United Cerebral Palsy Heartland
In-Home Supports Program Guidelines

Eligibility for the In-Home Supports Program

Our program is funded by the Productive Living Board. To be eligible for the In-Home Supports Program, the applicant must have a developmental disability as defined by the Productive Living Board and he or she must live in St. Louis County. In addition, the participant must live in the natural family home or with a guardian.

Enrollment and acceptance into the Program

- Families complete an application packet. Only complete application packets will be reviewed for eligibility and acceptance into the program.
- If the applicant is eligible and the information is complete on the application, UCP Heartland will send a letter stating that the applicant is accepted into the program and the number of allocated in-home hours for the program participant to use from July 1 through June 30. The number of hours allocated is based upon the need of the applicant.

Selection and approval of your Provider

- The parent/guardian selects a provider **who is over age 16** and is **NOT** living in the same residence. An immediate family member such as a mother, father, or sibling who is responsible for the day-to-day care of the individual with a developmental disability is **NOT** an eligible provider.
- The family of the program participant is responsible for training and supervising the provider.
- The provider is not an employee of UCP Heartland.
- The provider/family receives a tax document (1099) in January stating the amount paid by UCP Heartland, if the provider was paid $600 or more.
- The parent/guardian and provider complete provider forms and return them to UCP Heartland. These forms must be received and approved by UCP Heartland prior to using the allocated hours.
- Once a provider is approved, UCP Heartland will send In Home Support Service Report forms for the family to report hours used on a monthly basis.

Use your allocated in-home support hours on a monthly basis with these guidelines

- In-Home Support Services are defined as temporary relief to the primary caregiver from the challenge of caring for a family member with a developmental disability. The services shall be used for the primary purpose of relieving families of the responsibilities inherent in caring for a family member with a developmental disability for a few hours, a day, a weekend, or other short-term periods of time.
  In Home Support Services does NOT include
  - **Daily care on an ongoing or regularly scheduled basis,**
  - **Regularly scheduled before and/or after school or work care,**
  - **Services for more than two consecutive weeks,**
  - **Care provided by an immediate family member or any other individual in the home of the participant,**
  - **Care associated with personal care assistants,**
  - **During school hours,**
  - **Non-qualifying siblings.**
- Allocated in-home support hours are meant to last the full year, July 1 through June 30. Be sure to budget hours accordingly.
- The parent/guardian and the provider complete the In Home Support Service Report forms. After services are provided, the completed forms are sent to UCPH. Reports are due by end of business on the 10th of the month following service and checks will be issued on the 20th. If the due dates fall on a weekend, reports are due by the Friday before.
- Recipient of reimbursement must be clearly marked or payment will go to the provider by default.
- Incomplete or inaccurate service reports will not be paid.
- In-home supports are meant to provide temporary relief care. It would be irregular to use more than 100 hours in any given month**. Notification and documentation by letter is required to the agency**

for 100 hrs or more. Using over 200 per month requires written **PRE-authorization** from UCP Heartland and the Productive Living Board. Hours in excess of 199 will not be paid without this preauthorization.

- Hours used in excess of your annual allotted hours will not be paid. If more hours are needed please contact UCP Heartland prior to usage.
- UCP Heartland pays providers at the rate of $6.83 per hour for up to 14 hours a day. Although the provider may stay overnight, the maximum payment will be for 14 hours. We have various rates for families with more than one qualifying child. All children receiving services must qualify or the sibling rate will not apply. See chart below for rates.

# of Children	Amount Paid per Hour
1	$6.83
2	$11.95
3	$17.07
4	$22.19

Annual re-enrollment

- In the spring families will receive an update packet from UCP Heartland. The forms, survey and any other requested documents must be returned to UCP Heartland to ensure continued enrollment in the program.
- UCP Heartland will send a confirmation letter indicating the allocated number of in-home support for the program participant to use from July 1 through June 30. The number of hours allocated is based upon the need of the applicant and the number of hours the agency has available.

Exit from program

Participation in the UCP Heartland In-Home Support program is voluntary and NOT an entitlement. Families who fail to meet the guidelines of the program will be immediately discharged. Other reasons for discharge:

- Failure to treat staff with dignity and respect
- Falsification of documents
- Relocation out of the services territory
- Failure to comply with program guidelines
- A family will be discharged from the program if they do not use the in home support program for a period of more than 12 months and/or they fail to complete the necessary annual reenrollment application and survey.
- Families may voluntarily exit from the program at any time. We ask that you notify us so that we may make your space available for another family in need
-

Understanding and Agreement

I understand the In-Home Supports Program Guidelines and agree to use the program within the guidelines.

