Upper Valley Options, Inc.
1120 Stocks Ave
Rexburg, ID 83440
208-359-3133

Developmental Disabilities Agency

We appreciate your interest in Upper Valley Options. Enclosed is an intake application for the Adult Services.

Please fill it out completely and return it as soon as possible.

When we receive applications, we will send out the releases in order to gather the needed information to determine eligibility.

- Documentation of developmental disability from physician
- A copy of the participant's most current physical completed within the last year. If the participant has not been seen by their physician, please schedule a physical as soon as possible. Many physicians will not provide a referral without a current physical.
- If the participant has a dual diagnosis or takes mood altering medications, a current Psychological Evaluation is needed.
- Service Coordinator Plan (If applicable)
- Speech Therapy, Occupational Therapy, Physical Therapy Evaluations (If applicable)

If you have any of these documents, please submit them with the application. This will expedite the process.

Once the needed information is received the Department Specialist from Upper Valley Options will contact you to review the participant's needs and services that he/she is eligible for and schedule a meeting to identify how we can address those needs. This may take up to 2 weeks depending on the information received.

Thank you again for choosing Upper Valley Options as your Developmental Disability Agency. We look forward to working with you. If we can be of any further assistance, please contact us at 208-359-3133

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Developmental Disabilities Agency

This information is kept with the participants daily record so that it can be referenced by all workers

Participant Name:_____ Date:_____

LIKE

_____
_____

DISLIKE

_____
_____

MEANS OF COMMUNICATION/GESTURES

_____
_____

DIETARY NEEDS OR DIETARY RESTRICTIONS

_____
_____

ALLERGIES/PHYSICAL LIMITATIONS

_____
_____

SPECIAL INSTRUCTIONS FOR STAFF WORKING WITH PARTICIPANT

_____
_____

Upper Valley Options, Inc.
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208-359-3133

Developmental Disabilities Agency

EMERGENCY MEDICAL CARE RELEASE

I give permission for Upper Valley Options Inc. to take _____to a medial emergency room or hospital in the event of a minor medical emergency and participant/guardian/care provider is not available to provide assistance or transportation. In the event of a serious medical emergency, 911 will be called.

Pertinent medial information, such as medications, seizures, allergies, etc. will be provided, if required to the medical facility providing emergency care.

It is understood that Upper Valley Options Inc. is not responsible for the cost or quality of emergency care provided. Upper Valley Options Inc. is only acting as a good Samaritan and has no other responsibilities implied or assumed.

Participants Full Name: _____
Medicaid Number_____
Insurance Name & Policy_____

Participant's Signature_____ Date_____
Guardian's Signature_____ Date_____
Representative of Upper Valley Options_____ Date_____

EMERGENCY CONTACT

Primary Contact:
Name: _____ Relationship: _____
Home/Cell Phone: _____ Work Phone: _____
Address: _____
Email: _____

Secondary Contact:
Name_____ Relationship: _____
Home/Cell phone: _____ Work Phone: _____
Address: _____
Email: _____

Upper Valley Options, Inc.
1120 Stocks Ave
Rexburg, ID 83440
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Developmental Disabilities Agency

Participant Rights

Verification of Receipt of Participant's Rights (16.03.21.505.02)

Provided Under Idaho Code. Section 66-412, 66-413 Idaho Code, as well as additional rights listed in 16.03.21.505.01 provide the following rights for participants:

- Humane care and treatment.
- Not be put in isolation.
- Be free of restraints, unless necessary for the safety of that person or for the safety of others.
- Be free of mental and physical abuse.
- Voice grievances and recommend changes in policies or services being offered.
- Practice their own religion.
- Wear their own clothing and retain and use personal possessions.
- Be informed of their medical and habilitative condition, of services available at the agency, and the charges for the services.
- Reasonable access to all records concerning themselves.
- Refuse services; and
- Exercise all civil rights established by law, unless limited by prior court order.
- Privacy and confidentiality.
- Receive a response from the agency to any request made within (14) fourteen business days.
- Receive services that enhance the participant's social image and personal competencies and, whenever possible, promote inclusion in the community.
- Refuse to perform services for the agency. If the participant is hired to perform services for the agency the wage paid must be consistent with state and federal law.
- Review the results of the most recent survey conducted by the Department and the accompanying plan of correction.

