PA., Ch. 6400 Program – Admission Packet

The individual that you have referred to Keystone Community Resources, Inc., has been accepted for admission into our Program. Please complete the following attachments to assist us in meeting admission requirements and to provide appropriate planning for the individual:

1. Personal Data Form: Please complete all sections in full. (SEE ATTACHMENT A)

2. **Physical Examination**: Please have the enclosed Resident Physical Examination complete in full by physician, including the TB testing by Mantoux method. **Very Important** (SEE ATTACHMENT B)

3. Please have the parent/guardian review and sign the enclosed consent/release form labeled “Consent for Hepatitis B Virus Vaccine.” (SEE ATTACHMENT C)

   Please note: if the individual has had Hepatitis B Screening and/or the Vaccine Series, please provide documentation.

4. Please have the parent/guardian review and sign the enclosed consents/releases as follows:

   a. General Consent and Release Page: 3
   b. Consent for Emergency Hospital Admission: Page: 5
   c. Medical/Dental Consent Page: 6
   d. Consent for Activity Programs, Day Visits & Therapeutic Leave Page: 7
   e. Consent for Publicity Page: 8
   f. Consent for Participation in Day Habilitation Services Page: 9
   g. Consent for Assistance with Financial Management/Entrustment of Funds: Page: 10
   h. Grievance Policy Page: 11
   i. Individual Rights Page: 14
   j. Consent for Release of Information (for current providers) Page: 19

5. Annual Assessment - Part I - Skill Assessment - Please have someone who is familiar with the individual complete this form. Feel free to put as many comments as you would like. This form is used to complete each individual’s Annual Service Plan but is also helpful to us at the time of admission. Program staff will complete another assessment prior to the individual’s initial Annual Service Plan, which will be held within 45 days of their admission. If you have a similar assessment tool that gives an accurate view of the individual’s abilities you may send it instead of completing and returning this assessment. (SEE ATTACHMENT D)

6. Confirmation of Funding Letter.
In addition to completing the attached Personal Data Form you will need to enclose the following items:

1. Birth Certificate and Social Security Card. If the individual was born outside of the U.S. please enclose their Resident Alien Card (copies are acceptable).

2. Health Insurance Card(s). Please provide a copy now and original card at time of admission.

3. Proof of guardianship. If individual has a court appointed guardian we require a copy of the court order.

4. Family Service Plan (Exclusive to individuals funded through Ch. 3800 program).

5. Most recent IEP and/or CER for individual under the age of 21. Over 21 years of age please enclose most recent service plan from any day services program that they attend.

6. Most recent Service Plan (ISP).

7. Most recent Psychological Report, including IQ and level of adaptive functioning.

8. Most recent Psychiatric Evaluation, including specific psychiatric diagnoses (if applicable).

9. Behavioral support plans that are in place for the individual.

10. Immunization Record - A complete and up to date immunization record is required.

11. Medical History, if one is available or a brief medical history, which includes all current medical concerns and any, follow up necessary.

12. A 7-day supply of medication(s) and written prescription(s) from physician treating the individual.

13. A copy of the Home and Community – Based Services packet for individuals that are waived, including form 162 C.

14. Additional Attachments:
   a. Voter Registration

Admissions procedures and the provision of services shall be made without regard to race, color, religious creed, disability, handicap, ancestry, national origin, age, or sexual orientation.
General Consent and Release Form

It is expressly understood and agreed that Keystone Community Resources, Inc. shall not be responsible or legally liable for any losses of personal property or for any bodily injuries, or the results thereof, incurred and suffered by on any property of Keystone Community Resources, Inc. or in connection with any activities or programs, unless such loss or injury results directly from the negligent or willful act of an employee of Keystone Community Resources, Inc., acting within the scope of his/her employment.

I understand I may request, in writing to the Residential Director, a copy of any of the Policies and Procedures for Keystone Community Resources.

__________________________
Parent/Guardian Signature

__________________________
Witness

DATE

DATE

NOTE: This consent shall remain in effect indefinitely unless otherwise revoked in writing. Photostatic copies of this form will be considered as valid as the original.
EMERGENCY MEDICAL PLAN

In the event of a medical emergency the following should be followed:

1. Staff will assess the extent of the injury or illness.
2. Staff will administer first aid as necessary.
3. If emergency medical treatment is needed, staff will phone 911 for emergency services. Staff will meet EMT at the CMC Hospital located at 1800 Mulberry Street, Scranton, PA 18510 (or appropriate substitute).

In a situation where staffing shortages exists, the area supervisor will be contacted and will provide emergency staffing services.

4. Conditions warranting emergency services are:

   Unconsciousness          Poisoning
   Uncontrolled external bleeding  Fainting episode
   Choking                   Severe burns
   Combined chest/arm/jaw pain  Stroke (suspected)
   Pressure, fullness or squeezing chest pain  Weakness on one side
   last for more than a few minutes  Persistent nausea or vomiting
   Sudden paralysis          Fall with a suspected injury
   No breathing or difficulty breathing  Severe or worsening reaction to sting or bite
   Unusual difficulty with or slurred speech  Severe swelling of face, tongue, eyes
   Trauma to head, neck, chest, back, abdomen, pelvis  Sudden change in ability to walk or function in other ways with no apparent cause
   Seizures, recurring or uncontrolled  No signs of life (breathing or movement)
   1st time seizures or seizures if pregnant or diabetic  Burns to genitals, face, neck, arms
   1 or more restraints totaling longer than  Psychiatric symptoms that pose an imminent risk to the health or safety of self or others
   15 minutes within a 2 hour period

CPR must be initiated if the person is not breathing after two rescue breaths

This plan is provided to all guardians/custodians at the time of admission.
CONSENT FOR EMERGENCY HOSPITAL ADMISSION

It is the policy of Keystone Community Resources, Inc. to utilize this consent for emergency hospital admission in the event an emergency situation occurs and a delay in treatment would result in further hazards to the Individual. Additional consents for specific procedures will be required and obtained from the admitting hospital. Medical reports will also accompany the individual so that the physician on duty will have appropriate and useable medical information. Please read the following authorization, sign and date. The signature of a witness to your signature is also required.

I hereby authorize Keystone Community Resources, Inc. to consent to an emergency medical treatment that may be necessary for __________________________ in the event that it is necessary for Keystone Community Resources, Inc. to transport the above named to any hospital for medical treatment. I do further authorize said Keystone Community Resources, Inc. to agree to such treatment without the necessity of my also authorizing the treatment in writing and do authorize the said hospital to render such treatment. In addition to treatment, I also authorize the hospital to forward a copy of the medical record to Keystone Community Resources, Inc. I expressly intend to be legally bound by the authorization granted to said Keystone Community Resources, Inc. as above mentioned.

