Location:_____ Form #157DP – 05/15

Case #:_____

The Center

DAY PROGRAM INTAKE CHECKLIST

Name: _____ Date of Birth _____

All documents should be submitted to Records Management within 5 working days <u>prior</u> to the entry date.

PRE – ADMISSION DOCUMENTATION REQUIREMENTS

Internal Documents Required Before Starting

_____ Application for Services #145 *(revised 04/2013)*
_____ Admission Funding Data #151 *(revised 09/2015)*
_____ Emergency Information and Authorization #41
_____ Advanced Directives #45
_____ Notice of Privacy Practices Acknowledgment #110
_____ Rights Acknowledgment #111
_____ Medication Policy #06
_____ Seizure Classification #165 *(if applicable)*
_____ Admissions Medication History #18
_____ Physician's Orders #08 *(if applicable)*
_____ DHS #3055 Physician's Orders *(if applicable)*
_____ Physical Examination #04 *(less than 1 year old)*
_____ Copy of TB Test #76 *(less than 1 year old)*
_____ Copy of DPT/td #120 *(less than 10 years old)*

External Documents Required Before Starting

_____ Copy of Letter of Guardianship and
Verification of annual renewal *(if applicable)*
_____ DMR – Determination of Mental Retardation **or**
_____ Psychological Evaluation *(less than 10 years old)*
_____ ICAP *(if applicable)*
_____ Full Body Photo _____ Head and Chest Photo

Additional Documents – if available

_____ Copy of Birth Certificate
_____ Copy of Texas Identification Card
_____ Copy of Social Security Card
_____ Copy of Medicaid Card
_____ Copy of Medicare Card
_____ Copy of HMO/PPO/Other Insurance Card
_____ Copy of SSI Award Letter

30 DAY ASSESSMENT DOCUMENTATION REQUIREMENTS

A T E S

_____ 30 Day Person Directed Support Plan *(#49 or #50)*
_____ Team Identification #28 *(if applicable)*
_____ External Coordinator ID #131 *(if applicable)*
_____ Job Readiness Profile #87 *(if applicable)*
_____ Day Program Personal Skills Profile #107 *(if applicable)*
_____ Know Your Caseload #139
_____ Training Objective #25 *(if applicable)*
_____ Medication History Update #53 *(if applicable)*
_____ Physician's Orders #08 *(if applicable)*

A A C

_____ DHS #3049 Health Assessment
_____ DHS #3050 Individual Service Plan
_____ DHS #3055 Physician's Orders
_____ Team Identification #28
_____ Frequency Chart #38 *(if applicable)*
_____ Day Program Personal Skills Profile #107
_____ Know Your Caseload #139
_____ Nutritional Assessment #42 *(if applicable)*

OTHER DOCUMENTS RECEIVED

_____Other_____ _____Other_____
_____Other_____ _____Other_____

THE CENTER

APPLICATION FOR SERVICES / ENROLLMENT FORM

GENERAL INFORMATION

DATE OF APPLICATION: _____

NAME OF APPLICANT: _____
Last Name First Name Middle Initial

PRESENT ADDRESS: Street Address: _____

City: _____ State: _____ Zip: _____

PHONE NUMBER: [Home] (____)_____ [Emergency] (____)_____

EMERGENCY CONTACT: _____ **RELATIONSHIP:** _____

DATE OF BIRTH: _____ **AGE:** _____ **S/S #**_____ **SEX**: ☐ Male ☐ Female

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

PRIMARY LANGUAGE: ☐ English ☐ Spanish ☐ Other, specify: _____

COMMUNICATION MODE: ☐ Verbal ☐ Gestures ☐ Vocalizations ☐ Sign Language

COMMUNICATION DEVICE(S): _____ **RELIGION:** _____

HAIR: _____**EYE:** _____**HEIGHT:** _____**WEIGHT:** _____**ETHNICITY:** _____

CLIENT OR GUARDIAN _____ **DATE:** _____
Signature

FOR OFFICE USE ONLY

PROGRAMS APPLYING FOR

☐ AAC - West Dallas
☐ ATES – Day Habilitation
☐ ATES - Vocational
☐ ATES – Young At Heart
☐ Cullen - Assisted Living Room # _____
☐ Cullen - Independent Living Room #_____
☐ Willow River Farm House # _____
☐ WRF-Assisted Living House # _____
☐ WRF-Day Program
☐ HCS Foster Companion Care
☐ HCS Supervised Home Lvg
☐ HCS Residential Supervised
☐ HCS Supported Living

FUNDING

☐ Private Pay ☐ TXHML ☐ ICF/MR ☐ The Center HCS

☐ Medicaid MCO ☐ Contract ☐ Other HCS: _____

DATE FUNDING VERIFIED by ADMISSIONS COORDINATOR: _____

ADMISSION DECISION Date Applicant Informed of Decision: _____

☐ Approved ☐ Approved - Waiting List ☐ Not Approved

Enter Date: _____ Entered on List: _____ Reason: _____

Assigned Program Coordinator: _____

_____ _____ _____
Signature of Social Worker Signature of Dept. Director/Manager Signature of Chief Operating Officer

THE CENTER
APPLICATION FOR SERVICES / ENROLLMENT FORM

NAME:_____ **DOB:** _____ **DATE:** _____

FAMILY/CONTACTS

NAME OF FATHER: _____

Describe Contact: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: [Home] (____)_____ [Work] (____)_____

Phone: [Cell] (____)_____ **Email Address:** _____

NAME OF MOTHER: _____

Describe Contact: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: [Home] (____)_____ [Other/Emergency] (____)_____

