Revised 2023

Admissions Packet

3595 Linecrest Rd. Ellenwood, GA 30294 | 770-469-4418 | (F) 770-469-4438

www.thesmartplace.org

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Adult & Children Services, Inc.
Helping You Help Those In Need

**Grievance Policy located in Welcome Bundle*

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AGREEMENT FOR SERVICE

NAME:_____

D.O.B.: _____ S.S.N.: _____

MEDICAID#: _____ Source of Payment: _____

If the client is accepted for services of this agency:

1. I/We agree to cooperate with the administration and staff of this agency in every way possible. I/We will see that this client attends the program regularly. I will participate in service planning and accept recommendations for the participant when at The Smart Place Day Support Center.

2. I/We agree to release this agency from any responsibility for property damage, illness, accidents, or injuries incurred by this participant at this facility, not due to negligence on the part of the staff/personnel.

3. I/We agree to allow this client to be transported to and from The Smart Place Day Support Center, and within the community with the understanding that this agency shall not be responsible for accidents or injuries, not due to negligence on the part of the staff/personnel.

4. I/We agree to allow this agency, at the expense of the undersigned, to institute emergency medical treatment through my family physician or other recognized medical resource. When possible, this agency shall contact the undersigned before such action. If an emergency arises, and the undersigned cannot be contacted, the staff of The Smart Place Day Support Center will proceed with emergency procedures.

5. I/We agree to permit the staff of this agency to obtain emergency medical transportation for this client at the expense of the undersigned.

6. I/We allow this agency to aid in the administration of psychological and other tests needed with the understanding that such information shall be kept strictly confidential and be used in developing an individualized service plan for this client.

7. I/We agree to permit the use of volunteers and university trainees to work with this client as part of this client's program at this agency. I understand that volunteers and/or student trainees may have access to client records after receiving training in confidentiality requirements by this agency.

8. I/We agree to provide a report of any medical changes of this client to The Smart Place Day Support Center.

9. I/We agree to make a separate application for the extended day services offered by this agency, if needed, understanding the approval for this service is at the discretion of the agency, according to the availability of space. I/We agree that the undersigned will provide transportation.

10. I/We agree to abide by the decisions of the administration of this agency upon the recommendation of the staff, in reference to the following

a. The suitability of the agency program for this client
b. The eligibility of this client for transfer to a program, service site or agency suited to his/her needs.
c. The transfer of this client to a more appropriate program when he/she has derived maximum benefits from the current program.

11. I/We agree to permit this client to participate in activities recommended by the staff.

12. I/We agree to furnish this agency with the limited items requested for this client's use at this agency.

13. I/We agree to communicate to The Smart Place Day Support Center verbally and/or in writing any client absences from the center. Absenteeism not due to illness/emergency requires written notification prior to absenteeism.

14. I/We agree to allow this client to be videotaped and/or photographed and the reproductions to be published for the express purpose of public enlightenment and awareness of Mental Disabilities and the services offered at The Smart Place.

Participant Signature Date

Authorized Representative Signature Date

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PARTICIPANT DEMOGRAPHIC PROFILE

NAME: _____

GOES BY: _____ LANGUAGE:_____

ADDRESS: _____

CITY/STATE/ZIP: _____ COUNTY:_____

D.O.B.: _____RACE:_____GENDER:_____

PHYSICIAN:_____ PHONE:_____

SSN:_____MEDICAID #:_____

PROVIDER/PARENT_____ PHONE:_____

EMAIL: _____

GUARDIANSHIP STATUS: _____

EMERGENCY CONTACT 2:_____ PHONE:_____

SUPPORT COORDINATOR:_____ PHONE:_____

DIAGNOSIS: _____

CHARACTERISTICS:_____

SUPERVISION:_____

WAIVER/FUNDING: _____

APPROVED BY: _____

PARENT/ PROVIDER
PERMISSION FOR EMERGENCY DROP OFF

PARTICIPANTS NAME: _____

PARENT/PROVIDER: _____

In case of emergency in which no one is present at the regular drop off location to receive my PARTICIPANT, I request that he/she be delivered to the following address:
(MUST BE WITHIN A 5 MILE RADIUS OF ORIGINAL DROP OFF ADDRESS)

Address:_____

_____

PERSON RESPONSIBLE:	
TELEPHONE NUMBER:	

(A) This person has agreed to receive my PARTICIPANT. I understand that this procedure is for emergencies only.

