Generations Adult Day Services

Best Friend Application

(All information will remain confidential)

Name: _____ Today's Date: _____

DOB: _____ Age as of Today: _____

Gender Male ( ) Female ( ) Race: _____

Address: _____

City/State/Zip: _____ Phone: _____

Social Security #: _____ Medicare #: _____

Lives Alone ( ) Lives with someone else ( ) If so, with whom _____

Primary Caregiver/ Responsible Party Information:

Name: _____ Relationship to Applicant: _____

Address: _____

City/State/Zip: _____ Phone : _____

Guardian: _____

Address: _____

City/State/Zip: _____ Phone: _____

Is Billing Information Same as Above? Yes ( ) No ( ) If no, please provide information below

Billing Name: _____

Billing Address: _____

Advanced Directives

Power of Attorney for Health Care: Yes ( ) No ( ) Agent: _____

Power of Attorney for Finances: Yes ( ) No ( ) Agent: _____

DNR: Yes ( ) No ( ) Prescribing Physician: _____

(Please provide copy of applicable documents to Generations)

Emergency Contacts and Persons Authorized to transport Best Friend

Name: _____ Relationship: _____

Address: _____ City/State: _____

Phone 1): _____ Phone 2): _____

Name: _____ Relationship: _____

Address: _____ City/State: _____

Phone 1): _____ Phone 2): _____

Name: _____ Relationship: _____

Address: _____ City/State: _____

Phone 1): _____ Phone 2): _____

Preferred Days of Attendance (Please circle): Monday/ Tuesday/ Wednesday/ Thursday/Friday

Generations Adult Day Services

History & Physical/ Family Report

Best Friend's Name: _____ Today's Date: _____

Height: _____ Weight: _____

Primary Care Physician: _____

Address: _____

Phone: _____ Fax: _____

Diagnosis: _____

_____

Date of Last Visit with Primary Care Physician: _____

Food Allergies:

_____

_____

_____

Drug Allergies:

_____

_____

_____

List of Current Medications: (please list all medication to be taken at the center, and medication taken at home)

Medication:	Dose:	How often?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Immunizations given:

☐Flu When?_____ ☐ Pneumonia When?_____ ☐ Shingles When? _____ Other_____

Medical History

☐Acne	☐ Fatigue
☐Allergies/Hay fever	☐Fibromyalgia
☐Alzheimer's Disease	☐Glaucoma
☐Anemia	☐Gout
☐Anger Problems	☐GERD
☐Anxiety	☐Heartburn
☐Arthritis	☐High Blood Pressure
☐Back Pain	☐Hearing Problems
☐Cancer_____	☐Heart Disease_____
☐Cerebral Palsy	☐Kidney Failure
☐Chronic Bronchitis	☐Kidney Stones
☐Constipation	☐Kidney Disease
☐COPD	☐Memory Loss
☐Crohn's Disease	☐Multiple Sclerosis
☐Dementia	☐Neck Pain
☐Depression	☐Panic Disorder
☐Diabetes Type 1	☐Parkinson's Disease
☐Diabetes Type 2	☐Seizure Disorder
☐Diarrhea	☐Skin Disease
☐Difficulty Swallowing	☐Sleep Apnea
☐Diverticulitis	☐STDs_____
☐Diverticulosis	☐Thyroid Disease
☐Drug/Alcohol Abuse	☐Tuberculosis
☐Eating Disorder	☐Ulcerative Colitis
☐Emphysema	☐Other_____

Surgeries/ Hospitalizations

Has there been a recent ☐Weight Loss ☐ Weight gain How much?_____

Does the applicant use tobacco products? ☐Yes ☐No if yes, what kind?_____ How much?_____

Can the applicant read? ☐Yes ☐No Does the applicant write? ☐Yes ☐No

Is the applicant: ☐Right Handed ☐Left Handed

Does the applicant have any hearing impairment? ☐Yes☐No If yes, please answer the following:

What ear? ☐Right ear ☐Left ear ☐Both ears

How much impairment? ☐Some hearing loss ☐Complete hearing loss

Does the applicant wear hearing aids? ☐Yes Which ear?_____ ☐No ☐Refuses to wear them

Does the applicant have a vision impairment? ☐Yes ☐No if yes, please answer the following:

Which eye? ☐Right☐Left

Does the applicant have implants? ☐Yes ☐No

Does the applicant have glasses? No☐ Yes☐ What Kind? ☐Reading ☐Distance☐ Bifocal

Does the applicant wear dentures?☐Yes ☐No ☐No, does not have teeth.

if yes, please answer the following:

Upper? ☐Full ☐Partial ☐Bridge

Lower? ☐Full ☐Partial ☐Bridge

Describe how well the applicant functions with these Activities of Daily Living.

