

2. **Is anyone else in the individual's family/household currently using People Inc. SD Services** YES NO
- If Yes, please provide the name of the family or household member: _____
3. **Does the person/family have access to a computer or smart phone?** YES NO
NOTE: We use an electronic database for all reimbursement requests, staff timesheets, billing notes, expense reports, etc.
4. **Are they looking to self-hire staff?** (Includes Respite, Community Habilitation, SEMP) YES NO
- If Yes, please answer the following:
 - What services are you looking to self-hire? Community Hab. Respite SEMP
 - Do they have staff identified? YES NO
 - Does the person require assistance with lifting and transferring? YES NO
5. **What is the person looking for from your self-directed budget?**
6. **Has the Person/family attended an OPWDD Self-Direction Information session?** YES NO
- Date of Attendance: _____
7. **Are there any behavioral concerns we should know about?**
8. **Are there any personal care/medical needs that we should know about?**
9. **Are there any legal issues/concerns we should be made aware of** (ie. Parole, Probation, SOIRA, Community Restrictions)?
10. **Does the person currently have ISS Housing Subsidy?** YES NO
- If Yes, what agency is the provider of the subsidy: _____

Required Documentation: Items noted with a * need the family/Individual signature and must be returned to us in order for us to submit the startup/transfer budget request.

<input type="checkbox"/> Life Plan	<input type="checkbox"/> LCED
<input type="checkbox"/> DDP2 (Shows questions with answers selected)	<input type="checkbox"/> CR4/TABS Report
<input type="checkbox"/> NOD (Notice of Decision)	<input type="checkbox"/> SD Authorization Letter
<input type="checkbox"/> Letter of Guardianship (if applicable)	<input type="checkbox"/> Behavior Plan (If applicable)
<input type="checkbox"/> *Liability Notice/MOU	<input type="checkbox"/> *General Rights and Responsibilities
<input type="checkbox"/> *HIPPA, Notice of Privacy Practices	

- We have responsibility for all payroll and personnel activities.
- We will review the service documentation that is completed by staff to ensure that the services are consistent with the individual's needs. We will submit claims for payment based on this documentation.
- We will maintain a record of service hours and report the rate of usage to the Manager of Services monthly. This information is also available in our electronic system for review at any time by the SD Participant/Designee.
- If we find it necessary to discontinue this agreement, we will notify the SD Participant/Designee at least 30 days in advance. We will also be responsible for notifying the Care Coordinator/Manager and the DDRO at least 30 days in advance; and we will continue to be party to this agreement until the 30 day period is completed or until alternative arrangements begin, whichever is sooner.

The FI and SD Participant/Designee have read and agree to the responsibilities outlined in this Liability Notice/MOU. In addition, the FI and SD Participant/Designee agree to meet with the Circle of Support to resolve any issues that may arise. Failure to comply with these responsibilities may result in termination of this agreement and all SD supports and services.

Signed:

_____ Dated: _____
Fiscal Intermediary

_____ Dated: _____
Self Direction Participant/Designee

_____ Dated: _____
Additional Designee, if applicable

GENERAL RIGHTS AND RESPONSIBILITIES, OCCUPANCY AGREEMENT AND NOTICE OF RIGHT TO OBJECT

The terms of this document represent a delineation of rights and responsibilities of persons receiving services and do not create any additional remedy or review process regarding the above said items which are subject to review under 14 NYCRR Section 633.12 or create a separate enforceable obligation of the Provider.

I affirm I will give my Provider copies of all relevant documents reasonably necessary for my care under the services I receive, such as without limitation; medical records, guardianship papers, benefit information and assets/income information that may impact benefits.

Should any part of this document violate or be prohibited by any code, regulation, statute or law, only that portion shall be deemed to be void and of no effect, without affecting the remaining provisions of this document and said code, regulation, statute or law shall be controlling. Nothing herein is intended to modify or increase applicable Provider responsibility under applicable rules, regulations or laws.

Affirmation of Receipt of Rights, Occupancy Agreement and Right to Object

I have read (or been informed of) the above and understand and agree to the rights and responsibilities, rights to object and if I am receiving residential placement, I understand and consent to the terms of the above Occupancy Agreement. I have received a copy of the General Rights and Responsibilities, Occupancy Agreement and The Notice Of Right To Object and the process for resolution.

Printed name: _____

Signature: _____
Signature of Person Receiving Services

Date: _____

Representative: _____
Signature of Parent, Guardian, Advocate, or Correspondent

Date: _____

Printed name of representative: _____

Please Note: People Inc. Rights & Responsibilities will be reviewed on an annual basis. The review may be documented in the People Inc. Program training material. Failure to review annually does not impact the applicability of 14 NYCRR 633.4 to applicable programs. This notice will remain in effect until replaced.

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Notice of Right to Object.doc
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INDIVIDUAL'S WRITTEN ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Name: _____

I acknowledge that I have received a copy of the Provider's Notice of Privacy Practices and have been advised of how the Provider [and the other named individuals and organizations listed in the Notice] will handle my Protected Health Information. I have also been advised of my rights to obtain access to and control my Protected Health Information. I understand that I may receive other notices which describe how the Provider will handle specialized forms of Protected Health Information such as HIV/AIDS-related, alcohol and drug abuse, and genetic information and psychotherapy notes.

