UCP United Cerebral Palsy
of Mobile and Central Alabama
*Life without limits for people with disabilities*

DOWN SYNDROME HYDROCEPHALUS
ACQUIRED BRAIN INJURY RHETT'S SYNDROME
DEVELOPMENTAL DISABILITY VISUAL IMPAIRMENT MUSCULAR DYSTROPHY
65 YEARS STRONG
TRAUMATIC BRAIN INJURY CEREBRAL PALSY
MULTIPLE SCLEROSIS
AUTISM SPECTRUM DISORDER
SPINAL CORD INJURY
MENTAL ILLNESS
SEIZURE DISORDER
LEARNING DISABILITY
SPINA BIFIDA
ADHD/ADD
HEARING IMPAIRMENT
WE ARE MORE THAN OUR NAME

**TO:** **Respite Families**

**FROM:** Matrisza Alvarez
Director of Youth and Family Services
respite@ucpmobile.org

**Date:** **9/1/23**

**RE:** HEARTS Respite Application

Thank you for participating in United Cerebral Palsy's HEARTS respite program. We are excited to begin a new grant year.

All families wishing to participate in the HEARTS Respite Program this coming year must complete a new application and return it, along with the requested documents.

***Please complete the enclosed forms to let us know you wish to participate in the HEARTS program for the next year. You will then be mailed an approval letter that your family's application is approved, and you will automatically be awarded a voucher for the 1st Quarter. Remember services are first-come first-served, so return your proof of diagnosis, forms and applications promptly. Also remember the vouchers for 2nd-4th quarter are not automatic; you must email on the assigned date of each quarter to request a voucher. (*see quarterly schedule below*)***

It is our hope and belief that the HEARTS Respite Program will continue to be funded through Children's Trust Fund, to make respite care available for families and to give them a choice in selecting their caregivers.

Thank you.

Matrisza Alvarez
Director of Youth and Family Services
respite@ucpmobile.org

1st Quarter October 1st - December 31st (DO NOT EMAIL)
2nd Quarter January 1st - March 31st (Email Thursday, January 4, 2024)
3rd Quarter April 1st - June 30th (Email Monday, April 1, 2024)
4th Quarter July 1st – September 30th (Email Monday, July 1, 2024)

# H.E.A.R.T.S. Enrollment & Program Procedures

H.E.A.R.T.S. provides respite care for families of children 21 years of age or younger with special needs. The future of this program will depend heavily on the willingness of parents/guardians to take active roles in advocating the need for respite in our state. As opportunities arise, we will inform you of contacts that will need to be made. Together, we have a greater chance of securing funding for this crucial service.

**Voucher respite** is designed to allow families to choose their own caregivers, offering flexibility of when, where, and how much respite is provided. The Program Procedures are as follows:

Families wishing to enroll in HEARTS respite and hire their own providers will **complete the Intake Packet and return it to UCP**. **All forms must be completed in order to enroll.**

- **All Applicants must enroll each year and provide verification of the child's medical diagnosis (copy of IEP/IFSP, or doctor's note).**

- **You will not receive a voucher until you provide a current proof of medical diagnosis (copy of IEP/IFSP, or doctor's note), even if your child has been enrolled in the HEARTS Respite Program in the past.**

- **ALL information must be received before a family can be enrolled in the program.** You will be notified if information is needed to complete your application.

  Families will be notified by mail if they are approved for H.E.A.R.T.S. **Applications received in the 1st Quarter (Oct. 1st- Dec. 31st) will be viewed as a request for a voucher. Vouchers will be approved on a first-come, first-served, basis once diagnosis is provided.**

- After the First Quarter, families will need to request voucher approval at the **beginning of each quarter by emailing respite@ucpmobile.org.** Please do not email before the first day of the quarter. The quarter dates are:

  **2nd Quarter** **January 1st - March 31st (Email Thursday, January 4, 2024)**

  **3rd Quarter** **April 1st - June 30th (Email Monday, April 1, 2024)**

  **4th Quarter** **July 1st – September 30th (Email Monday, July 1, 2024)**

- **CALLS ARE NO LONGER ACCEPTED, YOU MUST EMAIL respite@ucpmobile.org TO REQUEST A VOUCHER ON THE ABOVE ASSIGNED DATES.**

respite@ucpmobile.org

- Vouchers will be **given out on a first-come, first-served basis** until funds are depleted for each Quarter

- Once a family is approved for a Quarterly Voucher, UCP will mail the Voucher approval form with the amount approved, as well as a Service Report form to the family.

