The Arc Mid-South
3485 Poplar Ave, Suite 210
Memphis, TN 38111-4633

T 901 327-2473
F 901 327-1197
www.thearcmidsouth.org

Achieve with us.

Thank you for contacting The Arc Mid-South's Family Support Services. Please complete the attached application if you are interested in our summer camp, weekend retreats, respite care or direct care services. When the office receives the application, the Program Manager will contact you and schedule a home visit with you and your child/family member. During the home visit, you will learn about our services in greater detail and have an opportunity to ask questions. If you have additional questions, please contact Karen McQueen, Program Manager, at (901) 327-2473.

Also take into consideration your application must be processed by our office prior to providing any of above mentioned services.

Sincerely,

Carlene I. Leaper
Executive Director

APPLICATION FOR SERVICES

The Arc of the Mid-South is an equal opportunity employer and service provider according to law prohibiting discrimination based on race, color, sex, religion, national origin, ancestry, age, handicap, or marital status. Your responses to any questions will not be used as a basis for discrimination, but will be judged on its relevance to the position or service you are seeking.

Instructions: Please print or type legibly. **Date of App** ____________________

Name ____ **DOB** ____________________

Social Security # ______________________________________ **Sex** **F** ☐ ☐ **M**

Parent/Guardian: Name ____________________________ **Phone #1** ____________________

Email Address ____ **Phone #2** ____________________

Home Address ____**City/State/ZIP** ____________________

EMERGENCY INFORMATION

Doctor's Name ______________________________ **Office #** ________________ **Fax #** ____________________

Address ____________________ **City/State** ____________________ **ZIP** __________

Emergency Contact Person #1______________________________ ____

Emergency Contact Person #2 ____

Relationship to Applicant ______________________________

Primary Diagnosis ______________________________

Services Requested	☐ Personal Assistance ☐ Weekend Retreat ☐ Summer Camp ☐ ECF ☐ ED Care ☐ Jobs ☐ Advocacy
Referral Source:	

The above information has been answered to the best of my knowledge. I hereby give The Arc of the Mid-South permission to discuss with professional persons mentioned in this application any relevant information and to secure from those individuals and/or agencies any further relevant information.

Signature of Parent/Guardian	Date

Revised 8-23-2017

The Arc Mid-South
Liability Release

I, the undersigned (parent or guardian), do hereby give my permission for ____

to be a client of The Arc Mid-South for respite care, weekend retreats, camp, and other special services.

In recognition of services rendered and benefits conferred by The Arc Mid-South, the undersigned hereby releases and forever discharges the officers, directors, agents, or employees of The Arc Mid-South and its providers from any claim for damage or suit by reason of injury, illness, or damage to person or property during the course of The Arc Mid-South services, including transportation to or from any location while in the care of a provider or employee.

If this client should require any minor medical or surgical treatment and/or medication during their services with The Arc Mid-South, I authorize such physician or medical staff as The Arc Mid-South may appoint or designate to carry out the necessary treatment or take the client to the emergency room of the nearest hospital. I further authorize the hospital and its medical staff to provide treatment deemed necessary by them for the well being of the client. I further authorize the provider of the weekend retreat supervisor to give the client medication in its specific dosage and at indicated time(s) written by me. I release The Arc Mid-South and the provider or supervisor from liability on account or injury of damage as related above. If hospitalization or treatment of a more serious nature is required, I will be contacted for permission. I understand that I, as parent/guardian, am financially responsible for such medical costs incurred and that The Arc Mid-South is released from any liability in connection with said expenses.

I hereby irrevocably grant The Arc Mid-South permission to use the client's photograph or likeness in agency brochures and for related media use in furthering the objective of the organization. I hereby release them from any and all claims regarding their usage.

I, the undersigned, am a parent or guardian of the above specified client. I have fully read and understand the provisions of the above releases. I hereby agree that said client and I will be bound thereby and I shall defend The Arc Mid-South and hold The Arc Mid-South harmless from any disaffirmation thereof by said clients.

