The Center
DAY PROGRAM INTAKE CHECKLIST

Name: ________________________________ Date of Birth ____________________

All documents should be submitted to Records Management within 5 working days prior to the entry date.

### PRE – ADMISSION DOCUMENTATION REQUIREMENTS

#### Internal Documents Required Before Starting

- Application for Services #145 (revised 04/2013)
- Admission Funding Data #151 (revised 09/2015)
- Emergency Information and Authorization #41
- Advanced Directives #45
- Notice of Privacy Practices Acknowledgment #110
- Rights Acknowledgment #111
- Medication Policy #06
- Seizure Classification #165 (if applicable)
- Admissions Medication History #18
- Physician’s Orders #08 (if applicable)
- DHS #3055 Physician’s Orders (if applicable)
- Physical Examination #04 (less than 1 year old)
- Copy of TB Test #76 (less than 1 year old)
- Copy of DPT/td #120 (less than 10 years old)

#### Additional Documents – if available

- Copy of Birth Certificate
- Copy of Texas Identification Card
- Copy of Social Security Card
- Copy of Medicaid Card
- Copy of Medicare Card
- Copy of HMO/PPO/Other Insurance Card
- Copy of SSI Award Letter

#### External Documents Required Before Starting

- Copy of Letter of Guardianship and Verification of annual renewal (if applicable)
- DMR – Determination of Mental Retardation or Psychological Evaluation (less than 10 years old)
- ICAP (if applicable)
- Full Body Photo
- Head and Chest Photo

### 30 DAY ASSESSMENT DOCUMENTATION REQUIREMENTS

#### A T E S

- 30 Day Person Directed Support Plan (#49 or #50)
- Team Identification #28 (if applicable)
- External Coordinator ID #131 (if applicable)
- Job Readiness Profile #87 (if applicable)
- Day Program Personal Skills Profile #107 (if applicable)
- Know Your Caseload #139
- Training Objective #25 (if applicable)
- Medication History Update #53 (if applicable)
- Physician’s Orders #08 (if applicable)

#### A A C

- DHS #3049 Health Assessment
- DHS #3050 Individual Service Plan
- DHS #3055 Physician’s Orders
- Team Identification #28
- Frequency Chart #38 (if applicable)
- Day Program Personal Skills Profile #107
- Know Your Caseload #139
- Nutritional Assessment #42 (if applicable)

### OTHER DOCUMENTS RECEIVED

- Other ____________________________ Other __________________________
- Other ____________________________ Other __________________________
THE CENTER
APPLICATION FOR SERVICES / ENROLLMENT FORM

GENERAL INFORMATION

DATE OF APPLICATION: __________________________

NAME OF APPLICANT: _________________________________________________________
Last Name    First Name    Middle Initial

PRESENT ADDRESS: Street Address: ____________________________________________
City: _____________________  State: _______   Zip: ____________

PHONE NUMBER: [Home] (____)________________   [Emergency] (____)_______________

EMERGENCY CONTACT: ________________________   RELATIONSHIP: _______________

DATE OF BIRTH: ______   AGE: _____   S/S #___________________   SEX: □ Male □ Female

MARITAL STATUS: □ Single □ Married □ Divorced □ Widowed

PRIMARY LANGUAGE: □ English □ Spanish □ Other, specify: _______________________

COMMUNICATION MODE: □ Verbal □ Gestures □ Vocalizations □ Sign Language

COMMUNICATION DEVICE(S): ________________________

RELIGION: _________________

HAIR: _______EYE: _______HEIGHT: _________WEIGHT: _______ETHNICITY: ________

CLIENT OR GUARDIAN ________________________________ DATE: ___________________

Signature

FOR OFFICE USE ONLY

PROGRAMS APPLYING FOR

□ AAC - West Dallas  □ Cullen - Assisted Living  □ Willow River Farm  □ HCS Foster Companion Care
□ ATES – Day Habilitation  □ Room #________  □ House #________  □ HCS Supervised Home Lvg
□ ATES - Vocational  □ Cullen - Independent Living  □ WRF-Assisted Living  □ HCS Residential Supervised
□ ATES – Young At Heart  □ Room #________  □ House #________  □ HCS Supported Living

FUNDING

□ Private Pay  □ TXHML  □ ICF/MR  □ The Center HCS
□ Medicaid MCO  □ Contract  □ Other HCS: ____________________________

DATE FUNDING VERIFIED by ADMISSIONS COORDINATOR: __________________________

ADMISSION DECISION

Date Applicant Informed of Decision: __________________________

□ Approved  □ Approved - Waiting List  □ Not Approved
Enter Date: _________  Entered on List: _________  Reason: __________________________

Assigned Program Coordinator: ________________________________ _________________________________

Signature of Social Worker  Signature of Dept. Director/Manager  Signature of Chief Operating Officer
THE CENTER
APPLICATION FOR SERVICES / ENROLLMENT FORM

NAME:____________________________ DOB: _______________ DATE: _______________

FAMILY/CONTACTS

NAME OF FATHER: ________________________________
Describe Contact: ________________________________________________
Address: _________________________________________________________
City: ___________________________ State: ___________ Zip: ___________
Phone: [Home] (____)______________ [Work] (____)____________________
Phone: [Cell] (____)______________ Email Address: ____________________

NAME OF MOTHER: ________________________________
Describe Contact: ________________________________________________
Address: _________________________________________________________
City: ___________________________ State: ___________ Zip: ___________
Phone: [Home] (____)______________ [Other/Emergency] (____)__________
Phone: [Cell] (____)______________ Email Address: ____________________