- Families will **select, hire, and train a caregiver of their choice and schedule respite care.** Families may select any rate of pay up to a maximum of $15.00 per hour.

- **Families will not be paid more than the approved amount for each quarter.**

- **Vouchers will expire at the end of each quarter.** Funds that are not used by the end of the quarter will be added back to the budget.

- Families must complete a Service Report for each respite session. **Each Service Report needs dates of service, hours of service, rate of pay, and signatures of parent/guardian, name and signature of the selected caregiver.**

- Family will mail Service Reports to UCP to receive payment for services. **(Please allow four to six weeks for check to be processed).**

- **All Service Reports must be received within 5 days after the end of each quarter in order to receive payment.**

- UCP will mail payment to parent/guardian. Parent/guardian will pay selected caregiver.

- **Please keep Enrollment procedures which includes the notice of privacy practices and client rights for you use and records.**

Contact Matrisza Alvarez at 251-479-4900 if you have any questions.


respite@ucpmobile.org

PARENT/GUARDIAN COPY

**UCP OF MOBILE, INC.**
**NOTICE OF PRIVACY PRACTICES**

At United Cerebral Palsy of Mobile ("UCP"), we are committed to treating protected health information about you responsibly. Federal law known as the Privacy Standards has requirements for the use and disclosure of Protected Health Information ("PHI"). This notice will tell you about the ways in which we may use and disclose your PHI. We also describe your rights under the Federal Privacy Standards and certain obligations we have regarding the use and disclosure of PHI.

Under the Federal Privacy Standards, we are required by law to:

- Make sure that medical information that identifies you is kept private.
- Give you this notice of our legal duties and privacy practices with respect to medical information about you.
- Make a good faith effort to obtain your acknowledgement that you have received this notice.
- Follow the terms of the notice that is currently in effect.

**USES AND DISCLOSURES OF YOUR MEDICAL INFORMATION**

**FOR TREATMENT**: We may use your PHI to provide you with medical treatment or services. We may disclose your PHI to other personnel in our organization or outside of our organization that are involved in taking care of you. For example, we may need to tell a Service Coordinator about your condition in order to coordinate the different things you need, such as therapy.

**FOR PAYMENT**: We may use and disclose your PHI so that the services you receive from us or other providers may be billed and payment may be collected from you, an insurance company or a third party. For example, we may give your health plan information about treatment you received, so it will pay us or reimburse you for the treatment.

**FOR HEALTH CARE OPERATIONS**: We may use and disclose your PHI for our operations and to make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services, and to evaluate the performance of our staff in caring for you. We may disclose PHI to "business associates" who provide contracted services such as accounting, legal representation, claims processing, accreditation, and consulting. If we do disclose your PHI to a business associate, we will require the business associate to appropriately safeguard it.

**APPOINTMENTS / TREATMENT ALTERNATIVES**: We may use and disclose PHI to schedule appointments and remind you of them, and to give you information about treatment alternatives or services that may be of interest to you.

**COMMUNICATION WITH FAMILY**: If you do not object, we may release medical information about you to a friend or family member that is involved in your medical care. In addition, we may disclose your PHI to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.
**FUNDRAISING**: We may contact you as part of a fundraising effort for our programs. You have the right to request not to receive fundraising materials.

**RESEARCH:** We may disclose PHI to researchers when their research has been approved by a committee that has reviewed the research protocol and has established protocols to ensure the privacy of your health information.

**AS REQUIRED BY LAW**: We will disclose PHI when required to do so by federal, state or local law, including to the Department of Health and Human Services when required to determine our compliance with the Privacy Standards.

**TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY**: We may use and disclose your PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

**ORGAN DONATION**: If you are an organ donor, we may release medical information to organizations that handle organ procurement, as necessary to facilitate donation and transplantation.