PARENT/GUARDIAN __________________________ DATE __________

SIGNATURE OF WITNESS __________________________ DATE __________

INDIVIDUAL’S SIGNATURE (if applicable) __________________________ DATE __________

SIGNATURE OF WITNESS __________________________ DATE __________

NOTE: This consent shall remain in effect indefinitely unless otherwise revoked in writing. Photostatic copies of this form will be considered as valid as the original.
MEDICAL/DENTAL CONSENT

1. I hereby give my consent to Keystone Community Resources, Inc., presently caring for _______________ _______________, to arrange for routine medical/dental care and such medical/dental treatment as the named physician consider being necessary.

2. I further give my consent to all emergency medical/dental procedures which are necessary to preserve his/her life or prevent permanent impairment of his/her health in cast time does not permit obtaining my personal consent to these procedures. I agree to allow Keystone Community Resources, Inc. to transfer and to authorize admission to a general hospital in the event that the necessary medical /dental procedures cannot be performed at the facility and, in my absence, to consent to any surgical or medical/dental procedures that may be necessary.

3. Being fully aware of the risks and complications involved, I hereby release Keystone Community Resources, Inc. and its professional staff and employees, as well as any and all doctors, dentists, hygienists, technicians, assistants and nurses who may provide treatment from any and all liability which may arise out of such treatment.

4. I understand that the practice of medicine and therapy is not an exact science and that diagnosis and treatment may involve certain risks. I acknowledge that no guarantees have been made to me concerning the care for my child.

5. I understand that some of the professionals who provide care and treatment are not employees of Keystone Community Resources, Inc., but rather, are independent consultants who have been retained for the purpose of providing specialized professional care.

6. I am authorized to execute this consent, and I am aware of no relative or guardian whose interest may be adverse to my own.

7. This form has been fully explained to me, and I certify and acknowledge that I understand content and significance.

____________________________________                        ______
PARENT/GUARDIAN                                      DATE

____________________________________                        ______
WITNESS                                      DATE

NOTE: This consent shall remain in effect indefinitely unless otherwise revoked in writing. Photostatic copies of this form will be considered as valid as the original.
CONSENT FOR ACTIVITY PROGRAMS, DAY VISITS AND THERAPEUTIC LEAVE

1. Permission and authority are hereby granted for Keystone Community Resources, Inc. to allow __________________________ to take walks, field trips and excursions persons approved by the administration of Keystone Community Resources, Inc.
   
   YES __________ NO __________

2. Permission and authority are hereby granted for Keystone Community Resources, Inc. to allow __________________________ to go on day visits to the homes of persons approved by the administration of Keystone Community Resources, Inc.
   
   YES __________ NO __________

3. Permission and authority are hereby granted for Keystone Community Resources, Inc. to allow __________________________ to go on Therapeutic Leave (Overnight visits) to the homes of persons approved by the administration of Keystone Community Resources, Inc.
   
   YES __________ NO __________

4. I wish to be contacted before my child goes on any Therapeutic Leave (overnight visits).
   
   YES __________ NO __________

PARENT/GUARDIAN __________________________ DATE __________

WITNESS __________________________ DATE __________

NOTE: This permission shall remain in effect indefinitely unless otherwise revoked in writing. Photostatic copies of this form will be considered as valid as the original.

(CONSENT 01/00)
CONSENT FOR PUBLICITY

I, ____________________________, ____________________________,
(Name) (Relationship)

give consent for ____________________________ to be photographed for the purpose of publicizing,
(Name of Individual)
demonstrating, or explaining the nature and scope of programs at Keystone Community Resources, Inc. I give
my permission for the following (unless indicated below):

- Slide Presentations
- Television Coverage
- Newspaper Coverage
- Keystone Key Views
- Presentations
- Web Site
- (Keystone Publication)

Please indicate your preference below:

I Do Not Want any Identity
First Name Only
Full Name May be Used

__________________________  _______________________
PARENT/GUARDIAN SIGNATURE  DATE

__________________________  _______________________
WITNESS  DATE

I, ____________________________, do not give my permission for ____________________________ to be
photographed for the purpose of publicizing, demonstrating, and explaining the nature and scope of programs at
Keystone Community Resources, Inc.  

__________________________  _______________________
Parent/Guardian Signature  Date

Keystone Community Resources cannot be held responsible for outside entities photographing individuals for
the purpose of publicizing.

Keystone Community Resources does not act as Representative Payee on behalf of any consumer receiving its
services

NOTE: This consent shall remain in effect indefinitely unless otherwise revoked in writing. Photostatic
copies of this form will be considered as valid as the original.
CONSENT FOR PARTICIPATION IN DAY HABILITATION SERVICES

I hereby give consent for ______________________ to participate in the Day Habilitation Services operated by Keystone Community Resources, Inc. This program includes activities in the facility as well as the community.

I further understand that I may revoke this consent at any time by contacting either the Director of Vocational Services or the Director of Day Services.

PARENT/GUARDIAN ______________________ DATE ______

WITNESS ______________________ DATE ______

NOTE: This consent shall remain in effect indefinitely unless otherwise revoked in writing. Photostatic copies of this form will be considered as valid as the original.
CONSENT FOR ASSISTANCE WITH FINANCIAL MANAGEMENT/ENTRUSTMENT OF FUNDS

I _______________________________ consent to have Keystone Community Resources, Inc. (KCR) staff assist and handle my personal finances as indicated below (please indicate by an “X.”)

<table>
<thead>
<tr>
<th>N/A</th>
<th>YES</th>
<th>NO</th>
<th>Fund Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>___</td>
<td>___</td>
<td>___</td>
<td>Funds forwarded from Representative Payees/Family</td>
</tr>
<tr>
<td>___</td>
<td>___</td>
<td>___</td>
<td>Cash Gifts/Gift Cards</td>
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<tr>
<td>___</td>
<td>___</td>
<td>___</td>
<td>Personal Needs Allowance(PNA)/ Trust Funds</td>
</tr>
<tr>
<td>___</td>
<td>___</td>
<td>___</td>
<td>Funds for Expenses (medical, clothing, activities, etc.)</td>
</tr>
<tr>
<td>___</td>
<td>___</td>
<td>___</td>
<td>Tax Refunds</td>
</tr>
<tr>
<td>___</td>
<td>___</td>
<td>___</td>
<td>Insurance Claims</td>
</tr>
<tr>
<td>___</td>
<td>___</td>
<td>___</td>
<td>Earned Income: Paychecks/Stipends/Commissions</td>
</tr>
<tr>
<td>___</td>
<td>___</td>
<td>___</td>
<td>SSI/SSA/Public Assistance*</td>
</tr>
</tbody>
</table>

This consent encompasses assisting in payment of expenses, holding and dispensing personal funds, as well as holding savings and/or checking accounts.

