Aspire
Turning Disabilities
Into Capabilities

The Arc.
Erie County
New York

Date: _____

Dear _____

Regarding: _____

The above listed individual has been referred to the Article 16 Clinic (satellite location of Aspire of WNY) at The Arc Erie County New York. Below is a list of paperwork needed in order to receive services in the Article 16 Clinic, as well as instructions about the amendment that needs to be written for the service(s). Please provide the requested paperwork as soon as possible to avoid a delay in services. You may fax the completed forms to (716) 332-3570, mail them to 30 Wilson Road, Williamsville, NY 14221 or email them to awheeler@arceriecounty.org.

Completed forms completed & returned from the packet you received:

- Clinical Services request form
- Completed Health Services Intake Form
- Intake Information/Social Summary
- A prescription for EACH discipline/therapy requested, to read as follows:
  "Evaluate and treat for (occupational therapy, physical therapy, speech therapy) as necessary"

Forms requiring signature from the individual/legal guardian:
Student in-training Authorization Form
Article 16 Clinic Statement of Services & Fees
Authorization to Use Protected Health Information
Individual Authorization and Agreement
Article 16 Clinic Sign-Off Sheet
Legal Guardianship Form
Mutual Release of Information

Forms for individual/legal guardian to review & keep:
Individual Rights and Responsibilities
Hours and 24-Hour Coverage
Notice of Health Information Privacy Practices
Incident Management
Attendance Policy
Individual Grievance Process

(Continued to next page)

The following documentation is also required for admittance to the Article 16 Clinic:
-Current Physical
-Last 2 PPDs
-Current ISP with any attachments, including IPOPs
-Previous Psychological Evaluation/Verification of Developmental Disability
-Documentation of OPWDD Eligibility (NOD)
-LCED
-Documentation of Legal Guardian (where applicable)
-List of Current Medications
-Copy of Insurance Cards

Should the individual qualify to receive services, an addendum is needed for each service (OT/PT/Speech) the individual receives, as well as a valued outcome. Please see below for the details:

Article 16 Clinic
Type of Service: (OT/PT/Speech)
The Arc Erie County New York – Satellite Location of Aspire of WNY
Address: (Address based on where patient will receive services – only choose one)
30 Wilson Road, Williamsville, NY 14221 OR 2643 Main Street, Buffalo, NY 14214 OR
60 Main Street, Hamburg, NY 14075
Contact: Ashley Wheeler, Treatment Coordinator Phone Number: (716) 529-3087
Start Date:

Should you have any questions or need assistance please contact us at (716) 529-3087.
Thank you,

Awheeler

Ashley Wheeler
Treatment Coordinator
The Arc Erie County New York

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ARTICLE 16 CLINIC
CLINIC SERVICE REQUEST/REFERRAL INFORMATION

Name: _____ **TABS#** _____ **DOB:** _____

Address: _____ **Phone:** _____

Services Coordinator Name: _____

SC Agency: _____ **Phone:** _____

Developmental Disability Diagnosis (if known)

Mild ID | Moderate ID | Severe ID | Profound ID

Autism | Cerebral Palsy | Epilepsy | Neurological Impairment

Other (Specify): _____

Other relevant medical or psychological diagnoses: _____

_____

Clinic Service(s) Requested:
(CHECK ALL THAT APPLY)

- Occupational Therapy
- Physical Therapy
- Speech/Language Therapy
- Mental Health Counseling

*** A PRESCRIPTION FROM THE PRIMARY M.D. IS REQUIRED FOR ALL SERVICES ***

Reason for Referral: (Provide specific needs/issues to be addressed)

_____

_____

_____

_____

Referred by:

Address (Agency/ Street): _____

If not service coordinator, was service coordinator notified? Yes No

THE FOLLOWING DOCUMENTATION IS REQUIRED FOR THE REFERRAL TO BE PROCESSED:

- CURRENT PHYSICAL EXAM & PPD
- HEALTH SERVICES INTAKE FORM
- INTAKE FORM & SOCIAL HISTORY
- PSYCHOLOGICAL/VERIFICATION OF DD DIAGNOSIS
- DOCUMENTATION OF DD ELIGIBILITY (NOD)
- SIGNED AGENCY CONSENTS, RELEASES & AUTHORIZATIONS
- RECORDS OF PREVIOUS THERAPY (W/IN PAST 2 YEARS)
- PRESCRIPTION FROM PRIMARY MD FOR EVALUATION IN EACH SERVICE AREA
- GUARDIANSHIP FORM
- CURRENT ISP
- STUDENT AUTHORIZATION
- STATEMENT OF SERVICES/FEES
- COPY OF INSURANCE CARDS
- LIST OF CURRENT MEDICATIONS
- VERIFICATION OF HIPPA NOTICE

For Clinic Use Only:

Treatment Coordinator _____ **Date Received** _____

Medical Director's Determination: Approved Denied **Comments:** _____

_____

Medical Director Signature: _____ **Date:** _____

Forwarded to Supervisor/Representative of OT PT ST MH **Date:** _____

7 COMMUNITY DRIVE ◆ BUFFALO, NEW YORK 1
PHONE 716/505.5630 ◆ FAX 716/892.1936

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HEALTH SERVICES INTAKE FORM
ARTICLE 16 & 28 CLINICS

Name: _____
Last First MI

Gender: ____ Male ____ Female DOB: _____ Social Security #: _____

Address: _____

Home Phone: (___) _____ Other Phone: (___) _____

Ethnicity: [ ] American Indian [ ] Asian/Middle East/Pacific Islander [ ] Black
[ ] Hispanic [ ] Multi-Racial [ ] White

Living Situation:
[ ] Independent Living [ ] With Family [ ] Family Care [ ] Nursing Home
[ ] Group Home (agency? _____) [ ] ICF (agency? _____)
[ ] Other: _____

Primary Contact Person _____ Relationship _____
Address: _____
Phone #s H: (___) _____ W: (___) _____ Cell: (___) _____

Secondary Contact Person _____ Relationship _____
Phone #s H: (___) _____ W: (___) _____ Cell: (___) _____

Primary Physician: _____ Phone: (___) _____
Address: _____

Service Coordinator/Social Worker: _____
Agency: _____ Phone: (___) _____

Insurance Information *****Please attach copies of all insurance cards

Medicaid? _____ Yes _____ No If yes, Medicaid # : _____

Medicare? _____ Yes _____ No If yes, Medicare # : _____

Other Insurance (HMO/Private) ? _____ Yes _____ No

If yes, Insurance Company: _____
Policy#: _____ Group #: _____
Subscriber Name: _____ Effective Date: _____
Subscriber's Employer: _____

Other Coverage? (Additional Insurance, Civil Service, Railroad, Veterans, etc.) _____ Yes _____ No
If yes, Please specify: _____

Continued ▸

MEDICAL INFORMATION:

Primary Diagnosis: _____
Secondary Diagnosis: _____

Communication Status: [ ] Verbal - Language(s) spoken: _____
[ ] Non-verbal [ ] Uses sign language [ ] Uses picture symbols
[ ] Uses Communication Device – Type: _____
[ ] Understand spoken English [ ] Hearing impaired [ ] Deaf
[ ] Other – Please specify: _____

Allergies? _____ Yes _____ No Known Allergies Latex Allergy? _____ Yes _____ No
(If yes, Please list allergies plus reactions to exposure)

Allergic to	Reaction to Exposure

Special Medical Alerts:
Seizures? _____ Yes _____ No If yes, type & duration: _____
Asthma? _____ Yes _____ No If yes, causative factors: _____
& treatment: _____
Other special Medical Alerts (Please specify): _____

Diet:
Swallowing difficulty? _____ Yes _____ No
If yes, please describe: _____
Diet Texture: ____ Regular ____Soft ____Cut -up _____ Chopped ____Ground ____ Pureed
Liquid Recommendations: ____Regular/Thin ____Nectar Thick ___Honey Thick _____Pudding Thick
Other: _____ Tube-fed _____ No Oral Feeds ____Tastes/Pleasure Feeds only

Mobility and Transfers:
Transfers: _____ Independently _____With Physical Assistance ____ With assistive device
Mobility: _____ Independent _____With Physical Assistance ____ With assistive device

Please list any assistive device used for mobility and transfers: _____

Service Needs:
What type of Services are you looking for?

