Affinity FAMILY CARE

You're Never Alone With Affinity

Dear Parent or Legal Guardian:

Thank you so much for expressing an interest in joining our "Affinity Family". We are very excited to be working with you and for allowing us to provide what we hope to be an exceptional service to you and your child.

To give you some background: Affinity Family Care, LLC was founded in the fall of 2005. My husband and I are proud parents of a boy, whose name is Cole. He possesses a rare chromosome deletion and is diagnosed with Mental Retardation, ADHD and Autistic characteristics. Over the years we have been his advocates, coordinated his medical care and worked together with his case managers in order to develop and maintain his goals. We now use our experiences to help improve the lives of individuals with disabilities and their families. We are a personalized agency who takes the time to ensure the needs of the individuals, families and providers are being met.

In this packet, there are two documents. Attached to this letter are client orientation forms that must be completed by the parent and/or legal guardian and returned to us within 10 business days. We are enclosing a self-addressed stamped envelope for your convenience in returning these documents. Additionally, there is a Client Handbook which is yours to keep. It addresses the policies that providers must adhere to when working with your child.

Our agency sincerely believes that each and every child has endless potential and our staff will work closely with you to develop, write and implement individualized Habilitation objectives. These goals and objectives are measurable which is required for state documentation requirements to show progress and/or regression. Each goal reflects the criteria of each step the child has to do in order for the goal to be mastered, the suggested teaching strategies per Article 9, and the current assessment. We remain dedicated to helping each child reach their fullest potential both in their homes and community.

As I close, I want you to know that all of us at Affinity Family Care, LLC remain a strong sense of commitment, dedication and loyalty to you. Each day that I wake up, I feel blessed to be able to fulfill my lifetime dream; to run an agency that changes lives. As you journey ahead, all of us here at Affinity Family Care are here to support you every step of the way. Welcome to our "Affinity Family" and always remember "You're Never Alone with Affinity".

Sincerely,

Tracy Stewart
Executive Director

OUR OFFICE LOCATION
1423 South Higley Road Suite #115 Mesa, AZ 85206
Tel. (480) 558-3600 * Fax (480) 558-1806
www.AFFINITYFAMILY.com

PLEASE FILL OUT

THE ATTACHED DOCUMENTS

AND RETURN TO US WITHIN 10 BUSINESS DAYS

(Per State of Arizona and Division of Developmental Disabilities regulations)

For your convenience a self-addressed stamped envelope is enclosed to make it a little easier in returning these forms back to us.

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Telephone: (480) 558-3600 Fax: (480) 558-1806

PRE-SERVICE INFORMATION

Individuals Name:_____DOB_____/_____/_____Age:_____Sex: M / F

Home Address:_____City:_____Zip Code:_____

Parent(s)/Guardian(s) Name:_____

Parent(s)/guardian(s) Address:_____City:_____Zip Code:_____

Home Phone #(_____) _____ Mother/Guardian Cell Phone#(_____)_____

Father/Guardian Cell Phone #(_____) _____ Work #(_____)_____ Who's_____

Work #(_____)_____Who's_____E-mail:_____

Diagnosis:_____

Support Coordinator's Name:_____Phone #(_____)_____

Whom may we thank for referring you to our office?_____

DAY PROGRAM INFORMATION

Name of Day Program (School or Center)_____Phone # (_____)_____

Days and hours of Attendance_____Transportation Method_____

Day Program Address:_____City:_____Zip Code:_____

MEDICAL / MISCELLANEOUS INFORMATION

Is the Individual on any medications at this time? If so, then please list:

_____

_____

Special Medication Instructions:

_____

NOTE: Providers are required to complete a medication log for all prescription medications administered to Affinity Family Care, LLC. Clients. Medication logs are due on the 1st of every month for the previous month and must be signed by the parent or guardian.

