Project HEART

Assessment and Consent

Please fill out the Information page and attached consent forms. Once completed, turn in all forms and include a copy of your most recent ISP to the Project Heart Coordinator, and you will be contacted to schedule an intake meeting. The packet may be emailed to Kristenj@willowsway.org or faxed to 636-757-0518. An intake meeting is required prior to attending the first class to discuss the supports you may need to ensure your success. This is the time when interested individuals should report any necessary information needed in order for us to support them appropriately, we will also discuss class options at this meeting.

Name (First, Middle, Last) _____

Phone Number: (_____) _____ DMH Number:_____

Social Security Number:_____ Case Manager:_____

Address:_____
Street City State Zip Code

Date of Birth:_____ Email Address(es)_____

Do you drive: _____ Do you have any allergies: _____

Emergency Contact: _____
Name Relationship

(_____)_____(_____)_____(_____)_____
Home Cell Phone Work

1. What do you 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 you 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. Do you answer yes/no questions with accuracy?

___ most of the time ___occasionally ___some of the time ___rarely

4. What type of the support do you 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 do you do (school/career) during the day/week?
___ attend school ___ work at a workshop ___stay at home ___attend day program

___ work part-time in competitive job ___work full-time in competitive job

6. We encourage interested participants to provide Project HEART staff with any information from their Individual Support Plan that may help better assist them in classes. 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 understand Project HEART activities and classes are to provide participants with information and skills to have a healthy life. I understand the risks involved in participation in the classes including those that are exercise and cooking related.

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

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

_____	_____	_____
Name (print)	Signature	Date
_____	_____	_____
Name of Guardian (if applicable) (print)	Signature	Date

_____

Guardian Address (if applicable)

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 outvomes, 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