I also agree to take an active part as possible in handling my personal finances and participating in a plan that will enable me to prepare for financial independence.

Keystone Community Resources, Inc. agrees to hold my personal expense funds and checking and/or savings accounts and keep this material in a secure area at all times. Keystone Community Resources, Inc. agrees to keep an accurate total of funds and to present an audit of funds upon request.

This consent will be in effect for the duration of my enrollment at Keystone Community Resources, Inc. I may revise or revoke this consent at any time by notifying the Director in writing.

I, _______________________________ agree to the terms of this agreement and understand the responsibilities of all parties concerned. This consent shall remain in effect indefinitely unless otherwise revoked in writing. Photostatic copies of this form will be considered as valid as the original.

_________________________________________  DATE
INDIVIDUAL

_________________________________________  DATE
PARENT/GUARDIAN

_________________________________________  DATE
WITNESS
GRIEVANCE POLICY

Keystone Community Resources strives to provide a positive environment where individuals have the continued opportunity to learn and grow;

Consumers have the right to be treated with dignity and respect; including the right to be free from: physical, verbal, psychological and sexual abuse, neglect, corporal punishment, and involuntary seclusion, physical/chemical restraints for the purpose of discipline or convenience;

Consumers have the right to a safe and caring environment that is free of hazards; Consumers have the right to an environment that promotes their development and independence;

The Grievance procedure does not replace incident reporting guidelines. Staff who become aware of allegations of abuse, neglect, or rights allegations must report, as required by Incident Management policies.

- An individual or the consumer’s legal guardian has the right to voice a complaint/grievance regarding the services provided by Keystone Community Resources or Keystone Independent Living without the worry/threat of reprisal from the agency or agency personnel;

- An individual has the right to challenge program rules associated with the home/program in which they participate;

- An individual has the right to have their complaint/grievance reviewed/investigated, and to receive appropriate feedback in regards to it;

- A grievance must be filed in writing. A suggested written format is attached; however any written format is acceptable. Consumers who cannot write will receive staff assistance with drafting and submitting a grievance. It is not acceptable for staff to represent their own opinion in a grievance.

- All formal grievances will receive a written response within 10 business days from the time the grievance was originally received;

- A grievance should be filed to the appropriate level of management in the following order:
  1. Program Coordinator
  2. Program Director
  3. Executive Director

- Additional external agencies exist to assist with an individual’s grievances when the individual feels they have not received appropriate response from this agency. These organizations are referenced on the attached document;
The grievance procedure will be reviewed with the consumer and their legal guardian at the time of admission, and annually thereafter (in conjunction with Individualized Service Plan and annual review of individual rights).

A signed copy will be maintained in the individual’s residential file. If the individual’s guardian is not available, Keystone Community Resources will document by letter to the guardian that a copy of the grievance procedure is available and will be mailed upon request.

For additional assistance with a grievance, a resident may contact any of the agencies listed below:

**Director of Human Resources**
Keystone Community Resources / Keystone Independent Living
100 Abington Executive Park, Suite B
5th Floor
Clarks Summit, PA 18411
Telephone: (570) 702-8000
Fax: (570) 702-8097

**PA Human Relations Commission**
Harrisburg Regional Office
Riverfront Office Center
1101 South Front Street,
Harrisburg, PA 17104
Telephone: (717) 787-4410
Fax: (717) 787-0420 / (717) 772-4340

**Department of Public Welfare**
Bureau of Equal Opportunity
Room 223 Health & Welfare Bldg.
PO Box 2675
Harrisburg, PA 17105-2675
Telephone: (717) 787-9695
Fax: (717) 772-4366

**U.S. Department of Health & Human**
Office of Civil Rights
Suite 372, Public Ledger Building
150 South Independence Mall West
Philadelphia, PA 19106-1911
Telephone: (215) 861-4441
TDD (215) 861-4440; 1-800-368-1019

**DPW Bureau of Equal Opportunity**
Northern Regional Office
Room 331 Scranton State Office Bldg.
100 Lackawanna Avenue
Scranton, PA 18503-1923
Telephone: (570) 963-4342
Fax: (570) 963-3370

*Resident’s Case manager or Supports Coordinator*

*Additional Resources for New Jersey Funded Individuals:*
I have read or have had read the Grievance Policy to me. I have had an opportunity to ask questions regarding this policy and feel comfortable in my understanding of this policy.

I have signed this document and have received a copy of it. Additionally, agency polices are available for review by contacting the Program Director. I understand my request will be processed and mailed within 10 business days of request.

Legal Guardian Signature ________________________________ Date _____________

Consumer Signature ________________________________ Date _____________

Keystone Representative ______________________________ Date _____________
RESIDENT RIGHTS

Every person has the right to make choices or decisions about matters which affect them. If the person’s judgment is impaired she/he may benefit from guidance. As service providers, we must all value and respect the right of the residents we serve to make choices by respecting their individual preferences, wants and needs. When choices are acknowledged and supported, residents learn that they have some control over events in their home.

The residents we serve are vulnerable to exploitation, exclusion and other forms of rights denial. When resident’s rights are violated it is often due to lack of information about how to encourage and teach residents to be assertive in expressing their rights.

We at Keystone are committed to delivering quality services. As an employee, it is your responsibility to become informed about resident rights and take a proactive approach in helping residents learn about and assert their rights as individuals. This is an ongoing process which sensitizes and empowers the individual to assert his/her own rights and to gain the confidence necessary to express their opinion and enter into the decision making process.

The following is the statement of resident rights practices at Keystone. These are reviewed with the resident upon admission, and annually thereafter.

Individuals participating in the Prader-Willi Program will have exceptions to some of these rights as indicated by an asterisk (*). These exceptions are to insure their health, safety, and well-being while residing within our program.

Resident Rights

Admission procedures and the provision of services shall be made without regard to race, color, religious creed, disability, handicap, ancestry, national origin, age or sex. If you or any person acting on your behalf believes you have been discriminated against you may file a complaint of discrimination with The Director of Quality Improvement, KCR; Bureau of Civil Rights Compliance, Harrisburg, Office of Civil Rights, Philadelphia; or Pennsylvania Human Relations Commissions, Harrisburg.

Upon admission to Keystone, you will be informed of the facility services and related charges, of your rights and responsibilities and of all house rules, policies and regulations governing residents conduct and responsibilities.

You are entitled by law, to all of the rights stated in this document. If you believe any of your rights have been violated, you may file a complaint with the Coordinator of Incident Management.
You also have the right to be informed of these rights, orally and in writing, upon admission and annually thereafter. This list of resident rights is posted conspicuously in the facility. If you do not understand your rights, you may request to talk with a representative of the facility who may explain your rights to you or provide educational materials and information.