Individual Name:_____DOB_____

MEDICAL / MISCELLANEOUS INFORMATION Continue

Is your child on any special diet? **YES / NO** If yes, please clarify:_____

_____

Does individual have any food allergies?_____

Does individual have any known drug / miscellaneous allergies? **YES / NO** If yes, please list:_____
_____

Is individual allergic to Bee Stings? **YES / NO** If yes, please describe medical need:_____
_____

Is individual have other allergies? **YES / NO** If yes, please describe and medical needs:_____
_____

Please give any additional details for recommended response to allergic reactions:_____
_____

Does Individual demonstrate aggressive / dangerous behaviors? **YES / NO** If yes, please explain:_____
_____

Does Individual have seizures? **YES / NO** If yes, please explain (triggers etc):_____
_____
_____Frequency_____Approximate duration_____
Recommended response_____ Other Information:_____

Does Individual use an Assisted Device? Vision_____Hearing_____
Dental Appliances:_____Other_____
Instructions for Use:_____

Does Individual use a Protective Device? **YES / NO** If yes, please explain:_____
Instructions for Use:_____Purpose:_____

Other Individualized Health Care Routines or Concerns not listed above **YES / NO** If yes, please explain:_____
_____
_____

FEEDING

Does individual self-feed? **YES / NO**

Do you have any concerns about your child's diet and/or feedings/meals? Is your child on a special Diet? **YES / NO**
If yes, please explain:_____
_____

Individual Name:_____DOB_____

FEEDING Continued

Circle the appropriate response:

Independent with utensils? **YES / NO** Independent with specific utensils? **YES / NO**

Requires Limited Assistance? **YES / NO** Requires Significant Assistance? **YES / NO**

Does food present a choking hazard? **YES / NO**

Required consistency of Food (circle response): **NORMAL CHOPPED PUREED**

Please explain:_____

Does individual have an eating disorder? **YES / NO** If yes, please explain:_____
_____

Is Individual G-Tube Fed? **YES / NO** If yes, special instructions:_____
_____

_____

Does individual require any special instructions in regards to feeding?_____
_____
_____

BEVERAGES

Is Individual independent with any cup/glass? **YES / NO** Independent with adaptive container? **YES / NO**

Does individual require limited assistance with drinking? **YES / NO**

Does individual require significant assistance with drinking? **YES / NO**

Is individual independent in obtaining / requesting beverages? **YES / NO**

Is adaptive eating / drinking equipment required? **YES / NO** If yes, please describe:_____
_____
_____

If special liquid intake needs, please describe:_____
_____
_____

System for Fluid Intake and/or special instructions in regards to beverages: (If applicable):_____
_____
_____

Individual Name:_____DOB_____

COMMUNICATION SKILLS

Briefly explain individuals current communication skills: ***(Circle all that apply)***

Speaks in complex sentences Speaks in simple sentences Nods yes / no

Gestures Sign Language Picture Exchange Communication (PECS)

Other ***(Briefly explain):***_____
_____
_____

Does individual use Augmentative Communication Devices? **YES / NO** If yes, please explain: _____
_____

Has your child ever lost language or regressed? **YES / NO** At what age did this occur?_____
Briefly explain:_____
_____

At what age did your child accomplish the following:

Babble:_____ Spoke first word:_____ Put several words together:_____

Please explain individuals current social skills: (include 1-1 ratios, small / large groups, people he/she is familiar and unfamiliar with)
_____
_____
_____
_____

MOBILITY

What is individuals current condition in regards to Balance While Standing?: **(Circle all that apply)**

Excellent (Not an issue/concern) Moderate (Stumbles, etc.) Poor (Very unsteady; falls) Non-Ambulatory

At what age did your child accomplish the following independently:

Roll Over_____ Crawling_____ Sit up alone:_____

Kneeling_____ Walking_____ Running_____

Climbing_____ Dressed Self_____

Does individual utilize Adaptive Aids for balance? **YES / NO**

Mobility Balance Aids utilized: **(Circle all that apply)**

N/A Walker Cane Crutches AFO's Leg Braces Wheelchair Arm Braces Stander

Gate Trainer Adapted Stroller Other:_____

Individual Name:_____DOB_____

MOBILITY Continued

Balance Aid Instructions (If applicable, please describe):_____
_____
_____

Positioning Instructions (If applicable, please describe):_____
_____
_____

Lifting/Carrying Instructions (If applicable, please describe):_____
_____
_____

PERSONAL CARE SKILLS

	Dressing	Toileting	Bathing	Dental Care	Menses	Med. Admin	Other_____
Independent							
Requires Prompting/Reminding							
Requires Limited Assistance/Supervision							
Requires Significant Assistance							

