

Independent Living Services Referral Packet

We are pleased you are interested in learning more about programs offered at Independent Living Services. Please let us know if you have any questions or need assistance completing the forms. Our numbers are listed at the bottom of this page.

LEFT POCKET

The forms listed below must be completed to be eligible for admittance:

- _____ 1. Application for Services
- _____ 2. Annual Forms ***Profiles Only**
- _____ 3. Planning For My Future Questionnaire ***Profiles Only**
- _____ 4. Independent Living Skills Assessment Tool ***Profiles Only**
- _____ 5. Receipt of Notice of Privacy Practices (attached to Notice of Privacy Practices)
- _____ 6. Healthcare Declaration
- _____ 7. Physical Exam Form (must be completed by Primary Care Physician)
- _____ 8. Physician Referral Form for Services (must be completed by Primary Care Physician) ***Profiles Only**
- _____ 9. ADDT Medication Management Plan ***Profiles Only**
- _____ 10. HUD Funding ***Residential/Waiver Services Only**
- _____ 11. Supported Employment Application ***Supported Employment Only**

RIGHT POCKET (INFORMATIONAL ONLY – DO NOT RETURN TO ILS)

- 1. Independent Living Services pamphlet
- 2. Arkansas Adult Services Guide
- 3. Medicaid Waiver Information Sheet
- 4. Medicaid Waiver Contact Sheet
- 5. Consumer Handbook

REQUIRED DOCUMENTS

Copies of the documents listed below are required. Please attach them with the above completed forms:

- _____ 1. Recent psychological evaluation
- _____ 2. Birth certificate
- _____ 3. Medicaid card (proof of existing Medicaid number)
- _____ 4. PASSE Card (Empower, Summit or AR Total Care)
- _____ 5. Social Security card
- _____ 6. High school diploma / cert. of completion (**ONLY if individual is under 21 years of age**) ***Profiles Only**
- _____ 7. Guardianship papers (**ONLY needed if individual does not retain legal guardianship**)

If you have any questions, please give us a call:

Caleb Walker, Director of Day Services	501-327-5234 x 324
Evelyn Fecher-Ward, Program Director (Residential/Waiver)	501-327-5234 x 303
Robert Wright, Director of Supported Employment	501-327-5234 x 314

PO Box 1070, Conway, AR 72033 Phone (501)-327-5234 / Fax (501)-548-6432

Independent
Living Services

Independent Living Services & Creative Living

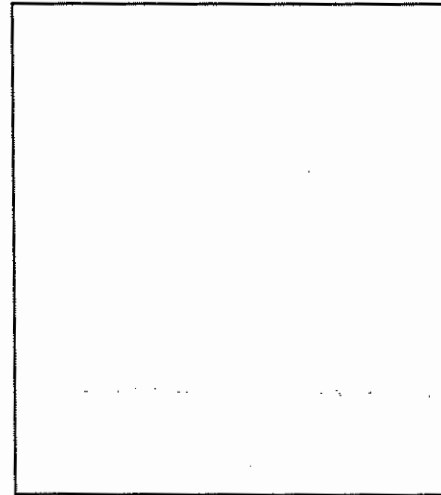
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Application for services from Independent Living Services, Inc.

The following items must be attached for the application to be complete:

1. Recent photo
2. Birth certificate (if available)
3. Psychological evaluations and results
4. Current medical information and history
5. High School diploma/Certificate of Completion (if under 21 years)
6. Guardianship papers, if applicable



Please check all the service(s) requested:

- _____ Group Home-Supervised Living (waiver, personal care, transportation)
- _____ Apartment Complex-Supervised Living (waiver, personal care, transportation)
- _____ Intermediate Care-Facility – Individual with Intellectual Disabilities (ICF/IID)
- _____ Medicaid Waiver Services in home
- _____ Profiles Adult Developmental Services (ADDT)
- _____ Profiles Productions Enrichment Center (Work Center)
- _____ Supported Employment

Licensed by the state divisions of Developmental Disabilities and Long Term Care Services
Please contact us if you require this information in another format



Revised 05/2016

**APPLICATION FOR ADMISSION
INDEPENDENT LIVING SERVICES, INC.
P.O. BOX 1070
CONWAY, AR 72033
(501) 327-5234**

Date Application Received: _____ Date of Admission: _____

Referral Source: _____



Name of Applicant (full): _____ Nickname: _____

Home Address: _____

Home Phone: _____ Cell Phone: _____ E-mail: _____

Date of Birth: _____ Birthplace: _____

Gender: _____ Marital Status: _____

Social Security #: _____ Medicaid Number: _____

Medicare #: _____ Part D Medicare: _____

Third Party Insurance: _____ Third Party Insurance #: _____

Name of Parent: _____ Phone: _____

Guardian: _____ Address: _____

Legal Status (i.e., competency) _____

SERVICES

Indicate the services that have been received, or are now being received by the applicant:

- | | |
|---|-------------------------------|
| _____ Adult Developmental Day Treatment | _____ HCBS Waiver |
| _____ Special Education | _____ Residential Services |
| _____ Regular school classes | _____ Mental Health Center |
| _____ Work Center | _____ Rehabilitation Services |
| _____ Supported Employment | _____ Nursing home |
| _____ ICF/IID | _____ Other: _____ |

Please use the back of this page to give details of any of the above services that were received or are now being received by the applicant. Include dates, place, type of service.

PERSONAL AND FAMILY INFORMATION

Briefly comment on the following items:

Social skills: _____

Abilities/Strengths: _____

Behavior concerns: _____

Relationship with family members: _____

Cultural issues needing consideration: _____

Please list members of the family below:

<u>Name</u>	<u>Relationship</u>	<u>Address</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

EMPLOYMENT FACTORS

List any special skills/training the applicant has for employment purposes:

Employer _____	Supervisor _____
Address _____	Phone _____
Length of employment _____	Salary/wage _____
Former employer _____	Type of work _____
Employer _____	Supervisor _____
Address _____	Phone _____
Length of employment _____	Salary/wage _____

FINANCIAL RESOURCES
(Answer Yes/No to following)

_____ SSI	_____ Pension/Annuity	_____ Savings
_____ SSDI	_____ Trust	_____ Checking
_____ Rep. Payee		

LIABILITY FACTORS

Primary diagnosis (proof must be attached) _____

Secondary diagnosis _____ Physical disabilities _____

MEDICAL INFORMATION

List any special medical care, diets, or physical limitations pertaining to the applicant's care.

Is the applicant currently being treated for a medical condition? _____

If so, explain in detail condition being treated (use back of form if additional space is needed)

Give Name, Dates of Last Visit and Address to the following:

Medical doctor _____

Dentist _____

Optometrist _____

Orthopedic Specialist _____

Speech Therapist _____

Physical Therapist _____

Occupational Therapist _____

Neurologist _____

Counseling Service _____

Please list other doctors, hospitals, clinics, agencies, etc. **(if possible with addresses)** that have additional information on the applicant.

Please explain any treatment and/or therapy now being received by the applicant.

Applicant's general health: Good _____ Fair _____ Poor _____

Comment on areas needing "special supervision" or where applicant may be at risk. Address potential or known risk that the applicant may present in new environment.

MEDICAL HISTORY

IMMUNIZATION RECORD

	Date Original Vaccination	Date Booster Given	Date Reaction Indication	Date Diagnosed
Diphtheria (DTP/DtaP/DT)				
Pertussis				
Typhoid				
Whooping Cough				
Polio (IVP or OPV)				
Tetanus				
Small Pox (Varcella)				
Mumps				
Rubella/Red/3-day/German				
Rubella/Hard/10-day Measles				
Hepatitis B				
Chicken Pox				
Tuberculin				
Flu				

INDICATE AGE AT WHICH ANY OF THE FOLLOWING OCCURRED:

- | | |
|-------------------------------|----------------------------------|
| _____ Asthma | _____ Convulsive Disorder |
| _____ Chronic Cough | _____ Cysts, Tumors |
| _____ Diabetes | _____ Dizziness |
| _____ Fainting | _____ Eye Problems |
| _____ Frequent Depression | _____ Gallbladder problems |
| _____ Hay Fever | _____ Heart Palpitations |
| _____ Headaches/Migraines | _____ Hepatitis B |
| _____ High Blood Pressure | _____ HIV/Aids |
| _____ Insomnia | _____ Jaundice |
| _____ Kidney Disease | _____ Lung Disease |
| _____ Frequent Constipation | _____ Malaria |
| _____ Recurrent Head Colds | _____ Recurrent Diarrhea |
| _____ Recent Weight Gain/Loss | _____ Rheumatic Fever |
| _____ High Fever | _____ Scarlet Fever |
| _____ Seizure | _____ Sinusitis |
| _____ Strep Throat | _____ Stomach/Intestinal Disease |
| _____ Tuberculosis | _____ Venereal Disease |
| _____ Herpes | _____ Weakness/Paralysis |

SURGERIES

- | | |
|--------------------------|---------------------|
| _____ Appendectomy | _____ Tonsillectomy |
| _____ Hernia Repair | _____ Hysterectomy |
| _____ Tubal Legation | _____ Vasectomy |
| _____ Corrective Surgery | _____ Other: _____ |

LIST ANY CONGENITAL CONDITIONS

Do you have severe headaches? _____ How often do headaches occur? _____

Name of medicine(s) you take for headache _____

Have you ever had a seizure? _____ Age of first seizure _____

Do you know when you are going to have a seizure? (List warning signs) _____

Do any of the following cause you to have a seizure? _____

Getting too hot _____ Physical exercise _____

Excitement _____ Crowds _____

Have you had an EEG? _____ If yes, when? _____ Where _____

(TO BE ANSWERED BY WOMEN ONLY)

Do you have regular menstrual periods? Yes _____ No _____
(If answered no, please explain)

Describe any problems you have with your periods (such as pain, vomiting, etc.) _____

Are you now, or have you in the past taken birth control pills? _____

Date you began taking birth control pills _____

Date of last menstrual period _____ Date of last Pap Smear _____

Name of doctor and clinic where last Pap Smear was done _____

Date of last Mammogram _____

Clinic where Mammogram was done _____

MEDICATION RECORD

Are you allergic to any medicine? _____

Describe allergic reaction _____

List Medication you are currently taking (Prescription and Over the Counter)

Medication	Dosage	Doctor	Starting Date	Why medicine was prescribed

List Medications you have taken in the past, but are not currently taking. _____

Do you have any food allergies or other allergies? _____

List any dietary restrictions or requirements you have _____

FAMILY HISTORY

	(If Living)			(If Deceased)
	AGE	HEALTH	AGE AT DEATH	CAUSE
Father				
Mother				
Brother/Sister				

Please indicate any blood relative that has or had the following: **(Circle and give relationship)**

Stroke _____	Migraine _____	Tuberculosis _____
Cancer _____	Diabetes _____	Mental Health Issues _____
Goiter _____	Epilepsy _____	Stomach Ulcers _____
Asthma _____	Hay Fever _____	Rheumatic Heart _____
Arthritis _____	Heart Attack _____	High Blood Pressure _____
Suicide _____	Congenital Heart _____	Kidney Disease _____
Colitis _____	Leukemia _____	Bleeding Tendency _____

PERSONAL HABITS

Circle Yes/ No		
Yes	No	Do you regularly smoke? Cigarettes ___ Pipe ___ Cigars ___ How long _____
Yes	No	Do you usually drink over 6 cups of coffee per day?
Yes	No	Do you regularly drink alcohol? 1 oz./2 oz./ 4 oz./ over 6 oz. per day Beer: 1 bottle per day ___ 2 bottles per day ___ Over 5 bottles per day ___
Yes	No	Do you have difficulty falling asleep?
Yes	No	Do you awaken early in the morning without apparent cause?

Write in names of diseases you have had which required hospitalization:

Describe any serious injuries or accidents _____

List any injury that limits your ability to lift, walk, or participate in physical activities.

Do you wear glasses? _____ How long? _____

Do you wear a hearing aid? _____ How long? _____

Information completed by:

Name _____ Relationship _____

Agency _____ Title _____

Signature of Parent/Guardian/Applicant

Date

RELEASE STATEMENT

Answer

Yes

No

I fully understand and agree that I assume all risks in case of personal injury and I authorize Independent Living Services, Inc. to call a physician in case of emergency treatment.

I authorize ILS to give me First Aid measures as deemed necessary.

In case of emergency, notify: _____

Relationship: _____ Phone No. _____

Authority is hereby granted to ILS to use my photograph and name in news releases and stories for/in relation to the agency.

Permission is granted for me to attend field trips with the agency.

I understand ILS may use physical restraints to insure my safety and well being in a crisis situation.

I fully understand and agree to hold ILS harmless in the event of accident or injury to me or my personal property and will further agree to indemnify the facility for any losses incurred by such acts of negligence or injury.

Residential only:

Authority is hereby granted to authorized personnel of the facility to supervise, counsel and advise me in the proper handling of my personal finances. However, neither the facility nor the personnel can be or will be directly responsible for my misuse of my money.

Signature of Parent/Guardian/Applicant

Date

This release expires one year from date of signature.

**INDEPENDENT LIVING SERVICES, INC.
INFORMED CONSENT FOR SERVICES**

NAME: _____ **DATE OF BIRTH:** _____

I understand as a participant in ILS' programs, I am eligible to receive a range of services. The type and extent of services I may receive will be determined following an initial assessment and through discussion with me and my Interdisciplinary Team. The goal of the assessment process is to determine the best possible services and treatment for me.

I understand all information shared with the staff at ILS is confidential and no information will be released without my consent. During the course of treatment at ILS, it may be necessary for my case manager to communicate with other staff at ILS regarding my services. In all other circumstances, consent to release information is given through written authorization. Verbal consent for limited release of information may be necessary in special circumstances. I further understand there are specific and limited exceptions to this confidentiality which include the following:

- When there is risk of imminent danger to myself or to another person, the staff is ethically bound to take necessary steps to prevent such danger.
- When there is suspicion a person is being sexually, physically, or verbally abused or is at risk of such abuse, the staff is legally required to take steps to protect the person and to inform the proper authorities.
- When any incident occurs that requires mandatory reporting to Developmental Disability Services.
- When a valid court order is issued for medical records, the case manager and the agency are bound by law to comply with such requests.

I understand ILS services are provided by a range of professional staff.

I understand while services at ILS may provide significant benefits, it may also pose some risks. These risks may include such things as: industrial grade equipment operation, manipulation of the body through physical and occupational therapy, general risks all individuals have when living in the community.

If I have any questions regarding this consent form or about the services offered at ILS, I may discuss them with my case manager. I have read and understand the above. I consent to participate in the assessment and services offered to me by ILS. I understand I may stop services at any time.

Signature of Parent/Guardian/Applicant

Date

ANNUAL RELEASE STATEMENT

Please check yes or no to the following:

I fully understand and agree that I assume all risks in case of personal injury and I authorize Independent Living Services to call a physician in case of emergency treatment. Yes: _____ No: _____

I hereby permit authorized personnel of ILS to give and/or watch me take medication, which has been prescribed by a physician on a prescription basis, as evidenced by the prescription label. I authorize Independent Living Services to give First-Aid measures as are deemed necessary. Yes: _____ No: _____

In case of emergency, notify: _____

Relationship: _____ Phone: _____

Authority is hereby granted to ILS for permission to use my photograph and name in news releases and stories for/in relation to activities of Independent Living Services. Yes: _____ No: _____

Permission is also granted to ILS for me to go on supervised field trips on an as-needed basis. Yes: _____ No: _____

I grant ILS permission to use physical restraints to insure my safety and well-being in a crisis situation. Yes: _____ No: _____

I fully understand and agree to hold ILS harmless in the event of accident or injury to me or my personal property and will further agree to indemnify ILS for any losses incurred by such acts of negligence or injury. Yes: _____ No: _____

Authority is hereby granted to authorized personnel of ILS to supervise, counsel, and advise me in the proper handling of my personal finances. However, neither ILS nor the personnel can be or will be directly responsible for my misuse of my money. Yes: _____ No: _____

Signature

Date

Signature of Guardian

Date

This release expires one year from date of signature.

**INDEPENDENT LIVING SERVICES, INC.
ARTS & CRAFTS PROGRAM**

I understand that the Arts & Crafts program offered at Independent Living Services, Inc. is a volunteer program and that I am not required to participate in these activities.

I understand that I have creative rights to all products that I may make while participating in the arts and crafts program and that I have full ownership of the product.

I understand that many of the products from the arts and craft program are used in marketing the services that ILS provides; however, the product does not become the property of ILS.

I understand that I may receive compensation for any product that I choose to sell and is eventually sold. If ILS receives any of the profit from a product that is produced in the arts and craft program, the proceeds from the sell of that product will be used to purchase additional materials for the arts and crafts program.

_____ I agree to voluntarily participate in the arts and craft program and understand the conditions listed above.

_____ I do not wish to participate in the arts and crafts program based on the conditions listed above.

Consumer Signature

Date

Guardian Signature

Date

Independent Living Services

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FAMILY CONTACT RELEASE

I, , legal guardian of

hereby release the following:

I give INDEPENDENT LIVING SERVICES, INC. staff permission to talk or correspond with another family member in regard to programming, behavior, and other matters relative to

participation at INDEPENDENT LIVING SERVICES, INC.

I can withdraw this request at any time in writing.

Family member(s): _____

Reason: _____

Guardian

Date

Witness

Date

Independent Living Services

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www.indliving.org

FAMILY CONTACT RELEASE

I, , being my own legal guardian, hereby release the following:

I give INDEPENDENT LIVING SERVICES, INC. staff permission to talk or correspond with a family member or my parent(s) in regard to programming, behavior, and other matters relative to my participation at INDEPENDENT LIVING SERVICES, INC.

I can withdraw this request at any time in writing.

Client Signature

Date

Witness

Date

Appendix I

CONSUMER AGREEMENT AND CONSENT TO DRUG AND/OR ALCOHOL TESTING

I hereby agree, upon a request made under the drug/alcohol testing policy of Independent Living Services, Inc./Creative Living, Inc. (ILS/CLI), to submit to a drug or alcohol test and to furnish a sample of my urine, breath, and/or blood for analysis. I understand and agree that if I at any time refuse to submit to a drug or alcohol test under company policy, or if I otherwise fail to cooperate with the testing procedures, I will be subject to immediate action. I further authorize and give full permission to have ILS/CLI and/or its company physician send the specimen or specimens so collected to a laboratory for a screening test for the presence of any prohibited substances under the policy, and for the laboratory or other testing facility to release any and all documentation relating to such test to ILS/CLI and/or to any governmental entity involved in a legal proceeding or investigation connected with the test.

I will hold harmless ILS/CLI, its company physician, and any testing laboratory ILS/CLI might use, meaning that I will not sue or hold responsible such parties for any alleged harm to me that might result from such testing, including loss of employment or any other kind of adverse job action that might arise as a result of the drug or alcohol test, even if a Company or laboratory representative makes an error in the administration or analysis of the test or the reporting of the results. I will further hold harmless ILS/CLI, its company physician, and any testing laboratory ILS/CLI might use for any alleged harm to me that might result from the release or use of information or documentation relating to the drug or alcohol test, as long as the release or use of the information is within the scope of this policy and the procedures as explained in the paragraph above.

This policy and authorization have been explained to me in a language I understand, and I have been told that if I have any questions about the test or the policy, they will be answered.

Signature of Individual/Guardian

Date

Appendix K

Independent Living Services, Inc. Consumer Handbook including Residential & Waiver Handbook / Profiles and Profile Productions

My signature below indicates that I have received and reviewed the Independent Living Services Consumer Handbook and had the opportunity to ask questions.

Information covered in the handbook includes:

Description of Developmental Disability Service Options
Confidentiality
Advocacy Services
Individual Rights
Individual Grievance Procedures
Civil Responsibilities
Management of Inappropriate Behaviors
Conflict of Interest
Solicitation
Emergency Drills
Transportation
ILS Drug and Alcohol Policy
Staff Qualifications
Leaving the Program

Residential & Waiver

Residential Services Options
Application Process
Costs
Funding
Individual Program Planning
Individual Responsibilities
Moving to a Supervised Apartment

Profiles & Profiles Productions

Services Offered
Eligibility and Application Process

HIPAA/Notice of Privacy Practices
DDS Appeal Policy #1076
Waiver Specialist Contact Information
Board Member
Organizational Chart
Contact Numbers

Hours of Operation
Lunch
Medication
Illness
Dress Code
Individual Responsibilities
Stolen Property
Consumer Council
Funding
Expectations from Services
Profile Productions

Funding Sources
DDS Alternative Community and
Employment Supports (CES) Waiver
Consumer Agreement and Consent to
Drug and /or Alcohol Testing

Signature of Individual/Guardian

Date

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Adult Care)

Facility Name: _____

Part 1. All Household Members

Name of Enrolled Adult(s):		
Names of Adult Participants (First, Middle Initial, Last)	Date of Birth	CHECK IF NO INCOME

Part 2. Benefits: If any member of your household received [State SNAP], [FDPIR], [State SSI] or [Medicaid], provide the name and case number for the person who receives benefits. If no one receives these benefits, skip to part 3.

NAME: _____ CASE NUMBER: _____
A Case number is not the number found on the SNAP EBT card.

Part 3. Total Household Gross Income—You must tell us how much and how often: weekly, monthly, yearly

A. Name (List only the participant(s), spouse and dependent children of participant(s))	B. Gross income and how often it was received			
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA Benefits	4. All Other Income
	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____
	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____
	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____
	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____
	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____

Part 4. Signature and Last Four Digits of Social Security Number

An adult household member must sign this form. **If Part 3 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.** (See Statement on the back of this page.)

