



Project HEART

Assessment and Consent

Please fill out the Information page and attached consent forms, once finished contact our Project Heart Coordinator at 636-757-0515, to schedule an intake meeting. This meeting is necessary in order for us to help all individuals succeed and be supported appropriately. An intake meeting is required prior to attending the first class; we will discuss class options at this meeting. The packet may also be emailed to bethh@willowsway.org

Participant Name (First, Middle, Last) _____

Phone Number: (_____) _____

Address: _____

Street City State Zip Code

Date of Birth: _____ Email Address(es) _____

Does the Individual Drive: _____ List Allergies: _____

Emergency Contact: _____

Name Relationship

(_____) (_____) (_____) _____

Home Cell Phone Work

1. What does the individual require assistance with?

- reading math skills
- writing classroom behavior (turn taking, speaking at appropriate times)
- test taking independent in all areas listed

2. Project Heart classes are led by 2 teachers in a setting with up to 20 people. Will the individual be able to succeed in this setting? yes no

If unable to succeed in this setting we ask that a support person attend the classes as well.

3. Does the individual answer yes/no questions with accuracy?

- most of the time occasionally some of the time rarely

4. What type of the support does the individual receive?

- lives on own, case management only lives with family and attends school only
 lives on own, up to 15 support hours a week lives with support during waking hours only
 lives with family, case management only lives with support 24 hours a day
 lives with family, up to 15 support hours a week _____other

5. What does the individual do (school/career) during the day/week?

- attends school works at workshop stays at home attends day program
 works part-time in competitive job works full-time in competitive job

6. Please list any additional information below that you feel may be pertinent for the staff at Project

HEART to be aware of:

Client Rights

You have the right to:

be treated with dignity and respect.

receive good medical treatment from a doctor of your choice.

live in a clean, safe place.

choose to attend or not to attend religious services and worship in your own way.

receive the support you need to help you do your best and meet your goals.

choose the goals in your Person Centered Plan.

receive an explanation of services provided by Willows Way, as well as other agencies.

refuse to participate in experimental research.

live in an environment that lets you be as independent as possible.

refuse medical treatment.

receive a well-balanced diet.

be protected from bad or unfair treatment.

be protected from people who might take advantage of you.

make a complaint and have people help you.

have your own attorney.

contact your guardian, family members, friends, DMH case manager, Human Rights Committee.

have information about you kept private.

communicate privately by mail, telephone, internet, or in person.

be paid fair wages for work you do.

not work.

wear the clothes you want and keep your personal possessions.

have friends of your choice.

access your medical/mental health records and ask questions.

be free from chemical or physical restraint, seclusion, or isolation.

have your money spent only for you.

keep and spend your money and manage your own finances.

receive the services that best meet your needs and help you to do things on your own to the best of your ability.

participate in or refuse services.

try new things.

be informed of your rights and responsibilities and any rules you must follow.

vote (if you do not have a full guardian).

have intimate relationships with persons of your choosing.

pursue a driver's license (if you do not have a full guardian).

have a guardian to help you make decisions, if needed.

choose what agency provides your services.

receive services no matter what your race, color, sex, age, religion, national origin, or disability.

Client Responsibilities

You have the responsibility to:

treat others with respect and dignity.

be honest with your doctor/psychiatrist/therapist, listen to his/her suggestions, and follow them in order to get better.

ask questions about your treatment, services, or medications.

keep your home clean and safe.

ask for help when you need it.

ask for services when you need them.

ask staff to help you practice your religion/spirituality.

work toward your plan goals to the best of your ability and change them as necessary.

work cooperatively with staff.

not yell and cuss at others, call them names, or threaten them.

be informed before you sign permission for anything.

obey the law.

see that your activities do not hurt someone else or yourself.

let someone know where you are so others know you are safe.

keep yourself healthy by eating nutritious foods and following your diet, if needed.

tell someone you trust if you are being hurt or mistreated, or if you see someone else being hurt or mistreated.

tell the truth about situations where you believe your rights have been violated.

respect the privacy of others.

get permission from the owner before using/taking something that does not belong to you.

pay your bills and live within your financial means.