_____

PARENT / PROVIDER SIGNATURE DATE

(B) I give permission for my PARTICIPANT to be left at home alone. He/she has access to enter without assistance.

_____

PARENT / PROVIDER SIGNATURE DATE

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MEDICAL PROFILE

NAME: _____
D.O.B.: _____ HEIGHT: _____ WEIGHT: _____
PHYSICIAN: _____PHONE_____
HOSPITAL PREFERENCE: _____
CURRENT DIAGNOSIS: _____
PHYSICAL LIMITATIONS: _____
MENTAL HEALTH LIMITATIONS:_____
SPECIALIST:_____PHONE_____
SUPPORT SERVICES NEEDED: _____
ADVANCE DIRECTIVE IN PLACE: YES NO

MODE OF ADMINISTRATIONS: A =Self administration B =Needs supervision for self-administration C =Needs administrations by licensed professional

List Medication	Mode: CIRCLE	NOTES
	A B C	
	A B C	
	A B C	
	A B C	
	A B C	
	A B C	
DIET INSTRUCTIONS	**CIRCLE**	
Regular	Restrictions	Liquid Consistencies
Diet Instructions:		

Status:	**CIRCLE**	Needs	Needs	Needs	**CIRCLE**
Ambulating	Independent	Supervision	Assistance	Total Help	Bedridden
Bathing	Independent	Supervision	Assistance	Total Help	
Dressing	Independent	Supervision	Assistance	Total Help	
Eating	Independent	Supervision	Assistance	Total Help	Tube feeding
Grooming	Independent	Supervision	Assistance	Total Help	
Skin Integrity Location:	No sores	Stage 1	Stage 2	Stage 3	Stage 4
Toileting	Independent	Supervision	Hygiene Assistance	Total Help	
Transferring	Independent	Supervision	Assistance	Total Help	

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ALLERGIES

LIST ALL FOOD AND/OR DRUG ALLERGIES AND DESCRIBE REACTION:

ALLERGY	REACTION

DOES PARTICIPANT REQUIRE EMERGENCY HOSPITILIZATION/TREATMENT FROM ALLERGIC REATIONS? **YES** **NO**

SEIZURES

HAS YOUR PARTICIPANT EVER HAD SEIZURES? **YES** **NO**

DOES HE/SHE PRESENTLY HAVE SEIZURES? **YES** **NO**

FREQUENCY OF SEIZURE OCCURANCE:

DESCRIPTION OF USUAL SEIZURE?

HOW LONG DOES SEIZUE LAST?

WHEN DID HE/SHE LAST HAVE A SEIZURE?

CHECK BOX FOR ANY ILLNESS PARTICIPANT HAS HAD:	YES	NO
MENINGITIS		
TUBERCULOSIS		
OTHER [SPECIFY]:		
MAJOR MEDICAL PROBLEMS:	YES	NO
HEART DISEASE		
HIGH BLOOD PRESSURE		
KIDNEY DISEASE		
DIABETES		
HIV/AIDS		
OTHER [SPECIFY]:		
CHRONIC ILLNESS PARTICIPANT IS PRONE TO DEVELOP:	YES	NO
SEVERE ALLERGIES		
PNEUMONIA		
CONSTIPATION		
DIARRHEA		
MALNUTRITION		
OTHER [SPECIFY]:		

HOW MUCH HELP DOES HE/SHE NEED WITH SELF-CARE ACTIVITIES?