____ ______________

Signature

UCP Heartland, Inc.
13975 Manchester Road
Manchester, MO 63011
Phone: 636-227-6030 Fax: (636)779-2270

In-Home Support Services Application for Services
FY' 2017-2018

1. General Participant Information:

Participant's Name:	Date of Birth:	Social Security Number:
Address:	City, State, Zip:	Phone Number:
Race: (please check all that apply) African-American __ Hispanic/Latino __ Asian __ Multi-racial __ Bosnian __ Native Amer/Alaskan __ Caucasian __ Other __ Hawaiian/Pacific Islander __	Sex:	Marital Status:

2. St. Louis Regional Center Information:

A. Is the participant enrolled with St. Louis Regional Center? _______ Yes _____ No

B. If yes, please provide:

________________________________ ____________ ____________
Casemanager Name Phone ID #

B. If no, has the above named participant ever applied for, and been rejected for St. Louis Regional Center Services? ____ Yes _____ No

Why: ____

3. Current Residence:

______ Natural Home ______ Lives Independently

______ Foster Home (enclose guardianship documents)

______ Emergency Placement ______ Other; ________________________________

4. **Disability Information**

A. Please check the Participant's Primary Diagnosis:

___Learning Disability ___Autism ___Epilepsy

___Intellectual Disability ___Cerebral Palsy

___Other: ___________________________

B. Level of Disability

___ Mild ___Moderate ___ Severe ___Profound

C. Secondary Diagnosis: ____

D. **Attach a copy of information that verifies the participant's diagnosis from your physician, the St. Louis Regional Center, or other licensed clinician.**

5. **Current Services:**

School/Day Program: _______________________ Contact Person: ________________________

Address: ____ Phone: _________________________

Employment: ____

Other funding provided to consumer____

6. **General Family/Guardian Information:**

Mother:	Mother's address & Zip:	Mother's Employer:
Mother's Home Phone:	Mother's Other Phone:	Mother's Email:
Father:	Father's Address & Zip:	Father's Employer:
Father's Home Phone	Father's Other Phone:	Father's Email:

If in DFS Custody, Caseworker: ____________________ County: ______________

7. **Proof Of Identity and Residency <u>of St Louis County</u> to be attached to this application**

   A. **Attach a copy of the participant's social security card**
   B. **Attach a copy of parent/guardian photo ID**
   C. **Check and attach one of the following for the family's primary residency**
      - ☐ Most recent utility bill (home phone, water, gas, electric or sewer)
      - ☐ Most recent voter registration card
      - ☐ Most recent bank statement
      - ☐ Most recent government pay check stub
      - ☐ Current personal property tax receipt
      - ☐ Housing or rental contract
      - ☐ Mortgage documents

8. **Demographic Information** (this information is requested by United Way for reporting)**:**

   Does consumer have health insurance: ___ yes ___ no

   Number of people living in the house: _______

   Annual Family Income: __ $0 to $9,999 __ $10,000-$14,999 __ $15,000-$19,999
   __ $20,000-$29,999 __ $30,000-$49,999 __ $50,000-$99,999 __ $100,000 & greater

9. **Signatures:**

I certify that the participant and family live in St Louis County.
I certify that the providers used do NOT live in the same residence as the participant.

Your signature verifies the above information to be true and accurate to the best of your knowledge and provides consent for participation in UCP Heartland Program.

_________________________________ ____________
Parent/Guardian Date

Disability Information

To be completed and signed by physician or SLRO representative

Participant's Name: ____

1. Did the participant's disability manifest prior to the age of twenty-two?

_____ Yes ______ No

2. Please specify the participant's disability in detail and check two of more functional limitations in the following major life areas:

____

____

____

____

____ Self Care

____ Learning

____ Self-Direction

____ Mobility

____ Receptive and Expressive Language

____ Capacity for Independent Living & Economic Self Sufficiency

Additional Information: ____

3. The participant's evaluation regarding diagnosis was completed by:

Name of Professional: ______________________________ Date: ____________________

Address: ____

Phone: ____________________

4. Attach a copy of the evaluation/diagnosis from Physician/Psychologist.

_____________________________ _______________

Physician/Case Manager SLRO Date

UCP Heartland
13975 Manchester Road
Manchester, MO 63011
Phone: 636-779-2280
Fax: (636) 779-2270

PARTICIPANT RIGHTS

UCP Heartland exists to provide the most effective care and treatment possible to individuals who need it. Services will be delivered while respecting each client's rights and dignity.

1. Under Title VI of the Civil Rights Act of 1964, (PL 88-352), and the Americans with Disabilities Act of 1990 (ADA PL 101-336), no client shall be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination on the grounds of race, color, national origin, or disability.