In the interest of protecting and promoting the rights of each resident in our facility, we support the following rights:

1. The Right to Exercise Individual Rights – You will be encouraged and assisted to exercise your rights as a resident of the facility and a citizen of the United States. It is your right to voice grievances and file complaints concerning treatment, and to recommend changes in policies and service, without interference, discrimination or reprisal for voicing grievances. You have the right to prompt efforts by the facility to resolve any grievances you may have.

2. The Right To Be Treated with Dignity and Respect in a Safe and Caring Environment Where you can Learn and Grow – The right to be treated with dignity and respect includes the right to be free from:

   a. Physical abuse
   b. Verbal abuse
   c. Sexual abuse
   d. Psychological abuse
   e. Neglect
   f. Corporal punishment
   g. Involuntary seclusion
   h. Physical/chemical restraints imposed for purposes of discipline or convenience.

The right to a safe and caring environment where you can learn and grow includes the right to:

   a. A living environment that is safe and free of hazards
   b. A living environment that promotes your education and your interests

*Within the Prader-Willi Program, the environment is modified to meet the needs of the individual with Prader-Willi Syndrome. The modifications are based on the compulsions of the individual with Prader-Willi Syndrome and are in place to help decrease the compulsion to hoard, forage, and steal food items that if obtained could affect their health negatively. The following environmental modifications are in place:

   a. Refrigerators and cupboards containing food items and kitchen are kept locked.
   b. Garbage is disposed of by staff.
   c. Individuals within the program are encouraged not to discuss food.
   d. Individuals are encouraged not to look into the kitchen during meal preparation.
   e. Food will only be served at designated meal times (Breakfast, Lunch, Dinner and Snack). If meals are not consumed at meal times, they will be discarded.
3. **The Right to Freedom of Participation** – You have the opportunity to participate, at your discretion and by personal choice, in social, religious, and community activities that do not interfere with the rights of other residents in the facility. You will never be required to participate in research projects.

*Individuals within the Prader-Willi Program are encouraged to exercise for one hour daily. This is in place to insure appropriate caloric utilization and to assist in improving the health and stamina of the individuals residing within the program.*

4. **The Right to Have and Manage Personal Funds** – You have the right to access your funds and manage your financial affairs to the fullest extent of your capacity. If you give written authorization to the facility to assist you in managing your finances the facility must hold, safeguard and account for your funds in keeping with established facility policies. You have the right to request and receive access to your account record.

*Due to the compulsion to obtain food items with actual funds access to cash, checks and money orders is limited to directly supervised transactions. Individuals within the program are encouraged to utilize their funds as they are available to purchase needed and desired items.*

5. **The Right to Participate in Program Planning that affects you** – You have the right to be informed of any treatment/programming related to your identified individual needs as well as information related to your medical condition and developmental and behavioral status. You have the right to be informed of any associated risks of such treatment/programming and you have the right to refuse such treatment/programming. This includes the right to refuse a restricted diet and to refuse medical treatment.

*Individuals within the Prader-Willi Program are encouraged to follow the restricted diets prescribed by their physician. However, opportunities for discussion with the physician will be provided to take into consideration exercise and calorie adjustments.*

6. **The Right to Personal Privacy** – You have the right to privacy and confidentiality with respect to:

   a. Accommodations, especially in bedrooms, bathrooms and during personal care.
   b. Medical and other treatments
   c. Written communication, including personal and clinical records
   d. Telephone communication
   e. Visits
   f. Meetings

*Due to the prevalence of self-injurious type behaviors in persons with Prader-Willi Syndrome, some individuals may require supervision while in the bathroom or their bedroom.*
7. **The Right to Personal Possessions** – You have the right to:
   
   a. Receive, purchase, have and use personal possessions as space permits *excluding food items.
   b. Wear your own clothing
   c. Choose your own dress and hairstyle
   d. Separate storage areas for keeping personal property

   *Individuals residing within the Prader-Willi Program should not utilize other person’s property without first obtaining their permission.

8. **The Right to Freedom of Association** – You have the right to communicate, associate and meet privately with whom you choose unless doing so would infringe upon the rights of other residents or clearly pose a threat to your own health and safety. You also have the right to send and receive unopened mail.

9. **The Right to Use the Telephone** – It is your right to have access to telephone with privacy for incoming and outgoing local and long distance calls. Exceptions to this must be identified in your service plan. You are responsible for payment of your personal long distance charges.

10. **The Right to Vote** – You have the right to vote at age 18. You have the right to be assisted, if necessary, in registering and voting in elections.

11. **The Right to Freedom of Religion** – You have the right to practice or abstain from the religious practice of your choice. Others may not impose their religious practices on you.

12. **The Right to be Free from Physical Restraint and Excessive Medication** – you have the right to be free of unnecessary behavior control medication and unnecessary physical restraint. You have the right to competent medical supervision and treatment/programming, as medically appropriate, to reduce your dependency upon such medication and physical restraint.

13. **The Right to Payment for Work** – You have the right to refuse to perform services for the facility except for the upkeep of your personal area and your share in the upkeep of the common living area and grounds. If you do choose to work for the facility, your compensation will be consistent with state and federal law.

14. **The Right to Examine Survey Results upon Reasonable Request** – you have the right to examine and results of the most recent survey of the facility conducted by the Department of Welfare and Quality Improvement with respect to the facility and any plan of correction in effect with respect to the facility.

15. **The Right to Participate in Choosing an Alternate Living Arrangement** – You have the right to participate in the decision to move to another location, unless the right to make this decision has been altered through a legal process. You have the right to receive timely written notice prior to the date of your discharge or transfer.
The statement of resident rights has been explained to me.

NAME ___________________________ DATE ________________

WITNESS ___________________________ DATE ________________

WITNESS ___________________________ DATE ________________
CONSENT FOR RELEASE OF INFORMATION

I hereby authorize ____________________________ to release information to Keystone Community Resource from the record of ________________________________.

<table>
<thead>
<tr>
<th>Name</th>
<th>Birth Date</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The information released will be used for ____________________________.

This release is valid from __________ to __________. I understand, I need not consent to the release of this information; however, I choose to do so voluntarily.

_________________________ Date
Consumer

_________________________ Date
Program Director

_________________________ Date
Parent/Legal Guardian

Verbal Release of information

This section is to be used for clients who are unable to provide a signature. We have witnessed that the client understands the nature of this release and has freely given consent.