Who Referred you to Aspire? _____

Name Of Person Completing Form: _____

Title/Relationship: _____ Phone #: _____

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ARTICLE 16 CLINIC

Intake Information/Social Summary

Date Form Completed: _____

Identifying Information:
Name: _____
Address: _____
_____
County: _____
Phone#: _____
Type of Residence: _____
DOB: _____
Birthplace: _____
Social Security#: _____
TABS# _____

Marital status: _____
Spouse Name: _____

Primary Income Source: _____
Amount if Known: _____
Responsible Person/Rep Payee __Yes __No
Name: _____

Education History:
Name of School: _____
Course/Grade Completed: _____
Years of Completion: _____

Special Needs/Concerns: _____
_____
_____

Hobbies & Interests: _____
_____

MSC
Name: _____
MSC Agency: _____
Address: _____
_____
Phone#: _____
Email: _____

Primary Contact
Name: _____
Address: _____
_____
Phone#: _____
Alt. Phone: _____
Relationship: _____

Emergency Contact
Name: _____
Address: _____
_____
Phone#: _____
Work Place: _____
Work Phone#: _____
Relationship: _____

Legal Guardian
Name: _____
Phone: _____

Advocate
Name: _____
Phone: _____

Medical & Clinical Information:
DD Diagnoses: _____
Date: _____ By Whom: _____
Other Diagnoses: _____
_____
Current Clinic Provider: _____
Physician: _____
Address: _____
_____
Phone #: _____
Fax #: _____

Hospital: _____
Address: _____
Phone#: _____
Healthcare Proxy: ____Yes ____No
DNR: ____Yes ____No
MH: Diagnosis: _____
MH Counselor/Agency: _____
_____
MH Phone: _____

Continued ▶

Individual Name: _____

Employment/Programmatic Information: (if applicable)

Day Habilitation
Pre-Vocational Program
Workshop
Supported Employment
Competitive Employment
Self Employed
Other:

Agency/Location: _____
Address: _____
_____
Phone #: _____

Program Contact: _____
Program Coordinator: _____
Job Dev./Trainer: _____
Employer/Supervisor: _____
Other Employment or Program Contact:
_____
Transporter: _____
Phone#: _____
Additional Information: _____
_____
_____

Program/Employment History:

Program Placement/Place of Employment: **Dates Enrolled/Employed**

_____
_____
_____
_____
_____
_____
_____
_____

Additional Comments/Concerns:

_____
_____
_____
_____
_____
_____
_____
_____

_____
Signature/Title

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ARTICLE 28 & 16 CLINICS

Student-in-Training Authorization Form

Individual Name:_____

Dear Participant, Parent, Guardian or Medicaid Service Coordinator;

Throughout the year, the Aspire Article 28 & 16 clinics have students-in-training from local colleges who complete internships with Aspire clinicians. Whenever a student works with a consumer, the licensed Aspire clinician is also there to provide direct support and supervision for every aspect of the evaluation and treatment provided by the student. This is an excellent learning opportunity for both the students-in-training as well as for the consumers.

If you are willing to have a student provide services either to you or the individual you represent, please indicate which service(s) you would allow, and then sign your name below. This consent will be in effect until otherwise noted. You may change your mind at any time by letting your Medicaid Service Coordinator or Clinic Treatment Coordinator know your wishes. Thank you.

(Please check appropriate boxes below)

☐ I am providing authorization to work with Students-In-Training in the following areas:

Occupational Therapy
Physical Therapy
Speech Therapy
Mental Health Counseling

I do not wish to work with Students-In Training

Signature of Patient/Legal Guardian _____ Relationship to Consumer _____ Date _____

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ARTICLE 16 CLINIC
STATEMENT OF SERVICES & FEES

The following services will be provided or assured by the staff of Medicaid eligible participants with no cost to participants, family and/or guardian. Individuals who are not eligible for Medicaid may still receive Clinic services; but may be billed either in full or at a standardized reduced rate based upon their income. Clinic services provided will be based on assessed needs and will be incorporated into the participant's Individual Service Plan.

As a participant in the clinic, you are entitled to and will be provided with the following:

Medical Services
The article 16 Clinic Medical Director provides supervision of clinical services and authorization of all the therapy provided in the clinic. This physician may consult with a participant's primary medical physician, as needed, in order to provide a comprehensive approach to treatment; however, he will not be the primary health care provider for any participant. The Medical Director may conduct face-to-face assessments.

Treatment Coordination Services
A treatment coordinator is assigned to each participant in the clinic for the purpose of coordinating the provision of all clinic treatments, activities or therapies prescribed for the individual and ensuring that there is no duplication of clinic services provided elsewhere. The treatment Coordinator is the primary person for a participant, family member or Medicaid Service Coordinator to contact for clinic related issues.

Clinical Services
When a person is admitted to the Article 16 Clinic, they will be assigned to a clinician based upon the type and location of the service needed. The clinician completes their assessment and makes recommendations as to whether or not services will be provided. If services are recommended, a Treatment Plan is then developed and authorized by the Medical Director.

Anyone receiving Article 16 Clinic services will have those services reviewed every six months. Each Participant's Treatment plan will be re-evaluated annually and revised by the team as needed.

Services provided in the Aspire Article 16 Clinic include:

- Occupational Therapy
- Physical Therapy Services
- Speech/ Language Services
- Social Work Counseling
- Psychological Counseling

I have read (or have been told of) the information provided above. I understand and agree to the services and fees for the clinic, as stated.

Patient _____ Date_____

Parent/Legal Guardian_____ Date_____

ASPIRE OF WNY

Authorization for the Use and Disclosure of Protected Health Information

Individual Name: _____ Date: _____

Address _____ Birth Date: _____

Aspire of WNY understands that Health information about you and/or your family member is personal and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your written authorization to use or disclose your protected health information for the purposes described below. This form provides that authorization and helps Aspire make sure that you/your family member are properly informed of how this information will be used or disclosed. Please read the information carefully before signing this form.

Use and Disclosure Covered by this Authorization

Who will disclose this information? The Arc Erie County New York & Aspire of WNY

Who will use and/or receive this information? The Arc Erie County New York & Aspire of WNY

The Protected Health Information that may be used or disclosed by this authorization is described as follows and only includes:

- ☐ Medical Information
- ☐ Service Plans
- ☐ Therapy Records
- ☐ All of the Above
- ☐ Other: _____

The specific purpose(s) of the use or disclosure of this Authorization is(are) (indicate if the Consumer requested the use or disclosure and if the purpose was not disclosed):

- ☐ To Coordinate Services
- ☐ To Apply for Services
- ☐ For Medical Care
- ☐ All of the Above
- ☐ Other: _____

Important Information Regarding this Authorization:

By signing this authorization form the Individual and/or Authorized Representative authorizes the use or disclosure of protected health information as described above. This information may be re-disclosed if the recipient(s) described on this form is not required by law to protect the privacy of the information, and such information is no longer protected by federal health information privacy regulations.

You have a right to refuse to sign this authorization. Your services/health plan will not be affected if you do not sign this authorization.

You have the right to put a limit to the amount of information to be used or disclosed or limit the length of time this authorization is in effect.

You have a right to see and copy the information describe on this authorization form in accordance with Aspire policies. You have a right to receive a copy of this form after you have signed it.

You may revoke this authorization in writing at any time, except that the revocation will not have any effect on any action already taken by the Agency based upon your authorization before written notice was received. To revoke this authorization, please write to Aspire's Privacy Office at 2356 North Forest Road, Getzville, New York 14068.

SIGNATURE

I have read and understand the terms of this Authorization. I have had an opportunity to ask questions about the use or disclosure of my Protected Health Information.

Signature of Individual and/or Authorized Representative:_____

Print Name of Individual and/or Authorized Representative:_____

Description of Authorized Representative's Authority:_____

Date:_____

CONTACT INFORMATION

Contact information of the Authorized Representative who signed this form:

Address:_____

_____

Telephone: _____(Daytime) _____(Evening)

For Agency Use Only

For Agency Use Only.

Date Agency Obtained Authorization: _____

Name and Title of Person Obtaining Authorization:_____

Action Taken by Agency on Authorization:_____

Date Agency Received Request to Revoke Authorization: _____

Name and Title of Person Handling Request to Revoke Authorization:_____

Action Taken by Agency on Revocation:_____

ASPIRE OF WESTERN NEW YORK, INC.

