COMMUNITY VENTURES IN LIVING, LTD

Individual Enrollment Checklist / Sign Off

INDIVIDUAL NAME: ________________________________ **ENROLLMENT DATE**: ______________________

_________ Individual Rights have been reviewed with me in my usual mode of communication and I have received a copy.

_________ Appeal process has been reviewed with me in my usual mode of communication and I have received a copy.

_________ Individual Information Form

_________ Individual Specific Medication Administration

_________ Home Inspection (via Home Environment Checklist)

_________ Emergency Plan

_________ Emergency Evacuation

_________ Individual Specific Training Tool / Individual Risk Tool

_________ Emergency Treatment Services Consent

_________ Notice of Privacy Practices

_________ Individual Consents

_________ Emergency Phone numbers

_________ Credit History

_________ Back-Up Plan (if applicable)

_________ Reportable Incidents (if applicable)

_________ Seizure Plan (if applicable)

_________ Guardianship Papers (if applicable)

_________ Behavior Support Plan (if applicable)

Other information as needed:

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____

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____

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____ ____

Program DIRECTOR SIGNATURE **COMPLETION DATE**

Community Ventures in Living, Ltd

Individual Rights Statement and Policy

Individual Name: ______________________________________ Date: ______________________________

Policy Statement

Community Ventures in Living, Ltd (CVL) is committed to providing services in a manner that protects the rights of each individual and encourages an individual to exercise those rights when he or she so desires.
CVL will ensure that an individual's rights as guaranteed by the Constitution of the United States, the Constitution of Indiana and the United Nations statement on human rights are not infringed upon. CVL will provide a copy of this Individual Rights Statement Policy to the individual and/or individual's representative at the initial service establishment and in no case more than seven (7) days after providing services to the individual.

Procedure

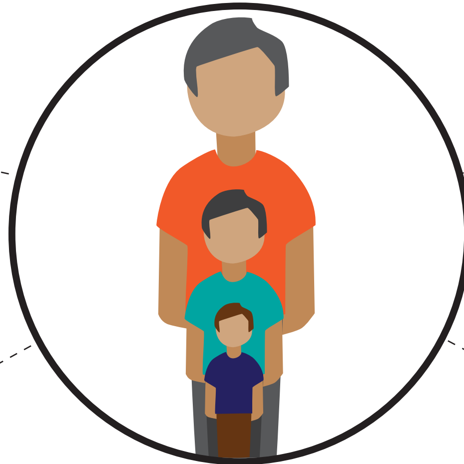
CVL will assure that every individual has the right to:

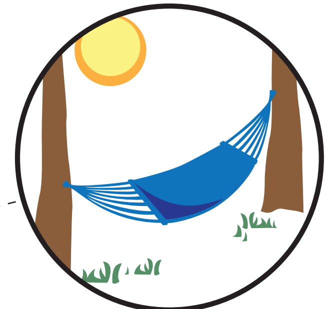
1. receive information necessary to give informed consents prior to the start of any service, and;
2. refuse treatments, intervention and services, and;
3. humane care and protection from harm, and;
4. be encouraged and assisted to submit complaints or recommendations concerning the policies and services of Community Ventures in Living, its Executive Director, Director of Quality, Program Directors, CSC or other employees, without fear of negative consequences to their services at 765.449.0784, and;
5. be treated with consideration, respect and to receive full recognition of dignity and individuality, and;
6. be protected from maltreatment, abuse, exploitation, or neglect. Any alleged violation of this right is to be reported to the agency's Executive Director and will be investigated, and;
7. be given privacy during the care of personal needs, and;
8. have records and service treated confidentially, including name, personal/family information and agency records. Also, to give written consent before information from records may be released to someone not otherwise authorized by law to receive it, and;
9. examine and copy records, at their expense, in accordance with applicable laws and proper notice, and;
10. be informed of anticipated termination of service or plans for the transfer of service to another agency, and;
11. have property treated with respect, and;
12. temporarily suspend, permanently terminate, temporarily add, and permanently add services in the service plan, and;
13. file grievances regarding services furnished or regarding the lack of respect for property by the personal services agency and is not subject to discrimination or reprisal for filing a grievance, and;
14. be free from verbal, physical, and psychological abuse and to be treated with dignity, and;
15. know that CVL office hours are Monday through Thursday 8:00am to 4:30 pm, Friday 8:00am to 2:00pm and our offices are closed Saturdays, Sundays, and all national holidays. Any changes in office hours will be communicated in writing to the individual at their home address, and that the CVL office contact information is:
    i. Office Address is: 60 Professional Court, Lafayette Indiana 47905
    ii. Office phone number is: 765.449.0784.
    iii. Toll free number is: 800.474.2571
    iv. Fax number is: 888.901.4782
16. know that CVL has a manager On-call after normal business hour and can be reached by calling: 765.449.0784 or 800.474.2571.

I have received a copy of these rights as an individual of CVL services.	
Individual or Individual's Rep Signature:	Date:
CVL Employee or Witness Signature:	Date:

