OPTIONS Inc.

Thank you for considering the services of Options.

Enclosed you will find an application for services and related forms required for admission. You may need to review and sign the Release of Information forms to give permission for other people to forward information to us. If you need assistance understanding what the Release of Information form means, ask someone to help you. With this information, we will be able to proceed with your application and identify and develop an appropriate program plan for you.

Options will notify the referred person/legal representative within 30-days of receipt of a **completed** intake packet along with all required documentation of the admission decision. Reasons for denial of service request will be given along with potential alternative services. Options Inc. will maintain a written record of each application/referral for a period of four years.

If you have any questions or concerns regarding this intake packet, please contact:

Brenda Geldert
Executive Director
763.263.3684 Ext. 277
brendageldert@options-inc.org

OPTIONS, INC. APPLICATION FOR SERVICE

AS-002
Revised 7/22

Date: _____

I wish to apply to Options, Inc. for admission for: _____

Signature: _____ Title: _____
Case Manager, and/or Legal Guardian

The following **must** be completed prior to Application Review:

____Case Manager's statement of *Non-Duplication of Services*
____Consent for Release of Information
____Standard Release of Information
____Admission Form-Data Sheet and General Contacts
____Vocational and Living Skills Assessment
____Authorization for Medication and Treatment
____Physical Examination Form
____WIOA Youth Requirement: *Age 24 or younger* (if applicable)
____Current Support Plan
____Psychological Evaluation

If eligible for services funding authorization will need to be secured before services will begin.

Options Use Only:

Date Received: _____
Reviewed by: _____
Referral Source: _____
Admission Meeting: _____

Options, Inc.
Non-Duplication of Services Statement

To the best knowledge of this case manager, the services provided to _____ by Options are not replacing services that are the statutory responsibility of a local education agency or that are otherwise available from a rehabilitation agency funded under Section 110 of the Rehabilitation Act of 1973, United Sates Code, Title 29, Section 730 as amended through October 31, 1986.

Case Manager Signature Date

OPTIONS, INC. SPECIFIC RELEASE OF INFORMATION

DPF-008

MN Statutes, section 13.05, subdivision 4: Private or confidential data on an individual shall not be collected, stored, used, or disseminated by government entities for any purposes other than those stated to the individual at the time of collection in accordance with section 13.04, except as provided in this subdivision.

Date:

I, hereby, authorize:

(person(s) or agencies the data subject is authorizing to disclose information)

to disclose the information described below regarding:
(specific nature of the information to be disclosed)

which has been requested

(person(s) or entities to whom the subject is authorizing information to be disclosed)

Describe the requested information completely:

Describe the purpose(s) for which the information will be used, both at the time of the disclosure and at any time in the future:

I understand that only the information described above will be released, and that it will be used solely for the purpose described above. It will not be disclosed to any other source unless specifically authorized by me. I have been informed that I may refuse to authorize the release of this information and the consequences of such a refusal have been explained to me.

☐ This authorization will expire upon receipt of the information specified herein

or

☒ This authorization will remain in full force and effect subject to my right to revoke it at any time, until:

(date of termination; not to exceed one year)

I understand that I may revoke this authorization at any time and that I may review the information before authorizing its release, subject to my right to review this information under the controlling State and Federal law.

Person served and/or legal representative signature

Date

OPTIONS, INC. STANDARD RELEASE OF INFORMATION

Name: **Date:** DPF-007

I understand that I and my legal representative have full access to my records and recorded information that is maintained, collected, stored, or disseminated by the company. Private data are records or recorded information that includes personal, financial, service, health, and medical information. I, hereby, authorize **Options, Inc.** to routinely release my private information those staff of **Options, Inc.** who have a need to know including: executive and administrative staff, financial and nursing staff including assigned or consulting nurses, management staff including the Designated Coordinator and/or Designated Manager, and direct support staff. In addition, my support team or expanded support team may receive my private information as needed, including my county case manager, employer, behavior professionals, and other licensed service providers.

I understand the purposes for collecting and releasing my private information. I also understand that the information released by this company will be used only by authorized agencies or entities.
The MN Government Data Practices Act protects your privacy, but also lets us release information about you to others if 1.) a law or government regulation requires it and 2) we tell you before we do it. The information below tells why and when we will ask for information about you that we do not currently have and release information about you. It applies to all future contacts you will have with us. Options will obtain authorization to release information of persons served when consultants, sub-contractors, or volunteers are working with Options to the extent necessary to carry out the necessary duties.