Phone: [Cell] (____)_____ **Email Address:** _____

NAME OF EMERGENCY CONTACT: _____

Relationship to Applicant: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: [Home] (____)_____ [Other/Emergency] (____)_____

Phone: [Cell] (____)_____ **Email Address:** _____

NAME OF EMERGENCY CONTACT: _____

Relationship to Applicant: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: [Home] (____)_____ [Other/Emergency] (____)_____

Phone: [Cell] (____)_____ **Email Address:** _____

THE CENTER
APPLICATION FOR SERVICES / ENROLLMENT FORM

NAME:_____ **DOB:** _____ **DATE:** _____

BACKGROUND

PLACE OF BIRTH: City: _____ County: _____ State: _____

US CITIZENSHIP ☐ Yes ☐ No **LEGAL STATUS** ☐ Competent ☐ Incapacitated

if has a court appointed Guardian:
Name of Guardian: _____

Relationship to Applicant: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: [Home] (____)_____ [Other/Emergency] (____)_____

Date Appointed by Court: _____ Court Case Number: _____

County: _____ State: _____

INSURANCE

MEDICAID
☐ Yes, Number (#): _____
☐ No, have applied and been denied
☐ No, have never applied

MEDICARE
☐ Yes, Number (#): _____
☐ No, have applied and been denied
☐ No, have never applied

HMO/PPO ☐ Yes, Policy Number (#): _____
Company Name: _____
☐ No

LIFE INSURANCE (needed only if applying for a residential program) ☐ Yes, Policy Number (#): _____
Company Name: _____
☐ No

BURIAL INSURANCE (needed only if applying for a residential program) ☐ Yes, Policy Number (#): _____
Company Name: _____
☐ No

INCOME

ESTIMATED ANNUAL INCOME OF APPLICANT: _____

PRIMARY SOURCE OF INCOME: ***(check one)***
☐ SSI ☐ Wages ☐ Other, specify: _____

OTHER MEANS OF FINANCIAL SUPPORT: _____

DESCRIBE APPLICANT'S PARTICIPATION IN COMMUNITY/NEIGHBORHOOD:

THE CENTER
APPLICATION FOR SERVICES / ENROLLMENT FORM

NAME:_____ **DOB:** _____ **DATE:** _____

MOBILITY/SELF CARE

Mobility ***(check one)***

☐ Walks Independently ☐ Walks with Assistance from Others
☐ Uses Wheelchair Independently ☐ Uses Wheelchair with Assistance from Others

Describe/List Any Adaptive Equipment Used for Mobility: _____

Describe Assistance Needed to Get from One Place to Another: _____

Eats Meals Independently ☐ Yes ☐ No, please describe help needed: _____

Bathes Independently ☐ Yes ☐ No, please describe help needed: _____

Dresses Independently ☐ Yes ☐ No, please describe help needed: _____

THE CENTER
APPLICATION FOR SERVICES / ENROLLMENT FORM

NAME:_____ **DOB:** _____ **DATE:** _____

Uses Rest Room Independently ☐ Yes ☐ No, please describe help needed: _____

_____

_____

Describe Any Other Assistance Needed/Comments: _____

_____

_____

_____

_____

_____

MEDICAL/HEALTH CARE

PRIMARY PHYSICIAN: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: [Office] (____)_____ [Fax] (____)_____

KNOWN ALLERGIES ***(food, medication, other)***: _____

_____

EXISTING MEDICAL CONDITIONS/DIAGNOSES: _____

_____

_____

SEIZURES ☐ No ☐ Yes, please explain: _____

_____

_____

HEARING IMPAIRMENT ☐ No ☐ Yes, please explain: _____

_____

_____

THE CENTER
APPLICATION FOR SERVICES / ENROLLMENT FORM

NAME:_____ **DOB:** _____ **DATE:** _____

VISION IMPAIRMENT ☐ No ☐ Yes, please explain: _____

_____

_____

ADAPTIVE EQUIPMENT/POSITIONING ☐ No ☐ Yes, please explain: _____

_____

_____

_____

TAKES MEDICATIONS INDEPENDENTLY ☐ Yes ☐ No, please explain: _____

_____

_____

MEDICAL/HEALTH CARE

CURRENT MEDICATIONS

Medication	Date Prescribed	Reason for Use

MEDICAL HISTORY **please list/describe hospitalizations and significant illnesses**

Date	List or Describe Hospitalization or Surgery or Illness

THE CENTER
APPLICATION FOR SERVICES / ENROLLMENT FORM

NAME:_____ **DOB:** _____ **DATE:** _____

ADDITIONAL COMMENTS RELATED TO MEDICAL/HEALTH CARE: _____

FOR OFFICE USE ONLY

Advance Directive ☐ No ☐ Yes (attach copy) DNR Order ☐ No ☐ Yes (attach copy)

INTERACTIONS

DESCRIBE HOW APPLICANT INTERACTS WITH OTHERS: _____

DESCRIBE BEST WAY TO INTERACT WITH THE APPLICANT: _____

DESCRIBE THINGS THAT THE APPLICANT LIKES OR THAT MOTIVATE HIM/HER:

THE CENTER
APPLICATION FOR SERVICES / ENROLLMENT FORM

NAME:_____ **DOB:** _____ **DATE:** _____

DESCRIBE APPLICANT'S ABILITY TO MAKE CHOICES: _____

_____

_____

_____

DESCRIBE ANY SIGNIFICANT BEHAVIORS: _____

_____

_____

_____

_____

EDUCATION/SERVICES/EMPLOYMENT

EDUCATION (schools attended)