____

Signature   Date

AUTHORIZATION TO RELEASE INFORMATION

Pursuant to federal guidelines concerning my right to confidentially, I,

____ | ______________

(Service Recipient or Conservator Name) (Service Recipient Social Security Number)

authorize **The Arc Mid-South** to release to, or obtain information from:

____

(Medical Facility Name and Address)

the following specific information: (check all that apply)

- o Medical History and Physical (Including but not limited to Neurology, Vision, OBGYN, Hearing, Cholesterol, Blood work, Dental, TD Screen)
- o Medical Progress Notes
- o Laboratory/X-Ray Reports
- o ISP (Individual Support Plan)
- o Discharge Summary
- o Social History
- o Psychological/Psychiatric Evaluation
- o Immunization Records
- o Therapy Information including PT, SLP, OT, BA, RD
- o Name and/or Picture
- o Incident Management
- o IEP (Individual Education Plan)
- o Medication Management
- O Other___________________

For the purpose of:

- o Developing a diagnosis, treatment and habilitation plan for me
- o Coordinating medical, psychological and social habilitation processes for my care
- o Public relations articles pertaining to facility activities I have participated in
- o Coordinating personal assistance/community based day/transportation services
- o Training for individuals who provide care for me
- O Other____

Form in which information will be released:

- o Document
- o Disc or DVD
- o Picture
- o Verbal Communication
- o Other

I understand my right to revoke authorization at any time in writing by submitting this to the Family Support Services Department. Applicable exception to this right under the Privacy Rule is discharge of services by Family Support Services Department. I also understand that any release which has been made prior to my revocation shall not constitute a breach of my right to confidentiality. This consent to release information shall expire one year from the date of the signature below. At that time, no expressed revocation shall be needed to terminate my consent. I understand all information interchanged by the above stated parties will be considered confidential and will be made available only to authorized parties.

______________________________________ ______________________

Service Recipient/Conservator Date

______________________________________ ______________________

Agency Representative Date

State of Tennessee
Department of Disability and Aging

DISCRIMINATION IS PROHIBITED

TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 REQUIRES THAT FEDERALLY ASSISTED PROGRAMS BE FREE OF DISCRIMINATION. THE TENNESSEE DEPARTMENT OF DISABILITY AND AGING ALSO REQUIRES THAT ITS ACTIVITIES BE CONDUCTED WITHOUT REGARD TO RACE, COLOR, OR NATIONAL ORIGIN.

Prohibited Practices Include:

- Denying any individual any services, opportunity, or other benefit for which he or she is otherwise qualified;
- Providing any individual with any service or other benefit, which is different or is provided in a different manner from that which is provided to others under the program;
- Subjecting any individual to segregated or separate treatment in any manner related to his or her receipt of service;
- Restricting any individual in any way in the enjoyment of services; facilities; or any other advantage, privilege, or benefit provided to others under the program;
- Adopting methods of administration that would limit participation by any group of persons supported or subject them to discrimination;
- Addressing an individual in a manner that denotes inferiority because of race, color, or national origin;
- Subjecting any individual to incidents of racial or ethnic harassment, the creation of a hostile racial or ethnic environment, and a disproportionate burden of environmental health risks on minority communities.

Should you feel you have been discriminated against, please contact the local Title VI coordinator.

Name: Ruth Kirby Title: Business Manager
Address: 3485 Poplar Ave, Suite 210
Phone Number: 901/327-2473 Fax: 901/327-1197

- **Any individual may file a Title VI complaint with the below listed entities. It is preferable that complaints be registered at the local level first.**

DEPARTMENT OF DISABILITY AND AGING
Title VI Compliance Director
Vickey Coleman, Ph.D.
Citizens Plaza
400 Deaderick Street
NASHVILLE, TN 37243

OR

U.S. DEPARTMENT OF JUSTICE
COORDINATION & REVIEW SECTION - NYA
CIVIL RIGHTS DIVISION
950 PENNSYLVANIA AVENUE, N.W.
WASHINGTON, D.C. 20530
(888) 848-5306 (toll free voice and TDD)

______________________ Person Supported ______ Date ______________ Service Provider ______________________ Agency Representative ______ Date

______________________ Legal Representative ______ Date

0940-5-06 Client Rights in All Facilities

(1) The following rights must be afforded to all clients by all licensees and are not subject to modification.