NAME OF EMERGENCY CONTACT: ________________________________
Relationship to Applicant: _________________________________________
Address: _________________________________________________________
City: ___________________________ State: ___________ Zip: ___________
Phone: [Home] (____)______________ [Other/Emergency] (____)__________
Phone: [Cell] (____)______________ Email Address: ____________________

NAME OF EMERGENCY CONTACT: ________________________________
Relationship to Applicant: _________________________________________
Address: _________________________________________________________
City: ___________________________ State: ___________ Zip: ___________
Phone: [Home] (____)______________ [Other/Emergency] (____)__________
Phone: [Cell] (____)______________ Email Address: ____________________
# THE CENTER

## APPLICATION FOR SERVICES / ENROLLMENT FORM

**NAME:** ______________________________  **DOB:** _______________  **DATE:** _______________

### BACKGROUND

**PLACE OF BIRTH:**
- City: ____________________
- County: ________________
- State: _______

**US CITIZENSHIP**
- Yes ☐
- No ☐

**LEGAL STATUS**
- Competent ☐
- Incapacitated ☐

*If has a court appointed Guardian:*
- Name of Guardian: ________________________________________________________
- Relationship to Applicant: _________________________________________________
- Address: ___________________________________________________________________
  - City: __________________________
  - State: ___________
  - Zip: _ ___________
- Phone:  [Home] (____)______________  [Other/Emergency] (_ ___)______________
  
**Date Appointed by Court:** ___________________  
**Court Case Number:** ________________

**County:** __________________________

### INSURANCE

**M E D I C A I D**
- Yes, Number (#): _______________________

**M E D I C A R E**
- Yes, Number (#): ____________________

- No, have applied and been denied ☐
- No, have never applied ☐

**H M O / P P O**
- Yes, Policy Number (#): __________________________
- Company Name: __________________________________________
- No ☐

**L I F E I N S U R A N C E**
- Yes, Policy Number (#): __________________________
- Company Name: __________________________________________
- No ☐

**B U R I A L I N S U R A N C E**
- Yes, Policy Number (#): __________________________
- Company Name: __________________________________________
- No ☐

### INCOME

**ESTIMATED ANNUAL INCOME OF APPLICANT:** ________________________________

**PRIMARY SOURCE OF INCOME:**  (check one)
- SSI ☐
- Wages ☐
- Other, specify: _________________________________________________
- No ☐

**OTHER MEANS OF FINANCIAL SUPPORT:** __________________________________

**DESCRIBE APPLICANT’S PARTICIPATION IN COMMUNITY/NEIGHBORHOOD:**
THE CENTER
APPLICATION FOR SERVICES / ENROLLMENT FORM

NAME:____________________________DOB: _______________DATE: _______________

_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________
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MOBILITY/SELF CARE

Mobility (check one)
☐ Walks Independently       ☐ Walks with Assistance from Others
☐ Uses Wheelchair Independently  ☐ Uses Wheelchair with Assistance from Others

Describe/List Any Adaptive Equipment Used for Mobility: ____________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________

Describe Assistance Needed to Get from One Place to Another: ________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________

Eats Meals Independently  ☐ Yes       ☐ No, please describe help needed: ________________________
_______________________________________________________________________________________

Bathes Independently   ☐ Yes       ☐ No, please describe help needed: ________________________
_______________________________________________________________________________________

Dresses Independently   ☐ Yes       ☐ No, please describe help needed: ________________________
_______________________________________________________________________________________
THE CENTER
APPLICATION FOR SERVICES / ENROLLMENT FORM

NAME: ____________________________ DOB: ___________ DATE: ___________

Uses Rest Room Independently  □ Yes  □ No, please describe help needed: ________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

Describe Any Other Assistance Needed/Comments: ________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

MEDICAL/HEALTH CARE

PRIMARY PHYSICIAN: ____________________________________________________________
Address: ____________________________________________________________
City: ____________________________ State: ___________ Zip: __________
Phone: [Office] (____)_____________________ [Fax] (____)________________________

KNOWN ALLERGIES (food, medication, other): ______________________________________
_________________________________________________________________________________

EXISTING MEDICAL CONDITIONS/DIAGNOSES: ___________________________________
_________________________________________________________________________________
_________________________________________________________________________________

SEIZURES  □ No  □ Yes, please explain: _____________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

HEARING IMPAIRMENT  □ No  □ Yes, please explain: ________________________________
_________________________________________________________________________________
_________________________________________________________________________________
THE CENTER
APPLICATION FOR SERVICES / ENROLLMENT FORM

NAME:____________________________ DOB: _______________ DATE: _______________

VISION IMPAIRMENT  □ No  □ Yes, please explain: ______________________________
__________________________________________________________________________
__________________________________________________________________________

ADAPTIVE EQUIPMENT/POSITIONING  □ No  □ Yes, please explain: __________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

TAKES MEDICATIONS INDEPENDENTLY  □ Yes  □ No, please explain: ______________ 
__________________________________________________________________________
__________________________________________________________________________

MEDICAL/HEALTH CARE

CURRENT MEDICATIONS

<table>
<thead>
<tr>
<th>Medication</th>
<th>Date Prescribed</th>
<th>Reason for Use</th>
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MEDICAL HISTORY  please list/describe hospitalizations and significant illnesses

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<tr>
<th>Date</th>
<th>List or Describe Hospitalization or Surgery or Illness</th>
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THE CENTER
APPLICATION FOR SERVICES / ENROLLMENT FORM

NAME:____________________________ DOB: _______________ DATE: _______________

ADDITIONAL COMMENTS RELATED TO MEDICAL/HEALTH CARE: ________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

FOR OFFICE USE ONLY
Advance Directive  □ No  □ Yes (attach copy)  DNR Order  □ No  □ Yes (attach copy)