Name of School	City	State	Dates Attended From/To	Highest Grade Completed

CURRENT SERVICES ***(includes residential, vocational, job training, in-home care)***

Date Services Began	Type of Service(s)	Agency Providing the Service(s)	City	State

THE CENTER
APPLICATION FOR SERVICES / ENROLLMENT FORM

NAME:_____ **DOB:** _____ **DATE:** _____

PREVIOUS SERVICES ***(includes residential, vocational, job training, in-home care)***

Dates of Service From/To	Type of Service(s)	Agency that Provided the Service(s)	City	State

CURRENT EMPLOYMENT

Name of Employer	Job Title	Hire Date	Wage	Location

PREVIOUS EMPLOYMENT

Name of Employer	Job Title	Dates of Employment	Wage	Location

TRANSPORTATION

TRANSPORTATION ***(check all that apply)***

- ☐ Uses City Bus/Cab Independently
- ☐ Family/Friends Provide Transportation
- ☐ Operates Own Vehicle (Car/Bike)
- ☐ Uses Para Transit (Metro Lift)
- ☐ Agency (group home) Provides Transportation
- ☐ Other, _____

Comments: _____

_____

THE CENTER
APPLICATION FOR SERVICES / ENROLLMENT FORM

NAME:_____ **DOB:** _____ **DATE:** _____

Has the Applicant ever been Convicted (or adjudicated) of a public offense? ☐ No ☐ Yes
If yes, will the conviction interfere with the admission at The Center? ☐ No ☐ Yes

If yes, please explain: _____

_____

_____

Please submit documents requested on the Application for Services Documentation Checklist.

Your application will not be considered complete until all documents have been given to The Center's Admissions Coordinator.

Please contact The Center's Admissions Coordinator (713) 525-8318 with any questions or for assistance.

I agree that the information provided is, to the best of my ability, accurate and complete.

_____ _____
Applicant Signature **Date** **Guardian Signature** **Date**

_____
Witness Signature **Date**

Form #151 – 01/98
Revised 09/15

THE CENTER
ADMISSION FUNDING DATA

NAME OF INDIVIDUAL: _____
Last Name First Name Middle Initial

PRESENT ADDRESS: Street Address**:** _____

City**:** _____ State**:** _____ Zip**:** _____

PHONE NUMBER: [Home] **(____)**_____ [Other/Emergency] **(____)**_____

DATE OF BIRTH: _____ **GENDER:** ☐ Male ☐ Female

SOCIAL SECURITY NUMBER: _____

PROGRAM(S)	LOCATION CODE	ADMISSION DATE	FUNDING SOURCE(S)	FUNDING AMOUNT
Adult Activity Center	**AAC**			
ATES - Caning	**CAN**			
ATES - West Dallas Day Habilitation Classroom	**DHC**			
ATES - West Dallas Day Habilitation Workshop	**DHW**			
ATES - West Dallas Vocational Workshop	**WDW**			
ATES - Young At Heart	**YAH**			
Cullen - Assisted Living	**AL**			
Cullen - Independent Living	**IL**			
Willow River Farm - Residential	**WRF**			
Willow River Farm - Assisted Living	**WRFAL**			
Willow River Farm – Day Habilitation	**WRFDH**			

INVOICE MAILING ADDRESS:

Street Address: _____

City: _____ State: _____ Zip: _____

COMMENTS:_____

_____

_____

_____

_____
Signature of Program Director/Manager **Date**

_____
Signature of Admission Coordinator **Date**

Send a copy to Accounting within 5 working days prior to entry date; original submitted with Intake Checklist to Records.

Location:_____

Case #:_____

Form #18 – 03/79
Revised 09/12

The Center

ADMISSION MEDICATION HISTORY

NAME:_____ DATE OF BIRTH:_____

List any allergic reactions to medications:_____

A. CURRENT MEDICATIONS:

Name of Medication Presently Prescribed	Reason for Medication	Date Prescribed	Prescribing Doctor	No. of Times per Day	How Much Medicine Each Time	Where is Medication Taken

B. PAST MEDICATIONS

Name of Medication Prescribed	Reason for Medication	Date Prescribed	Date Discontinued

SIGNATURE:_____ DATE:_____
(Individual / Parent / Guardian)

Location:_____

Case#: _____

The Center
PROGRAM INFORMATION RECEIPT

Name of Individual: _____ Date of Birth: _____

Note check off all applicable handouts.

_____ Admission and Discharge Criteria Information

_____ Fee Policy and Fee Payment Agreement

_____ Adult Rights Handbook

_____ Notice of Privacy Practices

_____ Adult Activity Center Services Guide / Program Information

_____ Adult Training and Employment Services Guide / Program Information

_____ Resident's Handbook

_____ Other:_____

_____

_____

I have received a written copy of the above checked items. The items checked off have been explained to me in language that I can understand. I was given the opportunity to discuss and ask questions pertaining to the received copies. Any questions I had have been answered. I understand that I can ask more questions later if I need to.

_____

Signature of Individual Served Date

_____

Signature of Parent/Guardian Date
(Required if the individual is under age 18 or has a legal guardian.)

_____

Signature of Witness Date
(Required if the signature of the individual served/parent/guardian is not legible.)