What is current activity level?

☐High- Very active and participates with others

☐Moderate-Enjoys spending time active, but needs frequent rest periods

☐Low- Does not interact very much with others, and sits a lot

Walking: ☐Steady on feet ☐With supervision☐ With some help

☐With assistive device- What device?_____

Eating: ☐With no help ☐ Needs Cueing ☐ With some help ☐With special assistive device- What Device?_____

☐Needs total assistance

Does the applicant have difficulty swallowing? ☐Yes ☐No

Does the applicant store food in mouth?☐Yes ☐No

Diet Information:

☐Regular Diet ☐No extra sugar ☐No extra salt ☐Other Restrictions_____

☐Dietary Supplement- What supplement? _____

Appetite: ☐Good☐ Fair ☐Poor

Please list any food dislikes:

_____

_____

Toileting:

Can the applicant use the bathroom on their own? ☐Yes ☐No If no, please answer the following:

☐Needs total assistance ☐Needs some help ☐Needs supervision ☐Personal Care

Is the applicant incontinent? ☐No ☐Only Rarely ☐Yes if yes, answer the following:

Incontinent of: ☐Bladder ☐Bowel ☐Both

Does the applicant use any of the following?

☐Indwelling foley catheter ☐Suprapubic catheter ☐Condom catheter ☐In and Out catheter

Products used during the daytime: ☐Nothing ☐Panty liner ☐Incontinence pads ☐Pull up ☐Briefs

Dressing:

Can the applicant get dressed on their own? ☐Yes ☐No If no, What kind of help do they need?

☐Some help ☐ Total assistance ☐Supervision

Behavior:

Does the applicant exhibit any of the following :

☐ Difficulty communicating wants and needs
☐Difficulty completing sentences
☐Sentences do not make sense
☐Difficulty naming people
☐Difficulty expressing self
☐Has difficulty concentrating on a task or activity
☐Takes little or no interest in activity
☐ Exit seeking behavior
☐Often asks the same questions over and over
☐Misplaces objects
☐ Hoards objects
☐Cannot be left alone
☐ Demands constant attention
☐ Becomes verbally abusive
☐Becomes combative
☐Becomes anxious
☐Becomes agitated
☐ Is stubborn or uncooperative
☐ Engages in embarrassing or socially inappropriate behavior
☐ Talks to people they do not know
☐ Seems unaware of anything wrong
☐Reports seeing or hearing things that are not there
☐Is depressed or withdrawn
☐ Engages in activity that is potentially dangerous to self or others

Personality:

Describe personality in the past_____

Describe current personality_____

Applicant's previous occupation:_____

Interests:

Listening to music	☐Current	☐Past
Sports	☐Current	☐Past
Knitting	☐Current	☐Past
Gardening/ Mr. Fix it	☐Current	☐Past
Children	☐Current	☐Past
Singing	☐Current	☐Past
Games	☐Current	☐Past
Drawing/Painting	☐Current	☐Past
Crafts	☐Current	☐Past
Walking	☐Current	☐Past
Dancing	☐Current	☐Past
Other_____	☐Current	☐Past

Family Goals for Daycare:

☐Socialization ☐Stimulation ☐Family relief ☐Supervision ☐Other_____

Anything else we need to know so we can best serve you and your loved one? Please List here:

_____
_____
_____
_____

Generations Adult Day Services

Best Friend's Life Story

Name _____ Birthdate _____

Birthplace _____ Nickname _____

Mother _____ Father _____

Brother/Sisters 1) _____ 2) _____

3) _____ 4) _____

Marital Status _____ Spouse _____

Children's Names 1) _____ 2) _____

3) _____ 4) _____

# of Grandchildren _____ # of Great Grandchildren _____

Where Have You Lived? _____

_____

Schools Attended _____

_____

Hobbies/ Interests _____

_____

Jobs Held _____

_____

Military Service? Yes ( ) No ( ) Branch _____

Religious Affiliation _____ Church Affiliation _____

Information about Best Friend that would help us converse with them? _____

_____

_____

_____

_____

_____

_____

_____

_____

Updated 12/08/2015

Generations
ADULT DAY SERVICES

Fee Policy

Effective 02/01/2019, Generations will charge $9.00 per hour for services rendered to private pay individuals. No minimum hours are required but it is highly recommended that participants come on a regular schedule to maximize program benefit.

