not be denied appropriate care on the basis of the individual's race, religion, color, national origin, sex, age, disability, marital status, or source of payment.
11. Not be prohibited from communicating in the individual's native language with other individuals or employees for the purpose of acquiring any type of treatment, care or services.

MEMBERS' BILL OF RIGHTS -CONTINUED

12. Present grievances on his/her own or another's behalf to the director, manager, state agencies, or other persons without threat of reprisal in and manner and expectation of response from the person providing services.

13. Engage in unrestricted communication, including person visitation with any person of the individual's choice, including family members and representatives of advocacy groups and community service organizations at any reasonable hour.

14. Make contacts with the community and achieve the highest level of independence, autonomy, and interaction with the community of which the person is capable.

15. Manage financial affairs or have at least quarterly accounting of financial transactions made by others with the individual's written consent.

16. Inspect one's own personal records maintained by service providers.

17. Have the person providing the services answer questions concerning health, treatment, and condition unless a physician determines that the knowledge would harm the individual and documents it in the record.

18. Refuse treatment, including medications, after the possible consequences of refusing are fully explained.

19. Be provided unaccompanied access to a telephone at a reasonable hour in case of an emergency or personal crisis.

20. Retain and use personal property in the immediate program space.

21. Refuse to perform services for the program, except as the contracted for the individual and facility.

22. Be informed, in writing, by the person providing services of available services and the applicable charges of the services are not covered by insurance, etc.

23. Unless previously arranged, not be transferred or discharged, except in an emergency situation, in which case the individual or guardians must be notified immediately.

24. Leave the program temporarily or permanently, subject to contractual or financial obligations.

25. Due process procedures for any member who refuses the use of restrictive interventions. These types of interventions are outlined in the Consent for Use of Least Restrictive Alternatives & Interventions form which must be maintained in the member record and signed by the member/guardian and qualified professional staff on an annual basis. For the safety of Hinds' Feet Farm's members and staff, Hinds' Feet Farm will not admit or renew program membership for any involuntary member who refuses the use of restrictive interventions.

(Adopted in part from the Brain Injury Association of America's American Academy for the Certification of Brain Injury Specialists)

In addition, Hinds' Feet Farm will uphold the following additional rights for Residential Members as specified in **North Carolina Statutes Chapter 122C, Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985, Article 3, Clients' Rights and Advance Instruction, 122C-61 and 122C-62:**

"**§ 122C-61. Treatment rights in 24-hour facilities.**

In addition to the rights set forth in G.S. 122C-57, each client who is receiving services at a 24-hour facility has the following rights:

(1) The right to receive necessary treatment for and prevention of physical ailments based upon the client's condition and projected length of stay. The facility may seek to collect appropriate reimbursement for its costs in providing the treatment and prevention; and

(2) The right to have, as soon as practical during treatment or habilitation but not later than the time of discharge, an individualized written discharge plan containing recommendations for further services designed to enable the client to live as normally as possible. A discharge plan may not be required when it is not feasible because of an unanticipated discontinuation of a client's treatment. With the consent of the client or his legally responsible

person, the professionals responsible for the plans shall contact appropriate agencies at the client's destination or in his home community before formulating the recommendations. A copy of the plan shall be furnished to the client or to his legally responsible person and, with the consent of the client, to the client's next of kin. (1973, c. 475, s. 1; c. 1436, ss. 6, 7; 1981, c. 328, ss. 1, 2; 1985, c. 589, s. 2.)

§ 122C-62. Additional rights in 24-hour facilities.

(a) In addition to the rights enumerated in G.S. 122C-51 through G.S. 122C-61, each adult client who is receiving treatment or habilitation in a 24-hour facility keeps the right to:

(1) Send and receive sealed mail and have access to writing material, postage, and staff assistance when necessary;

(2) Contact and consult with, at his own expense and at no cost to the facility, legal counsel, private physicians, and private mental health, developmental disabilities, or substance abuse professionals of his choice; and

(3) Contact and consult with a client advocate if there is a client advocate.