**MILITARY, VETERANS, AND SPECIFIC GOVERNMENT FUNCTIONS**: We may release your PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law, and other national security activities authorized by law, and so they may provide protection to the President of the United States or certain other officials

or conduct special investigations. If you are a member of the Armed Forces, we may release your PHI as required by military command authorities.

**WORKERS COMPENSATION**: We may disclose health information to the extent authorized by and the extent necessary to comply with laws relating to workers' compensation or similar programs. When that occurs, we will give you notice about the disclosure.

**PUBLIC HEALTH**: We may disclose your PHI for public health activities (such as reports of communicable diseases, vital statistics, reactions to mediations or problems with products, to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease) or to notify the appropriate government authority if we believe a consumer has been the victim of abuse, neglect or domestic violence.

**HEALTH OVERSIGHT AGENCIES**: We may disclose PHI to health oversight agencies such as Medicare and state agencies for activities such as audits and investigations that are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**COURT ORDERS AND SUBPOENAS**: We may disclose PHI in response to a court or administrative order. We may also disclose PHI in response to a subpoena, discovery request, or other lawful process, but only if a reasonable effort has been made to tell you about the request or to obtain an order protecting the information requested.

**LAW ENFORCEMENT**: We may release PHI for certain law enforcement purposes, including, for example, reports required by law, to comply with a court order or warrant, or to report or answer questions about a crime.

**CORONERS AND FUNERAL DIRECTORS**: We may release PHI to a coroner, medical examiner, or funeral director as necessary so they can carry out their duties.

**USES AND DISCLOSURES WITH YOUR AUTHORIZATION**

We will ask you to sign an Admission Consent Form, which covers the uses and disclosures of PHI for treatment, payment and health care operations. It also has sections, which help you exercise the rights described in the next part of this notice. Other uses and disclosure of PHI not covered by this notice or the laws that apply to us will be made only with your written authorization. All disclosures of psychotherapy notes require your written authorization, with certain very limited exceptions such as disclosures necessary to protect your safety or the safety of others or as otherwise required by law. You may revoke your Admission Consent or an Authorization at any time, by doing so in writing. Ask the staff for the form to use. If you revoke your permission, we will no longer use or disclose PHI for the purposes covered by that Consent or Authorization. You understand that we are unable to take back any disclosures we have already made with your permission.

**YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION**

Listed below are your rights regarding your PHI. To exercise these rights, make the request in writing. Ask the Program Director for the proper form. We have the right to deny your request in certain circumstances, and we will inform you if your request is denied.

**REQUEST RESTRICTION**

You have to right to request a restriction on the PHI we use or disclose about you for treatment, payment or health care operations, or to someone who is involved in your care.

**CONFIDENTIAL COMMUNICATIONS**

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we only send mail to a Post Office Box.

**ACCESS**

You have the right to inspect and obtain a copy of the medical records that we have about you. We may charge a reasonable fee for copying and mailing. Your records remain the property of UCP.

**REQUEST AMENDMENT**

If you feel that medical information that we have about you is incorrect or incomplete, you may ask us to amend the information.

**REQUEST AN ACCOUNTING OF DISCLOSURES**

You have the right to request a list of disclosures that we made after August 1, 2003, of your PHI, except for treatment, billing and health care operations, or as a result of your written or verbal authorization.

**QUESTIONS OR COMPLAINTS**

For more information, or to report an incident where you feel that your privacy rights have been compromised by a UCP staff person, you may file a complaint with the Compliance Officer, UCP of Mobile, 3058 Dauphin Square Connector, Mobile, AL 36607, 251-479-4900. You may also file a complaint with the U.S. Secretary of the Department of Health and Human Services. Please contact the Compliance Officer for that contact information.