Participant's Name: Parent/Guardian Date

Upper Valley Representative Signature Date

Upper Valley Options, Inc.
1120 Stocks Ave
Rexburg, ID 83440
208-359-3133

Developmental Disabilities Agency

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- Be free of mental and physical abuse.
- Voice grievances and recommend changes in policies or services being offered.
- Practice their own religion.
- Wear their own clothing and retain and use personal possessions.
- Be informed of their medical and habilitative condition, of services available at the agency, and the charges for the services.
- Reasonable access to all records concerning themselves.
- Refuse services; and
- Exercise all civil rights established by law, unless limited by prior court order.
- Privacy and confidentiality.
- Receive a response from the agency to any request made within (14) fourteen business days.
- Receive services that enhance the participant's social image and personal competencies and, whenever possible, promote inclusion in the community.
- Refuse to perform services for the agency. If the participant is hired to perform services for the agency the wage paid must be consistent with state and federal law.
- Review the results of the most recent survey conducted by the Department and the accompanying plan of correction.

Participants Copy

Upper Valley Options, Inc.
1120 Stocks Ave
Rexburg, ID 83440
208-359-3133

Developmental Disabilities Agency

Transportation Release

Participant Name:_____ Date_____

I give my permission or the above-named client to be transported by Upper Valley Options, Inc. its employees and/or a commercial carrier to and from community activities.

Signature: _____ Date:_____

Upper Valley Options, Inc.
1120 Stocks Ave
Rexburg, ID 83440
208-359-3133

Developmental Disabilities Agency

Participant Grievance Procedure

16.03.21.406

This document is to ensure that participant and guardian are aware of the process to place a grievance. The participant or guardian have the right to disagree with the decision of the multidisciplinary treatment team when their decision concerns you. If you disagree, you can ask that the decision be reviewed. To do this, follow these suggested steps.

Administrative Review of Appeal/Grievance

All complaints shall be filed in written form and given to the agency administrator or supervisor. if administrator and supervisor are the same person, complaint may be turned in to the human resource staff. If the complainant cannot or is not able to write, Upper Valley Options, Inc. will, on an individual basis, accommodate the complainant in expressing her/his complaint in written form.

The appeal/grievance shall be addressed to the appropriate supervisor. If the supervisor is the target of the grievance, it shall be addressed to the Administrator, in which case it shall be deemed an Executive Review, pursuant to the following section. The initial appeal/grievance will result in an Administrative Review by the supervisor (except as noted above). If administrator is the same person as the supervisor, the complaint will then be reviewed by the human resource staff.

The Administrative Review shall be completed within (14) days or less of receipt of the request. The findings of the Review shall be written unless the complainant does not read. In such case, the Review shall be communicated in the complainant's alternate communication format.

A report of the findings of the review by the supervisor shall be sent to the complainant within (14) days or less of the date filed.

Executive Review of Appeal/Grievance

Should the complainant be dissatisfied with any determination made within an Administrative Review, the complainant may request an Executive Review by the Administrator. This appeal/grievance shall be in written form unless the complainant cannot or is not able to write.

The Executive Review shall be held within thirty (30) days after the receipt of the initial request for the review. The decision of the Executive Review shall set forth the issues, relevant facts, pertinent provisions on which the decision is based, and reasoning that led to the decision. The complainant shall be sent the decision within ten (10) days from the completion of the Review. Reasonable time extensions may be made for good cause shown by either party or at the request of either party with the approval of both parties

Actions which the supervisor or Administrator may take include, but are not limited to

1. determining that the complaint is invalid;
2. meeting informally with the advocate to correct substantiated allegations;
3. reassigning the case to another advocate;
4. reflecting the substantiated grievance on personnel evaluations;
5. changing Upper Valley Options, Inc. policy; and/or
6. incorporating substantiated allegations into appropriate proceedings for termination of employment.

The Executive Review is the final determination of the agency; however, utilization of the appeal/grievance procedure does not preclude initiation of other grievance procedures that may be authorized by state or federal laws.