If applicable, describe special personal care needs and preferences:_____
_____
_____

BEHAVIORAL CONCERNS

Brief Description	**Approximate Frequency**	**Recommended Intervention**
Agression		
_____	_____	_____
Self-Injurious Behavior		
_____	_____	_____
Property Destruction		
_____	_____	_____
AWOL		
_____	_____	_____
Self Stimulation		
_____	_____	_____

Individual Name:_____DOB_____

BEHAVIORAL CONCERNS Continued

Sexual Acting Out

_____ _____ _____
Other

_____ _____ _____
Other

_____ _____ _____
Other

_____ _____ _____

Under Article 9 guidelines, all employees of Affinity Family Care, LLC are only allowed to limit an individuals' freedom of movement (ie. Restrain) in the event that the individual is engaging in a sudden, intense, or out of control behavior endangering the health or safety of the individual or another person. ***In the event that an employee uses a physical management measure to manage a sudden, intense behavior, the person employing that measure shall contact the Affinity Family Care office within 24 hours to report the Emergency measure. An incident report is required and must be submitted to your support coordinator.***

In the event that an individual engages in intense or uncontrolled behaviors which make them at risk of endangering themselves or others, the Division of Developmental Disabilities may require the individual providers are trained in Client Intervention Training (CIT Training). This must be specifically written in the individuals Individual Support Plan (ISP) and approved by the Division of Developmental Disabilities. Additionally, a Behavior Treatment Plan may be required and written by your support coordinator.

Currently, does the individual have a Behavior Treatment Plan available for additional information? **YES / NO**

What is the reason for the Behavior Treatment Plan? Please describe_____

_____

_____

Are providers working with individual required to have CIT Training? **YES / NO**

Is there any additional information that you would like to provide to Affinity Family Care, LLC that has not been previously discussed in this document? Please explain_____
_____
_____
_____
_____

Individual Name:_____DOB_____

SIGNATURES / PERMISSION

By signing below, I agree that the information provided in the Pre-Service Information Packet is true and accurate to the best of my knowledge. I agree that I am the parent and/or legal guardian of the above referenced client. Additionally, I give express permission to Affinity Family Care, LLC office staff, directors, officers and management to release this document to all provider(s), employees, office staff and management working directly with the individual discussed in this document.

This authorization will be in force until either written notice is given by the Individual, Parent or Legal Guardian or when the Individual is no longer active with Affinity Family Care, LLC.

Signature of person completing this form:_____

Relationship:_____ Date_____

Print Name of Person completing this form:_____

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CLIENT EMERGENCY CONTACT INFORMATION

CLIENT NAME _____ **Date**_____

INSURANCE NAME & ID NUMBER_____

Primary Cary Physician_____**Phone (____)**_____

Allergies_____

Current Medications_____

Other Medical Information (hospital/doctor of choice)_____

_____

Father or Guardian Name _____

Home Phone (____)_____ **Work Phone (____)**_____

Cell Phone (____)_____ **Pager (____)**_____

Address: _____

Mother or Guardian Name_____

Home Phone (____)_____ **Work Phone (____)**_____

Cell Phone (____)_____ **Pager (____)**_____

Address: _____

Alternate Emergency Contact Name _____

Relationship to Client_____

Home Phone (____)_____ **Work Phone (____)**_____

Cell Phone (____)_____ **Pager (____)**_____

Address: _____

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PAYROLL / HOURS BILLED AGREEMENT

Affinity Family Care, LLC has two pay periods per month: Timesheets are due on the 16th of the month by 5:00pm for the days worked from the 1st through the 15th of the month.

Timesheets are due on the 1st of the month by 5:00pm for the days worked from the 16th through the 31st (last day) of the month.

Progress reports for Habilitation and Attendant Care are due on the 1st of the month for the previous month.