Please list any special problems or concerns about participants' health: i.e.: hygiene, safety, weight loss/gain, appetite increase/decrease, change in behavior or sleep patterns, skin sensitivities, incontinence care, adaptive equipment, ambulation concerns:

Authorized Representative Signature Date

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ANNUAL PHYSICAL EXAMINATION

Name: _____ Sex: Male / Female DOB: _____ Age: _____
Address: _____
Allergies: _____
Medical History (include all medical diagnosis and recent problems): _____
Vital Signs Temp: _____ Blood Pressure _____Pulse: _____ Respiration: _____
Ht: _____Wt: _____
Current Diet: _____Do you wish to change diet: Yes No **(If yes, please attach nutritional guidelines)**

Clinical Evaluation

Areas Evaluated	WNL	Abnormal Findings
Eyes		
Ears, Nose, Throat		
Dental		
Endocrine		
Respiratory		
GI Abnormal		
Cardiovascular		
Genito-Urinary		
Musculoskeletal		
Skin		
Neurological		
Sensorimotor		

HEALTH MAINTENCE (enter date , ✓ If done today, R for Refused Treatment, or WS for "will schedule")					
Labs	CBC	BMP	TSH	Lipid profile	TB
Preventative Healthcare		Last Dental Visit:_____		Last Vision Screening:_____ _	Last Hearing Test:_____
		Last Pap:_____		Last Mammogram :_____	Other:_____

TB Test **(must be done annually)**: Read on: _____ Results: _____
Rx written for:

Medication	Dosage	Frequency	Purpose

Physician Comments and Diagnosis: **Referral/Follow-Up: (with PT, OT, Audiology, Ophthalmology, etc.)**

Physician Signature: _____
Date: _____

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SPACS HEALTH POLICY

Participant's Name _____

If any participant experiences one of the following symptoms listed in the box below the parent/provider will be called immediately.

Individuals who present with symptoms, test positive, or are exposed to someone with COVID-19 should continue to follow all district-wide protocols and consistently and correctly wear masks to protect others as well as themselves.

Diarrhea *(illness or laxative induced)*, boils, extreme or increased coughing, excessive nasal drainage (*with or without discolored secretions*) or any possible contagious disease, conjunctivitis (pinkeye), vomiting, temperature of 100 degrees or more.

You will be expected to pick up the participant as soon as possible (within the hour), you may also need a doctor's excuse prior to returning him/her to the day support center.

Parent/Provider Name_____Number_____

Thank you in advance for your help in this very important matter.

The Smart Place Medical Staff

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Medical PRN

This form is to be completed annually during the annual physical examination.

CONSUMER'S NAME: _____ Home # _____

PARENT/GUARDIAN/CONSUMER'S SIGNATURE: _____

PHYSICIAN'S PRINTED NAME: _____ DATE: _____

PHYSICIAN'S SIGNATURE: _____

ALLERGIES: _____

DIAGNOSIS: _____

AUTHORIZATION	MEDICATION	INDICATION	DOSE
___yes____no	TYLENOL	fever, headache, menstrual cramps	325mg tablet 2 tablets every 4-6 hours PRN
___yes____no	MOTRIN	Fever, headache, toothache, menstrual cramps	200mg tablets' 2 tablets every 4-6 hours PRN
___yes____no	ROBITUSSIN	Cough, congestion, runny nose	1-2 teaspoons every 4-6 hours PRN
___yes____no	KAOPECTATE SOLUTION	Diarrhea	1-2 teaspoons every 4-6 hours PRN
___yes____no	MYLANTA LIQUID	Indigestion, stomach discomfort	1-2 teaspoons every 4-6 hours PRN
___yes____no	BENADRYL	Allergic reaction, allergies	25mg tablet; 1 tablet every 8 hours PRN
___yes____no	DRAMAMINE	Nausea, vomiting	50mg give 1 tablet every 4-6 hours PRN
___yes____no	TYLENOL EXTRA STRENGTH	Fever, headache, menstrual cramps	500mg (1 tab) 3-4 times daily X24hrs.

___yes____no	METAMUCIL	Stool softener, constipation prevention	1 tsp in 8 oz water 1-3 times/day X24 then 1-2 times/day
___yes____no	FIBER	Stool softener, constipation prevention	1 tsp in 8 oz water 1-3 times/day X24 then 1-2 times/day
__yes____no	MILK OF MAGNESIA	Laxative, severe constipation	2-4 tablespoons followed with 8 oz water q 3-4 days as needed. Do not give if abdominal pain, nausea, vomiting
___yes____no	CITRATE OF MAGNESIA	Laxative, severe constipation	½ 1 full bottle followed by 8 oz water q4-5 days as needed. Do not give if abdominal pain, nausea, vomiting
___yes____no	PEPTOL BISMOL	Nausea, common diarrhea	2 tablespoons. Repeat q30 minutes to 1 hour if needed up to 8 doses.
___yes____no	NEOSPORIN	Minor cuts and abrasions	Clean affected area well. Apply directed to affected area and cover with DSD/band aid as needed. May apply 2-5 times/day for no longer than 3 days.