_________________________ Date
Witness/Relationship

_________________________ Date
Witness/Relationship

Please return the requested information to:

- [ ] Keystone Community Resources, Inc.
  ATTN:
  100 Abington Executive Park, Suite B
  Clarks Summit, PA 18411

- [ ] Keystone Community Resources, Inc.
  ATTN:
  215 Hickory Street
  Scranton, PA 18505

- [ ] Keystone Community Resources, Inc.
  ATTN:
  1501 Sanderson Avenue
  Scranton, PA 18509

- [ ] Keystone Community Resources, Inc.
  ATTN:
  921 Penn Avenue
  Scranton, PA 18509

IN ACCORDANCE WITH PENNSYLVANIA REGULATIONS:

"This information has been disclosed to you from records whose confidentiality is protected by State Law. State Regulations limit your right to make any further disclosure of this information without the prior written consent of the person to whom it pertains."
ATTACHMENT A  PERSONAL DATA

Name:______________________________________________________________
Male______ Female:_________
Alias or Name Preferred:______________________________________________

Reason for Referral and approximate length of placement desired:_____________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Date of Birth:________________________ Social Security #:____________________
City and State of Birth:________________________ County of Birth:_______________
Race:________________________ Religion:________________________
Citizenship:________________________ Language Spoken or Understood:__________
Eye Color:________________________ Hair Color:________________________
Height:________________________ Weight:________________________

Identifying Marks (Birth marks, scars, tattoos, etc.):________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
ATTACHMENT A

PARENTS/GUARDIANSHIP

Father’s Name: ____________________________________________
Phone Number: (     )-__________

Father’s Address: ____________________________________________
Are there any guidelines on visitation and/or phone contacts:_________ If yes, please enclose legal documents.

Mother’s Name: _____________________________Maiden Name (if applicable)________________
Phone Number: (     )-__________

Mother’s Address: ____________________________________________
Are there any guidelines on visitation and/or phone contacts:_________ If yes, please enclose legal documents.

Siblings (Please give names and ages. If continued contact between siblings is desired, please give address and/or phone numbers):

________________________________________________________________
________________________________________________________________
________________________________________________________________

Other interested family members:

________________________________________________________________
________________________________________________________________
________________________________________________________________

Legal Guardian and Relationship to Applicant: _____________________________
Phone Number: (     )-__________
Address: ____________________________________________

Person to Contact in Case of an Emergency (when the parent/guardian cannot be reached)
________________________________________________________________
Relationship: _____________________________
Phone Number: (     )-__________
Address: ____________________________________________
ATTACHMENT A
CASE MANAGEMENT AND FUNDING INFORMATION

Support Coordination Responsibility(s): Who will be the individual’s Support Coordinator following admission (If two agencies are involved please include both):

1. Name & Title: 
   Address: 
   Phone Number: (+) - Phone Number: (+) - 

2. Name & Title: 
   Address: 
   Phone Number: (+) - Phone Number: (+) - 

Are there any other agencies/advocates/persons involved with the individual's case?:
Name & Relationship to individual: 
Address: 
Phone Number: (+) - Fax Number: (+) - 

Source(s) of income (please list all and include the amount and frequency):
1. SSA: 
2. SSI: 
3. Veteran’s: 
4. Other: 

Who is currently the individual’s Representative Payee? 
Following admission, who will be the individual's Representative Payee? 
Who is responsible for payment of individual's Room and Board? 
Does the individual have a Burial Account? 

Health Insurance Plan and Number (If more than one, please list the primary first):

1. 

ATTACHMENT A

EDUCATIONAL/VOCATIONAL

Name of School last attended: ________________________________________________
District: ________________________________________________________________
Address: __________________________________________________________________
Phone Number: (   ) - _______________
Type of classroom setting (regular or special educ.): ___________________________

PREVIOUS PARTICIPATION IN RESIDENTIAL PROGRAMS

Please begin with most recent.

Facility: __________________________________________________________________
Address: __________________________________________________________________
Phone Number: (   ) - _______________ Fax Number: (   ) - __________
Date of Participation: _________ to _____________
Reason for Discharge: ______________________________________________________

Facility: __________________________________________________________________
Address: __________________________________________________________________
Phone Number: (   ) - _______________ Fax Number: (   ) - __________
Date of Participation: _________ to _____________
Reason for Discharge: ______________________________________________________

BEHAVIORAL HISTORY

Please describe any maladaptive behaviors: ______________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
ATTACHMENT A

MEDICAL INFORMATION

Medications: Please list any medication currently prescribed and taken by the applicant:

Please provide a 10-day supply of medication or original prescription upon admission. If out-of-state, please provide a 30-day supply of medication (out-of-state prescription is not valid).

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Time</th>
<th>Reason Prescribed</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Is medication self-administered?: ____________________________

Female Menstrual History:
Onset of Menstrual Cycle: ____________________________
Pain or Cramps with Menses?: ____________________________
Date of last Menses?: ____________________________

** Please remember to provide us with a Lifetime Medical History or a medical history including current, pertinent medical information, treatment they are receiving and follow-up required once they are admitted into our program.
### Physical Examination

<table>
<thead>
<tr>
<th>Name</th>
<th>Birth date</th>
<th>Age</th>
<th>Telephone number</th>
<th>Date of Exam</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

**Address**

<table>
<thead>
<tr>
<th>Medical History:</th>
<th>Mental Retardation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

**Current Prescribed Medications**

<p>| | | |</p>
<table>
<thead>
<tr>
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</tr>
</tbody>
</table>

**Special Instructions for Medication/Recommended Intervals for Blood work**

**Limitations or Restrictions for Physical Activities**

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>BMI</th>
<th>Vision</th>
<th>Blood Pressure:</th>
</tr>
</thead>
<tbody>
<tr>
<td>______&quot; ______ percentile</td>
<td>______lbs. ______ percentile</td>
<td>______%</td>
<td>Date ______</td>
<td>______ / ______</td>
</tr>
<tr>
<td>______ normal ______ abnormal</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Hearing (Audiometry or Equivalent**

Date: ______
Results: ______ normal ______ abnormal

**Emergency Medical Information/Allergies/Contraindicated Medications**

Free from communicable diseases? ______ yes
If no, what precautions to be taken?
### Eyes

<table>
<thead>
<tr>
<th></th>
<th>Normal</th>
<th>Abnormal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ears/Nose</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mouth/Throat</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lungs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiovascular</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast exam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extremities/Joints</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin/Lymph Nodes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genitals</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Mammogram: Female 40 y > every 2yrs
- Date: ______
- Results: ______ Normal
  - ______ Abnormal

#### Prostate: Male 40 yrs >
- Date: __________________
- Results: ______ Normal
  - ______ Abnormal

### Health Maintenance Needs: Wt Control/Exercise/Hygiene Practices:

#### Diet Restriction: [ ] YES [ ] NO
If yes Diet Restriction Recommendation:

#### DPT: ______ 2 months
- Oral Polio: ______ 2 months
- Measles – 15 months or older ______  (date)
- 4 months
- 4 months
- Mumps – 15 months or older ______  (date)
- 18 months
- 18 months
- Rubella – 15 months or older ______  (date)
- 1-8 years
- 1-8 years
- Variella/Disease ______  (date)
- Booster
- Booster
- TB Testing (within 2 yrs) ______  (date)
- Booster
- Booster
- Booster
- Booster
- Booster

