People Inc
Where your world opens up

Self-Directed Services Referral Form

Please return this form and all required documentation to **selfdirection@people-inc.org**

All Required Documentation noted on page 3 **must** be included before this form is reviewed. Intakes are processed based on availability in region. Please use the subject line: FI Intake, (County person lives)

About the Person

Full Name:	Date of Birth:
Address (Street, City, Zip):	
Email:	Primary Phone:

Current Living arrangement:
- ☐ Independent/Alone
- ☐ With Family or Friends
- ☐ Certified Setting: If selected, specify operating agency

Who is the Individual's Guardian?
- ☐ Parent(s) or Family Name(s):
- ☐ Self
- ☐ Other Name(s):

Demographic Information

Funders are increasingly requesting information from nonprofits and human service agencies regarding the demographics of staff, board members, and people we serve. Personally identifiable information will be kept confidential. Any demographics shared will be for reporting purposes only.

Race (choose all that apply):
- ☐ Alaskan Native
- ☐ Asian
- ☐ Black
- ☐ Caucasian
- ☐ Native American
- ☐ Pacific Islander
- ☐ Other:
- ☐ Declined to Specify

Ethnicity:
- ☐ Hispanic
- ☐ Non-Hispanic
- ☐ Other:
- ☐ Declined to Specify

Pronouns:
- ☐ Co/Cos
- ☐ E/Em/Eir
- ☐ En/Ens
- ☐ Ey/Em/Eir
- ☐ He/Him/His
- ☐ She/Her
- ☐ Sie/Hir
- ☐ Tey/Ter/Tem
- ☐ They/Them/Their
- ☐ Ve/Ver/Vis
- ☐ Xie/Hir
- ☐ Yo/Yos
- ☐ Ze/Zir
- ☐ Zie/Zim/Zir
- ☐ Declined to Specify

Gender Identity:
- ☐ Agender
- ☐ Androgynous
- ☐ Bi-Gendered
- ☐ Female
- ☐ Female-to-Male
- ☐ Gender Fluid
- ☐ Gender Queer
- ☐ Male
- ☐ Male-to-Female
- ☐ Non-Binary
- ☐ Pangender
- ☐ Third Sex
- ☐ Trans
- ☐ Transexual
- ☐ Transgender
- ☐ Transperson
- ☐ Declined to Specify

Primary Language: If Primary/secondary language is not English, please include that language here:

Diagnosis: Are there any new diagnosis that are not reflected in the life plan (If yes, please list those here):

Primary contact, if not the person seeking services	
Full Name:	Relation to Individual:
Current address (Street, City, Zip - *If different from Person's):*	
Email:	Phone:

Care Coordinator Contact	
Full Name:	Agency:
Email:	Phone:

Broker Contact	
Full Name:	Agency/Independent:
Email:	Phone:

1. **Does the person have an active self-directed budget?** ☐ YES ☐ NO
   - ➢ If yes, please provide the additional information below:
     1. Name of the Current FI Agency:
     2. Are they looking to switch FI agencies to People Inc.? ☐ YES ☐ NO
     3. Email of the Current FI:
        - ➢ If yes, why are they looking to transfer from their current FI?
        - ➢ What type of budget does the person have: ☐ Startup ☐ Full Budget
     4. Does the person have staff that work for another agency? ☐ YES ☐ NO

2. **Is anyone else in the person's family/household currently using People Inc. SD Services?** ☐ YES ☐ NO
   - If yes, please provide the name(s) of the family/household member:

3. **Does the person/family have access to a computer or smart phone?** ☐ YES ☐ NO
   NOTE: We use an electronic database for all reimbursement requests, staff timesheets, billing notes, expense reports, etc.