2. Each client will be entitled to the following rights without limitations:
   - a) To humane care and treatment
   - b) To the extent that the facilities, day programs, equipment and personnel are available, to medical care and treatment in accordance with the highest standards accepted in medical practice
   - c) To safe and sanitary housing
   - d) To not participate in non-therapeutic labor
   - e) To attend or not attend religious services
   - f) To receive prompt evaluation and care, treatment and habilitation about which she/he is informed insofar as she/he is incapable of understanding
   - g) To be treated with dignity as a human being
   - h) To not be subject of experimental research without his/her written consent or that of his/her parent/guardian if a minor
   - i) To be evaluated, habilitated or treated in the least restrictive environment
   - j) To a nourishing, well-balanced diet
   - k) To have records kept confidential
   - l) To be free from verbal and physical abuse
   - m) To an impartial review of alleged violations of rights

3. Each client shall be entitled to the following rights, except if the executive director or program director that it is inconsistent with the client's therapeutic care, treatment, habilitation or rehabilitation determines it.
   - a) To wear his/her own clothing and to keep and use his/her own personal possessions
   - b) To communicate by sealed mail or otherwise with persons including agencies inside or outside the facilities
   - c) To have reasonable access to a telephone both to make and receive confidential calls
   - d) To have access to his/her mental and medical records
   - e) To have opportunities for physical exercise and outdoor recreation
   - f) To have reasonable prompt access to current newspaper, magazine, radio, and television programming.

Please sign below to indicate that you have reviewed and understood these rights.

__________________________	____________________
Signature	Date
__________________________	____________________
Staff Signature	Date

UCP Heartland, Inc.
13975 Manchester Rd
Manchester, MO 63011
636-227-6030

Family Service Agreement and Release of Liability

I ________________________________, _________________________, of ________________________
Name Relationship Consumer Name

have been fully informed of the policies and procedures of the UCP Heartland In-Home Support Service Program. I agree to cooperate fully with program staff, follow program policies and procedures and supply any and all pertinent information deemed necessary to safeguard the welfare of my family member. I understand that participation in this program is voluntary and I may withdraw or be withdrawn from the program at any time.

I understand that I am responsible for choosing any and all providers who care for my family member and for ensuring that each provider is fully informed of his/her individual care requirements. I agree to establish emergency procedures to be carried out in the event of illness or injury and to provide those procedures to my chosen provider.

I understand that I am responsible for screening, interviewing, checking references, including but not limited to police checks and child abuse and neglect screenings, and final selection of potential providers.

Furthermore, I understand that the individual(s) that I choose to provide in-home support services is not an employee of UCP Heartland, but is an independent contractor. I understand that UCP Heartland does not control and does not have the right to control the actions and activities of the person(s) I have selected to be my provider.

In consideration of in home support services provided or to be provided, I (we) hereby release and discharge UCP Heartland and its employees, volunteers, officers and directors from any liability arisen out of the providers' care of my family members or other aspect of service delivery.

I (we) have fully disclosed to the staff of UCP Heartland, all pertinent facts about my (our) family member's needs and problems and acknowledge full responsibility for failure to do so.

I (we) have fully disclosed to the provider all pertinent facts about my (our) family member's needs and problems and acknowledge full responsibility for failure to do so.

This agreement is specifically meant to release UCP Heartland from liability for injuries suffered by my (our) family member caused by the supervision or care given my (our) family member.

Parent/Guardian: ____Date: _____________________

Reviewed by UCP Heartland: ____________________________Date: _____________________

UCP Heartland

Individual Support Plan and Family Survey

July 1, 2017 – June 30, 2018

Please note: This survey should be completed and thorough. We use this information for yearly hour allocation.

Participant's Name: ___________________________ Parents/Guardian Name: _______________________ Date: ______________

What is the participant's primary disability? ____

How many people reside in the household: __________18 & Over _______Under age 18

Approximately how many hours of support will you use this year? _______ HOURS

Is your family receiving supports through sources other than the Productive Living Board (ex: DMH, DDR, EMAP)? _______ YES _______ NO

If YES, please explain: ____

Does your family use another organization or Agency for in home or residential supports (respite) _______ YES _______ NO
(Example: ARC, Edgewood, Children's Home Society, Marlborough Hall, Recreation Council)
If YES, please name Agencies: ____

How do you use your in home supports? Please check all that apply.

_____ Brief Breaks
_____ Socialization/outings
_____ Emergencies Only
_____ Routine/Scheduled
_____ Vacations (2 weeks or less)
_____ Weekends
_____ Overnights
_____ Evenings
_____ Other, Please Specify:
____
____

What services/supports does your family member with a developmental disability receive? Please check all that apply.

_____ Respite
_____ Community Integration
_____ Special School District
_____ Summer Camp
_____ Personal Care Assistance
_____ Nursing/nanny care
_____ Sheltered Workshop
_____ Supportive Employment
_____ Competitive Employment
_____ Preschool or daycare
_____ Adult Day Care
_____ Other - please specify: ____
_____ Division of Aging
_____ Recreation Programs(s) please list:
____
____

SURVEY CONTINUED ON THE OTHER SIDE

Who do you generally use as in home support providers? Please check all that apply.

_____ Friend
_____ Neighbor
_____ Teacher
_____ Family member (older than 16 residing outside the home)
_____ Church/synagogue member
_____ Other – please specify: ____

How many in home support providers do you currently use? ________________

Does your family member with a developmental disability have any medical/health problems at the present time? _______ YES _______ NO

If YES, please explain:

____

Does your family member with a developmental disability have any challenging behaviors? _______ YES _______ NO

If YES, please explain:

____

Are there any health problems with the parents/guardians of the family member with the disability? _______ YES _______ NO

If YES, please explain:

____

Are there any other extenuating problems or circumstances in your home at the present time? _______ YES _______ NO

If YES, please explain:

____

Do you consider out of home placement for your family member with a developmental disability a critical need (meaning in the next 1-3 years)? _______ YES _______ NO

List 1 or 2 goals that you would like your family member to achieve through the in-home supports:

____

____

What is the level of need your family member requires?