Authorization and Agreement: Consent for Treatment and Payment

Individual Name _____ Account No. _____

Address _____

Date of Birth _____ Social Security Number _____

Consent for Care/Treatment/Services: The Individual and/or Authorized Representative consent(s) to the receipt of services and medical treatment by Aspire of Western New York, Inc. ("Aspire"), and its affiliated health care and service providers. Aspire will provide the Individual and/or Authorized Representative with an explanation of the services and treatment to be provided, their purpose(s), the risks and/or benefits, and any viable alternatives. The Individual and/or Authorized Representative have the right to choose such services and treatment as he/she/they deem most beneficial and appropriate, and will be informed of changes in service plans and modalities as required by law.

Consent to Use and Disclose Protected Health Information: The Individual and/or Authorized Representative authorize(s) the use and disclosure of the health, psychological, social, educational, and service information for the purposes of planning and providing the Individual's services and treatment, communicating with other service and health care providers, obtaining payment for its services and treatment, and conducting health care operations. The Individual and/or Authorized Representative understand(s) that Aspire's Notice of Privacy Practices provides further information on Aspire's uses and disclosures of the Protected Health Information.

Acknowledgement of Receipt of Privacy Notice: The Individual and/or Authorized Representative acknowledges by signature below that they have received Aspire's Notice of Health Information Privacy Practices.

Release of Information to the Individual: The Individual and/or Authorized Representative may request access to the Individual's information contained in Aspire's files. Aspire will make such information available to the Individual and/or Authorized Representative for inspection and copying to the extent permitted by law.

Payment and Insurance Benefits: The Individual and/or Authorized Representative agree(s) to: (1) pay for, or have paid for by insurance, all services and treatment; (2) apply for, and maintain, all applicable health insurance covering the Individual, (3) provide Aspire with all health insurance information necessary for Aspire to be paid for its services and treatment; (4) notify Aspire of any changes in the Individual's health insurance, denials of benefits, or termination of insurance coverage, (5) assign to Aspire sufficient monies from the Individual's insurance(s) to pay for its services and treatment, and (6) guarantees prompt payment of all such services not paid by insurance carriers or third parties within thirty (30) days. The Individual

and/or Authorized Representative understands that if payment is not received within thirty (30) days of due date the bill may be turned over to an attorney or a collection agency and, if so, the Individual and/or Authorized Representative may be charged attorney's fees and/or collection fees in addition to payment owed. The Individual and/or Authorized Representative gives Aspire the right examine any credit report for financial information relating to responsibility to pay for medical services.

Medicare Recipients: The Individual and/or Authorized Representative certify that the information provided in applying for payment under Title XVIII of the Social Security Act (Medicare) is correct, and authorize(s) any holder of medical or other health information about the Individual to release to the Social Security Administration and CMS or its intermediaries and carriers, any information needed for this or a related Medicare claim. The Individual and/or Authorized Representative request(s) that payment of authorized benefits be made on the Individual's behalf.

Certification and Revocation: The Individual and/or Authorized Representative have read this Agreement, had an opportunity to discuss this Agreement with Aspire's representative(s), and have a basic understanding of its terms. He/She/They freely and knowingly agree(s) to be bound by its terms. The Authorized Representative has authority to sign this Agreement on behalf of the Individual. The Individual and/or Authorized Representative may revoke this Agreement at any time by providing Aspire with written notification of his/her/their revocation.

SIGNATURE

Signature of Individual or Authorized Representative:_____

Print Name of Individual or Authorized Representative:_____

Description of Authorized Representative's Authority:_____

Witness:_____ Date:_____

CONTACT INFORMATION

Contact information of the Authorized Representative who signed this form:

Address:_____

_____

_____

Telephone: _____(Daytime) _____(Evening)

Aspire

Turning Disabilities
Into Capabilities

Aspire of WNY, Inc.
Health Services – Article 28 & 16 Clinics
Sign-Off Sheet

( ) Yes ( ) No	I have received a copy of the Patient Rights and Responsibilities.
( ) Yes ( ) No	I have received a copy of the Grievance Procedure in the Health Services Center. The Grievance Procedure outlines the means to resolve objections, problems or grievances relative to services and treatment.
( ) Yes ( ) No	I have received a copy of how to contact the Aspire Health Services Center at any time, the hours of operation at the clinic(s) and services offered.
( ) Yes ( ) No	I verify that I have received a copy of the Health Information Privacy Practices (HIPPA) of Aspire of Western New York.
( ) Yes ( ) No	I verify that I have received a copy of the Incident Reporting Brochure.
( ) Yes ( ) No	I verify that I have received a copy of the Attendance Policy.

_____ _____

Patient Signature Date

_____ _____

Parent/Legal Guardian Signature Date

Aspire

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ARTICLE 16 CLINIC
Legal Guardianship

Name:_____ DOB:_____

Do you have a legal guardian? _____ Yes _____ No

IF YES, Name of guardian:_____

Type of guardianship? (check)

A. _____ General Guardian, both person and property
B. _____ Limited Guardianship, property only
C. _____ Standby Guardian _____
D. _____ Corporate Guardian _____

*****PLEASE PROVIDE A COPY OF GUARDIANSHIP PAPERS, IF AVAILABLE*******

_____ _____
Signature Date

_____ _____
Witness Date

IF NO, Is there anyone planning to seek legal guardianship or in the process of obtaining legal guardianship? _____Yes _____No
Please name the person planning or obtaining legal guardianship:

_____

DEFINITIONS:

General Guardianship: General guardianship is guardianship of both person and property. It is unlimited form of guardianship, which gives the guardian general custody and control over the life if a developmentally disabled person.

Limited Guardianship: This is a guardianship of property only. It applies only to a situation where the developmentally disabled person is entirely or substantially self-supporting. The limited guardian manages all property of the developmentally disabled person other than his/her wages.

Standby Guardianship: This is guardianship of person/property, but does not commence until the death of the surviving parent. A standby guardian can only be appointed with the consent of the living parent(s).

Corporate Guardianship: This is guardianship of the person only. The corporate guardian must be a New York Corporation formed for not-for-profit purposes. It purpose and powers must include the power to act as a guardian for the developmentally disabled person.

The Arc.
Erie County
New York

Aspire
Turning Disabilities
Into Capabilities

MUTUAL RELEASE OF INFORMATION AUTHORIZATION

I,_____, hereby authorize the mutual release of the following (please circle selection(s) written, verbal, video and/or audio information:

_____

_____

_____

about _____
Individual (date of birth) or Family Member

BETWEEN

Agency/Service Name: ***The Arc Erie County New York***

Address: *30 Wilson Road, Williamsville, NY 14221*
2643 Main Street, Buffalo, NY 14214
60 Main Street, Hamburg, NY 14075

AND
Aspire of WNY, Inc
(Address of Program)

7 Community Drive
Cheektowaga, NY 14225

I UNDERSTAND THAT THIS INFORMATION WILL BE USED FOR MYSELF (OR MY FAMILY MEMBERS) TREATMENT, RECEIVING SERVICES, PLANNING, AND DOCUMENTATION OF PROGRESS. THE INFORMATION IS TO BE MAINTAINED, PROCESSED AND USED IN A CONFIDENTIALITY AND SECURE WAY. I UNDERSTAND THAT THIS AUTHORIZATION REMAINS IN EFFECT UNTIL MODIFIED OR REVOKED. I ALSO UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION IN WRITING AT ANY TIME.

_____ _____
Signature of Individual Consumer *Date*

_____ _____
Signature of Parent or Legal Guardian and Relationship (if necessary) *Date*

Please keep the enclosed documents for your reference/information

Please contact The Arc Erie County New York's Article 16 Clinic (satellite location of Aspire of WNY) with any questions at 716-529-3087

Aspire

Turning Disabilities
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ASPIRE OF WNY, INC.
Article 28 Clinic
INDIVIDUAL RIGHTS AND RESPONSIBILITIES

I. INDIVIDUAL RIGHTS

My rights as an Article 28 & 16 Clinic Services participant at Aspire of WNY are as follows:

1. The right to privacy, and sufficient space for personal belongings used on a day-to-day basis.
2. The right to be free from physical or psychological restraints or pressure, subject to the provisions of section 33.04 of the Mental Hygiene Law.
3. The right to engage in all appropriate activities consistent with my needs, interests and capabilities.
4. The right to appropriate and humane medical and dental care as it is required during the service day.
5. The right to utilizing individually owned clothing, which fits properly, is maintained properly, and is appropriate for the age, season and activity and the right to be involved in the selection.
6. The right to meaningful and productive activities within my capacity which is based on the individuals interests.
7. The right to the use of my personal money and property.
8. The right to receive assistance and guidance from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity.
9. The right to freedom from commercial exploitation or other exploitation.
10. The right to freedom from corporal punishment.
11. The right to freedom from excessive use of medication.
12. The right to be free of unnecessary use of mechanical restraints.
13. The right to be informed of charges and services prior to admission and as changes are made.
14. The right to be free of discrimination, abuse or any adverse action based on my status as one who is the subject for an HIV related test or who has been diagnosed as having HIV infection, AIDS or HIV related illness.

