

Dear Family,

Enclosed please find an application for respite services and general information about the Metropolitan Atlanta Respite Cooperative (MARC) and Right in the Community. This application is universal among all the MARC agencies so you will need only to complete one application to access all of the respite options. If you have any questions regarding the application process, please do not hesitate to call Ioana B. Marlow or Jerrie V. Paschal at 770-427-8401.

Please note that it is very important to provide documentation for a developmental disability. This can be an IEP or a doctor's statement. Your application cannot be processed without this. You will also need to include proof of income for your family if the consumer is fewer than 18 years of age and for the consumer if he is over 18 years of age. Proof of income includes the most current tax return or SSI/SSA statement letters.

Once we have received your application, we will evaluate it and send it along to MARC (Metro Atlanta Respite Cooperative) for approval. Once you have been approved, you may schedule respite at the RitC Respite Home, another facility, or with an in-home or host provider. To schedule respite at the RitC Respite Home, you should call 770-427-8401.

Also enclosed is a family information packet that explains the respite program and its procedures. Please read this thoroughly, as it will provide you with an understanding of how the respite program operates.

We look forward to hearing from you soon. Please do not hesitate to call on us if you have questions.

Sincerely,
Right in the Community, Inc.

Ioana Marlow

Ioana B. Marlow, Respite Coordinator
615 Roswell Street NE, Suite 150
Marietta, GA 30060
770/ 427-8401
770/ 427-8402 fax
ibm@rightinthecommunity.org



METROPOLITAN ATLANTA RESPITE COOPERATIVE (MARC)

A group of agencies including Georgia Community Support & Solutions, Inc.(GCSS), Right in the Community, Inc.(RitC), Douglas County Retardation Association (DCRA), Metro Atlanta Respite and Developmental Services (MARDS), and Jewish Family and Career Services (JF&CS) have banded together to form a respite cooperative in order to expand and create respite care choices in the Metropolitan Atlanta area for families of individuals with disabilities. The philosophy of the cooperative is based on two principals: 1) Families have different needs for respite care and should have options in their community to meet these needs and 2) Families of individuals with developmental disabilities, regardless of their severity, should be provided with as many options as possible for accessing respite care. The program is based on a family choice model. Eligible families are able to choose respite care from the MARC pool of providers or any resource they know, formal or informal, in order to receive subsidized respite care. This can include agencies that are not participating in the cooperative or individuals that they know as long as enrollment criteria is met (for example: friends of the family, teachers, extended family, etc.) The only criteria placed on a family choosing a provider is that they cannot live in the same home and they must have a fingerprint/criminal records check, current first aid, and CPR certification. Formal providers would include agencies enrolled that are not a part of the MARC Cooperative. They must meet formal provider enrollment criteria.

Because the service is based on family preference:

- Families can choose any agency or provider they want.
- Families can choose to use any or all respite options: staff trained for the specific needs of the individual will be placed in that option.
- Respite care is arranged by issuing a voucher requested by the family or the agency that is providing respite care.

The current agency options are:

MARC AGENCIES	TYPE OF RESPITE	OFFICE LOCATION
Jewish and Family Career Services	In Home and Host Family (in your home or in a provider’s home)	4549 Chamblee Dunwoody Rd Atlanta, GA 30338-6210 770-677-9341
Right in the Community Respite House	Group Respite Home (call for address)	615 Roswell Street NE Suite 150 Marietta, GA 30060 770-427-8401
Douglas County Retardation Association- Robert Chadwick Home	Group Respite Home (call for address)	PO Box 1318 Douglasville, GA 30138 770-942-1131
Metro Atlanta Respite and Developmental Services	Facility Based Weekend Respite	1335 Kimberly Rd. SW Atlanta, GA 30331 404-691-5570
*Georgia Community Support and Solutions (Lead Agency)	In Home and Host Family RRA Home/Richard’s Home (call for address)	1945 Cliff Valley Way, Ste. 220 Atlanta, GA 30329 404-634-4222

Currently, there are three levels of subsidies (fees) based on the level of care required by the individual. MARC agencies, in conjunction with the family, assess the individual and assign a level of care required by the individual.

DESCRIPTIONS OF LEVELS OF CARE

LEVEL I:

Requires supervision only for safety issues/companionship--No behavior issues.
Includes: Medication assistance and apnea monitoring

LEVEL II:

Requires assistance in meeting the five (5) basic needs:
Includes: Feeding, Bathing, Dressing, Toileting, and Transferring--can be total care and/or minor behavior issues

LEVEL III:

Medically involved or excessive behavioral issues
Medical needs include: Tracheotomy suctioning, sterile procedures, any medically invasive care, but not treatment
Behavioral needs include: Behaviors that are considered aggressive, self-abusive, or destructive. Behaviors must be considered extensive and a barrier to typical respite care--examples are excessive biting, hair pulling, hitting, etc.

