ATHC Referral/Admission Packet

Thank you for inquiring about the Adult Training & Habilitation Center. We are dedicated to providing the best services possible based upon each participant’s individual needs and goals. To do this, we ask you to provide us with the requested information in this packet. When complete, please return all information to the desired site:

<table>
<thead>
<tr>
<th>ATHC-WINSTED</th>
<th>ATHC-WEST</th>
<th>ATHC DOUGLAS KUGLER ECO-SITE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Candice Kisner</td>
<td>Kelly Nelson</td>
<td>Elysia Hillmyer</td>
</tr>
<tr>
<td>311 Fairlawn Ave W</td>
<td>425 California St. NW</td>
<td>676 Industrial Blvd.</td>
</tr>
<tr>
<td>Winsted, MN 55395</td>
<td>Hutchinson, MN 55350</td>
<td>Watertown, MN 55388</td>
</tr>
<tr>
<td>Phone: 320-485-4191</td>
<td>Phone: 320-587-5052</td>
<td>Phone: 952-955-1130</td>
</tr>
<tr>
<td>Fax: 320-485-4763</td>
<td>Fax: 320-587-0454</td>
<td>Fax: 952-955-1143</td>
</tr>
<tr>
<td><a href="mailto:candice.kisner@athc.org">candice.kisner@athc.org</a></td>
<td><a href="mailto:kelly.nelson@athc.org">kelly.nelson@athc.org</a></td>
<td><a href="mailto:elysia.hillmyer@athc.org">elysia.hillmyer@athc.org</a></td>
</tr>
</tbody>
</table>

Please complete the following forms included in the referral/admission packet for the Adult Training & Habilitation Center:

- Application form
- Staff ratio requirement
- Consent for release of information (please note that this must be signed by the guardian)

Along with the above forms, please include the following information (if applicable):

- Coordinated Service & Support Plan (CSSP)/ Individual Service Plan (ISP) or equivalent form including social history
- Copy of most recent physical exam and any other pertinent medical information
- Psychological evaluation
- Current residential program information and Intensive Service & Support Plan/(Self-Assessment) and Individual Program Abuse Prevention Plan, CSSP addendum
- Current day program/vocational information and Intensive Service & Support Plan/(Self-Assessment) and Individual Program Abuse Prevention Plan, CSSP Addendum
- List of dietary needs/allergies/physical restrictions or any other special needs
- Recent behavior/incident reports (if any) and copy of behavior management program, if required

Please contact us with any questions you may have and/or would like to schedule a tour.

THANK YOU!

Kle11/14 >Admission & Annual Forms
ATHC STAFF RATIO REQUIREMENT

Consumer Name:___________________________________________________________________

RATIO 1:4 Two of the three must be true on Screening Document (DHS-3067)
Block 30 (mobility) coded 7 or 8
Block 32 (expressive communication) coded 7 or 8
Block 36a (self care) coded 5

OR
Block 38a or b or c or e or f or h coded 5 (very severe self injurious or aggressive behavior)

RATIO 1:8 Two of the three must be true on Screening Document (DHS-3067)
Block 30 (mobility) coded 1, 2, 3 or 4
Block 32 (expressive communication) coded 1, 2, or 3
Block 36a (self care) coded 1 or 2

AND
Block 38 (behavior) coded 1 or 2 on all items

RATIO 1:6 The individual does not meet the requirements for 1:4 or 1:8

30. MOBILITY: ______
01-No impairment
02-Walks short distances independently
03-Walks aided (walker, crutches, assistance of a person, etc)
04-Propels own wheelchair, bears weight for transfers
05-Propels own wheelchair, total assistance with transfers
06-Uses electric wheelchair
07-Unable to propel wheelchair
08-Not mobile due to overriding medical conditions (specify in notes)
99-Unknown (justify in notes)

32. EXPRESSIVE COMMUNICATION: ______
01-Functional
02-Speech intelligible to familiar listeners
03-Speech difficult to understand
04-Speech unintelligible even to familiar listeners
05-Combines signs and/or gestures to communicate
06-Uses single signs or gestures to express wants and needs
07-Uses augmentative communication aid
08-Does not have functional expressive communication
99-Unknown (justify in notes)

34. SELF PRESERVATION: ______
01-Is capable of self-preservation
02-Requires verbal/physical prompts for preservation
03-Is not capable of self-preservation
99-Unknown (justify in notes)

36. INDEPENDENT LIVING SKILLS
(A) Self Care…………………………………………………
(B) Daily Living Skills/House Mgmt……………………
(C) Money Management……………………………………
(D) Community Living……………………………………
(E) Leisure & Recreation…………………………………..