ASPIRE OF WNY, INC.
Article 28 Clinic
INDIVIDUAL RIGHTS AND RESPONSIBILITIES

15. Not be denied confidentiality with regard to all information contained in my record and access to such information will be subject to applicable laws and regulations. Confidentiality with regard to HIV related information shall be maintained in accordance with article 27-F of the public health law, a copy of which will be provided upon admission and as changes occur.

16. The right to adequate individually owned personal hygiene and grooming supplies.

17. The right to vote, and the right to participate in activities that educate the person in his or her civic responsibilities.

18. The right of the myself, my parents or guardians to express grievances, concerns, and suggestions, without fear of reprisal.

19. The right of the myself, my parents or correspondents, to be informed of the individual's rights under law and regulation, and the guarantee that such rights shall not be abridged. A statement of the rights included in this section and any others established by facility policy shall be maintained in each individual's Individual Program Plan and transmitted to each individual's parent and/or correspondent.

20. The opportunity to make or have made on my behalf decisions regarding cardiopulmonary resuscitation. (The agency will abide by such a right/decision in the event that there is a living will in place).

21. The right to a safe and sanitary environment.

22. The right to observe and participate in the religion of my, through the means of his or her choice, including the right to not participate.

23. The right to receive information regarding Advance Directives, that include Health Care Proxy and the right to make such a determination.

ADDITIONAL RIGHTS INCLUDE:

The facility staff shall inform each individual, in writing, of his/her rights as an individual, upon admission. Such notification will be documented by the signing of the Individuals Rights & and the Responsibilities and Services and Fees by both the individual & facility staff. In the event that the individual is incapable of comprehending his/her rights, or has been deemed incompetent, such signing shall be completed by the next of kin or designated advocate/correspondent.

1. RIGHTS: Individual Rights

Individuals retain all human and civil rights guaranteed in the U.S. Constitution. This includes the right to vote, if legally competent. They must adhere to the programmatic guidelines developed by the Office of Mental Retardation and Developmental Disabilities and must respect each other's rights as members of a shared household. Individuals will participate in the selection of group activities and needs.

ASPIRE OF WNY, INC.
Article 28 Clinic
INDIVIDUAL RIGHTS AND RESPONSIBILITIES

No individual shall be discriminated against because of race, creed, color, age, sex, national origin, disability or marital status. No overt or covert physical or psychological pressure shall be applied to prevent an individual who desires to leave, from doing so.

2. PRIVACY:

Individuals shall be provided a reasonable degree of privacy in, bathing and toileting areas. The only exception to this is the presence of suspicion of an emergency situation.

3. PERSONAL PROPERTY:

Individuals may have any personal possessions, which are normally found in a day or working environment. Items, which are considered potentially harmful to the individual or others, may not be retained by the individual without special permission from the Director of Day Services and Executive Director. If it becomes necessary for staff to remove items of personal property from an individual because their continued presence threatens the individual's development or the health and safety of the individual or others, such actions shall be undertaken in accordance with the individual's service plan.

Aspire

Turning Disabilities
Into Capabilities

Aspire Health Care Center
Article 28 & Article 16 Clinics
24-Hour Coverage

The Aspire of WNY Health Care Center operates during the following hours:

7 Community Drive
8 a.m. to 4 p.m. and evenings upon request

Satellite Offices Article 16 Clinic –
The Arc Erie County New York
30 Wilson Road, Williamsville, NY 14221
2643 Main Street, Buffalo, NY 14214
60 Main Street, Hamburg, NY 14075
8:30 a.m. to 3 p.m.
(716) 272-3743

The Aspire of WNY Health Care Center offers 24-hour access to its services.

During regular hours of operation, patients may call the health center directly to schedule appointments or speak to medical personnel at 716-505-5630.

After hours, the message on the health center's answering machine will direct the patient to call the answering service. The answering service will contact the on-call Registered Nurse who will respond to the patient's call, assess the situation and give further directions. The on-call Registered Nurse will have an on-call physician available for consultation.

The on-call nursing and physician system is in effect 24 hours a day.

To access this system during normal business hours call: 716-505-5630.

After hours and on holidays please call the Answering Service at 1-888-225-1736.

Aspire of WNY Inc.

Notice of Privacy Practices

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

Aspire of WNY INC. (Aspire) uses your Protected Health Information for your treatment, to obtain payment for our services and for our operational purposes, such as improving the quality of care we provide to you. We are committed to maintaining your confidentiality and protecting your health information. We are required by law to provide you with this Notice, which describes our health information privacy and those of affiliated health care providers.

This Notice applies to all information and records related to your care that Aspire's workforce members and Business Associates have received or created. It also applies to health care professionals, such as physicians, and organizations that provide care to you from the various Aspire Departments. It informs you about the possible uses and disclosures of your Protected Health Information and describes your rights and our obligations regarding your Protected Health Information.

We are required by law to:

- Maintain the privacy of your Protected Health Information;
- Provide to you this detailed Notice of our legal duties and privacy practices relating to your Protected Heath Information; and
- Abide by the terms of the Notice that are currently in effect. We reserve the right to change the terms of this Notice, and will notify you or your personal representative if we make any material changes to the Notice.

I. WITH YOUR CONSENT, WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

We are required by New York State Law to obtain a signed Consent *(Attachment A-3)* allowing us to use and disclose your Protected Health Information or Private Information (collectively referred to as "Protected Health Information") to others to provide you with treatment, obtain payment for our services, and run our health care operations. Here are examples of how we may use and disclose your health care information.

FOR TREATMENT: Our staff and affiliated health care professionals may review and record information in your record about your treatment and care. We will use and disclose this health information to health care professionals in order to treat and care for you. For example, a physician may consult with another physician located at another location to determine how to best diagnose and treat you.

FOR PAYMENT: Aspire may use and disclose your Protected Health Information to others in order for the Provider to bill for your health care services and receive payment. For example, we may include your health information in our claim to Blue Cross/Blue Shield or Medicare in order to receive payment for services provided to you. We may also disclose your health information to other health care providers so that they can receive payment for their services.

FOR HEALTH CARE OPERATIONS: We may use and disclose your Protected Health Information to others for Aspire's business operations. For example, we may use Protected Health Information to evaluate the Provider's services, including the performance of our staff, and to educate our staff.

II. WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR OTHER SPECIFIC PURPOSES

BUSINESS ASSOCIATES: We may share your Protected Health Information with our vendors and agents who create, receive, maintain or transmit PHI for certain functions or activities on behalf of Aspire. These are called our "Business Associates". To protect and safeguard your health information, we require our Business Associates and subcontractors to appropriately safeguard your information.

FAMILY AND FRIENDS INVOLVED IN YOUR CARE: Unless you object, we may disclose your Protected Health Information to a family member or close personal friend, including clergy, who is involved in your care or payment for that care.

PERSONAL REPRESENTATIVE: If you have a personal representative, such as a legal guardian, we will treat that person as if that person is you with respect to disclsoures of your health information. If you become deceased, we may disclose health information to an executor or administrator of your estate to the extent that person is acting as your personal representative or to your next of kin, as permitted under state and federal law.

DISASTER RELIEF: We may disclose your Protected Health Information to an organization assisting in a disaster relief effort.

PUBLIC HEALTH ACTIVITIES: We may disclose your Protected Health Information for public health activities including the reporting of disease, injury, vital events, and the conduct of public health surveillance, investigation and/or intervention. We may also disclose your information to notify a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition if a law permits us to do so.

HEALTH OVERSIGHT ACTIVITIES: We may disclose your Protected Health Information to health oversight agencies authorized by law to conduct audits, investigations, inspections and licensure actions or other legal proceedings. These agencies provide oversight for the Medicare and Medicaid programs, among others.