Generations does accept Medicaid waiver reimbursement for HCB2, Michelle P. & SCL2 waiver recipients. For individuals that are eligible for the waivers, Medicaid reimburses Generations at an amount set forth by the state and dependent of the level of care required.

Please be advised that Medicaid may expect that copay is rendered to Generations Adult Day Services by the participant. This copay is determined by the State of Kentucky and is dependent on the participant's income.

Generations does accept payment from some private insurance. Generations will work with you and your insurance company to the best of our ability. Please be advised you may have copay and/ or deductible that is applicable.

Generations Adult Day Services

Statement of Understanding

I acknowledge that policy and procedures of Generations Adult Day Services have been discussed with me and will be made available to me in writing upon my request. I agree to comply with all Generations policies and procedures.

_____ _____

Name Date

Civil Rights Compliance

I acknowledge that I have been provided the CFHS Civil Rights compliance brochure and that Generations will abide by standards set forth in that brochure.

_____ _____

Name Date

Complaint Procedures

I acknowledge that I have received a copy of the written complaint procedures from Generations Adult Day Services. I also acknowledge that if I have a complaint, I will follow the policy to rectify the concern.

_____ _____

Name Date

Financial Responsibility Statement

I acknowledge that Generations Adult Day Services provides a service to me and my family member attending the program. I understand there are fees associated with this service. I acknowledge I have been provided the fee schedule. I understand that I am responsible for the fees that are accumulated by using this service. I understand that my family member may obtain assistance in paying full or part of these services by qualifying for HCB Medicaid waiver services. I understand that I may have a co-pay that I am responsible for each month that is set by the state of KY or that I may be responsible for the entire fee, which ever case is applicable to me. I understand that I will be

billed monthly and that failure to pay for these services may result in the discharge of my family member from this program unless prior arrangements have been made with me and the Executive Director.

_____ _____

Name Date

==========

Media Permission

I, _____, do ( ) do not ( ) give permission to for Generations Adult Day Services to photograph, video or record _____.

I understand that this media may be used for public education. Such media may be but is not limited to, brochures, our Face Book page, our website, in newsletters or in other promotional material.

_____ _____

Name Date

==========

Permission to Provide Medical Treatment

Generations will follow the State requirements in training for CPR and First Aid in an attempt to provide on the spot treatment. I give permission to Generations staff to provide emergency medical treatment as needed for _____.

_____ _____

Name Date

==========

Privacy Practices Policy

I acknowledge that I have been provided the Privacy Practices Policy and that Generations will abide by standards set forth in that policy.

_____ _____

Name Date

Refusal to Serve

Generations Adult Day Services will, at all times, strive to provide the best service to your loved one. There may be circumstances however, wherein Generations does not believe they can adequately serve your loved one and/or believes that your loved one is not suited to benefit from our services. As such, Generations reserves the right to refuse service to individuals.

_____ _____

Name Date

Release of Liability

I understand that Generations Adult Day Services strives to provide the best possible care to my loved one at all times, but unforeseen accidents may occur. I understand that Generations will treat my loved one for first and CPR in the instance such a need may arise, but that Generations will call for emergency services in the event that the accident requires further medical attention beyond the scope of care the Generations can provide. I will not hold Generations accountable for the cost of treatment or the cost of ambulance services.

_____ _____

Name Date

Release of Information

I, _____ herby request that permission be granted to Generations Adult Day Services, to receive medical information for _____, for the purpose of compliance with their state mandated regulations.

_____ _____

Name Date

NOTICE OF PRIVACY PRACTICES

Generations Adult Day Services
225 West Water Street, Mayfield, KY 42066
270-247-1311
Maureen Platt-Russell, Privacy Officer & Executive Director

Effective Date: 01/05/2016

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

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

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A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical

information to members of your family or others who can help you when you are sick or injured, or after you die.
2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts

4. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office.