(a) Clients have the right to be fully informed before or upon admission about their rights and responsibilities and about any limitations on these rights imposed by the facility. The facility must ensure that the client is given oral and/or written rights information that includes the following:

1. A statement of the specific rights guaranteed the client by these rules and applicable to state law.
2. A description of the facility's grievance procedure.
3. A listing of all available services
4. A copy of all general facility rules

Clients must be present when the information is presented in a manner that promotes understanding, and they must be given the opportunity to ask questions. If a client who is unable to understand this information at the time of admission later becomes able to do so, the information must be presented to him/her at that time. If a client is likely to continue indefinitely to be unable to understand this information, the facility must promptly attempt to provide the information to a parent, guardian or other appropriate person or agency responsible for protecting the client's rights.

(b) Clients have the right to voice grievances to facility staff, licensees and outside representatives of their choice with freedom from restraint, interference, coercion, discrimination or reprisal.

(c) Clients have the right to be treated with consideration, respect and full recognition of their dignity and individuality.

(d) Clients have the right to be protected by licensee from neglect; physical, verbal and emotional abuse (including corporal punishment), and all forms of exploitation.

(e) Clients have the right to be assisted by the facility in the exercise of their civil rights.

(f) Clients have the right to be free of any requirement by the facility that they perform services that usually are performed by facility staff.

(g) If residential services are provided, clients must be allowed to send personal mail unopened and to receive mail and packages that might be opened in the presence of staff when there is reason to believe that the contents thereof might harm the client or others.

<u>ADDENDUM: The Arc Mid-South Grievance Procedure for Clients</u>

Clients may contact the director of Family Support Services with any grievance concerning a provider or retreat/camp staff member and/or the services provided. If clients do not receive a satisfactory response within a month of the initial complaint, the client may contact the executive director. If the grievance concerns the FSS director, clients may report their grievance directly to the executive director. If they do not receive a satisfactory response within a month and/or matters are not resolved to the client's satisfaction, they may request in writing further review of the matter with the Personnel Committee chairperson. If the chairperson thinks the situation warrants further review, he/she will ask the president for assistance.

I, the parent/guardian/client, have read the above client rights and grievance procedure for The Arc Mid-South. I understand the content and agree to abide by the policies and procedure set forth in this document.

Signature____ Date ___________________________

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Memo

To: Service Recipients/Consumers/Caregiver/Guardian/Conservator

From: Family Support Services

CC: Karen McQueen, Program Manager

Re: Demographic

Enclosed are forms to be filled out by all families and/or service recipients presently receiving services or who have received services from Family Support Services Department/ The Arc Mid-South in the past year. These forms will be mailed twice a year if you are new to the program or haven't completed this survey previously and once a year if you have already completed a survey in the past. This information is reported to funding sources to be processed. The enclosed forms will provide a means for Family Support Services to compare the progress/regression of those receiving services. If you have any further questions or comments please contact Brandi Sharp at (901) 507-8583. Your cooperation in returning these forms to The Arc Mid-South in a timely manner is greatly appreciated.