REPORTING VICTIMS OF ABUSE, NEGLECT, OR DOMESTIC VIOLENCE: If we have reason to believe that you have been a victim of abuse, neglect or domestic violence, we may use and disclose your Protected Health Information to notify a government authority if required or authorized by law, or if you agree to the report.

LAW ENFORCEMENT: We may disclose your Protected Health Information for certain law enforcement purposes or other specialized governmental functions.

JUDICIAL AND ADMINISTRATIVE PROCEEDINGS: We may disclose your Protected Health Information in the course of certain judicial or administrative proceedings.

RESEARCH: We will request that you sign a written authorization before using your Protected Health Information or disclosing it to others for research purposes.

CORONERS, MEDICAL EXAMINERS, FUNERAL DIRECTORS, ORGAN PROCUREMENT ORGANIZATIONS: We may release your Protected Health Information to a coroner, medical examiner, funeral director or, if you are an organ donor, to an organization involved in the donation of organs and tissue.

TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY: We may use and disclose your Protected Health Information when necessary to prevent a serious threat to your health or safety or the health or safety of the public or another person. However, any disclosure would be made only to someone able to help prevent the threat.

MILITARY AND VETERANS: If you are, or were, a member of the armed forces, we may use and disclose your Protected Health Information as required by military command authorities. We may also use and disclose Protected Health Information about foreign military personnel as required by the appropriate foreign military authority.

WORKERS' COMPENSATION: We may use or disclose your Protected Health Information to comply with laws relating to worker's compensation or similar programs.

NATIONAL SECURITY AND INTELLIGENCE ACTIVITIES; PROTECTIVE SERVICES: We may disclose Protected Health Information to authorized federal officials who are conducting national security and intelligence activities or as needed to provide protection to the President of the United States, or other important officials.

AS REQUIRED BY LAW: We will disclose your Protected Health Information when required by law to do so.

III. YOUR AUTHORIZATION IS REQUIRED FOR OTHER USES OF YOUR PROTECTED HEALTH INFORMATION

We will use and disclose your Protected Health Information other than as described in this Notice or required by law only with your written Authorization. You may revoke your authorization to use or disclose Protected Health Information in writing, at any time. To revoke your Authorization, contact the appropriate Aspire Staff. If you revoke your Authorization, then we will no longer use or disclose your Protected Health Information for the purposes covered by the Authorization, except where we have already relied on the Authorization.

Fundraising [if applicable].

Aspire may contact you or your personal representative to raise money for Aspire. We may also share your demographic information with a charitable foundation that may contact you or your personal representative to raise money on our behalf. In certain circumstances, you must provide us with your written authorization for our use of your information for fundraising and you also have the opportunity to opt out or restrict your receiving future fundraising communications. Your request to opt out of receiving future fundraising communication will revoke any prior authorizations and you will not receive any future communications.

Marketing [if applicable].

In most circumstances, Aspire is required by law to receive your written authorization before we use or disclose your health information for marketing purposes. Under no circumstances will we sell our individual lists or your health information to a third party without your written authorization.

Psychotherapy Notes [if applicable].

In most circumstances, Aspire is required by law to obtain your written authorization before we use or disclose psychotherapy notes.

IV. YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following rights with respect to your health information. If you wish to exercise any of these rights, you should make your request to the appropriate Aspire Staff.

RIGHT OF ACCESS TO PROTECTED HEALTH INFORMATION: You have the right to request, either orally or in writing to inspect and obtain a copy of your Protected Health Information, subject to some limited exceptions. If available, you have the right to access your information in electronic format. We must allow you to inspect your records within 10 days of your request. If you request copies of the records, we must furnish you a copy within 30 days of that request if the records are maintained on site and within 60 days if maintained off site. We may charge a reasonable fee for our costs in copying and mailing your requested information or provision of information in electronic format.
In certain limited circumstances, we may deny your request to inspect or receive copies. If we deny access to your Protected Health Information, we will provide you with a summary of the information, and you have a right to request review of the denial. We will provide you with information on how to request a review of our denial and how to file a complaint with us or the Secretary of the Department of Health and Human Services.

RIGHT TO REQUEST RESTRICTIONS: You have the right to request restrictions on the way we use and disclose your Protected Health Information for our treatment, payment or health care operations. You also have the right to request restrictions on our disclosures of your Protected Health Information to a family member, friend or other person who is involved in your care or the payment for your care.

We are not required to agree to your requested restriction, and in some cases, the law may not permit us to accept your restriction. However, if we do agree to accept your restriction then we will comply with your restriction EXCEPT IF: (1) you are being transferred to another health care institution; (2) the release of records is required by law, or (3) the release of information is needed to provide you emergency treatment. If your restriction applies to disclosure of information to a health plan for payment or health care operations purposes and is not otherwise required by law, and where you paid out of pocket, in full, for items or services, we are required to honor that request.

RIGHT TO RECEIVE NOTICE OF A BREACH. We will notify you by first class mail or by e-mail (if you have indicated a preference to receive information by e-mail), of any breaches of Unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days following the discovery of the breach. A "Breach" means the unauthorized access, acquisition, use, or disclosure of Protected Health Information which compromises the security or privacy of Protected Health Information, except: (1) an unauthorized person to whom such information is disclosed would not reasonably have been able to retain such information; (2) any unintentional acquisition, access, or use of PHI by an employee or individual acting under the authority of a covered entity or business associate (a) was made in good faith and within the course and scope of the employment or other professional relationship of such employee, or individual, respectively, with the covered entity or business associate; and (b) such information is not further acquired, accessed, or used or disclosed by any person; or (3) any inadvertent disclosure from an individual who is otherwise authorized to access PHI at a facility operated by a covered entity or business assosciate to another similarly situated individual at the same facility provided that any such information received as a result of such disclosure is not further acquired, accessed, used, or disclosed without authorization. Aspire must notify you of any breach unless we can demonstrate, based on a risk assessment, that there is a low probability that the PHI has been compromised.

"Unsecured Protected Health Information" is information that is not secured through the use of a technology or methodology identified by the U.S. Department of Health and Human Services to render the Protected Health Information unusable, unreadable and undecipherable to unauthorized users. The notice is required to include the following information:

- a brief description of the breach, including the date of the breach and the date of its discovery, if known;
- a description of the type of Unsecured Protected Health Information involved in the breach;
- steps you should take to protect yourself from potential harm resulting from the breach;
- a brief description of action we are taking to investigate the breach, mitigate losses, and protect against further breaches; and
- contact information, including a toll-free number, e-mail address, Website or postal address to permit you to ask questions or obtain additional information.

In the event the breach involves 10 or more individuals whose contact information is out of date, we will post a notice of the breach on the home page of our web site or in a major print or broadcast media. If the breach involves more than 500 individuals in the state or jurisdiction, we will send notices to prominent media outlets.

If the breach involves more than 500 residents, we are required to immediately notify the Secretary of Health and Human Services. We are also required to submit an annual report to the Secretary of a breach that involved less than 500 individuals during the year and

will maintain a written log of breaches involving less than 500 residents. Notification to the Secretary will occur within 60 days of the end of the calendar year in which the breach was discovered.

RIGHT TO AN ACCOUNTING OF DISCLOSURES: You have the right to request an "accounting" of our disclosures of your Protected Health Information. This is a listing of certain disclosures of your Protected Health Information made by Aspire or by others on our behalf, but does not include disclosures made for treatment, payment and health care operations or certain other purposes unless the records are maintained in an Electronic Health Record. Records maintained in an Electronic Health Record will include disclosures made for treatment, payment, health care operations and other purposes.

You must submit a request in writing, stating a time period beginning after April 13, 2003 that is within six years from the date of your request. Where an Electronic Health Record is used, we will provide you with an accounting of disclosures for a 3 year period. You are entitled to one free accounting within one 12-month period. For additional requests, we may charge you our costs.

We will usually respond to your request within 60 days. Occasionally, we may need additional time to prepare the accounting. If so, we will notify you of our delay, the reason for the delay, and the date when you can expect the accounting.

RIGHT TO REQUEST AMENDMENT: If you think that your Protected Health Information is not accurate or complete, then you have the right to request that Aspire amend such information for as long as the information is kept in our records. Your request must be in writing and state the reason for the requested amendment. We will usually respond within 60 days, but will notify you within 60 days if we need additional time to respond, the reason for the delay and when you can expect our response. We may deny your request for amendment, and if we do so, we will give you a written denial including the reasons for the denial and an explanation of your right to submit a written statement disagreeing with the denial.