The Center
3550 West Dallas Houston, Texas 77019
(713) 525-8400

REPORT OF PHYSICAL EXAMINATION

NAME: _____ **DATE OF BIRTH:** _____ **M**____ **F**____

SECTION I - Condensed Medical History: _____

_____

_____

_____

Known Allergies: _____

SECTION II - Medication Presently Prescribed and Reason for Use: _____

_____

_____

_____

SECTION III - Results of Physical Examination:

HT: _____ **WT:** _____ **PULSE RATE:** _____ **BLOOD PRESSURE:** _____

NUTRITIONAL STATUS: _____ **Good** _____ **Fair** _____ **Poor - Recommendations (DIET):**

_____

EYES: _____ **Normal** _____ **Abnormal - Comments:** _____

_____

Describe ability to see: _____

Visual Acuity: R. 20/_____ **L. 20/**_____ **With glasses: R. 20/**_____ **L. 20/**_____

EARS: _____ **Normal** _____ **Abnormal - Comments:** _____

_____

Describe ability to hear: _____

NOSE: _____

MOUTH: _____

THROAT & NECK: _____

BREAST: _____

THORAX & LUNGS: _____

NAME: _____ **DATE OF BIRTH:** _____

CIRCULATORY SYSTEM: Heart _____

EXTREMITIES: _____

ABDOMEN: _____

HERNIAS: _____

GENITO-URINARY-GYNECOLOGICAL & RECTAL: _____

_____

OSSEOUS & MUSCULAR SYSTEM: _____

SKIN: _____

NEUROLOGICAL: _____

MENTAL STATUS: _____
If on psychoactive medication, note any Side Effects and results of Assessment of Involuntary Movement:

_____

HISTORY OF SEIZURES: _____ **No** _____ **Yes, list type:** _____
If on anticonvulsant medication, comment on any side-effects noted:

_____

DIAGNOSTIC FINDINGS AND/OR IMPRESSIONS: _____

_____

Is this person free from communicable diseases? _____ **YES** _____ **NO - If No, Explain:** _____

_____

Is this person able to attend program without restrictions? _____ **YES** _____ **NO - If No, Specify:** _____

_____

OTHER EXAMINATIONS/LABORATORY TESTS NEEDED: _____

_____

(Forward results when completed)

_____
Physician's Signature

_____
Print or Type Physicians Name

_____

_____
Full Address and Telephone Number

_____
Date of Examination

FOR AGENCY USE ONLY:

Reviewed by: _____

Date: _____

RESIDENTS ONLY:

The above results have been explained to me.

_____
Resident's Signature

Location: _____ **The Center** Form #06
Revised 11/16

Case #: _____

MEDICATION POLICY

Name: _____ Date of Birth: _____

The following items apply to all persons served receiving medications/treatments in any Center program:

1. A doctor's order for the medication/treatment must be provided to The Center before the medication/ treatment can be given. This includes:
   * all prescribed medications/treatments, routine or short term
   * over-the-counter medications/treatments

   Written doctors' orders are required. A verbal order from the doctor taken by a nurse is acceptable so long as the nurse follows proper documentation procedures and obtains the physician's original signature within 72 hours from when the order was taken. If needed, forms to give to the doctor are available from The Center staff.

2. All medications/treatments must be in pharmacy labeled containers. Samples of medications that a doctor may provide need to be in a container with the name of the medication, instructions for use, the prescribing doctor's name and the date it was provided to you.

3. The label on the medication/treatment container must match the doctor's order. If the label does not match, the medication/treatment will not be accepted or maintained. Only a pharmacist may change a label.

4. Medications/Treatments with worn, illegible, missing or altered labels will not be accepted or maintained. Additionally, medications/treatments that are outdated, expired, stopped or discontinued will not be accepted or maintained.

5. All medications/treatments will be administered by licensed/certified staff **unless a doctor's order is obtained authorizing a person served to take his/her medication under supervision or independently**.

6. Doctor's orders must be reviewed as follows:
   * routine prescription and over-the-counter medications/treatments must be renewed at least every 12 months
   * psychoactive medications must be renewed at least every 6 months
   * authorization for supervised administration of medication or self administration of medication without supervision must be renewed at least every 12 months
   * other orders should be renewed as needed, but at least every 12 months
   * orders to discontinue medication should be provided as needed

7. Each doctor's order shall be explained to the person served/Guardian and/or Medical Power of Attorney in order to obtain consent for the medication/treatment.

8. The Center's residential facility, Cullen Residence Hall, will provide transportation to client's chosen physician as needed. It is expected that a Cullen resident will be taken care of based on the current medical guidelines, **however if the family member (acting under a Medical Power of Attorney) or as Guardian refuses care, they will be asked to get their own physician or document this as The Center and its staff will not be held liable for any outcomes from their decision.**

I have received a copy and had the above policy explained to me in a language, which I understand. I was offered a chance to discuss these topics, and any questions I had have been answered. I know that I can ask more questions later, if I need to.

_____ _____
Signature of Person Served Date

_____ _____ _____
Signature of Guardian Date
(Required if the person served is under age 18 or has a legal guardian.)

_____ _____
Signature of Staff Person Explaining the Form / Witness Date

Location: _____

Case #: _____

The Center
3550 West Dallas
Houston, Texas 77019
(713) 525-8400

Form #8 - 08/84
Revised 09/12
Non-Residential Services

PHYSICIAN'S REQUEST FOR ADMINISTRATION OF MEDICATION

Name: _____ Birth Date: _____ Date: _____

Diagnosis: _____

Allergies: _____

Reason for referral to physician: _____

Diet: _____

CURRENT ORDERS: Signature of physician indicates these orders are renewed unless discontinued in new order section below.