LEVELS	Subsidy (fee) schedule per hour*	
	HOME BASED	FACILITY BASED
I	\$6.00	\$7.00
II	\$7.00	\$8.00
III	Range from \$8.00-\$12.00	Range from \$8.00-\$12.00

*In a 24 hour period, there is a cap of 10 hours. Any amount used over 10 hours will still be considered 10 hours

Families are responsible for a percentage of the cost of respite. The family's subsidy rate is determined by the age of the individual needing care, the level of care that is needed, the family's annual income, and the number of people living in the home. The cost per hour (determined by the level of care above) is multiplied by the assigned subsidy rate (determined by the following chart). For example, a family of four has an income of \$30,000 per year and level of care needed is level 2, the family is responsible for 30% of the cost of care per hour of 30% or \$7.00 per hour for home based respite. This comes to \$2.10 per hour and if respite is used for over 10 hours, the maximum a family would pay would be \$21.00 for the entire day up to 24 actual hours.

SUBSIDY RATES

ANNUAL INCOME	NO. OF FAMILY MEMBERS		
	4 or more	3	2 or less
\$0.00 - \$12,999	10.00%	12.00%	14.00%
\$13,000 - \$16,999	16.00%	18.00%	20.00%
\$17,000 - \$20,999	22.00%	24.00%	26.00%
\$21,000 - \$24,999	28.00%	30.00%	32.00%
\$25,000 - \$28,999	34.00%	36.00%	38.00%
\$29,000 - \$32,999	40.00%	42.00%	44.00%
\$33,000 - \$36,999	46.00%	48.00%	50.00%
\$37,000 - \$40,999	52.00%	54.00%	56.00%
\$41,000 - \$44,999	58.00%	60.00%	62.00%
\$45,000 - \$48,999	64.00%	66.00%	68.00%
\$49,000 - \$52,999	70.00%	72.00%	74.00%
\$53,000 - \$56,999	76.00%	78.00%	80.00%
\$57,000 - \$60,999	82.00%	84.00%	86.00%
\$61,000 - \$64,999	88.00%	90.00%	92.00%
\$65,000 - \$68,999	94.00%	96.00%	98.00%
\$69,000 and Over	100.00%	100.00%	100.00%

All respite is arranged and tracked through a voucher system. This system allows Georgia Community Support and Solutions to monitor and collect data. Most importantly it is used to monitor who is using respite, how much respite is being used, and who is providing the respite. It is suggested that families limit their use of respite to twenty-five (25) hours per month with a **maximum** of three hundred (300) hours per fiscal year or as the budget may allow. Families do not have to use respite every month, however, if it is not used one month, it does not carry over to the next month. **Respite is on a first come, first serve basis depending on the budget.**

Voucher Process

- Respite is requested by the family either through GCSS or another MARC agency.
- If approved, a voucher for the respite sit is issued and sent to the family or the MARC agency. It is recommended that families schedule respite up to 30 days in advance. Families may access twenty-five (25) hours of respite per month, budget permitting.
- After the respite occurs, the voucher is signed by both the family and the provider verifying that all given information is correct.
- The voucher is then returned to Georgia Community Support and Solutions for redemption.
- The voucher is redeemed and logged against the family's budget.

OTHER INFORMATION

- As stated, levels of care will be assigned by the intake agency based upon the application and the intake information. The level of care is subject to change over time based upon different programs and the individual's needs.
- Although the Cooperative has developed policies and guidelines, each individual MARC agency reserves the right to maintain its own standards and policies for operation.
- Family and Provider applications are universal throughout the Cooperative. These applications may be shared with other agencies in the MARC Cooperative when consent for release has been given on the information release in the application or the family may call in the request verbally.
- Individuals over the age of 18 are considered to be a family of one. The subsidy rate is based upon the individual's income (SSI).
- Respite is scheduled on a first come, first serve basis. At least 24 hour notice is needed when scheduling respite. Respite may be approved as much as **30** days in advance.
- Respite is not to be used for day care or after school care. It is to provide an occasional break in care taking responsibilities.
- Emergency/Crisis respite care is available for participants who are enrolled and are eligible to receive respite services. For this service please contact your coordinator or call (404) 634-4222. If it is after regular working hours please call (404) 362-8077 and the answering service will activate the pager system.
- If a voucher is not returned within **30** days of the respite sit, the voucher will become void.
- **All vouchers must be signed by both the provider and the family.** If a voucher is sent without both signatures it will not be redeemed and will be returned to the provider or family in order to obtain the signature that is needed.
- We cannot receive faxed signed vouchers.
- All requests must come from the family and all vouchers must be mailed to the family.
- Families and providers have the right to submit complaints without fear of discrimination or retaliation and to have them investigated within a reasonable period of time. When a complaint is submitted, both parties involved in the complaint will be questioned regarding the issue. Further action will be taken as deemed necessary by a coordinator.