____

What additional comments do you have for us?

____

____

I certify that the above information is true to the best of my knowledge.

Parent/Guardian:____

Date: _________________________

Office Use Only

Date Received: ________________

Received By: ___________________________

UCP Heartland
13975 Manchester Rd
Manchester, MO 63011
(636) 227-6030
In-Home Supports
Service & Provider Agreement

This agreement is between UCP Heartland, ______________________________ and ______________________________.
The Family The Family's Chosen Provider

1. **UCP Heartland**, **the family** and **the provider** recognize the above provider as an independent contractor chosen by the above family to provide in-home support services. It is understood that the family determines when and if services occur within the established family authorization. Agreement to become a provider does not imply that the provider is an employee of UCP Heartland, nor, does it imply a commitment by the above family for a set number of hours requested.

PROVIDER INFORMATION:

Provider's Name	Provider's Home Phone
Provider's Home Address (Attach proof of address)	Provider's Social Security Number

REQUIRED ATTACHMENT – Proof of Residency (check and attach one of the following):

- ☐ Most recent utility bill (home phone, water, gas, electric or sewer)
- ☐ Most recent voter registration card
- ☐ Most recent bank statement
- ☐ Most recent government pay check stub
- ☐ Current personal property tax receipt
- ☐ Housing or rental contract
- ☐ Mortgage documents

2. The provider must be over age 16. The provider may **NOT** live in the same residence as the family. An immediate family member such as a mother, father, or sibling who is responsible for the day-to-day care of the individual with a developmental disability is **NOT** an eligible provider. By initialing, I certify this to be true: __________

3. **The provider** and **the family** understand that their selected provider(s) is **NOT** an-employee of UCP Heartland. UCP Heartland does **NOT approve, certify, train, schedule or select** providers and does **NOT** complete a criminal background check on providers.

4. **The family** agrees to be responsible for finding and training their provider.

5. **The family** may request a quarterly estimate of respite hours utilized from UCP Heartland.

6. **The family** may arrange services with their provider as they require to the number of hours authorized annually by UCP Heartland (for all In-home Support Services regardless of type and Agency). **Provider Agreement, Release of Liability, W-9 and proof of residency must be submitted to UCP Heartland prior to services. UCP Heartland requires that a completed W-9 be on file before any reimbursement will be made to the provider or family.** The chosen provider has the right to reject a request for services for that family at any time.

7. **The provider and family** agree that as an independent contractor, he/she is responsible for his/her own tax withholdings. The provider and family are also responsible for their own record keeping and reporting of income received. UCP Heartland will issue a 1099 for any provider/family receiving over $600.00 per calendar year.

8. **The provider** agrees to be responsible for his/her own liability insurance, workers' compensation insurance, and unemployment taxes. As an independent contractor the provider is not eligible for any UCP Heartland employee benefits.

9. UCP Heartland pays providers at the reimbursement rate for authorized services rendered for one participant $6.83/hour for up to 14 hours. Although the provider may stay overnight, the maximum payment will be for 14 hours. We have various rates for families with more than one qualifying child. All children receiving services must qualify or the sibling rate will not apply. See chart below for rates.

# of Children	Amount Paid per Hour
1	$6.83
2	$11.95
3	$17.07
4	$22.19

10. **Reimbursement checks** are issued on the 20th of the month following service.

11. **The family** agrees to be responsible for payment of services rendered if Service Reports include unauthorized services and cannot be processed.

12. **The family** agrees to hold UCP Heartland harmless for all services and providers of services.

The parties have executed this agreement this ______ day of ______________________, 20_____. The signing of this agreement renders all prior agreements null and void. This agreement may be immediately terminated by either party.

____ ____

Family Signature / Date Provider / Date

Verified for Completeness: ____

UCP Heartland / Date

Attach a copy of photo ID and current proof of residency for provider

UCP Heartland
Full Service Direct Deposit (FSDD) Enrollment Form

To enroll in Full Service Direct Deposit, simply fill out this form and return it to UCPH. **Attach a voided check** for checking accounts or a bank issued document for savings accounts and pre-paid debit card accounts**.** If depositing to a savings/pre-paid debit account, ask your bank to give you the Routing/Transit Number for your account. It isn't always the same as the number on the deposit slip. This will help ensure that you are paid correctly.

Below is a sample check detailing where the information necessary to complete the form can be found.

Important! Please read and sign before completing and submitting.

I hereby authorize UCP Heartland (hereinafter 'Company') to deposit any amounts owed me by initiating credit entries to my account at the financial institution (hereinafter 'Bank') indicated on this form. Further, I authorize Bank to accept and to credit any credit entries indicated by Company to my account. In the event that Company deposits funds erroneously into my account, I authorize Company to debit my account for an amount not to exceed the original amount of the erroneous credit.