01-Independent
02-Minimal supervision (formal program needed)
03-Instruction required with expected outcome of increased independence
04-Person participates with another’s assistance for all or portions of an activity
05-Person unable to participate in activity
99-Unknown (justify in notes)

38. CHALLENGING (EXCESS) BEHAVIOR SCALES
(A) Eating non-nutritive substances…………………..
(B) Injurious to self……………………………………
(C) Aggressive physical………………………………
(D) Aggressive verbal/gestural…………………………
(E) Inappropriate sexual behavior……………………
(F) Property destruction………………………………
(G) Runs away/elopes…………………………………
(H) Breaks laws………………………………………
(I) Temper outbursts…………………………………
(J) Other (specify in notes)……………………………

01-None
02-Mild
03-Moderate
04-Severe
05-Very Severe
99-Unknown (justify in notes)

NOTES:________________________________________________________________________

______________________________________________________________________________

Individul requires _____ to _____ staff ratio.

Case Manager Signature:__________ Date:___________________________

Reviewed by:____________________ Date:___________________________

11/08
**APPLICATION/ADMISSION FORM AND DATA SHEET**

*This form is completed at service initiation and update as needed. Dated signatures are obtained at initiation and when changes are made.*

### PERSONAL INFORMATION

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>Home telephone number:</td>
</tr>
<tr>
<td>Cell phone number:</td>
<td>Email address:</td>
</tr>
<tr>
<td>Date of admission or re-admission:</td>
<td>Language(s) spoken:</td>
</tr>
<tr>
<td>Guardianship type (self, private, public):</td>
<td>Religious preference:</td>
</tr>
<tr>
<td>Marital status:</td>
<td>Other:</td>
</tr>
</tbody>
</table>

### IDENTIFYING CHARACTERISTICS

<table>
<thead>
<tr>
<th>Gender</th>
<th>Race:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Height</td>
<td>Weight:</td>
</tr>
<tr>
<td>Hair color</td>
<td>Eye color:</td>
</tr>
</tbody>
</table>

Distinguishing characteristics/identifying marks:

### FINANCIAL INFORMATION

<table>
<thead>
<tr>
<th>Social Security Number (SSN):</th>
<th>Medical Assistance Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>County of responsibility:</td>
<td>PMI number:</td>
</tr>
<tr>
<td>County of financial responsibility:</td>
<td>Burial account number:</td>
</tr>
</tbody>
</table>

### MEDICAL INFORMATION

<table>
<thead>
<tr>
<th>Diagnoses:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies:</td>
</tr>
<tr>
<td>Protocols (seizure, diabetic, etc.):</td>
</tr>
<tr>
<td>Medical equipment, devices, or adaptive aides or technology used:</td>
</tr>
</tbody>
</table>
## General Contact Information

<table>
<thead>
<tr>
<th>Role</th>
<th>Contact person:</th>
<th>Address:</th>
<th>Phone:</th>
<th>Cell Phone:</th>
<th>Preference for information: email/fax/mail</th>
<th>Emergency contact #:</th>
<th>Preference for information: email/fax/mail</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Manager</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residential</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Legal Representative</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Role</th>
<th>Name:</th>
<th>Address:</th>
<th>Phone:</th>
<th>Cell Phone:</th>
<th>Preference for information: email/fax/mail</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Member</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Member</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Member</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial worker:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Health-Related Contact Information

<table>
<thead>
<tr>
<th>Role</th>
<th>Name:</th>
<th>Address:</th>
<th>Phone:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Health Care Professional:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Preference:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dentist:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurologist:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Optometrist/Ophthalmologist:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Audiologist:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacy:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other health professional:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

DPF-004  ATHC >Admission  New 7/14
Adult Training & Habilitation Center

Briefly describe reason for referral:

______________________________________________________________________________________________
_____________________________________________________________________________________________________
_____________________________________________________________________________________________________

Education, DT&H, other employment history (include start and end dates):

_____________________________________________________________________________________________________
_____________________________________________________________________________________________________
_____________________________________________________________________________________________________

Residential History – include move in out dates is able:

_____________________________________________________________________________________________________
_____________________________________________________________________________________________________
_____________________________________________________________________________________________________

Person served and/or legal representative  
*(signed at Admission meeting)*

Date  (* dated at Admission meeting)
I understand that I and my legal representative have full access to my records and recorded information that is maintained, collected, stored, or disseminated by the company. Private data are records or recorded information that includes personal, financial, service, health, and medical information. I, hereby, authorize Adult Training & Habilitation Center to routinely release my private information those staff of Adult Training & Habilitation Center who have a need to know including: executive and administrative staff, financial and nursing staff including assigned or consulting nurses, management staff including the Designated Coordinator and/or Designated Manager, and direct support staff. In addition, my support team or expanded support team may receive my private information as needed, including my county case manager, employer, behavior professionals, and other licensed service providers.