**Clients have the right to:**

1. **Access the established procedures for handling their complaints and/or mistreatment.**
2. **Be informed of services available.**
3. **Communication regarding program.**
4. **A safe and humane service environment.**
5. **Be protected from abuse, neglect, and/or mistreatment.**
6. **Privacy which promotes their quality of life.**
7. **Exercise personal religious beliefs.**
8. **Confidentiality of records.**
9. **Receive appropriate quality of service.**
10. **Participate in the planning of their service.**
11. **Prompt and appropriate medical care and emergency medical treatment.**


respite@ucpmobile.org

# HEARTS ENROLLMENT FORM
## 2023-2024

Mail to: Matrisza Alvarez, United Cerebral Palsy of Mobile
3058 Dauphin Square Connector
Mobile, AL 36607
(251)-479-4900
respite@ucpmobile.org

*Please complete ALL information. The demographic information is used only for statistical purposes in reporting to ou funding sources about the ages, counties, etc., that we serve.*

**Please answer all the questions below:**

1. Is your child 21 or younger? Yes or No

2. Do you care for this child in your home? Yes or No

3. Was your family in HEARTS Respite last year? Yes or No; In past years? Yes or No

4. Do you receive respite services from other providers? Yes or No
   If yes, list program_____

**Please PRINT Clearly and fill in all sections:**

Date: _____
Client Name: _____ Sex: Male Female
Date of Birth _____ Age: ____ Race _____ Hispanic/Latino origins Yes No
Number of Child's Siblings: ____ How many other children in the home have a disability? _____
Parent/Guardian Name: _____ Relationship to child: _____
Mailing address: _____ E-Mail: _____
City: _____ St: _____ Zip: _____ County: _____
Home Phone: _____ Cell Phone: _____ Other: _____
Emergency Contact: _____ Phone: _____

*******MUST ATTACH PROOF OF DIAGNOSIS THAT CLEARLY INDICATES DISABILITY*******

**Child's disability: (Please Check ALL That Apply)**

_____Visual impairment
_____Speech/language impairment
_____Hearing impairment
_____Orthopedic impairment
_____Other health impairment
_____Emotional behavioral disability
_____Developmental delay
_____Autism
_____Intellectual disability
_____Traumatic brain injury
_____Specific learning disability
_____Other – please specify: _____

**HEARTS ENROLLMENT FORM**
**2023-2024**

**United Cerebral Palsy of Mobile**
**3058 Dauphin Square Connector**
**Mobile, Al 36607**
**251-479-4900**

## PARENT CONTRACT AGREEMENT

**Please read the following carefully initial each to show your understanding:**

____I wish to enroll in UCP's Respite Voucher Program and I understand that funding is based on a first-come-first-served basis until funds are depleted.

____ I understand that I **must provide proof of the child's disability or diagnosis** with this enrollment form and complete all forms for your enrollment to be processed (Examples of proof: Copy of IFSP or IEP, Doctor's Note, or clinic /hospital record)

____I understand that once I am approved for respite, it is my responsibility to select and train a trustworthy caregiver (provider must not reside in the home nor be a parent of the client). UCP or ADCANP will not be held responsible for any actions taken by the selected caregiver.

_____I understand that, in order to receive reimbursement for respite services, my Voucher Service Report form must be completed, signed by me and the caregiver, and received in the UCP of Mobile office no later than 5 days after the expiration date stated on the form.

_____I understand that, in order to receive reimbursement for respite services, my Respite Care Programs survey must be received in the UCP of Mobile office by the end of the quarter or, for the fourth quarter, by September 15th.

_____I understand that reimbursement checks may be mailed up to **4-6 weeks after** I turn in my Voucher Service Report and Respite Care Programs survey and my reimbursement check will be mailed to my address provided on the form.

_____I understand that I must email for approval of voucher at the beginning of each quarter after initial enrollment.

I agree to the above conditions and funds will be used **ONLY** for respite care.

Signature: _____ Date: _____

## NOTICE OF CLIENT RIGHTS

I have read the CLIENT RIGHTS, and I understand those rights as presented to me. (A copy for your records was included in packet and is available at www.ucpmobile.org under respite tab.)

Parent / Legal Guardian signature _____ Date _____

## NOTICE OF RECEIPT OF PRIVACY PRACTICES

I have received a copy of United Cerebral Palsy of Mobile's Privacy Practices (A copy for your records was included in packet and is available at www.ucpmobile.org under the respite tab.)

Parent / Legal Guardian signature _____ Date _____

respite@ucpmobile.org

You must have an e-mail to register for the residential rules webinar trainings.