Client ID = First two letters of last name and last 4 digits of social security number

Date of Enrollment = First day of services from Family Support Services/The Arc Mid-South

Enhancing the Lives of Adults with Disabilities and Seniors
Client Form

Today's Date: _____/_____/_____
Month Day Year

Who is completing this form?
☐ Agency staff ☐ Client ☐ Caregiver

Agency Name: The Arc Mid-South___________

Program Name: Date of Enrollment: _____/_____/_____
Month Day Year

Client ID (First 2 letters of last name and last 4 digits of social security number): ____________________

Zip Code: _______________

1. Client is: ☐ Male ☐ Female ☐ Transgendered **2. Client's birth date Age:**________________ _____/_____/_____ Month Day Year	**3. Race/ethnicity:** ☐ African American/Black ☐ Native American ☐ Asian/Pacific Islander (Specify: ___________) ☐ Latino/Hispanic (Specify: ________________) ☐ White ☐ Something else (Specify: ________________)
4. With whom does client live? ☐ Alone ☐ With spouse/partner ☐ With other relative(s) ☐ With non-relative(s)	**5. Where does client live?** ☐ Single family dwelling (house/apartment) ☐ Independent living facility ☐ Assisted living facility ☐ Nursing home ☐ Group/care home ☐ Transitional housing/shelter ☐ Somewhere else (where? ____________ ________________________________
6. What is the client's current marital status? ☐ Married ☐ Widowed ☐ Divorced ☐ Never married	**7. Highest level of education achieved is:** ☐ Less than high school ☐ High School Diploma/GED/Special Education Certificate ☐ Bachelor's degree ☐ Graduate degree ☐ Other, specify _____________________

8. Does client have any of the following chronic conditions? (check all that apply)

☐ Heart disease
☐ Hypertension
☐ Stroke
☐ Emphysema
☐ Arthritic symptoms
☐ Orthopedic (e.g., limb loss, fracture, etc.)
☐ Asthma
☐ Chronic bronchitis
☐ Any cancer
☐ Diabetes
☐ HIV/AIDS
☐ Other (What?_____________________)

Revised 2011

9. Does client have any of the following disabilities? (check all that apply)

- ☐ Visual
- ☐ Physical
- ☐ Hearing
- ☐ Learning
- ☐ Mental
- ☐ Emotional
- ☐ Speech or language
- ☐ Other (specify:____________________)

10. Is the client unable to perform any of the following physical tasks? (check all that apply)

- ☐ Stoop/kneel
- ☐ Reach over head
- ☐ Write
- ☐ Walk 2-3 blocks
- ☐ Lift 10 pounds

Please answer the following questions.

11. How often do you feel…	Never	Rarely	Sometimes	Very Often	Always
That your relative asks for more help than he/she needs?	☐	☐	☐	☐	☐
You don't have enough time for yourself, because of the time you spend helping your relative?	☐	☐	☐	☐	☐
Stressed between helping your relative and trying to meet other responsibilities for family or work?	☐	☐	☐	☐	☐
That your health has suffered because of your involvement with your relative?	☐	☐	☐	☐	☐
Angry when you are around the person(s) you are helping?	☐	☐	☐	☐	☐
That your social life has suffered because you are taking caring of your relative?	☐	☐	☐	☐	☐
That you don't have enough money to take care of your relative much longer?	☐	☐	☐	☐	☐
That you will be unable to take care of your relative much longer?	☐	☐	☐	☐	☐
That you would like to leave the care of your relative to someone else?	☐	☐	☐	☐	☐
Burdened by taking care of your relative?	☐	☐	☐	☐	☐

12. In the past 3 months, have you seriously discussed/considered alternative housing options that provide a higher level of care for your relative?

- ☐ Yes, *why?*____
- ☐ No

13. To what extent would you say Mid-South Arc's Family Services Program has helped you maintain in-home care for your family member?

- ☐ Not at all
- ☐ A little
- ☐ A moderate amount
- ☐ Very much
- ☐ To a great extent

14. Household Income (Please choose one): ☐ Under $26,800 ☐$26,800-$42,880 ☐Over $42,880

15. Age: (Please choose one)

- ☐ 0-5 Years
- ☐ 6-8 Years
- ☐ 9-12 Years
- ☐ 13-15 Years
- ☐ 16-19 Years
- ☐ 20-29 Years
- ☐ 30-39 Years
- ☐ 40-49 Years
- ☐ 50-59 Years
- ☐ 60-69 Years
- ☐ 70-79 Years
- ☐ 80+ Years