I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Sign here: _____ Print name: _____

Date: _____ (form valid for one (1) year from this date)

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

Last four digits of Social Security Number: * * * * I do not have a Social Security Number
(required)

Part 5. Participant's ethnic and racial identities (optional)

Racial and Ethnic data is optional and is collected in accordance with FNS Instruction 113-1 Section XII (a)(2). This information is requested solely for the purpose of determining the State's compliance with Federal civil rights laws, and your response will not affect consideration of your application and may be protected by the Privacy Act. By providing this information, you will assist us in assuring that this program is administered in a nondiscriminatory manner.

NAME OF ENROLLED ADULTS	AGE	DATE OF BIRTH	HISPANIC OR LATINO		American Indian or Alaskan Native	Asian	Black or African American	Hawaiian Native or Other Pacific Islander	White
			Yes	No					
			<input type="checkbox"/>	<input type="checkbox"/>					
			<input type="checkbox"/>	<input type="checkbox"/>					
			<input type="checkbox"/>	<input type="checkbox"/>					
			<input type="checkbox"/>	<input type="checkbox"/>					

Don't fill out this part. This is for official use only.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income _____ Weekly Every 2 Weeks Twice a Month Month Year Household Size: _____

Categorical Eligibility: ___ Date Withdrawn: _____ Eligibility: Free ___ Reduced ___ Denied ___ Tier I ___ Tier II ___

Reason: _____

Temporary: Free ___ Reduced ___ Time Period: _____ (expires after ___ days)

Determining Official's Signature: _____ Date: _____

If applicable, Sponsor Signature: _____ Date: _____

Refer to the current USDA Income Eligibility Guidelines for making determinations of 'Free', 'Reduced', or 'Paid'.

HNP Representative Initials/Date
(for use during CACFP Reviews)

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced-price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced-price meals, and for administration and enforcement of the Program.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly. "In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer."

Planning for my Future

Please complete this information to help plan your program. Please ask if you need assistance.

Consumer:

Date:

Guardian:

Date:

Strengths (What you can do and like to do)

Needs (What you want to do on your own)

At home:

At home:

At work:

At work:

In the community:

In the community:

For fun:

For fun:

What skills would you like included in your program plans? _____

What time of the day do you like to be active and productive? _____

What time of day do you like to rest and relax? _____

Most of the time, I prefer to be:
(Circle the appropriate response)

- | | | |
|---|------------------------|---------------------|
| A. Alone | With One Other Person | With a Group |
| B. Independent | Supervised | Dependent |
| C. With Similar Aged Peers | With Older People | With Younger People |
| D. I like to be involved in Activities that are: | | |
| Fast Paced | Moderate Paced | Slow Paced |
| E. I like to be engaged in Activities that are: | | |
| Highly Repetitive | Moderately Repetitive | Non-Repetitive |
| F. Highly Competitive | Moderately Competitive | Non-Competitive |
| G. Highly Structured | Moderately Structured | Non-Structured |

All about Me

Answer the following questions to help with your planning.

1. What kind of choices do you make on your own? _____
2. What type of choices are you most comfortable to make? _____
3. Why do you think they are most comfortable? _____
4. What other type of skills do you think you need? _____
5. What do you think are your best skills? _____
6. What are your long-term plans? _____
7. Have you ever had a job? _____
8. Where did you work? _____
9. Would you like to work again? _____
10. What kind of job do you want? _____
11. Who would you ask about getting a job? _____
12. Who would decide you should get a job? _____
13. How would you get to work? _____
14. Are you working now? _____
15. Do you like your job? _____
16. Who is your supervisor? _____
17. What hours do you work? _____

INDEPENDENT LIVING SKILLS ASSEMENT TOOL

Consumer:

Date:

Interviewer:

Date:

Mark circle only if individual has this skill

Money Management

- Knows values of coins and currency.
- Can make a transaction at a local store and count change.
- Has an understanding of the difference between “luxuries” and “necessities” in food, transportation, clothing, and housing.
- Understands the difference between “sale price” and “regular price”.
- Can write checks/make withdrawals and make deposits.
- Can record banking transactions (either checking or savings).
- Can balance a checkbook.
- Can budget allowance to last for a week. (Shows an understanding of the concept of saving.)
- Can use a calculator to add, subtract, divide and multiply.
- Can make out monthly budget covering regular expenses for independent living.
- Can comparison shop using unit pricing information.
- Knows how to clip and use coupons.
- Budgets for unanticipated emergencies, seasonal bills, etc.
- Understands payroll deductions, taxes, FICA, insurance.

INDEPENDENT LIVING SKILLS ASSEMENT TOOL

Daily Living Skills

- Washes hands before eating and preparing food.
- Has “good” table manners (can use knife, fork, spoons, napkin appropriately).
- Can order in a cafeteria or fast food restaurant.
- Brushes teeth regularly.
- Showers and bathes regularly.
- Keeps hair clean and neat.
- Dresses in reasonably clean clothing.
- Knows appropriate clothing to wear for almost all occasions.
- Can read clothing labels and determine which clothes is to be dry cleaned, hand washed and machine-washed.

Health and Consumer Awareness

- Knows that drugs, alcohol and tobacco may be harmful to your health.
- Knows parts of the body and sexual functioning.
- Knows how pregnancy occurs.
- Knows how and where to get emergency health care.
- Can recognize and describe symptoms of colds, flu and other common health problems.
- Knows what to do for a minor cut, a minor burn, a splinter.
- Can take own temperature using an oral thermometer.

INDEPENDENT LIVING SKILLS ASSEMENT TOOL

- Can nurse self through cold or flu.
- Recognizes/ makes correct use of “over the counter” drugs for pain, stomach upset, diarrhea, fever, cold/allergy.
- Can call a doctor or dentist and schedule an appointment.
- Can read a prescription label correctly and follow the instructions.
- Can take medication without supervision.
- Knows how to use what is included in the First Aid Kit.
- In conscious of diet, exercise, good eating habits, and other preventative measures.
- Can determine when to go to an emergency room and when to make an appointment with the family doctor or clinic.

Job Preparation Skills

- Knows what the minimum wage is.
- Can fill out a standard job application form.
- Can read the want ads and find appropriate answers to potential questions.
- Can make appointment for a job interview.
- Knows appropriate clothing to wear for the interview.
- Can complete a job interview.
- Is able to maturely weigh the advantages of one job over another.

INDEPENDENT LIVING SKILLS ASSEMENT TOOL

Job Maintenance Skills

- Dresses for work appropriately.
- Reports to work on time.
- Knows job responsibilities and how to complete job tasks.
- Knows to contact employer when not able to go to work.
- Know how to read a pay stub.
- Knows appropriate way to talk to supervisor.
- Knows what behaviors will get a person fired immediately.
- Knows how to ask for help with a problem on the job.
- Has a plan for handling anger when angry at supervisor, co-workers, or customers.

Emergency and Safety Skills

- Knows functions of police, ambulance and fire department. Can reach each by calling 911.
- Is trained to evacuate the residence in case of fire.
- Knows how lock and unlock doors and windows.
- Understands basic fire prevention (No smoking in bed, using gas stove to heat, excessive use of extension cords, frayed electrical cords, etc.
- Can usually determine when professional medical help is needed.
- Can describe the relationship between actions and consequences.

INDEPENDENT LIVING SKILLS ASSEMENT TOOL

- Avoids hurtful or dangerous relationships.
- Labels and expresses anger or other strong feelings appropriately, “talks out” problems.
- Has demonstrated the ability to say “no” to peers.
- Can develop and carry out a personal plan for goal achievement without supervision.
- Can close a relationship or say “good bye” in a healthy manner.

INDEPENDENT LIVING SERVICES, INC. & CREATIVE LIVING, INC.

**RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM.**

I, _____, have received a copy of Independent Living Services, Inc.
Client Name
Notice of Privacy Practices.

Signature of Client or Guardian

Date

INDEPENDENT LIVING SERVICES, INC. & CREATIVE LIVING, INC.

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A CLIENT OF THIS AGENCY) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our agency is dedicated to maintaining the privacy of your individually identifiable health information as protected by law, including the Health Information Portability and Accountability Act (HIPAA). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our agency concerning your protected health information (PHI). By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI
- Your privacy rights in your PHI
- Our obligations concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI that are created or retained by our agency. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our agency has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our agency will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Privacy Officer – P.O. Box 1070, Conway, AR 72033, (501) 327-5234 x 317

C. WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your PHI.

1. Treatment. Our agency may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our agency – including, but not limited to, our case managers and community skills trainers – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents.

Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

2. Payment. Our agency may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health Care Operations. Our agency may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our agency may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our agency. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

5. Genetic Information Nondiscrimination Act (GINA). Our agency does not use genetic information.

6. Treatment Options. Our agency may use and disclose your PHI to inform you of potential treatment options or alternatives.

7. Health-Related Benefits and Services. Our agency may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

8. Fundraising. We may contact you to raise funds for our organization. In connection with any fundraising, we may disclose your demographic information and the dates when you received care here to our fundraising staff. If you are not interested in participating in fundraising please contact 327-5234 x 314.

9. Disclosures Required By Law. Our agency will use and disclose your PHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our agency may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled
- notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our agency may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our agency may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release PHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person

- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. Deceased Patients. Our agency may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Research. Our agency may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when Internal or Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

7. Serious Threats to Health or Safety. Our agency may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

8. Military. Our agency may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

9. National Security. Our agency may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

10. Inmates. Our agency may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

11. Workers' Compensation. Our agency may release your PHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding the PHI that we maintain about you:

1. Confidential Communications. You have the right to request that our agency communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to the Privacy Officer specifying the requested method of contact, or the location where you wish to be contacted. Our agency will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request unless you are privately paying for your services;** however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to the Privacy Officer. Your request must describe in a clear and concise fashion:

- (a) the information you wish restricted;
- (b) whether you are requesting to limit our agency's use, disclosure or both; and
- (c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the Privacy Officer in order to inspect and/or obtain a copy of your PHI. Our agency may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our agency may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our agency. To request an amendment, your request must be made in writing and submitted to the Privacy Officer. You must provide us with a reason that supports your request for amendment. Our agency will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the agency; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our agency, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our agency has made of your PHI for non-treatment, non-payment or non-operations purposes. Use

of your PHI as part of the routine patient care in our agency is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. Also, we are not required to document disclosures made pursuant to an authorization signed by you. In order to obtain an accounting of disclosures, you must submit your request in writing to the Privacy Officer. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our agency may charge you for additional lists within the same 12-month period. Our agency will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

Independent Living Services is required by law to notify our patients in case of a breach of their unsecured protected health information when it has been or is reasonably believed to have been accessed, acquired, used, or disclosed in violation of privacy regulations.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact the Privacy Officer.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our agency or with the Secretary of the Department of Health and Human Services. To file a complaint with our agency, contact the Privacy Officer. We urge you to file your complaint with us first and give us the opportunity to address your concerns. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

8. Right to Provide an Authorization for Other Uses and Disclosures. Our agency will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact the Privacy Officer.

**DECLARATION
(In the Event of a Terminal Condition)**

For Residents of
ARKANSAS

If I should have an incurable or irreversible condition that will cause my death within a relatively short time, and I am no longer able to make decisions regarding my medical treatment, I direct my attending physician, pursuant to the Arkansas Rights of the Terminally Ill or Permanently Unconscious Act, to:

(CHECK ONE BOX)

1. Withhold or withdraw treatment that only prolongs the process of dying and is not necessary to my comfort or to alleviate pain;

2. Follow the instructions of _____
(Name)

(Address) _____ (Phone)

whom I appoint as my health care proxy to decide whether life-sustaining treatment should be withheld or withdrawn.

Signed this _____ day of _____, _____

Signature _____

Address _____

The declarant voluntarily signed this writing in my presence.

Witness _____ Witness _____

Address _____ Address _____

**DECLARATION
(In the Event of Permanent Unconsciousness)**

If I should become permanently unconscious, I direct my attending physician, pursuant to the Arkansas Rights of the Terminally Ill or Permanently Unconscious Act to:

(CHECK ONE BOX)

1. Withhold or withdraw life-sustaining treatments that are no longer necessary to my comfort or to alleviate pain;

2. Follow the instructions of _____
(Name)

(Address) _____ (Phone)

whom I appoint as my health care proxy to decide whether life-sustaining treatment should be withheld or withdrawn.

Signed this _____ day of _____, _____

Signature _____

Address _____

The declarant voluntarily signed this writing in my presence.

Witness _____ Witness _____

Address _____ Address _____

INDEPENDENT LIVING SERVICES, INC.
PHYSICAL EXAM
TO BE COMPLETED BY MEDICAL PERSONNEL

Name: _____ DOB: _____ Sex: M/F

Address: _____

Height: _____ Weight: _____ Temp: _____ Pulse: _____

Respiration: _____ Blood Pressure: _____

Diagnosis: (please check all that apply)

- Intellectual Disability
- Mental Illness
- Cerebral Palsy
- Epilepsy
- Autism
- Other: _____

Special Diet Needs: _____

Special Accommodations needing to be addressed: _____

Describe any Limitation of Motion: _____

Medication Summary:

Current Prescribed Medications

Name of Medication	Dosage	Time/Frequency	Reason for Medication

<p>Are there any medications this individual should avoid due to possible interactions with any of these medications? YES OR NO If yes, please list below.</p>

Physician Printed Name: _____

Physician Signature: _____ Date: _____

**Division of Medical Services
Arkansas Medicaid Primary Care Physician Managed Care Program**

REFERRAL FORM

Independent Living Services, Inc.
Medicaid Provider Receiving Referral

I have performed a clinical assessment of the patient named below, whom I am referring for:

Intellectual Disability with the need for habilitation training that is provided by Adult Development services. This individual lacks survival skills in the following areas: food/nutrition, money management, health and hygiene, home safety, behavior management street survival skills, medication assistance, and sexual awareness and safety. Please advise me as appropriate, on your medical findings and diagnosis, treatment plan, and/or services you provide subsequent to this referral. Please note that services beyond the scope of this referral require a new referral.

Medicaid Recipient Name/DOB

Medicaid Recipient ID Number

Primary Care Physician

PCP Medicaid Provider Number

PCP Signature

PCP Phone Number

Date

MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

1. School/Agency Name	2. Site Name	3. Site Telephone Number	
4. Name of Child or Adult Participant		5. Age or Date of Birth	
6. Name of Parent or Guardian		7. Telephone Number	
8. Check One: <input type="checkbox"/> Participant has a disability or a medical condition that requires a special meal and/or accommodation. (Refer to definitions on reverse side of this form.) Schools and agencies participating in federal nutrition programs must comply with requests for special meals and any adaptive equipment. <input type="checkbox"/> Participant does not have a disability, but is requesting a special meal or accommodation due to a food intolerance or other medical reason. Food preferences are not an appropriate use of this form. Schools and agencies participating in federal nutrition programs are encouraged to accommodate reasonable requests. A licensed physician, physician assistant, or nurse practitioner must complete and sign this form.			
9. The participant's disability or medical condition requiring a special meal or accommodation:			
10. If participant has a disability, provide a brief description of his/her major life activity affected by the disability:			
11. Diet prescription and/or accommodation (please describe in detail to ensure proper implementation-use extra pages as needed):			
12. Indicate food texture for above participant: <input type="checkbox"/> Regular <input type="checkbox"/> Chopped <input type="checkbox"/> Ground <input type="checkbox"/> Pureed			
13. Foods to be omitted and substitutions (please list specific foods to be omitted and suggested substitutions. You may attach a sheet with additional information as needed):			
A. Foods To Be Omitted		B. Suggested Substitutions	
14. Adaptive equipment to be used:			
15. Signature of Recognized Medical Authority*	16. Printed Name	17. Telephone Number	18. Date

The information on this form should be updated to reflect the current medical and/or nutritional needs of the participant.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW Washington, D.C. 20250-9410; fax: (202) 690-7442; or email: program.intake@usda.gov. This institution is an equal opportunity provider.

ADDT Medication Management Plan

Please list all medications that will need to be given during day program hours:

Medication	Dose	Time given	Reason	Route	Prescribing MD

Insulin will be given by licensed staff (RN or LPN), all oral medication can be assisted by trained direct care staff (manager or director) if RN/LPN unavailable. If there is any medication that you wish to only be given by LPN/RN please let manager know. All medication will be documented on medication record or PRN log. All medications should be in original prescribed container. Any new medications will need a new prescription sent to us.

Medication	Potential Side Effects

Are there any over-the-counter medications this client cannot have? Please list name & reason.

Signature of Guardian or Client: _____ Date: _____

Signature of Director of Nursing: _____ Date: _____

Signature of Manager: _____ Date: _____

Independent Living Services, Inc.

P.O. Box 1070, Conway, AR 72033 (501) 327-5234 or (501) 358-6192. Fax (501) 327-7251
www.indliving.org

HUD FUNDING

ILS Apartments, Independent Living of Greenbrier, Sheltered Living Services Inc., ILS Group Homes, Florentz Estates are facilities that are assisted financially through the Department of Housing and Urban Development (HUD). If you would like to apply for housing assistance at one of these facilities, please fill out the attached application.

PRIVACY ACT NOTICE

The Department of Housing and Urban Development (HUD) is authorized to collect this information by the U.S. Housing Act of 1937 (42 U.S.C. 1437 et. Seq.), by the Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d), and by the Fair Housing Act (42 U.S.C. 3601-19). The Housing and Community Development Act of 1987 (42 U.S.C. 3543) requires applicants and participants to submit the social security number of each household member who is 6 years old or older.

Purpose: Your income and other information are being collected by HUD to determine your eligibility, the appropriate bedroom size, and the amount your family will pay toward rent and utilities.

Other Uses: HUD uses your family income and other information to assist in managing and monitoring HUD-assisted housing programs, to protect the Government's financial interest, and to verify the accuracy of the information you provide. This information may be released to appropriate federal, state, and local agencies, when relevant, and to civil, criminal, or regulatory investigators and prosecutors. However, the information will not be otherwise disclosed or released outside of HUD, except as permitted or required by law.

Penalty: You must provide all of the information requested by the owner, including all social security numbers you, and all other household members, have and use. Giving the social security number of all household members is mandatory, and not providing the social security numbers will affect your eligibility. Failure to provide any of the requested information may result in a delay or rejection or your eligibility approval.



APPLICATION FOR HUD SERVICES



PERSONAL INFORMATION

Full Name: _____
First Name MI Last Name

Street: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Message Number: _____

Is the head of household or any family member a person with a disability? _____

If yes, does this person require a handicapped accessible unit? _____

If age 62 or older as of January 31, 2010 and do not have a SSN, were you receiving HUD rental assistance at another location on January 10, 2010? _____

If any household member is a student, what is the student status? _____

Is the family seeking housing due to a Presidential Declared Disaster? _____

If any household members are children, Is there a custody arrangement? _____

Is any household member a veteran and can supply identification? _____

How did you learn about our facilities? _____

Current housing circumstance: (circle one) standard/substandard, conventional/public housing, lacking a fixed nighttime residence, fleeing/attempting to flee violence

Facility (Please check each facility for which you would like to apply.)

ILS Apartments—Conway

Independent Living of Greenbrier

ILS Group Homes

Sheltered Living Services (Patterson House)

Florentz Estates

First Name	Middle Name	Last Name	Sex or decline to disclose	Relationship	Birthdate	Social Security

SCREENING INFORMATION

How many people currently live in your _____ unit? How many bedrooms do you have? _____

Are you being evicted? _____ If yes, why? _____

Prior Landlords:

1. _____
Name _____ Address _____
2. _____
Name _____ Address _____
3. _____
Name _____ Address _____

Have you ever been convicted of a felony? _____ If yes, when? _____

Is any household member listed on any state's lifetime sex offender registry? Y or N

List all states that all household members have ever lived: _____

HUD requires that a background/criminal record check be completed on all applicants before moving into a facility that receives HUD funding.

ASSET INFORMATION

List all checking and savings accounts (including IRAs, Keogh Accounts, and Certificates of Deposits) of all household members, including amounts disposed of during the past two years.

Family Member	Bank Name	Account Number	Current Balance

List value of all stocks, bonds, trusts, pension contributions, or other assets: _____

Do you own a home or other real estate? Yes _____ No _____

Have you sold or given away real estate or other assets in the past two years?

Yes _____ No _____ If yes, what is the current market value of the real estate or assets? \$ _____

INCOME INFORMATION

Please answer each of the following questions. For each "Yes" answer, provide the details in the chart following the questions.

- | | YES | NO |
|---|-------|-------|
| 1. Is any member of your household employed, full-time, part-time, seasonally? | _____ | _____ |
| 2. Does any member of your household expect to work for any period in the next 12 months? | _____ | _____ |
| 3. Does any member of your household work for someone who pays him or her in cash? | _____ | _____ |
| 4. Is any member of your household on leave of absence from work due to layoff, medical, maternity, or military leave? | _____ | _____ |
| 5. Does any member of your household now receive, or expect to receive unemployment benefits? | _____ | _____ |
| 6. Does any member of your household now receive, or expect to receive child support? | _____ | _____ |
| 7. Is any member of your household entitled to child support that he/she is not receiving? | _____ | _____ |
| 8. Does any member of your household now receive, or expect to receive alimony payments? | _____ | _____ |
| 9. Is any member of your household entitled to alimony payments that he/she is not receiving? | _____ | _____ |
| 10. Does any member of your household receive, or expect to receive social security benefits? | _____ | _____ |
| 11. Does any member of your household receive, or expect to receive AFDC income? | _____ | _____ |
| 12. Does any member of your household receive, or expect to receive income from a pension or annuity? | _____ | _____ |
| 13. Does any member of your household receive any cash contributions from individuals not living in the unit or from other agencies/sources? | _____ | _____ |
| 14. Does any member of your household receive income from assets, including interest on checking or savings accounts, interest and dividends from certificates of deposit, stocks or bonds, income from rental of property? | _____ | _____ |

15. Does any member of your household receive, or expect to receive an earned income tax credit? _____

16. Does any member of your household receive financial aid from attending a college or university? _____

17. Does anyone outside of your household pay for any of your bills or give you or a member of your household money?
If yes, explain: _____

18. Have you, or any other member of your household, used any other name(s) or social security number(s) other than the one you are currently using?
If yes, explain: _____

Additional explanation for previous question responses (please note question number): _____

Income Information Continued

Family Member	Employer Name	Rate of Pay	Annual Salary

It is required that all applicants fill out the attached Declaration Format to establish their citizenship status. Applicants are also required to fill out the attached consent for an individual record check. Applicants will be required to sign consent forms to verify the information supplied in this application.