Additional resources are also available to you:

_____

Participant Name(Print) Parent/Guardian Date

_____

Upper Valley Options Representative Date

Community Advocacy Resources

CO_AD	Department of Health and Welfare Reg. 7	Adult Protection	Adult/Children Dev. Center
845 W Center Suite C 107	24775 Leslie Avenue	357 Constitution Way	2475 Leslie Ave,
Pocatello, ID 83404	Idaho Falls, ID 83402	Idaho Falls, ID 83401	Idaho Falls, ID 83402
208-232.0922	208-525.7223	208-522.5391	208-525-7223

Upper Valley Options, Inc.
1120 Stocks Ave
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Developmental Disabilities Agency

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The Administrative Review shall be completed within thirty (30) working days of receipt of the request. The findings of the Review shall be written unless the complainant does not read. In such case, the Review shall be communicated in the complainant's alternate communication format.
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COMMUNITY ADVOCACY RESOURCES

CO_AD 845 W Center Suite C 107 Pocatello, ID 83404 208-232.0922	Department of Health and Welfare Reg. 7 24775 Leslie Avenue Idaho Falls, ID 83402 208-525.7223	Adult Protection 357 Constitution Way Idaho Falls, ID 83401 208-522.5391	Adult/Children Dev. Center 2475 Leslie Ave, Idaho Falls, ID 83402 208-525-7223

Client Copy

Upper Valley Options, Inc.
1120 Stocks Ave
Rexburg, ID 83440
208-359-3133

Developmental Disabilities Agency

NOTICE OF PRIVACY PRACTICES- PROTECTED HEALTH INFORMATION

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

The health Insurance Portability and Accountability Act of 1996 (HIPPA) established requirements for health care providers that govern the use and disclosure of individual health information. This information, known as protected health information (PHI) includes virtually all individually identifiable health information held by Upper Valley Options Inc. Protected health information may include your name, address, phone number, birth date, social security number, employment information, and health claim information as well as other data. This Notice describes the privacy practices of Upper Valley Options, Inc. used in the treatment, payment, or health care operations.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Upper Valley Options Inc. is required by law to maintain the privacy of your protected health information (PHI) and to provide you with this Notice of Upper Valley Options Inc. legal duties and privacy practices with respect to your PHI.

Upper Valley Options Inc. uses PHI to determine your eligibility for benefits, to process your benefits claims, and to administer its operations. In some cases, your PHI may only be disclosed with your written authorization, while in other instances, your authorization is not required. For example, Upper Valley Options, Inc. may enclose your PHI, without your authorization, to insurer, third party administrators, and health care providers for treatment, payment, and health care operations purposes. Upper Valley Options, Inc. may also disclose your PHI, without your authorization to third parties that assist Upper Valley Options, Inc. in its operations, to government and law enforcements agencies, to your family members in limited instances, and to certain other persons. Except as outlined below, we will not use or disclose your PHI unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing except to the extent that we have acted in reliance upon the authorization.

For Treatment: Treatment includes providing, coordinating, or managing health care by one or more health care provider. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referral between providers.

For Payment: We may make request, uses, and disclosures of your PHI as necessary for payment purposes. This can include eligibility determinations, utilization management activities, claims management and billing. For example, Upper Valley Options, Inc. may share information about you to coordinate payment of benefits.

For Health Care Operations: We may use and disclose your PHI as necessary for our health care operations. Example of health care operations include creation, renewal or replacement of client program, compliance auditing, business management, quality improvement and assurance, and other functions related to your care at Upper Valley Options, Inc.

Business Associate: Upper Valley Options, Inc. discloses your PHI, without authorization, to its business associates, which are third parties that assist Upper Valley Options, Inc. in its operations, for treatment, payment, and health care operations. For example, Upper Valley Options, Inc may share your health information with a business associate for the purpose of handling enrollment and disenrollment. Upper Valley Options, Inc. enters into agreement with its business associates to ensure that the privacy of your health information is protected from unauthorized disclosures.

Upper Valley Options, Inc.
1120 Stocks Ave
Rexburg, ID 83440
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Developmental Disabilities Agency

Other Products and Services: We may use and disclose your PHI for the purpose of communicating to you about your services that could enhance or substitute for existing services.

Other Uses and Disclosures That May Be Made Without Your Authorization: The federal health privacy laws provides for specific uses or disclosures of your PHI hat Upper Valley Options; Inc. may make without your authorization as described below.

Required by law: Upper Valley Options, Inc. may use and disclose PHI as required by federal, state, or local law. For example, Upper Valley Options, Inc. may disclose your PHI for the following purposes:

- For judicial or administrative proceeding pursuant to court or administrative order, legal process, and authority
- To assist law enforcement officials in their law enforcement duties
- To report information if we suspect abuse, neglect, or domestic violence.