TYPICAL LIFE CYCLE

Work & Fair Pay




Leisure & Rest

Marriage & Children

Equal Education

HEALTH & SAFETY

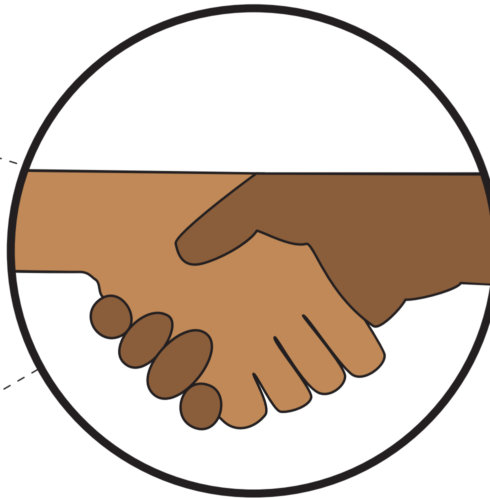
Access to Healthcare

Food Shelter & Clothing

Freedom from Harm

DIGNITY & RESPECT

Control of Finances



Privacy

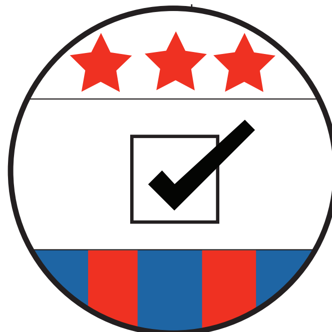
Due Process

CHOICES & DECISIONS

Assembly & Association

Freedom of Religion

Freedom of Speech


Right to Vote & Citizenship

Posession & Ownership

INDIVIDUAL NAME: ______________________________________

An individual applying for or currently receiving services from Community Ventures in Living, Ltd. who may have a grievance in regard to services they are receiving or have been denied shall have the right to and may file a request for a review and possible determination. The individual, family member or advocate must initiate the appeal process within 30 days of the action as follows:

A. If the person is currently receiving services, the problem shall be first directed to the direct service staff for the person receiving services.

B. If the individual, family member or advocate is dissatisfied with the results, an appeal may be made verbally to the Program Director.

The Program Director will:

A. Review the appeal and surrounding circumstances.
B. Within five working days of being presented with the appeal, a meeting will be scheduled at a mutually convenient time for all involved, no later than 14 days from contact, to discuss the appeal. The Program Director will facilitate this meeting.
C. If the individual, family member or advocate is dissatisfied with the results, an appeal may be made in writing to the Director of Services and Executive Director.

The Director of Services and Executive Director will:

A. Review the appeal and previous findings or recommendations.
B. Within five working days of receipt of the appeal, a meeting will be scheduled at a mutually convenient time for all involved, no later than 10 days from contact, to discuss the appeal. This will include the Director of Services, Executive Director, Program Director, CSC or Respite Provider, Individual, family member and or advocate, funding source manager and others as appropriate.
C. Within five working days the Executive Director will inform all parties of the results of the case consultation in writing. This notice will include information on how to access services or reviews by the service funding source, Indiana Advocacy, and Adult or Child Protection Service.
D. If the individual, family member or advocate is dissatisfied with the results, appeal may be made in writing to the Board of Directors.
E. The Board of Directors will review all pertinent information regarding the services provided in the case.
F. The Board of Director will make the final determination in the matter. All parties will be notified in writing.

I have received a copy of the appeal process and understand the procedures to follow if I feel that an appeal needs to be made.

INDIVIDUAL SIGNATURE: ____ **DATE:** ______________________________

COMMUNITY VENTURES IN LIVING REPRESENTATIVE: ____

Community Ventures in Living, Ltd

Individual Information Form

First Name *	Middle Name	Last Name *	Gender *	SSN Last 5 *	DOB *
Medicaid # *	Medicare #	Region	Date Enrolled	Legal Status *	Waiver *

Contact *

Address	Phone	County

Emergency Contact *

Name	Address	Phone

Guardian *

Guardian	Address	Phone

Services Available

End of Contract(s)

Personal Supports

Case Manager

Case Manager	Address	Email	Cell	Fax
BDDS District / #	BDDS Service Coordinator	BDDS Service Coordinator - Email		

Representative Payee / Trustee

Representative Payee / Trustee / Financial Support	Address	Phone

Residential Supports

Staff	Leads	Managers	Directors

Landlord

Landlord	Address	Phone

Employment

Employment	Address	Email	Phone

Day Services

Day Service	Address	Email	Phone

Behavior Specialist

Name	Address	Email	Phone

Medical Information

Physician *

Physician	Address	Phone

Last Medical Visits

Physical	Dental	Vision

Medical/Disability Concerns *

Medical Notes *

Special Precautions *

Allergies *

Medical Supports

Name	Specialty	Contact	Notes

Medications

Comments or Other Information

Client Contact Notes

INDIVIDUAL NAME: ____ **DATE:** ______________________________

Follow Community Ventures in Living Policies for all medication administration, but apply the following to meet this individual's specific needs:

How are the medications provided?

- ☐ Calendar Card/bubble packs
- ☐ Traditional Pharmacy Bottles
- ☐ Flip top pill boxes (*if checked, prepared by*): ____

Are the medications locked or unlocked?

- ☐ Locked at all times when not in use **per IDT approval.**
- ☐ May be left unlocked (Must be specified in ISP that the individual is safe with medications and is ok to have medications unlocked).

During Medication Administration:

Knowledge of Medication

- ☐ Individual to identify medication
- ☐ Individual to tell the purpose for the medication
- ☐ Will repeat name of medication and purpose for taking it
- ☐ Is to be informed of the medication and purpose for taking it
- ☐ The individual does not identify or state purpose for medication because: ___________________ ____

Oral Medications:

Calendar card/bubble packs

- ☐ Able to identify without any staff involvement, correct bubble to get medication from
- ☐ Requires staff assistance to monitor/identify correct bubbles to get medication from
- ☐ Able to pop medication out of bubble without any staff involvement
- ☐ Requires verbal prompts to punch medication out of bubble
- ☐ Requires physicial prompts to punch medication out of bubble
- ☐ Medication is punched out of card into medication cup
- ☐ Medication is punched out of card into individual's hand

Traditional Pharmacy Bottles

- ☐ Individual can identify correct bottle and amount to take
- ☐ Individual can prepare correct dose from the bottle without staff intervention
- ☐ Staff to assist individual in obtaining correct dose of medication from the bottle

Altering Medication

- ☐ Consumes all medication in form provided from pharmacy
- ☐ Requires pills crushed and placed in small amount of food*
- ☐ Requires capsules to be pulled apart and contents placed in small amount of food*
- ☐ Other ____