#### Hepatitis B Testing:
- Date: ______
- Results: HbsAg ______ HbcAB ______
- Hepatitis Series:
  - (1) ______
  - (2) ______
  - (3) ______

#### Recommend Further Medical Tests or Examinations on the Following:
- Vision
- Neurology
- Blood Studies
- Blood Pressure Monitoring
- Hearing
- Gynecology
- Immunization (specify)
- Specialty Exams

### Medication Orders/New Prescriptions or Annual Prescription

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

### To the best of my knowledge, the patient’s medical condition and related needs are as listed above. I recommend that the services and care to meet these needs can be provided at the level of care indicated- check only one: [ ] no
<table>
<thead>
<tr>
<th>Nursing Facility</th>
<th>Personal Care Home</th>
<th>ICF/MR care</th>
<th>ICF/ORC Care</th>
<th>Inpatient Psychiatric Care</th>
<th>Other (please specify)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Physician’s Signature</th>
<th>Date</th>
<th>Printed name of Physician</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Physician’s Address:</th>
<th>Telephone Number:</th>
</tr>
</thead>
</table>
ATTACHMENT C: INFORMATION ABOUT HEPATITIS B VACCINE

THE DISEASE

Hepatitis B is a viral infection caused by Hepatitis B Virus (HBVS). Most people with Hepatitis B recover completely, but approximately 5-10% become chronic carriers of the virus. Most of these people have no symptoms, but can continue to transmit the disease to others. Some may develop chronic active Hepatitis and cirrhosis. HBV also appears to be a causative factor in the development of liver cancer. Thus, immunization against Hepatitis B can prevent acute Hepatitis and also reduce sickness and death from chronic active Hepatitis, cirrhosis and liver cancer.

THE VACCINE – DESCRIPTION

-RECOMBIVAX HB* (Hepatitis B Vaccine (Recombinant), MSD) is a non infectious subunit viral vaccine derived from Hepatitis B surface antigen (HBsAg) produced in yeast cells. A portion of the Hepatitis B Virus gene, coding for HBsAg, is cloned into a yeast, and the vaccine for Hepatitis B is produced from cultures of this recombinant yeast strain according to methods developed in the Merck Sharp and Dohme Research Laboratories.

- The antigen is harvested and purified by a series of physical and chemical methods. The vaccine contains no detectable yeast DNA but may contain not more than 1% yeast protein. The vaccine produced by the Merck method has been shown to be comparable to the plasma-derived vaccine in terms of animal potency (mouse, monkey, and chimpanzee) and protective efficacy (chimpanzee and human).
- The vaccine against Hepatitis B, prepared from recombinant yeast cultures, is free of association with human blood or blood products.
-Each lot of Hepatitis B Vaccine is tested for safety, in mice and guinea pigs and for sterility.
-RECOMBIVAX HB is a sterile suspension for intramuscular injection. However, for persons at risk of hemorrhage following intramuscular injection, the vaccine may be administered subcutaneously.

POSSIBLE ADVERSE REACTIONS

Injections site reaction consisting principally of soreness, and including pain, tenderness, pruritus, erythema, ecchymosis, swelling, warmth, and nodule formation. The most frequent systemic complaints include fatigue, weakness, headache, fever, and malaise. Nausea and diarrhea have also been noted.

IF YOU HAVE ANY QUESTIONS ABOUT HEPATITIS B VACCINE, PLEASE ASK

I have read the above statement about Hepatitis B and the Hepatitis B Vaccine. I have had the opportunity to ask questions and understand the benefits and risks of Hepatitis B Vaccination. I understand that three (3) doses of the vaccine are required to confer immunity. However, as with all medical treatment, there is no guarantee that I become immune or that I will not experience any adverse side effects from the vaccine. I request that it be given to me or the person named below of who I am the parent or guardian.

Name of person to receive vaccine ____________________________
Signature of person receiving vaccine or parent/guardian ____________________________

Signature of person refusing vaccine ____________________________
Signature of person who will accept vaccine in future if transferred to acceptable area ____________________________

DATE VACCINATED: 1. ________________ 2. ________________ 3. ________________
**ATTACHMENT D: ANNUAL SKILL ASSESSMENT**

Name: ___________________________ Date of Birth: ___________________________
Date of Admission: _______________ Disability: ________________________________

**Part I of IV - SKILL ASSESSMENT**

This section has been developed for use in assessing skills and serves as a basis for developing the annual service plan and determining progress and growth in various areas. The assessment results are based on interviews, progress notes and observations. The Program Specialist is responsible for coordinating the assessment. Using the criteria below, rate each behavior and use an “x” to indicate those items which do not apply.

1. **Total Guidance:** Individual requires physical manipulation and is assisted through the entire process.
2. **Partial Guidance:** Individual requires gestural (visible signal) or physical prompt (touch) to perform behavior.
3. **Verbal Instruction:** Individual exhibits behavior given only simple instructions and no other help.
4. **Independent:** Individual initiates and performs the behavior without a word, gesture or touch.

**Does Not Apply:** Skill is not applicable to the personal needs or care of the individual.

<table>
<thead>
<tr>
<th>LEVELS OF SUPERVISION - HOME</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can locate basic first aid supplies</td>
<td></td>
</tr>
<tr>
<td>Knows how to respond to emergency situations (ex: fire, tornado, toilet/bathtub overflow, power outage)</td>
<td></td>
</tr>
<tr>
<td>Knows how to evacuate in case of fire</td>
<td></td>
</tr>
<tr>
<td>Knows how to reach designated contact person if needed</td>
<td></td>
</tr>
<tr>
<td>Can locate and dial emergency contact numbers in home</td>
<td></td>
</tr>
<tr>
<td>Can lock/unlock exterior doors without assistance</td>
<td></td>
</tr>
<tr>
<td>Can answer door/phone</td>
<td></td>
</tr>
<tr>
<td>Can manage leisure time safely in the home</td>
<td></td>
</tr>
<tr>
<td>Can be alone in the home without supervision or support from staff. If a “4,” refer to PART III of the Skill Assessment - UNSUPERVISED TIME CONTINGENCY PLAN.</td>
<td></td>
</tr>
<tr>
<td>Length of time the individual can be <strong>alone in the home</strong> without supervision or support from staff</td>
<td>Time</td>
</tr>
</tbody>
</table>

Does the individual require any additional staff support **in the home**? (Yes or No)