Independent Living Services does not discriminate on the basis of disability status in the admission or access to, or treatment or employment in, its federally assisted programs and activities.

The person named below has been designated to coordinate compliance with the nondiscrimination requirements contained in the Department of Housing and Urban Development's regulations implementing Section 504 (24CFR, part 8 dated June 2, 1988).

Kaleena Meachum
1615 Independence
Conway, AR 72034
501-358-6192 x406

I certify that the information supplied in this application is accurate and complete to the best of my knowledge.

"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 use 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). Violation of these provisions are cited as violations of 42 U.S.C. 408 (a) (7) and (8)**"

Signature of Applicant

Date

Signature of Co-applicant

Date

Supplemental and Optional Contact Information for HUD-Assisted Housing Applicants

SUPPLEMENT TO APPLICATION FOR FEDERALLY ASSISTED HOUSING

This form is to be provided to each applicant for federally assisted housing

Instructions: Optional Contact Person or Organization: You have the right by law to include as part of your application for housing, the name, address, telephone number, and other relevant information of a family member, friend, or social, health, advocacy, or other organization. This contact information is for the purpose of identifying a person or organization that may be able to help in resolving any issues that may arise during your tenancy or to assist in providing any special care or services you may require. **You may update, remove, or change the information you provide on this form at any time.** You are not required to provide this contact information, but if you choose to do so, please include the relevant information on this form.

Applicant Name:	
Mailing Address:	
Telephone No:	Cell Phone No:
Name of Additional Contact Person or Organization:	
Address:	
Telephone No:	Cell Phone No:
E-Mail Address (if applicable):	
Relationship to Applicant:	
Reason for Contact: (Check all that apply)	
<input type="checkbox"/> Emergency	<input type="checkbox"/> Assist with Recertification Process
<input type="checkbox"/> Unable to contact you	<input type="checkbox"/> Change in lease terms
<input type="checkbox"/> Termination of rental assistance	<input type="checkbox"/> Change in house rules
<input type="checkbox"/> Eviction from unit	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Late payment of rent	
Commitment of Housing Authority or Owner: If you are approved for housing, this information will be kept as part of your tenant file. If issues arise during your tenancy or if you require any services or special care, we may contact the person or organization you listed to assist in resolving the issues or in providing any services or special care to you.	
Confidentiality Statement: The information provided on this form is confidential and will not be disclosed to anyone except as permitted by the applicant or applicable law.	
Legal Notification: Section 644 of the Housing and Community Development Act of 1992 (Public Law 102-550, approved October 28, 1992) requires each applicant for federally assisted housing to be offered the option of providing information regarding an additional contact person or organization. By accepting the applicant's application, the housing provider agrees to comply with the non-discrimination and equal opportunity requirements of 24 CFR section 5.105, including the prohibitions on discrimination in admission to or participation in federally assisted housing programs on the basis of race, color, religion, national origin, sex, disability, and familial status under the Fair Housing Act, and the prohibition on age discrimination under the Age Discrimination Act of 1975.	

Check this box if you choose not to provide the contact information.

--	--

Signature of Applicant

Date

The information collection requirements contained in this form were submitted to the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501-3520). The public reporting burden is estimated at 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Section 644 of the Housing and Community Development Act of 1992 (42 U.S.C. 13604) imposed on HUD the obligation to require housing providers participating in HUD's assisted housing programs to provide any individual or family applying for occupancy in HUD-assisted housing with the option to include in the application for occupancy the name, address, telephone number, and other relevant information of a family member, friend, or person associated with a social, health, advocacy, or similar organization. The objective of providing such information is to facilitate contact by the housing provider with the person or organization identified by the tenant to assist in providing any delivery of services or special care to the tenant and assist with resolving any tenancy issues arising during the tenancy of such tenant. This supplemental application information is to be maintained by the housing provider and maintained as confidential information. Providing the information is basic to the operations of the HUD Assisted-Housing Program and is voluntary. It supports statutory requirements and program and management controls that prevent fraud, waste and mismanagement. In accordance with the Paperwork Reduction Act, an agency may not conduct or sponsor, and a person is not required to respond to, a collection of information, unless the collection displays a currently valid OMB control number.

Privacy Statement: Public Law 102-550, authorizes the Department of Housing and Urban Development (HUD) to collect all the information (except the Social Security Number (SSN)) which will be used by HUD to protect disbursement data from fraudulent actions.

Race and Ethnic Data Reporting Form

U.S. Department of Housing and Urban Development
Office of Housing

OMB Approval No. 2502-0204
(Exp. 06/30/2017)

Name of Property	Project No.	Address of Property
Name of Owner/Managing Agent		Type of Assistance or Program Title:
Name of Head of Household		Name of Household Member

Date (mm/dd/yyyy): _____

Ethnic Categories*	Select One
Hispanic or Latino	<input type="checkbox"/>
Not-Hispanic or Latino	<input type="checkbox"/>
Racial Categories*	Select All that Apply
American Indian or Alaska Native	<input type="checkbox"/>
Asian	<input type="checkbox"/>
Black or African American	<input type="checkbox"/>
Native Hawaiian or Other Pacific Islander	<input type="checkbox"/>
White	<input type="checkbox"/>
Other	<input type="checkbox"/>

***Definitions of these categories may be found on the reverse side.**

There is no penalty for persons who do not complete the form.

Signature

Date

Public reporting burden for this collection is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. This information is required to obtain benefits and voluntary. HUD may not collect this information, and you are not required to complete this form, unless it displays a currently valid OMB control number.

This information is authorized by the U.S. Housing Act of 1937 as amended, the Housing and Urban Rural Recovery Act of 1983 and Housing and Community Development Technical Amendments of 1984. This information is needed to be in compliance with OMB-mandated changes to Ethnicity and Race categories for recording the 50059 Data Requirements to HUD. Owners/agents must offer the opportunity to the head and co-head of each household to "self certify" during the application interview or lease signing. In-place tenants must complete the format as part of their next interim or annual re-certification. This process will allow the owner/agent to collect the needed information on all members of the household. Completed documents should be stapled together for each household and placed in the household's file. Parents or guardians are to complete the self-certification for children under the age of 18. Once system development funds are provided and the appropriate system upgrades have been implemented, owners/agents will be required to report the race and ethnicity data electronically to the TRACS (Tenant Rental Assistance Certification System). This information is considered non-sensitive and does not require any special protection.

DATA SHEET, NOT APPLICATION

(Clients not currently enrolled in secondary education)

Demographic Information

Counselor _____

Ph. 501-730-9725 Fax 501-730-9728

Please complete as much of this form as you can. This information will assist the Vocational Rehabilitation Counselor in determining your eligibility and vocational planning. **Your information will be kept confidential and only used as necessary for your rehabilitation.**

IF YOU NEED HELP FILLING OUT THIS FORM, ASK YOUR COUNSELOR FOR HELP.

PERSONAL INFORMATION

Social Security Number	Last Name	First Name	Middle Initial	
Street/Mailing Address	City	County	State	Zip Code
Telephone Number (with area code)		Voice <input type="checkbox"/>	TY/TDD <input type="checkbox"/>	
Email Address				
Gender: Male <input type="checkbox"/>	Female <input type="checkbox"/>	AGE	DATE OF BIRTH:	

Transportation Information (Choose all that apply)

- Do you have a valid driver's license?
- Do you own your vehicle?
- Do you have access to a vehicle other than your own?
- Can someone give you a ride?
- Do you use Public Transportation?
- Other?

Have you ever attended Arkansas Career Training Institute ? Yes No

HOUSEHOLD MEMBER NAMES RELATIONSHIP AGE EMPLOYMENT

HOUSEHOLD MEMBER NAMES	RELATIONSHIP	AGE	EMPLOYMENT

HOUSEHOLD INCOME FOR ALL SOURCES AND/OR BENEFITS \$

CONTACT INFORMATION (REQUIRED)

If we are unable to reach you, whom should we contact? **(List 3 people living outside your home)**

Name	Relationship	Address	Telephone Number

Other languages besides English? _____

Referral Specifics

Are you receiving Social Security Disability Benefits or SSA retirement? Yes No Amount \$ _____

Are you receiving SSI Disability Benefits? Yes No Amount \$ _____

Assistance requested _____

Who referred you to Rehabilitation Services? _____

What is (are) your disability(s)? Please list

Are you working now? Yes No

Do you need help with: keeping a job ___ getting a job ___ transitioning from school to college or work ___

How does your disability keep you from working?

When did you last work? ___ / ___ / ___

Why aren't you working now?

Are you ready to go to work now? Yes No

Have you been looking for work on your own? _____

Explain _____

Other Agencies you are dealing with (DHHS, Mental Health, etc.) _____

Educational History

High School _____ City & State _____ Highest Grade _____

Graduated? Yes No Year _____ GED? Yes No Year _____ Where? _____

College/University/Votech _____ Major area(s) of study/Degrees _____ Dates _____

Other schools or training: _____ Major area(s) of study/Degrees _____ Dates _____

Do you have any special skills, certificates, or licenses? Yes No
If yes, explain briefly _____

WORK HISTORY START WITH YOUR PRESENT OR LAST JOB

Job Title _____ Employer _____ City & State _____

How long _____ Dates // - //
days per week _____ # hrs per week _____ Salary \$ _____ per _____

Reason for leaving _____

Job Duties: _____

Job Title _____ Employer _____ City & State _____

How long _____ Dates // - //
days per week _____ # hrs per week _____ Salary \$ _____ per _____

Reason for leaving _____

Job Duties: _____

Job Title _____ Employer _____ City & State _____

How long _____ Dates // - //
days per week _____ # hrs per week _____ Salary \$ _____ per _____

Reason for leaving _____

Job Duties: _____

VR Intake

RACE / ETHNICITY

Please check the appropriate box(es) below regarding your race/ethnicity.

- | | |
|---|---|
| <input type="checkbox"/> White/European American | <input type="checkbox"/> Black/African American |
| <input type="checkbox"/> American Indian/Alaskan Native | <input type="checkbox"/> Asian |
| <input type="checkbox"/> Native Hawaii/Other Island | <input type="checkbox"/> Hispanic/Latin |

MEDICAL AND PSYCHOLOGICAL INFORMATION

Do you have one or more physical, emotional or learning problems that affect your ability to work?

Yes No

Physical problem AGE Cause: _____

Emotional problem AGE Cause: _____

Learning Problems AGE What Kind: _____

Have you ever-received treatment, inpatient or outpatient, for drug or alcohol use?

Yes No

Have drugs or alcohol caused problems with your personal life, family, job, or created problems that resulted in a fine and/or incarceration? Yes No

Where? _____ When? _____

Have you ever gone to a Counselor for any kind of personal problem? Yes No

When _____ Where _____

Have you ever-lost consciousness due to a blow to the head, seizure or blackout? Yes No

If yes explain briefly when and why:

List the physicians or specialists involved in the treatment of all your condition(s).

NAME	ADDRESS	DATES OF TREATMENT

Have you ever been hospitalized related to your disabilities? Yes No

Name of Hospital
Dates of Treatment
Reason for Hospitalization
Name of Hospital
Dates of Treatment
Reason for Hospitalization

Present living arrangements? (Private home, group home, nursing home)

Do you have medical insurance? Yes Private Medicaid No Medicare Is this medical insurance provided by your employer? Yes VA No Workers Comp

Other income amounts: SSDI _____ SSI _____ TEA _____ VA _____
Worker's Comp _____ Other _____ Free or reduced school lunch _____
Primary source of income/support _____

Special categories Y=Yes N=no

Honorably discharged Veteran? _____ History Special Education or Resource _____

Eligible to work in USA? _____ Previous criminal history? _____

Have you received a Ticket to Work? _____

OUR AGENCY OBJECTIVE IS JOB PLACEMENT. ANY AND ALL TRANSFERABLE JOB SKILLS WILL APPLY BEFORE TRAINING IS CONSIDERED.

ADDITIONAL INFORMATION NEEDED AT APPLICATION INTERVIEW:

1. PROOF OF GUARDIANSHIP, IF APPLICABLE / COURT ORDER
2. MEDICAL RECORDS/DOCUMENTATION OF DISABILITY
3. PROOF OF INCOME (CURRENT TAX RETURN, CHECK STUB)
4. SSI/SSDI AWARD LETTER
5. SOCIAL SECURITY CARD AND PICTURE ID (Cannot complete application without social security card or verification letter)

MAILING ADDRESS IS:

**Arkansas Rehabilitation Services
1150 N. Museum Rd. Ste. 3
Conway, AR 72032**

Independent Living Services, Inc. Winter Weather Closing Procedures for Profiles

As the school systems have moved to providing virtual options for students, Independent Living Services will no longer follow school closures for snow days. Here is the procedure we will be following for inclement weather at our day program.

Notifications:

We will notify everyone of closures or delays as soon as a determination has been made but no later than 5:30 a.m. on the date of closures. All closures and delays will be posted on Independent Living Services social media page.

We will send a text blast out to all families, staff and consumers impacted by closures or delays. We are asking for a good number for everyone who attends Profiles so that we can add them to our text blast.

Closure:

If we determine the weather and roads are too bad then we will close Profiles entirely for the day.

Van Routes Closed:

If we determine some routes are passable for vans and others are not passable, we will cancel transportation on specific van routes. If Profiles is open and the bus route is not running, a family can choose to transport someone to and from Profiles themselves.

Delayed Openings:

We may determine to have a delayed opening based on the forecast. We will notify individuals impacted by the delays.

Early Closure:

We may determine we have to have an early closure based on the weather forecast. We will notify individuals and their families impacted by the schedule change.

Staff:

Staff will be notified of closures and delayed openings. It is expected they communicate with their supervisor regarding their ability to be at work. We will maintain our required ratios for services when we are open. Staff please see employee handbook for more information on closures and how it impacts employees.

Profiles Contact Information

Please complete the following information and return to Profiles as soon as possible.

Consumer Name: _____

Responsible Party to Contact: _____

Number to Text: _____

Updated Email Address: _____

Please return this page to Profiles.

Arkansas Adult Services Guide



This booklet is the result of a collaborative effort between these two state programs and volunteers that share common goals in serving the citizens of Arkansas. Thanks to Alexander Human Development Center and Pathfinder Inc for photograph submissions.

Division of Developmental Disabilities Services
Donaghey Plaza North
PO Box 1437, Slot N502
Waiver Services: (501) 682-8689
Adult Intake and Referral: (501) 682-8678
Little Rock, AR 72204-1437
Phone (501) 682-8689 or 682-8678
Fax (501) 682-8687
www.arkansas.gov/dhs/ddds

Division of Aging & Adult Services
700 Main Street, PO Box 1437, Slot S530
Little Rock, AR 72205-1437
Phone (501) 682-2241
Fax (501) 682-8155
www.state.ar.us/dhs/aging/asmp.html

To order additional copies of this guide, contact either of the agencies listed above.

Disclaimer: This guide is provided for informational purposes only. This is not a legal document. If you have specific questions, please contact the Division of Developmental Disabilities Services at (501) 682-8689.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act (ADA) Coordinator at (501) 682-8920 or TDD (501) 682-8933.

This pamphlet is a continuing work in progress that was supported in part by the Community Intergrated Personal Assistance Service and Supports (C-PASS) Grant No.18-P91567/6-01 from the Department of Human Services, Centers for Medicare and Medicaid Services (CMS) and Grant No. 90AM2912 from the Administration on Aging, Department of Human Services.

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PROMOTING SELF DETERMINATION FOR ADULTS - WHERE TO BEGIN?

You Are Not Alone.

Although you may feel isolated and overwhelmed by the challenges associated with your disability, many services and supports are available to assist you. Much of the information that you need is *“in the hands, heads, and hearts of other adults like yourself.”*¹

Seek out others who have “been there” and “done that.”

Arkansas has a number of non-profit cross-disability organizations whose members are adults with disabilities and parents of persons with disabilities. Two of these are Advocates Needed Today, Inc. and Arkansas People First. They can provide emotional support and a wealth of information on how to get the services you need. They conduct training sessions for persons across the State and provide one on one personal assistance.

¹ Brown, Goodman and Kupper (2003) *The Unplanned Journey: When You Learn That Your Child Has a Disability*, NICHCY News Digest

AND



**2592 North Gregg Ave. Ste 1
Fayetteville, AR 72703
Toll free: 1-888-488-6040**

"Working together for our rights as PEOPLE FIRST, speaking for ourselves as members of the community."



Other organizations provide support and information about specific conditions – like cerebral palsy, autism, or spinal cord injury or service programs.

For a complete list of organizations and access to a library of educational materials on disabilities and disability services, contact:

The Arkansas Independent Living Council (AIRC)
8500 West Markham, Ste 215
Little Rock, AR 72205
501-372-0607
Toll free: 1-800-772-0607



OR

The Governor’s Developmental Disabilities Council
Freeway Medical Tower, 5800 West 10th Street
Little Rock, AR 72204
(501) 661-2589
Toll-free: 1-800-462-0599, Extension 2589



Be sure to request a “Vital Records Guide” from the DD Council to keep track of important medical and personal care information.

and

Information about the Alternative Community Services Home and Community Based Waiver that serves both adults and children, and other resources, can be obtained from the

Arkansas Waiver Association
<http://www.arkansaswaiver.com/>

or

AR-AWA-subscribe@yahoogroups.com



WHAT ARE THE RIGHTS OF A PERSON WITH DISABILITIES?

First and foremost, you have the same constitutional and legal rights as every other citizen, plus additional rights that have to do with having a disability.

Right to be free from discrimination because you have a disability:²

- To have equal employment opportunities.
- To benefit from public programs such as education, employment, transportation, recreation, health care, social services, courts, voting, and town meetings, etc.
- To have equal access to public transportation (city buses, subways, commuter rails, etc) that is accessible (within reach, especially for persons in wheelchairs).
- To have access to public buildings and public accommodations such as restaurants, hotels, movie theaters, recreational facilities, etc.
- To have the use of special telephone services³ and closed captioning of TV public service announcements for people with hearing and speech disabilities.



² The Americans with Disabilities Act (ADA)

³ Telecommunications relay services (TRS)

Right to equal housing opportunities:⁴

- Landlords must make exceptions to a “no pets” rule for service animals (like guide dogs or hearing dogs, for example).
- Landlords must allow tenants to make changes to their private living area and common use spaces to make them handicapped accessible.



Right to vote:⁵

- Polling places must be physically accessible to people with disabilities or provide alternate means to cast ballots.
- Voting aids must be provided for elderly and disabled voters, including telecommunications devices for the deaf.

Right to fly:⁶

- People with disabilities must be assisted with boarding.
- Airplanes must have accessible features.

⁴ Fair Housing Act

⁵ Voting Accessibility for the Elderly and Handicapped Act

⁶ Air Carrier Access Act

Right to free appropriate public education (FAPE):

- Transition services must be provided or should have been provided to prepare you for further education, employment and independent living, and must begin no later than age 16. (A transition is a change from one environment or service delivery model to another – for example, leaving high school to enter higher education models or work.)
- Schools must outline clear and specific transition goals in the IEP based on “*age appropriate transition assessments.*” These assessments provide the foundation for moving into adult services.

If you feel that your rights are not being honored, contact:

**The Disability Rights Center (DRC)
1100 North University Avenue, Suite 201
Little Rock, AR 72207
501-296-1775 v/tty
Toll free 1-800-482-1174 v/tty
www.arkdisabilityrights.org**

DRC is the Protection and Advocacy System and Client Assistance Program for people with disabilities in Arkansas.



LEARN THE LANGUAGE.

What is a disability?

A disability is *“a physical or mental impairment [injury] that substantially limits a major life function.”*⁷

What is a developmental disability?

A developmental disability is a substantial, long-term disability that begins any time from birth through age 21 and is expected to last for a lifetime. Although you may not always be able to see these disabilities, they can seriously limit daily activities of life, including self-care, communication, learning, mobility (the ability to move), or being able to work or live independently.

Arkansas law says that a developmental disability is *“an impairment of general intellectual functioning or adaptive behavior”* that is a *“substantial handicap to the person’s ability to function without appropriate support services, including, but not limited to, planned recreational activities, medical services such as physical therapy and speech therapy, and possibilities for sheltered employment or job training.”* It is caused by mental retardation or a closely related condition; cerebral palsy; epilepsy; autism; or dyslexia (difficulty learning to read and spell) resulting from cerebral palsy, epilepsy, or autism.⁸

What is mental retardation?