** must check with pharmacy on all new medications to assure effectiveness if altered*

*** if placing medication in food, follow dietary guidelines when applicable*

Getting the Medication to Mouth

- ☐ Individual is independent with ability to get hand / med cup to mouth without staff assistance
- ☐ Individual needs verbal prompts to get hand / med cup to mouth
- ☐ Individual needs physical prompts to get hand / med cup to mouth (hand over hand)
- ☐ Other ____

Swallowing

- ☐ Individual is independent with swallowing
- ☐ Requires verbal prompts to swallow medication

Checking Mouth

- ☐ No need to check the individual's mouth to assure the medication is swallowed
- ☐ Staff must check mouth to assure medication was consumed

Topical Medication:

- ☐ Independent in application of medication
- ☐ Requires Partial staff assistance with topical medications
  - ☐ Requires verbal prompts on identifying area of application
  - ☐ Requires physical prompts on identifying area of application
  - ☐ Requires verbal prompts on amount of medication required
  - ☐ Requires physical prompts on amount of medication required
  - ☐ Requires verbal prompts on actual application of topical medication
  - ☐ Requires physical prompts on actual application of topical medication

Eye/Ear Drops:

- ☐ Independent in application of eye/ear drops
- ☐ Requires partial staff assistance with eye/ear drops
  - ☐ Requires verbal prompts on administraion of eye/ear drops
  - ☐ Requires physicial prompts on administration of eye/ear drops

Inhalers:

- ☐ Independent with use of inhaled medication
- ☐ Requires partial staff assistance with inhaled medications
    - ☐ Independent with placement of inhaler/spacer in mouth
    - ☐ Requires staff prompting on placement of inhaler/spacer in mouth
    - ☐ Independent with pushing inhaler to dispense medication while individual is inhaling
    - ☐ Requires verbal prompts form staff on when to push inhaler to coincide with inhalation
    - ☐ Requires hand over hand and staff demonstration exhale and inhale to get the medication administered at correct time
- ☐ Independent with cleaning inhaler/spacer after use
- ☐ Requires verbal prompts with cleaning inhaler/spacer after use
- ☐ Requires physical prompts with cleaning inhaler/spacer after use
- ☐ Staff must clean inhaler/spacer after use

Nasal Sprays:

- ☐ Independent with use of nasal spray
- ☐ Requires partial staff assistance with nasal sprays
    - ☐ Requires verbal prompts on administration of nasal sprays
    - ☐ Requires physical prompts on administration of nasal sprays
- ☐ Independent with cleaning nasal spray after use
- ☐ Requires verbal prompts with cleaning nasal spray after use
- ☐ Requires physical prompts with cleaning nasal spray after use
- ☐ Staff must clean nasal spray after use

Other specific individual medication administration needs not listed above:

____
____
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COMMUNITY VENTURES IN LIVING, LTD

Annual Home Environment Checklist

INDIVIDUAL'S NAME: ________________________________ **CHECK COMPLETED BY:** ________________________________

ADDRESS: ____ **DATE:** __________________________

Exterior:

☐Yes ☐No ☐N/A The foundation is solid and free from defects.

☐Yes ☐No ☐N/A Sidewalks and driveway are in safe, usable condition.

☐Yes ☐No ☐N/A Stairs, rails, and porches are sound and free from hazards.

☐Yes ☐No ☐N/A Handrails are installed where there are four or more steps.

☐Yes ☐No ☐N/A Roof, gutters, and downspouts are in sound, clean condition.

☐Yes ☐No ☐N/A Walls of the residence look straight and are free from loose trim or siding.

☐Yes ☐No ☐N/A Storage buildings and garages are in safe, solid condition.

☐Yes ☐No ☐N/A Window and doorframes are weather-tight and watertight.

☐Yes ☐No ☐N/A House number is visible from the street.

☐Yes ☐No ☐N/A Fencing, gates, and safety covers are in place around a pool or hot tub.

Interior Physical Environment:

☐Yes ☐No ☐N/A Electrical outlets and switches have unbroken cover plates.

☐Yes ☐No ☐N/A Electrical outlets and switches are in working order.

☐Yes ☐No ☐N/A Ceilings and walls are clean and free of dangerous hazards

☐Yes ☐No ☐N/A Rooms are free from cracked, peeling paint.

☐Yes ☐No ☐N/A Flooring is clean, level, and free from cracks and damage.

☐Yes ☐No ☐N/A Baseboards are free from holes and/or gaps.

☐Yes ☐No ☐N/A Windows are airtight and have no broken windowpanes.

☐Yes ☐No ☐N/A Home is free from pest infestation.

☐Yes ☐No ☐N/A All kitchen stove burners work and all knobs are present.

☐Yes ☐No ☐N/A Kitchen has a working oven, refrigerator, sink, and properly installed plumbing.

☐Yes ☐No ☐N/A Bathroom has a working toilet, sink, and tub or shower.

☐Yes ☐No ☐N/A Home is equipped with hot and cold running water.

☐Yes ☐No ☐N/A Temperature on water heater has been adjusted as needed to prevent scalding.

☐Yes ☐No ☐N/A Bathroom plumbing is properly installed and in working order.

☐Yes ☐No ☐N/A Basement is dry and there are no or minimal wall cracks.

☐Yes ☐No ☐N/A Fireplaces or wood burning stoves are protected by guards to prevent burns.

☐Yes ☐No ☐N/A Furnace is properly installed and in working order.

☐Yes ☐No ☐N/A Room temperatures are at reasonable levels.

☐Yes ☐No ☐N/A Home is entirely free of broken light fixtures.

☐Yes ☐No ☐N/A Stairways are equipped with handrails.

☐Yes ☐No ☐N/A There are adequate facilities for disposal of garbage.

☐Yes ☐No ☐N/A All cleaners, detergents, medications, and potential poisons are stored separately from food.