INTERACTIONS

DESCRIBE HOW APPLICANT INTERACTS WITH OTHERS: ____________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

DESCRIBE BEST WAY TO INTERACT WITH THE APPLICANT: __________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

DESCRIBE THINGS THAT THE APPLICANT LIKES OR THAT MOTIVATE HIM/HER:
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
THE CENTER
APPLICATION FOR SERVICES / ENROLLMENT FORM

NAME:____________________________DOB: _______________DATE: _______________

DESCRIBE APPLICANT’S ABILITY TO MAKE CHOICES: ____________________________
_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________

DESCRIBE ANY SIGNIFICANT BEHAVIORS: ____________________________
_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________

EDUCATION/SERVICES/EMPLOYMENT

EDUCATION (schools attended)

<table>
<thead>
<tr>
<th>Name of School</th>
<th>City</th>
<th>State</th>
<th>Dates Attended From/To</th>
<th>Highest Grade Completed</th>
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</table>

CURRENT SERVICES (includes residential, vocational, job training, in-home care)

<table>
<thead>
<tr>
<th>Date Services Began</th>
<th>Type of Service(s)</th>
<th>Agency Providing the Service(s)</th>
<th>City</th>
<th>State</th>
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</table>
THE CENTER
APPLICATION FOR SERVICES / ENROLLMENT FORM

NAME:____________________________ DOB: _______________ DATE: _______________

PREVIOUS SERVICES  *(includes residential, vocational, job training, in-home care)*

<table>
<thead>
<tr>
<th>Dates of Service From/To</th>
<th>Type of Service(s)</th>
<th>Agency that Provided the Service(s)</th>
<th>City</th>
<th>State</th>
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</table>

CURRENT EMPLOYMENT

<table>
<thead>
<tr>
<th>Name of Employer</th>
<th>Job Title</th>
<th>Hire Date</th>
<th>Wage</th>
<th>Location</th>
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<tbody>
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</table>

PREVIOUS EMPLOYMENT

<table>
<thead>
<tr>
<th>Name of Employer</th>
<th>Job Title</th>
<th>Dates of Employment</th>
<th>Wage</th>
<th>Location</th>
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</table>

TRANSPORTATION

TRANSPORTATION *(check all that apply)*

- Uses City Bus/Cab Independently
- Uses Para Transit (Metro Lift)
- Family/Friends Provide Transportation
- Agency (group home) Provides Transportation
- Operates Own Vehicle (Car/Bike)
- Other, ________________________

Comments: __________________________________________________________

____________________________________________________________________
THE CENTER
APPLICATION FOR SERVICES / ENROLLMENT FORM

NAME:____________________________  DOB: _______________  DATE: _______________

Has the Applicant ever been Convicted (or adjudicated) of a public offense?  □ No  □ Yes
If yes, will the conviction interfere with the admission at The Center?  □ No  □ Yes
If yes, please explain: _____________________________________
_____________________________________________________________________
_____________________________________________________________________

Please submit documents requested on the Application for Services Documentation Checklist.
Your application will not be considered complete until all documents have been given to The Center’s Admissions Coordinator.
Please contact The Center’s Admissions Coordinator (713) 525-8318 with any questions or for assistance.

I agree that the information provided is, to the best of my ability, accurate and complete.

Applicant Signature                          Date                          Guardian Signature                          Date

Witness Signature                          Date
**THE CENTER**

**ADMISSION FUNDING DATA**

**NAME OF INDIVIDUAL:**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
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**PRESENT ADDRESS:**

<table>
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<tr>
<th>Street Address:</th>
<th>City:</th>
<th>State:</th>
<th>Zip:</th>
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**PHONE NUMBER:**

[Home] (____)____________ [Other/Emergency] (____)___________

**DATE OF BIRTH:** ________________  **GENDER:**  □ Male  □ Female

**SOCIAL SECURITY NUMBER:** ____________________________

<table>
<thead>
<tr>
<th>PROGRAM(S)</th>
<th>LOCATION CODE</th>
<th>ADMISSION DATE</th>
<th>FUNDING SOURCE(S)</th>
<th>FUNDING AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Activity Center</td>
<td>AAC</td>
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<tr>
<td>ATES - Caning</td>
<td>CAN</td>
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<tr>
<td>ATES - West Dallas Day Habilitation Classroom</td>
<td>DHC</td>
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<tr>
<td>ATES - West Dallas Day Habilitation Workshop</td>
<td>DHW</td>
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<tr>
<td>ATES - West Dallas Vocational Workshop</td>
<td>WDW</td>
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<td>ATES - Young At Heart</td>
<td>YAH</td>
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<tr>
<td>Cullen - Assisted Living</td>
<td>AL</td>
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<tr>
<td>Cullen - Independent Living</td>
<td>IL</td>
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<tr>
<td>Willow River Farm - Residential</td>
<td>WRF</td>
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<tr>
<td>Willow River Farm - Assisted Living</td>
<td>WRFAL</td>
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<tr>
<td>Willow River Farm – Day Habilitation</td>
<td>WRFDH</td>
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**INVOICE MAILING ADDRESS:**

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<th>Street Address:</th>
<th>City:</th>
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**COMMENTS:**

______________________________________________________________________________
______________________________________________________________________________
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**Signature of Program Director/Manager**

**Date**

**Signature of Admission Coordinator**

**Date**

_Send a copy to Accounting within 5 working days prior to entry date; original submitted with Intake Checklist to Records._
The Center

ADMISSION MEDICATION HISTORY

NAME:________________________________________ DATE OF BIRTH:_____________________

List any allergic reactions to medications:_____________________________________________________________

A. CURRENT MEDICATIONS:

<table>
<thead>
<tr>
<th>Name of Medication Presently Prescribed</th>
<th>Reason for Medication</th>
<th>Date Prescribed</th>
<th>Prescribing Doctor</th>
<th>No. of Times per Day</th>
<th>How Much Medicine Each Time</th>
<th>Where is Medication Taken</th>
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B. PAST MEDICATIONS

<table>
<thead>
<tr>
<th>Name of Medication Prescribed</th>
<th>Reason for Medication</th>
<th>Date Prescribed</th>
<th>Date Discontinued</th>
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SIGNATURE:_______________________________________  DATE:_____________________

(Individual / Parent / Guardian)
The Center

PROGRAM INFORMATION RECEIPT

Name of Individual: ________________________________ Date of Birth: ____________

Note check off all applicable handouts.