This authorization is to remain in full force and effect until Company and Bank have received written notice from me of its termination in such time and in such manner as to afford Company and Bank reasonable opportunity to act on it.

Printed Name: ___________________________________ Social Security Number: ________________________

Signature: ____ Date: _________________________

Account Information: **(attach bank issued document)**

☐ Checking Account ☐ Savings Account ☐ Pre-paid Debit Account

Bank Name/City/State: ____

Routing/Transit Number: __ __ __ __ __ __ __ __ __ Account Number: ________________________________

OFFICE USE: UCPH will keep each original enrollment form on file as long as the provider is using FSDD and for two years afterward.

Vendor #_____________

FY18

UCP
Heartland

In Home Supports Handbook

Revised April 2014

Manchester Road
13975 Manchester Rd
Manchester Mo 63011
636-227-6030

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Welcome and History

UCP Heartland (UCPH) combines 136 years of expertise serving children and adults with disabilities to ensure that all people with disabilities have equal opportunities to live, learn, work and play in their communities. You may learn more at www.ucpheartland.org.

This Handbook is prepared to help you understand the policies of the Agency. After you have read the handbook, please sign the attached Statement of Understandings and return them for inclusion in your record.

Mission

UCP Heartland's mission is to provide the highest quality of programs, services and supports while advancing the independence, productivity and full citizenship of individuals with disabilities.

Code of Ethics and Core Values

UCPH has established and published its Code of Ethics and Core Values to provide guidance for the actions of its employees, Board of Directors, marketing and public relations activities, fiscal and business practices and the programs, supports and activities relating to individuals served by the Agency. To assure adherence to these Codes of Ethics, every employee and Board member is required to review and sign off on these codes acknowledging that they are aware of the contents of said code and that they will abide by these codes in their entirety. Any employee who violates any one of the Agency's Codes of Ethics may be subject to disciplinary action. Board members may be subject to Board action should any member violate any portion of these Codes of Ethics.

Funding

UCPH is a private not-for-profit organization. The Agency receives financial support from many sources such as the United Way, the Missouri Department of Mental Health, the Missouri Department of Health, Medicaid Program, SB 40 Boards, contributions, and from fees paid by families.

UCPH In-Home Supports program is funded through the Productive Living Board of St Louis County. Occasionally, UCPH accepts contracts from the Department of Mental Health – Regional Center. Families must meet the guidelines set forth through UCPH contract with any third-party payers to be eligible for services. Because the In-Home Support program is solely dependent on payment from third party payers, any changes in funding level, policy or procedure by any third party payers will result in changes to the In Home Supports services.

Fiscal Practices

- All financial and business practices of the Agency will be conducted in accordance with all applicable federal, state and local laws, as well as those that are assigned by funding sources of the Agency.
- All financial matters of the Agency shall be conducted within the standards set forth within the generally accepted standards (i.e., GAAP, IRS, and Department of Revenue) of sound fiscal management practices.
- All fiscal and business activities that are governed by the Agency's policies and procedures will comply with those policies and practices.
- All fiscal and business matters that are governed by the Agency's Bylaws shall be conducted in accordance with those Bylaws.

General Information

It is the goal of UCPH to help people to become and stay active in their communities. The difference in life styles between people with disabilities and others will lessen as our consumers learn the skills that are necessary

to function as independently and as fully as possible in their community. The In Home Supports program is fully funded by the Productive Living Board.

Individual/Family Support provides in-home and in-facility supports to maintain consumers in their natural family home. Supports promote the acquisition of skills for independence. Supports must be directed to increase the consumer's residential living skills, formation of social roles, relationships and self-reliance.

Family Supports Programs

- *In Home supports - a year-round reimbursement program; the family selects their own provider to deliver support services in the home, which helps individuals achieve greater independence and enhances quality of family life*.
- Marlborough Hall - Provides temporary scheduled respite care for children and adults and emergency residential care both 24/7, 363 days per year.
- Summer Camp - a day camp that provides quality camping experiences for children in St. Louis County ages 10 – 19 during the summer when school is not in session.
- Educational Day - teens and preteens engage in structured educational and leisure activities when school is closed during winter and spring breaks.
- Summer Voucher - a financial assistance program offered during the months when school is closed. Reimbursement helps the family pay for programs such as day camps or in-home supports while school is not in session.

Communication and Family Involvement

Any concerns regarding the In-Home program should be communicated to the Assistant Director.

We believe that UCPH provides vital services and support for consumers and families. We are committed to providing the highest quality services possible, and with the active cooperation and understanding of consumes and families, we are confident that the standards of service we have established and which we strive to attain will be met in the most effective and caring manner possible.

In order to assist us in maintaining effective and efficient services, families will be asked to complete satisfaction surveys three times a year. These surveys help us monitor and improve the quality of services provided. Information is treated in a confidential manner.