I understand the purposes for collecting and releasing my private information. I also understand that the information released by this company will be used only by authorized agencies or entities.

The MN Government Data Practices Act protects your privacy, but also lets us release information about you to others if 1.) a law or government regulation requires it and 2) we tell you before we do it. The information below tells why and when we will ask for information about you that we do not currently have and release information about you. It applies to all future contacts you will have with us. The company will obtain authorization to release information of persons served when consultants, sub-contractors, or volunteers are working with the company to the extent necessary to carry out the necessary duties. The company will obtain authorization to release information of persons served when consultants, sub-contractors, or volunteers are working with the company to the extent necessary to carry out the necessary duties.

What are some reasons we use your information?
There are many reason we use your private information regarding service provision and continuity of care purposes. Your information allows us to tell you from other persons who get the same service; to understand what services you may need; deliver those services in the most effective and efficient way possible, to work efficiently and effectively with other organizations or people who also support you; to protect your rights; collect money from the federal, state, or county agencies for services provided; to make reports, audit, and evaluate our services to make them better; and/or to ensure that our services are designed and delivered in accordance with all federal, state, or county laws and regulations.

Do you have to provide us with information? What will happen if you do not provide us all the information? What happens if you do not release your information to others?
Generally, the law says you do not have to give us all the information we ask for; however, we need some information to give you services. If we do not get it, or if we cannot share it with others who work with you, then we might not be able to assist you or assist you effectively. Also, it is possible laws or regulations might order us to obtain or release it later. Our agency might receive fines or corrective action as a result of not having the information.

Who else may access your information when required?
The following entities also have access to persons’ private data as authorized by applicable state or federal laws, regulations, or rules. Other entities or individuals authorized by law:
- Minnesota Department of Human Services
- County of company’s social services
- U.S. Department of Health and Human Services
- Social Security Administration
- Federal, state, or county auditors
- Adult or Child Protection units and investigators
- The MN Ombudsman for Mental Health or Developmental Disabilities
- County of financial responsibility
- Local or state health departments
- Law enforcement personnel and attorneys
- Various state departments
- Representative payee and financial workers
- Other licensed service providers as needed

You have the right to access your information and to request copies.
You and/or legal representative have the right to request that your records or recorded information and documentation be altered and/or to request copies. If you would like copies of your information, please provide us with five (5) days notice, if possible. Information will be disclosed to appropriate parties in connection with an emergency if knowledge of the information is necessary to protect the health or safety of the person served or other individuals or persons.
will be maintained on this disclosure and you may request this information and request copies.

**What can you do if you believe your information is inaccurate?**
Your objections must be in writing and should be submitted to our company. This written notice must include why you believe the information is incorrect. Please include an explanation of the information that you disagree with. A copy of this objection you submitted in writing will be maintained in your service recipient record. Your explanation will be attached any time that information is shared with another agency.

**Summary/consequences – I know that state and federal privacy laws protect my records. I know:**
- Why I am being asked to release this information.
- I do not have to consent to the release of this information. But not doing so may affect this company's ability to provide needed services to me.
- If I do not consent, the information will not be released unless the law otherwise allows it.
- I may stop this consent with a written notice at any time, but this written notice will not affect information this company has already released.
- The person(s) or agency(ies) who receive my information may need to pass it on to others.
- If my information is passed on to others by this company, it may no longer be protected by this authorization.
- This consent will end in one annual year from the date I sign it, unless the law allows for a longer period.

I understand that without my prior, written consent, the sharing of my information will not occur with any agency not listed above, for any reason not described above, or for any use not described above. I understand that I also have the right to review any information which is maintained by Adult Training & Habilitation Center about me, as provided for in MN Government Data Practices Act, section 13.46. I further understand that I may review the information before it is released, subject to my right to review this information under the controlling federal and state laws.

___________________________________________                  ________________________
Person served and/or legal representative                                      Date