☐Yes ☐No ☐N/A Individual has their own space for storage of personal belongings and privacy.

☐Yes ☐No ☐N/A Privacy is taken into consideration with regard to window coverings, interior door locks, and personal space.

☐Yes ☐No ☐N/A Physical accessibly has been met with regard to width of doorways, grab bars in bathroom, non-skid pads and rugs, ramps, and window/door access.

☐Yes ☐No ☐N/A Age-appropriate furnishings and décor have been encouraged and utilized.

Emergency Procedures:

☐Yes ☐No ☐N/A All windows and doors are equipped with working locks.

☐Yes ☐No ☐N/A There is more than one way to exit the unit.

☐Yes ☐No ☐N/A There is more than one way to exit the individual's bedroom.

☐Yes ☐No ☐N/A Exits are not obstructed and are easily opened.

☐Yes ☐No ☐N/A Emergency lighting is readily available (flashlights, candles as appropriate).

☐Yes ☐No ☐N/A There is at least one smoke alarm for each floor level.

☐Yes ☐No ☐N/A There is a working fire extinguisher in the home.

☐Yes ☐No ☐N/A A working phone is available for emergencies.

☐Yes ☐No ☐N/A Back-up supply of non-perishable food and water is available in case of an emergency.

☐Yes ☐No ☐N/A If home uses gas, there is at least one carbon monoxide detector on each floor level.

☐Yes ☐No ☐N/A Emergency drills are conducted and logged on a monthly basis.

Recommendations/Remarks:

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____

____

____

____

Community Ventures in Living, Ltd

Emergency Plan

Individual Name: ____________________________________ **Date**: ________________________

Address: ____

Fire Safety

Install smoke detectors and a working fire extinguisher in your home.

Practice a fire drill at least once per month.

If you or someone else catches fire, follow Stop, drop and roll techniques:

- **STOP**; do not run
- **DROP** to the floor (cover face with hands)
- **ROLL** over and over to smother the flames

Fire Emergency Plan

Identify two escape routes from your home:

1. ____

2. ____

Where will you meet once you are outside the home?

____

____

____

Tornado Safety

Seek shelter on the lowest floor of your home or current building.

If your home or building does not have a basement, seek shelter in interior spaces with no windows (bathroom or closet)

If possible, sit/squat and use your arms to protect your head from flying objects

Tornado Emergency Plan

In the event of a tornado, identify the two safest locations in your home or building:

1. ____

2. ____

Natural Gas Safety

A gas leak smells similar to rotten eggs; This is your warning to leave the home.

Install carbon monoxide detectors in your home. An alarm will sound if carbon monoxide is detected.

Natural Gas Leak Emergency Plan

If you think you may have a leak or your carbon monoxide detector goes off, do the following:

1. If possible, open doors and windows
2. Leave your home immediately
3. Call your gas company (from outside the home)

Gas company phone #: ______________________

Emergency Evacuation Log

Community Ventures in Living

Individual Served: ______________________________

Address: ______________________________

Support Professional (Print Name)	Initials	Date	Time	Notes or issues	Drill Type		Equipment Check		
					Gas Leak / Fire Drill	Tornado Drill	Carbon Monoxide Detector	Smoke Detector	Fire Extinguisher

Update this sheet after completing the Emergency Evacuation Drill webform (**www.cvl-in.org/emergency-evacuation-drill**) for a monthly Drills and Equipment Check.
Complete the Drill/Check information and select corresponding box for type of drill and /or equipment check.
If there are any issues such as an unsuccessful drill, equipment failure, or general comments, check the column *'Notes or Issues'* and describe issue fully in the webform.
As part of the individual's care team it is important to make sure that the individual served, to the best of their ability, understands safety precautions and their equipment.
Please document any areas where improvement can be made to ensure an individual's safety.
In order to maintain safety standards, individuals should be assisted in a minimum of the following inspections:
(6) Fire Drills, (6) Tornado Drills, (4) Carbon Monoxide, (9) Smoke Detector, (2) Fire Extinguisher

Individual Training Layout

Individual: ____________________

Plan Reviewed: ____________________

Plan Updated: ____________________

Authorized By: ____________________

Individual Specific Training	
Dietary:	**Other Resources:**
•	•
Behavioral Support:	**Other Resources:**
•	•
Ambulation:	**Other Resources:**
•	•
Communication:	**Other Resources:**
•	•
Personality:	**Other Resources:**
•	•
Medical:	**Other Resources:**
•	•
Personal Care:	**Other Resources:**
•	•
Other:	**Other Resources:**
•	•

Individual Training Layout

Individual: ______________________

Plan Reviewed: ______________________

Plan Updated: ______________________

Authorized By: ______________________

Risk	Background / Baseline	Assessment / Outcome	Planning and Implementation	Evaluation
Identify specific risk area	Describe why the risk is a risk and why intervention is required	Describe the desired outcomes and illustrate what a successful plan looks like	Specify actions those working with the individual will take to ensure desired outcomes are accomplished	Describe responsibilities required to ensure the plan is adequate, followed, and updated as needed
•	•	•	•	•
•	•	•	•	•
•	•	•	•	•
•	•	•	•	•
•	•	•	•	•
•	•	•	•	•
•	•	•	•	•
•	•	•	•	•

Risk Issues Identification Tool

Name of Individual:	
Annual Meeting Date:	
Date Completed:	

Provider Name:	Service(s):
Name of Person Completing this Form:	Role:

Directions: When using this tool it should be completed by **all IST members** supporting the person noted above prior to the annual team meeting. The Case Manager will need this tool **no less than 5 days** prior to the annual team meeting date.

- Identify individual risks that are **specific to the Individual.**
- Include factual and detailed information as to why the noted area **currently** presents a particular risk to this Individual, or how the issue has presented **significant** risk in the past and might impact the Individual currently.
- You may include a recommended strategy for managing or eliminating the risk, if desired.
- During the annual team meeting, decisions and plans, if needed, will be made around each risk identified.