A person is considered to be mentally retarded if: he or she has *“a mental deficit requiring him or her to have special evaluation, treatment, care, education, training, supervision,*

⁷ Arkansas Code 16-123-102(3)

⁸ Arkansas Code. 20-48-101 and Act 729 of 1993

or control in his or her home or community, or in a state institution for the mentally retarded.”⁹

The definition also includes *“a functionally retarded person who may not exhibit an intellectual deficit on standard psychological tests, but who, because of other handicaps, functions as a retarded person.”*



Other developmental disabilities:

Autism is a complicated developmental disability that has a negative effect on verbal and nonverbal communication, social interaction, and schoolwork. Autistic people perform repetitive activities and movements, repeat words or phrases just spoken by others, and resist change in their surroundings or in daily routines. Autism usually appears during the first 3 years of life and affects each child differently, which makes early diagnosis and treatment very important.

⁹ Arkansas Code 20-48-202(6)

Cerebral palsy is a group of long-term conditions affecting body movements and muscle control and coordination. It is caused by damage to the brain during fetal development or shortly following birth. People with cerebral palsy may not be able to walk, talk, eat or play in the same ways as most other children. They may have involuntary movements, problems with sight, hearing or speech, and/or seizures.

Epilepsy is a brain disorder or ailment that causes seizures where the person may or may not lose consciousness and/or move or behave in an unusual way. It may be hereditary (passed down in families) or related to a brain injury, but most of the time the cause is unknown.

Seizures are not a disease. They are a symptom or warning sign of many different disorders that can affect the brain. Some seizures cause loss of consciousness, with twitching or shaking of the body. However, others consist of staring spells that can easily go unnoticed.

What is a learning disability?

Simply stated, a learning disability is a problem with listening, speaking, reading, writing, spelling, reasoning and/or doing mathematics that is not caused by a visual or hearing problem, mental retardation, or cultural or economic disadvantage.

Federal law defines it as *“a disorder in one or more of the basic psychological [mental] processes involved in understanding or in using language, spoken or written...including conditions such as perceptual disabilities [related to awareness and understanding], brain injury, minimal brain dysfunction [impairment], dyslexia [difficulty learning to*

read and spell], and developmental aphasia” (See [Dictionary of Words You Need to Know](#)) that is not related to environmental, cultural, or economic disadvantage.¹⁰ If the learning disability causes a person to function like a person with mental retardation, this condition may meet the definition of developmental disability.

LANGUAGE YOU SHOULD USE:

In recent years, people with disabilities have acquired a will and a voice of their own. More and more, self-advocates and their families are shaping public policy regarding the rights of people with disabilities and their wishes with regard to self-determination, equal opportunities, and self-respect.

They have made it clear that they want to be viewed as people, rather than problems or conditions. To this end, they prefer the positive perception created by **“people first” language** that puts the person before the disability – “people with disabilities,” not “disabled people.”

Although federal and state law and regulations use the terms “mental retardation” and “mentally retarded,” you should not. People with mental retardation are considered to be “developmentally disabled.” Arkansas law says that developmental disabilities include conditions other than mental retardation (See [Learn the Language](#)). However, it is preferable to always say, “a person has a developmental disability,” rather than “he is mentally retarded.”

Mental illness is another term that creates a negative perception. Instead of saying “mentally ill person,” say “a person with an emotional disturbance” or “behavioral problem.”

¹⁰ IDEA

Organizations that have been around for a long time – like the ARC (previously the Association of Retarded Citizens) or VOR (previously the Voice of the Retarded) no longer spell out their names. Neither does NAMI (previously the National Alliance for the Mentally Ill). This is similar to the situation with AARP. It is no longer the American Association for Retired Persons because older people are working longer and retiring later. However, they continue to use the name AARP.

People with disabilities view some of the older terminology as derogatory and hurtful, so **WATCH YOUR WORDS!**



SERVICES FOR ADULTS WITH DISABILITIES:

The good news is that many services are provided to meet the needs adults with disabilities – primarily through the Arkansas Department of Human Services (DHS). They work with members of a statewide network of provider organizations that offer a variety of services from evaluations to specialty care.

The bad news is that it is up to YOU to learn how the system works, to apply for financial assistance if you need it, and to monitor (supervise) the care you receive. This can be a daunting task.

Needs assessment, the first step:

You know or think you have a disability. You have never requested or received services from the Department of Human Services, Division of Developmental Disabilities. Your first step is to get a diagnostic evaluation or “needs assessment” to find out what kind of disability you have. If you already know and have this information be sure it is readily available when you begin asking for assistance.

Start by contacting your local Department of Human Services (DHS) County Office. For the address and phone number of the office closest to your home, call:

**DHS Client Assistance at:
1-800-482-8988**

The county DHS offices are listed in the blue pages of your phone book under **STATE OFFICES**. Look for **HUMAN SERVICES DEPARTMENT**. The local offices are listed alphabetically in that section. (They are not listed in the section for **COUNTY OFFICES**.)

Ask for the DDS Intake and Referral Specialist for Adult Services.

Do not be concerned if you are not sure that your adult disability is a “developmental disability” (See *Learn the Language*) because most of the services for persons with disabilities are provided by the DHS Division of Developmental Disabilities Services (DDS).

The DDS Intake and Referral Unit will:

- Assist you to get a needs assessment, through a referral from your doctor or the school you last attended.
- Determine whether you are eligible for some kind of financial assistance (Medicaid, Special Needs, etc.) to pay for your services (See *Who Will Pay For Your Care?*).
- Develop a service plan for you.
- Refer you to the provider organizations that will furnish your services, and coordinate and monitor those services.
- Refer you to your local Community Mental Health Center (CMHC) if problems are behavioral only.
- Refer you to the Division of Aging and Adult Services if you are interested in receiving services through Waivers they operate or other services that may be available.
- Explain various programs and services that may be available to help meet your needs
- Assist you in completing forms and applications for services and programs.
- Provide you with provider lists containing address and contact information. This will enable you to contact and visit with providers who may have services that meet your needs.

DDS Alternative Community Services (ACS) Home and Community Based Waiver:

This is a Medicaid home- and community-based waiver¹¹ (See *Who Will Pay For Your Services?*) that serves individuals of

¹¹ A Waiver is a tool used by states to get federal Medicaid money for long-term care services for patients who do not live in institutions.

all ages with developmental disabilities, who, without these services, would have to live in an institution such as a nursing home or intermediate care facility for the mentally retarded (ICF/MR). No more than 3598 people can be participating in this program at any one time.

The following services are provided:

- Case management (monitoring the provision of services included in the person's **Multi-Agency Plan of Service (MAPS). This plan is similar to and synonymous with individual program plan.** Case management services include locating, coordinating and monitoring all services and supports regardless of funding source.
- Supportive living services (to help you acquire, retain and improve self-help, socialization and adaptive skills necessary to reside successfully in a home-and community-based setting) and ensuring the delivery of all direct care services, including making alternative living arrangements.
- Community experiences (flexible services to prepare you to function well in a community setting).



- Respite care (Short term care in or outside the home to allow parents and primary caregivers a break.
- Non-medical transportation
- Adaptive equipment services (purchase, leasing and, as necessary, repair of adaptive, therapeutic and augmentative equipment to help people perform daily life tasks that would not be possible otherwise)
- Environmental modifications
- Supplemental support services (such as emergency medical costs, transitional expenses, fees for activities that are therapeutic in nature and complement and reinforce community living)
- Specialized Medical Supplies
- Consultation Services (provided by psychologists, social workers, counselors, certified parent educators, speech pathologists, occupational therapists, physical therapists, registered nurses, and certified providers of adaptive equipment aids)



- Crisis intervention services (by a mobile intervention team or professional) to provide technical assistance and training in areas of behavior already identified
- Crisis Center Services that provide for specialized care and programming in the management of behaviors that cause a person short term inability to remain in their home in the community.
- Supported Employment that provides for paid employment through the use of job coaches. It is available when the same services are otherwise funded under the Rehabilitation Act of 1973 or Public Law 94-142(re-numbered) are exhausted or are not available.

Who is eligible?

- Persons of all ages, as long as the age of onset of the developmental disability is prior to the 22nd birthday.
- The developmental disability must be severe enough that the individual meets the level of care criteria for admission to an ICF/MR.
- Persons who are Medicaid Income eligible at 300% of the poverty level.



For information about ACS Waiver

**Contact the DDS Adult Specialist at your local
DHS Office**

Other Adult Waivers:

Waiver Program	Agency	Program Eligibility Criteria	Age
ACS Home and Community Based Waiver	DDS	ICF/MR and Medicaid income eligibility and 300% poverty level	All Ages
ElderChoice	DAAS	Special income level equal to 300% of the SSI Federal Benefit (for 2007 it is \$1,869.00 a month); countable resources that do not exceed the current long term care limitations, the patient must meet the medical criteria for nursing home intermediate level of care.	Age 65 and Older
Living Choices	DAAS	Same as ElderChoice. In addition, the nurse will complete an assessment of Assisted Living Waiver Client's Tier of Need.	21 Years of Age or Older
Alternatives for Adults with Physical Disabilities (AAPD)	DAAS	Same as ElderChoice.	Age 21-64
Independent Choices	DAAS	Only Categorically Needy Medicaid recipients are eligible. Must have physical disability necessitating the need for assistance with personal assistance services. On February 1, 2008 persons with developmental disabilities not residing in a congregate setting will become eligible.	Age 18 or Older

**For more information about Division of Aging & Adult
Services (DAAS) Waivers**

Call (501) 682-2441

Community Mental Health Center (CMHC) services:

- Twenty-four-hour emergency care in the outpatient mental health clinic
- Diagnostic evaluation
- Treatment planning
- Individual or group therapy
- Medication management
- Case management
- Crisis services
- Vocational, housing and educational support
- Transportation
- Rehabilitative and day treatment services

**For information about Community Mental Health Centers
Contact the DDS Adult Specialist at your local
DHS Office**

Individual Support Services:

- Integrated Supports to help a person with a developmental disability live, work, and enjoy recreational opportunities in the community – independently or in a family environment. Services similar to those provided in the ACS waiver are available.
- Community Integration Companion: Activities to instruct the individual in daily living and community living skills in integrated settings (for example, shopping, sports, participation, etc.)
- Special Needs services such as transportation, respite for the primary family caregiver for an eligible individual who requires intensive care or is in an emergency situation, or to allow the parents/family to attend to other necessary activities of daily life, adaptive equipment, home modifications, utility deposits, rental assistance/deposits, etc.

Who is eligible?

- Any person who requires services from multiple state and local agencies, and
- Who is exhibiting intense or excessive emotional, interpersonal, or behavioral challenges within the home, school, or community inconsistent with his or her age, intellectual level, and cultural background, and



- Who has an emergency, crisis, or life threatening situation
- Who is transitioning to a less restrictive environment and
- There is formal documentation that all other service options within both natural environments and formal programs have been sought and denied.

Other Service Options

- Developmental Day Treatment Services (DDTCS) is a program for adults age 21 (age 18 to 21 if the person has a diploma /certificate of completion). Services are provided in a clinic setting on an out-patient basis. Services include evaluation, instruction in areas of self-help, socialization and communication to help the person to develop and retain skills related to their ability to live in the community. Options for speech, physical and occupational therapy are available.
- Sheltered Workshop activities provide training and/or compensation focusing on independent living and vocational skills





For information about These Services

**Contact the DDS Adult Specialist at your local
DHS Office**

WHO WILL PAY FOR YOUR SERVICES?

Some of the services discussed above will be provided at no cost to you. Funding comes from the federal and state government, Medicaid, and private insurance. Whether you will have to pay something toward the cost depends on the specific services and your income.

To find out if you are eligible for financial assistance contact your local DHS Office and ask for the **DDS Adult Services Specialist**.

Supplemental Security Income (SSI) Benefits For Adults with Disabilities:

Supplemental Security Income supplements (adds to) a person's income up to a certain level. The level varies from one state to another and can go up every year based on cost-of-living increases. Your local Social Security office can tell you more about the Arkansas SSI benefit levels.

**To find your local Social Security office or
for information about SSI benefits,
call Toll Free: 1-800-772-1213.**

OR

**Toll Free tty: 1-800-325-0778
<http://www.socialsecurity.gov>**



Social Security rules for adults with disabilities:

- When you turn age 18, Social Security no longer considers parental income and assets in deciding if you get SSI. If you were not eligible for SSI before your 18th birthday because your parent's income or assets were too high may become eligible at age 18.
- If you are getting SSI and turn age 18 and continue to live with your parents and do not pay for food or shelter, a lower SSI payment rate may apply.

SSI Definition of "Disability:"

A person is considered to be disabled if he or she has a physical or mental condition (or a combination of conditions) that results in "marked and severe functional limitations."

If your impairment(s) does not meet or medically equal any of the impairments in the official Social Security listing of disabilities, a determination must be made as to whether it "functionally equals" a condition included in the listings. This involves an assessment of your condition and comparison of functioning to that of others the same age who do not have impairments:

- 1) Social Security Benefits For Adults Who Have Had a Disability Since Childhood.** If a person received SSI as a child, he or she can continue to receive Medicaid through the local DHS Office under the Disabled Adult Child program. Although most of the people getting these benefits are in their 20s and 30s (or older), the benefit is considered to be a "child's" benefit because it is parent's Social Security earnings record.

Understanding Medicaid:

MEDICAID is a joint federal and state health care assistance program that pays for medical care and services for people who meet the income and assets eligibility requirements.

If you are eligible for Medicaid-funded services, Medicaid will pay either for services in a residential setting (long term care facility) or for home and community based services under a waiver. Medicaid waivers are tools used by states to obtain federal Medicaid matching funds to provide long term care to people in settings other than institutions.

The Alternative Community Services (ACS) is a Medicaid funded program that allows people whose medical condition or disability generally would require admission to a hospital nursing facility or intermediate care facility for people with mental retardation to receive the services in the home.





Medicaid may also pay for some related clinic based services such as occupational, physical and speech therapy; adult development and work activity. Contact the DDS Specialist at your local DHS County office for information about Medicaid-funded services.

Funding For Specific Programs or Services:

What if you have private insurance?

If you have private health insurance, the cost of some of your services may be covered. Your private health insurance must be billed first. However, when these costs exceed your maximum benefit, the DDS Adult Specialist at your local DHS County Office will assist you to locate and access other resources to pay for these services, including Medicaid.

WHERE WILL YOU LIVE?

All over the nation, home and community-based care is increasingly being viewed as a preferable alternative to long term institutional care, not only for the people who may remain among friends and family as they grow into an adult, but also for the State, because services may be provided for less than the cost of institutional care.

However, there are residential treatment options for people who do not have the resources, cannot handle the responsibility of living in the community, have complex health care needs, severe behavioral problems, and/or a combination of these.

Human Development Centers (HDCs):

An HDC is an institution maintained for the care and training of persons with developmental disabilities.¹²

Arkansas has six HDCs that provide a comprehensive array of services and supports to individuals who, due to developmental disability, are incapable of managing their affairs and require special care, training, and treatment in a sheltered residential setting. Care is long term on a 24 hour a day, 7 days a week basis. Short term emergency respite care may be available.

Admission criteria – individuals must:

- Be 18 years of age or older, unless there are significant medical or behavioral challenges;
- Have a developmental disability attributable to mental retardation, cerebral palsy, epilepsy, and/or autism; and
- Have needs that can be met by the facility.

¹² Arkansas Code 20-48-101(3)



Services provided at HDCs include:

- Medical/nursing
- Physical, occupational, and speech therapy
- Orthotics (which deals with the use of specialized mechanical devices to support or supplement weakened or abnormal joints or limbs)
- Intensive behavioral treatment and support for conditions such as aggression, destruction, self-injury, and noncompliance
- Special education services for children 18 and younger
- Adult transitioning skill training
- Placement and follow-up services
- Respite

**For information about Arkansas Human
Development Centers, call
DDS Quality Assurance at: 501-683-3619**

**Intermediate Care Facilities for the Mentally
Retarded (ICFs/MR):**

Arkansas has ICFs/MR that provide diagnosis, active treatment, and rehabilitation of persons with mental retardation or related conditions in a protective residential setting – small facilities that house 10 residents and larger facilities for 16 or more residents. These facilities are not state operated; rather they are owned and operated by private, not-for-profit providers.

**For information about ICFs/MR,
call the Office of Long Term Care
at: 501-682-8430
Or the DDS Adult Specialist at your local
DHS County Office**

Group Homes:

Group homes are private not-for-profit provider owned and operated residences located in the community. They provide congregate living settings for up to 14 people. Various services can be accessed such as personal care, transportation to and delivery from community activities.

Supported Living Apartments:

Supported Living Apartments are not-for-profit provider owned and operated apartment complexes, generally HUD financed, that offer a range of services and activities such as in Group Homes but in a more integrated and independent living arrangement setting.



For information about Group Homes or Supported Living Apartments, call the DDS Adult Specialist at your local DHS Office

Lists of providers with contact information are available for providers in the geographical area of your choice or on a statewide basis.

A word about freedom:

Freedom is defined as the capacity to exercise choice – free will. Nothing is a greater testament to the importance of free will than the fact that, at any point in history, there have been people fighting and dying for it.

In this country, the civil rights movement was followed by a movement to provide equal rights for people with disabilities. That movement led to the Americans with Disabilities Act (ADA) and the Individuals with Disabilities Education Act (IDEA)

Today the disability movement, composed primarily of people with disabilities and parents, is advocating for **The Principles of Self-Determination**. These are.

- **Freedom** – to live a meaningful life in the community;
- **Authority** – over dollars needed for support;
- **Support** – to organize resources in ways that are life enhancing and meaningful;
- **Responsibility** – for the wise use of public dollars; and
- **Confirmation** – of the important leadership that self advocates must hold in a newly designed system.

We need to “look at outcomes for people with disabilities and chronic illness in the context of the expectations and aspirations shared by all humans, not just standards specific to the human service system. These values include (but are not limited to): choice and control, valued and enduring relationships, freedom, health and safety and decent places to live, economic security, opportunities for community membership and contribution, and support by nurturing and caring human relationships and committed support personnel.”¹³

The decisions you or your legal representatives make may determine whether you will be able to work at a job, live in the community, attend church, swim in a public pool, or choose which color of socks to wear. Every person should have the opportunity to make choices – even little ones. That’s what happiness is all about.

WHAT IS HEALTHCARE FRAUD AND WHY YOU SHOULD CARE ABOUT IT?

As an adult or the legal representative of an adult with special needs, you have responsibilities that others may not have. You begin by finding out everything you can about your condition and how to live life to its fullest. Then you will become an expert on where to find services and supports, you will monitor your care with an eagle eye, and you will apply for financial aid, if you need it.

As you learn about the different federal and state programs available, it will become clear that these programs are

¹³ Nerney, T (2004). *Lost Lives: Why We Need A New Approach to Quality*. The Center for Self Determination at: http://www.selfdetermination.com/pdf/lost_lives.pdf.

budget limited – that is, the number of people served and the number of individual services provided for each person depend on availability of state and federal funds (primarily Medicaid and federal block grant dollars).

Like Medicaid programs across the country, Arkansas' Medicaid budget is growing at an alarming rate and competes with other necessary services for the citizens of the State. What happens when the money runs out? The answer is that services may be cut and the number of people on waiting lists for waiver services or admission to a long-term care facility may get longer.

As an adult or legal representative of an adult with disabilities, you have a major stake in protecting the services and programs that may be needed – possibly for the rest of your or his or her life. You also have a responsibility to become a good steward of the taxpayers' money throughout the life span.

When providers bill Medicaid for services never performed or medical equipment or supplies not ordered, or bill for a service at a higher rate than is actually justified, it may be fraud.

Healthcare fraud affects everyone who pays taxes by wasting billions of tax dollars. It affects those who depend on Medicaid by diminishing the quality of the treatment they receive and putting their services at risk. Loss of money to fraud and abuse means that less money is available for necessary services and programs to assist un-paid caregivers, like parents. In addition, poor quality of care can impact your or your adult child's functional level, which may extend the need for services.

So what should you do? You can make a point of finding out whether the services being billed to Medicaid and other programs really match the services you/he or she receives. For example, are the physical, occupational or speech therapy sessions received in DDTCS really one-on-one, or are they group sessions billed at a higher rate? Are therapy sessions a full hour or half hour, or are they only 20 minutes or less. When direct service care givers do not report to or are late for work, are they paid by the provider? You are entitled to know, so don't be timid about asking. Unethical health care providers count on people not worrying about Medicaid bills – after all, it's not your money.

Generally, people on Medicaid do not receive payment summaries. Therefore, it may be hard for you to check whether Medicaid has been billed correctly for the care and services provided. However, if you suspect that Medicaid is being billed incorrectly you can request an Explanation of Medicaid Benefits (EOMB) or Medicaid Summary Notice (MSN) from the State Medicaid Agency.



**You may also contact the DDS Intake and
Referral Specialist
at your local DHS Office**

**To Request a Medicaid Statement
Call Customer Service at 1-800-482-5431 or
1-800-482-8988**

OR

**Write to DHS-DMS
PO Box 1437, Slot S-401
Little Rock, AR 72203**

**Say that you want to receive a “PAID HISTORY” and give
the following information:**

- **Your name**
- **Your Medicaid number**
- **The types of services, equipment, or supplies involved**
- **The dates of service**
- **Any other information that would make the request
more specific**

You should review the Medicaid statement as you would your
bank statement. Ask yourself three questions:

1. Did you receive the service or product for which Medicaid
is being billed?
2. Did your doctor order the service or product?
3. To the best of your knowledge, is the service or product
appropriate for your diagnosis or treatment?



Make sure you recognize the date(s) of service, the name of the doctor(s), the location of the doctor's office or clinic, and the services or supplies that were received.

If you have questions about payments Medicaid or other insurers have made on behalf of you or your adult child, call ASMP at 1-866-726-2916.