The rights specified in this subsection may not be restricted by the facility and each adult client may exercise these rights at all reasonable times.

(b) Except as provided in subsections (e) and (h) of this section, each adult client who is receiving treatment or habilitation in a 24-hour facility at all times keeps the right to:

(1) Make and receive confidential telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party;

(2) Receive visitors between the hours of 8:00 a.m. and 9:00 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over therapies;

(3) Communicate and meet under appropriate supervision with individuals of his own choice upon the consent of the individuals;

(4) Make visits outside the custody of the facility unless:

a. Commitment proceedings were initiated as the result of the client's being charged with a violent crime, including a crime involving an assault with a deadly weapon, and the respondent was found not guilty by reason of insanity or incapable of proceeding;

b. The client was voluntarily admitted or committed to the facility while under order of commitment to a correctional facility of the Division of Adult Correction of the Department of Public Safety; or

c. The client is being held to determine capacity to proceed pursuant to G.S. 15A-1002;

A court order may expressly authorize visits otherwise prohibited by the existence of the conditions prescribed by this subdivision;

(5) Be out of doors daily and have access to facilities and equipment for physical exercise several times a week;

(6) Except as prohibited by law, keep and use personal clothing and possessions, unless the client is being held to determine capacity to proceed pursuant to G.S. 15A-1002;

(7) Participate in religious worship;

(8) Keep and spend a reasonable sum of his own money;

(9) Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes; and

(10) Have access to individual storage space for his private use.

(c) In addition to the rights enumerated in G.S. 122C-51 through G.S. 122C-57 and G.S. 122C-59 through G.S. 122C-61, each minor client who is receiving treatment or habilitation in a 24-hour facility has the right to have access to proper adult supervision and guidance. In recognition of the minor's status as a developing individual, the minor shall be provided opportunities to enable him to mature physically, emotionally, intellectually, socially, and vocationally. In view of the physical, emotional, and intellectual immaturity of the minor, the 24-hour facility shall provide appropriate structure, supervision and control consistent with the rights given to the minor pursuant to this Part. The facility shall also, where practical, make reasonable efforts to ensure that each minor client receives treatment apart and separate from adult clients unless the treatment needs of the minor client dictate otherwise.

Each minor client who is receiving treatment or habilitation from a 24-hour facility has the right to:

(1) Communicate and consult with his parents or guardian or the agency or individual having legal custody of him;

(2) Contact and consult with, at his own expense or that of his legally responsible person and at no cost to the facility, legal counsel, private physicians, private mental health, developmental disabilities, or substance abuse professionals, of his or his legally responsible person's choice; and

(3) Contact and consult with a client advocate, if there is a client advocate.

The rights specified in this subsection may not be restricted by the facility and each minor client may exercise these rights at all reasonable times.

(d) Except as provided in subsections (e) and (h) of this section, each minor client who is receiving treatment or habilitation in a 24-hour facility has the right to:

(1) Make and receive telephone calls. All long distance calls shall be paid for by the client at the time of making the call

or made collect to the receiving party;

(2) Send and receive mail and have access to writing materials, postage, and staff assistance when necessary;

(3) Under appropriate supervision, receive visitors between the hours of 8:00 a.m. and 9:00 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over school or therapies;

(4) Receive special education and vocational training in accordance with federal and State law;

(5) Be out of doors daily and participate in play, recreation, and physical exercise on a regular basis in accordance with his needs;

(6) Except as prohibited by law, keep and use personal clothing and possessions under appropriate supervision, unless the client is being held to determine capacity to proceed pursuant to G.S. 15A-1002;

(7) Participate in religious worship;

(8) Have access to individual storage space for the safekeeping of personal belongings;

(9) Have access to and spend a reasonable sum of his own money; and

(10) Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes.