What are some reasons we use your information?
There are many reason we use your private information regarding service provision and continuity of care purposes. Your information allows us to tell you from other persons who get the same service; to understand what services you may need; deliver those services in the most effective and efficient way possible, to work efficiently and effectively with other organizations or people who also support you; to protect your rights; collect money from the federal, state, or county agencies for services provided; to make reports, audit, and evaluate our services to make them better; and/or to ensure that our services are designed and delivered in accordance with all federal, state, or county laws and regulations.

Do you have to provide us with information? What will happen if you do not provide us all the information? What happens if you do not release your information to others?
Generally, the law says you do not have to give us all the information we ask for; however, we need some information to give you services. If we do not get it, or if we cannot share it with others who work with you, then we might not be able to assist you or assist you effectively. Also, it is possible laws or regulations might order us to obtain or release it later. Our agency might receive fines or corrective action as a result of not having the information.

Who else may access your information when required?
The following entities also have access to persons' private data as authorized by applicable state or federal laws, regulations, or rules. Other entities or individuals authorized by law:

- Minnesota Department of Human Services
- County of company's social services
- U.S. Department of Health and Human Services
- Social Security Administration
- Federal, state, or county auditors
- Adult or Child Protection units and investigators
- The MN Ombudsman for Mental Health or Developmental Disabilities
- Agents of the welfare system or investigators
- County of financial responsibility
- Local or state health departments
- Law enforcement personnel and attorneys
- Various state departments
- Representative payee and financial workers
- Other licensed service providers as needed

You have the right to access your information and to request copies.
You and/or legal representative have the right to request that your records or recorded information and documentation be altered and/or to request copies. If you would like copies of your information, please provide us with five (5) days notice, if possible. Information will be disclosed to appropriate parties in connection with an emergency if knowledge of the information is necessary to protect the health or safety of the person served or other individuals or persons. Information will be maintained on this disclosure and you may request this information and request copies.

What can you do if you believe your information is inaccurate?
Your objections must be in writing and should be submitted to our company. This written notice must include why you believe the information is incorrect. Please include an explanation of the information that you disagree with. A copy of this objection you submitted in writing will be maintained in your service recipient record. Your explanation will be attached any time that information is shared with another agency.

Summary/consequences – I know that state and federal privacy laws protect my records. I know:

- Why I am being asked to release this information.
- I do not have to consent to the release of this information. But not doing so may affect this company's ability to provide needed services to me.
- If I do not consent, the information will not be released unless the law otherwise allows it.
- I may stop this consent with a written notice at any time, but this written notice will not affect information this company has already released.
- The person(s) or agency(ies) who receive my information may need to pass it on to others.
- If my information is passed on to others by this company, it may no longer be protected by this authorization.
- This consent will end in one annual year from the date I sign it, unless the law allows for a longer period.

Over the course of the year, opportunities arise for Options, Inc. to use a photograph(s) of you for different purposes.
Please write YES if you do want the photograph used in any of these applications.
Please write NO if you do not want the use of a photograph used in any of these applications:

_____Photographs displayed at Options, Inc.
_____Photographs displayed on Options, Inc. website
_____Photographs displayed at community work sites
_____Options' advertisements/marketing materials for public view
_____Photographs displayed on Options' Facebook page

I understand that without my prior, written consent, the sharing of my information will not occur with any agency not listed above, for any reason not described above, or for any use not described above. I understand that I also have the right to review any information which is maintained by **Options, Inc.** about me, as provided for in MN Government Data Practices Act, section 13.46. I further understand that I may review the information before it is released, subject to my right to review this information under the controlling federal and state laws.