The Role of the Attorney General:

In Arkansas, the Attorney General's Medicaid Fraud Control Unit (MFCU) investigates and prosecutes health care providers who commit Medicaid fraud.

How Can You Prevent Healthcare Fraud?

- Ask questions! You have a RIGHT to know everything about your or your adult child's medical care, including costs billed to Medicaid.
- Educate yourself about what services are paid for by Medicaid and other publicly-funded programs.

It is in your best interest and that of all citizens to report suspected fraud. Healthcare fraud, whether against Medicaid, Medicare, another government program or private insurers, increases everyone's health care costs, much the same as shoplifting increases the costs of the food we eat and the clothes we wear. If we are to maintain and sustain our current health care system, we must work together to reduce costs. If you have reason to believe someone is defrauding the Arkansas Medicaid Program, contact:

**The Arkansas Attorney General's Medicaid
Fraud Control Unit.**

**Office of the Attorney General
323 Center Street, Suite 200
Little Rock, Arkansas 72201
(501) 682-2007
1-800-482-8982
oag@arkansasag.gov**

OR

**Contact ASMP
1-866-726-2916
PO Box 1437, Slot 530
Little Rock, AR 72203
<http://www.state.ar.us/dhs/aging/asmp.html>**

**BE INFORMED
BE AWARE
BE INVOLVED**

DICTIONARY OF MORE WORDS YOU MAY NEED TO KNOW

Aphasia: Loss of the ability to speak or understand words due to a brain injury.

Assistive technology device: Item, equipment, or product that increases, maintains, or improves the ability of a person with a disability to function – in terms of mobility (ability to move), communication, learning, and employment. These devices have made it possible for persons with disabilities to be educated in regular classrooms alongside non disabled students. Some examples are: electronic communication aids, devices to enlarge printed words on a computer screen, devices that help people with hearing impairments to communicate, prosthetic devices (used to replace a missing body part, such as a limb, tooth, eye, or heart valve), Braille (a system of writing for the blind) writers, and keyboards adapted for fist or foot use.

Assistive technology services help a person with a disability to choose, get, or use an assistive technology device.

Developmental (congenital) aphasia is an inability to speak or understand words that becomes apparent during the language development process and is not the result of a specific brain damage. This is usually associated with immediate and involuntary repetition of words or phrases just spoken by others, poor attention, hyperactivity, poor eye contact, and difficulty understanding simple yes/no questions.

Diagnosis is the process of determining the nature and cause of a disease or injury by examination of the patient, evaluation of the patient's history, and review of the results of laboratory tests

Durable Medical Equipment (DME) is medically necessary equipment, prescribed by a doctor, that can withstand repeated use, generally is not useful to a person in the absence of an illness or injury, and is appropriate for use in the home (such as wheelchairs, walkers, hospital beds, etc.)

Dyslexia is difficulty learning to read. Some definitions also include difficulties with: writing; spelling; listening; speaking; and mathematics.

Individuals with Disabilities Education Act (IDEA): A federal law that guarantees the delivery of special education services to all students with disabilities ages 3 through 21.

Individualized Education Program (IEP): A written educational plan for a student receiving special education services. The plan includes statements of present level of functioning, annual goals, short term instructional objectives, specific educational services needed, dates of service, participation in regular education programs, and procedures for evaluating the person's progress on the IEP.

Inclusion: The practice of including people with disabilities in settings or activities along with non disabled people.

Medically necessary refers to health care products and services that are considered to be appropriate and would assist in the diagnosis or treatment of a disease.

Medically necessary services, durable medical equipment (DME) and supplies are appropriate and required to diagnose or treat a medical condition; meet the standards of good medical practice in the local area, and are not mainly for the convenience of the person or the prescribing physician.

Multidisciplinary refers to a group of qualified people who have different areas of training and experience – generally used when talking about diagnostic evaluations.

Outpatients are individuals who travel to and from a treatment site on the same day, who do not live in an intermediate care facility for the mentally retarded (ICF/MR), and who are not inpatients of a hospital.

Placement: The site where a person receives services or lives (such as own home, group home, supported living assisted apartment, HDC, RCF, etc

Referral: A formal request sent to potential service providers to assist/consider a person for services or to obtain test assessments to determine if a person is eligible for Division or program services.

You and Your: As used in this Guide means the person who is in need of services and assistance, or the person appointed as a person's legal representative to act in their behalf in these matters.

ALPHABET SOUP

ACS = DDS Alternative Community Services Waiver

ADA = Americans with Disabilities Act, a federal law that assures the full civil rights of all individuals with disabilities

ADD = Attention Deficit Disorder, an inability to focus or maintain attention (same as AD/HD).

ADE = Arkansas Department of Education

AD/HD = Attention-Deficit/Hyperactivity Disorder

ASB = Arkansas School for the Blind

ASD = Arkansas School for the Deaf

CMHC = Community Mental Health Center

CMS = Centers for Medicare and Medicaid Services.

DD = developmental disability;

DDS = Developmental Disabilities Services; also Disability Determination Service of the Social Security Administration

DDTCS = Developmental Day Treatment Clinic Services

DME = durable medical equipment

DOE = Department of Education

EOMB = Explanation of Medicaid Benefits

FAPE = Free Appropriate Public Education

HDC = Human Development Center, a long-term care institution housing people with disabilities

ICF/MR = Intermediate care facility for the mentally retarded

IDEA = Individuals with Disabilities Education Act, a federal law that assures all children with disabilities a free public education (FAPE) in the least restrictive environment (LRE).

IEP = Individualized Education Program

IFSP = Individualized Family Service Plan

LRE = least restrictive environment

MAPS = Multi-Agency Plan of Service

MSN = Medicaid Summary Notice

OT = Occupational Therapy

PRTF = Psychiatric Residential Treatment Facility

PT = Physical Therapy

PWD = People with disabilities

SEA = State Education Agency

SSI = Supplemental Security Income, a federal assistance program.

SSDI = Social Security Disability Income, a federal assistance program for disabled people who have paid Social Security taxes or are dependents of people who have paid.

ST = Speech Therapy



Waiver Information Sheet

What is Medicaid Waiver?

- The correct full name is Alternative Community Services (ACS) Home and Community Based Waiver (HCBW). Federal Medicaid and State monies fund it.
- It is a service and support program, through a network community provider, that is designed to assist persons with developmental disabilities, to live, work and recreate in their home community of choice.
- Its purpose is to help de-institutionalize individuals or prevent institutionalization of individuals who can live at home or in the community. It offers greater freedom, choices & opportunities for families.
- Waiver is not an entitlement it is a voluntary program. There are only a certain number of people who can be served annually based on funding to support services.
- The HCBS Waiver is renewed every 5 years.
- CMMS (Center for Medicare/ Medicaid Services) formerly known as HCFA (Health Care Finance Administration) of the Social Security Administration must approve each state's service plan.

Who is Eligible for Waiver Services?

- An individual who is Medicaid Eligible
- ICF/IID Level of Care Eligibility (Intermediate Care Facility for Mentally Retarded) A person must have a severe, chronic disability. The disability must be manifested before age 22 and be likely to continue indefinitely. Psychological and other information is reviewed to determine if the person qualifies categorically and adaptively. Categorical qualifiers are:
 1. Intellectual Disability with IQ of approximately 70 or below
 2. Epilepsy (Documented Seizure Disorder)
 3. Cerebral Palsy
 4. Autism
 5. Other Condition(s) other than mental illness closely related to MR because it results in impairment
 6. Areas of need: The individual must have substantial functional limitations in 3 or more of 6 areas of major life activity: Self-Care, Understanding & Use of Language, Learning Mobility, Self-Direction and Capacity for Independent Living.

What Services are available through Medicaid Waiver Program?

Case Management Services

Each individual who receives Waiver Services receives case management through a chosen Case Management Provider. The Case Manager is responsible for assisting you in identifying services to meet your needs. They can help you locate and access services in your community. The Case Manager works closely with you and your Integrated Support of Direct Service Provider to assure that services you receive meet your needs and are in accordance with the written plan of services you have agreed to.

Integrated Supports or Direct Services

Your Direct Service Provider is responsible for providing those services to you that are allowable under the Waiver program to assist you in remaining in the community. Services that are provided must not be available from any other source. These are the day to day services that can assist in the individual to be all they can be and avoid being institutionalized.

For Waiver Services (Home and Community Base Waiver),
Please call (Sharon Sisk) Developmental Disabilities Services,
Medicaid Waiver Intake. Ms. Sisk's telephone number in
Conway is:
501-730-9916

To receive residential support from ILS, you must have a waiver
support in place prior to admission.

Day Services and work activities can be accessed through
Profiles with a Medicaid card. Waiver services do not need to
be in place for Profiles placement.

If you should have questions, please feel free to call the
numbers below.

Elissa Douglas, Executive Director: 501 327-5234 x 302

Evelyn Fecher-Ward, Program Director: 501 327-5234 x 303

Caleb Walker, Profiles Program Director: 501 327-5234 x 324

Robert Wright, Supported Employment: 501-358-6567

Independent Living Services, Inc.

**Consumer Handbook including
Residential & Waiver Services
Profiles & Profile Productions**

**P.O. Box 1070
Conway, AR 72033
(501) 327-5234 Phone
(501) 327-5620 Fax**

Updated March 2022

Mission Statement

Advocate independence, purpose and dignity for individuals with disabilities.

Guiding Principles

The Board of Directors will approve a statement of values that will focus on rights that all people cherish and recognize as important to establishing a good life.

Guiding principles: The board, employees and volunteers of ILS/CL will be guided by the following principles:

- ▶ Each person has value
- ▶ Each person is capable of growth and development
- ▶ Each person is unique and deserves services that are tailor made
- ▶ Each person has the right to live in the community and participate in services of their choice
- ▶ Each person needs access to opportunities and information in order to make choices and exercise basic rights
- ▶ Each person deserves access to supports and services that enhance development, independence, and productivity
- ▶ Each person deserves access to a decent and appropriate place to live and the opportunity to work and retire from work when health and/or age make it desirable.
- ▶ Each person deserves the right to an explanation of services, including the right to refuse treatment, provided by ILS/CL or any other service entity
- ▶ Each person has a right to participate in their individual plan of care/services
- ▶ Each person is a citizen of the United States of America and has the right to fully exercise those rights guaranteed by the Constitution.

General

What is Independent Living Services (ILS):

ILS is a private non-profit entity that was established in 1970 to provide services to adults with intellectual and or developmental disabilities. Our mission is to assist in making a better life possible for people with developmental disabilities within their own home or ILS's residences. ILS recognizes each person is different and provides an array of services to best meet individual needs.

ILS will strive to:

- Provide services in an atmosphere of dignity and respect as people work toward reaching their life goals while living in the community.
- Provide a safe, healthy, caring environment where people can live a good quality of life.
- Provide training and assistance that will enable the person to perform well within the community
- Assist in establishing a network of friends and family connections that will assist the individual through the adventures of daily living.

Services offered by ILS include: Residential Services such as group homes and apartments, and an intermediate care facility. Waiver Services including: supported living, community integration, transportation, support management, and respite services. Adult Development Services include: Therapy Services, Sheltered Employment, Personal Care, Adaptive Equipment, Durable Medical Equipment, Consultation, and Transportation Services.

Description of Developmental Disability Service Options Provided by ILS/CLI

Adult Development Day Treatment Center: Independent Living Services offers adult development and vocational maintenance programs for adults 18 years of age and older who had a developmental disability before the age of 22. If the person is age 18-21 they must have a high school diploma or certificate of completion and be eligible for Medicaid to be eligible for the programs.

Group Homes: This residential option is located in communities. They provide experience to assist adults in attaining independence.

Intermediate Care Facility (ICF/IID Ten Bed or Less): This option provides the same types of services and is operated by the same rules and regulations as the Human Development Centers. These facilities are community based for a maximum of ten persons.

Medicaid Waiver: This option offers a full range of home and community-based services that otherwise would be available only in an institutional setting. They include day habilitation services, in-home supportive living services, transportation, respite care, consultation, alternate living, structural modification/adaptive equipment, and support management.

Sheltered Workshop: This option provides training programs for adults focusing on independent living and/or vocational skills.

Supervised Apartments: This option offers residential services in which persons live in an apartment setting with supervision/supports as needed.

Adaptive Equipment: Any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve the functional capabilities of individual with disabilities. Assistive Technology Service means a service that directly assists an individual with a disability in the selection, acquisition, or use of an assistive technology device.

Respite: Services providing temporary direct supervision and care to an individual during the absence of the primary care giver.

Supported Employment: Services assist individuals in all aspects of Competitive Integrated Employment. Supported employment assists with job searching, interview skills, on the job coaching and assistance navigating the workplace.

Confidentiality

Our agency is dedicated to maintaining the privacy of your individually identifiable health information as protected by law, including Health Information Portability and Accountability Act (HIPPA). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. As part of your admission to any ILS/CLI service and review of information, you will be given a copy of the ILS Notice of Privacy Practices.

Advocacy and Advocacy Services

Our manager will also assist you with obtaining other services that you may need, these may include such things locating and accessing community resources, legal representation, medical services, advocacy services, and any other services you may need.

The main advocacy services in Arkansas consist of:

Disability Rights Center 1-800-482-1174
DDS Licensure 1-501-682-8665
Office Long Term Care 1-501- 682-1919
Adult Protective Services 1-800-482-8049
Emergency Services 911

What are your rights:

1. The right to be free from:
 - Physical or psychological abuse or neglect
 - Retaliation
 - Coercion
 - Humiliation
 - Financial exploitation
 - Corporal punishment “Corporal punishment” refers to the application of painful stimuli to the body in an attempt to terminate behavior or as a penalty for behavior.
2. The freedom to control their own financial resources.
3. The freedom to receive, purchase, possess, and use individual personal property. Any restriction on this right must be supported by an assessed need and justified in the individual’s person centered service plan (“PCSP”).
4. The freedom to actively and meaningfully make decisions affecting their life and access pertinent information in a timely manner to facilitate such decision making.
 - If an individual is age eighteen (18) or older, they are considered competent unless there is a court appointed legal guardian. Competent adults must always sign their own consents, releases, or other documentation requiring a signature.
 - An individual who has a court appointed legal guardian retains all legal and civil rights except those which have been expressly limited by the court in the court order, or which have been specifically granted to the legal guardian pursuant to the court order.
 - Adult individuals who are legally competent shall have the right to decide whether their family will be involved in planning and implementing the PCSP.
5. The right to privacy. Any restriction on this right must be supported by an assessed need and justified in the PCSP.
6. The right to choice of roommate when sharing a bedroom.
7. The freedom to associate and communicate publicly or privately with any person or group of people of the individual’s choice at any time. Any restriction on this right must be supported by an assessed need and justified in the PCSP.
8. The freedom to have visitors of their choosing at any time.
9. The freedom of religion.
10. The right to be free from the inappropriate use of a physical or chemical restraint, medication, or isolation as punishment.

11. The opportunity to seek employment and work in competitive, integrated settings to the same degree as those not receiving home and community based services through Medicaid.
12. Freedom from being required to work without compensation.
13. The right to be treated with dignity and respect.
14. The right to receive due process.
15. The right to contest and appeal Provider decisions affecting the individual.
16. The right to request and receive an investigation in connection with an alleged infringement of an individual's rights.
17. The freedom to access their own records, including information regarding how their funds are accessed and utilized and what services were billed for on the individual's behalf.
 - Contact the Manager or Program Director request a copy of this information. Upon request the Manager or Program Director will ensure copies of requested documents which we are legally required provide will be given to individuals, their families or guardians.
18. The right to live in a manner that optimizes, but does not regiment, individuals initiative, autonomy, and independence in making life choices, including but not limited to:
 - Choice of Provider
 - Service delivery
 - Release of information
 - Composition of the service delivery team
 - Involvement in research projects, if applicable
 - Daily activities
 - Physical environment
 - With whom to interact
19. Other legal and constitutional rights.
 - a) Having input in to your individual plan, requesting changes to your plan, and signing your plan
 - b) Aware that the program is voluntary
 - c) Participating in campaigns for publicity efforts or to raise funds is on a voluntary basis only.
 - d) Being informed of the rules of the program and having input into those rules
 - e) Being informed of your constitutional rights:

- Right of freedom of speech and expression
 - Right to freedom of religion
 - Right to association
 - Right to marry, procreate, and raise children
 - Right to vote
 - Right to meaningful and fair access to courts, including legal representation.
 - Right to contract and the right to own and dispose of property
 - Right to privacy
 - Right to be free from cruel and unusual punishment,
 - Right to equal protection and due process of law
 - Right to fair and equal treatment by public agencies
 - Right to equal educational opportunities
 - Right to an equal employment opportunity
 - Right to have residential and educational services provided in a humane and least restrictive environment
- f) Right to refuse any experimental or non-standard form of treatment.
- g) Aware of confidential nature of personal information and have the right to approve or deny the release of identifiable information.
- h) The right to be paid for the work you do
- i) The right to request a copy of any public report concerning ILS services done by local, state, or federal authorities or any personal information in my case files
- j) The right be informed of the reason for discharge and exit procedures for the program
- k) The right to decide if family members and other interested parties can be involved in the planning and implementation of your services (if you are your own legal guardian)
- l) The right to services that best fit your needs and in a way that provides the most freedom possible
- m) Right to be free from restraint or seclusion except in an emergency
- n) Right to be free from abuse, neglect, humiliation, or retaliation
- o) Right to refuse services, unless that right has been taken away by the courts
- p) Ability to exercise your rights without fear of punishment, or denial of services
- q) Have all information explained to you in a manner that is understandable for you
- r) The right to be informed of the grievance procedure.

You may contact Human Resources to request this information provided in an alternative format.

Individual/Parent/Guardian Grievance/Recommendations Procedure

Complaints and Recommendations Procedures

ILS/CL strives to provide quality services for all individuals, however, we also recognize that there may be times when an individual/parent/guardian may not be satisfied with the services they are receiving and will want to file a complaint and/or grievance. If that situation should arise, ILS/CL will assist the individual in obtaining advocacy assistance in filing the complaint,

if the individual requests such assistance. Individuals can present their grievance/complaint in good faith, without fear of reprisal, retaliation or barrier to services.

In the event that an individual wishes to voice a complaint or recommendation concerning any person/action, service, policy, procedure, or event involving ILS/CL, the following process is available:

Discuss the complaint/recommendation with the supervising staff person on duty. If an equitable solution is not possible, fill out a complaint form or write comments to be given to the program or executive director. Arrangements will be made to enable the complainant to contact the Program Director/designee within ten **(10) working days**.

If an equitable solution to the complaint/recommendation is not possible at this point, arrangements will be made to enable the complainant to contact the Executive Director/designee within ten **(10) working days**.

If an equitable solution to the complaint/recommendation is still not possible, arrangements will be made to enable the complainant to contact and/or meet with the Board of Directors within **ten (10) working days**.

If an equitable solution to the complaint/recommendation is still not possible, arrangements will be made to enable the complainant to contact the Developmental Disabilities Licensing Division and request intervention. The DDS licensing division is the contact for such complaints. The information is: phone: 501-682-8697.

The address is:
Developmental Disabilities Service
P.O. Box 1437, Slot 2500
Little Rock, Arkansas 72203-1437

You may contact Human Resources to request this information provided in an alternative format.

Civil Responsibilities:

If you are 18 years of age or older you have the following responsibilities:

- If you agree to buy something, you must pay for it before it actually becomes yours.
- If you buy something on credit, you must make each payment on time until all payments are made.
- If you sign your name to any kind of contract, you can be held to the terms of the contract.
- If you do not fulfill the terms of the contract you sign, you can be taken to court.

- If you break a law, you can be taken to court, and a judgment made as to your punishment.
- If you are accused of breaking a law, you will be given a trial to decide if you are guilty.
- If you wish to own an automobile or motorcycle and drive it, you must get a driver's license, buy a tag, get insurance, and obey all rules listed in the drivers manual.
- If you choose to possess or consume alcohol you are subject to all the laws governing drinking.
- Possession of drugs except those prescribed by your doctor is against the law.
- Buying alcohol for anyone under 21 is against the law.
- If you are not 18 or not your own legal guardian you must have your parent/guardians approval by signature before you sign any contracts, buy on credit, get a driver's license, buy alcohol, or exercise other rights of majority.

Management of Inappropriate Behaviors:

If an individual exhibits inappropriate behavior, i.e., yells, curses, striking others or self, destroying property, etc. counseling will be provided and the individual may be given down time to reorganize their thoughts and actions. A positive behavior support plan is required by DDS for any consumer that takes psychotropic medications. The plan will be developed and monitored by support manager/direct support supervisor. Corporal punishment is prohibited. "Corporal punishment" refers to the application of painful stimuli to the body in an attempt to terminate behavior or as a penalty for behavior.

Conflict of Interest:

A conflict of interest can exist when a staff person is in a position to influence a decision you make that may result in personal gain for the employee or may cause you to do something you do not want to do. An example is a staff member trying to sell you something or trying to get you to buy something from or for them. If you ever feel that there is a conflict of interest taking place please talk with your support manager or program director immediately. You can also follow the grievance process if you wish.

Solicitation Statement:

Independent Living Services does not allow solicitation of services. Solicitation is defined as an attempt to unduly influence an individual served by a nonprofit community program or program component or his or her family to transfer from one program to another program. If an ILS staff person or provider asks you or your guardian to change providers please contact your Support Manager or your DDS Waiver Specialist.

Emergency Evacuation Drills:

Emergency Drills are conducted at all Programs on a regular basis. Fire and tornado drills are held monthly and drills for earthquakes, violence in the workplace, natural disasters, nuclear disasters, etc. are held or discussed at least twice a year. You are required to participate in all drills regardless of time of day or night.