Note: Affinity Family Care, LLC writes very measurable goals and objectives for all clients, which gives providers more information on how to work and manage the clients they are working for. It is the provider's responsibility to complete the monthly progress reports, however the parent/guardian must sign approving what is written. It is important that the providers write the areas of deficiency and where the client still struggles to improve their goals, as well as the progress the client has made. We also suggest they write the teaching strategies utilized to help them with this goal.

We close out the previous month on the first of the month and will not allow days to be billed after the first of the month. For example, on May 1st all hours are due for April. Hours are not allowed to be billed for April after May 1st. If your provider misses a time period or chooses to be paid one time per month, it is ok to skip the 16th of the month but ***Everything must be turned in on the 1st of the month.***

Affinity Family Care, LLC has a website www.affinityfamily.com on that website there are calendars and due dates which reflect when everything is due and the specific items that are needed.

We allow providers to fax in their time sheets and progress reports; however we must have the original timesheets and progress reports in our office within 5 business days following the payroll due date. They can be mailed or hand delivered to our office. This is an AHCCCS/Medicaid violation if we do not have them.

Please ensure you are signing all timesheets and progress reports. Do not allow a provider to sign for you as this is an AHCCCS/Medicaid violation and can be punishable by law. Providers can only record hours that are actually worked in 15 minute increments. Any false or incorrect timesheets are an AHCCCS/Medicaid violation and subject to recoupment of funds paid and punishable by law. You agree when signing that they are true and accurate.

Our agency sends out usage reports on a monthly basis for those billing 2 times per month and every other month for those billing 1 time per month. These reports reflect all hours billed, and remaining balances for all services authorized with Affinity Family Care, LLC. ***Please review these reports for billing accuracy. All discrepancies must be reported to Affinity Family Care, LLC within 5 business days if incorrect.***

The usage reports are sent to parent/guardians only. Please share them with your providers as it has valuable information in regards to hours that they can bill and for billing accuracy.

By signing below I am aware and agree to comply with the policies outlined in the Payroll/Hours Billed Agreement implemented and provided by Affinity Family Care, LLC.

CLIENT NAME:_____ Date of Birth_____

_____ _____ _____

Signature **Print Name** **Date**

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RELEASE OF INFORMATION

Client Name:_____ Date of Birth _____

Address_____City_____State_____Zip_____

Parent/Guardian Name_____

Authorization for Disclosure of Information

I agree that the above reflected individual is a client of Affinity Family Care, LLC. To work with the above referenced client, Affinity Family Care, LLC needs to release information about the client's disability(s) and information about how that disability affects the client's ability to complete tasks and activities of daily living. This information is retrieved from the Individual Service Plan (ISP), or the Individual Family Service Plan (IFSP), the Pre-Service materials completed by the parent/guardian, a Person Centered Plan (PCP), Habilitation Objectives, Attendant Care Agreement, Risk Assessment and other necessary documents our office may receive by the parent/guardian, Division of Developmental Disabilities, or the clients medical insurance.

I give my express permission to have these documents and all other necessary information released to all Affinity Family Care, LLC providers, office staff, directors, officers and management who are working directly with the above referenced client, for the sole purpose of providing quality care and for them to have an understanding of the client and the specific disabilities.

Note: Affinity Family Care, LLC has a strict policy regarding confidential records and information for providers and clients. In the event that you require us to release information, progress reports and/or records to anyone other than Affinity Family Care, LLC providers, office staff, directors, officers and management working directly with the client and/or representatives from the Division of Developmental Disabilities, and the State of Arizona I understand and agree to complete a "Release to Share Confidential Records" form.

By signing below, I give express permission for Affinity Family Care, LLC to release information to all providers, office staff, directors, officers and management working directly with the above referenced client, and any representatives from the State of Arizona to include the Division of Developmental Disabilities.

This authorization shall be in force until either written notice is given by the parent/guardian or client OR the client file is no longer active with Affinity Family Care, LLC.