(e) No right enumerated in subsections (b) or (d) of this section may be limited or restricted except by the qualified professional responsible for the formulation of the client's treatment or habilitation plan. A written statement shall be placed in the client's record that indicates the detailed reason for the restriction. The restriction shall be reasonable and related to the client's treatment or habilitation needs. A restriction is effective for a period not to exceed 30 days. An evaluation of each restriction shall be conducted by the qualified professional at least every seven days, at which time the restriction may be removed. Each evaluation of a restriction shall be documented in the client's record. Restrictions on rights may be renewed only by a written statement entered by the qualified professional in the client's record that states the reason for the renewal of the restriction. In the case of an adult client who has not been adjudicated incompetent, in each instance of an initial restriction or renewal of a restriction of rights, an individual designated by the client shall, upon the consent of the client, be notified of the restriction and of the reason for it. In the case of a minor client or an incompetent adult client, the legally responsible person shall be notified of each instance of an initial restriction or renewal of a restriction of rights and of the reason for it. Notification of the designated individual or legally responsible person shall be documented in writing in the client's record.

(f) The Commission may adopt rules to implement subsection (e) of this section.

(g) With regard to clients being held to determine capacity to proceed pursuant to G.S. 15A-1002 or clients in a facility for substance abuse, and notwithstanding the prior provisions of this section, the Commission may adopt rules restricting the rights set forth under (b)(2), (b)(3), and (d)(3) of this section if restrictions are necessary and reasonable in order to protect the health, safety, and welfare of the client involved or other clients.

(h) The rights stated in subdivisions (b)(2), (b)(4), (b)(5), (b)(10), (d)(3), (d)(5) and (d)(8) may be modified in a general hospital by that hospital to be the same as for other patients in that hospital; provided that any restriction of a specific client's rights shall be done in accordance with the provisions of subsection (e) of this section. (1973, c. 475, s. 1; c. 1436, ss. 2-5, 8; 1985, c. 589, s. 2; 1989, c. 625, s. 10; 1995, c. 299, s. 2; 1997-456, s. 27; 2011-145, s. 19.1(h).)”

MEMBER’S RESPONSIBILITY

Your Responsibilities:

- Give us all the facts about the problems you want help with and bring a list of all other professional s providing care for you.
- Follow your person-centered plan once have agreed to it.
- If you have Medicaid or other insurance, bring in your card each time you come to your member/family treatment meeting.
- Let us know about changes in your name, insurance, address, telephone numbers or your finances.
- Let us know when you have complaints or suggestions.
- Be very involved in developing and reviewing your person-centered plan. Ask for information about your service.

Talk to your case manager, counselor, or other staff often about your needs, preferences, and goals and how you think you are doing at meeting your goals.

PROGRAM RULES

Program Rules:

- Day Program members sign in and out at the Main Office when you arrive and leave.

The following are not allowed:

- Alcohol, illegal drugs. Tobacco products are allowed in designated areas only.
- Physical violence toward people or property.
- Sexual activity or sexual harassment.
- Weapons.
- Profanity.
- Theft, destruction of property and/or vandalism.

I, ____, have received information related to the Members'

Rights and Responsibilities on (date) ___________________.

______________________________	______________
Name & Signature	**Date**
Parent/Guardian's Name & Signature (if applicable)	**Date**
Hinds' Feet Farm Staff Name & Signature	**Date**

HINDS' FEET FARM
CONSENT FOR USE OF
LEAST RESTRICTIVE ALTERNATIVES & INTERVENTIONS

Least Restrictive Alternatives

Hinds' Feet Farm will promote a safe and respectful environment which will include:

1. Using the least restrictive, most appropriate and effective treatment modality
2. Promoting coping and engagement skills that are alternatives to injurious behavior to self or others
3. Providing choices of activities meaningful to the members served
4. Sharing of control over decisions with the member, legally responsible person, and staff

