Project HEART

(Health Enrichment And Resource Training)

HEART PACKET

What is Project HEART?

- Project HEART offers FREE education classes for people 16 years and older with a developmental disability living in St. Charles County.
- Must be eligible for case management services by DMH or DDRB
- Classes focus on health related topics such as cooking and nutrition, exercising, relationships and much more.
- We want to know what you've learned in class, so we ask ten easy-to-answer questions before and after class. Assistance is provided, as needed.
- Monthly calendars are developed and distributed two weeks before classes are to be held. Topics, days of the week and times vary each month.
- Calendars are distributed by e-mail or can be found at www.willowsway.org on the Project HEART page. A Participant Handbook and the latest HEARTbeat Newsletter can also be found on the Project HEART webpage. If you do not have access to a computer, please make Project HEART staff aware and we will be sure you get the information you need.

The Project HEART Philosophy

The Project HEART philosophy is that each of us learns best by doing and having fun. Each class is designed for everyone to participate, not just sit and listen. Because of the unique needs of each participant, classroom information and activities change to accommodate learning styles and abilities.

PROJECT HEART Staff

Sherry Jeffries, Coordinator
636.757.0515/sherryj@willowsway.org

HEART PACKET

In order to provide you with the inventive, fun and knowledgeable classes Project HEART offers, we must have important information about your learning needs and interests, releases for participation, permission to share information with our funding source (DDRB), as well as proof of eligibility for services. Please complete the forms provided for you in this packet and return to Project HEART.
The packet contains:

Project HEART Assessment & Consent
DDRB Client Information Release Form
Authorization for Disclosure of Consumer Medical/Health Information

Project HEART

Assessment & Consent

Each participant should complete this assessment and consent, with help if needed, and return to Project HEART. Our goal is to provide education, while developing new and improved skills in the best learning environment for each participant. Thank you. ☺

Participant Name:_____ **Phone Number: _(_____)**_____

Address: _____
Street City State Zip Code

Date of Birth:_____**E-mail Address(es)**_____

Agency &/or School Affiliation:_____ **List any known Allergies:** _____

Emergency Contact: _____
Name Relationship
(____)_____(____)_____(____)_____
Home Phone Work Phone Cell Phone

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1. What is the reading level of the participant?
   - ____reads without assistance
   - ____reads with very little assistance
   - ____reads some sight words well
   - ____reads with much assistance
   - ____does not read most words accurately
   - ____does not read
2. What are the physical abilities and limitations of the participant?
   - ____wheelchair
   - ____walker
   - ____uneven gait
   - ____balance difficulty
   - ____writing difficulty
   - ____no physical limitations
3. Does the participant answer yes/no questions with accuracy?
   - ____most of the time
   - ____some of the time
   - ____occasionally
   - ____rarely
4. What type of support does the participant receive?
   - ____lives on own, case management only
   - ____lives on own, up to 15 support hours a week
   - ____lives with family, case management only
   - ____lives with family, up to 15 support hours a week
   - ____lives with family and attends school only
   - ____lives with support during waking hours only
   - ____lives with support 24 hours a day
   - _____other
5. What does the participant do (school/career) during the day/week?
   - ____attends school
   - ____stays at home
   - ____attends day program
   - ____works at workshop
   - ____works part-time in competitive job
   - ____works full-time in competitive job
   - _____other

Other important information to know:

Please list any additional information below that you feel may be pertinent for the staff at Project HEART to be aware of:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Customer Rights

You have the right…….

- to be treated with dignity and respect.
- to receive good medical treatment from a doctor of your choice.
- to live in a clean, safe place.
- to choose to attend or not to attend religious services and worship in your own way.
- to receive the support you need to help you do your best and meet your goals.
- to choose the goals in your Person Centered Plan.
- to receive an explanation of services provided by *Willows Way*, as well as other agencies.
- to refuse to participate in experimental research.
- to live in an environment that lets you be as independent as possible.
- to refuse medical treatment.
- to receive a well-balanced diet.
- to be protected from bad or unfair treatment.
- to be protected from people who might take advantage of you.
- to make a complaint and have people help you.
- to have your own attorney.
- to contact your guardian, family members, friends, DMH case manager, Human Rights Committee.
- to have information about you kept private.
- to communicate privately by mail, telephone, Internet, or in person.
- to be paid fair wages for work you do.
- to not to work.
- to wear the clothes you want and keep your personal possessions.
- to have friends of your choice.
- to access your medical/mental health records and ask questions.
- to be free from chemical or physical restraint, seclusion, or isolation.
- to have your money spent only for you.
- to keep and spend your money and manage your own finances.
- to receive the services that best meet your needs and help you to do things on your own to the best of your ability.
- to participate in or refuse services.
- to try new things.
- to be informed of your rights and responsibilities and any rules you must follow.
- to vote. (if you do not have a full guardian)
- to have intimate relationships with persons of your choosing.
- to pursue a driver's license (if you do not have a full guardian)
- to have a guardian to help you make decisions, if needed.
- to choose what agency provides your services.
- to receive services no matter what your race, color, sex, age, religion, national origin or disability.