Parents or other responsible parties should notify the Assistant Director immediately whenever there is to be or has been a change in the consumer's address or phone number.

Admission Criteria – In Home Supports

The In Home Supports Program is funded by the Productive Living Board. Admission requires the following:

- Completion of all admission, permission and enrollment forms;
- Consumer and family live in St Louis County;
- Consumer lives in natural family home or with a guardian;
- Consumer must have a diagnosed developmental disability that meets the definition of the Productive Living Board.

Admission Procedure – In Home Supports

Referrals may be made by anyone – such as parents, local and area health departments, hospitals, other community agencies, public welfare workers, and doctors.

During the first inquiry, an explanation of services is provided and the applicant is asked for information. If UCPH programs and services are thought to be right for the person, an application is mailed within three

working days. When the completed application packet containing all necessary attachments is received, it will be processed.

Based on the information obtained, the number of available support hours will be allotted. The maximum any family is eligible for is 504 hours per fiscal year.

Waiting Lists – In Home Supports

Admission into the program may be delayed for any one of the following:

- Capacity enrollment in appropriate program
- Pending receipt of further information

Up-to-date waiting lists (if applicable) will be maintained by the Assistant Director of the program. Individuals shall be enrolled on a first-come basis based on the date of their referral/application and/or eligibility determination for service.

A delay in program enrollment (placed on the waiting list) does not mean a delay in initiating other Agency services.

Notice of Withdrawal/Discharge/Re-entry – In Home Supports

Participation in the UCPH In-Home Support program is voluntary and NOT an entitlement. Families who fail to meet the guidelines of the program will be immediately discharged. Other reasons for discharge:

- Falsification of documents
- Relocation out of St. Louis County
- Failure to comply with program guidelines
- A family will be discharged from the program if they do not use the in-home support program for a period of more than 12 months and/or they fail to complete the necessary annual reenrollment application and survey
- Families may voluntarily exit from the program at any time. We ask that you notify us so that we may make your space available for another family in need
- Families are eligible to re-enter the program if they move back into St Louis County and meet all other eligibility requirements

Annual re-enrollment – In Home Supports

Annual re-enrollment is required.

- In the spring families will receive an update packet from UCPH. The forms, survey and any other requested documents must be returned to UCPH to ensure continued enrollment in the program.
- UCPH will send a confirmation letter indicating the allocated number of in-home support for the program participant to use from July 1 through June 30. The number of hours allocated is based upon the need of the applicant.

Agency Marketing and Public Relations Activities

- Marketing and Public Relations activities are integral components of the Agency's accountability to the public at large.
- Marketing and Public Relations efforts/activities will always respect the dignity and privacy rights of individuals served.
- Marketing and Public Relations activities will never consciously misrepresent the Agency or mislead/misinform the public.
- All Marketing and Public Relations activities will uphold and support the integrity and character of the Agency so as to merit the continued support and trust of the public.

Hours of Operation/Holidays

The UCPH In-Home Supports program business hours are 8:00-4:00 Monday through Friday.

The Office will be closed on the following holidays:

New Year's Day	Good Friday	Memorial Day
Independence Day	Labor Day	Thanksgiving
Friday after Thanksgiving	Christmas Day	

Statement on Consumer Rights

UCP Heartland (UCPH) acknowledges that you are entitled to all Legal and Civil Rights defined by law, and these additional rights as listed and established by UCPH, without limitation or reservation. You will be encouraged and supported at all times to exercise your rights as a citizen.

1. **Information**
   Before you receive services through UCPH, and each year thereafter, information about what is expected of you and what you can expect of others will be explained to you in a language that you understand.

2. **Medical Treatment**
   You have the right to have a doctor explain your health and medical condition.

   You have the right to seek a second opinion from another doctor.

   The Agency will seek emergency medical treatment as it deems necessary. You have the right to refuse treatment by a hospital or medical professional thereafter.

   You have the right to receive prompt medical care.

   You have the right to voluntarily participate in a test study after you have been told what the test is and you have given written permission.

   You have the right to be examined and treated with dignity, respect and in privacy as applicable.

3. **Advance Notification of Program Change**
   You have the right to be informed of any changes in services which are proposed to be made before those changes occur. Information will be communicated in an acceptable, identified format that you comprehend.

4. **Exercising of Civil Rights**
   You have the right not to be discriminated against because of your race, gender, sexual orientation, creed, marital status, national origin, disability, or age.

   You have the same rights and responsibilities, unless stated by law, as any other citizen of the United States.

   You have the right to receive a fair review of alleged violations of the rights listed and any rights otherwise assured by law.

   You will be encouraged and supported at all times to exercise your rights as a citizen.

You have the right to express your concerns and complaints, recommend changes in policies, procedures and services to the administration, staff, and other representatives without the fear of punishment or retribution.

5. **Personal Financial Affairs**

   You have the right to be paid fairly for work performed, according to U.S. Department of Labor guidelines.

   You have the right to manage your own money. If it is determined that you are unable to do so and you or your guardian give written permission, the Agency will help you in managing your personal funds.