Medication / Strength	Route	Directions	No. Units / Stop Order Date	Medication / Strength	Route	Directions	No. Units / Stop Order Date

NEW ORDERS: 1) Generic Equivalent approved for use on all legend and non-legend medications unless otherwise indicated. 2) Please indicate calendar-date stop order for each medication ordered. Medications for behavior management must, according to standards under which The Center operates, have a calendar date stop order of 30 days or less.

Medication / Strength	Route	Directions	No. Units / Stop Order Date	Medication / Strength	Route	Directions	No. Units / Stop Order Date

Activity Restrictions: _____

TEST RESULTS: Please indicate any laboratory tests, x-rays, blood levels, etc. performed. You will be called for results if they are unavailable at time of this report (continue on reverse side if necessary). _____

_____

Return Appointment Date / Time: _____ / _____

Physician's Signature: _____ Date: _____

(Please print or type the Physician's Name, Office Address & Telephone Number on the line below.)

_____

Signature of Nurse Receiving Orders (LVN/RN) _____ Date / Time _____ / _____

This is your permission to administer the above medications, treatments, and/or procedures as requested by physician.

Signature of Individual / Guardian: _____ Date: _____

Location: _____ Form #120 – 11/2007
Revised 05/13

Case # _____

The Center

3550 West Dallas - Houston, Texas 77019
MAIN 713-525-8400 FAX 713-525-8493

Tetanus/Diphtheria (Td) Immunization

INDIVIDUAL _____ DATE _____

DATE OF BIRTH _____ SOCIAL SECURITY # _____

As part of our Admissions process, The Center requires all individuals enrolled in one or more of our programs to have a Td shot, which is a combination immunization providing immunity against tetanus and diphtheria for individuals 13 years and older.

Although not required, it is highly recommended that your Td immunization be updated every 10 years.

Please indicate date Td Immunization was given: _____

Form must be signed by the Primary Care Physician or the Licensed Nurse who administered the immunization.

Primary Care Physician's Name: _____

Primary Care Physician's Signature: _____

Date Signed: _____

Licensed Nurse's Name: _____

Licensed Nurse's Signature: _____

Date Signed: _____

Once the immunization has been recorded, **please return the form to The Center / Admissions Department at 3550 West Dallas, Houston, Texas 77019.**

Original: Individual Master Record

Location: _____

Case #: _____

Form #165
Revised 09/12

THE CENTER

SEIZURE CLASSIFICATIONS

Individual Name: _____ Date Of Birth: _____

Seizure Classification Number(s): _____

Please indicate above the number and/or numbers of the following that describe the seizure activity noted for the individual being classified.

SEIZURE TYPES:

I. **GENERALIZED TONIC-CLONIC** (formerly called Grand Mal)
Characteristics: Sudden cry, fall, rigidity, followed by muscle jerks, shallow breathing or temporarily suspended breathing, bluish skin, possible loss of bladder or bowel control, usually lasts a couple of minutes. Normal breathing then starts again. There may be some confusion and/or fatigue, followed by return to full consciousness.

II. **ABSENCE** (formerly called Petit Mal)
Characteristics: A blank stare, beginning and ending abruptly, lasting only a few seconds, most common in children. May be accompanied by rapid blinking, some chewing movements of the mouth. Child is unaware of what's going on during the seizure, but quickly returns to full awareness once it has stopped. May result in learning difficulties if not recognized and treated.

III. **SIMPLE PARTIAL**
Characteristics: Jerking may begin in one area of body, arm, leg, or face. Can't be stopped, but patient stays awake and aware. Jerking may proceed from one area of the body to another, and sometimes spreads to become a convulsive seizure. Partial sensory seizures may not be obvious to an onlooker. Patient experiences a distorted environment. May see or hear things that aren't there, may feel unexplained fear, sadness, anger, or joy. May have nausea, experience odd smells, and have a generally "funny" feeling in the stomach.

IV. **COMPLEX PARTIAL** (also called Psychomotor or Temporal Lobe)
Characteristics: Usually starts with blank stare, followed by random activity. Person appears unaware of surroundings, may seem dazed and mumble. Unresponsive. Actions clumsy, not directed. May pick at clothing, pick up objects, try to take clothes off. May run, appear afraid. May struggle or flail at restraint. Once pattern established, same set of actions usually occur with each seizure. Lasts a few minutes, but post-seizure confusion can last substantially longer. No memory of what happened during the seizure period.

V. **ATONIC SEIZURES** (also called Drop Attacks)
Characteristics: A child or adult suddenly collapses and falls. After 10 seconds to a minute he recovers, regains consciousness, and can stand and walk again.

VI. **MYOCLONIC SEIZURES**
Characteristics: Sudden brief, massive muscle jerks that may involve the whole body or parts of the body. May cause person to spill what they were holding or fall off a chair.

VII. **INFANTILE SPASMS**
Characteristics: These are a cluster of quick, sudden movements that start between three months and two years of age. If a child is sitting up, the head will fall forward, and the arms will flex forward. If lying down, the knees will be drawn up, with arms and head flexed forward as if the baby is reaching for support.

VIII. **UNCLASSIFIED**

Signature of Physician or Nurse Date

Location: _____

Case #: _____

Form #45 -11/01
Revised 09/12

The Center

Advanced Directives

The Living Will and Durable Power Of Attorney For Healthcare

The Living Will (Or Directive to Physician)

The Living Will offers people a way to communicate their wishes about medical treatment at some time in the future when they are unable to make their wishes known because of illness or injury. This document is recognized in cases in which the patient has an irreversible condition (for example, permanent coma or incurable cancer) and is unable to communicate these wishes.