4. **Are they looking for self-hire staff?** *(Includes Respite, Community Habilitation, SEMP)* ☐ YES ☐ No
   - If yes, please answer the following:
     1. What services are they looking to self-hire? ☐ Community Hab. ☐ Respite ☐ SEMP
     2. Do they have staff identified? ☐ YES ☐ NO
     3. Do they require assistance with lifting and transferring? ☐ YES ☐ NO

5. **Has the person/family attended an OPWDD Self-Direction Information Session?** ☐ YES ☐ NO
   - Date of attendance:

6. **Are there any behavioral concerns we should know about** (*Are the behavior concerns outlined in the DDP2 accurate and can you elaborate those behavioral concerns)***?**

7. **Does the person need support with personal care or medical support?** ☐ YES ☐ NO
   - If yes, please describe the support needed

8. **Are there any legal issues/concerns we should be made aware of** *(ie. Parole, Probation, SOIRA, Community Restrictions)***?**

9. **Does the person currently have ISS Housing Subsidy?** ☐ YES ☐ NO
   - If yes, what agency is the provider of the subsidy:

List of Required Documentation: Items noted with a * need the family/Individual signature and must be returned to us for us to submit the startup/transfer budget request.
☐ Life Plan
☐ DDP2 *(Shows questions with answers selected)*
☐ NOD.01 (Notice of Decision – HCBS/Waiver)
☐ Letter of Guardianship *(if applicable)*
☐ LCED
☐ CR4/TABS Report/Individual Inquiry from Choices
☐ SD Authorization Letter or NOD.09
☐ Behavior Plan *(If applicable)*
☐ *Liability Notice/MOU
☐ *General Rights and Responsibilities
☐ *HIPPA, Notice of Privacy Practices

- We have responsibility for all payroll and personnel activities.
- We will review the service documentation that is completed by staff to ensure that the services are consistent with the individual's needs. We will submit claims for payment based on this documentation.
- We will maintain a record of service hours and report the rate of usage to the Manager of Services monthly. This information is also available in our electronic system for review at any time by the SD Participant/ Designee.
- If we find it necessary to discontinue this agreement, we will notify the SD Participant/Designee at least 30 days in advance. We will also be responsible for notifying the Care Coordinator/Manager and the DDRO at least 30 days in advance; and we will continue to be party to this agreement until the 30 day period is completed or until alternative arrangements begin, whichever is sooner.

The FI and SD Participant/Designee have read and agree to the responsibilities outlined in this Liability Notice/MOU. In addition, the FI and SD Participant/Designee agree to meet with the Circle of Support to resolve any issues that may arise. Failure to comply with these responsibilities may result in termination of this agreement and all SD supports and services.

Signed:

______________________________ Dated: ____________________
Fiscal Intermediary

______________________________ Dated: ____________________
Self Direction Participant/Designee

______________________________ Dated: ____________________
Additional Designee, if applicable

Affirmation of Receipt of Rights, PCP, HCBS and Right to Object

I have read (or been informed of) the above and understand and agree to the rights and responsibilities, rights to object and if I am receiving residential placement, I understand and consent to the terms of the above Occupancy Agreement. I have received a copy of the General Rights and Responsibilities, Occupancy Agreement and The Notice Of Right To Object and the process for resolution.

Person Receiving Services:

Printed Name: ____

Signature: ____

Date: ____

Representative (parent, guardian, advocate, correspondent):

Printed Name: ____

Signature: ____

Date: ____

Doc #1846212.1

INDIVIDUAL'S WRITTEN ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Name: ____

I acknowledge that I have received a copy of the Provider's Notice of Privacy Practices and have been advised of how the Provider [and the other named individuals and organizations listed in the Notice] will handle my Protected Health Information. I have also been advised of my rights to obtain access to and control my Protected Health Information. I understand that I may receive other notices which describe how the Provider will handle specialized forms of Protected Health Information such as HIV/AIDS-related, alcohol and drug abuse, and genetic information and psychotherapy notes.

SIGNATURE

I have received a copy of the Provider's Notice of Privacy Practices. I have had an opportunity to ask questions about the Notice and the use or disclosure of my Protected Health Information.

Signature of Individual or Personal Representative:_______________________________

Print Name of Individual or Personal Representative:______________________________

Description of Individual Representative's Authority:______________________________

Date:_________________________

CONTACT INFORMATION

Contact information of the personal representative who signed this form:

Address:____

____

____

Telephone: _______________________(Daytime) _______________________(Evening)

For Provider Use Only

Date Notice Provided __________________

Name of Staff Member______________________________Title_______________________

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Attachement A-3

Consent to Use and Disclose Protected Health Information for Treatment, Payment and Health Care Operations

Section A:

Individual Name: ______________________Individual ID Number: ________________

I authorize the use and disclosure of my Protected Health Information by the Provider listed below and by the Provider's staff and Business Associates for purposes of treatment, payment and health care operations.