_____	_____	_____
Parent/Guardian Signature	**Print Name**	**Date**
_____	_____	_____
Client Signature (if over age 18)	**Print Name**	**Date**

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TRANSPORTATION RELEASE - CLIENT

Client Name:_____ Date of Birth _____

Address_____City_____State_____Zip_____

Parent/Guardian Name_____

As parent and/or legal guardian of the above referenced client, I give express permission for all providers, office staff, directors, officers and management working directly with the client listed above to transport the client during scheduled sessions. This transportation can be in the employee's vehicle and/or public transportation. In order to transport, all providers must maintain current driver's license, vehicle registration, and insurance coverage for all vehicles used for transportation, on file at all times. If vehicle insurance is not in the employee's name, proof that the employee is insured on the policy must be provided to AFFINITY FAMILY CARE, by providing the insurance policy declaration page. In addition, an Affinity Family Care Transportation Release form must be signed by both employee and parent and/or legal guardian, prior to transportation being approved. The parent/guardian agrees to train the employee on all vehicle restraints to include seatbelts, car seats, booster seats etc. Providers are instructed to notify parent/guardian before transporting a client to any specified event and/or location. Affinity Family Care, LLC does not reimburse for mileage, and it is the parent/guardians responsibility. I also agree that Habilitation or Attendant Care cannot be billed during anytime providers are transporting the client. Respite can be billed as long as it is written in the Individual Service Plan (ISP) or the Individual Family Service Plan (IFSP).

By signing below, I understand and expressly assume all dangers of transporting the above referenced client and agree to the above/below written statements. I agree that Affinity Family Care, LLC, its providers, office staff, directors, officers, employees and management assume no responsibility. I waive all claims arising out of the transport whether caused by negligence, breach of contract or otherwise, and whether for bodily injury, property damage or loss or otherwise, that I may ever have against Affinity Family Care, LLC, its successors and assigns, and its officers, directors, agents (e.g. volunteers), providers, office staff, management and employees, and their executors, administrators and heirs.

By signing below, I agree that I am the parent or legal guardian of the above referenced client. I agree and give express permission to have my child transported. I have had the chance to read and think about the content of this authorization form and willingly without coercion confirm my consent and agree to follow the policies outlined above. I agree to release, indemnify, and hold harmless Affinity Family Care, LLC, and any of their officers, employees, providers, directors, agents (ex. Volunteers) and their executors, administrators and heirs from lawsuit, claim, demand, or action against them for transporting the above referenced client.

This authorization shall be in force until either written notice is given by the parent/guardian or client OR the client file is no longer active with Affinity Family Care, LLC.

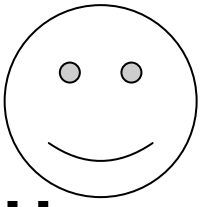
_____	_____	_____
Parent/Guardian Signature	**Print Name**	**Date**
_____	_____	_____
Client Signature (if over age 18)	**Print Name**	**Date**

DDD-1258AFORFF (2-06)

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

EMERGENCY CONTACT PLAN

Place Photo



Here

NAME	GOES BY

MEDICAL/PHYSICAL/COMMUNICATION LIMITATIONS

-
-
-
-
-

WHAT MAY BE PRESENTED IN AN EMERGENCY

1.
2.
3.
4.
5.

DO NOT

-
-
-
-
-

RECOMMENDED INTERVENTIONS

-
-
-
-

EMERGENCY CONTACTS – IN MEDICAL EMERGENCIES CALL 911 FIRST			
	NAME	**PHONE NO.**	**PHONE NO.**
Provider		**( )**	**( )**
Therapist		**( )**	**( )**
Guardian		**( )**	**( )**
Support Coordinator		**( )**	**( )**
Case Manager		**( )**	**( )**
		( )	**( )**

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MEDICAL TREATMENT AUTHORIZATION FORM

Client Name:_____ Date of Birth _____

Address_____City_____State_____Zip_____

Parent/Guardian Name_____

Affinity Family Care, LLC will make an effort to contact you in the event of an emergency. However, if the emergency is critical and medical care is required immediately, we ask that you give us permission to seek emergency care for the client named above on your behalf. The purpose of this agreement is to give Affinity Family Care, LLC administrative staff (Executive Director, management and office staff) the powers to make health care decisions for the client in the interim until we can contact one of the emergency contacts listed below:

Emergency Contacts:

Name_____Home # (_____)_____Cell # (_____)_____
Work # (_____)_____ Other # (_____)_____Relationship to client_____