- All complaints may be submitted to any Respite Coordinator at Georgia Community Support and Solutions, 1945 Cliff Valley Way, Ste. 220, Atlanta, GA. 30329 or call (404) 634-4222.
- Any questions regarding licensing or questions/concerns regarding the funding may be directed to Georgia Community Support and Solutions Respite Program, (404) 634-4222 or the appropriate Regional Board:

Region 3 Office (Cherokee, Clayton, Cobb, DeKalb, Douglas, Fayette, Fulton, Gwinnett, Henry, Rockdale)
100 Crescent Centre Parkway, Suite 900
Tucker, GA 30084
(770) 414-3052

Region 2 Regional Board (Newton County) (706) 792-7733

Family Application

Today's Date: _____

PARTICIPANT INFORMATION

Name of Family Member _____

Social Security # _____ Birthdate _____

Address: _____

Street Address City

State Zip Code County

Race _____ Sex _____ Hair Color _____ Height _____ Weight _____

Eye Color _____

Disability(ies) of the Participant: _____

Does participant have Waivered services? _____ If yes, what are the Waivered services? _____

What is the agency providing the Waivered services? _____

Please give a brief description of the participant's condition and special needs:

Legal Status of Participant: _____

(minor, competent adult, or incompetent adult)

Relation to Responsible Party: _____

RESPONSIBLE PARTY INFORMATION

Name of Parent/Legal Guardian _____

Address: _____

Street Address City

State Zip Code County

Birth Date: _____ Marital Status: _____

Occupation: _____ Employer: _____

Home Phone:(____) _____ Work Phone:(____) _____ Fax: (____) _____

Car Phone:(____) _____ Pager:(____) _____

e-mail address: _____

Does the Participant have seizures? Yes_____ No_____ If yes, describe the seizure activity (include length, frequency):

Does anything ever occur to warn you of a seizure? Please describe:_____

What does the participant do after the seizure (for example--sleep):_____

Does the participant use adaptive equipment (e.g. communication device, wheelchair, etc.)? Yes_____ No_____ If yes please describe:_____

Special Instructions for use and storage_____

For how long and at what times is this equipment used?_____

How long has the participant been using this equipment?_____

Who may we contact for repairs in the event of an emergency?_____

COMMUNICATION

How does the participant communicate?
Please check all that apply.

- Can talk without difficulty ()
Can talk with some difficulty ()
Makes sounds that are understandable
to the parent ()
Uses Sign Language ()
Uses communication device ()
 Signboard ()
 Augmentative Communication ()
Other: (Please List) ()

- Communicates with facial expressions ()
Does not communicate ()
Other: _____ ()

**How well does the participant understand
what is said to him/her?**

- Has no problem with understanding ()
Requires simple one or two step
instructions ()
Needs gestures to understand ()
Doesn't understand language ()
Uses facial expression to understand ()
Other means of understanding:

Sleep Habits

- When is wake up time? _____
When is bed time? _____
When is nap time? _____

Sleeping Arrangements

- Sleeps in a regular bed ()
Sleeps in a crib ()
Sleeps in a bed w/ rails ()
Sleeps in a hospital bed ()
Other (please describe) ()

PARTICIPANT PREFERENCES

Does the participant have a certain
schedule of activities? If yes, please
list times and activities.

Does the participant have favorite
activities? Please list.

Does the participant have favorite
foods? Please list

Are there certain foods or activities
to avoid? Please list

Does the participant have specific fears that staff or care providers should know about (e.g. dogs, loud noises)

Are there any specific house rules or other requirements to be enforced by the respite care provider/agency?