Customer Responsibilities

You have the responsibility……

- to treat others with respect and dignity.
- to be honest with your doctor/psychiatrist/therapist, listen to his/her suggestions, and follow them in order to get better.
- to ask questions about your treatment, services, or medications.
- to keep your home clean and safe.
- to ask for help when you need it.
- to ask for services when you need them.
- to ask staff to help you practice your religion/spirituality.
- to work toward your plan goals to the best of your ability and change them as necessary.
- to work cooperatively with staff.
- not to yell and cuss at others, call them names or threaten them.
- to be informed before you sign permission for anything.
- to obey the law.
- to see that your activities do not hurt someone else or yourself.
- to let someone know where you are so others know you are safe.
- to keep yourself healthy by eating nutritious foods and following your diet, if needed.
- to tell someone you trust if you are being hurt or mistreated, or if you see someone else being hurt or mistreated.
- to tell the truth about situations where you believe your rights have been violated.
- to respect the privacy of others.
- to get permission from the owner before using/taking something that does not belong to you.
- to pay your bills and to live within your financial means.
- to wear appropriate clothing for the setting.
- to keep your possessions clean and neat, to replace as needed, and to discard as necessary.
- to be courteous to your guests.
- to tell your staff any medical/mental health information needed to support you.
- to spend your money wisely, budgeting for necessities before spending on desires.
- to apply what you have learned in order to live independently.
- to help plan for your future by attending your Person Centered Planning meeting and expressing your dreams/goals/needs.
- to carefully consider the possible good and bad consequences of a decision before making it.
- to consider how your decision will affect other people.
- not to violate someone's rights.
- to educate yourself on the issues and candidates before casting your vote.
- to communicate your preferences and opinions.
- to drive safely and maintain car insurance.
- to advocate for yourself and your rights.
- to fulfill your responsibilities.

☐ I/We understand that Project HEART (Health Enrichment And Resource Training) activities and classes are to provide participants with information and skills to have a healthy life. I/We understand the risks involved in participation in the classes including those that are exercise and cooking related.

☐ I/We give permission for any known personal health information to be given should the participant need to be treated for illness or injury.

☐ I also grant Project HEART the right to photograph and/or videotape me while participating in the Project HEART activity and understand, should Project HEART wish to use my name, face, likeness, voice, and appearance for exhibitions, advertising, and promotional materials, I will be contacted to obtain my permission.

I/We HAVE READ THIS CAREFULLY AND KNOW IT CONTAINS A RELEASE effective for one year from the date of my/our signature(s).

Name of Participant (print): _____ Signature:_____Date: _____

Name of Guardian (print):_____ Signature:_____Date: _____

Guardian Address:_____

DDRB
Client Information Release Form

The Developmental Disabilities Resource Board of St. Charles County (DDRB) is a Senate Bill 40 Board that enables St. Charles County voters to tax themselves to pay for services for people with certain disabilities. The DDRB provides funding for the programs and services you receive from Willows Way.

The DDRB periodically reviews individual files/records to assure compliance with agency outcomes, eligibility and quality assurance. This is notice to you that as a funding entity the DDRB will have access to your information on file with Willows Way for the purpose of planning and review.

The information reviewed/obtained by the DDRB may be released to a professional consultant contracted by the DDRB for the purpose of general data collection to identify trends in the service delivery. Personal identifiable data will not be released to any other party. The DDRB maintains its client information in accordance with the Health Insurance Portability and Accountability Act (HIPAA). The DDRB does not sell or share its customer information with other entities except as noted above.

By signing this document, you give permission for Willows Way to share information with the DDRB to help with better continuity of the supports you receive.

I agree to Willows Way sharing information regarding my records with the Developmental Disabilities Resource Board of St. Charles County. I understand that refusal to sign this document will forfeit my ability to receive funds from DDRB.

This release is valid for one year from date of signature.

_____ _____
Printed Name of Service Recipient Date

_____
Street Address City State Zip Code

_____ _____
Signature of Service Recipient Date

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Agency Representative Date

Authorization for Disclosure of Consumer Medical/Health Information

I, _____ authorize and request
(Name of Consumer, Parent, Guardian/Legal Representative)

[X] Department of Mental Health [ ] Department of Social Services [ ] Department of Health and Senior Services
[X] Department of Elementary and Secondary Ed [ ] Other _____

to **disclose/release** the below specified information of (name) _____
(date of birth): _____ (social security number) _____
who received services from _____ To _____
(Date) (Date)
to:
[ ] Department of Mental Health [ ] Department of Social Services [ ] Department of Health and Senior Services
[ ] Department of Elementary and Secondary Ed [X] Other Willows Way, Project HEART
(Name of indicated Facility, Agency, Mental Health Center, Person)

800 Friedens Road
(Address)

St. Charles, MO 63303
(City, State, Zip)