Name_____Home # (_____)_____Cell # (_____)_____
Work # (_____)_____ Other # (_____)_____Relationship to client_____

Primary Care Physican: Name_____Telephone #(_____)_____

Hospital of Choice: Name_____Telephone #(_____)_____

NOTE: There is no guarantee that client will be transported to this hospital in an emergency situation

As parent or legal guardian of the above referenced client, I agree and give express permission to allow Affinity Family Care, LLC directors, management and office staff to seek medical treatment until an emergency contact can be reached. This includes them being able to make decisions for the above referenced client concerning the above referenced clients personal care, medical treatment, hospitalization, and health care. I give express permission to Affinity Family Care, LLC directors, providers, management and office staff to release and disclose confidential client records for the sole purpose of obtaining medical care.

By signing below, you agree to allow Affinity Family Care, LLC directors, providers, management and office staff to seek emergency care for the client listed above. I agree that I am the legal guardian and/or parent to the above referenced client. I have had the chance to read and think about the content of this authorization form and willingly without coercion confirm my consent for Medical Care and Treatment. I agree to release, indemnify, and hold harmless Affinity Family Care, LLC. and any of their officers, employees, providers, directors, agents (eg. Volunteers) and their executors, administrators and heirs from lawsuit, claim, demand, or action against them for any/all situations that would arise out of obtaining medical care for the above referenced client.

I understand that this authorization shall be in force until either written notice is given by the parent/guardian or client OR the client file is no longer active with Affinity Family Care, LLC.

_____	_____	_____
Parent/Guardian Signature	**Print Name**	**Date**
_____	_____	_____
Client Signature (if over age 18)	**Print Name**	**Date**

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ADMINISTRATION OF MEDICINES AUTHORIZATION FORM

Client Name:_____ Date of Birth _____

Address_____City_____State_____Zip_____

Parent/Guardian Name_____

Affinity Family Care, LLC providers are NOT permitted to give over-the-counter or prescription medications on an "as needed" basis simply at the request of parents for medical and/or behavioral reasons as outlined in Article 9. As needed means the decision to administer and/or increase the dosage of the medication is based on the paid provider's discretion. PRN medications administration by paid providers is a violation of Article 9 and is not permitted.

Affinity Family Care, LLC providers are trained that prescription medications must be in the original container with pharmacy label listing the client's name, medication name, dosage and the prescriber's name. Providers cannot administer sample medications given by healthcare professionals unless there is a doctor or pharmacy label listing the client's name, medication name, dosage and the prescriber's name. Over the counter medications must be in the original packaging with clear recommended dosage instructions. Providers cannot deviate from the recommended dosages for both over the counter medications and prescription medications even at the consent of a parent and/or legal guardian.

Parents and/or legal guardians will make every attempt to administer medications to the client listed above. In the event that a provider does administer prescription and/or over the counter medications a Medication Log must be completed and submitted by the 1st of every month. This log reflects the name of the medication, the dosage, when it was administered and how it was administered and the specific amounts. It must be signed by both the parent and/or legal guardian. Parents and legal guardians agree that they will provide written instructions to all providers working directly with the above referenced client, specifically outlining the medication, the dosage, the amount, how it should be administered, the specific times of the day, the purpose of the medication being administered and any potential side effects.

By signing below, I agree that I am the parent or legal guardian of the above referenced client. I agree and give express permission to allow Affinity Family Care, LLC staff members, employees, directors and providers to administer medications to the above referenced client. I have had the chance to read and think about the content of this authorization form and willingly without coercion confirm my consent for Medication Administration and agree to follow the policies outlined above. I agree to release, indemnify, and hold harmless Affinity Family Care, LLC. and any of their officers, employees, providers, directors, agents (eg. Volunteers) and their executors, administrators and heirs from lawsuit, claim, demand, or action against them for administering medication to the above referenced client.

I understand that this authorization shall be in force until either written notice is given by the parent/guardian or client OR the client file is no longer active with Affinity Family Care, LLC.

_____	_____	_____
Parent/Guardian Signature	**Print Name**	**Date**
_____	_____	_____
Client Signature (if over age 18)	**Print Name**	**Date**