PERSONAL CARE NEEDS

Mobility

Walks independently ()
Crawls ()
Uses walker or crutches ()
Walks w/ assistance ()
Uses wheelchair independently ()
Can sit w/out wheelchair ()
Uses wheelchair w/assistance ()
Requires transfers ()
Uses stroller/travel chair ()

Toileting

Independent ()
Bladder Control ()
Bowel Control ()
Needs assistance ()
Wears diapers/attends ()
Toilets on a schedule ()
(Schedule)_____

Needs enema ()
Requires catheterization ()

Hygiene

Prefers Shower() Bath ()
Washes independently ()
Cannot wash self ()
Needs assistance ()
Please explain:_____

Shampoos hair ()
Cannot Shampoo hair ()
Needs assistance ()
Brushes/combs hair ()
Cannot brush/comb hair ()
Needs assistance ()
Brushes teeth ()
Cannot brush teeth ()
Needs assistance ()
Please explain:_____

Shaving ()
Needs assistance ()
Menstruation ()
Needs assistance ()

Feeding

Eats independently ()
Drinks independently ()
Bottle fed ()
Blended or special diet ()
G, J, or NG tube fed ()
Feeds self w/ spoon ()
Feeds self w/ fork ()
Must have food cut()

Needs assistance with w/
utensils ()
Needs other assistance ()
Please explain:_____

Feeding Difficulties

- Tongue thrust ()
 - Gag reflex ()
 - Swallowing difficulties ()
 - Difficulty chewing ()
 - Other ()
 - Explain: _____
-

Dressing

- Dresses independently ()
 - Needs assistance ()
 - Please explain: _____
-

Other Needs

Behavior

- Hitting, biting, or fighting ()
 - Self abusive behavior ()
 - Running away ()
 - Hyper/Overactive behaviors ()
 - Other ()
 - Please explain: _____
-

Medical Needs

- Has a G-tube ()
 - Has a J-tube ()
 - Has a NG-tube ()
 - Is on a apnea monitor ()
 - Has a tracheotomy ()
 - Requires shallow suction ()
 - Requires deep suction ()
 - Oxygen dependent ()
 - Ventilator dependent ()
 - Requires injections ()
 - Other ()
 - Please explain: _____
-

When do you think you will use respite care?

Weekdays _____ Vacations _____
Weeknights _____ Overnights _____
Weekends _____ Other _____
Please Specify _____

What type of respite do you think you will use most?

Group Respite Home _____ In another family's Home _____
Group Respite Facility _____ Only from a provider you know _____
In-Your-Home _____ Other _____
Please Specify: _____

If you choose facility based respite options, do you have transportation? _____

Are there other services that you are interested in and/or would like to see developed? Please check the services that you see a need for in relation to your family member with a disability. This information will be used in data collection and reporting family needs in the Metro Atlanta area.

Residential Living Alternatives

Group Home _____
Supported Living Options _____
Institution _____

Recreation Programs

With other people with a disability _____
Based on the individual _____

Advocacy Programs _____

Lifelong Service Coordination _____

Other: _____

Employment Services

Workshop _____
Mental Retardation Service Center _____
Supported Employment _____
Competitive Employment _____

Child/Adult Care _____
Child Day Care _____
After school Care _____
Summer Camp _____
Summer Day Programs _____
Adult Day Programs _____

Seniors with Disabilities Programs _____
Integrated Senior Services _____
Specialized Senior Programs _____

Would you agree, with prior notice and approval, to discuss with other families the care your family member received from individual care providers and agency programs?

Yes_____ No_____

How were you referred to the MARC program?_____

Referral Name:_____

Address:_____

Phone : ()_____

I hereby confirm that the information given at the time of application is true to the best of my knowledge.

Signature of Parent/Guardian:_____

Parent/Guardian Name (Print):_____

Relationship to the Participant:_____

Other Parent/Guardian Signature:_____

Parent/Guardian Name (Print):_____

Relationship to the Participant:_____

Participant Signature:_____

Participant Name (Print):_____

Date:_____

****Remember to attach documentation of disability**

OPTIONAL: We would like to include a recent photograph of the respite participant in his/her permanent respite file. Please attach a photograph with the participant's name written on the back.



FINANCIAL INFORMATION STATEMENT

I, _____ acknowledge that my **annual**
(Your name)

net family income is _____. I understand that this information will be
used in determining subsidies for the MARC Respite Program.

Please attach a copy of **one** of the following for **all** primary caregivers if your child or family member is
under the age of 18.

_____ Most recent tax return indicating net annual income

_____ Most recent pay stub for **each** primary caregiver

**Please check here if the participant is over the age of 18 _____. If your child or family member is
over the age of 18, please include a copy of social security income documentation.**

Please check the number of family members currently living in your home:

_____ **2 or less** _____ **3** _____ **4 or more**

Signature of **Parent/Guardian/Primary Caretaker**

Printed Name of **Parent/Guardian/Primary Caretaker**

Date

Printed Name of Family Member

Date of Birth



METROPOLITAN ATLANTA RESPITE COOPERATIVE (MARC) INFORMATION RELEASE

Participant Name: _____

Address: _____

Date of Birth: _____

I hereby authorize _____ to release information on my family's (the agency with whom you initially enrolled) respite care application to the following respite program(s) in order to subsidize or provide care to my family member.