wear appropriate clothing for the setting.

keep your possessions clean and neat, to replace as needed, and to discard as necessary.

be courteous to your guests.

tell your staff any medical/mental health information needed to support you.

spend your money wisely, budgeting for necessities before spending on desires.

apply what you have learned in order to live independently.

help plan for your future by attending your Person Centered Planning meeting and expressing your dreams/goals/needs.

carefully consider the possible good and bad consequences of a decision before making it.

consider how your decision will affect other people.

not violate someone's rights.

education yourself on the issues and candidates before casting your vote.

communicate your preferences and opinions.

drive safely and maintain car insurance.

advocate for yourself and your rights.

fulfill your responsibilities.

___ I/We understand Project HEART activities and classes are to provide participants with information and skills to have a healthy life. I/We understand the risks involved in participation in the classes including those that are exercise and cooking related.

___ I/We give permission for any known personal health information to be given should the participant need to be treated for illness or injury.

I/We have read this carefully and know it contains a release effective for one year from the date of my/our signature(s).

| | | |
|-----------------------------|-----------|-------|
| _____ | _____ | _____ |
| Name of Participant (print) | Signature | Date |

| | | |
|--------------------------|-----------|-------|
| _____ | _____ | _____ |
| Name of Guardian (print) | Signature | Date |

Guardian Address

DDRB Client Information Release Form

The Developmental Disabilities Resource Board of Saint Charles County (DDRB) is a Senate Bill 40 Board that enables St. Charles County voters to tax themselves to pay for services for people with certain disabilities. The DDRB provides funding for the programs and services you receive from Willows Way.

The DDRB periodically reviews individual files/records to assure compliance with agency outcomes, eligibility and quality assurance. This is notice to you that as a funding entity the DDRB will have access to your information on file with Willows Way for the purpose of planning and review.

The information reviewed/obtained by the DDRB may be released to a professional consultant contracted by the DDRB for the purpose of general data collection to identify trends in the service delivery. Personal identifiable data will not be released to any other party. The DDRB maintains its client information in accordance with the Health Insurance Portability and Accountability Act (HIPAA). The DDRB does not sell or share its customer information with other entities except as noted above.

By signing this document, you give permission for Willows Way to share information with the DDRB to help with better continuity of the supports you receive.

I agree to allow Willows Way to share information regarding my records with the Developmental Disabilities Resource Board of St. Charles County. I understand that refusal to sign this document will forfeit my ability to receive funds from DDRB.

This release is valid for one year from date of signature.

Printed Name of Service Recipient

Date

Street Address

City

State

Zip Code

Signature of Service Recipient

Date

Printed Name and Signature of Parent/Guardian

Date

Printed Name and Signature of Willows Way Representative

Date

Willows Way, Inc.
800 Friedens Rd., Suite 100, St. Charles, MO 63303 636-947-6591 FAX 636-947-7385

Media Release and Waiver

I authorize Willows Way, Inc. to use the following information about _____

_____ Name _____ quote _____ video
_____ Picture _____ comments _____ personal information

for the following purpose(s):

_____ Newsletter _____ video _____ training
_____ Brochures _____ website/ Facebook _____ external publications
_____ Event materials _____ Presentation materials

I release Willows Way from any liability from using or disclosing my permitted information. I understand that the information used or disclosed may be subject to re-disclosure by the person(s) or class of person(s) receiving it and no longer protected by the federal privacy regulations.

I understand that I may revoke this authorization at any time by notifying the Privacy Officer at Willows Way, **Tom Bay**, in writing. However, I understand that if I revoke this authorization, it will not have any affect on actions already taken by Willows Way before revocation of this release. I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain services.

I understand this authorization will expire on: _____, 2_____.

Client Printed Name (First, Last, MI or D.O.B.): _____

Client Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Co-Guardian Signature: _____ Date: _____

Agency Representative Printed Name/Title _____

Agency Representative Signature: _____ Date: _____

A photocopy of this release is deemed valid

| | |
|---|--|
| Distribution: | |
| _____ Copy given to client/guardian | _____ Copy(s) placed in client book(s) |
| _____ Electronic copy placed in client file | |