6. Notification and Communication with Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

9. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

15. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

16. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

17. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

18. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

19. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

20. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

21. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

23. Fundraising. We may use or disclose your demographic information in order to contact you for our fundraising activities. For example, we may use the dates that you received treatment, the department of service, your treating physician, outcome information and health insurance status to identify individuals that may be interested in participating in fundraising activities. If you do not want to receive these materials, notify the Privacy Officer listed at the top of this Notice of Privacy Practices and we will stop any further fundraising communications. Similarly, you should notify the Privacy Officer if you decide you want to start receiving these solicitations again.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in section 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Southeast Region - Atlanta (Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee)

Timothy Noonan, Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services
Sam Nunn Atlanta Federal Center, Suite 16T70
61 Forsyth Street, S.W.
Atlanta, GA 30303-8909
Customer Response Center: (800) 368-1019
Fax: (202) 619-3818
TDD :(800) 537-7697
Email: ocrmail@hhs.gov

The complaint form may be found at **www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf**.

You will not be penalized in any way for filing a complaint.

(11/2012)

PARTICIPANT RIGHTS

The participant rights as recognized by providers of services shall include:

1. The right to access accurate and easy-to-read information.
2. The right to be treated with dignity and respect and to maintain one's dignity and individuality.
3. The right to voice grievances and complaints regarding services and supports that are furnished, without fear of retaliation, discrimination, coercion, or reprisal.
4. The right to a choice of approved service provider(s).
5. The right to accept or refuse services.
6. The right to be informed of and participate in preparing the Person Centered Plan of Care and any changes in the Plan of Care.
7. The right to be advised in advance of the provider(s) who will furnish services and the frequency and duration of services.
8. The right to confidential treatment of all information, including information in the participant's record(s).
9. The right to receive services in accordance with the current Person Centered Plan of Care.
10. The right to be informed of the name, business, telephone number, and business address of the person supervising the services and how to contact the person.
11. The right to have property and residence treated with respect.
12. The right to be fully informed of any cost share liability and the consequences if any cost share is not paid.
13. The right to review the individual participant's records upon request.
14. The right to receive adequate and appropriate services without discrimination.
15. The right to be free from mental, verbal, sexual, and physical abuse, neglect, exploitation, isolation, corporal or unusual punishment, including interference with daily functions of living.
16. The right to be free from mechanical, chemical, or physical restraints.
17. The right to live and work in an integrated setting.
18. The right to time, space, and opportunity for personal privacy.
19. The right to communicate, associate, and meet privately with the person of choice.
20. The right to send and receive unopened mail.
21. The right to retain and use personal possessions, including clothing and personal articles.
22. The right to private, accessible use of a telephone or cell phone.

I acknowledge that the above Rights have been reviewed and explained to me and that I understand these rights.

Signature of Participant/Guardian

Date

I affirm the above Rights were reviewed with the Participant and Guardian as applicable.

Signature of Case Manager

Date

For Recipients of SNAP, WIC or other USDA or HHS funded services:

In accordance with federal law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and in some cases religion and political beliefs. The U.S. Department of Agriculture also prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.

Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the State Information/Hotline Numbers (click the link for a listing of hotline numbers by State); found online at http://www.fns.usda.gov/snap/contact_info/hotlines.htm.

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (TTY). USDA and HHS are equal opportunity providers and employers.

Civil rights complaints may be filed with the following:

Kentucky Cabinet for Health and Family Services
EEO/Civil Rights Compliance Branch
275 E. Main St., 5 C-D
Frankfort, KY 40621
502-564-7770

Kentucky Commission on Human Rights
The Heyburn Building, Suite 700
332 W. Broadway
Louisville, KY 40202
800-292-5566

US Department of Agriculture
Director, Office of Adjudication
1400 Independence Avenue, SW
Washington, D.C. 20250-9410
866-632-9992

US Department of Education
Office for Civil Rights
600 Independence Avenue SW
Washington, DC 20202-1100
800-421-3481

US Department of Health and Human Services
HHS Director, Office for Civil Rights
Room 515-F, 200 Independence Avenue SW
Washington, D.C. 20201
202-619-0403

US Department of Justice
Office of the Assistant Attorney General
Civil Rights Division
PO Box 65808
Washington, DC 20035-5808
202-514-2151

US Department of Labor
Office of Federal Contract Compliance
Atlanta Federal Center, Room 7B75
100 Alabama Street SW
Atlanta, Georgia 30303
404-562-2424

The Kentucky Cabinet for Health and Family Services is an Equal Opportunity Provider.