- Georgia Community Support & Solutions _____yes_____no
- Right in the Community _____yes_____no
- Atlanta Jewish Community Center _____yes_____no
- Metropolitan Atlanta Respite and Developmental Services _____yes_____no
- Jewish Family & Career Services _____yes_____no
- Douglas County Retardation Association _____yes_____no
- Other: _____yes_____no

Please note: Only consented agencies will receive this application.

I further understand that I can withdraw this consent at any time except to the extent that action has been taken.

I authorize the use of information contained on my application to be used as part of group statistics to determine future and ongoing community needs. Under this authorization, I understand that my family name will not be released as part of these statistics.
_____Yes _____No

I understand that I can withdraw this consent at any time except to the extent that action has been taken.

Signature of Participant/Parent/Guardian: _____

Participant/Parent./Guardian Name (please print): _____

Date: _____

**GEORGIA COMMUNITY SUPPORT AND SOLUTIONS
RESPITE CARE VOUCHER PROGRAM**

WAIVER AND RELEASE

As a voluntary participant in the Georgia Community Support and Solutions Respite Care Voucher Program, (“Program”), I understand and acknowledge that the Georgia Community Support and Solutions (“GCSS”) is not involved and has not been involved in any way with the selection of the respite care provider or respite care agency which will provide respite care to my family member. I also understand and acknowledge that GCSS has not evaluated, tested, or screened the care provider or respite care agency, and that GCSS makes no representations about the care provider or his or her capability or suitability.

I accept that it is my responsibility as a family member in using this program to select a respite care provider or agency to provide respite to my family member with a disability. I understand that it is my responsibility also to determine the suitability of the respite care provider or respite care agency to provide adequate care to my family member, to acquaint them with the particular needs of my family member receiving respite care and provide evaluation and supervision of all respite care received by my family member. Therefore, on my own behalf and on behalf of my family, I freely and voluntarily accept all risk of personal injury and property damage arising from my family’s participation in the Program.

In consideration of my being allowed to participate in the Program and to receive a respite care voucher, I hereby release and discharge GCSS, its officers, directors, employees, agents, and successors, from any and all claims losses and demands whatsoever that I or my family may hereafter have for injuries or property arising or resulting from my and my family’s participation in the Program, all of which claims I hereby waive. I waive my and my family’s rights with the full knowledge that GCSS assumes no liability or responsibility for personal injury or property damage arising from my family’s participation in the Program and that GCSS will not compensate me or my family in any way for any loss or injury I or my family may sustain. I understand and agree that this waiver and release will be fully binding on me, all members of my family, our estates, and our heirs, and that neither I nor any member of my family nor anyone claiming through me or any member of my family will have any legal right assert a claim against GCSS or its officers, directors, employees, and agents or any of their successors, relating to me and my family’s participation in the Program.

This _____ day of _____, 20__.

WITNESS

FAMILY/PARTICIPANT SIGNATURE

PRINTED FAMILY/PARTICIPANT NAME



EMERGENCY MEDICAL TREATMENT INFORMATION AND RELEASE

Participants Name _____ SS # _____

Address _____

Date of Birth _____ Age _____ Birthplace _____

Disability(ies) _____

Physician's Name _____ Phone _____

Address _____

Preferred Hospital _____

Name of Insurance Company _____ Policy Number _____

Medicaid # _____ Medicare # _____

Person(s) to Contact in Case of Emergencies:

Table with 3 columns: Name, Phone, Relationship. Three rows of blank lines for entry.

Allergies: _____

Other Health Information: _____

I agree to allow my Respite Care Provider, at the expense of the undersigned, to institute emergency medical treatment through the designated physician or other recognized medical resource. When possible, my Respite Care Provider shall contact the undersigned prior to such action. Also, I agree to allow my Respite Care Provider to obtain emergency medical transportation, at the expense of the undersigned.

Signature of Participant/Parent/Guardian _____

Date _____

PARTICIPANT AND FAMILY RIGHTS AND RESPONSIBILITIES
The Metropolitan Atlanta Respite Cooperative

METROPOLITAN ATLANTA RESPITE COOPERATIVE is a family centered program that allows families to assist in the identifying their need for services and involves families in the service design and implementation. The respite program does not discriminate because of race, color, sex, creed, religion, age, or national origin of the participant, family and/or provider.