I. Individual Risks: Relevant to Health

✓	Identified Risk Issue	Describe the incident(s) or issue(s) that indicates this as a current Risk?	Is this risk issue addressed somewhere now? If so, how?
	Lack of Mobility: Lack of mobility that could result in skin breakdown/pressure sores. Substantially limits access to home or community.		
	Significant weight gain/loss or change in eating patterns: Excessive weight loss or gain within the reporting year that is not intentional. Weight loss so excessive that could be related to additional concerns. Eating habits or patterns have changed to include loss or increase in appetite, not eating the foods that they had previously liked, coughing while eating, experiencing difficulty chewing or swallowing etc.		
	Choking and/or aspiration or swallowing disorders: Has a diagnosis of dysphagia (difficulty swallowing) or demonstrates problems with swallowing, choking, refuses to eat or coughs while eating etc. Has been treated for aspiration pneumonia		
	Inability to tolerate a medical examination/procedure: Due to apprehension, fear, medical condition, previous unpleasant experiences etc. the person is unable to tolerate a medical examination or procedure. This might include dental visits, intrusive procedures, or responds negatively to any type of medical intervention for reasons unknown.		
	Increased or unusual falls: Increased or unusual falling that results in injury such as fractures or severe injury.		
	Seizures: Has a diagnosis of seizure disorder that is not controlled. Has active seizures		

Disclaimer: The use of this tool is not a requirement for services received through the Bureau of the Developmental Disabilities Services.

Risk Issues Identification Tool

	Allergies/Allergic Reaction: Allergic reaction could cause serious illness or possible death.		

II. Individual Risks: Relevant to Personal Safety

√	Identified Risk Issue	Describe the incident(s) or issue(s) that indicates this as a current Risk?	Is this risk issue addressed somewhere now? If so, how?
	History of smoking in bed: Individual smokes in bed but has a tendency to fall asleep.		
	Inability to pay bills: Individual has a tendency to give all their money away.		
	History of pedestrian safety issues: History of walking into street in front of cars. Lacks understanding of pedestrian safety.		
	Unable to safely evacuate during an emergency: Inability to evacuate from a building without assistance.		
	Exploitation: Allows individuals to live in home without being on the lease. Gives away or spends all their money to/on strangers.		

III. Individual Risks: Relevant to Behavior

√	Identified Risk Issue	Describe the behavior or issue(s) that indicates this as a current Risk?	Is this risk issue addressed somewhere now? If so, how?
	History of or presently engages in aggressive or dangerous behavior: History of extremely serious criminal acts such as: pedophilia, murder, rape, arson, etc. (Note: History of a less severe act, that is now managed and no longer occurs, should be closely reviewed to determine if it continues to be a risk.)		
	Criminal justice involvement: Criminal justice involvement which can lead to incarceration and/or the risk of being exploited, abused, medically neglected and loss of services.		
	Fascination with fire or of fire setting: Currently demonstrates or expresses an intense interest in fire, matches,setting fires etc. or has any history of arson.		

Risk Issues Identification Tool

	Contact with Emergency Medical Services, law enforcement, or mobile crisis: Engages in dangerous behavior that can only be managed by calling an emergency entity. Recent suicidal ideation or attempts to commit suicide. Destruction of property so serious that it could lead to criminal charges.		

Disclaimer: The use of this tool is not a requirement for services received through the Bureau of the Developmental Disabilities Services.

Risk Analysis and Planning Tool

Name of Individual:	
Meeting Date:	
Date Completed:	
Name of Person Completing this Form:	

Team Members:

Directions: *Before the annual team meeting the case manager may use the following grid to record the individual risks that have been identified by all team members (e.g. Individual, guardian/family, providers, etc.) (i.e., using the "Risk Issues Identification Tool"). At the team meeting, you may use the grid to facilitate open discussion, analysis, brainstorming and planning in order to:*

Review with the team all the identified Individual risks that were recorded on the Risk Issues Identification Tool, or as otherwise identified during the team meeting;
Review the reasons associated with each risk issue identified;
Develop final actions, supports, and services for addressing each risk; and
Note where the information to address each risk will be documented in the PCISP (i.e. which Life Domain).

Risk Score

Risk	History/Frequency	Risk Matrix				Is a Risk Mitigation Plan needed to solve a problem?
		Severity	Likelihood	Total Risk Score	Risk Level	

Disclaimer: The use of this tool is not a requirement for services received through the Bureau of the Developmental Disabilities Services.

Risk Analysis and Planning Tool

Discuss during the Team Meeting

What is the risk?	What is the problem we are trying to solve with this risk mitigation plan?	What if we do not put a risk mitigation plan in place (e.g. do nothing)?	What action did the IST decide to take to manage this risk?	Which Life Domain should this risk be included? (Note: only should be noted once in PCISP.)

Identified Risks the IST agreed are no longer a risk or are not determined to be a risk or a risk that does not warrant a risk mitigation plan.

Identify the possible risk	Why the identified risk is no longer a risk or determined not to be a risk or a risk that does not warrant a risk mitigation plan by the IST?	Which Life Domain of the PCISP will this be noted?

Disclaimer: The use of this tool is not a requirement for services received through the Bureau of the Developmental Disabilities Services.

INDIVIDUAL NAME: ______________________________

This document authorizes the Representatives of Community Ventures in Living to have my full and free consent to procure any medical care that may be required for emergencies in the areas of medical, dental, mental health and surgical services that may be deemed necessary for my health and welfare.