**UNSUPERVISED TIME IN A VEHICLE**

<table>
<thead>
<tr>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has “stranger awareness” - knows not to leave with a stranger or let stranger into vehicle.</td>
</tr>
<tr>
<td>Can lock/unlock vehicle door</td>
</tr>
<tr>
<td>Can hook/unhook seatbelt</td>
</tr>
</tbody>
</table>
Knows how to respond to emergency situations while in vehicle (ex.- fire, tornado, vehicle accident)
Can locate basic first aid supplies in vehicle
Ability to open window/door in response to overheating in vehicle
Knows how to reach designated contact person in case of emergency
Can leave car safely, if needed, to locate assistance
Can be alone in a vehicle without supervision from caregiver. If a “4,” refer to PART III of the Skill Assessment - UNSUPERVISED TIME CONTINGENCY PLAN.

| Length of time individual can be **alone in a vehicle** without supervision |
|---|---|---|

<table>
<thead>
<tr>
<th>LEVELS OF SUPERVISION – COMMUNITY or OUTSIDE ON PROPERTY OF HOME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knows how to reach designated contact person in case of emergency</td>
</tr>
<tr>
<td>Able to access community safely (transportation via bus, bicycle, walking, etc.)</td>
</tr>
<tr>
<td>Knows route to and from home</td>
</tr>
<tr>
<td>Able to pay for items with money and knows that he/she should get change back</td>
</tr>
<tr>
<td>Has “stranger awareness”/knows not to leave with a stranger or get into stranger’s vehicle</td>
</tr>
<tr>
<td>Knows what to do if someone approaches and he/she doesn’t feel comfortable with that person</td>
</tr>
<tr>
<td>Knows how to use phone/has access to phone in case of emergency</td>
</tr>
<tr>
<td>Knows how to find/use public restroom.</td>
</tr>
<tr>
<td>Knows name, home address and phone number</td>
</tr>
<tr>
<td>Can manage leisure time safely in the community</td>
</tr>
<tr>
<td>Can be alone outside on property of home without supervision from caregiver. If “4,” refer to PART III of the Skill Assessment – UNSUPERVISED TIME CONTINGENCY PLAN</td>
</tr>
</tbody>
</table>

| Length of time individual can be **alone outside on property of home** without supervision |
|---|---|---|

| Can be alone in the community without supervision from caregiver. If “4,” refer to PART III of the Skill Assessment - UNSUPERVISED TIME CONTINGENCY PLAN. |

| Length of time individual can be **alone in the community** without supervision |
|---|---|---|

<table>
<thead>
<tr>
<th>Does the individual require any additional staff support when in the community? (Yes or No)</th>
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</table>

<table>
<thead>
<tr>
<th>SAFETY SKILLS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge of danger from heat sources and ability to sense and move away quickly from heat sources that exceed 120 degrees F. and are not insulated.</td>
</tr>
<tr>
<td>Knowledge of water safety</td>
</tr>
<tr>
<td>Ability to swim</td>
</tr>
<tr>
<td>Ability to safely use or avoid poisonous material when in their presence</td>
</tr>
<tr>
<td>Internet Safety</td>
</tr>
</tbody>
</table>
**SAFETY SKILLS SECTION**

<table>
<thead>
<tr>
<th>Comments/ Year ________</th>
<th>________</th>
</tr>
</thead>
</table>

**SELF CARE SKILLS: PERSONAL HYGIENE AND GROOMING**

<table>
<thead>
<tr>
<th>Activity</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day time toileting</td>
<td></td>
</tr>
<tr>
<td>Night time toileting</td>
<td></td>
</tr>
<tr>
<td>Combs/brushes hair</td>
<td></td>
</tr>
<tr>
<td>Washes hair</td>
<td></td>
</tr>
<tr>
<td>Oral care: teeth and/or gums</td>
<td></td>
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<tr>
<td>Nail care</td>
<td></td>
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<tr>
<td>Nasal hygiene</td>
<td></td>
</tr>
<tr>
<td>Shaving</td>
<td></td>
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<tr>
<td>Menstrual care</td>
<td></td>
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<tr>
<td>Skin care</td>
<td></td>
</tr>
<tr>
<td>Dressing</td>
<td></td>
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<tr>
<td>Undressing</td>
<td></td>
</tr>
<tr>
<td>Drinking</td>
<td></td>
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<tr>
<td>Feeding him/herself</td>
<td></td>
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<tr>
<td>Ambulation (walking)</td>
<td></td>
</tr>
<tr>
<td>Functional transfers (for example, getting out of bed)</td>
<td></td>
</tr>
<tr>
<td>Able to use adaptive equipment for mobility, as applicable</td>
<td></td>
</tr>
<tr>
<td><em>Bathing or showering (Level of Supervision Item- Home)</em></td>
<td></td>
</tr>
<tr>
<td>INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs)</td>
<td>DATE</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>Able to safely avoid food which trigger allergic symptoms</td>
<td></td>
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<tr>
<td>Uses appropriate table manners</td>
<td></td>
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<tr>
<td>Clothing care/laundry skills</td>
<td></td>
</tr>
<tr>
<td>Able to complete simple household chores (ex. vacuuming, dusting, mopping, sweeping)</td>
<td></td>
</tr>
<tr>
<td>Shopping (groceries, clothing, personal items)</td>
<td></td>
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<tr>
<td>Telephone Use</td>
<td></td>
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<tr>
<td>Technology Use (as applicable)</td>
<td></td>
</tr>
<tr>
<td>Able to identify own medications by name</td>
<td></td>
</tr>
<tr>
<td>Able to identify own medication by dosage</td>
<td></td>
</tr>
<tr>
<td>Able to identify own medication administration time(s)</td>
<td></td>
</tr>
<tr>
<td>Able to identify own medication by right route</td>
<td></td>
</tr>
<tr>
<td>Recognizes that money has value</td>
<td></td>
</tr>
<tr>
<td>Managing money</td>
<td></td>
</tr>
<tr>
<td>Individual is capable of handling the following amount of money at one time</td>
<td>Amount</td>
</tr>
<tr>
<td>Able to tell time on a digital clock (Level of Supervision Item - Community)</td>
<td></td>
</tr>
<tr>
<td>Able to tell time on an analogue clock (Level of Supervision Item - Community)</td>
<td></td>
</tr>
<tr>
<td>*Able to self Medicate (Level of Supervision item - Home and Community)</td>
<td></td>
</tr>
<tr>
<td>*Simple Meal preparation (Level of Supervision Item - Home)</td>
<td></td>
</tr>
<tr>
<td><strong>COMMUNICATION SKILLS</strong></td>
<td><strong>DATE</strong></td>
</tr>
<tr>
<td>--------------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>Communicates verbally with others</td>
<td></td>
</tr>
<tr>
<td>Communicates primarily using gestures and/or sign language</td>
<td></td>
</tr>
<tr>
<td>Use of assistive technology (as applicable- describe below)</td>
<td></td>
</tr>
</tbody>
</table>