_____ _____
Individual served Date

_____ _____
Legal Representative (when applicable) Date

OPTIONS, INC. ADMISSION FORM AND DATA SHEET

DPF-003

Date Updated:	Options' standing orders Updated:
*This form is completed at service initiation and update as needed. Dated signatures are obtained at initiation and annually thereafter.	
PERSONAL INFORMATION	
Name:	Date of birth:
First Date of Service:	Language(s) spoken:
Guardianship type (self, private, public):	Cultural/Religious consideration:
Marital status:	Other:
IDENTIFYING CHARACTERISTICS	
Gender:	Race:
Height:	Weight:
Hair color:	Eye color:
Communication Mode:	
Distinguishing characteristics/identifying marks:	
FINANCIAL INFORMATION	
Social Security Number (SSN):	Medical Assistance Number:
County of responsibility:	PMI number:
County of financial responsibility:	Funding Source:
MEDICAL INFORMATION	
Diagnoses/History:	
Allergies (Drug, Food, Enviromental):	
Protocols (seizure, diabetic, Epi pen, etc.):	
Medical equipment, devices, or adaptive aides or technology used:	Specialized dietary needs:
MEDICATIONS/TREATMENTS	
IMMUNIZATIONS	
Tetanus:	Influenza:
Hepatitis B:	Pneumonia:
Mantoux:	Other:

HEALTH-RELATED CONTACT INFORMATION	
Name	**Address and telephone numbers**
Emergency Contact:	
Primary health care professional:	
Psychiatrist/Mental health professional:	
Other Mental health professional:	
Hospital of preference:	
Other health professional:	
Other health professional:	

GENERAL CONTACT INFORMATION		
	Name and Address	**Telephone Number/E-Mail**
Individual:		
Legal representative: Primary emergency contact:		
Residential contact:		
Case manager:		
Residential Director:		
Family member:		
Direct Deposit Email Address:		
Options Staff:		

OPTIONS, INC. EMERGENCY CALL LIST	DPF-028

Name:

Date:

List in order of preference the individual who should be called in the event of the following. If it is the same, please indicate

EMERGENCY:

Name:	Phone:
Name:	Phone:
Name:	Phone:

ILLNESS:

Name:	Phone:
Name:	Phone:
Name:	Phone:

WEATHER CLOSING NOTIFICATION:

Name:	Phone:
Name:	Phone:
Name:	Phone:

☐ When being transported home with Options, Inc.,
CAN be left at home without visual contact of a responsible party.

☐ When being transported home with Options, Inc.,
CANNOT be left at home without visual contact of a responsible party.

Vocational and Independent Living Skills Assessment AS-005

Name:

Date:

In order to better understand the applicant's abilities, needs and to make initial plans for developing a service plan, we ask that you provide us with the following information:

Placement History

Please list prior programs and or employers, include their dates of attendance and type of services received.

Location	Dates From:	To:	Services

What are your current expectations for service areas for the applicant?

- ☐ Non-Vocational Day Supports
- ☐ Center Based Prevocational Work
- ☐ Community Crew Supports
- ☐ Independent Job Supports

Summary of Strenghts and Preferences

Social/community preferences:

Rituals/Routine:

Likes/Dislikes:

Strengths:

Important to individual:

Important for individual:

Preferred type of work if applicable (office, janitorial, industrial/assembly, food service, child care, etc.):

Independent Living Skills

Please provide a brief description of the applicant's abilities and needs, including your assessment of whether assistance and training would be appropriate in these areas.

Problem Solving (phone, time, numbers, reading, emergencies):

Personal Living Skills:

Eating:

Toilet Use:

General Appearance:

Physical Abilities:

Mobility:

Fine Motor:

Money Handling:

Street Safety & Transportation:

Communication and Learning Style

Preferred method of communication:

Receptive language skills and abilities:

Expressive language skills and abilities:

Techniques used for learning style:

Interpersonal & Emotional Skills

Has difficulty accepting direction from supervisors?

Does the applicant readily accept changes in routine?

Is the applicant distracted by the presence of others?

Does the applicant recognize/respect the personal space of others?

Does the applicant exhibit excessive dependency (constant requests for reassurance, approval, affection.)

Does the applicant exhibit unrealistic fears or feelings of persecution? Does applicant make false accusations towards others?

Does the applicant resist following instructions (refuses or does the opposite)?

Does the applicant takes advantage of/or manipulates others?

Does the applicant use inappropriate or obscene language or gestures when frustrated or upset?

Does the applicant require physical contact or instructional techniques used on an continuious basis to:
(Please indicate by checking each box that applies.)

☐ Calm or comfort a person by holding that person without resistance.

☐ Protect a person known to be at risk or injury due to frequent falls as a result of a medical condition. *(Such as a seizure disorder.)*

☐ Facilitate the completion of a task or response when the person does not resist or the resistance is minimal intensity or duration. This includes hand-over-hand training.