______________________________	______________________
SIGNATURE OF INDIVIDUAL	**DATE**
______________________________	______________________
SIGNATURE OF PARENT OR GUARDIAN	**DATE**
______________________________	______________________
SIGNATURE OF WITNESS	**DATE**

COMMUNITY VENTURES IN LIVING, LTD

Notice of Privacy Practices Summary and Acknowledgement

INDIVIDUAL NAME: ___________________________________

YOUR RIGHTS - YOU HAVE THE RIGHT TO:

Get a copy of your paper or electronic medical record
Correct your paper or electronic medical record
Request confidential communication
Ask us to limit the information we share
Get a list of those with whom we've shared your information
Get a copy of this privacy notice
Choose someone to act for you
File a complaint if you believe your privacy rights have been violated

YOUR CHOICES - YOU HAVE SOME CHOICES IN THE WAY THAT WE USE AND SHARE INFORMATION AS WE:

Tell family and friends about your condition
Provide disaster relief
Include you in an individual directory
Provide mental health care
Market our services
Raise funds

OUR USES AND DISCLOSURES - WE MAY USE AND SHARE YOUR INFORMATION AS WE:

Treat you
Run our organization
Bill for your services
Help with public health and safety issues
Do research
Comply with the law
Respond to organ and tissue donation requests
Work with a medical examiner or funeral director
Address workers' compensation, law enforcement, and other government requests
Respond to lawsuits and legal actions

I acknowledge that I have reviewed and understand the CVL Notice of Privacy Practices "Your Information. Your Rights. Our Responsibilities" summarized above. This document was provided to me in writing and, if I require, in my usual mode of communication. I understand my Rights and Choices regarding my medical information.

INDIVIDUAL SIGNATURE: ____ **DATE:** ____________________________

COMMUNITY VENTURES IN LIVING REPRESENTATIVE: ____

I hereby request and authorize Community Ventures in Living to exchange information

with __________________________ pertaining to _______________________________

for the purpose of ____.

This consent is effective __________________________ and will be valid for a period of one year. I understand that I may contact a CVL representative to request that certain sections of the records not be released or referred to in the course of taking action upon this request. I understand that I may revoke this consent, verbally or in writing, at any time. I, the undersigned, have read or have had this consent fully explained to me and understand it. All blanks were filled in before I signed the consent.

____	____________________
(SIGNATURE OF INDIVIDUAL SERVED)	**(DATE)**
____	____________________
(SIGNATURE OF GUARDIAN/PARENT)	**(DATE)**
____	____________________
(SIGNATURE OF WITNESS)	**(DATE)**

INDIVIDUAL'S NAME: ____

DATE OF BIRTH: ____

ADDRESS: ____

____

Community Ventures in Living, Ltd

Emergency Phone Numbers

Individual Name: ___________________________________ **Phone Number:** _________________________

Home Address: ____

Police or Fire: 911

Community Ventures in Living, Ltd		**765-449-0784**
Community Ventures in Living, Ltd		**1-800-474-2571**
BDDS Service Coordinator		
Waiver Ombudsman		
Adult Protective Services		**1-800-992-6978**
Child Protective Services		**1-800-422-4453**
Poison Control		**1-800-222-1222**
Waiver Case Manager		
Behaviorist		

Emergency Contacts

HAVE A PROBLEM?

WHEN SOMETHING IS NOT RIGHT IN MY HOME, I NEED TO CALL:

765-449-0784

OR

1-800-474-2571

THIS WILL GET ME TO SOMEONE AT CVL WHO KNOWS ME.

I WILL CALL 911 IF I NEED FAST MEDICAL HELP!

I, ____ give my permission for Community Ventures in Living to run a Credit Report to assure I am not a victim of exploitation.

Full Social Security Number: _________________________________

_______________________________________	_________________________
Individual/Guardian Signature	**Date**
_______________________________________	_________________________
Signature of Agency Representative Running Report	**Date Processed**

Running Credit Scores/Reports

We recommend using a website that is both safe and easy to use. Many of our employees and individuals served use www.CreditKarma.com

SUPPORT PERSON: ______________________________ **INDIVIDUAL SERVED:** _______________________________

BACK-UP SUPPORT: ____________________________________ **PHONE NUMBER:** _________________________

ADDRESS: ____

BACK-UP PLAN OVERVIEW

This section should include the location where back-up services intend to be provided; whether the provider of back-up services is employed by CVL, a natural support or other; any other relevant information or instruction.

____

____

____

____

____

____

____

____

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____

____

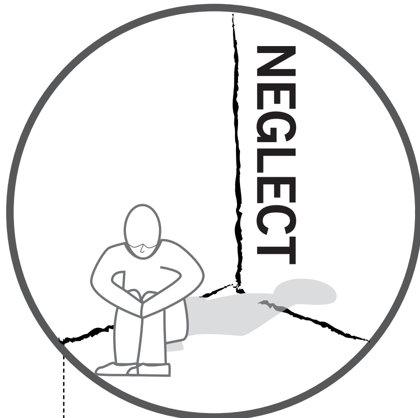
_______________________________________ _______________________________________

SIGNATURE, SUPPORT PERSON / DATE **SIGNATURE, BACK-UP SUPPORT / DATE**

Community Ventures in Living

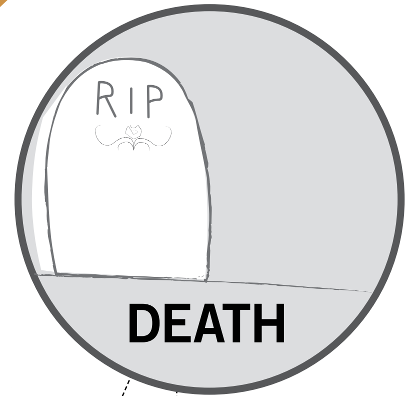
REPORTABLE INCIDENTS

CVL keeps track of certain incidents to insure the safety of those we serve. If something happens that puts an individual's health and safety at risk, please report it immediately to CVL at 1-800-474-2571 or 765-4490784. An incident report must be filed with the State within 24hrs of its occurence.