Medical PRN

OTHER: __ _____ _____

_____ _____

_____ _____

_____ _____

Note:

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INFORMED CONSENT *(as adapted from DBHDD Informed Consent form)*

Agency THE SMART PLACE ADULT AND CHILDREN SERVICES, INC.

Name _____Guardian/Parent_____

It is your legal right to determine the extent of any treatment/procedure requiring the use of a Behavior Management Program. Experimental research or Psychotropic Medication (a drug intended to affect behavior or produce an altering effect on the mind). The information on this form will be explained to you and you are free to ask any questions you need to better understand the information presented. You have the right to refuse this treatment procedure. You can also change your mind to agree to this procedure anytime without retribution (unless court ordered).

I, _____ have been told of my need for the following:

_____ ISP/BSP with RESTRICTIVE PROCEDURE

Description of Restrictive Procedure:

_____

_____

_____

_____

_____ PSYCHTROPIC MEDICATION

Medication_____

Dosage/Frequency_____

Psychiatric Diagnosis (Specific to medication taken

_____

_____ EXPERIMENTAL RESEARCH?

Potential Discomforts: _____

Potential Risks: _____

Expected Benefits: _____

I have been offered a chance to ask all the questions I want and have had the questions answered. I understand that I may change my mind and withdraw my consent at any time. I also understand that I do not give my consent or if I choose to withdraw my consent, it will not prejudice future provision of appropriate services and supports.

Signature: _____ Date: _____

Guardian/Parent: _____ Date: _____

Psychiatrist: _____ Date: _____

All information on the informed consent has been read and explained to me. I understand I may withdraw consent anytime.

Signature: _____ Date: _____

Guardian(if applicable): _____ Date: _____

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HEALTH PROTOCOLS

This form is to be completed annually during the annual physical examination.

INDIVIDUAL NAME: _____

Location _____DATE _____

THIS FORM MUST BE SIGNED AND DATED BY THE PHYSICIAN TREATING THE ABOVE INDIVIDUAL.
IF NOT TREATING A LISTED CONDITION, CHECK NON-APPLICABLE AND SIGN AND DATE ACCORDINGLY.

DIABETIC INDIVIDUALS: NON-APPLICABLE: _____

CHECK BLOOD GLUCOSE LEVEL: _____ TIMES DAILY AND DOCUMENT

IF BLOOD GLUCOSE IS ABOVE: _____ CALL MD/RN/LPN

IF BLOOD GLUCOSE IS BELOW: _____ HOLD GLUCOSE MED AND CALL MD/RN/LPN

HYPERTENSIVE INDIVIDUALS: NON-APPLICABLE: _____

CHECK BLOOD PRESSURE: _____ TIMES PER DAY, WEEK or MONTH AND DOCUMENT

IF BLOOD PRESSURE IS ABOVE: _____ CALL MD/RN/LPN

IF BLOOD PRESSURE IS BELOW: _____ HOLD B/P MEDS AND CALL MD/RN/LPN

BOWEL MANAGEMENT TRACKING INDIVIDUALS: NON-APPLICABLE: _____

IF INDIVIDUAL HAS SIGNS AND/OR SYMPTOMS OF **CONSTIPATION**
LASTING MORE THAN _____ DAYS, GIVE _____
PER MD/RN/LPN DIRECTIONS AND DOCUMENT

IF INDIVIDUAL HAS SIGNS AND/OR SYMPTOMS OF **DIARREA**
LASTING MORE THAN _____ DAYS, GIVE _____
PER MD/RN/LPN DIRECTIONS AND DOCUMENT

SEIZURE DISORDER/HISTORY OF SEIZURE INDIVIDUALS: NON-APPLICABLE: _____
DOCUMENT AND REPORT ALL SEIZURES
IF SEIZURE LASTS_____ MINUTES OR LONGER CALL 911

HIGH CHOKE RISK INDIVIDUALS: NON-APPLICABLE _____

PRESCRIBED DIET: Chopped or Puree diet.