As a family enrolled in the Metropolitan Atlanta Respite Cooperative, you and your family have the right to:

1. Participate in the preparation of the respite and be informed about the services;
2. Be promptly and fully informed of any changes in the respite program;
3. Accept and refuse respite services;
4. Be treated in such a manner as to assure their safety, health, and comfort and shall be treated as an individual with his or her strengths, unique characteristics and needs acknowledged and respected;
5. Has the right to the maximum amount of privacy consistent with age, level of functioning, and effective delivery of services; the participant has a right to respect and respect of their property;
6. Have the right to confidentiality of all records and activities, within legal limits;
7. Have the right to submit complaints without fear of discrimination or retaliation and to have them investigated within a reasonable period of time. All complaints may be submitted to any Respite Coordinator at Georgia Community Support and Solutions or (404) 634-4222. Any questions regarding licensing or questions or concerns regarding the funding streams may be directed to address previously stated or to the appropriate Regional Boards:

Region 3 (770) 414-3052
Region 2 (Newton county only) (706)792-7733
8. Not be subjected to humiliation or mental or physical abuse in any fashion and must be accorded dignity at all times; shall not be exploited in any way;
9. Have the right to prompt and adequate medical treatment when needed;
10. Obtain a copy of the provider's most recent report of licensure inspection from the provider upon written request (reasonable photocopying fees may be charged).

As a family enrolled in the Metropolitan Atlanta Respite Cooperative, you and your family have the responsibility to:

1. Provide complete and accurate information to the best of your ability about your family member and the disability, the home situation, and any events which may effect the needed services;
2. Assure that financial obligations are fulfilled as promptly as possible; and
3. Be considerate of your respite provider.

I have received and reviewed the participant and family rights and responsibilities.

Family/Participant/Guardian Signature

Date

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METROPOLITAN ATLANTA RESPITE COOPERATIVE**

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2. Assure that financial obligations are fulfilled as promptly as possible; and
3. Be considerate of your respite provider.



NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice is effective April 14, 2003. It is provided to you pursuant to provisions of the Health Insurance Portability and Accountability Act of 1996 and related federal regulations. If you have questions about this notice please contact the Department's Privacy Officer or Divisions Coordinator at the address below.

The Department of Human Resources is an agency of the State of Georgia responsible for numerous programs that deal with medical and other confidential information. Both federal and state laws establish strict requirements for most programs regarding the disclosure of confidential information, and the Department must comply with those laws. For situations where stricter disclosure requirements do not apply, this Notice of Privacy Practices describes how the department may use and disclose your protected health information for treatment, payment, health care operations and for certain other purposes. This notice also describes your rights to access and control your protected health information, and provides information about your right to make a complaint if you believe the Department has improperly identify you and relates your "protected health information." Protected health information is information that may personally identify you and relates to you past, present, and future physical or mental health or condition and related health care services. The Department is required to abide by the terms of this Notice of Privacy Practices, and may change the terms of this notice, at any time. A new notice will be effective for all protected health information that the Department maintains at the time of issuance. Upon request, the Department will provide you with a revised Notice of Privacy Practices by posting copies at its facilities, publication on the Department's website, in response to a telephone or facsimile request to the Privacy Office, or in person at any facility where you receive services from the department.

- 1. Uses and Disclosures of Protected Health Information:** Your protected health information may be used and disclosed by the department, its administration is clinical staff and others involved in your care and treated for the purpose of providing health care services to you, and to assist in obtaining payment of your health care bills.
- a. **Treatment:** Your protected health information may be used to provide, coordinate, and manage your health care and any related services, including coordination of your health care with a third party that has your permission to have access to your protected health information, such as, for example, a health care professional who may be treating you, or to another health care provider such as a specialist or laboratory.
 - b. **Payment:** Your protected health information may be used to obtain payment for your health care services. For example this may include activities that a health insurance plan requires before it approves or pays for health care services such as: making a determination of eligibility or coverage, reviewing services provided to you for medical necessity, and undertaking utilization review activities.
 - c. **Health Care Operations:** The Department may use or disclose your protected health information to support the business activities of the Department, including, for example but not limited to, quality assessment activities, employee review activities of the Department, including, for example, but not limited to, quality assessments activities, employee review activities, Training, licensing, and other business activities. Your protected health information may be used to contact you about appointments or for other operational reasons. Your protected health information may be used to contact you about appointments or for to there operational reasons. Your protected health information may be shared with third party "business associates" who perform various activities that assist us in the provision of your services.

2. Other Permitted or Required uses and Disclosures with Your Authorization or Opportunity to Object: Other uses and disclosures of your protected health information will be made only with your written authorization, which you may revoke at any time, except as permitted or required by law as described below. Generally, if there is protected health information that identifies you as a person who has applied for or received substance abuse services, that information will not be disclosed without your consent unless the law allows or requires such a disclosure. The Department may use and disclose your protected health information when you authorize in writing such use or disclosure of all or part of your protected health information. If you are hospitalized, the Department may use and disclose certain protected health information to your representative, as that is defined in the Georgia Mental Health Code, upon your admission or discharge: you may be given a chance to object to certain other disclosures to your representative.