Name of Provider Using and Disclosing the Information:

People Inc.
____

Provider's Address:

280 Spindrift Dr. | 1860 Buffalo Rd.

Williamsville, NY 14221 | Rochester, NY 14624

Section B: Important Information Regarding Consent:

1. I understand New York laws require my consent before the Provider may use or disclose my Protected Health Information for treatment, payment or health care operations.

2. I understand that this information may be used or disclosed by the Provider to:
   - Plan my care and treatment;
   - Communicate among various health care professionals who are involved in my care or treatment;
   - Obtain payment for care provided by the Provider or for the payment of activities of another health care provider or entity;
   - Provide information to my health insurance company or plan;
   - Obtain payment from my health insurance company or plan; and review the quality of my care.

3. I understand that my signature on the consent is required in order for me to receive care from the Provider and that the Provider may condition my

treatment on obtaining my consent for use and disclosure of my Protected Health Information for treatment, payment and health care operations.

4. I understand that further information on the Provider's uses and disclosures of my Protected Health Information for treatment, payment and health care operations is included in the Provider's Notice of Privacy Practices which I have received.

SIGNATURE

I have read and understand the terms of this consent. I have had an opportunity to ask questions about the disclosure of my Protected Health Information.

Signature of Individual or Personal Representative: ________________________________

Print Name of Individual or Personal Representative: ______________________________

Description of Personal Representative's Authority: _______________________________

Date: _______________________________

CONTACT INFORMATION

Address: ____
____
____

Telephone: ___________________(Daytime) ______________________(Evening)

For Provider Use Only

Date Provider Obtained Consent: _________________________

Name and Title of Person Obtaining Consent: ______________________________

Action Taken by Provider on Consent: ____
____
____

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Section C: Authorization Use of E-mail

I authorize the use or discloser of my protected health information ("PHI") by the provider via E - mail. The provider is authorized to use or disclose my PHI via E-mail to the following people at the following E-mail address:

Name (please print)	**E-mail** (please print)
1. Care Coordination Organization (CCO)	1. ______
2. Broker	2. ______
3. OPWDD/DDRO	3. ______
4. ______	4. ______
5. ______	5. ______

I have been informed that if the person(s) listed above is not a health care provider, a health plan, or a health plan clearinghouse that they may disclose the PHI without obtaining my permission. Furthermore, I recognize that once the PHI is disclosed to the person(s) listed above, the provider can not control further disclosures by the person(s).

I understand that once an email is sent over the internet, third-parties may gain access to the contents of the email regardless of the level of security used by the provider and that the provider does not have any control or authority over who has access to the above-named recipient's computer and the level of security used by the above-name recipients.

I hereby release, discharge, and agree to indemnify and hold harmless People Inc. and its directors, officers, agents, employees, volunteers, and administrators from any and all liabilities, claims, demands, losses, damages, or costs (including, but not limited to, attorneys' fees and litigation expenses) arising out of or relating to this Authorization that I or anyone acting on behalf of me or Individual shall make.

I understand that I may revoke and/or modify this authorization at any time by sending a written notice to People Inc. to the following: **Corporate Compliance Officer, People Inc., 1219 North Forest Road, Williamsville, NY 14221**. I understand that such revocation or modification will become effective on the date that People Inc. receives the revocation or modification and will have no effect on the uses and/or disclosures made prior to that date. I understand that I am under no obligation to sign this form, but if I do sign it, I must be provided a copy of the signed form.

This authorization will be effective until revoked or modified in writing in accordance with the above paragraph or until such date that Individual no longer receives any services from provider.

I have been informed that I am under no obligation to sign this Authorization and that the provider will not condition services or treatment on my decision to sign this form. I have signed this form voluntarily

I have had an opportunity to read and understand the contents of this Authorization, and my signature confirms that the Authorization accurately reflects my understandings and wishes.

Signature of Individual or Personal Representative ______ Date ______

Authority/Relationship of Personal Representative (if applicable)

______

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