RIGHT TO A PAPER COPY OF THIS NOTICE: It is Aspire's policy to provide you with a paper copy of this notice.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS: You have the right to request that we communicate with you concerning personal health matters in a certain manner or at a certain location. For example, you can request that we speak to you only at certain private locations. We will accommodate your reasonable requests.

V. COMPLAINTS

If you believe that your privacy rights have been violated, then you may file a complaint in writing with Aspire or with the Office of Civil Rights in the U.S. Department of Health and Human Services. To file a complaint with Aspire, contact:

Maria Torgalski, Vice President of Quality
2356 North Forest Road
Getzville, NY 14068
716-505-5511
mtorgalski@aspirewny.org

No one will retaliate or take action against you for filing a complaint.

VI. CHANGES TO THIS NOTICE

We will promptly revise and distribute this Notice whenever there is a material change to the uses or disclosures, your individual rights, our legal duties, or other privacy practices stated in this Notice. We reserve the right to change this Notice and to make the revised or new Notice provisions effective for all Protected Health Information already received and maintained by Aspire as well as for all Protected Health Information we receive in the future. We will post a copy of the current Notice in the appropriate Aspire Departments. In addition, we will provide a copy of the revised Notice to all individuals/consumers upon request.

If you have any questions about this Notice or would like further information concerning your privacy rights, then please contact:

Maria Torgalski, Vice President of Quality
2356 North Forest Road
Getzville, NY 14068
716-505-5511

Aspire of WNY

One-of-a-kind services
for one-of-a-kind people.

GENERAL INFORMATION
716.838.0047

EXECUTIVE OFFICES
2356 North Forest Road
Getzville, New York 14068
716.505.5500 | 716.894.8257 FAX
Brock Day Program
716.505.5720 | 716.632.2865 FAX
Communication & Development
716.505.5510 | 716.505.5608 FAX
Day Services Management
716.505.5508 | 716.894.8257 FAX
Fiscal Management
716.505.5560 | 716.894.0148 FAX
Human Resources
716.505.5610 | 716.894.6130 FAX
Purchasing
716.505.5509 | 716..505.5819 FAX

7 COMMUNITY CENTER
7 Community Drive
Buffalo, New York 14225
7 Community Day Program
716.505.5530 | 716.894.6397 FAX
Community Integration Program
716.505.5668 | 716.505.5536 FAX
Health Care Center
716.505.5530 | 716.892.1936 FAX

TRI-MAIN CENTER
2495 Main Street
Buffalo, New York 14214
Central Intake & Home Services
716.838.0047 | 716.838.5925 FAX
CO-OP Program
716.512.6788 | 716.512.6789 FAX
Housing & Residential Programs
716.505.5790 | 716.505.5799 FAX
Service Coordination
716.505.5830 | 716.838.3393 FAX
Individualized Career & Transition Services
716.836.7235 | 716.831.1145 FAX
Technology Today
Buffalo:
716.836.7232 | 716.838.0865 FAX
Tonawanda:
716.743.8372 | 716.743.0847 FAX
Workforce Development
716.505.7130 | 716.505.5799 FAX

CENTER FOR LEARNING
4535 Union Road
Buffalo, New York 14225
716.505.5700 | 716.633.9351 FAX
Children's Discovery Corner
716.505.5700 | 716.633.9351 FAX

ENVIRONMENT, SAFETY & TRANSPORTATION
3330 Clinton Street
Buffalo, New York 14224
716.505.5715 | 716.656.1644 FAX

Aspire of WNY will manage incidents by ensuring the timely and appropriate reporting, recording, investigation, review, and follow up of all incidents. Effective incident management enhances the quality of care provided to persons with developmental disabilities, protects them (to the extent possible) from harm, and ensures that such persons are free from abuse and neglect.

Aspire does not take any retaliatory action against anyone who reports an incident or co-operates with the investigation of a report made to the NYS Justice Center (JC) or the Office for People with Developmental Disabilities (OPWDD.)

Thomas Sy, President and CEO designates to Maria Torgalski, Vice President of Quality, designated Quality Assurance personnel, Division Vice Presidents and Designated Program Administrators the authority to manage the incident reporting process in accordance with regulation and approved Agency policy and procedure.

Attached are OPWDD's Learning about Incident Brochure and Aspire's Incident Management Brochure for Individuals and Families.

You can access Aspire's Incident Reporting and Management Policies and OPWDD's Part 624 regulations at: https://www.aspirewny.org/

Should you require paper copies of these documents please send a written request to:
Maria Torgalski
VP of Quality
2356 North Forest Road
Getzville, NY 14068
mtorgalski@aspirewny.org

Sincerely,

Maria J. Torgalski

VP of Quality

Incident Management at Aspire of WNY for Office for People With Developmental Disabilities (OPWDD) Services
Important Information for Individuals receiving services and Families/Guardians/Advocates

What happens when an incident occurs or is discovered?

- Immediate corrective and Protective actions are taken to ensure health and safety and prevent the incident from happening again
- Immediate Notifications are made to:
  - NYS Justice Center (JC) for all OPWDD Certified Facilities
  - OPWDD for all OPWDD Certified, Non-Certified, and Funded Services
  - Aspire Incident Management Unit (AIM)
  - Division Vice President
- Other Notifications within 24 hours:
  - Service Recipient (when appropriate)
  - Parent/Active Family member/Guardian/Advocate
  - Medicaid Service Coordinator (MSC)
- Law enforcement (when it is suspected a crime may have been committed)
- Your rights under Jonathan's Law
  - Right to have a meeting to discuss corrective actions
  - Report on actions taken (OPWDD 148) will be sent within 10 days
  - Right to request a copy of the OPWDD 147 (request must be in writing)
  - Right to request the outcome of investigations of Reportable Incidents
  - Right to request a copy of the investigation report of Reportable Incident (request must be in writing)
- Chapter 394:
  - Requires Aspire to notify Personal Representatives of Service Recipients that the Service Recipient may be interviewed during the course of an investigation

Investigation and Review

- An investigation is a systematic collection of information to describe and explain an event or a series of events
- An investigation of all Incidents (Reportable Abuse and Neglect, Reportable Significant Incidents, Serious Notable Occurrences and Minor Notable Occurrences) is required of all OPWDD agencies
- This process is in place to protect individuals and employees while Aspire determines what happened and how to prevent the incident from happening again
- All possible witnesses will be interviewed
- All documentary evidence is reviewed and copies are maintained
- Aspire makes every effort to complete investigations within 30 days
- Sometimes the JC or OPWDD may investigate the incident
- Aspire's Special Incident Review Committee (SIRC) has representation from Aspire's Board of Directors, Agency Administration, Clinical staff, a Direct Support Professional, a Service Recipient, and a member of an advocacy organization
- SIRC meets every 28 days to review all Reportable Incidents, Serious Notable Occurrences
- There is a Sub-Committee that reviews Minor Notable Occurrences
- The Justice Center reviews the investigation record and makes the final determination about the finding for Incidents accepted as Reportable Abuse and Neglect
- OPWDD reviews the investigation record for all incidents reported as abuse and neglect and all Deaths
- OPWDD reviews the final investigation report for all Reportable Significant Incidents, Serious Notable Occurrences, and Minor Notable Occurrences
- OPWDD and the Justice Center have access to Aspire's incident information through OPWDD's Incident Reporting Management Application (IRMA)

Resources

Aspire Incident Policies and Resources

Regulations that Govern Incident Management:

OPWDD Resources about Incidents

Justice Center Information for Individuals and Families

Note: Paper copies of policies and regulations will be provided upon receipt of written request.

Written requests can be addressed to:
Maria Torgalski
VP of Quality
2356 North Forest Road
Getzville, NY 14068

Andrew M. Cuomo
Governor

NYS Office For People With Developmental Disabilities
Putting People First

Kerry A. Delaney
Acting Commissioner

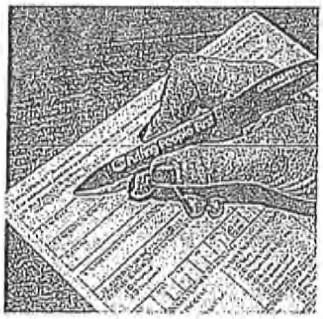
LEARNING ABOUT INCIDENTS

REISSUED APRIL 2014

OPWDD'S COMMITMENT TO PROTECTION FROM HARM

OPWDD's mission is to help people with developmental disabilities live richer lives. OPWDD, in coordination with the Justice Center for the Protection of People with Special Needs, has established requirements and oversight procedures to protect people receiving services from harm.