SIGNATURE

I have received a copy of the Provider's Notice of Privacy Practices. I have had an opportunity to ask questions about the Notice and the use or disclosure of my Protected Health Information.

Signature of Individual or Personal Representative: _____

Print Name of Individual or Personal Representative: _____

Description of Individual Representative's Authority: _____

Date: _____

CONTACT INFORMATION

Contact information of the personal representative who signed this form:

Address: _____

Telephone: _____ (Daytime) _____ (Evening)

For Provider Use Only

Date Notice Provided _____

Name of Staff Member _____ Title _____



Consent to Use and Disclose Protected Health Information for Treatment, Payment and Health Care Operations

Section A:

Individual Name: _____ Individual ID Number: _____

I authorize the use and disclosure of my Protected Health Information by the Provider listed below and by the Provider's staff and Business Associates for purposes of treatment, payment and health care operations.

Name of Provider Using and Disclosing the Information:

People Inc.

Provider's Address:

280 Spindrift Dr. | 1860 Buffalo Rd.

Williamsville, NY 14221 | Rochester, NY 14624

Section B: Important Information Regarding Consent:

1. I understand New York laws require my consent before the Provider may use or disclose my Protected Health Information for treatment, payment or health care operations.
2. I understand that this information may be used or disclosed by the Provider to:
 - Plan my care and treatment;
 - Communicate among various health care professionals who are involved in my care or treatment;
 - Obtain payment for care provided by the Provider or for the payment of activities of another health care provider or entity;
 - Provide information to my health insurance company or plan;
 - Obtain payment from my health insurance company or plan; and review the quality of my care.
3. I understand that my signature on the consent is required in order for me to receive care from the Provider and that the Provider may condition my

treatment on obtaining my consent for use and disclosure of my Protected Health Information for treatment, payment and health care operations.

4. I understand that further information on the Provider's uses and disclosures of my Protected Health Information for treatment, payment and health care operations is included in the Provider's Notice of Privacy Practices which I have received.

SIGNATURE

I have read and understand the terms of this consent. I have had an opportunity to ask questions about the disclosure of my Protected Health Information.

Signature of Individual or Personal Representative: _____

Print Name of Individual or Personal Representative: _____

Description of Personal Representative's Authority: _____

Date: _____

CONTACT INFORMATION

Address: _____

Telephone: _____(Daytime) _____(Evening)

For Provider Use Only

Date Provider Obtained Consent: _____

Name and Title of Person Obtaining Consent: _____

Action Taken by Provider on Consent: _____

Doc #1846193.1

Section C: Authorization Use of E-mail

I authorize the use or disclosure of my protected health information (“PHI”) by the provider via E - mail. The provider is authorized to use or disclose my PHI via E-mail to the following people at the following E-mail address:

<u>Name (please print)</u>	<u>E-mail (please print)</u>
1. Care Coordination Organization (CCO) _____	1. _____
2. Broker _____	2. _____
3. OPWDD/DDRO _____	3. _____
4. _____	4. _____
5. _____	5. _____

I have been informed that if the person(s) listed above is not a health care provider, a health plan, or a health plan clearinghouse that they may disclose the PHI without obtaining my permission. Furthermore, I recognize that once the PHI is disclosed to the person(s) listed above, the provider can not control further disclosures by the person(s).

I understand that once an email is sent over the internet, third-parties may gain access to the contents of the email regardless of the level of security used by the provider and that the provider does not have any control or authority over who has access to the above-named recipient’s computer and the level of security used by the above-name recipients.

I hereby release, discharge, and agree to indemnify and hold harmless People Inc. and its directors, officers, agents, employees, volunteers, and administrators from any and all liabilities, claims, demands, losses, damages, or costs (including, but not limited to, attorneys’ fees and litigation expenses) arising out of or relating to this Authorization that I or anyone acting on behalf of me or Individual shall make.

I understand that I may revoke and/or modify this authorization at any time by sending a written notice to People Inc. to the following: **Corporate Compliance Officer, People Inc., 1219 North Forest Road, Williamsville, NY 14221**. I understand that such revocation or modification will become effective on the date that People Inc. receives the revocation or modification and will have no effect on the uses and/or disclosures made prior to that date. I understand that I am under no obligation to sign this form, but if I do sign it, I must be provided a copy of the signed form.

This authorization will be effective until revoked or modified in writing in accordance with the above paragraph or until such date that Individual no longer receives any services from provider.

I have been informed that I am under no obligation to sign this Authorization and that the provider will not condition services or treatment on my decision to sign this form. I have signed this form voluntarily

I have had an opportunity to read and understand the contents of this Authorization, and my signature confirms that the Authorization accurately reflects my understandings and wishes.

Signature of Individual or Personal Representative	Date
_____	_____
Authority/Relationship of Personal Representative (if applicable)	