3. Permitted or Reported Uses and Disclosures without Your Authorization or Opportunity to Object The Department may use or disclose your protected health information without your authorization for continuity of your care or for your treatment in an emergency or when clinically required; when required to do so by law; for public health purposes; to a person who may be a risk of contracting a communicable disease; to a health oversight agency; to an authority authorized to receive reports of abuse or neglect; in certain legal proceeding; and for certain law enforcement purposes. Protected health information may also be disclosed without your authorization to a coroner or medical examiner, and to the representatives of your estate.

4. Required Uses and Disclosures: Under the law, the Department must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine the Department's compliance with the requirement of the Privacy Rule at 45 CFR Sections 164.500 et..seq.

5. Your Rights: The following is a statement of your rights with respect to your protected health information and belief description of how you may exercise these rights.

- a. **You have the right to inspect and copy your protected health information.** You may inspect and obtain a copy of protected health information about you for as long as the Department maintains the protected health information. This information includes medical and billing records and other records the department uses for making medical and other decisions about you. A reasonable, cost-based fee for copying, postage and labor expense may apply. Under federal law you may not inspect or copy psychotherapy notes; information compiled in anticipation of, or for use in, a civil, criminal, or administrative proceeding, or protected health information that is subject to a federal or state law prohibiting access to such information.
- b. **You have the right to request restrictions of your protected health information.** You may ask the Department not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations, and not to disclose protected health information to family members or friends who may be involved in your care. Such a request must state the specific restriction requested and to whom you want the restrictions to apply. The Department is not required to agree to a restrictions requested, and if the Department believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted, except as required by law. If the Department does agree to the requested restriction, the Department may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment.
- c. **You have the right to request to receive confidential communication from us by alternative means or at an alternative location.** Upon written request to a person listed in section 6 below, the department will accommodate reasonable requests for alternative means of communication of confidential information, but may condition this accommodation upon your provision of an alternative address or other method of contact. The department will not request an explanation from you as to the basis for the request.
- d. **You have the right to request an amendment of your protected health information.** If the Department created your protected health information, you may request an amendment of that information for as long as the Department maintains it. The Department may deny your request for an amendment, and if it does so will provide information as to any further rights you may have with respect to such denial. Please contact one of the persons listed in section 6 below if you have questions about amending your medical information.
- e. **You have a right to receive an accounting of certain disclosures the Department has made of your protected health information.** This right applies only to disclosures for purposes other than treatment, payment or healthcare operations, excluding any disclosures the Department made to you, to family members or friends involved in your care, or for national security, intelligence or notification of purposes. You have the right to receive legally specified information regarding disclosures occurring after 14, 2003, subject to certain exceptions, restrictions and limitations.
- f. **You have the right to obtain a paper copy of this notice from the Department,** upon request.

6. Complaints: You may complain to us and to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint by notifying the Department's Privacy Officer of the bases for your complaint. The Department will not retaliate against you for filing a complaint.

You may contact the Department's Privacy Officer:

404.656.4421. Phone 404.657.1123 Fax
2 Peachtree Street, NW
Room 29.210
Atlanta, GA 30303-3142

OR

The Divisions Privacy Coordinator

404.657.6423 Phone 404.657.6424 Fax
2 Peachtree Street, NW
Room 22.240
Atlanta, GA 30303-3142

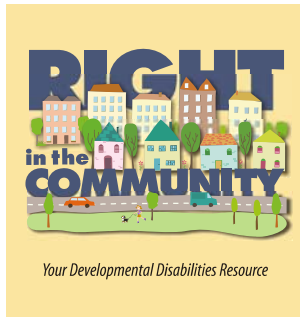
OR

To the staff of your provider for further information about the complaint process or this notice.

Please sign a copy of this notice of Privacy Practices for the Department's Records.

I have received a copy of this Notice on the date indicated below.

Signature of Individual/Resident or legally Authorized Person



Permission to Provide Emergency Medical Treatment

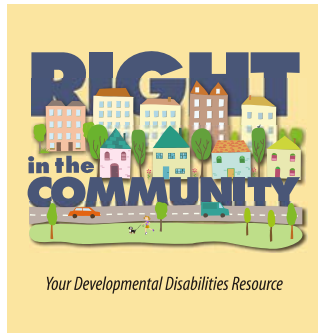
I authorize the staff at RitC Respite Home to organize any medical and first aid procedure, use Crisis Intervention (a description of which has been provided to me and I hereby acknowledge receipt thereof), if necessary, or to take the client to any hospital emergency room for treatment. I understand that the staff will try to contact me at the emergency contact number(s) that I have provided beforehand.

