TO: **Respite Families**

FROM: Matrisza Alvarez
Director of Youth and Family Services

Date: **7/17/17**

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 forms and applications promptly. Also remember the vouchers for 2nd-4th quarter are not automatic; you must to call on the first day 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.

http://www.legislature.state.al.us/aliswww/AlaLegResources.aspx

Thank you.

Matrisza Alvarez
Director of Youth and Family Services

UCP United Cerebral Palsy of Mobile
Life without limits for people with disabilities

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Mobile, AL 36607

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fax 334-566-7987

Post Office Box 618
McIntosh, AL 36553

tel 251-944-8696
fax 251-944-8697

1260 Perry Hill Road
Montgomery, AL 36109

tel 334-271-2280
fax 334-271-8018

Troy Supported
Employment Program
518 South Brundidge Street
Troy, AL 36081

tel 334-566-2491
fax 334-566-9415

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 9 page 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)
- **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 (Aug. 1st- Oct. 31st) will be viewed as a request for a voucher. Vouchers will be approved on a first-come, first-served basis.**

- After the First Quarter, families will need to request voucher approval at the **beginning of each quarter by calling our office.** Please do not call or email before the first day of the quarter. The quarter dates are**:**

2nd Quarter Nov. 1st - Jan. 31st

3rd Quarter Feb. 1st - April 30th

4th Quarter May 1st - June 30th

- 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 $10.00 per hour.

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

- **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.**

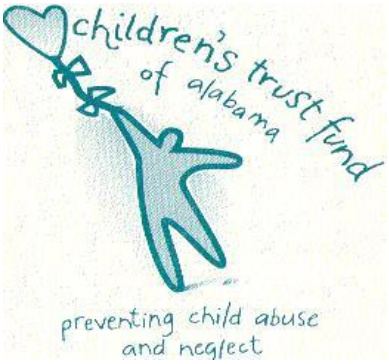
- Family will mail Service Reports to UCP to receive payment for services. (**Please allow four to six weeks for check to be processed).**

- **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 or Missy DiCesare at 251-479-4900 if you have any questions.



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.**

HEARTS ENROLLMENT FORM

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

Please complete ALL information. The demographic information is used only for statistical purposes in reporting to our 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: _____
_____

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Participant ID

Enrolled Date (month/day/year): / /

Completed Date (month/day/year): / /

10 Questions About You

Instructions:
Please mark your answer to the following questions about yourself. Your answers will be kept confidential. If you have any questions, please notify the program staff. **USE DARK (BLUE/BLACK) PENCIL / INK**

1. What is your sex? O Female O Male

2. What is your age in years?

3. What is your current relationship status?

O Single, never married O Committed relationship (not married) O Married
O Separated O Divorced O Widowed

4. Are you of Hispanic, Latino or Spanish ethnicity? O Yes O No

5. What is your race? You may mark more than one.

O American Indian or Alaska Native O Asian O Black or African American
O Native Hawaiian / Pacific Islander O White O Other - list below

6. What is the highest level of education you have attained?

O Did not finish high school O High school diploma / GED O Trade school / technical certificate
O Associate's degree O Bachelor's degree O Master's degree / advanced degree

7. What is your current employment / job status?

O I work full time O I work part time O I am retired
O I am a student O I am disabled O I am unemployed

8. What is your current yearly income?

O Less than $10,000 O $10,000 - $19,000 O $20,000 - $29,000
O $30,000 - $39,000 O $40,000 - $49,000 O $50,000 - $59,000
O $60,000 - $69,000 O $70,000 - $79,000 O More than $80,000


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9. Are you currently incarcerated (in jail)? O Yes O No

10. How many children do you have? Mark all that apply.

Your biological child(ren)
How Many? ☐☐

Your foster child(ren)
How Many? ☐☐

Your step-child(ren)
How Many? ☐☐

Your adopted child(ren)
How Many? ☐☐

Your grandchild(ren)
How Many? ☐☐

How many of these children have special needs? ☐☐

What is / are the special need(s)?

- O ADD/ADHD
- O Aphasia/Dysphasia
- O Apraxia/Dyspraxia
- O Auditory Processing
- O Autism/Aspergers
- O Cystic Fibrosis
- O Cerebral Palsy
- O Developmental Delays
- O Down Syndrome
- O Dyslexia
- O Emotional/Behavior Disorders
- O Fetal Alcohol Syndrome
- O Fragile "X"
- O Hearing Impaired
- O Learning Disabilities
- O Intellectual Disability
- O Neurological Disabilities
- O Seizure Disorder
- O Support Groups
- O Visual Impairment
- O Other - list below

HEARTS ENROLLMENT FORM
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). 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 June 15th.

_____I understand that reimbursement checks usually take 2 weeks to process but may be mailed up to 30 days 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 call 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 _____