The use of a restrictive intervention procedure designed to reduce a behavior shall always be accompanied by actions designed to insure dignity and respect during and after the intervention. These include:

1. Using the intervention as a last resort
2. Employing the intervention by people trained in its use

(APSM95-2, 10A NCAC 27E.0101)

The program shall center on the use of positive treatment or habilitation methods to reduce maladaptive behaviors. The following are examples of positive treatment or habilitation methods:

- The deliberative teaching/reinforcement of behaviors which are non-injurious.
- The improvement of conditions associated with non-injurious behaviors such as an enriched education and social environment.
- The alteration or elimination of environmental conditions, which are reliably correlated with self-injury.
- Using the least restrictive and most appropriate settings and methods.
- Promoting coping and engagement skills that are alternatives to injurious behavior to self or others.

Types of Interventions

Hinds' Feet Farm designates interventions that can be used with and without prior approval from a qualified professional in order to provide guidance to staff in implementing behavior management plans. Hinds' Feet Farm also designates interventions that are prohibited procedures under any circumstance. Hinds' Feet Farm's Board of Directors may determine to prohibit use of any interventions deemed unacceptable.

Hinds' Feet Farm employees who are trained in North Carolina Interventions (NCI) Core Plus are allowed to use Restrictive Intervention only in the following circumstances:

1. When member exhibits behavior that will put he/she or others in an unsafe situation which includes but not limited to; physical aggression, use of objects, running towards moving vehicle, etc., AND
2. Consent a for a Positive Behavior Support Plan and Psychotropic Medications form and/or Consent for Use of Least Restrictive Alternatives and Interventions form must be explained and signed by member or parent/legal guardian, the Program Director or QP staff designee, and Client Rights Committee Chairperson (if applicable) AND
3. Use of any planned restrictive intervention must be included in the member's Positive Behavior Support Plan and Person Centered Plan.

Interventions Allowable Without Prior Approval From a Qualified Professional

The emergency interventions that staff may implement, if needed, before obtaining supervisory authorization from a qualified professional include:

- Correction - This involves verbally directing and physically prompting a member to restore to their original state, an aspect of the environment or other person's property, which they have inappropriately changed. This procedure does not involve physically forcing the member to comply or using abusive language or threats to obtain compliance.
- Response Cost - This involves removing an object, including a personal possession or food, which the member is using in a dangerous or inappropriate manner, or denying access to a routinely scheduled activity. A scheduled meal may not be denied, but may be delayed for up to 30 minutes if a member is behaving inappropriately and is not able to participate in normal mealtime activities. If the member is unable to continue or participate in a meal within the time allotted, then a nutritionally equivalent substitute must be offered within 15 minutes of the time the member is able to behave adaptively.
- Contingent Observation Time-Out - which involves removing a member from an activity, but allowing them to remain in the room where the activity is in progress.
- Isolation Time-Out - which involves removing a member to an unlocked room or other part of the usual living area and maintaining the member in that area by verbal prompting or by engaging in an appropriate activity not to exceed 30 minutes. A staff member must remain in attendance to monitor, have continuous observation, and verbal interaction with the member, when appropriate. This observation must be documented in the member's record.
- NCI Walk - This involves using an approved North Carolina Intervention (NCI) therapeutic hold as to guide ambulation to move a member to a safe environment.
- Brief NCI Restraint - This involves limiting the movement of a member by using an approved NCI method to physically hold them for a period of up to fifteen (15) minutes. This restrictive intervention, also termed "personal restraint", may be used only to stop an on-going, highly dangerous behavior and may be implemented only by a person certified to use the hierarchy of restraints prescribed by the NCI manual. Any type of restrictive intervention must be documented in the member's record and an incident report that is submitted through North Carolina Incident Response Improvement System (NC IRIS). However, any restraint used where the member ends up in a prone or face-down position is strictly prohibited for any reason.