This _____ day of _____, 20__.

WITNESS

CLIENT or PARENT/GUARDIAN

PARENT/GUARDIAN, Acknowledging that their Child or Family Member has Signed this Document and The above Signature, Mark or Seal is Authentic



Release and Hold Harmless Agreement

In consideration for the modest fee paid for a client to stay at RitC Respite Home and being allowed to participate in this respite program, I hereby fully release and discharge the RitC Respite Home staff, Right in the Community, their directors, successors, agents, employees and RitC Respite Home staff members and hold them harmless from any and all liability, claims, damages, actions or injury to person or property, irrespective of how arising and however caused, including, but not limited to, all kinds of active or passive negligence on the part of Right in the Community, its staff, directors, employees and RitC Respite Home staff members.

I understand and acknowledge that the Participant and/or his/her Parent or Guardian agree to hold Right in the Community, its directors, successors, agents, employees and RitC Respite Home staff members harmless and to protect and indemnify them against any and all claims by any person whomsoever, involving liability for bodily injury or property damage caused by said Participant's actions while staying at RitC Respite Home. The Participant and his/her Parent or Guardian agree to be responsible for and to pay any claim that may be brought against Right in the Community, its directors, successors, agents, employees and RitC Respite Home staff members, including any judgment and costs and expenses, including attorney's fees, court costs, and expenses of litigation, as the result of said Participant's actions and conduct while staying at RitC Respite Home.

I understand and agree that this Release and Hold Harmless Agreement is fully binding on me, all members of my family, our estates, and our heirs, and that neither I nor any member of my family nor anyone claiming through me will have a legal right to assert a claim against Right in the community, its directors, successors, agents, employees and RitC Respite Home staff members relating to me and my family's participation in this respite program.

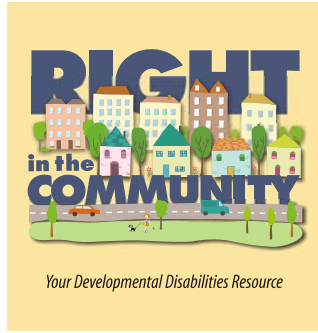
The Participant and his/her Parent or Guardian declare that they have read these Terms and Conditions and agree to them.

This _____ day of _____, 20__.

WITNESS

CLIENT or PARENT/GUARDIAN

PARENT/GUARDIAN, Acknowledging that their Child or Family Member has Signed this Document and The above Signature, Mark or Seal is Authentic



Right to Discontinue Right in the Community Respite Home Privileges

The undersigned hereby acknowledges and agrees that participation in and use of RitC Respite Home is a privilege. The RitC Respite Home Committee reserves the right to remove any participant from RitC Respite Home, upon notification of the parent, guardian, or custodian, and discontinue the privilege of continued use of RitC Respite Home if that participant evidences violent, dangerous or destructive behavior towards themselves, other participants or staff in such a manner that the staff cannot maintain their own safety and the safety of other participants at the RitC Respite Home.

The undersigned understand and acknowledge that RitC Respite Home cannot adequately serve the needs of its' clients if one participant consistently exhibits violent, dangerous or destructive behavior towards themselves, other participants or the staff.

The decision to remove and discontinue the privilege of use of the RitC Respite Home shall be in the sole discretion of the RitC Respite Home Committee appointed to oversee its' operation. Any participant, guardian or parent wishing to be heard by the RitC Respite Home Committee in connection with its' consideration of removal from the house or discontinuation of privileges, shall make a request in writing to the Committee Chairman, Darrell Tapp. All inquiries regarding RitC Respite Home Committee decisions are to be directed to the Committee Chairman.

The undersigned declares that he/she has read these Terms and Conditions, understands them and agrees to them.

This _____ day of _____, 20____.

WITNESS

Participant/Family/Legal Guardian

PARENT/GUARDIAN,
Acknowledging that their Child or Family
Member has Signed this Document and The
above Signature, Mark or Seal is Authentic



PHOTO/VIDEO RELEASE FORM

I hereby give permission for images of my child, captured during regular and special activities through video, photo, and digital camera, to be used solely for the purposes of Right in the Community's promotional material and publications, and waive any rights of compensation or ownership thereto.

Name of participant (please print): _____

Name of Parent/ Guardian (please print): _____

Parent/ Guardian's Signature: _____

Participant's Signature: _____
(if over 18 and has no guardian)

Date: _____