☐ Briefly block or redirect a person's limbs or body without holding the person or limiting movement to interrupt the person's behavior that may result in injury to self or others.

Please describe the contact or instructional technique identified above:

Has an Emergency Use of Manual Restraint *(EUMR)* been implemented with the applicant over the past year? If so, please describe.

Abuses or destroys property?

Has a history of or exhibits self-injurious behavior or Pica?

Has the applicant been physically aggressive towards staff or peers?

Does the applicant have a current Positive Support Transition Plan *(PSTP)* or have any other positive support programs that been a part of the applicant's Support Plan in the past year? If so, please describe briefly, including observations and effectiveness of these programs.

Sexuality Considerations

Does the individual have a history of sexually inappropriate contact with others?

Does the individual engage in sexually inappropriate comments or language?

Does the individual demonstrate a sexual pre-occupation with specific characteristics of an individual, object(s), or activity(s)?

Does the applicant have a history of exposing themselves to others? Self-stimulating behaviors in public? Disrobing in public?

Options, Inc.

AUTHORIZATION FOR MEDICATION
AND TREATMENT ADMINISTRATION AND ASSISTANCE DHF-005
Rev.7/22

Name: Date of birth:

If responsibility for medication and treatment administration or assistance (including medication set up) has been assigned to Options in the *Support Plan* and/or *Support Plan Addendum*, Options will obtain written authorization from the person served and/or legal representative prior to the administration of any medication or treatment.

I authorize the company to administer, assist with, or set up the following:

☐ Routine prescribed medications	☐ Prescribed PRN psychotropic medication
☐ Routine prescribed treatments	☐ Other, please specify:
☐ Prescribed psychotropic medication	☐ KI (Potassium Iodide): Emergency only*

*In the unlikely event of nuclear plant emergency, KI (Potassium Iodide) may be taken orally to reduce the risk of thyroid cancer from exposure to radioactive iodide. It does not protect any other part of your body and does not protect from other forms of radiation. A recommendation to take KI will be issued if the Monticello Nuclear Plant declares a General Emergency. WARNING: People should not take KI if they are allergic to iodine, have dermatitis herpetiformis or hypocomplementic vasculitis, or have nodular thyroid disease with heart disease. Consult your physician if you have further questions or concerns.

I authorize the company to administer, assist with, or set up the following over-the-counter medication:

☐ Tylenol 325mg 2 tablets/capsules every 4 hours	☐ Insect repellent that may contain DEET
☐ Ibuprofen 200mg 2 tablets/capsules every 4 hours	☐ Other, please specify:
☐ Sunscreen 15+ or higher	☐

Please describe any limitations, if any, to the above checked boxes:

Please list all medications currently prescribed to the person served:

Medication	Dispensed at Options?	Dosage	Frequency	Reason

I understand the following:

- I may refuse to authorize Options to administer medication or treatment and that Options will not administer the medication.
- This authorization will remain in effect unless withdrawn in writing and it may be withdrawn at any time.
- Options must notify the prescriber as expediently as possible if I refuse to authorize the administration of medication or treatment and any directives or orders given will be followed.
- A refusal to authorize the administration of a specific psychotropic medication is not grounds for service termination and does not constitute an emergency. A refusal to administer the psychotropic medication may not be overridden without a court order.
- This authorization will be obtained at service initiation before administering medications or treatments.
- This authorization will be re-obtained annually.

_____ _____
Person served and/or legal representative Date

ANNUAL PHYSICAL EXAMINATION DHF-001

Name:_____ Date: _____ **8/14**

Referred to (licensed health care professional): _____

DOB:_____ Allergies:_____ Diet:_____

Diagnoses:_____

_____

Current medications and doses: Purpose:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Current treatments: Purpose:

_____ _____

_____ _____

_____ _____

_____ _____

Health concerns:_____

_____

_____

Are there any medical or psychological contraindications to the use of staff implemented manual restraint to protect this person, when a person's conduct poses an imminent risk of physical harm to self or others and less restrictive strategies would not achieve safety? ☐ **Yes** ☐ **No**

If yes, what are they and are there any special adaptations or precautions staff may take to still use manual restraint in dangerous circumstances (list on next page)?

_____

EXAMINATION RESULTS:

The annual physical assessment is to include a physical examination, hearing and vision screening, CBC, urinalysis, chest x-ray or mantoux, pap smear, and a review of the medical treatment plan.