Health and Safety: Your health information may be disclosed to avert a threat to the health or safety of you, any other person, or the public, pursuant to applicable law. Your PHI also may be disclosed for public health activities, such as reporting disease, injury, birth, and death, and for public health investigation, and meeting the reporting and tracking requirements of government agencies.

Government Function: Your PHI may be disclosed to the government for specialized government functions, such as intelligence, national security activities and protection of public officials. Your PHI also may be disclosed to health oversight agencies that monitor the health care system for audits, investigation, licensure, and other oversight activities.

Emergency Situations: Your PHI may be used or disclosed to a family member or others involved in your care in the event of an emergency, or to a disaster relief entity in the event of a disaster.

Others Involved in Your Care: In limited instances, your health information may be used or disclosed to a family member, or others who Upper Valley Options, Inc. has verified are involved in your care or payment for your care.

Personal Representative: Your PHI may be disclosed to people you have authorized to receive such information or people who have the right to act on your behalf.

Treatment and Health Related Benefits Information: Upper Valley Options, Inc. and its business associates may contact you to provide information about treatment alternatives or other health related benefits and services that may interest you, including, for example, alternative treatment, services, or medication.

Research: Under certain circumstances, Upper Valley Options, Inc. may use or disclose your PHI for research purposes, as long as the procedures required by law to protect the privacy of research data are followed.

ANY OTHER USES AND DISCLOSURES REQUIRE YOUR EXPRESS AUTHORIZATION

Uses and disclosures of your PHI other than those described above will be made only with your express written authorization. You may revoke your authorization in writing. If you do so, Upper Valley Options, Inc. will not use or disclose your PHI authorized by the revoked authorization, except to the extent that Upper Valley Options, Inc. has relied on your authorization.

Upper Valley Options, Inc.
1120 Stocks Ave
Rexburg, ID 83440
208-359-3133

Developmental Disabilities Agency

Once your PHI has been disclosed pursuant to your authorization, the federal privacy protections may no longer apply to the disclosed health information, and that information may be re-disclosed by the recipient without your or Upper Valley Options, Inc. knowledge or authorization.

RIGHTS THAT YOU HAVE

Access to your PHI: You have the right to copy and/or inspect certain of your PHI that we maintain. Certain request for access to your PHI must be in writing, must state that you want access to your PHI and must be signed by you or your representative.

Accounting for Disclosures to your PHI: You have the right to request restrictions on certain of our uses and disclosures of your PHI for insurance payment or health care operations, disclosures made to persons involved in your care, and disclosures for disaster relief purposes. For example, you may request that we not disclose your PHI to your spouse. Your request must describe in detail the restriction you are requesting. HIPAA does not require us to agree to your request, but we will accommodate reasonable requests when appropriate. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by use, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed to restriction.

Request for Confidential Communication: You have the right to request that communications regarding your PHI be made by alternative means or at alternative locations. For example, you may request that messages not be left on voice mail or sent to a particular address. We are required to accommodate reasonable requests if you inform us that disclosure of all or part of your information could place you in danger. Requests for confidential communications must be in writing, signed by you or your representative.

Right to a Copy of This Notice: You have the right to a paper copy of this Notice upon request.

Complaints: If you believe your privacy rights have been violated, you can file a complaint with Upper Valley Options, Inc. in writing. You may also file a complaint in writing with the Secretary of U.S. Department of Health and Human Services in Washington, D.C., within 180 days of the violation of your rights. There will be no retaliation for filing a complaint.

In addition to the privacy policy, Upper Valley Options, Inc. also has instituted the following to safeguard your protected health information:

- Angelica Hernandez has been appointed privacy officer
- All faxes containing protected health information will be sent using the confidential fax cover sheet
- All client files must be labeled with a confidential sticker
- A notebook containing personal client information is locked in the reception desk to be used in case of an emergency such as a car accident where emergency contacts, medications, phone numbers would be needed
- All computers containing personal health information are protected by passwords that are changed every 90 days
- Quality Assurance practices contain verification that personal health information is being protected in compliance with HIPAA regulations and Upper Valley Options, Inc. policies and procedures.
- Business associates must sign a confidentiality agreement.

Upper Valley Options, Inc.
1120 Stocks Ave
Rexburg, ID 83440
208-359-3133

Developmental Disabilities Agency

Verification of Receipt of Notice of Privacy Practices

By signing this form, I verify that I have received a copy of Upper Valley Options, Inc. privacy practices.