A Living will can include other directions about a patient's course of health care. A patient can even name another person to make health care decisions in the event they are unable to do so. The form requires two signatures and does not have to be notarized.

Durable Power of Attorney for Healthcare (DPAH)

The Durable Power of Attorney for Healthcare, or DPAH, is a document whereby a patient gives someone, (for example, a relative or close friend) the authority to make decisions about medical treatment on behalf of the patient in situations where the patient is unable to do so. The authorized person may also refuse medical treatment for the patient.

Unlike the Living Will, it is not necessary for a patient to have a terminal or irreversible illness for the DPAH to be effective.

Also the DPAH only applies to health care decisions. It does not authorize decisions or actions about a patient's personal property or business affairs. A special form is required for a DPAH and it does not have to be notarized, but two adults, not related to the patient, are required to be witnesses.

The Center respects the client's right to accept or reject medical treatment. Whether a client has a Living Will or Durable Power of Attorney for Healthcare is the client's decision to make. But if the client has either or both of them, the Agency will do its best to follow client instructions. In any case, it is important that the client share their feelings with a physician or family member.

If you would like more information about the Living Will or the Durable Power of Attorney for Healthcare let your Social Worker or Service Coordinator know.

Clients at The Center are not required to have a Living Will or Durable Power of Attorney for Healthcare; but you have the right to give such advance directive should you chose to do so.

For more information ask a Social Worker or Service Coordinator or send a self-addressed stamped envelope to any of the following:

State Bar of Texas
P.O. Box 12487, Capitol Station
Austin, TX 78711

Choice in Dying
325 E. Oliver St.
Baltimore, MD 21202

Texas Medical Association
Attn: Living Will
401 West 15th Street
Austin, TX 78701

This is to certify that I have read or been informed of and understand my rights regarding access to records.

_____ _____

Signature of Individual **Date**

_____ _____

Signature of Guardian **Date**

(Required if the person served is under age 18 or has a legal guardian)

_____ _____

Signature of Staff Person reviewing this information with the individual. Date

Name of Individual: _____ Date of Birth: _____

Location: _____

Case #: _____

Form #45 -11/01
Revised 09/12

The Center

ADVANCE DIRECTIVES REGARDING HEALTH CARE

Acknowledgement Statement

I have received information about my rights to accept or refuse treatment and my rights to make advance directives regarding my health care. I have also received information regarding Center policies and procedures for assuring those rights.

Please check “Have” or “Have Not” in the following statements:

A. ❑ I Have ❑ I Have Not

Signed a Durable Power of Attorney for my health care decisions.

B. ❑ I Have ❑ I Have Not

Signed a Living Will (Directives to Physicians).

C. ❑ I Have ❑ I Have Not

Physician order for Out-of-Hospital DNR.

Please attach a copy if “Have” is checked.

Client/or Representative Signature Date

Signature of Staff Person reviewing this information with the individual. Date

Location: _____

Case # _____

Form #76 – 03/05
Revised 09/12

The Center

3550 West Dallas - Houston, Texas 77019
MAIN 713-525-8400 FAX 713-525-8493

ANNUAL TB TEST

INDIVIDUAL _____ DATE _____

DATE OF BIRTH _____ SOCIAL SECURITY # _____

Annual TB skin testing is recommended for all individuals served at The Center. Please provide your primary care physician with this form to have your skin test administered and/or read. Should the results of your skin test be positive, you are required to have a chest x-ray before you may return to The Center. Also, if you are a known positive reactor, you should have a chest x-ray every two years, or as often as recommended by your primary care physician.

Know the signs and symptoms of TB, which include but are not limited to: **PRODUCTIVE AND PROLONGED COUGH, COUGHING UP BLOOD, FEVER, CHILLS, LOSS OF APPETITE, WEIGHT LOSS, FATIGUE/WEAKNESS, OR NIGHT SWEATS.**

( ) ANNUAL SKIN TEST ( ) CHEST X-RAY ( ) EXEMPT

Once the TB test and/or Chest X-Ray have been read and the results recorded on this form, **please return this form to The Center / Records Department at 3550 West Dallas, Houston, Texas 77019.**

LICENSED NURSING STAFF ONLY:

Lot #_____

DATE OF TEST: _____

Expires: _____

SITE: LEFT ____ RIGHT ____

ADMINISTERED BY: _____

DATE READ: _____ **(Results of skin test must be read 48-72 hours after the test is administered.)**

RESULTS: POSITIVE ____ Millimeters NEGATIVE ____

READ BY: _____

CHEST X-RAY RESULTS (if applicable)

LICENSED STAFF ONLY:

DATE OF X-RAY: _____ ADMINISTERED BY: _____

RESULTS: POSITIVE ____ NEGATIVE ____ READ BY: _____

Original: Individual Master Record

Location: _____

Case #: _____

Form #110 – 03/2003
Revised 09/12

The Center
P. O. Box 130564 – Houston, Texas 77219
(713) 525-8400

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(45 CFR §164.520(c)(2)(ii))

Name of Individual: _____ **Date of Birth:** _____

This is to certify that I have received a copy of The Center's Notice of Privacy Practices dated April 14, 2003, as required by the Health Information Portability & Accountability Act (HIPAA) - Administrative Simplification Standards of 2002.