Transportation:

Each facility has a vehicle for transporting residents to work, doctor appointments, day programs, shopping sites, recreational activities, barber/beauty shop, social security/social services, etc. Transportation is also provided for Profiles and Profile Productions if the individual cannot locate other means of transportation and they are within the ILS transportation area. Consumers must receive at least one other ILS service to qualify for transportation service.

When you are in the vehicle, the following rules should be followed:

1. Always wear seat belts.
2. Remain seated at all times.
3. No yelling on the van – talk in a low voice.
4. Do not touch the driver or other riders.
5. No eating or drinking the vehicle
6. No hitting people or objects (like windows) on the vehicle.
7. No sexual misconduct including but not limited to fondling, kissing and inappropriate language.
8. No smoking in the vehicle.
9. Be aware of evacuation procedures.
10. No bullying

The driver will give a warning if any of the above rules are broken. Depending on the severity of the offense further actions will be taken up to and including notification of proper authorities and loss of ILS transportation.

If in an accident which disables the driver, follow the procedures below.

1. Exit vehicle through nearest door, if nearest door is blocked, find one that will work.
2. Do not push or shove.
3. Stand off the roadway away from the van until help arrives.

If van is turned on its side, exit through rear door as soon as possible.

Cash Management of Consumer Funds

Independent Living Services offers cash management services through management of consumer funds under Social Security Administration guidelines, and training and assistance so that a consumer can manage their own funds.

Cash Management of Individual Accounts

Independent Living Services can become representative payee for Social Security funds if requested by consumer or parent/guardian and approved by the Social Security Administration. Under this service, ILS is responsible for all disbursements from the individual checking account and the consumer is not allowed direct access to funds as per Social Security Administration rules and regulations. To safeguard funds the following procedures apply:

1. Consumer, caretaker, and or parent/guardian request a disbursement of consumer funds and a check is written by caretaker and recorded in the check register.
2. Check is approved and signed by division director or executive director.
3. Receipts from disbursement are turned into division director or accounting department.
4. Bank statements are received unopened by reconciliation specialist in accounting.
5. Check register is forwarded to accounting for reconciliation and review.
6. Bank reconciliations are prepared by specialist and made available to consumer, parent and/or guardian upon request. Copies of reconciliation are maintained in the consumer's financial file.
7. Receipts are reviewed by specialist for reasonableness and matched to check.
8. Finances/spending is reviewed with the consumer by support manager on a monthly basis or a monthly requested.

Cash Management of Consumer Trust Accounts

1. Consumer trust accounts for Patterson House and Creative Living are maintained in the Accounting Department.
2. A request for disbursement is sent to Accounts Payable Specialist and a check is prepared.
3. Check and request are reviewed by Director of Finance or Executive Director and check is signed by both.
4. A spreadsheet is maintained by AP Specialist with receipts and disbursements separated by consumer.
5. Bank statements are received by accounting department with reconciliation prepared by someone other than AP Specialist or Director of Finance.

Assistance and training for those who manage their own funds.

1. Cash management assistance will be identified, discussed, and documented in annual Person Centered Service Plan. Cash management assistance will be provided as directed by PCSP.
2. Cash management skills are taught as a subject for independent living at Profiles Adult Day Center.
3. Support manager will assist with cash management at the request of any consumer.

Drug and Alcohol Testing Policy:

It is the purpose of Independent Living Services, Inc. /Creative Living, Inc. (ILS/CLI) to help provide a safe and drug-free work environment for our consumers. With this goal in mind, we are establishing the following policy for existing and future consumers of Independent Living Services, Inc. /Creative Living, Inc.

ILS/CLI explicitly prohibits:

- The use, possession, solicitation for, or sale of narcotics or other illegal drugs, alcohol, or prescription medication without a prescription on ILS/CLI premises or while on and ILS/CLI sponsored event..
- Being impaired or under the influence of legal or illegal drugs or alcohol away from ILS/CLI , if such impairment or influence adversely affects the consumer's work performance, the safety of the consumer or of others, or puts at risk ILS/CLI's reputation.
- Possession, use, solicitation for, or sale of legal or illegal drugs or alcohol away from ILS/CLI, if such activity or involvement adversely affects the safety of the consumer or of others, or puts at risk ILS/CLI's reputation.
- The presence of any detectable amount of prohibited substances in the consumer's system while on the premises of ILS/CLI. "Prohibited substances" include illegal drugs, alcohol, or prescription drugs not taken in accordance with a prescription given to the consumer.

ILS/CLI will conduct drug testing under one or another of the following circumstances:

- FOR CAUSE TESTING: ILS/CLI may ask a consumer to submit to a drug test at any time it feels that the consumer may be under the influence of drugs or alcohol, including, but not limited to, the following circumstances: evidence of drugs or alcohol on or about the consumer's person or in the consumer's vicinity, unusual conduct on the consumer's part that suggests impairment or influence of drugs or alcohol, negative performance patterns, or excessive and unexplained absenteeism or tardiness.
- POST-ACCIDENT TESTING: Any consumer involved in an on-the-job accident or injury under circumstances that suggest possible use or influence of drugs or alcohol in the accident or injury event may be asked to submit to a drug and/or alcohol test. "Involved in an on-the-job accident or injury" means not only the one who was injured, but also any consumer who potentially contributed to the accident or injury event in any way.

If a consumer is tested for drugs or alcohol during and outside of the program context and the results indicate a violation of this policy, the consumer may be subject to appropriate disciplinary action up to and possibly including discharge. In such a case, the consumer will be given an opportunity to explain the circumstances prior to any final action becoming effective.

Staff Qualifications:

Our staff is hired because they have either experience working with individuals with disabilities or the desire to work with individuals with disabilities. Our staff is trained in CPR and First Aid, Positive Behavior Techniques, OSHA, Abuse and Neglect, and your rights among many other things. Our programs are licensed by Developmental Disability Services and the Office of Long

Term Care. Our staff are therefore mandated reporters to Adult Protective Services and Child Protective Services. All incidents, as described by DDS and/or OLTC, will be reported to DDS/DHS and/or OLTC and to the program and executive director of ILS. The staff takes great pride in being sure you have the skills and experience you will need to help you in making daily choices that impact your life.

Leaving the Program:

If you want to leave services:

We understand that at times people want to experience different options in the community. We request you give us 30 days' notice. When you do leave the program we will ask you to do an exit interview at which time we will ask how we were able to help you, and give us ideas on how to improve our program. We will also get any final information if you are moving so we know where to send your final paycheck.

Because our services are mainly government funded, there may be times that services have to be altered. If this situation should occur we will work with you to find alternate services that meet your needs.

If you are discharged from Services:

Individuals can be discharged from services under certain circumstances, such as; unsatisfactory performance after repeated counseling, behavior disruptive to the program or endangering the health, safety, and welfare of the others or yourself, consistent violation of the program rules, or if the person is found to be ineligible for services by a funding/regulatory source.

Individuals will be dismissed only after efforts to assist in correcting the inappropriate behaviors have failed.

If you are discharged, we will try to assist you in acquiring alternate placement/services suitable for meeting your needs.

Residential & Waiver Programs

What are ILS/CLI residential options:

The residential/transitional services provided by ILS include, Intermediate Care Facilities (ICF), Group Homes, Supervised Apartments, and Waiver Homes that are owned and/or leased by the agency. Residential/waiver services are also offered to individuals who live in their own apartments or homes in the community. You and your team will work together to determine the level of support, supervision, training, and services you will need to achieve your preferred lifestyle as you work toward greater independence and involvement in the community.

The Intermediate Care Facility **ICF/IID** offers 24 hour awake staff, as well as nursing staff. Professionals such as dietitians, social workers, doctors, and psychologists are also on contract to provide services for the individuals residing in the ICF/IID. A waiting list is maintained for this service.

The three (3) **Group Homes** offer 24 hour staff support. Individuals in the group home usually require moderate assistance in areas such as cooking, meal planning, shopping, personal hygiene, social skills, money management, medication monitoring, transportation, safety skills, and community awareness. A waiting list is maintained for this service

The three (3) **Supervised Apartment Complexes** offer various levels of support based on the individual's needs. Overnight asleep staff may be provided and support staff are available at varying times during the day based on the needs of the individuals at the complex. A waiting list is maintained for this service.

The ILS Owned Waiver Homes are located in the community and usually have 2 to 4 individuals who reside in the homes. The homes are staffed at different levels according to the needs of the individuals who live in the homes.

The **Waiver program** in general offers supports to individuals who live on their own in the community in supported living arrangements. The supports that are provided are determined based on the individuals needs as approved in their Person-Centered Services Plan and may consist of supported living services, community integration, transportation, support management, respite, adaptive equipment/environmental modifications. (See Appendix)

Admissions: When an individual applies for services residential and or Waiver Services there is an ILS Admission Committee meets to determine their eligibility for services, discuss medical concerns, diagnosis, behavior concerns/review of positive behavior supports plan legal issues/liabilities, and health and safety. Each individual will be considered on the basis of his/her needs, eligibility for DD services, emergency nature of the request, location in regard to family (if applicable), and whether or not ILS can safely meet the needs of the applicant consistent with its resources. ILS/CLI does not discriminate based on a person's age, race, sex, or national origin in compliance with the Civil Rights Act of 1964.

Application Process for Residential services in the Group Home or Apartments:

1. Applications for ILS HUD Housing may be picked up at 1615 Independence Street, Conway, AR.or requested by phone. If an alternative format of the application is needed please let us know at 501-58-6192 X 406
2. A completed returned application places applicant on the waiting list if HUD eligibility requirements including age, disability and income are met. If you need assistance in completing the application please let us know.
3. Individuals must furnish ILS with proof of income to establish eligibility and rent payments, (i.e. savings, SSI, Social Security, Veteran's Benefits, Unemployment, Railroad Retirement, earned income, pensions, and annuities, etc.)
4. Individual will be notified with information relative to tour and interview.

5. *Please feel free to call the Hud Specialist at (501) 358-6192 Extension 406 for an update on placement on the waiting list.*

Costs in the residential program:

Rent, utilities, food, and other costs are paid for by your source of income such as SSI, SSDI, employment income, or other income that you might have.

If ILS is chosen as representative payee for social security funds, the funds will be administered in accordance with rules, regulations and guidelines of the Social Security Administration as published in the Social Security Administration Guide for Representative Payees.

Group Home Costs:

1. **Rent** (utilities included) – Housing and Urban Development formula is used that computes the resident’s rent payment each month. The resident rent payment will be approximately 30% of his or her gross income. This rent is due and payable to the ILS financial office on or before the fifth (5) day of each month. Nonpayment of rent may result in eviction.
2. **Meals Program for Group Homes** – ILS offers an optional meal program to the residents of the group homes. The cost of the meals program is \$160.00 per month (see meals contract for more details). Any one choosing not to participate in the meals program will be responsible for supplying their own meals, snack, drinks, etc. ILS will not be responsible for transportation to obtain food or food supplies for residents that do not participate in the meals program. Residents that participate in the meals program who also receive food stamps will subtract the allotment of food stamps from the \$160.00 charge each month. Payable to the ILS office
3. **Security Deposit** – Before an applicant can move into ILS facilities, it is required that a security deposit be paid at the ILS office. The amount is equal to the greater of \$50 or one month’s rent. This is a Housing and Urban Development regulation for ILS.
4. **Moving Out** – An individual must give ILS a 30-day written notice before moving out of the group home or be responsible for his or her rent payment 30-days after they leave. ILS will not be responsible for items left over 30 days.
5. **Spending Money**– People need approximately \$60-\$100 a month for personal spending. This will take care of personal necessities, most medical needs, recreation, etc.
6. **Social Security and SSI checks** – ILS may request to become payee on government checks. This will be a co-operative effort on behalf of ILS/guardian/resident. If ILS is chosen as representative payee for social security funds, the funds will be administered in accordance with rules, regulations and guidelines of the Social Security Administration as published in the Social Security Administration Guide for Representative Payees.
7. **Phone, Cable, Internet** – are paid by you if you choose to have them connected in your bedroom.

Supervised Apartment Costs:

1. **Rent** (some utilities included) – Housing and Urban Development formula is used that computes the resident's rent payment each month. The resident rent payment will be approximately 30% of his or her gross income. This rent is due and payable to the ILS finance office on or before the fifth (5th) day of each month. Nonpayment of rent may result in eviction.
2. **Utilities** (phone, cable, internet) – These utilities are paid by you if you choose to have them connected in your apartment. Essential utilities such as gas, electric, and water must be turned on. Utilities such as phone, internet, and cable do not have to be turned on if you prefer not to have them.
3. **Security Deposit** – Before an applicant can move into ILS facilities, it is required that a security deposit be paid at the ILS office. The amount is equal to the greater of \$50 or one month's rent. This is a Housing and Urban Development regulation for ILS.
4. **Moving Out Notice** – An individual must give ILS a 30-day written notice before moving out of the apartment home or be responsible for his or her rent payment 30-days after they leave. ILS will not be responsible for items left over 30 days.
5. **Food** – ILS staff will assist you in purchasing healthy food and preparation of food if you need assistance.
6. **A Clean Apartment** –It is your responsibility to keep your apartment clean. Your apartment is subject to monthly inspection or when needed. You do not need to be present during an inspection.
7. **Spending Money**–You will need spending money for personal necessities, recreation, etc. Staff are available to assist residents with money management.
8. **Social Security and SSI checks** – ILS may request to become payee on government checks. This will be a co-operative effort on behalf of ILS/guardian/resident. If ILS is chosen as representative payee for social security funds, the funds will be administered in accordance with rules, regulations and guidelines of the Social Security Administration as published in the Social Security Administration Guide for Representative Payees.

Residential / Waiver Services Funding:

The residential programs are funded mainly by Waiver Services, Personal Care, and HUD. You must have current Medicaid Waiver funding to live in an ILS residential home or apartment. The cost will be discussed with you before you elect to receive services. If you are receiving waiver funding, but choose not to follow your approved waiver plan, you may be asked to assist with making up for lost funding due to your unwillingness to follow the plan.

Individual Program Planning:

For individuals residing in the ICFIID, a preadmission meeting is held to develop a temporary service plan. After 30 days has passed the team meets again and a full service plan is developed and implemented. The service plan is then reviewed every 30 days by the QIDP.

Your manager/QIDP will keep your file current and you can access your files at the time of your annual IPP meeting and at other times by simply making that request to your support manager/QIDP.

Our agency is dedicated to maintaining the privacy of your individually identifiable health information as protected by law, including Health Information Portability and Accountability Act (HIPPA). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. As part of your enrollment at Profiles and review of information, you will be given a copy of the ILS Notice of Privacy Practices.

Group Home and ICF/IID Residents Responsibilities:

In order to become a part of this home and community, individuals will be expected to make responsible decisions for and about him or herself. These Major Expectations must be followed to maintain membership in this home and community.

1. I will learn and respect the laws of the community and rules of the home. No use, possession or dealing of illegal drugs while I am at the ILS facility.
2. No use of, possession of alcohol within the ILS Group Homes and Creative Living.
3. No weapons, i.e. knives, guns, etc.
4. No physical violence or threats of violence.
5. Respect other people's possessions and need for privacy.
6. No possession of stolen goods or stealing.
7. Honesty is the foundation of all relationships within the home. All persons are expected to be honest in dealing with others and staff members.
8. I will inform the staff when I leave the facility. Report where I am going and when I will return.
9. I will attend to my Personal Responsibilities.

I further understand that because of the serious nature, if I violate a **Major Expectation** there will be consequences for my actions that may include loss of the services I am receiving.

Quiet Time –Be aware of your daily schedule and your needs for rest. Eight (8) hours of rest per night is adequate for most people. Keep noises within your room as not to disturb your other housemates. Staff will make bed checks. (Quiet hours are 10:30 p.m. – 6:00 a.m. Sunday through Thursday.)

Leaving the Facility – When you leave the facility, please inform your staff where you are going, whom you are going with, what time you expect to return.

Meals – Everyone living in the group home will prepare their own breakfast and lunch with staff. Training and supervision will be provided. Staff and residents prepare the evening meal. Please inform the staff if you plan to invite a guest to eat dinner with you. A charge of \$5 will be billed for each guest's meal. Good nutrition will be encouraged and menus will be monitored. Calorie reduction/diets will follow doctor's instruction.

Shopping – Staff will provide training and assistance with shopping for personal items as needed. Planning for large purchases and shopping will be done on an individual basis. Training will be provided in list making, money management, and appropriate selection of items.

Household Assignments – At ILS there are many chores that must be done. These assignments must be completed daily. Residents should check the calendar for duties assigned each day.

Emergency Evacuation Drills are conducted at each home on a regular basis. Fire and tornado drills are held monthly and drills for earthquakes, violence in the workplace, natural disasters, nuclear disasters, etc. are held or discussed on a quarterly basis. Participation in all drills is mandatory.

Phones – Resident who do not have their own phone or cell phone may make local calls on ILS telephones. Please limit calls to five (5) minutes. Residents are responsible for paying any long distances charges made on ILS phones. Residents may have a phone of their own and they are responsible for the cost of their own phone. Residents are not to call staff (Executive Director, Program Director, etc.) that is not on duty after 5:00 p.m. **ALWAYS CARRY THE ILS/CLI GROUP HOME AND DIRECTORS PHONE NUMBER IN CASE OF EMERGENCY.**

Food, Drinks, Smoking – No food or drink are allowed in residents bedrooms. No smoking is allowed in any ILS facility. Smoking includes electronic cigarettes (E-Cigarettes).

Friends – Family and friends are welcome to visit the home. Residents are responsible for guest and their behavior. All visitors must check in with the house manager on duty. All guests will abide by the rules of the home.

Employment – Residents are assisted in getting to his or her job on time by ILS transportation. If your work schedule should change, you are responsible for notifying transportation at least 24 hours before your new schedule begins. If you desire to be employed or change employment, you may access supported employment program through Independent Living Services or Arkansas Rehab services.

Medication– All medications are kept locked and must be properly labeled by a pharmacist and taken as directed. Staff will supervise residents taking his or her own medication. Staff will be trained as required by the Consumer Directed Care Act. Medication errors will be documented.

Medical Exams – Dental, optical, and medical appointments will be made on an as needed basis. ILS encourages routine and preventative care. Medical costs are the responsibility of the resident/guardian.

Visits away from the Group Home/ CLI – Residents may visit his or her family and friends on weekends, vacations, and holidays. Residents should leave the name, address, and phone number of where they can be reached with the house manager. Residents should supply staff with dates as to when he or she will be leaving and returning. Visits should coincide within the schedule on the individual PCSP plan, when possible.

Money – Residents must pay rent and meal charges. An individual payment schedule will be prepared for any resident unable to make monthly payments. Resident's weekly spending money will be maintained at the facility or by the resident based on the resident's individual management program. It is the resident's responsibility to turn in all receipts to the staff. All monies received and spent will be documented (exceptions for coke money, etc.) An audit will be performed at times during the year to insure good management.

Mail – All residents will open his or her mail. Residents may receive help in reading mail, if needed. Residents are encouraged to correspond with family. Staff will assist residents with reading and interrupting materials.

Personal items – Residents are discouraged from borrowing personal items from one another. Residents may sell items to each other if her or she is willing to sign a contract binding the sale. If a resident breaks something that belongs to another resident he or she is responsible for replacing or paying for the item.

Supervised Apartment Residents Responsibilities:

1. You will need to learn to respect the laws of the community and the guidelines of this manual. Example, no fighting, public drunkenness, verbal threats or abuse.
2. No use or possession or dealing of drugs while at the apartments.
3. You need to follow the specifications of your lease.
4. You will be expected to maintain a clean, hazard free environment inside and around the apartment complex.
5. We ask that you be honest and respectful in your dealings with the manager and other tenants at the complex
6. No stealing or possession of stolen goods.

Community Room: The community room is provided for various uses by the tenants. This includes washing machines for doing laundry, message board for keeping up with what is going on in the community, mail boxes for tenants' mail, and offices for tenants to bring any problems and/or questions.

Trash: A dumpster is available for tenants to dispose of trash. Do not pile trash in the apartments. If aluminum cans are collected, keep them in the outside storage closed, out of site.

Living Quarters: Please keep your apartment clean. ILS staff can enter your apartment for the following reasons: inspection and repairs and maintenance. The staff may enter your apartment at any time. It is your responsibility to keep your apartment clean. The Fire Marshall will do routine inspections and will notify both tenant and staff if your apartment is a fire hazard.

Medication– All medications are kept locked and must be properly labeled by a pharmacist and taken as directed. Staff will supervise residents taking his or her own medication. Staff will be trained as required by the Consumer Directed Care Act. Medication errors will be documented.

Pets: You may have an APPROVED pet if the facility you reside in allow pets. You must have written permission from the apartment program director of ILS and keep the pet in accordance with City Ordinance, i.e. rabies shots and leash law. There is a specific lease for pet/pets owner.

Maintenance: If there are any problems with household maintenance items, take them to the apartment office or apartment manager and get a maintenance form completed. Be sure that your commode does not continue to run after being flushed.

Laundry: There are coin operated washers and dryers.. ***Do not leave your laundry unattended, as others will need to use the machines, plus the risk of someone stealing your clothes.***

Mail: Mailboxes are provided and correspond with apartment number. Staff will assist in reading and understanding mail as needed.

Message Board: A message board is in the community room. Tenants should check the board for important program notices, current events, community business and other business that pertains to ILS apartments. This will keep you informed of what is going on in the local area and at the apartments. ***If you need assistance with reading the board, please let us know.***

Profiles and Profiles Productions

What Services are offered at Profiles and who is eligible for those services:

Profiles was established in 1996, and is a division of Independent Living Services, Inc. Profiles is a day time program that provides adults with developmental disabilities the opportunity to further their learning either in a classroom type environment or in a pre-vocational setting.