In order to support this mission, OPWDD and its provider agencies adhere to Title 14 of New York Codes, Rules and Regulations Part 624 (14 NYCRR Part 624), a regulation designed to protect people receiving OPWDD services. This regulation identifies steps to be taken when a person receiving services experiences an incident, as described on page 2, Types of Incidents. This regulation requires all providers of services to do the following:



- Ensure that staff report untoward events, called "reportable incidents" and "notable occurrences," that affect the well-being of people receiving services;
- Provide immediate care and protect the health, safety, and dignity of people with developmental disabilities involved in, or affected by, an incident;
- Investigate why incidents, including abuse and injuries, happen and take steps to prevent similar incidents from happening again;
- Establish an Incident Review Committee to review specific incidents and examine trends; and
- Develop procedures and provide staff training and oversight, as needed, to prevent similar incidents in the future.

This brochure provides an overview of OPWDD's expectations regarding incidents and explains the roles of qualified persons and other involved parties in advocating on behalf of the people we serve. Please refer to 14 NYCRR Part 624 for complete requirements of this regulation.
http://www.opwdd.ny.gov/regulations_guidance/opwdd_regulations

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WHO IS ABLE TO RECEIVE NOTICE AND ASK FOR INCIDENT INFORMATION?

Jonathan's Law requires that qualified persons are to be notified of certain events involving persons receiving services. Part 624, which includes Jonathan's Law notifications, requires that qualified persons are notified of all incidents.

Qualified persons include an individual receiving services, his or her legal guardian, or an involved parent, spouse, or adult child who has authority to provide consent for care and treatment.

Part 624 also requires that a person who does not meet the definition of a qualified person but who serves as an advocate for a person receiving services is to be notified of incidents.

Qualified persons, advocates, and correspondents may request incident information.

There are additional OPWDD directives on notifications involving Willowbrook class members.

HOW DO AGENCIES HANDLE INCIDENTS?

Incidents must be reported, investigated, recorded, reviewed by an Incident Review Committee, and acted upon to safeguard the well being of people receiving services.

Every provider must have a process for reporting the following incidents to OPWDD:

- Reportable Incidents of Abuse and Neglect
- Reportable Significant Incidents
- Serious Notable Occurrences

Providers must also have systems to manage Minor Notable Occurrences and other potentially harmful situations that do not rise to the level of a reportable incident or notable occurrence.

In addition, some incidents must be reported to the New York State Justice Center for the Protection of People with Special Needs (Justice Center). The Justice Center was created for the protection of people receiving services from facilities and programs that are certified or run by some State agencies, including OPWDD. Reportable incidents that happen in programs and services certified or run by OPWDD are reported to the Justice Center as well as OPWDD.

TYPES OF INCIDENTS...

Reportable incidents of abuse and neglect include physical, sexual, and psychological abuse, as well other prohibited conduct such as deliberate inappropriate use of restraint, and neglect.

Reportable significant incidents include medication errors that result in adverse effects, use of seclusion and other mistreatment, and some missing person and choking events.

Serious notable occurrences include injuries that require hospitalization, theft or financial exploitation (involving funds above $100 and benefit, debit, or credit cards), and deaths of people receiving services.

Minor notable occurrences include injuries that require treatment beyond first aid and theft and financial exploitation (involving $15 to $100).

See14 NYCRR Part 624 for a full list of types of incidents and their definitions.

When sharing the OPWDD 147, OPWDD 148 and other records/documents pertaining to allegations of abuse, providers are required by law to "redact" or edit to delete the names and identifying information regarding other individuals receiving services and employees.

HOW IS AN INVESTIGATION CONDUCTED?

- Every reportable incident must be thoroughly investigated.
- The investigator will gather information from a variety of sources and prepare a report that includes a summary of evidence, conclusions, and recommendations. In the case of a report of abuse or neglect, the report will also include a finding of "substantiated" or "unsubstantiated."
- The investigative report is submitted to the agency's Incident Review Committee for review. The committee is required to review and monitor investigatory procedures (except when the case is investigated by the Justice Center or the Central Office of OPWDD) and may in some cases, recommend further investigation.

HOW AND WHEN IS THIS INFORMATION AVAILABLE?

- Qualified persons, advocates, and correspondents will receive telephone notice as soon as reasonably possible following a report of an incident. They will also be provided with an offer to meet with the director of the agency (or his or her designee) to discuss the incident.
- Qualified persons and advocates who receive notice of an incident will automatically receive a report on actions taken (OPWDD Form 148) within 10 days of completion of the report.
- Qualified persons and advocates who receive notice of an incident may submit a written request for a copy of the incident report and should receive a redacted copy of the requested report within 10 days after the request is made.
- Qualified persons (called "eligible requestors" in Part 624) may also request additional information on reportable incidents, such as investigative reports. These reports, which must be redacted, are provided to requestors within 21 days after the closure of an incident or within 21 days following the request if an investigation is already completed.
- Written requests for records or documents from that investigation should be directed to the agency that reported the incident.
- Requests may be made for information on incidents that occurred in the past. Part 624 includes requirements regarding time frames applicable to these requests.
- By law, all requested records and documents pertaining to incidents must be redacted (edited) so names and identifying information about people involved in incidents are not available to those who request incident information.

WHO CAN AN ADVOCATE (INCLUDING A "QUALIFIED PERSON" OR CORRESPONDENT) SPEAK TO FOR FOLLOW UP?

An advocate should feel free to ask questions when he or she receives notice of an incident and may ask to speak with a supervisor for more information. The advocate may also accept the offer to meet with the agency director or designee.

If not satisfied, the advocate may direct questions or concerns to the director of the agency or other high level administrators.

For reports of abuse or neglect in a certified program, the Mental Hygiene Legal Services (MHLS) may also be a resource.

The OPWDD Incident Management Unit may also help resolve outstanding issues.

There is an administrative appeal process for advocates who have been denied incident records requested from an agency providing services.

Contact the OPWDD Incident Records Appeals Officer, 44 Holland Avenue, Albany, NY 12229 for more information.

Laurie A. Kelley, Acting Commissioner
New York State
Office for People With Developmental Disabilities
Standing Committee on Incident Review
44 Holland Avenue
Albany, NY 12229

For clarification on the information contained in this brochure, please contact:

OPWDD's

Standing Committee

on Incident Review.

opwdd.scir@opwdd.ny.gov

NYS Office For People With Developmental Disabilities

Putting People First

If you are a member of the public who wants to report abuse of an individual who receives services in the OPWDD system, there are several ways to do so:

- If you are aware of the name of the agency providing services to the individual, you may contact the provider agency directly to report abuse.
- If information on the service provider of an individual is unknown, you may report abuse to the OPWDD. You can access contact information for your local Incident Compliance Officer on OPWDD's website on the Incident Management Unit webpage. The Incident Management Unit also has an off-hours contact number at 1-888-479-6763.
- The NYS Justice Center for the Protection of People with Special Needs operates a 24 hour hotline for the reporting of Abuse, Neglect and Significant incidents for facilities and programs certified or operated by OPWDD at 1-855-373-2122.

How to Advocate and Protect Individuals from Harm

The *qualified person or advocate* and service provider should work together to ensure that the person is well served and safe. The partnership can begin at a team meeting, where the person's individualized plan for services and supports is reviewed; at that time, the team, including the *qualified person or advocate*, can discuss safeguards or interventions that may be required. Such safeguards often need to be individualized and specific to the person.

Particularly when unexplained injuries recur, the *qualified person or advocate* might ask what steps are being taken to protect the person from being exposed to the same or similar circumstances. While it is not always possible to anticipate the steps required, as they may be specific to the incident, some possible areas for discussion include:

- changes in the person's behavior or demeanor;
- the rhythm of the person's day and week;
- use of, possible need for, or change in adaptive equipment;
- any physical care, health or hygiene problems needing attention;
- exploration of interventions or supports that may be helpful or needed;
- evaluation including health or clinical assessment;
- level of supervision;
- staff training and re-training efforts; and/or
- conditions in the living or service environment.