   You have the right to receive your money in a timely manner when UCPH is the payee or the manager of your personal funds.

6. **Freedom From Abuse/Neglect**

   You have the right to be free from any verbal, physical, sexual or psychological abuse.
   You have the right to be free from actions or inactions that will/could compromise your health and safety.

7. **Freedom From Mechanical, Physical or Chemical Restraint**

   You have the right to be free from restraints except when allowed by you or your guardian and your support team, ordered by your doctor and with an approved Behavior Support Plan.

   a. Overcorrecting and compliance training will be used with the informed consent of the consumer and/or guardian.
   b. When ordered by a doctor, restraints are used to protect consumers from injury to themselves or others as needed.
   c. The staff of UCPH will never give medication solely for the convenience of staff.
   d. In emergency or crisis situations, the Agency will implement one-time use of restraints to ensure your safety and the safety of others.

8. **Confidentiality**

   You have the right to have your records kept confidential. Only after you or your guardian have given written permission will others, who are not otherwise authorized, know what is in your records.

   Only records generated by UCPH will be eligible for release by UCPH.

9. **Privacy**

   You have the right to privacy except when such privacy would hinder your safety or the safety of others.

10. **Relevant Support Services**

    Each person served has the right to receive appropriate services provided through UCPH without regard to race, color, creed, sex or disability. Each individual has the right to active and ongoing participation in the selection of relevant services available through UCPH or other agencies that would support accomplishing life goals as documented through their Person-Centered Plan. Each individual and/or their guardian has a right to a copy of the Plan and any subsequent documentation of changes to that Person-Centered Plan, and to request changes/amendments to the Plan at any time.

11. **Communication**

    You have the right to talk, spend time with, and have private meetings with anyone you choose, unless it infringes on the rights of others or otherwise have been legally restricted.

You have the right to send or receive personal mail.

12. Participation by Choice
You have the right to be a member of any social, religious or community group. You are encouraged to experience all activities offered in your community.

13. Personal Possessions
You have a right to own and keep personal items as space and regulations permit.

14. Least Restrictive Environment
You have the right to be supported in the most appropriate and least restrictive environment available to meet your individual needs.

You have the right to live, work and recreate in a barrier free environment.

You have the right to the dignity of risk proportionate to your abilities. The potential risks and benefits of your, or your guardian's, choices will be explained and acknowledged in writing by you or your guardian primarily through the Support Plan process, but may be accommodated through an alternate process as appropriate.

15. Sexuality
You have the right to sexual expression, reflective of age, social development, cultural values, and social responsibility.

16. Relationships
You have the right to develop friendships and emotional relationships where you can love and be loved and start and stop relationships as you so choose.

17. Food
You have the right to receive and consume a healthy and nutritious diet.

18. Termination of Services
You have the right to end or stop services provided by UCPH.

You or your legal guardian must inform UCPH if you want to end or stop services.

You have the right to be informed of the reasons when UCPH terminates your services and may appeal such termination within the Association's Grievance Policy.

19. Legal Services
You have the right to seek legal counsel.

In practice, it may be necessary to impose a one-time limited restriction of the consumer's rights in order to protect the consumer from eminent harm. When a consumer's right is restricted, the incident will be reported within 24 hours to the Human Rights Committee for immediate review and recommendations.

Statement of Acceptance and Acknowledgement: You or your guardian will be asked to confirm your acceptance of this information.

Privacy and HIPAA

Within Adult Day Services, we hold personal medical information in the highest confidence. Each participant's personal medical information is protected not only by our policies, but also by federal law. This federal law is called the Health Insurance Portability and Accountability Act (HIPAA). The following is a summary of our privacy policies.

We keep a file of pertinent information on each consumer. It includes such information as medical information, the support plan, releases of information, emergency contacts, and past incident reports. If may also include medical prescriptions, copies of evaluations, and progress notes.

Other than that which is required by funding sources, we will only release personal medical information to those persons or organizations that you select by written request. These releases of information are limited to each person or organization you specify, and only the specific authorized information. The releases can be revoked at any time, again with your written request. These releases are kept in the participant's permanent file. In addition, we are prohibited from releasing any information that was not generated by UCPH (for example, we cannot send a neurology report that we received to the consumers audiologist, rather the audiologist must ask the neurologist for it directly, or we can give you a copy and then you can give it to the audiologist).

If a consumer or guardian amended or submitted a written statement of disagreement for the participant's file, we are required to enclose that information along with any personal information that we release.

There are certain instances when we are required to release a participant's personal medical information without consent. These releases will only involve the minimal information necessary to address the specific issue. The following situations are types of circumstances we are required to release information without consent:

- Emergency treatment: If a consumer needs emergency care, we may need to give medical information to the medical personal.
- Public health: If a consumer has a communicable disease (ex: meningitis) that requires reporting to the public health authorities, we are required to report the relevant personal medical information.
- Abuse/neglect: Staff are mandated by law to report all suspected cases of abuse and neglect. Reports will include relevant personal medical information. Additional information on our abuse and neglect policy can be found in this handbook.
- As required by funding sources.