Eligibility and Application Process:

Profiles offers adult development and vocational maintenance programs for adults 18 years of age and older who had a developmental disability before the age of 22. If the person is age 18-21 they must have a high school diploma or certificate of completion to be eligible for the programs. The individual must also be able to function well with a ratio of 1 staff to 10 consumers. When an individual applies for services at Profiles there is an ILS Admission Committee meets to determine their eligibility for services, discuss medical concerns, diagnosis, behavior concerns/review of positive behavior supports plan legal issues/liabilities, and health and safety. Each individual will be considered on the basis of his/her needs, eligibility for DD services, emergency nature of the request, location in regard to family (if applicable), and whether or not ILS can safely meet the needs of the applicant consistent with its resources. Profiles does not discriminate based on a person's age, race, sex, or national origin in compliance with the Civil Rights Act of 1964.

Individuals can attend Profiles once they have submitted a **completed** application. At this time there is not a waiting list for services at Profiles. At Profiles Production we do maintain a waiting list due to limited space and staffing ratios. The average wait time for Profiles Productions is three month.

Individuals move through the Profiles Programs at their own pace. There are no set timelines that a person can attend our programs.

Profiles provides adult development services and is a place where you can increase your daily living skills, learn new crafts and hobbies, have opportunities for socialization and community integration, and receive any needed therapies. At Profiles a variety of classes are offered ranging from Art, Home Economics, Music, Computer, Money Skills, Self-Advocacy, Social Skills, Performing Arts, and Health and Fitness, as well as other areas. Profiles' also offers a variety of social activities, such as Bingo, dances, and parties throughout the year during evening and/or weekend hours. We work in conjunction with the UCA ACTS program on a very special arts program each semester. The participants then perform at Reynolds Performance Hall at the end of each semester. ACTS is made possible in part through funding provided by the central office of VSA arts, under an award from the U.S. Department of Education.

The vocational training program offered at Profiles is Profiles Productions. This is a work setting where individuals have the opportunity to work on vocational skills and earn a paycheck. Profiles Productions offers positions in recycling as well as contract work from various

companies. Individuals who work at Profiles Productions are paid on a piece rate basis for all production work they perform. All jobs have a different pay rate. For each job a time study has been completed and the pay is based on the percentage of industrial standard completed. Profiles Productions possesses a current certificate from the Wage and Hour Division of the United States Department of Labor. All time studies and payment of wages adhere to the regulations of the Department of Labor. Individuals are paid every 2 weeks. Any and all necessary safety equipment is provided for you.

Working in conjunction with the Independent Living Services Supported Employment team, Arkansas Rehab, the Conway Housing Authority, volunteer groups from Conway Universities and high schools, and other adult service providers in the county, Profiles programs offers the supports necessary for all individuals to take advantage of the potential for gainful employment and for successful community integration.

Hours of operation at Profiles Programs:

The hours of service at the programs offered by Profiles are 7:30 a.m. to 3:30 p.m. Monday through Friday. An individual can either attend Profiles for the full 8 hours each day or they can attend Profiles for 4 hours and Profile Productions for 4 hours a day. We also have individuals who work at part time jobs in the community and only attend Profiles when their work schedule allows. When an initial referral is made a discussion will be held regarding what days and hours you want to attend.

Each program offers a 15 minute break in the morning and in the afternoon and a lunch period.

Profiles closes for most major holidays, and a calendar is put out each year listing the closing dates.

Lunch/Snack:

Lunch and a snack are provided at Profiles programs', however, an individual can choose to bring their own lunch if they want to. If an individual has a prescription for a specific diet or restrictions, the kitchen will provide food within the prescription. Refrigerators and microwaves are provided for individuals to use.

Medication Monitoring:

Medication Monitoring is provided by Profiles. Prescribed medication is kept locked and must be properly labeled by a pharmacist and taken as directed. Staff will supervise/monitor individuals as they take their medications. Over the counter medications such as Tylenol, Tums, etc. can be obtained.

Illness:

If you are sick, running a fever or have been prescribed an antibiotic, you should wait at least 24 hours before returning to work. If you have an infectious disease you should not return to work

until you have a statement from your doctor stating you are no longer contagious. A contagious disease is defined as a disease capable of being easily diffused or spread through casual contact with others.

AIDS, HIV, Hepatitis B: The rights of individuals who have or who are perceived as having AIDS, HIV, or Hepatitis B or who are identified as carriers are protected and are not discriminated against. Confidentiality will be maintained for all information, concerning whether the individual admitted for services or anyone proposed for admission has been the subject of an HIV related test, has had an HIV infection, has an HIV related condition, has AIDS, has Hepatitis B or has been identified as a carrier.

Dress Code and Hygiene for Profiles Programs:

The programs offered at Profiles are directed toward developing acceptable behaviors and attitudes both at work and in the community. Therefore we recommend that you wear pants/jeans, a comfortable shirt, and enclosed shoes. If you are working at Profiles Productions, enclosed shoes are mandatory. Due to safety hazards you cannot wear sandals, flip flops, or heels when you are at work. Dangling jewelry should also not be worn when you are at the work program.

Halter tops, or clothing with obscene language or pictures are not permitted at the Profiles Programs. Shirts should be long enough to cover your stomach and should not be made of mesh fabric, or be see-through. Shorts may be worn as long as they are considered walking shorts.

It is expected that you be clean, teeth brushed, hair combed, and appropriately bathed before you come to class/work. Heavy perfume should not be worn in consideration of others. Individuals who come to work not appropriately dressed or groomed may be sent home. Remember you feel good when you look good.

Individual Responsibilities at Profiles Programs (Rules of Conduct):

While in the Profiles or Profiles Production programs you will have certain responsibilities and rules that will need to be followed. Those responsibilities and rules include:

- Always come in and report to the appropriate class or work area and let your supervisor know you are there.
- If you are sick or have an important reason for missing work, call the office or your supervisor to let them know you will not be coming in that day.
- If you know in advance that you will not be coming in on a certain day, please tell your supervisor as soon as you know you will not be attending that day.
- Do not give staff money or buy them gifts
- On the days you will not attend, please call the transportation department or your driver to let them know you will not need transportation.
- Always tell your supervisor before leaving your class/work area.

- When you are given a job/task to do concentrate on that task and do your very best until it is done.
- Do not interrupt others when they are working on a job or doing a project.
- Report any injuries or accidents to your supervisor and support manager immediately.
- Report any changes in medications to your supervisor.
- Always dispose of your own trash.
- Adhere to the dress code at all times.
- Individuals are not allowed to borrow food, money or cigarettes from other peers.
- Individuals should remain in their classroom or training area with their immediate instructor. Notify instructor if for any reason you need to leave your class area.
- I-Pods, MP3 players, radios, and walkie talkies are not allowed during class/work time unless it has been discussed with the team, however, they can be used at break and lunch times.
- Cell Phones must be approved by the Profiles Director.
- No weapons, such as guns or knives are allowed on Profiles premises
- No smoking is allowed within any Profiles buildings or property.
- No drugs or alcohol are allowed on Profiles premises and you should not come to work under the influence of drugs or alcohol
- No inappropriate work behaviors.
- You should not be sleeping while you are at work.
- Unacceptable behaviors will not be tolerated.
These behaviors include:
 1. Striking other consumers or staff
 2. Using foul or abusive language
 3. Running away
 4. Destruction of materials
 5. Tantrum behaviors
 6. Stealing
 7. Sexual misconduct
- If you have a problem of any kind, discuss it with your supervisor and support manager.
- All individuals attending Profiles Programs are on a probationary period for 1 month.

Violation of any of these rules may result in disciplinary action including write ups, suspension, and dismissal from the program.

Stolen Property:

Independent Living Services is not responsible for any personal property of its consumers that is lost, stolen or last seen at Profiles or Profile Productions. The individual bringing their personal items (i.e., money, iPod, cellphone, cd player, wallet, purse, etc.) assumes all risk when bringing possessions to Profiles or Profile Productions.

Profiles Consumer Council:

There is a Consumer Council at Profiles. Members are individuals who attend Profiles. They are elected by those attending the program and serve as representatives for everyone receiving services. Their purpose is to make suggestions and recommendations on ways to improve the services that are offered at Profiles and Profiles Productions.

Focus areas for the Council:

- Classes offered, class activities, outside speakers
- Extra-curricular activities, volunteer activities, etc.
- Identifying problems/concerns and offering solutions
- Improving communications between individuals served and others
- Focus on rights and self-advocacy
- Review of materials such as handbooks, rules, forms, etc. to assure they are easily understandable for individuals receiving services.

The council meets on a regular basis and the minutes of the meetings are documented and shared with all individuals in the program as well as agency staff and other interested parties.

Funding:

The programs offered at Profiles are funded through Medicaid's DDTCS (Developmental Day Treatment Clinic Services), PASSEs, state dollars, local funds, and contract services. If you do not have a funding source, you may be required to private pay for your services. Private pay situations may be available.

Expectations from Services:

Each of us has dreams for our future. Here at Profiles we refer to those dreams as your goals. When you enter the Profiles program we will want to hear more about your dreams/goals and we will develop an individualized service plan that will address your dreams/goals. We will help you to better define what steps you need to take to attain your goals and then provide support and training to assist you in taking the steps necessary to learn the skills to attain the goals. Your goals are reviewed on a quarterly basis and updated as needed to keep you on the path to achieving your dreams. Your support manager will keep your file current and you can access your files at the time of your annual IPP meeting and at other times by simply making that request to your support manager.

Profiles Productions:

Most employees at Profiles Productions work shifts, Monday through Friday in either the morning (8:00 a.m. – 12:00) or afternoon (12:00 – 3:00 p.m.). Specific work schedules may differ based upon individual considerations. Individual work schedules are subject to change without notice due to availability of work, specific job requirements and/or deadlines, or other events planned or unplanned.

Dress code requirements for employees of Profiles Productions may differ from those of other Profiles or ILS programs. All employees of Profiles Productions are expected to maintain positive, professional working relationships with co-workers and supervisors. Disciplinary action will be taken when violations of Profiles Programs Handbook rules occur. For some first-time violations, a verbal counseling will be given and documented. Second offenses will generally result in a written warning that will be documented and sent to the Director of Profiles and the individual's support manager for review. Any third offense in a ninety-day period may result in the employee being terminated from the work program.

Employees of Profiles Productions are expected to notify a supervisor in advance of a planned absence from work. Employees of Profiles Productions are expected to notify a supervisor (**call-in**) no less than one hour before their shift begins if unable to attend that day. Excessive unexcused absences may result in the termination of the consumer from the work program. If an employee of Profiles Productions chooses to leave the work program, they are required to notify the Assistant Director of the program. Employees leaving the work program are asked to give a two-week notice as a courtesy. Employees leaving the work program will be asked to complete an "Exit Interview".

Profiles Productions:

Setting the Stage for Success!

- I. Consumer (preferably) initiates steps toward employment.
- II. Person-centered meeting of involved persons.
- III. Pre-Voc or Vocational Assessment.
- IV. Application for Employment.
- V. Person-centered interview.
- VI. Hire
- VII. Job Description
- VIII. Profiles Programs Handbook.
- IX. Explanation of daily work schedule, breaks, etc.
- X. Workplace Safety Training: Potential Safety Hazard Awareness
 - a. Safe equipment operation
 - b. Location of PPE's and Safety Equipment
 - c. Fire/Storm response
 - d. Injury response/Basic First Aid.
- XI. Role of Employee and Supervisor.
- XII. Professional working relationships:
 - a. Supervisors
 - b. Co-workers
 - c. Customers
 - d. Visitors
- XIII. Explanation of wages earned under DOL Certificate.
- XIV. Person-centered employment plan:
 - a. Empowerment & Employability

- b. Identify target areas
- c. Develop current objectives
- d. Establish future goals
- XV. Thirty-day meeting and situation report.
- XVI. Ninety-day evaluation (rate adjustment?)
- XVII. Annual plan review:
 - a. Updated Job Description
 - b. Progress report
 - c. Plan adjustments
 - d. Chart progress to future goals
 - e. Discuss employment options

Appendix A
HIPAA / Notice of Privacy Practices

INDEPENDENT LIVING SERVICES, INC. & CREATIVE LIVING, INC.

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A CLIENT OF THIS AGENCY) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our agency is dedicated to maintaining the privacy of your individually identifiable health information as protected by law, including the Health Information Portability and Accountability Act (HIPAA). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our agency concerning your protected health information (PHI). By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI
- Your privacy rights in your PHI
- Our obligations concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI that are created or retained by our agency. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our agency has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our agency will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Privacy Officer – P.O. Box 1070, Conway, AR 72033, (501) 327-5234 x 317

C. WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your PHI.

1. Treatment. Our agency may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our agency – including, but not limited to, our support managers and community skills trainers – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

2. Payment. Our agency may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health Care Operations. Our agency may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our agency may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our agency. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

5. Genetic Information Nondiscrimination Act (GINA). Our agency does not use genetic information.

6. Treatment Options. Our agency may use and disclose your PHI to inform you of potential treatment options or alternatives.

7. Health-Related Benefits and Services. Our agency may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

8. Fundraising. We may contact you to raise funds for our organization. In connection with any fundraising, we may disclose your demographic information and the dates when you received care here to our fundraising staff. If you are not interested in participating in fundraising please contact 327-5234 x 314.

9. Disclosures Required By Law. Our agency will use and disclose your PHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our agency may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled
- notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our agency may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our agency may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release PHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices

- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. Deceased Patients. Our agency may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Research. Our agency may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when Internal or Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

7. Serious Threats to Health or Safety. Our agency may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

8. Military. Our agency may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

9. National Security. Our agency may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

10. Inmates. Our agency may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

11. Workers' Compensation. Our agency may release your PHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding the PHI that we maintain about you:

1. Confidential Communications. You have the right to request that our agency communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to the Privacy Officer specifying the requested method of contact, or the location where you wish to be contacted. Our agency will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request unless you are privately paying for your services;** however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to the Privacy Officer. Your request must describe in a clear and concise fashion:

- (a) the information you wish restricted;
- (b) whether you are requesting to limit our agency's use, disclosure or both; and
- (c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the Privacy Officer in order to inspect and/or obtain a copy of your PHI. Our agency may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our agency may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our agency. To request an amendment, your request must be made in writing and submitted to the Privacy Officer. You must provide us with a reason that supports your request for amendment. Our agency will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the agency; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our agency, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an “accounting of disclosures.” An “accounting of disclosures” is a list of certain non-routine disclosures our agency has made of your PHI for non-treatment, non-payment or non-operations purposes. Use of your PHI as part of the routine patient care in our agency is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. Also, we are not required to document disclosures made pursuant to an authorization signed by you. In order to obtain an accounting of disclosures, you must submit your request in writing to the Privacy Officer. All requests for an “accounting of disclosures” must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our agency may charge you for additional lists within the same 12-month period. Our agency will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

Independent Living Services is required by law to notify our patients in case of a breach of their unsecured protected health information when it has been or is reasonably believed to have been accessed, acquired, used, or disclosed in violation of privacy regulations.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact the Privacy Officer.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our agency or with the Secretary of the Department of Health and Human Services. To file a complaint with our agency, contact the Privacy Officer. We urge you to file your complaint with us first and give us the opportunity to address your concerns. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

8. Right to Provide an Authorization for Other Uses and Disclosures. Our agency will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact the Privacy Officer.

Appendix B
DDS Appeal Policy # 1076

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES
DDS DIRECTOR'S OFFICE POLICY MANUAL

Policy Type	Subject of Policy	Policy No.
Administrative	Appeals	1076

1. Purpose. This policy is provided to allow for appealing decisions made by Developmental Disabilities Services (DDS) regarding the following programs:
 - A. Human Development Centers (HDCs)
 - B. Community Programs and Services
 - C. Medicaid Home and Community Based Waiver Services
 - D. Licensure of Community Programs/Services and Certification of Providers of Waiver Services, Providers of Early Intervention Voucher Services and Independent (Self-Employed) Care Coordinators
 - E. Nursing Facility, PASSAR determinations. These determinations are made, as required, by the 1987 Omnibus Budget Reconciliation Act (OBRA) for persons with a ID/DD diagnosis who seek admission or for whom admission is sought to a Nursing Facility. It includes annual reviews for continued stay.

2. Scope. This policy applies to recipients of services, their parents/guardians, Community Programs, Service Providers, Care Coordinators, other interested parties and all DDS employees.

The Board of Developmental Disabilities Services, according to DDS Board Policy 1003, has delegated its authority to hear appeals to the DDS Director. The DDS Director hereby adopts this Appeal Policy to apply to all appeals of DDS services.

3. General Provisions:
 - A. All reconsiderations and appeals of DDS decisions shall be made in accordance with the Administrative Procedures Act, Ark. Code Ann. § 25-15-201 et seq.; the Medicaid Fairness Act, Ark. Code Ann. § 20-77-1701 et seq.; and the Medicaid Provider Manual §§ 160.000, 190.000, and 191.000.
 - B. Reconsiderations will be heard by the DDS Director or their designee, and must be filed within fifteen (15) business days of receipt of the denial notice. Reconsideration Requests should be mailed to:

DDS Director's Office
P.O. Box 1437, Slot N501
Little Rock, AR 72201-1437

References: DDS Board Policy #1003; Ark. Code Ann. § 25-15-201 et seq.; Ark. Code Ann. § 20-77-1701 et seq.; Medicaid Provider Manual §§ 160.000, 190.000, 191.000. Administrative Rules & Regulations Sub Committee of the Arkansas Legislative Council: _____.

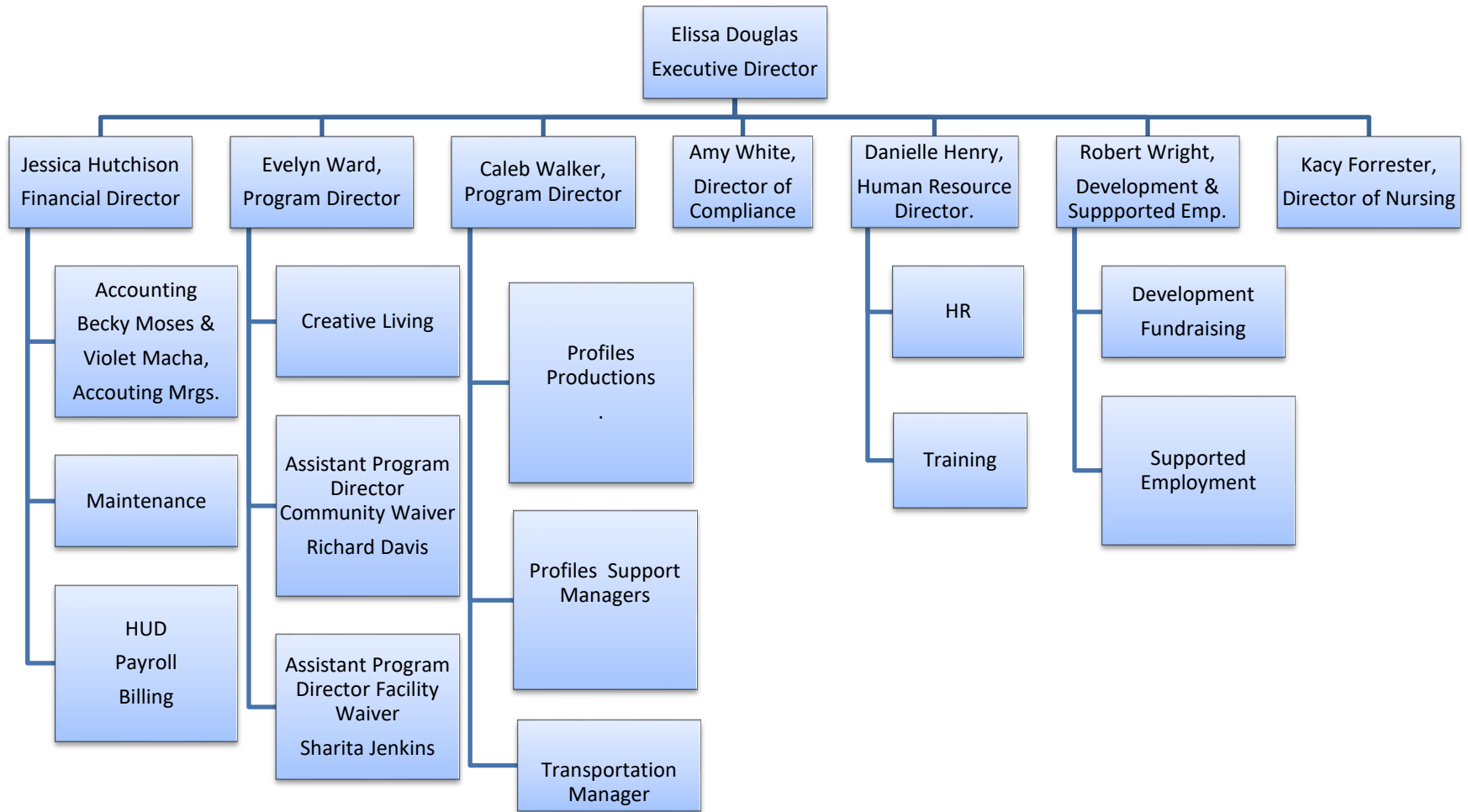
**Appendix C
DDS Waiver Specialist Telephone List**

Tora Aldridge (Nelson)	P.O. Box 354 Clarendon, AR. 72029	870 747-3329 x 123
Kimberly Green	P.O. Box 310 Conway, AR. 72033	501 730-9906
Tracey Brister	P.O. Box 310 Conway, AR. 72033	501 730-9915
Carter Wagner	P.O. Box 8083 Little Rock, AR 72203	501 371-1391
Heather Bailey Pulaski East	P.O. Box 8083 Conway, AR. 72203	501 371-1387
Sandra Hamilton St. Francis County	P.O. Box 493 Augusta, AR 72006	870 347-2537 x 104
Polly Hunt St. Francis County	P.O. Box 899 Forrest City, AR 72335	870 261-6660
Managers		
Alisa O'Neal North Central	1222 W. 6 th St., P.O. Box 5670 Pine Bluff, AR 71611	870 534-4200 x 548
Linda G. Wilson Central Area	1424 E 2 nd St. Little Rock, AR 72203	501 371-1383

Appendix D Board of Directors

Dr. Cathy Acre	30 Acres Cir.	Greenbrier, AR 72058	501 730-1717
Dr. Kathleen Atkins	2220 Raintree Dr.	Conway, AR 72034	501 327-4608
Melissa Britton	19 Porcupine Tril.	Conway, AR 72032	501 450-3084
Jason Hansen	P.O. Box 99	Conway, AR 72033	501 450-6011
Jayme Lemon	3 Treasure Hills Rd.	Conway, AR 72032	501-697-0909
Sandra Leyva	2305 Prince St.	Conway, AR 72034	206 890-7460
Josh Linden	2 Water Oak Dr.	Conway, AR 72034	501 328-4873
Mark McCuin	4830 Bay Hill Dr.	Conway, AR 72034	501 514-2977
Leann Parker	1000 LedgeLawn Dr.	Conway, AR 72034	501-328-3316
Umang Patel	P.O. Box 1013	Conway, AR 72033	501 45-3084
James Plaxco	607 South German Ln.	Conway, AR 72034	501 450-7010
Peggy Schneider	8 Forest	Conway, AR 72034	501-269-0621
Barbara Spradlin	2535 Holly Cove	Conway, AR 72034	501-450-0669
Dr. Rob Stevens	207 Ashford Dr.	Russellville, AR 72802	479 964-0545
Eric Treat	1709 Hutto St. Apt A	Conway, AR 72032	501 517-5006
Alan White	230 Chapel Creek Dr.	Conway, AR 72034	501 908-1255
David Williams	966 Paul Dr.	Conway, AR 72034	501 505-5871
Courtney Williams	1215 Sturgis Rd.	Conway, AR 72034	501 581-1070

**Appendix E
Organizational Chart**



Appendix F Independent Living Services Contact Information

Contact Information:

Thank you for giving us the opportunity to provide your services. If you should have any questions or need further information please let us know.