_______ Admission and Discharge Criteria Information
_______ Fee Policy and Fee Payment Agreement
_______ Adult Rights Handbook
_______ Notice of Privacy Practices
_______ Adult Activity Center Services Guide / Program Information
_______ Adult Training and Employment Services Guide / Program Information
_______ Resident’s Handbook
_______ Other: ___________________________________________

I have received a written copy of the above checked items. The items checked off have been explained to me in language that I can understand. I was given the opportunity to discuss and ask questions pertaining to the received copies. Any questions I had have been answered. I understand that I can ask more questions later if I need to.

Signature of Individual Served ________________________________ Date ______

Signature of Parent/Guardian ________________________________ Date ______
(Required if the individual is under age 18 or has a legal guardian.)

Signature of Witness ________________________________ Date ______
(Required if the signature of the individual served/parent/guardian is not legible.)
REPORT OF PHYSICAL EXAMINATION

NAME: ______________________________ DATE OF BIRTH: ____________ M _____ F _____

SECTION I - Condensed Medical History:

________________________________________________________________________________

________________________________________________________________________________

Known Allergies:

SECTION II - Medication Presently Prescribed and Reason for Use:

________________________________________________________________________________

________________________________________________________________________________

SECTION III - Results of Physical Examination:

HT: _______ WT: _______ PULSE RATE: _______________ BLOOD PRESSURE: _______________

NUTRITIONAL STATUS: ________ Good _________ Fair _________ Poor - Recommendations (DIET):

________________________________________________________________________________

EYES: ________ Normal ________ Abnormal - Comments: _________________________________

________________________________________________________________________________

Describe ability to see: _______________________________________________________________


EARS: ________ Normal ________ Abnormal - Comments: _________________________________

________________________________________________________________________________

Describe ability to hear: ______________________________________________________________

NOSE: __________________________________________________________

MOUTH: _____________________________________________________________

THROAT & NECK: ______________________________________________________

BREAST: _____________________________________________________________

THORAX & LUNGS: _______________________________________________________
NAME: _______________________________ DATE OF BIRTH: _______________

CIRCULATORY SYSTEM: Heart ________________________________

EXTREMITIES: ________________________________

ABDOMEN: ________________________________

HERNIAS: ________________________________

GENITO-URINARY-GYNECOLOGICAL & RECTAL: ________________________________

OSSEOUS & MUSCULAR SYSTEM: ________________________________

SKIN: ________________________________

NEUROLOGICAL: ________________________________

MENTAL STATUS: ________________________________

If on psychoactive medication, note any Side Effects and results of Assessment of Involuntary Movement:

HISTORY OF SEIZURES: No Yes, list type: ______________________________________________________

If on anticonvulsant medication, comment on any side-effects noted:

DIAGNOSTIC FINDINGS AND/OR IMPRESSIONS: ________________________________

Is this person free from communicable diseases? YES NO - If No, Explain: ________________________________

Is this person able to attend program without restrictions? YES NO - If No, Specify: ________________________________

OTHER EXAMINATIONS/LABORATORY TESTS NEEDED: ________________________________

(Forward results when completed)

FOR AGENCY USE ONLY:

Physician’s Signature

Reviewed by: ________________________________

Print or Type Physicians Name

Date: ________________________________

RESIDENTS ONLY:

Full Address and Telephone Number

The above results have been explained to me.

Date of Examination

Resident’s Signature
MEDICATION POLICY

The following items apply to all persons served receiving medications/treatments in any Center program:

1. A doctor’s order for the medication/treatment must be provided to The Center before the medication/treatment can be given. This includes:
   * all prescribed medications/treatments, routine or short term
   * over-the-counter medications/treatments

   Written doctors’ orders are required. A verbal order from the doctor taken by a nurse is acceptable so long as the nurse follows proper documentation procedures and obtains the physician’s original signature within 72 hours from when the order was taken. If needed, forms to give to the doctor are available from The Center staff.

2. All medications/treatments must be in pharmacy labeled containers. Samples of medications that a doctor may provide need to be in a container with the name of the medication, instructions for use, the prescribing doctor’s name and the date it was provided to you.

3. The label on the medication/treatment container must match the doctor’s order. If the label does not match, the medication/treatment will not be accepted or maintained. Only a pharmacist may change a label.

4. Medications/Treatments with worn, illegible, missing or altered labels will not be accepted or maintained. Additionally, medications/treatments that are outdated, expired, stopped or discontinued will not be accepted or maintained.

5. All medications/treatments will be administered by licensed/certified staff unless a doctor’s order is obtained authorizing a person served to take his/her medication under supervision or independently.

6. Doctor’s orders must be reviewed as follows:
   * routine prescription and over-the-counter medications/treatments must be renewed at least every 12 months
   * psychoactive medications must be renewed at least every 6 months
   * authorization for supervised administration of medication or self administration of medication without supervision must be renewed at least every 12 months
   * other orders should be renewed as needed, but at least every 12 months
   * orders to discontinue medication should be provided as needed

7. Each doctor’s order shall be explained to the person served/Guardian and/or Medical Power of Attorney in order to obtain consent for the medication/treatment.