MEDICATIONS: PLEASE CHECK PREFERRED METHOD:

CRUSHED_____ WHOLE_____CAPSULES OPENED_____ SPRINKLED_____ LIQUID_____

TAKEN W/ FOOD_____ TYPE OF FOOD_____

PSYCHOTROPIC MEDICATION MONTIORING SIGNS AND SYMPTOMS OF TARDIVE DYSKINESIA OR MEDICATION TOXICITY: NON-APPLICABLE: _____

IF INDIVIDUAL IS TAKING A MEDICATIONS THAT WILL POTENTIALLY ALTER HIS OR HER TOXICITY LEVELS: Please specify medication in Box below.

AIMS TESTING REQUIRED_____ FREQUENCY _____

OBSERVE, REPORT AND DOCUMENT ANY SIGNS OF EXTRA PYRAMIDAL SYMPTOMS (EPS) SUCH AS TARDIVE DYSKINESIA, PSEUDO PARKINSON OR ACUTE DYSTONIA AKATHISIA

ADDITIONAL INSTUCTIONS REGARDING ANY PARAMETER PROTOCOL CARE?

NAME	SIGNATURE	TITLE	DATE

FREEDOM OF CHOICE FORM INSTRUCTIONS

PURPOSE:
The intent of this form is to assure that the recipient and their representative will be:

1. Informed of any alternatives available under the waiver and
2. Given the choice of either institutional or home/community-based services.

This process ensures that recipients and their representatives can make an informed choice concerning service options. The presumption of the law is that a person may consent for him/herself. The presumption should be abandoned only when it is evident that the individual is not capable of doing so. The very nature of a diagnosed condition of mental retardation confirms that the individual who is labeled mentally retarded lacks capacity. The recognized reality and trend in the law is that individuals with intellectual disabilities are often neither wholly competent nor wholly incompetent. The NOW/COMP Waiver Program has chosen to involve and recognize the rights of all recipients while at the same time protecting the rights of recipients through the request of concurrent consent by recipients' authorized representative.

Whoever is selected as authorized representative must meet the three tests for effect consent; that is, he/she must be competent, adequately informed about the factors involved in the decision and be knowledgeable about the person for whom consent is sought, and voluntary (free from coercion or conflict of interest). The authorized representative must act based on the best interests of the person for whom his/her consent is sought. A suggested list of potential candidates for authorized representatives includes but is not limited to the following: guardian or conservator, parent, recipient's spouse, adult child, adult next-of-kin, any responsible relative, and attorney(s). In the absence of an available, suitable candidate an advocate appointed by the Georgia Advocacy Office may serve as the designated representative.

PROCESS:

Step 1: Provide an overview of the choice between institutional and community service options, noting pros and cons related to each option; this includes inherent and potential risks, benefits, and stigmas.

A) The content of the overview should make one reasonable familiar with service options.

B) The presentation of information should be designed to match the recipient's and/or his/her representative's level of comprehension.

C) Evidence of recipient/representative understanding of information should be evidenced in discussion of same

Step 2: Review available qualified service coordination agency choices and choices of service coordinators within each agency.

Step 3: Provide an overview of the choice between available qualified direct service providers.

Step 4: Once information has been provided and appears to be understood, the Clinical Evaluation and Support Services Team Coordinator (or designee) should verify that information has been provided appropriately and is understood. Once verified, the form should be signed at the designated sign-off under verification statement.

Step 5: Informed recipient / representative chooses a service option. The informed recipient / representative should sign under the appropriate statement that reflects their choice. In cases where the individual recipient is a minor, and/or unable due to physical and/or mental causes to sign his/her name, and/or unable to legibly write his/her name, the recipient's name should be printed, above signature or mark, if any, and initialed by the recipient's authorized representative. A witness should sign verifying both the recipient's and authorized representative's signature witness may be the team coordinator or his/her authorized designer.