Interventions Requiring Prior Approval from a Qualified Professional

Any extended NCI Restraint, which involves restricting a member's movement by holding them for periods longer than 15 minutes, may be used to protect an individual only after authorization by a qualified professional. However, any restraint used where the member ends up in a prone or face-down position is strictly prohibited for any reason.

Interventions Requiring Physician Approval

Protective interventions involving mechanical or chemical restraint may be implemented only upon written authorization by a physician at the time of the incident. A verbal order may be secured in an emergency by the qualified professional with a written order being secured within 24 hours. Standing orders shall not be used for mechanical or chemical restraint.

Mechanical Restraint - involves the use of any mechanical device such as bed restraints, splints, helmet, mittens or other device to limit movement of the member. Interventions required for medical issues

require written order of a physician. Interventions required for behavioral issues require the implementation of a Positive Behavior Support Plan and approval/consent from the Client Rights Committee Chairperson and guardian.

Chemical Restraint - involves the administration of a drug to subdue or calm the member. Chemical restraints must be ordered by the physician for a one time use only. Approved chemical restraints will only be administered by staff trained in interventions and medication administration. In conjunction with this order, staff will implement a Positive Behavior Support Plan and approval/consent from the Client Rights Committee Chairperson and guardian.

Prohibited Procedures

The use of the following procedures is specifically prohibited at Hinds' Feet Farm:

- Corporal Punishment - defined as physically striking an individual, using any physical force to cause painful bodily contact, or any intervention which would be considered corporal punishment under General Statute 122C – 59.
- Seclusion - defined as placing an individual alone, without supervision or monitoring, and in any room or area from which exit is prevented by any means.
- Restraint Furniture - defined as enclosed cribs, boxes, chairs, or other furniture designed to enclose or prevent movement of body parts.
- Restrictive Use of Appliances - defined as locking wheelchairs or denying access to an appliance necessary for ambulation contingent upon behavior without authorization as a protective intervention or as part of a planned program.
- Aversive Stimulation - defined as applying painful stimuli or substances to any body part or sense organ including, but not limited to electric shock, insulin shock, unpleasant tasting food, or noxious substances contingent upon behavior.
- Key-lock Doors - defined as using key-locks on doors for the purpose of confining an individual. Key-locks may be used to control entrance to storage areas.
- Discipline by Individuals - defined as allowing one peer to carry out restrictive interventions against another peer.
- Verbal Abuse - defined as communicating with an individual by word, tone of voice, facial expression or gesture in a way that frightens, intimidates, threatens or demeans the individual.
- Denying the individual access to food or water within their scheduled time solely for the purpose of "protection".
- Denial of Home Visits is an unnecessarily punitive restriction as a disciplinary action.
- Forced Physical Exercise to eliminate behaviors.
- Physically Painful Procedures, excluding prescribed injections, or stimulus which is administered to the client for the purpose of reducing the frequency or intensity of a behavior.
- Prone or Face-Down Restraints, any hold or technique which involves restricting an member's movement where the member ends up in a prone or face-down position.

Name & Signature	Date
Parent/Guardian's Name & Signature (if applicable)	Date
Hinds' Feet Farm Staff Name & Signature	Date

HINDS' FEET FARM AUTHORIZATION TO RELEASE MEDICAL RECORDS

I ________________________________, **Legally Responsible Person of** ____________________________,
(Member/Guardian's Name) (Member's Name)

Hereby Authorize ____
(Physician, hospital, healthcare provider, or other mental health service provider)

Address: ____
(Street/Suite) (City) (State) (Zip)

To ☐ disclose, ☐ obtain, ☐ exchange medical information (indicated below) under authorization by mail, fax or e-mail to:

Name: Hinds'Feet Farm **Address:** P.O. Box 2842 Huntersville, NC 28070

From the health/medical records of: Name: ____________________________________
(Name of person whose health/medical record is being disclosed)