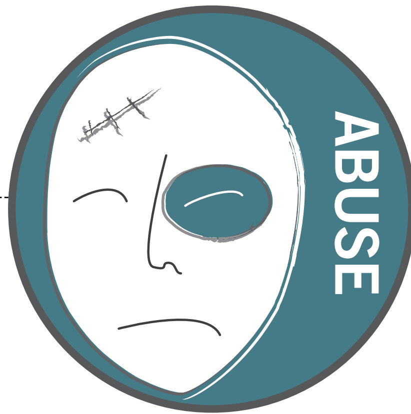


NEGLECT

you don't have a safe place to live, food to eat or medicine that you need



DEATH

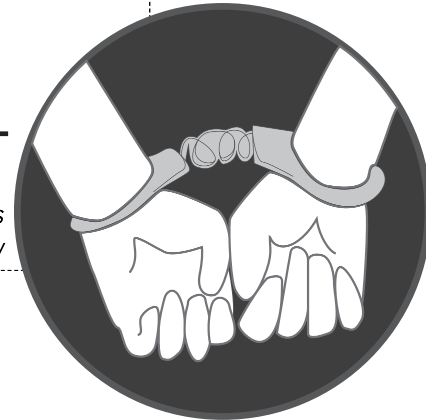


ABUSE

someone has hurt or mistreated you in any way

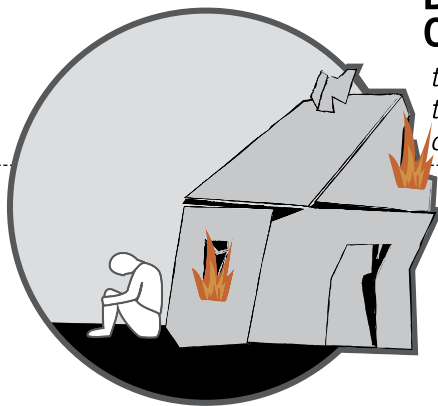
EXPLOITATION

someone has used your money, belongings or identity for their own, or someone else's, profit



CRIMINAL ACTIVITY

anything that is against the law



DANGEROUS CONDITIONS

things that make your home or the place that you receive services dangerous including infestation

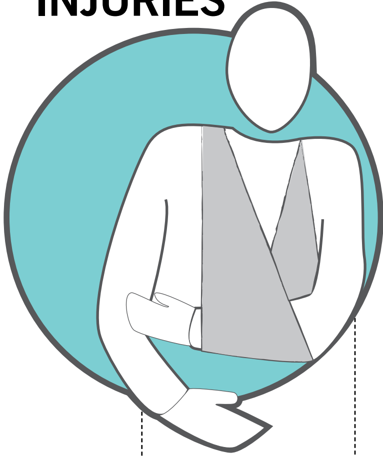
ELOPEMENT

someone has run away or is missing

PEER-TO-PEER AGGRESSION

a peer hurts you so badly that you need first aid or help from a doctor or nurse

SIGNIFICANT INJURIES

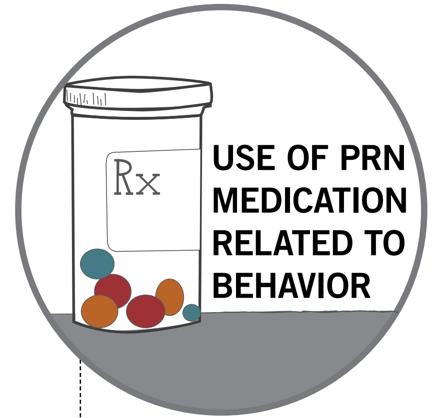


incuding, but not limited to: fractured or broken bones; any second or third degree burns; choking; three inch bruises or repeated bruising; a cut requiring nurse or doctor attention; bedsores; bite or puncture wounds; eating or drinking things that are not food or beverage

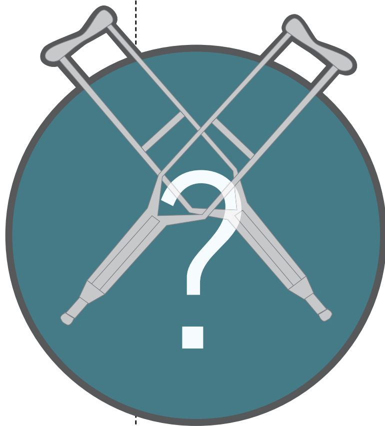
STAFF INJURIES

if an employee is injured while on the job

USE OF PRN MEDICATION RELATED TO BEHAVIOR



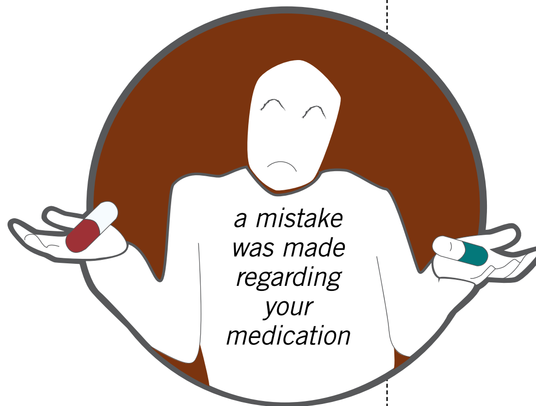
you are given medicine that you only receive when behaviors happen



INJURY WITH UNKNOWN CAUSE

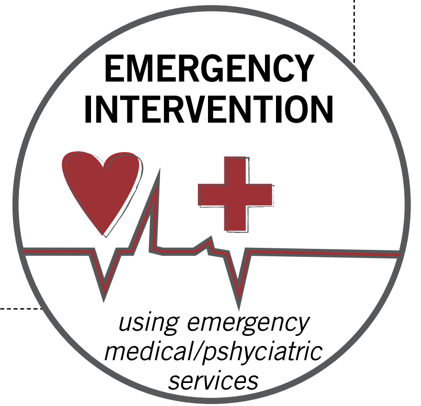
any type of injury and no one knows how it happened