Independent Living Services, Inc. & Creative Living – Phone List

	Office Number	Cell Number	E-Mail
Administration Fax 548-6432, 615 E. Robins St. Conway, AR 72032			
Elissa Douglas, Executive Director	327-5234 x 302	501 428-3922	elissa@indliving.org
Amy Roming-White, Dir of Compliance	327-5234 x 346	870 451-3543	amy.white@indliving.org
Kacy Forrester, Director of Nursing	327-5234 x 330	501 908-2780	kacy@indliving.org
Human Resources Fax 358-6059, 615 E. Robins St. Conway, AR 72032			
Danielle Henry, H.R. Director	327-5234 x 317	501 428-1093	danielle@indliving.org
Finance Fax 327-7251, 1615 Independence Conway, AR 72034			
Jessica Hutchison, Financial Director	358-6192 x 402	501 428-0490	jessica@indliving.org
Becky Moses, Accounting Manager	358-6192 x 403		becky@indliving.org
Violet Macha, Accounting Manager	358-6192 x 410		violet.macha@indliving.org
Profiles Fax 358-6059, 615 E. Robins St. Conway, AR 72032			
Caleb Walker, Director of Day Services	327-5234 x 324	327-0060	caleb.walker@indliving.org
Camden Stallard, Assistant Dir of Day Services	327-5234 x 341		camden.stallard@indliving.org
Katrina Smith, Profiles Support Manager	327-5234 x 323		katrina.smith@indliving.org
Reanna McKnight, Profiles Support Mgr.	327-5234 x 322		reanna.mcknight@indliving.org
Michael George, Transportation Coordinator	327-5234 x 319		michael@indliving.org
Supported Employment Fax 501 358-6446, 1014 Main St. Ste. 1 Conway, AR 72032			
Robert Wright, Dir. Develop & Supp Emp.	501 358-6567	501 580-0098	robert@indliving.org
Residential/Waiver Fax 548-6432, 615 E. Robins St. Conway, AR 72032			
Evelyn Fecher-Ward, Program Director	327-5234 x 303	501 450-0662	evelyn@indliving.org
Sharita Jenkins, Assistant Program Director	327-5234 x 304	501 269-4146	sharita.jenkins@indliving.org
Richard Davis, Assistant Program Director	327-5234 x 347	501 428-3370	richard.davis@indliving.org
CaSandra McCord, Support Manager	327-5234 x 305		cassandra.mccord@indliving.org
Toshia Thrall, Support Manager	327-5234 x 311		toshia.thrall@indliving.org
Aimee Pickard, Support Manager	327-5234 x 310		aimee.pickard@indliving.org
Facilities			
Britt Standridge, Manager Conway Apartment	327-0723		
Teresa Leak, Manager Florentz Estates	327-0660 x 102		teresa.jones@indliving.org
Jasmine Lamb, Manager Greenbrier Apts	501 679-5472		jasmine@indliving.org
Nymikia Norton, Manager	327-8909		nymikia.norton@indliving.org
Clara Anderson, Manager	327-7048		clara@indliving.org
LaQuecia Jones, Administrator in Training	329-1703		laquecia.jones@indliving.org
Kathy Nettles, Manager	336-9510		kathy.nettles@indliving.org

Appendix H

DDS Alternative Community and Employment Supports (CES) Services

211.000 Scope 10-1-17

The Medicaid program offers certain home and community-based services (HCBS) as an alternative to institutionalization. These services are available for eligible beneficiaries with a developmental disability who would otherwise require an intermediate care facility for the intellectually disabled/developmentally disabled (ICF/ID/DD) level of care. This waiver does not provide education or therapy services.

The purpose of the CES waiver is to support beneficiaries of all ages who have a developmental disability, meet the institutional level of care, and require waiver support services to live in the community and thus prevent institutionalization.

The goal is to create a flexible array of services that will allow people to reach their maximum potential in decision-making, employment and community integration; thus giving their lives the meaning and value they choose.

The objectives are as follows:

- A. To transition eligible persons who choose the waiver option from residential facilities into the community
- B. To provide priority services to persons who meet criteria for the third tier of service (requiring supports 24 hours a day, seven (7) days a week)
- C. To enhance and maintain community living for all persons participating in the waiver program

DDS is responsible for day-to-day operation of the waiver. All waiver services are accessed through DDS Adult Services, DDS Children's Services or the ICF/ID/DD services intake and referral staff.

All CES waiver services must be prior authorized by DDS and based on an independent assessment and functional evaluations. All services must be delivered based on the approved person-centered service plan.

Waiver services will not be furnished to persons while they are inpatients of a hospital, nursing facility (NF), or ICF/ID/DD unless payment to the hospital, NF, or ICF/ID/DD is being made through private pay or private insurance.

A person may be placed in abeyance in three-month increments (with status report every month) for up to 12 months when the following conditions are met:

- A. The need for absence must be for the purposes of treatment in a licensed or certified program or facility for the purposes of behavior stabilization, physical or mental health treatment.
- B. The loss of home or loss of the primary non-paid caregiver.
- C. The request must be in writing with supporting evidence included.
- D. The request must be prior approved by DDS.
- E. A minimum of one visit or one contact each month is required.

NOTE: The DDS Specialist is responsible for conducting or assuring the conducting of the contacts or monitoring visits with applicable documentation filed in the case record.

- F. All requests for abeyance are to be faxed to the DDS Waiver Program Director for Adult and Waiver Services. Monthly status reports are required to be submitted to the DDS Waiver Program Director as long as the person is in abeyance. Each request for continuance must be submitted in writing and supported by evidence of treatment status or progress. Requests for continuance must be made prior to the expiration of the abeyance period.

In order for beneficiaries to continue to be eligible for waiver services while they are in abeyance the following two requirements must be met:

- A. It must be demonstrated that an individual's needs support management and at least one other service as documented in their person-centered service plan.
- B. Beneficiaries must receive monthly monitoring of waiver services.

As stated in the Medical Services Manual, Section 1348, an individual living in a public institution is not eligible for Medicaid.

- A. Public institutions include county jails, state and federal penitentiaries, juvenile detention centers, and other correctional or holding facilities.
- B. Wilderness camps and boot camps are considered a public institution if a governmental unit has any degree of administrative control.
- C. Inmate status will continue until the indictment against the individual is dismissed or until he or she is released from custody either as "not guilty" or for some other reason (bail, parole, pardon, suspended sentence, home release program, probation, etc.)

Thus, a person who is living in a public institution as defined above would be deemed ineligible for Medicaid and thus the waiver program.

211.100 Selection Process for Entrance to the Waiver 10-1-17

Selection for entrance into the waiver is as follows:

- A. In order of waiver application eligibility determination date for persons determined to have successfully applied for the waiver, but whom through administrative error, were or are inadvertently omitted from the waiver wait list.

- B. In order of waiver application eligibility determination date of persons for whom waiver services are necessary to permit discharge from an institution, i.e., ICF/IID residents, nursing facility residents, and Arkansas State Hospital patients; or admission to Supported Living Arrangements (group homes and apartments).

- C. In order of date the Department of Human Services (DHS) custodian chose waiver services for eligible person in the custody of DHS Division of Children and Family Services or DHS Adult Protective Services.

- D. In order of waiver application eligibility determination date for all other persons. Selection for priority consideration is in the order identified above. When more than one category of priority is identified in a ranking, the order of release shall be by date of eligibility determination within each category. Releases occur only when there is a vacant waiver slot.

211.200 Risk Assessment 10-1-17

A. DDS will not authorize or continue waiver services under the following conditions:

- 1. The health and safety of the beneficiary, the beneficiary's caregivers, workers or others are not assured.

- 2. The beneficiary or legally responsible person has refused or refuses to participate in the plan of care development or to permit implementation of the plan of care or any part thereof that is deemed necessary to assure health and safety.

- 3. The beneficiary or legally responsible person refuses to permit the on-site entry of: care coordinator to conduct required visits, caregivers to provide scheduled care, DDS, DMS, DHS or CMS officials acting in their role as oversight authority for compliance or audit purposes.

- 4. The beneficiary applying for, or receiving, waiver services requires 24-hour nursing care on a continuous basis as prescribed by a physician.

- 5. The beneficiary participating in the waiver program is incarcerated or is an inmate in a state or local correctional facility.

6. The person is deemed ineligible based on a DDS Psychological Team assessment or reassessment for meeting ICF/IID level of care.
 7. The beneficiary is deemed ineligible based on not meeting or not complying with requirements for determining continued Medicaid income eligibility.
 8. The beneficiary does not undergo an independent assessment by a third-party vendor.
- B. Safeguards concerning the use of restraints or seclusion:
1. Physical restraints (use of a staff member's body to prevent injury to the beneficiary or another person) are allowed in cases of emergency. An emergency exists for any of the following conditions:
 - a. The beneficiary has not responded to de-escalation techniques and continues to escalate behavior
 - b. The beneficiary is a danger to self or others
 - c. The safety of the beneficiary and those nearby cannot be assured through positive reinforcers.

An individual must be continuously under direct observation of staff members during any use of restraints.

If the use of personal restraints occurs more than three (3) times per month, use should be discussed by the interdisciplinary team and addressed in the plan of care. When emergency procedures are implemented, person-centered service plan revisions including, but not limited to, psychological counseling, review of medications with possible medication change or a change in environmental stressors that are noted to precede escalation of behavior may be implemented.

1. Use of mechanical or chemical restraint is not allowed. Seclusion is not allowed.
 2. DDS standards require that providers will not allow maltreatment or corporal punishment (the application of painful stimuli to the body in an attempt to terminate behavior or as a penalty for behavior) of individuals. Providers' policies and procedures must state that corporal punishment is prohibited.
- C. Safeguards concerning the use of restrictive intervention:
1. Restrictive interventions may be used.
 2. DDS standards require the use of a behavior management plan for all beneficiaries whose behavior may warrant intervention. The behavior management plan must specify what will constitute the use of restrictive interventions, the length of time to be used, who will authorize the use of restrictive intervention and the methods for monitoring the beneficiary.

When the behavior plan is implemented, all use of restrictive interventions must be documented in the beneficiary's case record and should include the initiating behavior, length of time of restraint, name of authorizing personnel, names of all individuals involved and outcomes of the event.

3. Restrictive interventions include
 - a. Absence from a specific social activity
 - b. Temporary loss of a personal possession
 - c. Time out or separation
4. Restrictive interventions cannot include
 - a. Aversion techniques
 - b. Restrictions to an individual's rights, including the right to physically leave
 - c. Mechanical or chemical restraints
 - d. Seclusion

These interventions might be implemented to deal with aggressive or disruptive behaviors related to the activity or possession. Staff, families and the beneficiary are trained by the provider to recognize and report unauthorized use of restrictive interventions.

Before absence from a specific social activity or temporary loss of personal possession is implemented, the beneficiary is first counseled about the consequences of the behavior and the choices they can make.

1. All personnel who are involved in the use of restrictive interventions must receive training in behavior management techniques as well as training in abuse and neglect laws, rules and regulations and policies. The personnel must be qualified to perform, develop, implement and monitor or provide direction intervention as applicable.
 2. Use of restrictive interventions requires submission of an incident report that must be submitted no later than the end of the second business day following the incident. The DDS Quality Assurance staff investigates each incident and monitors use of restrictive interventions for possible overuse or inappropriate use. DDS Quality Assurance staff will notify entities involved with the complaint or service concern the results of their review. If there is credible evidence to support the complaint or concern, the provider will be required to submit a plan of correction. Failure to complete corrective action measures may result in the provider being placed on provisional status or revocation of certification.
- D. Behavior Management Plans

Before use of restraints or restrictive interventions, providers must develop a written behavior management plan to ensure the rights of beneficiaries. The plan must include a provision for alternative methods to avoid the use of restraints and seclusions.

The behavior management plan must

1. Be written or supervised by a qualified professional who is at minimum a Qualified Developmental Disabilities Professional (QDDP)
2. Be designed so that the rights of the individual are protected
3. Preclude procedures that are punishing, physically painful, emotionally frightening involve deprivation, or put the individual at medical risk
4. Identify the behavior to be decreased
5. Identify the behavior to be increased
6. Identify what things should be provided or avoided in the individual's environment on a daily basis to decrease the likelihood of the identified behavior
7. Identify the methods that staff should use to manage behavior, in order to ensure consistency from setting to setting and from person to person
8. Identify the event that likely occurs right before a behavior of concern
9. Identify what staff should do if the event occurs
10. Identify what staff should do if the behavior to be increased or decreased occurs, and
11. Involve the fewest interventions or strategies as possible

The behavior management plan must also specify the length of time the restraint or restrictive intervention is to be used, who will authorize the use of restraint or seclusion and the methods for monitoring the beneficiary.

Behavior management plans cannot include procedures that are punishing, physically painful, emotionally frightening, depriving, or that put the beneficiary at medical risk.

E. Reports of Use of Restraints or Restrictive Interventions

All use of restraint must be documented in the beneficiary's case record, including the initiating behavior, length of time of restraint, name of authorizing personnel, names of all individuals involved and outcomes of the event.

1. The use of restraint or unauthorized seclusion must be reported to the DDS Quality Assurance section via an incident report form that must be submitted no later than the end of the second business day following the incident. The DDS Quality Assurance staff investigates each incident and monitors use of restraints for possible overuse or inappropriate use of restraints or seclusion. DDS Quality Assurance staff will notify entities involved with the complaint or service concern the results of their review. If there is credible evidence to support the complaint or concern, the provider will be required to submit a plan of correction. Failure to complete corrective action measures may result in the provider being placed on provisional status or revocation of certification.
2. Each person working within the provider agency must complete Introduction to Behavior Management, Abuse and Neglect and any other training as deemed necessary as a result of deficiencies or corrective actions.

212.000 Description of Services 10-1-17

DDS CES services provide the support necessary for a beneficiary to live in the community. Without these services, the beneficiary would require institutionalization.

Services provided under this program are as follows:

- A. Supportive Living
- B. Respite Services
- C. Supported Employment
- D. Adaptive Equipment
- E. Environmental Modifications
- F. Specialized Medical Supplies
- G. Supplemental Support Service
- H. Care Coordination Services
- I. Consultation Services
- J. Crisis Intervention Services
- K. Community Transition Services

Appendix I

CONSUMER AGREEMENT AND CONSENT TO DRUG AND/OR ALCOHOL TESTING

I hereby agree, upon a request made under the drug/alcohol testing policy of Independent Living Services, Inc./Creative Living, Inc. (ILS/CLI), to submit to a drug or alcohol test and to furnish a sample of my urine, breath, and/or blood for analysis. I understand and agree that if I at any time refuse to submit to a drug or alcohol test under company policy, or if I otherwise fail to cooperate with the testing procedures, I will be subject to immediate action. I further authorize and give full permission to have ILS/CLI and/or its company physician send the specimen or specimens so collected to a laboratory for a screening test for the presence of any prohibited substances under the policy, and for the laboratory or other testing facility to release any and all documentation relating to such test to ILS/CLI and/or to any governmental entity involved in a legal proceeding or investigation connected with the test.

I will hold harmless ILS/CLI, its company physician, and any testing laboratory ILS/CLI might use, meaning that I will not sue or hold responsible such parties for any alleged harm to me that might result from such testing, including loss of employment or any other kind of adverse job action that might arise as a result of the drug or alcohol test, even if a Company or laboratory representative makes an error in the administration or analysis of the test or the reporting of the results. I will further hold harmless ILS/CLI, its company physician, and any testing laboratory ILS/CLI might use for any alleged harm to me that might result from the release or use of information or documentation relating to the drug or alcohol test, as long as the release or use of the information is within the scope of this policy and the procedures as explained in the paragraph above.

This policy and authorization have been explained to me in a language I understand, and I have been told that if I have any questions about the test or the policy, they will be answered.

Signature of Individual/Guardian

Date

Appendix J

Independent Living Services, Inc. Admissions Committee Team Procedure

PROCEDURE

Independent Living Services' Admissions Committee Team will use the following procedure in making decisions regarding admissions/discharges to services in Waiver, Residential, Schneider House, Profiles and Profile Productions.

When a notification of a new referral or a potential change in services for an individual already served is requested a meeting invitation is sent to discuss the changes in detail and a meeting is scheduled. Information is gathered between all members involved regarding the following:

- Eligibility for Services
- Medical Concerns
- Diagnosis
- Behavior concerns/Review of Positive Behavior Supports Plan
- Legal Issues/Liabilities
- Health and Safety

Within five (5) days the team will have an initial meeting, or communicate through email. A team decision is made regarding admission, denial of admission, or discharge of any part of services depending on the circumstances being reviewed within fourteen (14) days.

PERSON(S) RESPONSIBLE

Executive Director
Program Directors
Day Service Director
Nursing Staff

ADMISSION/DISCHARGE PLANNING (circle one)

Individual: _____

Date: _____

DISCUSSION POINTS	NOTES
1. Review Entire Packet/File Social history, assessments, psychological, current plan of care	
2. Request further information if needed	
3. Services requested	
4. Services currently receiving and where	
5. Current residence	
6. Guardianship / Legal Issues	
7. Medical Concerns/Diagnosis	
8. Behavioral Concerns/Behavior Plan	
9. Health and Safety	
10. Programming Schedule, staffing needs, budget, living environment, Day Program, Employment, equipment or other supplies, Financial (need Rep Payee)	
11. Miscellaneous Information to consider	

DECISION	NOTES
1. Admit to program – list all services to receive & any issues to be addressed	
2. Deny Admission – list reasons and persons to alert about decision and assure you give DDS appeal policy	
3. Discharge – list reasons, timeline to discharge, people to notify, assure discharge summary completed, assure you give DDS appeal policy	

Attendee List:	

Appendix K

Independent Living Services, Inc. Consumer Handbook including Residential & Waiver Handbook / Profiles and Profile Productions

My signature below indicates that I have received and reviewed the Independent Living Services Consumer Handbook and had the opportunity to ask questions.

Information covered in the handbook includes:

Description of Developmental Disability Service Options
Confidentiality
Advocacy Services
Individual Rights
Individual Grievance Procedures
Civil Responsibilities
Management of Inappropriate Behaviors
Conflict of Interest
Solicitation
Emergency Drills
Transportation
ILS Drug and Alcohol Policy
Staff Qualifications
Leaving the Program

Residential & Waiver

Residential Services Options
Application Process
Costs
Funding
Individual Program Planning
Individual Responsibilities
Moving to a Supervised Apartment

Profiles & Profiles Productions

Services Offered
Eligibility and Application Process

HIPAA/Notice of Privacy Practices
DDS Appeal Policy #1076
Waiver Specialist Contact Information
Board Member
Organizational Chart
Contact Numbers

Hours of Operation
Lunch
Medication
Illness
Dress Code
Individual Responsibilities
Stolen Property
Consumer Council
Funding
Expectations from Services
Profile Productions

Funding Sources
DDS Alternative Community and
Employment Supports (CES) Waiver
Consumer Agreement and Consent to
Drug and /or Alcohol Testing

Signature of Individual/Guardian

Date