Comments/ Year ________

Comments/ Year ________

Comments/ Year ________

Comments/ Year ________
<table>
<thead>
<tr>
<th>SOCIALIZATION SKILLS</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appropriately expresses emotions (happiness, sadness, anger, frustration)</td>
<td></td>
</tr>
<tr>
<td>Carries on a conversation</td>
<td></td>
</tr>
<tr>
<td>Careful with property of others</td>
<td></td>
</tr>
<tr>
<td>Maintains appropriate physical distance in social situations</td>
<td></td>
</tr>
<tr>
<td>Recognizes need for own personal privacy</td>
<td></td>
</tr>
<tr>
<td>Understands privacy needs of others</td>
<td></td>
</tr>
<tr>
<td>Distinguishes between friends and acquaintances</td>
<td></td>
</tr>
<tr>
<td>Understands concepts and consequences of owning, borrowing and lending</td>
<td></td>
</tr>
<tr>
<td>Appropriately greets and says goodbye to others</td>
<td></td>
</tr>
<tr>
<td>Able to self-advocate</td>
<td></td>
</tr>
<tr>
<td>Comments/ Year ________</td>
<td>SOCIALIZATION SKILLS SECTION</td>
</tr>
<tr>
<td>Comments/ Year ________</td>
<td></td>
</tr>
<tr>
<td>Comments/ Year ________</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LEARNING SKILLS</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Processes information independently (understands and remembers information given or spoken)</td>
<td></td>
</tr>
<tr>
<td>Reads</td>
<td></td>
</tr>
<tr>
<td>Writes</td>
<td></td>
</tr>
<tr>
<td>Reasons independently</td>
<td></td>
</tr>
<tr>
<td>Problem Solves (thinks through problems and can identify solutions)</td>
<td></td>
</tr>
<tr>
<td>Makes decisions independently</td>
<td></td>
</tr>
<tr>
<td>Recognizes numbers</td>
<td></td>
</tr>
<tr>
<td>Counts in sequential order</td>
<td></td>
</tr>
</tbody>
</table>
3800 PROGRAM ADDENDUM
COMPLETE FOR 3800 REGULATION PROGRAMS ONLY

Indicate each entry using the criteria below:

Y- Yes
N- No
S- Sometimes

<table>
<thead>
<tr>
<th>FAMILY/LEGAL GUARDIAN</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>The child has an existing family support system</td>
<td></td>
</tr>
<tr>
<td>Return to home is a realistic future goal.</td>
<td></td>
</tr>
<tr>
<td>The family is willing to participate in visitation on or off site.</td>
<td></td>
</tr>
<tr>
<td>The family home is a safe environment for visits or discharge.</td>
<td></td>
</tr>
<tr>
<td>The child understands why he/she is not currently living at home.</td>
<td></td>
</tr>
<tr>
<td>The child understands the goals that need to be met for discharge.</td>
<td></td>
</tr>
<tr>
<td>The family understands the necessary discharge goals.</td>
<td></td>
</tr>
<tr>
<td>The family has the skills necessary to manage their child in the home.</td>
<td></td>
</tr>
<tr>
<td>The family has legal issues to resolve prior to visitation or discharge.</td>
<td></td>
</tr>
<tr>
<td>The family needs to seek and complete treatment on their own.</td>
<td></td>
</tr>
<tr>
<td>The family is able to meet their child’s educational needs.</td>
<td></td>
</tr>
<tr>
<td>The family is cooperating with <strong>court-ordered</strong>/recommended treatment.</td>
<td></td>
</tr>
<tr>
<td>The family is cooperating with their child’s treatment.</td>
<td></td>
</tr>
<tr>
<td>The family covers up for their child’s misconduct.</td>
<td></td>
</tr>
<tr>
<td>The child has legal issues to resolve prior to discharge.</td>
<td></td>
</tr>
<tr>
<td>The family denies that they have issues needing treatment.</td>
<td></td>
</tr>
<tr>
<td>The family cooperates and participates in family counseling.</td>
<td></td>
</tr>
<tr>
<td>The child has been in previous placements outside of the home.</td>
<td></td>
</tr>
<tr>
<td>The family has the financial supports to care for the child.</td>
<td></td>
</tr>
<tr>
<td>The family actively interferes with their child’s treatment.</td>
<td></td>
</tr>
</tbody>
</table>

Comments/ Year ________                         FAMILY/LEGAL GUARDIAN SECTION (3800 only)
ANNUAL ASSESSMENT

Part II - ASSESSMENT RESULTS

1. As a result of the Annual Assessment are additional evaluations needed?
   Year/Date _________________
   ___ No
   ___ Yes  Identify: ________________________________

   Year/Date _________________
   ___ No
   ___ Yes  Identify: ________________________________

   Year/Date _________________
   ___ No
   ___ Yes  Identify: ________________________________

2. Year/Date _________________

   Does the individual have a need for additional staff support? If so, describe the individual’s needs and the additional staffing support necessary for the individual’s health and safety.
Does the individual have a need for additional staff support? If so, describe the individual’s needs and the additional staffing support necessary for the individual’s health and safety.

Does the individual have a need for additional staff support? If so, describe the individual’s needs and the additional staffing support necessary for the individual’s health and safety.

3. As a result of the Annual Assessment the following list of strong likes, dislikes, strengths and needs has been developed:

Strong interest, likes, dislikes, strengths and needs:

Strong interest, likes, dislikes, strengths and needs:

Strong interest, likes, dislikes, strengths and needs:

As a result of the Annual Assessment the following recommendations for specific areas of training, program planning, and services have been made:
The Annual Skill Assessment was coordinated by the Program Specialist with assistance from the following individuals:

Year/Date ________________

PRINTED NAME SIGNATURE RELATIONSHIP
________________________ ____________________________ Self
________________________ ____________________________ Program Specialist
________________________ ____________________________
________________________ ____________________________
________________________ ____________________________

Year/Date ________________

PRINTED NAME SIGNATURE RELATIONSHIP
ATTACHMENT E:

This Agency Offers Voter Registration

Ask staff for any assistance you may need to complete a voter registration application.

You may use the attached form to register to vote.

If you have moved or changed your name since you last registered to vote, you should use it to update your voter registration.

Please first complete the required information in this box:

“If you are not registered to vote where you live now, would you like to apply to register to vote here today?”

Check one box:  [ ] Yes
   [ ] No
   [ ] I’m already registered to vote at my current address.

Print name __________________________

Sign name ___________________________ Date ____________

If you do not check either box, you will be considered to have decided not to register to vote at this time.

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

If you complete the attached form and leave it with this agency, you will receive your voter registration card and the address for where you vote in the mail.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Secretary of the Commonwealth, Pennsylvania Department of State, 302 North Office Building, Harrisburg, PA 17120, or call toll-free at 1-800-552-VOTE (8683).

For staff only: If client refuses to check or sign the above, print their name and provide the date above and then place your initials here ____________