Date of Birth: ____________**SS#** __________________ **Address:** ____

For the purpose of: ____

My authorization extends only to those data elements indicated below:

- ☐ Social or Mental Health History
- ☐ Discharge Summary
- ☐ Records of Visits (all visits)
- ☐ Photographs, Videotapes or Other images
- ☐ Medical Assessment
- ☐ Consultation Report
- ☐ Progress Notes
- ☐ Assessment/Evaluations
- ☐ NC SNAP/Target POP
- ☐ Record of Visits for a Specific Date/Dates __________________________
- ☐ Substance Abuse (alcohol and drug abuse treatment).
- ☐ State of Charges or Payments
- ☐ Other (Must be Specific) __________________________
- ☐ All of the above

This authorization is freely given to (Hinds Feet Farm) with the understanding that:

1. I may revoke the authorization at any time, except where information has been released. This authorization is valid for a one (1) year period from the date it is signed, or for less time if revoked or less time, if noted below. The revocation must be in writing (form is available from Hinds Feet Farm).
2. All records, written, oral, or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
3. A photocopy or fax of this authorization is as valid as this original.
4. (Hinds' Feet Farm) its employees are hereby released from legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
5. Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon obtaining the Authorization.
6. Information use or disclosed pursuant to the Authorization may be subject to re-disclosure by the recipient and is no longer protected.

☐ **Yes**. I authorize Hinds' Feet Farm to re-disclose information that was generated by another agency separate from HFF.

☐ **No**. I do not authorize Hinds' Feet Farm to re-disclose information that was generated by another agency separate from HFF.

____ ____________________
Name & Signature **Date**

____ ____________________
Member/Guardian's Name & Signature (if applicable) **Date**

____ ____________________
Hinds' Feet Farm Staff Name & Signature **Date**

***To: Agencies receiving this information. PROHIBITION OF REDISCLOSURE: This information has been disclosed to you from a medical record whose confidentiality is protected. Any further re-disclosure is prohibited.**

FOR OFFICE USE ONLY	
Member Name:	**DOB:**
HFF ID #:	
Medicaid ID #:	

HINDS' FEET FARM INFECTIOUS & COMMUNICABLE DISEASE FORM

INFECTIOUS & COMMUNICABLE DISEASE FORM

For the protection of Hinds' Feet Farm (HFF) members, staff, community volunteers, student interns, and others, all participants and/or possible participants of Hinds' Feet Farm residential and day programs must attest to being free from any infectious or communicable disease, or the participant must inform Hinds' Feet Farm of which infectious/communicable disease they have. If a participant has an infectious/communicable disease, Hinds' Feet Farm will consult with the participant's doctor, HFF's Medical Director, and program staff to determine the participant's eligibility for program services.

Hinds' Feet Farm members, staff, community volunteers, student interns, and all others participating in residential and/or day programs who have contracted an infectious or communicable disease should refrain from reporting to work or participating in the programs until there is no risk of infecting others, and may be required to provide a signed note from a medical professional attesting to such.

All identified occurrence of infection exposure will be reportedly immediately to the Director and/or his/her designee so that the local Health Department can be notified for further instruction. An incident report will be completed. An investigation will occur into all incidents of infectious disease exposure. All findings will be reported to QA/QI committee for recommendations.

Hinds' Feet Farm members, staff, community volunteers, student interns, and all others participating at the day program will practice universal precautions and take other appropriate steps to prevent the spread of infectious and communicable diseases.

FOR OFFICE USE ONLY			
Member Name:		**DOB:**	
HFF ID #:			
Medicaid ID #:			

By signing below, you attest that you are free from any infectious/communicable disease (such as but not limited to HIV/AIDS, Hepatitis, TB, etc.).

Name & Signature	**Date**
Parent/Guardian's Name & Signature (if applicable)	**Date**
Hinds' Feet Farm Staff Name & Signature	**Date**

By signing below, you are confidentially informing Hinds' Feet Farm that you have an infectious or communicable disease and you understand that HFF reserves the right to determine participation eligibility.