8. The Center’s residential facility, Cullen Residence Hall, will provide transportation to client’s chosen physician as needed. It is expected that a Cullen resident will be taken care of based on the current medical guidelines, however if the family member (acting under a Medical Power of Attorney) or as Guardian refuses care, they will be asked to get their own physician or document this as The Center and its staff will not be held liable for any outcomes from their decision.

I have received a copy and had the above policy explained to me in a language, which I understand. I was offered a chance to discuss these topics, and any questions I had have been answered. I know that I can ask more questions later, if I need to.

___________________________________________________________
Signature of Person Served        Date

___________________________________________________________
Signature of Guardian         Date
(Required if the person served is under age 18 or has a legal guardian.)

___________________________________________________________
Signature of Staff Person Explaining the Form / Witness     Date
PHYSICIAN’S REQUEST FOR ADMINISTRATION OF MEDICATION

Name: ___________________________ Birth Date: ________________ Date: ________________

Diagnosis: ________________________________

Allergies: ________________________________

Reason for referral to physician: ________________________________

Diet: ________________________________

CURRENT ORDERS: Signature of physician indicates these orders are renewed unless discontinued in new order section below:

<table>
<thead>
<tr>
<th>Medication / Strength</th>
<th>Route</th>
<th>Directions</th>
<th>No. Units / Stop Order Date</th>
<th>Medication / Strength</th>
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NEW ORDERS: 1) Generic Equivalent approved for use on all legend and non-legend medications unless otherwise indicated. 2) Please indicate calendar-date stop order for each medication ordered. Medications for behavior management must, according to standards under which The Center operates, have a calendar date stop order of 30 days or less.

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<th>Medication / Strength</th>
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<th>Directions</th>
<th>No. Units / Stop Order Date</th>
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</table>

Activity Restrictions: ________________________________

TEST RESULTS: Please indicate any laboratory tests, x-rays, blood levels, etc. performed. You will be called for results if they are unavailable at time of this report (continue on reverse side if necessary): ________________________________

Return Appointment Date / Time: ________________________________

Physician’s Signature: ____________________________ Date: ________________

(Please print or type the Physician’s Name, Office Address & Telephone Number on the line below.)

Signature of Nurse Receiving Orders (LVN/RN) ____________________________ Date / Time ____________________________

This is your permission to administer the above medications, treatments, and/or procedures as requested by physician.

Signature of Individual / Guardian: ____________________________ Date: ________________
As part of our Admissions process, The Center requires all individuals enrolled in one or more of our programs to have a Td shot, which is a combination immunization providing immunity against tetanus and diphtheria for individuals 13 years and older.

Although not required, it is highly recommended that your Td immunization be updated every 10 years.

Please indicate date Td Immunization was given: ______________________________

Form must be signed by the Primary Care Physician or the Licensed Nurse who administered the immunization.

Primary Care Physician’s Name: ____________________________________________

Primary Care Physician’s Signature: ________________________________________

Date Signed: ____________________________________________________________

Licensed Nurse’s Name: _________________________________________________

Licensed Nurse’s Signature: _____________________________________________

Date Signed: ____________________________________________________________

Once the immunization has been recorded, please return the form to The Center / Admissions Department at 3550 West Dallas, Houston, Texas 77019.
THE CENTER

SEIZURE CLASSIFICATIONS

Individual Name: ______________________________ Date Of Birth: ______________________

Seizure Classification Number(s): ______________________________________________________

Please indicate above the number and/or numbers of the following that describe the seizure activity noted for the individual being classified.

SEIZURE TYPES:

I. GENERALIZED TONIC-CLONIC (formerly called Grand Mal)
   Characteristics: Sudden cry, fall, rigidity, followed by muscle jerks, shallow breathing or temporarily suspended breathing, bluish skin, possible loss of bladder or bowel control, usually lasts a couple of minutes. Normal breathing then starts again. There may be some confusion and/or fatigue, followed by return to full consciousness.

II. ABSENCE (formerly called Petit Mal)
    Characteristics: A blank stare, beginning and ending abruptly, lasting only a few seconds, most common in children. May be accompanied by rapid blinking, some chewing movements of the mouth. Child is unaware of what’s going on during the seizure, but quickly returns to full awareness once it has stopped. May result in learning difficulties if not recognized and treated.

III. SIMPLE PARTIAL
    Characteristics: Jerking may begin in one area of body, arm, leg, or face. Can’t be stopped, but patient stays awake and aware. Jerking may proceed from one area of the body to another, and sometimes spreads to become a convulsive seizure. Partial sensory seizures may not be obvious to an onlooker. Patient experiences a distorted environment. May see or hear things that aren’t there, may feel unexplained fear, sadness, anger, or joy. May have nausea, experience odd smells, and have a generally “funny” feeling in the stomach.

IV. COMPLEX PARTIAL (also called Psychomotor or Temporal Lobe)
    Characteristics: Usually starts with blank stare, followed by random activity. Person appears unaware of surroundings, may seem dazed and mumble. Unresponsive. Actions clumsy, not directed. May pick at clothing, pick up objects, try to take clothes off. May run, appear afraid. May struggle or flail at restraint. Once pattern established, same set of actions usually occur with each seizure. Lasts a few minutes, but post-seizure confusion can last substantially longer. No memory of what happened during the seizure period.

V. ATONIC SEIZURES (also called Drop Attacks)
   Characteristics: A child or adult suddenly collapses and falls. After 10 seconds to a minute he recovers, regains consciousness, and can stand and walk again.