Team meetings provide an invaluable forum for the qualified person or advocate and other members to advocate for protection from injuries, especially those that are unexplained and recurrent.

Aspire

Parties who can receive Complaints and Concerns

Aspire employees are committed to address all complaints and concerns in a timely manner. We encourage the individuals we support and families to address complaints and concerns directly with the service provider or their direct supervisor. Aspire recognizes that there may be times you may not feel comfortable bringing a complaint or concern to the attention of the service provider. Here is a list of people who can be contacted with complaints and concerns.

Aspire of WNY	
Name:	Maria Torgalski
Title:	Vice President Of Quality
Address Line 1:	2356 North Forest Road
Address Line 2:	Getzville, NY 14068
Phone:	716-505-5111
E-mail Address	mtorgalski@aspirewny.org
	If you would like to remain anonymous
Name:	Corporate Compliance Hotline
Phone:	716-505-5671
	If you prefer to remain anonymous
Name:	Thomas Sy
Title:	President and CEO
Address Line 1:	2356 North Forest Road
Address Line 2:	Getzville, NY 14068
Phone:	716-505-5502
E-mail Address:	ts@aspirewny.org

Office for People with Developmental Disabilities	
Name:	Kirk Mauer
Title:	Developmental Disabilities Regional Services Office Director
Address Line 1:	1200 E and West Rd
Address Line 2:	West Seneca, NY 14224
Phone:	800-487-6310
Name:	Kerry A. Delaney
Title:	Acting Commissioner
Address Line 1:	44 Holland Avenue
Address Line 2:	Albany, New York 12229
Phone:	(518) 474-3625
E-mail Address:	Commissioners.Correspondence.Unit@opwdd.ny.gov
Website Address:	Contact Information | OPWDD

Justice Center for the Protection of People with Special Needs	
Name:	NYS Justice Center General Information
Address Line 1:	161 Delaware Avenue
Address Line 2:	Delmar, New York 12054-1310
Phone:	(518) 549-0200
Website Address:	Contact the Justice Center | NYS Justice Center
Name:	NYS Justice Center Vulnerable Persons Registry (Report Abuse)
Phone:	1-855-373-2122
Name:	Individual and Family Support Unit
Phone:	1-800-624-4143

ASPIRE OF WNY POLICY AND PROCEDURE		
ASPIRE POLICY MANUAL	**TOPIC:** Attendance Policy	**SECTION:**
_x_ Article 16 Clinic Manual	**Original By:** Clinical Director	**Page:** 1 of 1
_x_ Article 28 Manual	**Date Approved:** 6/09	**Revision Dates:**
		Regulation: OMRDD 679

POLICY STATEMENT: It is the policy of the Aspire of WNY Health Center (Article 16/28) that regular and consistent attendance by individuals at their Clinic appointments is necessary to maximize the benefits from their treatment. Individuals and their care providers are responsible to see that this occurs.

Responsibility:

Individual

Health Center Staff

Procedure:

1. Attends scheduled appointments.

2. After 3 missed appointments, contacts the individual, their care provider, or their service coordinator to find out if there is a problem or different time or day that needs to be established.

3. If missed appointments continue without an acceptable excuse (i.e. severe illness, etc.) discharges individual from services until such a time individual is ready to consistently attend appointments.

Attachments: Receipt of Health Center Attendance Policy Sign Off

Thomas Sy *6/09*
Executive Director Date

Aspire

Turning Disabilities
Into Capabilities

Aspire of WNY, Inc.
Patient Grievance Process

POLICY:

Any Patient; Patient's Parent, Guardian or Correspondent may express complaints about the care and services provided at Aspire Health Services.

PROCEDURE:

1. When there is a complaint, informal resolution is encouraged through the objecting party and the Clinic Nursing Supervisor.

2. If there is nor resolution or the resolution is unsatisfactory, the objecting party has the right to request a meeting with the Director of Health Services or Medical Director in an attempt to resolve the issue.

3. A written decision by the Director of Health Services will be sent to the involved parties within thirty working days of the meeting. Attached to the written decision will be a notice that the objecting party may submit a formal written objection requesting a hearing to the Executive Director of Aspire (or designee.)

4. If there is no resolution or the objecting party is not satisfied with the decision, he or she may issue concerns to:

New York State Department of Health
Office of Health Systems Management
Buffalo Area Office
584 Delaware Avenue
Buffalo, New York 14202
(716) 847-4307

The Arc.
Erie County
New York

PHOTO, NAME, AND PROGRAM ENROLLMENT AUTHORIZATION FORM FOR PARENTS OR GUARDIANS ("AUTHORIZATION")

I_____ am the parent of a child under 18 years old and/or
(Name of Parent or Guardian)
the legal guardian of _____("Child or Guardianee").
(Name of Child and/or Guardianee)

Signer must check one or both boxes for authorization or box to decline for form to be valid

Photo Authorization

☐ I hereby grant to *The Arc Erie County New York* and all of their employees, officers, agents and/or directors, my permission, effective immediately as of the date of this Authorization, to use, reproduce, and publish photographs, images and digital reproductions of my Child and/or Guardianee and/or any drawings drawn by my Child and/or Guardianee for any purpose including, but not limited to, marketing such as newsletters, posting on *The Arc Erie County New York* website, brochures, public relations, electronic publishing via the Internet, social media such as Facebook, promotional items and/or any other lawful purpose

Use of Name / Program Enrollment Authorization

☐ I hereby grant to *The Arc Erie County New York* and all of their employees, officers, agents and/or directors, my permission, effective immediately as of the date of this Authorization, to use the name of my Child and/or Guardianee and to publicize their enrollment in services of *The Arc Erie County New York* for any purpose, in conjunction with publication of photographs, images, and digital reproduction including, but not limited to, marketing such as newsletters, posting on *The Arc Erie County New York* website, brochures, public relations, electronic publishing via the Internet, social media such as Facebook, promotional items and/or any other lawful purpose.

I am entering into this Authorizations voluntarily, fully understand the terms and conditions of this Authorization, know that I have the right to rescind and revoke this Authorization at any time, and fully understand that this Authorization will remain in effect, during and beyond my enrollment in services provided by *The Arc Erie County New York*, unless it is specifically revoked by me in writing and any written revocation by me of this Authorization is delivered to the Chief Legal Officer, Chief Executive Officer, and/or Compliance Officer of *The Arc Erie County New York*.

Declination of Both Authorizations

☐ I have been provided with the options shown above and do not authorize the use of images, digital reproductions, drawings, name, or program enrollment information of my Child and/or Guardianee for any marketing or public relations purpose.

In WITNESS WHEREOF, I have affixed my signature hereto as of the date referenced below.

_____ _____
SIGNATURE OF PARENT/GUARDIAN DATE

_____ _____
SIGNATURE OF GUARDIANEE DATE

_____ _____
ADDRESS PHONE NUMBER

The Arc.
Erie County
New York

PHOTO, NAME, AND PROGRAM ENROLLMENT AUTHORIZATION FORM FOR INDIVIDUALS ("AUTHORIZATION")

Signer must check one or both boxes for authorization or box to decline for form to be valid

Photo Authorization

☐ I hereby grant to *The Arc Erie County New York* and all of their employees, officers, agents and/or directors, my permission, effective immediately as of the date of this Authorization, to use, reproduce, and publish photographs, images and digital reproductions of me and/or any drawings drawn by me for any purpose including, but not limited to, marketing such as newsletters, posting on *The Arc Erie County New York* website, brochures, public relations, electronic publishing via the Internet, social media such as Facebook, promotional items and/or any other lawful purpose

Use of Name / Program Enrollment Authorization

☐ I hereby grant to *The Arc Erie County New York* and all of their employees, officers, agents and/or directors, my permission, effective immediately as of the date of this Authorization, to use my name and to publicize my enrollment in services of *The Arc Erie County New York* for any purpose, in conjunction with publication of photographs, images, and digital reproduction including, but not limited to, marketing such as newsletters, posting on *The Arc Erie County New York* website, brochures, public relations, electronic publishing via the Internet, social media such as Facebook, promotional items and/or any other lawful purpose.

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In WITNESS WHEREOF, I have affixed my signature hereto as of the date referenced below.

_____
PRINTED NAME

_____ _____
SIGNATURE DATE

_____ _____
ADDRESS PHONE NUMBER