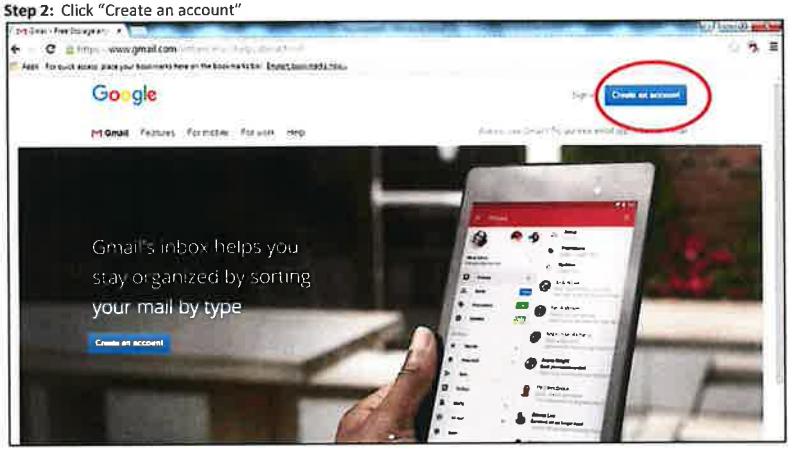
It is simple, easy and FREE to create a Gmail email account. Here is how you do it:

1) Go to Google website (www.google.com) and click "Gmail"
2) Click "Create an account"
3) Fill out the form and click "Next Step"
4) Done. You now have a Free Gmail email account.

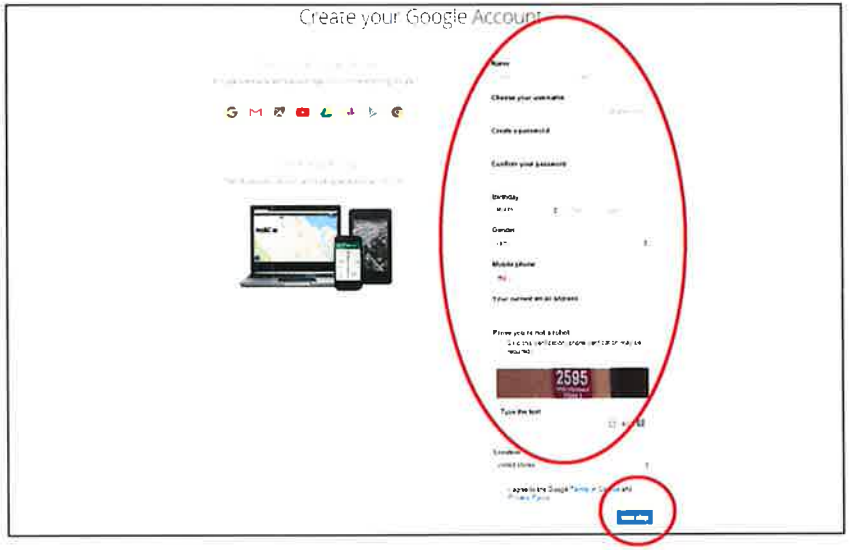
---

**Step 1:** Go to Google website (www.google.com) and click Gmail


**Step 2:** Click "Create an account"




**Step 3:** Fill out the form and click "Next Step"




**Step 4:** Done. You now have a FREE Gmail account.

# **IMPORTANT CHANGES**

- CALLS ARE **NO** LONGER ACCEPTED, YOU MUST EMAIL UCP @ respite@ucpmobile.org TO REQUEST A VOUCHER ON THE ASSIGNED DATES.

  2nd Quarter January 1st - March 31st (Email Thursday, January 4, 2024)

  3rd Quarter April 1st - June 30th (Email Monday, April 1, 2024)

  4th Quarter July 1st – September 30th (Email Monday, July 1, 2024)

- Please include the following in the body of the email:
  - Parent/Guardian Name
  - Child's Name
  - Current address
- UCP will award vouchers on a first come first serve basis according to the time stamp on the email received from the parent/guardian.
- DO NOT EMAIL OVER & OVER AGAIN, you will receive a confirmation email once UCP receives your email request.