KENTUCKY
CABINET FOR HEALTH
AND FAMILY SERVICES

CIVIL RIGHTS

EQUAL RIGHTS
FOR ALL
SERVICES
AND PROGRAMS

Revised December 2014

CHFS AND CIVIL RIGHTS

The Kentucky Cabinet for Health and Family Services does not discriminate against any person on the basis of political beliefs, race, color, national origin, religion, age, mental or physical disability or sex.

This policy protects the rights of the Cabinet's employees, service applicants and customers.

Vendors, agencies and organizations providing services to the Cabinet or its recipients of federally aided programs must also comply with this policy.

CHFS COMMITMENTS

The Kentucky Cabinet for Health and Family Services has made the following commitments:

- ✓ No one applying for or receiving assistance or services will directly, or through contractual or other arrangements, be denied aid, care, services, or other benefits provided by CHFS for which they are eligible.
- ✓ Services will be given in the same manner to all recipients, based on eligibility.
- ✓ No one applying for or receiving assistance will be subjected to segregation or different treatment in any matter related to receipt of the assistance.
- ✓ No one applying for or receiving assistance will be restricted in any way in the enjoyment of any advantages or privileges enjoyed by others receiving similar services.
- ✓ No one will be given different treatment in determining eligibility or meeting other requirements or conditions that must be met to receive benefits.
- ✓ CHFS will maintain an environment free from any type of harassment or discrimination and will respond promptly and effectively to such complaints.

DISCRIMINATION COMPLAINTS

Any applicant for or recipient of federally aided programs who feels discriminated against may file a complaint of discrimination.

FILING A COMPLAINT

All complaints of discrimination should be forwarded immediately to the EEO/Civil Rights Compliance Branch of the Cabinet's Office of Human Resource Management.

Kentucky Cabinet for Health and Family Services
EEO/Civil Rights Compliance Branch
275 E. Main St., 5 C-D
Frankfort, KY 40621
502-564-7770

You may file a complaint of discrimination at your local office. The allegation will then be forwarded to the Cabinet's EEO/Civil Rights Compliance Branch. The complainant may also file a complaint with an outside agency (listing on back.)

CONFIDENTIALITY
The complainant's identity will be kept confidential except to the extent needed to carry out the investigation and to remain within the confines of the Kentucky Open Records Act.

INCOME ELIGIBILITY GUIDELINES
For Adult Day Care Centers
(FOR INTERNAL/OFFICE USE ONLY)

INCOME ELIGIBILITY SCALE

The eligibility scale is for determining participating participant's eligibility category for federal meal reimbursement if they are not recipients of SNAP (Formerly food stamps), SSI or Medicaid. Participants from households with total gross incomes at or below the following levels may be eligible for free or reduced-price reimbursement rates.

Income Guidelines for Free/Reduced Price Meals Effective July 1, 2018-June 30, 2019				
Household Size	**Free Meals**		**Reduced Price Meals**	
	Monthly	*Yearly*	*Monthly*	*Yearly*
1	**$1,316**	$15,782	**$1,872**	$22,459
2	**$1,784**	$21,398	**$2,538**	$30,451
3	**$2,252**	$27,014	**$3,204**	$38,443
4	**$2,720**	$32,630	**$3,870**	$46,435
5	**$3,188**	$38,246	**$4,536**	$54,427
6	**$3,656**	$43,862	**$5,202**	$62,419
7	**$4,124**	$49,478	**$5,868**	$70,411
8	**$4,592**	$55,094	**$6,534**	$78,403
For each additional family member add:	**+$468**	+$5,616	**+$666**	+$7,992

The term "household" means a group of related or unrelated individuals who are not residents of an institution or boarding house but who are living as one economic unit, sharing housing and all significant income and expenses.