VI. MYOCLOWIC SEIZURES
    Characteristics: Sudden brief, massive muscle jerks that may involve the whole body or parts of the body. May cause person to spill what they were holding or fall off a chair.

VII. INFANTILE SPASMS
    Characteristics: These are a cluster of quick, sudden movements that start between three months and two years of age. If a child is sitting up, the head will fall forward, and the arms will flex forward. If lying down, the knees will be drawn up, with arms and head flexed forward as if the baby is reaching for support.

VIII. UNCLASSIFIED

______________________________
Signature of Physician or Nurse

______________________________
Date
The Center

Advanced Directives
The Living Will and Durable Power Of Attorney For Healthcare

The Living Will (Or Directive to Physician)

The Living Will offers people a way to communicate their wishes about medical treatment at some time in the future when they are unable to make their wishes known because of illness or injury. This document is recognized in cases in which the patient has an irreversible condition (for example, permanent coma or incurable cancer) and is unable to communicate these wishes.

A Living will can include other directions about a patient's course of health care. A patient can even name another person to make health care decisions in the event they are unable to do so. The form requires two signatures and does not have to be notarized.

Durable Power of Attorney for Healthcare (DPAH)

The Durable Power of Attorney for Healthcare, or DPAH, is a document whereby a patient gives someone, (for example, a relative or close friend) the authority to make decisions about medical treatment on behalf of the patient in situations where the patient is unable to do so. The authorized person may also refuse medical treatment for the patient.

Unlike the Living Will, it is not necessary for a patient to have a terminal or irreversible illness for the DPAH to be effective.

Also the DPAH only applies to health care decisions. It does not authorize decisions or actions about a patient’s personal property or business affairs. A special form is required for a DPAH and it does not have to be notarized, but two adults, not related to the patient, are required to be witnesses.

The Center respects the client's right to accept or reject medical treatment. Whether a client has a Living Will or Durable Power of Attorney for Healthcare is the client's decision to make. But if the client has either or both of them, the Agency will do its best to follow client instructions. In any case, it is important that the client share their feelings with a physician or family member.

If you would like more information about the Living Will or the Durable Power of Attorney for Healthcare let your Social Worker or Service Coordinator know.

Clients at The Center are not required to have a Living Will or Durable Power of Attorney for Healthcare; but you have the right to give such advance directive should you chose to do so.

For more information ask a Social Worker or Service Coordinator or send a self-addressed stamped envelope to any of the following:

State Bar of Texas
P.O. Box 12487, Capitol Station
Austin, TX 78711

Choice in Dying
325 E. Oliver St.
Baltimore, MD 21202

Texas Medical Association
Attn: Living Will
401 West 15th Street
Austin, TX 78701

This is to certify that I have read or been informed of and understand my rights regarding access to records.

____________________________________________ __________________ __
Signature of Individual         Date

____________________________________________ __________________ __
Signature of Guardian         Date
(Required if the person served is under age 18 or has a legal guardian)

____________________________________________ __________________ __
Signature of Staff Person reviewing this information with the individual. Date

Name of Individual: ____________________________  Date of Birth: __________
The Center

ADVANCE DIRECTIVES REGARDING HEALTH CARE

Acknowledgement Statement

I have received information about my rights to accept or refuse treatment and my rights to make advance directives regarding my health care. I have also received information regarding Center policies and procedures for assuring those rights.

Please check “Have” or “Have Not” in the following statements:

A. ☐ I Have ☐ I Have Not
   Signed a Durable Power of Attorney for my health care decisions.

B. ☐ I Have ☐ I Have Not
   Signed a Living Will (Directives to Physicians).

C. ☐ I Have ☐ I Have Not
   Physician order for Out-of-Hospital DNR.

Please attach a copy if “Have” is checked.

Client/or Representative Signature ___________________________ Date __________

Signature of Staff Person reviewing this information with the individual. Date __________
Annual TB skin testing is recommended for all individuals served at The Center. Please provide your primary care physician with this form to have your skin test administered and/or read. Should the results of your skin test be positive, you are required to have a chest x-ray before you may return to The Center. Also, if you are a known positive reactor, you should have a chest x-ray every two years, or as often as recommended by your primary care physician.

Know the signs and symptoms of TB, which include but are not limited to: PRODUCTIVE AND PROLONGED COUGH, COUGHING UP BLOOD, FEVER, CHILLS, LOSS OF APPETITE, WEIGHT LOSS, FATIGUE/WEAKNESS, OR NIGHT SWEATS.

( ) ANNUAL SKIN TEST  ( ) CHEST X-RAY  ( ) EXEMPT

Once the TB test and/or Chest X-Ray have been read and the results recorded on this form, please return this form to The Center / Records Department at 3550 West Dallas, Houston, Texas 77019.

LICENSED NURSING STAFF ONLY:
DATE OF TEST: ____________  Lot #: ____________
SITE: LEFT ___  RIGHT ___  Expires: ____________
ADMINISTERED BY: ________________________________
DATE READ: _________  (Results of skin test must be read 48-72 hours after the test is administered.)
RESULTS:  POSITIVE ___  Millimeters  NEGATIVE ___
READ BY: ________________________________

LICENSED STAFF ONLY:
CHEST X-RAY RESULTS (if applicable)
DATE OF X-RAY: ____________  ADMINISTERED BY: ________________________________
RESULTS:  POSITIVE ___  NEGATIVE ___  READ BY: ________________________________
ACKNOWLEDGMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES
(45 CFR §164.520(c)(2)(ii))

Name of Individual: ___________________________ Date of Birth: ____________

This is to certify that I have received a copy of The Center’s Notice of Privacy Practices dated April 14, 2003, as required by the Health Information Portability & Accountability Act (HIPAA) - Administrative Simplification Standards of 2002.