_____ _____
Participant Name (Print) Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Upper Valley Options, Inc. Representative Date

Upper Valley Options, Inc.
1120 Stocks Ave
Rexburg, ID 83440
208-359-3133

Developmental Disabilities Agency

Adult Day Care

Services:

Services that are included in the Adult Day Program include, but are not limited to, recreational activities, maintenance of self-help skills, assistance with activities of daily living, provisions for trips to social functions (additional transportation fees may need to be collected from individuals), and special dietary support. The specific activities and objectives for each participant are outlined in the Program Implementation Plan.

Expected Benefits and Risks:

This program creates opportunities for participants to engage in social activities in supportive settings that utilize the skills and sensitivity of trained staff. The focus is to offer flexible programming which will give participant's choices on types of activity, enhance their sense of belonging and well-being, provide successful experiences, and emphasize their value as a member of the community. As with any activity, there is a risk of injury to participants. Provider interventions promote participant empowerment and choice, within the programmatic confines of safe and effective services that do not endanger the participant or others in implementation. Participants are recognized as the primary decision-makers in accessing all.

Right to Refuse Service Participants

are recognized as the primary decision-makers in accessing all services unless a court has established an appropriate guardianship. Each participant has the right to refuse service or participate in an activity.

Alternative Forms of Services Available

- Developmental Therapy
- Respite
- Home Health Aide
- Supported Employment
- Nursing
- Transportation

Termination Policy

Discharge from the service will be made when the needs of the participant and/or family situations can no longer be met through adult day care. Notice of termination of services by either party must be given in writing no less than 15 calendar days prior to termination, unless both parties waive the advance notice requirement by a mutual written agreement Services may be terminated on notice shorter than 15 days under emergency or urgent circumstances, such as termination of our license to provide Adult Day Care services, a condition endangering the health, safety, or welfare of the participants, or if the participants presents a danger to self or others

Upper Valley Options, Inc.
1120 Stocks Ave
Rexburg, ID 83440
208-359-3133

Developmental Disabilities Agency

Enrollment Agreement

Personal Information:

Name: _____ Admission Date: _____
Marital Status: _____ Gender: _____
Guardian: _____
Name of Individual who completed enrollment form: _____
Medication: _____
_____
_____
Diet: _____
_____
_____
Allergies: _____
_____
_____
Services and treatment prescribed for the participant: _____
_____
_____
Services that Ault Day Care shall provide including, but not limited to:

- Recreational Activities
- Maintenance of self-help skills
- Assistance with activities of daily living
- Provision for trips to social functions
- Special diets
- Others

Adult Day Health: I have been informed of the service to be received while in Adult Day Health, the expected benefits, and attendant risks of receiving those services, of the rights to refuse services, terminations notice policy and alternative forms of service available.

Date: _____ Signature: _____ Witness: _____

Authorization to Coordinate Services:

Print Name: _____ Date: _____

By signing below, I authorize the staff of Upper Valley Options, Inc to participate in discussion with other individuals and or agencies as determine appropriate and necessary by the Administrator or Developmental Specialist.

This authorization is valid for the duration of the client's attendance at Upper Valley Options, Inc. I understand that I have the right to revoke this consent at any time in writing.

Date: _____ Signature: _____ Witness: _____

Upper Valley Options, Inc.
1120 Stocks Ave
Rexburg, ID 83440
208-359-3133

Developmental Disabilities Agency

Regarding:
IDAPA RULE 16.03.10.704.02 iv

As the Service Coordinator for _____
Attending Upper Valley Options, Inc., I have determined that due to the nature of the disability and/or limited functioning ability, this participant is unable to, or it is too difficult for them to provide a signature on the Adult Day service record.

Targeted Service Coordinator: _____ Date: _____
Targeted Service Coordinator Agency: _____

Upper Valley Options, Inc.
1120 Stocks Ave
Rexburg, ID 83440
208-359-3133

Developmental Disabilities Agency

Release of Records Exchange Form

Participant Name: _____ Date: _____

Information is to be exchanged between:

Upper Valley Options Inc.
1120 Stocks Ave. Suite A
Rexburg, ID 83440
Phone: 208-359-3133
Fax: 208-359-3163

Department of Health and Welfare: _____
Physician: _____
Service Coordinator: _____
Care Provider: _____
Physical Therapy: _____
Occupational Therapy: _____
Speech and Language Pathology: _____
Transportation: _____
Other: _____
Other: _____