Note: Participants that are recipients of the following programs are automatically eligible for the free reimbursement rate:

- SNAP (formerly known as Food Stamps)
- SSI
- Medicaid

ADULT ENROLLMENT FORM/INCOME APPLICATION

1. Participant Information: (To be completed by Caretaker/Guardian)

If an adult participant is a member of a SNAP, SSI or Medicaid participant, the adult participant is automatically eligible to receive free Program meal benefits, subject to the completion of the application as described in paragraph (e)(1)(iii) of this section;
**Adult participant means a person enrolled in an adult day care center who is functionally impaired with an Individual plan of care or 60 years of age or older. 7 CFR 226.2 (c)*

If your participant receives assistance from the items below, please complete and skip to section 3.

Participant's Last Name	Participant's First Name	Date of Birth	Meals Normally Eaten (Circle all that apply)	Snap, SSI or Medicaid # (List Entire Number Below)
			B AM L PM S LN	
			B AM L PM S LN	

***Caretaker/Guardian works multiple shifts and participants may be in care different days/hours ____yes ____no**

Does this Participant have a Plan of Care? (Less than 60 years of age) ____yes ____no

2. Income Application Household Members and Monthly Income:

NAMES OF HOUSEHOLD MEMBERS Last, First	GROSS MONTHLY Income From Work (Before Deductions	MONTHLY Income From Welfare Payments, Alimony	MONTHLY Income From Pensions, Retirement, Social Security, Unemployment Compensation	Any Other MONTHLY Income
1.	$	$	$	$
2.	$	$	$	$
3.	$	$	$	$
4.	$	$	$	$
5.	$	$	$	$

3. Signature and Social Security Number:

I certify that all of the above information is true and correct and that all income is reported. I understand that this information is being given for the receipt of federal funds and that deliberate misrepresentation may subject me to prosecution under applicable state and federal laws.

X_____ _____
Signature of Adult Household Member **Home/Cell Phone Number**

X_____ ☐ **No Social Security Number** X_____
Last four digits Social Security Number* **Date**

FOR SPONSOR USE ONLY. DO NOT WRITE BELOW THIS LINE.

Application approved for:
- ☐ Free Meals
- ☐ Reduced Price Meals
- ☐ Paid
- ☐ SNAP/SSI/Medicaid
- ☐ Income Household

Total Household Monthly Income_____

Household Size_____

_____
Signature of Determining Official

_____
Date

**7 CFR 226.15 (e)(2)*

(Revised June 2017)

"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 last four digits of the Social Security Number are 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."

USDA Nondiscrimination Statement

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: (1) mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov. This institution is an equal opportunity provider.

Generations Adult Day Services

Grievance Form

PARTICIPANT COMPLETES AND GIVES TO GENERATIONS EXECUTIVE DIRECTOR

IF FILING A GRIEVANCE

I, _____ am submitting a formal grievance to Generations Adult Day Services on this date, _____ for the following reasons:

(Use separate paper if more space is needed)

_____

_____

_____

_____

Proposed Solution: _____

_____

Contact number you can be reached at: _____

_____ _____

Signature of Program Participant Date Signature of Guardian (if applicable) Date

STEP 1:

Grievance received by: _____DATE_____

Grievance resolved on: _____ Conditions of resolution: _____

_____

STEP 2:

Grievance not resolved and escalated to Executive Director on:_____

Ruling from Executive Director received on: _____ Nature of ruling: _____

_____

_____

STEP 3:

Grievance not resolved and escalated to Grievance and Appeals Committee on: _____.
Ruling from Grievance Committee received on: _____

Nature of ruling: _____

STEP4:

Grievance not resolved by Grievance Committee and escalated to Ombudsman

Ruling of Ombudsman received on _____

Nature of the ruling:

_____

_____

Attachment 1

Revised FY2014-2015

Civil Rights Grievance Report Form
(Complainant Section)

Name _____ **Date** _____

Address _____ **Phone** _____

If your grievance concerns a discriminatory action due to race, color, national origin, sex, age, or disability, please be very specific and give full details concerning the occurrence.

State the reason(s) you are filing this grievance report.

_____

_____

_____

_____

_____

What response did you receive from the institution representative during the alleged occurrence?

_____

_____

_____

What results are you seeking from this communication?

_____

_____

_____

_____ _____

Signature of Complainant **Date**

"The U.S. Department of Agriculture (USDA) prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or if all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.

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FNS 113-1