The Purpose of this Disclosure is:
[ ] Aftercare [ ] Placement [ ] Transfer/Treatment [ ] Treatment Planning [ ] Assessment [ ] Consumer Request
[ ] Conditional/Unconditional Release Hearing [X] Eligibility Determination [ ] Continuity of Services/Care
[X] To share information with above agencies to obtain services consistent with DDRB of St. Charles County, MO
Name of program
[ ] Other specify _____

The Specific Information to be Disclosed is:
[ ] Discharge Summary [ ] Treatment Plan and/or Reviews [ ] Medical/Psychiatric Assessment(s)
[ ] Progress Notes [ ] Social Service Assessment
[ ] For MR-DD, testing: psychometric, neurological, IQ results, or other developmental test results
[ ] Educational Testing, IEP, transcript, grading reports
[X] Other DMH Consumer Diagnosis Form

1. **READ CAREFULLY:** I understand that my medical/health information records are confidential. I understand that by signing this authorization, I am allowing the release of my medical/health information. The protected health information (PHI) in my medical record includes mental/behavioral health information. In addition, it may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), other communicable diseases, and/or alcohol/drug abuse.
2. Alcohol and drug abuse information records are specifically protected by federal regulations (42 CFR 2) and by signing this authorization without restrictions I am allowing the release of any alcohol and/or drug information records (if any) to the agency or person specified above. Please sign if you are authorizing the release of alcohol and drug abuse information:

_____

3. This authorization includes both information presently compiled and information to be compiled during the course of treatment at the above-named facility during the specified time frame.

4. This authorization becomes effective on _____ This authorization automatically expires on the following date, event or special condition _____

5. If I fail to specify an expiration date, this authorization will expire in one year.

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so **in writing** and present my written revocation to the health information management department (medical records) or client information center at this facility. I further understand that actions already taken based on this authorization, prior to revocation, will **not** be affected.

7. I understand that I have the right to receive a copy of this authorization. **A photographic copy of this authorization is as valid as the original.**

8. I understand that authorizing the disclosure of this medical/health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may request to inspect or request a copy of information to be used or disclosed, as provided in 45 CFR Section 164.524. I understand that any disclosure of information carries with the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my medical/health information, I can contact the health information management director (medical records director) or client information center, or designee, or the Privacy Officer for this covered entity.

9. **THE FOLLOWING STATEMENT APPLIES TO ANY ALCOHOL AND/OR DRUG ABUSE TREATMENT INFORMATION RECORDS THAT WE DISCLOSE:** Prohibition on Redisclosure: This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR Part 2) prohibit you from making further disclosure of it without the specific written authorization of the person to whom it pertains, or as otherwise specified by such regulations. A general authorization for disclosure of medical or other information is NOT sufficient for this purpose.

Signature of Consumer:		**Date:**	
Signature of Witness:		**Date:**	
Signature of Parent/ Legal Guardian/Representative:		**Date:**	

(Please include a Description of Authority to Act on Consumer's Behalf):

NOTICE OF REVOCATION

I, _____ (Consumer) hereby revoke my authorization of this disclosure of information to the agency/person listed above. This revocation effectively makes null and void any permission for disclosure of information expressly given by the above authorization. I understand that any actions based on this authorization, prior to revocation, will not be affected.

Signature of Consumer:		**Date:**	
Signature of Witness:		**Date:**	
Signature of Parent/ Legal Guardian/Representative:		**Date:**	

If you choose to revoke your authorization, please provide a copy of the completed revocation to the Health Information Management Director (Medical Records Director), or the Client Information Center, or to the Privacy Officer of this facility.

Willows Way, Inc,
800 Friedens Rd., Suite 100, St. Charles, MO 63303 636-947-6591 FAX 636-947-7385

Media Release

I authorize Willows Way, Inc. to use the following information about me (initial those you approve):

_____ name _____ quote

_____ picture _____ comments _____ personal information

for the following purpose(s) (initial those you approve):

_____ newsletter _____ video _____ training

_____ brochures _____website _____external publications

_____ event: _____

_____ presentation: _____

I release Willows Way, Inc. from any liability from using or disclosing my permitted information. I understand that the information used or disclosed may be subject to re-disclosure by the person(s) or class of person(s) receiving it and no longer protected by the federal privacy regulations.

I understand that I may revoke this authorization by notifying the Willows Way Inc. HIPAA Privacy Officer, **Tom Bay** at the address above in writing of my desire to revoke it. However, I understand that if I revoke this authorization, it will not have any effect on actions already taken by Willows Way, Inc. before revocation of this release. I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.

I understand this authorization will expire on (check and complete one):

□ _____, 2_____ or □ on the happening of the following that relates to me or the purpose of the use or disclosure:

_____

_____

This form must be fully completed before signing.

Customer Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Co-Guardian Signature: _____ Date: _____

Agency Representative: _____ Date: _____

Comments:_____

_____

This form is to be reviewed at least annually if the media continues to be used. Please date and initial at each review.

_____ _____ _____ _____

*A photographic or carbon copy of this release is as valid as the original. *

Distribution: *(Initials of staff distributing required on original)*
____ Copy given to customer/guardian ____ Copy(s) placed in customer book(s)

____ Original to HIPAA Privacy Officer ____ Copy to person requesting the media release

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