I understand The Center reserves the right to change its Notice of Privacy Practices at any time. However, if a change is made copies of the new Notice will be available at each of The Center's facilities and posted on its website www.thecenterhouston.org. In addition, I may contact The Center's Privacy Officer should I have any questions concerning the contents of the Notice.

_____ _____
Signature of Individual Served Date

_____ _____
Signature of Parent/Guardian Date
(Required if the individual served is under age 18 or has a legal guardian.)

_____ _____
Signature of Witness Date
(Required if the signature of the individual served/parent/guardian is not legible.)

Location: _____
Case No: _____

Form #41 – 02/89
Revised – 09/12

The Center

EMERGENCY INFORMATION AND AUTHORIZATION

NAME _____ Date Of Birth _____ SSN _____

ADDRESS _____ HOME PHONE _____

KNOWN ALLERGIES _____

EXISTING MEDICAL CONDITIONS (such as seizures, diabetes, etc) _____

PRIMARY CARE PHYSICIAN _____ OFFICE PHONE _____

PRIMARY DENTIST _____ OFFICE PHONE _____

HOSPITAL PREFERENCE _____ PHONE _____

MENTAL HEALTH PROVIDER _____ PHONE _____

PHARMACY PREFERENCE _____ PHONE _____

FUNDING SOURCE: _____ FUNDING SOURCE CASE #: _____

(IF YOU DO NOT HAVE MEDICAID, AND/OR PRIMARY INSURANCE, PLEASE WRITE "NONE" IN THE APPROPRIATE BLANKS.)

PRIMARY INSURANCE _____ POLICY HOLDER _____

POLICY # _____ GROUP # _____ PHONE # _____

MEDICAID # _____ MEDICARE # _____ ADVANCE DIRECTIVE (on file) ___ NO ___ YES

GUARDIAN ___ NO ___ YES DURABLE POWER OF ATTORNEY FOR HEALTHCARE ___ NO ___ YES

(IF YOU CHECKED "YES" ON EITHER OF THE OPTIONS ABOVE, PLEASE COMPLETE BELOW.)

Name _____ Home Phone _____ Work Phone _____ Cell Phone _____

Address _____ Relationship _____ E-Mail _____

NAMES & TELEPHONE NUMBERS OF PEOPLE WHO MAY BE CALLED IN THE EVENT OF AN EMERGENCY:

Parents _____ Home Phone _____ Work Phone _____ Cell Phone _____

Address _____ Relationship _____ E-Mail _____

Name _____ Home Phone _____ Work Phone _____ Cell Phone _____

Address _____ Relationship _____ E-Mail _____

Name _____ Home Phone _____ Work Phone _____ Cell Phone _____

Address _____ Relationship _____ E-Mail _____

I hereby authorize a representative of The Center to render first aid and in the event of an emergency requiring immediate medical attention, to seek care through a physician or emergency room.

INDIVIDUAL'S SIGNATURE _____ DATE _____

GUARDIAN'S SIGNATURE _____ DATE _____
(If applicable.)

WITNESS' SIGNATURE _____ DATE _____
(Only when individual's signature is illegible.)

Location: _____

Case #: _____

Form #111
Revised 09/12

The Center

RIGHTS ACKNOWLEDGMENT

Name of Individual: _____ Date of Birth: _____

Funding Source: _____ Funding Source Case #: _____

This is to certify that I have received a copy of, and have had explained, the ASSURANCE OF RIGHTS OF PERSONS SERVED. I have also received a copy of, and have had explained, the RIGHTS PROTECTION HANDBOOK, including information regarding the Rights Protection Office and The Center's complaint and appeals processes. These rights, a description of how to exercise these rights and the responsibilities that come with the exercising of these rights have been explained to me in a language I can understand. I was offered a chance to discuss these rights, and any questions I had have been answered. I know that I can ask more questions later, if I need to.

_____ _____
Signature of Individual Served Date

_____ _____
Signature of Guardian Date
(required if the individual served has a legal guardian)

_____ _____
Signature of Family Member, Advocate or Legal Representative Date
(required if the individual served in under age 18)

_____ _____
Signature of Witness Date
(required if the signature of the individual served/parent/guardian is not legible)

I have given the above named individual served a copy of his/her rights. I have also explained those rights in a language that he/she can understand. I have offered to answer, and have answered, any questions pertaining to this explanation of rights. I believe this to be a fair advisement of his/her rights.

_____ _____
Signature/Title of Person Giving Explanation Date

Location: _____

Case #: _____

Form #111
Revised 09/12

ASSURANCE OF RIGHTS OF PERSONS SERVED

Rights of All People Receiving Intellectual & Developmental Disabilities Services

People receiving intellectual & developmental disabilities (IDD) services from IDD facilities and community centers have the following rights as required by the Persons with Intellectual & Development Disabilities Act of 1977 (Texas Civil Statutes, Article 5547-300), and by other state and federal laws and rules as noted:

(1) All rights, benefits, responsibilities, and privileges guaranteed by the constitutions and laws of the United States and Texas, except where lawfully restricted. These rights include the right to register and vote; the right to acquire, use, and dispose of property including contractual rights; the right to sue and to be sued; rights related to licenses, permits, and privileges and the law; the right to religious freedom.

(2) The right to protection from mistreatment, abuse, neglect, and exploitation.

(3) The right to live and receive services in the least restrictive setting appropriate to an person's needs and abilities, and to be served in the least intrusive manner appropriate to his or her needs.

(4) The right to education.

(5) The right to equal opportunity in employment.

(6) The right to equal housing opportunities.

(7) The right to treatment and habilitative services.