In accordance with Missouri's Data Breach Notification Law, any breach in protected health information (PHI) shall be reported to the President and CEO. A breach is the unauthorized acquisition of personal information maintained in a computerized form, that compromises the security, confidentiality or integrity of the personal information, (e.g. the theft of an employee laptop). A breach does not include the good faith acquisition of protected health information (PHI) by an entity for legitimate purpose so long as the information is used appropriately and not in violation of the applicable law. When a breach has been determined to have occurred, the President and CEO will send written notice to the affected individuals within 48 hours of discovering the breach.

If you have any questions regarding our privacy policies, please contact the Department Director. If you believe UCPH has violated your privacy rights or you are in disagreement with a decision made regarding your request, you may file a written complaint with the Privacy Officer at the UCPH Corporate Office or file a

complaint with the United States Secretary of Health and Human Services at: Office for Civil Rights

U.S. Department of Health and Human Services
200 Independence Ave. SW
Washington, D.C. 20201
877-696-6775

You will experience no negative consequence for filing a complaint.

Consumer Grievance Procedure

It shall be the policy of UCP Heartland that there be grievance procedures available to all consumers served, advocates, and guardians, who are aggrieved by some administrative action or when they feel an employee of the Agency has not acted in accordance with established Agency policies or procedures.

No consumer who, in good faith, reports a concern shall be subject to harassment, retaliation or adverse service consequences. Moreover, any employee or consumer who retaliates against a consumer who has reported a concern in good faith is subject to disciplinary action, up to and including their termination of employment or discharge from the service.

Procedure

1. The following practices apply to formal grievances by any consumer served, advocate, or guardian, but shall not be construed to exclude anyone from the right to informally approach the President or designee for the purpose of discussing their concerns.
2. Individual(s) are encouraged and expected to communicate through the applicable chain of command until resolution is reached. It is expected that most grievances will be able to be handled at this level in a professional and fair manner suitable to all parties concerned. However, if the issue cannot be resolved, the organization has established the following procedure:

Request for Formal Grievance Meeting

1. Any consumer who feels that he/she has cause for grievance in the case of is/her own situation concerning services, should first consult with the director regarding the grievance.
2. If the consumer and the director are unable to reach a satisfactory adjustment or solution, the matter may be referred in writing by either party to the person next in line of supervision. When the aggrieved party is unable to make a written request, an alternate format such as recorded voice may be used. A third party intermediary chosen by the aggrieved party may also be used. Note: All stages of grievance shall be submitted in writing, stating all facts specific to the grievance, and the reason for filing said grievance.
3. Upon coming to the President's attention, the President will attempt to seek a solution within 10 working days from the time the written grievance was received. The President shall respond, in writing, to the aggrieved consumer with his/her decision.
4. Should the President's determination of the grievance be unacceptable to the consumer, there shall be one Final Stage Of Grievance available. This final stage shall involve the Operations Committee's appointment of a 1-3 member Final Stage Grievance entity which will be comprised of individuals who are not paid staff of the organization. The aggrieved consumer will also need to sign a release of confidentiality form as well as a release of liability form, releasing the entity members from individual liability, before the Final Stage Grievance is formally addressed by this entity.
5. If a grievance involves an employee to whom a grievance is to be presented, the grievance may be directed to another member of management.

*Consumer as contained herein is defined as the person receiving UCP Heartland services, his or her parent acting on his or her behalf, or a legal guardian.

Consumer Rights
Acknowledgement Statement

This is to acknowledge that I have received and read or had read to me the UCP Heartland Consumer Rights. I have asked for and received to my satisfaction an explanation of anything I did not understand. I have retained a copy of my rights for my reference.

________________________________ __________________________
Consumer's Signature Date

________________________________ __________________________
Guardian's Signature - if applicable Date

________________________________ __________________________
Guardian's Signature - if applicable Date

(Original to be placed in Consumer's Central Case file)

Consumer Grievance Procedure
Acknowledgement Statement

This is to acknowledge that I have received and read or had read to me the UCP Heartland Grievance Procedure. I have asked for and received to my satisfaction an explanation of anything I did not understand. I have retained a copy of the procedure for my reference.

______________________________	______________________________
Consumer's Signature	Date
______________________________	______________________________
Guardian's Signature - if applicable	Date
______________________________	______________________________
Guardian's Signature - if applicable	Date

(Original to be placed in Consumer's Central Case file)

Consumer Handbook
Acknowledgement Statement

This is to acknowledge that I have received and read or had read to me the UCP Heartland In Home Supports Handbook. I have asked for and received to my satisfaction an explanation of anything I did not understand. I have retained a copy of the handbook for my reference.

_______________________________ _______________________________
Consumer's Signature Date

_______________________________ _______________________________
Guardian's Signature - if applicable Date

_______________________________ _______________________________
Guardian's Signature - if applicable Date

(Original to be placed in Consumer's Central Case file)