I understand The Center reserves the right to change its Notice of Privacy Practices at any time. However, if a change is made copies of the new Notice will be available at each of The Center’s facilities and posted on its website www.thecenterhouston.org. In addition, I may contact The Center’s Privacy Officer should I have any questions concerning the contents of the Notice.

______________________________  ______________________
Signature of Individual Served  Date

______________________________  ______________________
Signature of Parent/Guardian  Date
(Required if the individual served is under age 18 or has a legal guardian.)

______________________________  ______________________
Signature of Witness  Date
(Required if the signature of the individual served/parent/guardian is not legible.)
The Center

EMERGENCY INFORMATION AND AUTHORIZATION

NAME ___________________________ Date Of Birth _______________ SSN _______________________

ADDRESS ___________________________ HOME PHONE _______________________

KNOWN ALLERGIES ___________________________

EXISTING MEDICAL CONDITIONS (such as seizures, diabetes, etc) ___________________________

PRIMARY CARE PHYSICIAN ___________________________ OFFICE PHONE ______________________

PRIMARY DENTIST ___________________________ OFFICE PHONE ______________________

HOSPITAL PREFERENCE ___________________________ PHONE ______________________

MENTAL HEALTH PROVIDER ___________________________ PHONE ______________________

PHARMACY PREFERENCE ___________________________ PHONE ______________________

FUNDING SOURCE: ___________________________ FUNDING SOURCE CASE #: ______________

(IF YOU DO NOT HAVE MEDICAID, AND/OR PRIMARY INSURANCE, PLEASE WRITE “NONE” IN THE APPROPRIATE BLANKS.)

PRIMARY INSURANCE ___________________________ POLICY HOLDER ______________________

POLICY # __________________ GROUP # __________________ PHONE # __________________

MEDICAID # ______________ MEDICARE # ______________ ADVANCE DIRECTIVE (on file) __ NO __ YES

GUARDIAN ___ NO ___ YES DURABLE POWER OF ATTORNEY FOR HEALTHCARE ___ NO ___ YES

(IF YOU CHECKED “YES” ON EITHER OF THE OPTIONS ABOVE, PLEASE COMPLETE BELOW.)

Name ___________________________ Home Phone ___________ Work Phone ___________ Cell Phone ___________

Address ___________________________ Relationship ___________ E-Mail ______________________

NAMES & TELEPHONE NUMBERS OF PEOPLE WHO MAY BE CALLED IN THE EVENT OF AN EMERGENCY:

Parents ___________________________ Home Phone ___________ Work Phone ___________ Cell Phone ___________

Address ___________________________ Relationship ___________ E-Mail ______________________

Name ___________________________ Home Phone ___________ Work Phone ___________ Cell Phone ___________

Address ___________________________ Relationship ___________ E-Mail ______________________

Name ___________________________ Home Phone ___________ Work Phone ___________ Cell Phone ___________

Address ___________________________ Relationship ___________ E-Mail ______________________

I hereby authorize a representative of The Center to render first aid and in the event of an emergency requiring immediate medical attention, to seek care through a physician or emergency room.

INDIVIDUAL’S SIGNATURE ___________________________ DATE ______________________

GUARDIAN’S SIGNATURE ___________________________ DATE ______________________

(If applicable.)

WITNESS’ SIGNATURE ___________________________ DATE ______________________

(Only when individual’s signature is illegible.)
The Center

RIGHTS ACKNOWLEDGMENT

Name of Individual: ___________________________ Date of Birth: ______________ 

Funding Source: ___________________________ Funding Source Case #: ______________ 

This is to certify that I have received a copy of, and have had explained, the ASSURANCE OF RIGHTS OF PERSONS SERVED. I have also received a copy of, and have had explained, the RIGHTS PROTECTION HANDBOOK, including information regarding the Rights Protection Office and The Center’s complaint and appeals processes. These rights, a description of how to exercise these rights and the responsibilities that come with the exercising of these rights have been explained to me in a language I can understand. I was offered a chance to discuss these rights, and any questions I had have been answered. I know that I can ask more questions later, if I need to.

Signature of Individual Served ___________________________ Date ______________ 

Signature of Guardian ___________________________ Date ______________ 
(required if the individual served has a legal guardian) 

Signature of Family Member, Advocate or Legal Representative ___________________________ Date ______________ 
(required if the individual served in under age 18) 

Signature of Witness ___________________________ Date ______________ 
(required if the signature of the individual served/parent/guardian is not legible) 

I have given the above named individual served a copy of his/her rights. I have also explained those rights in a language that he/she can understand. I have offered to answer, and have answered, any questions pertaining to this explanation of rights. I believe this to be a fair advisement of his/her rights.

Signature/Title of Person Giving Explanation ______________ Date ___________________________
ASSURANCE OF RIGHTS OF PERSONS SERVED

Rights of All People Receiving Intellectual & Developmental Disabilities Services

People receiving intellectual & developmental disabilities (IDD) services from IDD facilities and community centers have the following rights as required by the Persons with Intellectual & Developmental Disabilities Act of 1977 (Texas Civil Statutes, Article 5547-300), and by other state and federal laws and rules as noted:

(1) All rights, benefits, responsibilities, and privileges guaranteed by the constitutions and laws of the United States and Texas, except where lawfully restricted. These rights include the right to register and vote; the right to acquire, use, and dispose of property including contractual rights; the right to sue and to be sued; rights related to licenses, permits, and privileges and the law; the right to religious freedom.

(2) The right to protection from mistreatment, abuse, neglect, and exploitation.

(3) The right to live and receive services in the least restrictive setting appropriate to an person’s needs and abilities, and to be served in the least intrusive manner appropriate to his or her needs.

(4) The right to education.