The following information is being requested (check all that apply):

_____ Current Physical
_____ Medical
_____ Healthy Connections Referral
_____ Doctor Referral
_____ Medical/Social Evaluation
_____ Developmental Evaluation
_____ Treatment Plan/Individual Program Plan
_____ Program Implementation Plan
_____ Psychological Evaluation
_____ Functional Assessment
_____ SIB-R & Results
_____ School Meeting Notes
_____ Physical Therapy Evaluation
_____ Speech/Communication Evaluation
_____ Occupational Therapy Evaluation
_____ Early Childhood Service Coordinator Plan
_____ Communication
_____ Other _____
_____ Other _____

All information exchanged will maintain confidentiality. This release expires one year from the date signed by the participant or guardian. The participant or guardian has the right to revoke this release at any time in writing, but not retroactive to the release of information made in good faith at the date indicated below or prior to the date consent is revoked.

Participant Signature: _____ Date: _____
Parent/Guardian Signature: _____ Date: _____
Upper Valley Options Representative: _____ Date: _____

Upper Valley Options, Inc.
1120 Stocks Ave
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Developmental Disabilities Agency

Region 7
Developmental Disability Agencies for Adults

I have had the opportunity to meet and interview the available Developmental Disability Agencies (DDAs) who provide services to adults. I understand that I have the right to choose the DDA provider I want to work with my child and that the DDA provider will help me write an Individual Program plan which includes developmental goals to address needs and desires within the DDA guidelines. I understand also that if I do not want a DDA or if I want to change to a different DDA provider that I have the right to change agencies.

Please mark the box next to the agency you choose and sign on the line below

☐ **Access Point Family Services** 2680 Channing Way Idaho Falls, Idaho 83406 Phone: (208)-522-4026 Fax: (208)-522-4138 Contact: Stephanie Galbreaith	☐ **The Adventure Center** 775 Lincoln Dr Idaho Falls, Idaho 83406 Phone: (208)-528-8639 Fax: (208)-528-8648 Contact: Melodie Hansen
☐ **Upper Valley Options Inc.** 1120 Stocks Ave. Suite A Rexburg, ID 83440 Phone: (208) 359-3133 Fax: (208) 359-3162 Contact: Ivette Acevedo & Angelica Hernandez	☐ **Home Link Trust, Inc.** 211 S. Woodruff Av., Suite F Idaho Falls, ID 83401 Phone: (208) 524-6375 Fax: (208) 528-0715 Contact: Edward Asikhia
☐ **Independence, Inc** 1230 N. Skyline Drive Suite A Idaho Falls, Idaho 83401 Phone: (208) 524-0881 Fax: (208) 524-0886 Contact: Diane Moore	☐ **Joshua D. Smith Foundation** 600 Van Dreff Street Salmon, Idaho 83467 Phone: (208) 756-6564 Fax: Same Contact: Amy Berasi
☐ **The Learning Center Innovative Health Care** 1545 S. Boulevard Idaho Falls, Idaho 83404 Phone: (208) 552-1810 Fax: (208) 552-1812 Contact: Lisa Peters-Smith	☐ **Development Workshop, Inc.** 275 Stationary Place Rexburg, ID 83440 Phone: (208) 356-3722 Fax: (208) 356-3773
☐ **Royal Journeys** 111 East Main Rigby, ID 83442 Phone: (208) 745-1334	☐ **Transition Inc.** 530 Lomax St. Idaho falls, ID 83401 Phone: (208) 524-5771

_____
DDA Participant

_____ _____
Parent/ Legal Guardian Date

Upper Valley Options, Inc.
1120 Stocks Ave
Rexburg, ID 83440
208-359-3133

Developmental Disabilities Agency

Statement of Order

This page to be filled out at the intake meeting

Participant Name_____
Staffing Date: _____ Developmental Specialist_____

Requested Services: Please check the following services you are interested in receiving

_____ Individual Developmental Therapy
_____Community _____ Center
_____ Group Developmental Therapy
_____ Community _____ Center
_____ Adult Day
_____ Intensive Behavioral Intervention
_____ Speech Therapy
_____ Occupational Therapy
_____ Physical Therapy

Plan approved to be implemented on _____
Projected Date of Review _____

Please give a short description of the major concerns and or goals that you would like to be addressed through developmental therapy or Intensive Behavioral Intervention:

_____
_____
_____
_____
_____

Care Provider Signature _____
Parent/Guardian Signature _____
Participant Signature _____
Developmental Specialist Signature _____
Res Hab Coordinator Signature _____
Service Coordinator Signature _____
Other: (Please specify) _____

Upper Valley Options, Inc.
1120 Stocks Ave
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208-359-3133

Developmental Disabilities Agency

Profile Sheet

16.03.21.301.05bii

Full Name (as it appears on Medicaid) _____
Street address: _____ City: _____
State: _____ Zip Code: _____ Phone: _____ Alternate # _____
Medicaid # _____ Gender: Male or Female DOB: _____ Age: _____
Current Living Arrangement: (16.03.21.301.05.bi)_____
Legal Status: _____
Special Dietary or Medical Needs: (16.03.21.301.05biv)

_____

_____

_____

Allergies: (16.03.21.301.05biv) _____

_____

(16.03.21.301.05.bii)
Parent/Guardian (Emergency Contact) _____
Street Address: _____ City: _____ State: _____
Zip Code _____ Phone: _____ Alternate: _____ Email: _____
Fax _____

Care Provider (Emergency Contact) _____
Street Address: _____ City: _____ State: _____
Zip Code _____ Phone: _____ Alternate: _____ Email: _____
Fax _____

Targeted Service Coordinator (Emergency Contact) _____
Street Address: _____ City: _____ State: _____
Zip Code _____ Phone: _____ Alternate: _____ Email: _____
Fax _____

Physician (Emergency Contact) _____
Street Address: _____ City: _____ State: _____
Zip Code _____ Phone: _____ Alternate: _____ Email: _____
Fax _____

Additional Emergency Contact _____

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Profile Sheet

List Of Medication
(16.03.21.301.05.biii)

Current Medication:	Dosage:	Current Medication:	Dosage

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Evaluation Of Service

Section A:

1. Participant Name: _____ Date: _____
2. Person Completing this questionnaire for the participant:

____ Self ____ Legal Guardian ____ Adult Relative of Participant
____ Foster Parent ____ Father
____ Mother ____ Other _____

Section B:

Instructions: Using the symbols as shown, circle your level of satisfaction based on your experience with developmental disability (DD) services for each of the following statements.

	Strongly Agree	Agree	Undecided/ Don't Know	Disagree	Strongly Disagree
					
1.	I am treated with courtesy and respect				
2.	My rights have been explained to me in a way that I understand				
3.	The types of services I receive are appropriate for my needs				
4.	I am satisfied with my safety while receiving DD services				
5.	I participate in developing an effective plan				
6.	My opinions and concerns are considered in the planning of my program				

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7. Personnel help me to set goals 
8. Personnel help me to reach my goals 
9. I am satisfied that staff members are knowledgeable about my unique needs 
10. Personnel are responsive to my needs 
11. I am allowed to make my own decisions 
12. I am assisted in considering options and choices 
13. I am satisfied with the amount of information I receive 
14. I would use the services of Upper Valley Options again 
15. I would recommend the services of Upper Valley Options to others 

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SECTION C:

Please rank from 1 to 3 the top three issues of most interest or concern to you

___ Less staff turnover
___ Increased parent involvement in oversight and quality of care
___ Better-trained staff
___ Staff assignment to clients
___ Increased participation in the community
___ Transportation

SECTION D:

Please provide any additional comments, concerns or suggestions about any other issues or areas about our system of care for people with developmental disabilities and their families.

_____
_____
_____
_____
_____

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Medication Release Form

Participant Name: _____

Personnel of Upper Valley Options, Inc. will not administer medication. They will assist the client in taking his/her medication under the following conditions:

1. The medication will be brought to the center by the client in a packaged container, which is appropriately labeled with the name of the medication, dosage, time, and amount to be taken.
2. Only licensed nurses and other legally authorized personnel may give a client medication injection.
3. No medication shall be given except under the written orders of a physician.
4. Medications will not be borrowed between clients
5. If discrepancies occur, the caretaker will be notified. No medication will be given until the discrepancy has been resolved. Upper Valley Options, Inc. staff will not be responsible for medications which do not match what is listed on the containers.

By signing below, I acknowledge having read the above policy as parent/guardian for this individual.

Date: _____ Signature: _____

Please note any changes or discontinued medication:

Date: _____

Medication Change:

_____

_____

Please note any changes or discontinued medication:

Date: _____

Medication Change:

_____

_____

_____