Step 6: Once the form is completed (signatures under appropriate statements), it should be attached to the Individualized Service Plan.

New Options Waiver Program and Comprehensive Supports Waiver Program

FREEDOM OF CHOICE

(Statement of Informed Consent)

As adapted from The Department of Behavioral Health and Developmental Disabilities

It is the policy of the State of Georgia that services are delivered in the least restrictive manner that addresses the service needs of the individual while enhancing the promotion of social integration. Further, it is the policy of the State to recognize the recipient's full citizenship and individual dignity; providing safeguards to protect rights, health, and the welfare of recipients.

Based on these beliefs the State of Georgia assures that potential recipients and their authorized representative(s) will be afforded an opportunity to make an informed choice concerning services and providers.

Once a recipient is determined to be likely to require the level of care provided in an SNF, ICF or ICF/ID the recipient and his/her authorized representative will be informed of any feasible alternative available under the waiver and given the choice of either institutional or home and community-based services. This choice of care is documented.

Recipients may request through the regional office that a different support coordinator be assigned. Recipients have the choice of qualified providers in all areas of care and may request a change in providers throughout the region.

The substance of the information provided will make one reasonably familiar with service options, provider options, their alternatives, and possible benefits and hazards, and the disclosure of said information is designed to be fully understood and appears to be fully understood.

Verification

I have verified that the recipient and his/her authorized representative have been informed about their choices in the manner outlined above. The recipient has received a copy of this signed form.

FREEDOM OF CHOICE SIGNATURE PAGE

_____
The Smart Place Adult and Children Services, INC.

_____
Date or Authorized Designee

Acceptance

I and/or my authorized representative have been informed of my choices and have chosen to accept the program and providers described in the attached Individualized Service Plan.

_____ _____
Recipient Date

_____ _____
Authorized Representative Date

_____ _____
Witness **Date**

Refusal

I and/or my authorized representative have been informed of my choices and have chosen to refuse waiver services.

_____ _____
Recipient Date

_____ _____
Authorized Representative Date

_____ _____
Witness Date

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PHOTOGRAPH AND MEDIA RELEASE

I hereby grant permission to the rights of my image, likeness and sound of my voice as recorded on audio or video tape without payment or any other consideration. I understand that my image may be edited, copied, exhibited, published, or distributed and waive the right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of my image or recording. I also understand that this material may be used in diverse settings within an unrestricted geographic area.

Photographic, audio/video recordings, or other media may be used for the following purposes, but not limited to:

- conference presentations
- educational presentations
- informational presentations
- marketing materials
- online website

By signing this release, I understand this permission signifies that photographic, video/audio recordings, or other media of me may be electronically displayed via the Internet or in the public setting.

There is no time limit on the validity of this release nor is there any geographic limitation on where these materials may be distributed.

By signing this form, I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I hereby release any and all claims against any person or organization utilizing this material for educational purposes.

Print Participant Name	Date
Parent/Guardian/Authorized Representative Signature	Date
The Smart Place Staff Signature	Date

ANNUAL ADMISSION DOCUMENT ACKNOWLEDGEMENT

- The Smart Place Adult and Children Services (SPACS) has a professional responsibility to ensure that participants served along with family members and providers have a clearly defined process of the required documentation for admission into our CAG or CRA services. This form serves as an annual acknowledgment of the company's processes in that regard. All documents will be maintained at The Smart Place at 3595 Linecrest Road, Ellenwood GA, where they will be confidentiality housed for a minimum of 5 years. An individual or family member may request copies of all obtained documents by written request for your records.

By placing my initials below, I acknowledge that I have reviewed and signed each of the following documents:

____Agreement for Services

____Medical Profile

____Annual Physical

____The Smart Place Health Policy

____Medical PRN

____Informed Consent

____Health Protocols/Plans

____Freedom of Choice

____Media Release Form

____HIPPA

____Human Rights

____Grievance Procedure

Individuals Name_____ Date_____

Signature of Individual_____ Date_____

Signature of Representative or Guardian_____ Date_____

Signature of SPACS Staff_____ Date_____