Height:_____ Weight:_____ Ideal Weight Range:_____

Temp.:_____ Pulse:_____ Blood Pressure:_____

Review of Systems: Optional

Skin:_____ Lymph Nodes:_____

Eyes: (R)_____ (L)_____ Ears: (R)_____ (L)_____

Nose:_____ Throat:_____ Mouth:_____

Neck:_____ Lungs:_____

Heart:_____ Breasts:_____

Abdomen:_____ Extremities:_____

Genito-Urinary:_____ Ano-Rectal:_____

Posture:_____ Gait:_____

Nervous System:_____

Fine Motor:_____ Gross Motor:_____

Note any physical abnormality:_____

Vision Screening: Results:_____

Is a more thorough vision exam recommended? ☐ Yes ☐ No

Hearing Screening: Results:_____

Is a more thorough audiology exam recommended? ☐ Yes ☐ No

Note any problems with speech and language:_____

Is referral to a speech/language therapist indicated? ☐ Yes ☐ No

Laboratory Data: Optional	**Date Administered**	**Notes/Results:** If test not administered, please list rationale
Cholesterol		
A1-C		
LFT		
CBC		
Urinalysis		
Mammogram		
Pap Smear		
Other_____		

Chest x-ray_____ or Mantoux given: _____ Location of Mantoux:_____
Date read:_____ Results:_____

Diphtheria-Tetanus shot given? ☐ Yes ☐ No Date of last Diphtheria-Tetanus shot: _____

I find this individual to be free of communicable disease: ☐ Yes ☐ No

General health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Summary of exam and diagnosis:_____

_____

_____

Treatment plan (new orders):_____

_____

Medications (new orders):_____

_____

Is individual capable of administering own medications? ☐ Yes ☐ No

Please Note:

1. All medications and treatments will be ordered for 1 year unless stop and start dates are indicated.
2. Your signature indicates you have reviewed these findings with the person/staff present.
3. Please provide instruction on when and to whom to report the following:
   a. Occurrence of adverse reactions to medications or treatments
   b. Medication not being administered or treatment performed as prescribed, whether by error of staff or refusal by the person
   c. Report to and when:

_____

_____

_____

_____

Physician signature: _____ Date: _____

Reviewed by: _____ Date: _____
Staff signature

Requirements of the Workforce Innovation & Opportunity Act (WIOA) for workers interested in attending Options Inc. Age 24 or younger:

WIOA is a federal law, enacted on July 22, 2016, intended to improve workforce development and training services for workers with disabilities. WIOA requires that all workers with disabilities complete various requirements that are designed to improve access to competitive, integrated employment including vocational rehabilitation and career counseling services **before** they begin to be employed at a special minimum wage.

~Youth 24 or younger who want to apply for **employment services** with Options Inc. must have completed these three requirements of the WIOA:

1)Transition Services under the Individuals with Disabilities Act (IDEA) and/or pre-employment services under WIOA
2)Vocational rehabilitation(VR) as follows
- a) The youth applied for VR services and was found ineligible OR
- b) The youth applied for VR services and was found eligible AND
  - i)had an Individualized plan for employment (IPE) AND
  - ii)worked toward an IPE employment outcome for a reasonable period without success AND
  - iii)the VR case was closed AND

3)Career counseling, including information and referrals to Federal and State programs and other resources in the employer's geographic area where received.

~If these three requirements are not met the youth 24 or younger will **not** engage in paid employment but would receive educational activities and experiences to strengthen the person's knowledge, interests and preferences for work. These educational activities will differ based on the person's needs stated in their Coordinated Services and Support Plan and may include orientation to work environment, work culture, safety in the work place, developing soft skills, employment education and support, career exploration, volunteer work experience, daily living and self-help skills, community participation and integration, and work place communication.

I have read the WIOA requirements and types of programs that Options Inc. is offering.
I am applying for (**choose one**):

☐ Paid employment with Options Inc. (I have met all 3 requirements of the WIOA and have documentation)

☐ Non-paid Day Support Services with Options Inc. (I have not met all 3 requirements of the WIOA but am in process)

☐ Non-paid Day Support Services with Options Inc. (I have not met all 3 requirements of the WIOA and refused to participate in VR services)

Individual: _____ Date: _____

Legal Representative: _____ Date: _____

Case Manager: _____ Date: _____