Type of Infectious/Communicable Disease

Name & Signature	**Date**
Parent/Guardian's Name & Signature (if applicable)	**Date**
Hinds' Feet Farm Staff Name & Signature	**Date**

FOR OFFICE USE ONLY	
Member Name:	**DOB:**
HFF ID #:	
Medicaid ID #:	

AGREEMENT, AUTHORIZATION, AND CONSENT FOR RELEASE OF BACKGROUND INFORMATION

PLEASE TYPE OR PRINT

I, ____

LAST NAME FIRST NAME MIDDLE NAME (PLEASE INCLUDE Jr., Sr., II, III Etc.)

understand and hereby voluntarily authorize that in conjunction with my application for residency at Hinds' Feet Farm (Puddin's Place), Hinds' Feet Farm, Inc. will use the services of an outside agency to conduct a criminal history and identity check. This agency will provide a written report of its findings to Hinds' Feet Farm, Inc.. Hinds' Feet Farm, Inc. uses Sterling, a consumer-reporting agency, as an agent to perform its Residency related background investigations.

Sterling will utilize various sources of information it deems appropriate including but not limited to: criminal records, current and former employers, department of motor vehicle records, military records, credit reporting agencies, education records, licensing authorities, state and federal sanctioning authorities, professional and personal references and workers compensation records including any and all injuries in compliance with the Americans with Disabilities Act. I agree, authorize and consent to the release and disclosure of any and all information including but not limited to the above to Hinds' Feet Farm, Inc., and Sterling.

I agree, authorize and consent to the procurement of a Consumer Report and/or an Investigative Consumer Report and understand that it may contain information about my credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics, or mode of living. I also understand that any misrepresentation, falsification or omission of facts herein may be grounds for disqualification, refusal, or immediate termination of lease. This authorization in original or copy form shall be valid for my term of Residency from the date indicated next to my signature. According to the Fair Credit Reporting Act, I will be notified by Hinds' Feet Farm, Inc. if Residency is denied because of information obtained from a Consumer Reporting Agency. Additionally, I understand that if requested within 60 days, I will be given a full and accurate disclosure as to the nature and substance of all information provided to Hinds' Feet Farm, Inc.. I further understand that I may request a copy of the report, and that when doing so, proper identification will be required and I should direct my request to: Sterling, 3009 Douglas Blvd., 3rd Floor, Roseville, CA 95661. I understand that residents of all states will automatically receive a copy of the report if an adverse action is taken regarding the residency application, or upon request as outlined herein.

LAW ENFORCEMENT AGENCIES AND OTHER ENTITIES FOR POSITIVE IDENTIFICATION PURPOSES REQUIRE THE FOLLOWING INFORMATION WHEN CHECKING PUBLIC RECORDS. IT IS CONFIDENTIAL AND WILL NOT BE USED FOR ANY OTHER PURPOSES. PLEASE PRINT CLEARLY.

______________________________ ______________________________

Signed **Today's Date**

______________________________ ______________________________

Name as it appears on your driver's license **Position Applied For**

____ - ____ - ____ ___ / ___ / ___ ______________________________

Social Security Number **Date of Birth** **Driver's License Number** **State**

Other names you have used, or are also known as, including maiden name, name changes and any aliases:

____

PLEASE PROVIDE ALL RESIDENTIAL ADDRESSES FOR THE PAST 7 YEARS

Mo./Yr. / Mo./Yr

Current Address: ____ /

Street **Apt.#** **City** **State** **Zip Code** **From / To?**

Former Address: ____ /

Street **Apt.#** **City** **State** **Zip Code** **From / To?**

Former Address: ____ /

Street **Apt.#** **City** **State** **Zip Code** **From / To?**

Former Address: ____ /

Street **Apt.#** **City** **State** **Zip Code** **From / To?**