MEDICATION ERROR



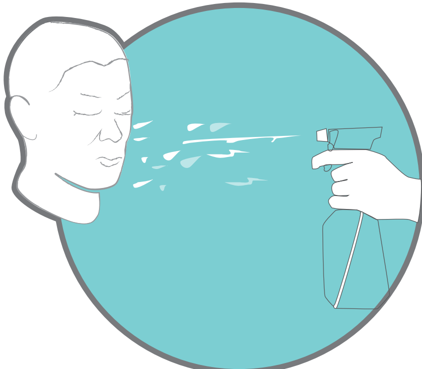
a mistake was made regarding your medication

EMERGENCY INTERVENTION



using emergency medical/pshyciatric services

USE OF ANY AVERSIVE TECHNIQUE



If any of these things is done to you, it must be reported.

any fall resulting in injury

USE OF ANY PHYSICAL OR MECHANICAL RESTRAINT

you are held in place so you cannot move

Community Ventures in Living, Ltd

Seizure Observation and Tracking Log

Individual Name	Date of Seizure	Time Seizure Began	Time Seizure Ended

Name of Person Reporting	Where Did Seizure Occur?

Please List All Curent Medications and Dosages (Not just for seizures):____________________________________

****

DURING SEIZURE, the individual was observed to: (Please check <u>ALL</u> Appropriate Categories Below)

CRY OUT ____ FALL ____ BECOME RIGID ____ BITE TONGUE ____ ROLL EYES _____ VOMIT _____

HAVE JERKING BODY MOTIONS _____ URINATE _____ DEFECATE _____ BECOME DISORIENTED _____

BECOME AGGRESSIVE _____ LOSE CONSCIOUSNESS _____ BECOME LIMP _____ STOP BREATHING _____

****

LENGTH OF TIME FOR SEIZURE ______________ MORE THAN ONE SEIZURE? (If yes, how many?) __________________

SEIZURE WAS OBSERVED BY (Name 1) ________________________________ (Name 2) ________________________________

INDIVIDUAL WAS INJURED? YES ___ NO ___ (If yes, describe all injuries) ____________________________________

RECEIVED TREATMENT? YES ___ NO ___ (If yes, describe treatment) ____________________________________

IMMEDIATELY AFTER SEIZURE (Briefly Describe Individual's Condition) ____________________________________

****

DOCTOR NOTIFIED? YES ___ NO ___ (If yes, doctor's recommendations) ____________________________________

Follow-up Details: ____

BEFORE SEIZURE, INDIVIDUAL: (Please check <u>ALL</u> Appropriate Categories Below)

STOPPED FROM DOING SOMETHING _____ WAS LOUD/DISRUPTIVE ______ WAS PROVOKED BY OTHERS ______

WAS ASKED TO DO A TASK _____ WAS IN A NOISY ENVIRONMENT _____ HAD SELF INJURIOUS BEHAVIOR _____

DESTROYED OWN PROPERTY _____ DESTROYED PROPERTY OF OTHERS _____ REFUSED MEDICATIONS ______

BECAME DISORIENTED _____ BECAME AGGRESSIVE _____ APPEARED BORED _____ WAS POUTY / UPSET ____

****

Other Comments: ____

Date Report Was Written	Date of Last Medication Level Check	Date of Next Visit

Signature of Individual Reporting	Date

Individual: ______________________________ **Date:** ___________________

Recognition of seizure disorders and knowledge of first aid is important. Seizures are often mistaken for something else.

Seizure Type Characteristics	First-Aid
Generalized Tonic Clonic - body becomes rigid then jerking, usually last 2-5 minutes with complete loss of consciousness.	1. Stay with person. 2. Ease to floor if possible. 3. Turn on side. Protect head (blanket or soft material). 4. Loosen tight clothing. 5. Move objects from vicinity 6. Provide privacy. Observe. Notify nurse.
Atonic- sudden loss of muscle tone.	No first aid unless person gets hurt from fall.
Myoclonic- sudden muscle jerks.	No first aid
Absence- brief seizures with loss of consciousness, stare, blinking, rolling of eyes or mouth movement	No first aid
Partial Simple- starts in one part of body or brain. May have sensory experience not obvious to an onlooker.	No first aid unless becomes secondarily generalized.
Complex- loss or impaired consciousness. Activity inappropriate, purposeless (i.e., lip smacking, chewing).	Speak calmly and reassuringly to person and others. Guide gently away from hazards. Stay with person until completely aware of environment.
Secondarily Generalized- starts in one area but progresses.	1. Stay with person. 2. Ease to floor if possible. 3. Turn on side. Protect head (blanket or soft material). 4. Loosen tight clothing. 5. Move objects from vicinity. 6. Provide privacy. Observe. Notify nurse.

People who provide support to people who have seizures should recognize an emergency situation and notify appropriate medical support immediately if:

1. A person has 3 seizures without regaining consciousness
2. A seizure lasts longer than 3 minutes
3. A person does not breathe for 30-60 seconds
4. The level of consciousness has not returned within 15 minutes

Health Care Plan Issue:

Maintain optimal seizure management.

Issue Clarification:

Type of Seizure: ____
Last Seizure Activity: ____
Controlled with Medication: ____
*Please refer to home file for medication information including side effects.

Implementation Plan (continue on back as needed):____
____
____

Training Implications:

All staff will be appropriately trained in seizure management.
All staff will be trained on individual's seizure medications, including side effects, signs & symptoms of toxicity.
All staff will be trained in specific type, signs, and symptoms.
All staff will be trained in proper documentation of seizure activity.

Implementation Plan **(continued):** ____
____
____
____
____
____
____
____