(5) The right to equal opportunity in employment.

(6) The right to equal housing opportunities.

(7) The right to treatment and habilitative services.

(8) The right to a comprehensive diagnosis and evaluation, and the right to an administrative hearing to contest the findings of such a diagnosis and evaluation.

(9) The right to presumption of competence.

(10) The right to due process in guardianship proceedings and in admission to residential services.

(11) The right to fair compensation for labor.

(12) The right to be free from discrimination on the basis of handicap in employment or in the provision of or eligibility for services. Additionally, these programs or activities must be provided in facilities, which are accessible to and usable, by handicapped persons.

(13) The right to be informed about and participate in individualized treatment, training, and habilitation plans.

(14) The right to periodic review and reevaluation.
(15) The right to withdraw from voluntary mental retardation services.

(16) The right to be free from unnecessary and excessive medication.

(17) The right to give or withhold consent to treatment.

(18) The right to initiate a complaint and to know how to contact the facility or center’s Rights Protection Officer, the facility or center’s Public Responsibility Committee, and the Office of Client Services and Rights Protection, TDMHMR Central Office, phone 1-800-252-8154.

(19) The right to be informed of rights.

(20) The right to access his or her own medical records except where lawfully restricted such as, but not limited to, when contraindicated by the consumer’s interdisciplinary team.

(21) The right to confidentiality of records except where disclosure is authorized under the Persons with Mental Retardation Act of 1977 and Texas Civil Statutes, Article 5561(h).

(22) The right to an administrative hearing to contest a proposed or refused transfer or discharge, except when such discharge is on the basis that the person is not mentally retarded.

Rights of People Receiving Intellectual & Developmental Disabilities Residential Services

A. People receiving intellectual & development disabilities residential services have the following additional specific rights under the Persons with Intellectual & Developmental Disabilities Act of 1977 (Texas Civil Statutes, Article 5547-300):

(1) Right to due process in guardianship proceedings and in admission and to prompt, adequate, and necessary medical and dental care and treatment.

(2) Right to a normalized residential environment.

(3) Right to a humane physical environment.

(4) Right to communication and visits.

(5) Right to personal property.

B. The following rights must be provided to consumers receiving Title XIX funds in accordance with federal requirements for certification/licensure as a certified intermediate care facility for persons with intellectual & developmental disabilities (ICF-MR) (42 CFR 442.403-442.406). These rights shall also be provided to all other consumers receiving intellectual & developmental disabilities residential services. These are in addition to the rights outlined in the Persons with Intellectual & Developmental Disabilities Act of 1977 as noted above:

(1) The right to be informed, before or at the time of admission, of his or her rights and responsibilities, and of all rules governing resident conduct. If the policies on consumer rights, responsibilities, and rules governing conduct are amended, then each consumer must be informed at that time.
(2) The right to be informed in writing of all available services in the facility or center and of the charges for the services (including charges for services not included in other payment resources such as Medicaid). Consumers must receive information about available services and charges to them at the time of admission and on a continuing basis as changes occur while the consumer is receiving services.

(3) The right to be informed by the physician of his or her health or medical condition unless the physician decides that informing the consumer is medically contraindicated. If the consumer’s physician decides that informing the consumer of his or her health and medical condition is medically contraindicated, the physician shall document this decision in the consumer’s record.

(4) The right to participate in planning his or her total care and medical treatment.

(5) The right to give or withhold informed, written consent before participating in experimental research.

(6) The right to be transferred or discharged only for:

   (a) medical reasons;
   (b) the consumer’s welfare or that of other residents; or
   (c) nonpayment, except as prohibited by the Medicaid Program.

(7) The right to encouragement and assistance in exercising his or her rights as a services recipient, as applicable, and as a citizen.

(8) The right to submit complaints or recommendations concerning the policies or the procedures and services of the facility or center to the staff or to outside representatives of the consumer’s choice, or both. In so doing, the consumer shall be free from restraint, interference, coercion, discrimination, or reprisal.

(9) The right to be free from mental and physical abuse from the facility or center.

(10) The right to be free from chemical or physical restraints unless the restraints are in compliance with state and agency regulations.

(11) The right to be treated with consideration, respect, and full recognition of his or her dignity and individuality.

(12) The right to privacy during treatment and care of personal needs.

(13) The right to confidentiality of records, including information in an automated data bank. Each consumer must give written consent before a facility or center may release information from his or her records to someone not otherwise authorized by law to receive it.

(14) The right to privacy during visits by his or her spouse. If both husband and wife reside in the same facility or center, they must be permitted to share a room.
(15) The right to not be required to perform services for the facility or center.

(16) The right to communicate, associate and meet privately with people of the consumer’s choice, unless this infringes on the rights of another consumer. Any restrictions to this right require recommendation of the interdisciplinary team with justification documented in the consumer’s record. The restrictions must be reevaluated each time the plan of care and medical orders are reviewed or at the consumer’s request.

(17) The right to send and receive personal mail unopened.

(18) The right to participate in social, religious and community group activities unless the treatment team determines that these activities are contraindicated and the justification is documented in the consumer record.

(19) The right to retain and use his or her personal possessions and clothing as space permits within the facility or center. Personal possessions may only be restricted in accordance with TDMHMR rules and ICF/MR guidelines including, as appropriate, consent of the consumer and/or parent/legal guardian and/or approval by the Behavior Therapy and Human Rights Committees;

(20) The right to manage his or her personal financial affairs. If a consumer requests assistance from the facility or center in managing personal and financial affairs, the request must be made in writing and documented in the consumer’s record. The facility or center must allow each consumer to possess and use money in normal ways, or be learning to do so, and must comply with TDMHMR rules regarding same.

(21) The right to have unrestricted visits from attorneys.