(8) The right to a comprehensive diagnosis and evaluation, and the right to an administrative hearing to contest the findings of such a diagnosis and evaluation.

(9) The right to presumption of competence.

(10) The right to due process in guardianship proceedings and in admission to residential services.

(11) The right to fair compensation for labor.

(12) The right to be free from discrimination on the basis of handicap in employment or in the provision of or eligibility for services. Additionally, these programs or activities must be provided in facilities, which are accessible to and usable, by handicapped persons.

(13) The right to be informed about and participate in individualized treatment, training, and habilitation plans.

(14) The right to periodic review and reevaluation.

(15) The right to withdraw from voluntary mental retardation services.

(16) The right to be free from unnecessary and excessive medication.

(17) The right to give or withhold consent to treatment.

(18) The right to initiate a complaint and to know how to contact the facility or center's Rights Protection Officer, the facility or center's Public Responsibility Committee, and the Office of Client Services and Rights Protection, TDMHMR Central Office, phone 1-800-252-8154.

(19) The right to be informed of rights.

(20) The right to access his or her own medical records except where lawfully restricted such as, but not limited to, when contraindicated by the consumer's interdisciplinary team.

(21) The right to confidentiality of records except where disclosure is authorized under the Persons with Mental Retardation Act of 1977 and Texas Civil Statutes, Article 5561(h).

(22) The right to an administrative hearing to contest a proposed or refused transfer or discharge, except when such discharge is on the basis that the person is not mentally retarded.

Rights of People Receiving Intellectual & Developmental Disabilities Residential Services

A. People receiving intellectual & development disabilities residential services have the following additional specific rights under the Persons with Intellectual & Developmental Disabilities Act of 1977 (Texas Civil Statutes, Article 5547-300):

(1) Right to due process in guardianship proceedings and in admission and to prompt, adequate, and necessary medical and dental care and treatment.
(2) Right to a normalized residential environment.
(3) Right to a humane physical environment.
(4) Right to communication and visits.
(5) Right to personal property.

B. The following rights must be provided to consumers receiving Title XIX funds in accordance with federal requirements for certification/licensure as a certified intermediate care facility for persons with intellectual & developmental disabilities (ICF-MR) (42 CFR 442.403-442.406). These rights shall also be provided to all other consumers receiving intellectual & developmental disabilities residential services. These are in addition to the rights outlined in the Persons with Intellectual & Developmental Disabilities Act of 1977 as noted above:

(1) The right to be informed, before or at the time of admission, of his or her rights and responsibilities, and of all rules governing resident conduct. If the policies on consumer rights, responsibilities, and rules governing conduct are amended, then each consumer must be informed at that time.

(2) The right to be informed in writing of all available services in the facility or center and of the charges for the services (including charges for services not included in other payment resources such as Medicaid). Consumers must receive information about available services and charges to them at the time of admission and on a continuing basis as changes occur while the consumer is receiving services.

(3) The right to be informed by the physician of his or her health or medical condition unless the physician decides that informing the consumer is medically contraindicated. If the consumer's physician decides that informing the consumer of his or her health and medical condition is medically contraindicated, the physician shall document this decision in the consumer's record.

(4) The right to participate in planning his or her total care and medical treatment.

(5) The right to give or withhold informed, written consent before participating in experimental research.

(6) The right to be transferred or discharged only for:

(a) medical reasons;
(b) the consumer's welfare or that of other residents; or
(c) nonpayment, except as prohibited by the Medicaid Program.

(7) The right to encouragement and assistance in exercising his or her rights as a services recipient, as applicable, and as a citizen.

(8) The right to submit complaints or recommendations concerning the policies or the procedures and services of the facility or center to the staff or to outside representatives of the consumer's choice, or both. In so doing, the consumer shall be free from restraint, interference, coercion, discrimination, or reprisal.

(9) The right to be free from mental and physical abuse from the facility or center.

(10) The right to be free from chemical or physical restraints unless the restraints are in compliance with state and agency regulations.

(11) The right to be treated with consideration, respect, and full recognition of his or her dignity and individuality.

(12) The right to privacy during treatment and care of personal needs.

(13) The right to confidentiality of records, including information in an automated data bank. Each consumer must give written consent before a facility or center may release information from his or her records to someone not otherwise authorized by law to receive it.

(14) The right to privacy during visits by his or her spouse. If both husband and wife reside in the same facility or center, they must be permitted to share a room.

(15) The right to not be required to perform services for the facility or center.

(16) The right to communicate, associate and meet privately with people of the consumer's choice, unless this infringes on the rights of another consumer. Any restrictions to this right require recommendation of the interdisciplinary team with justification documented in the consumer's record. The restrictions must be reevaluated each time the plan of care and medical orders are reviewed or at the consumer's request.

(17) The right to send and receive personal mail unopened.

(18) The right to participate in social, religious and community group activities unless the treatment team determines that these activities are contraindicated and the justification is documented in the consumer record.

(19) The right to retain and use his or her personal possessions and clothing as space permits within the facility or center. Personal possessions may only be restricted in accordance with TDMHMR rules and ICF/MR guidelines including, as appropriate, consent of the consumer and/or parent/legal guardian and/or approval by the Behavior Therapy and Human Rights Committees;

(20) The right to manage his or her personal financial affairs. If a consumer requests assistance from the facility or center in managing personal and financial affairs, the request must be made in writing and documented in the consumer's record. The facility or center must allow each consumer to possess and use money in normal ways, or be learning to do so, and must comply with TDMHMR rules regarding same.

(21) The right to have unrestricted visits from attorneys.