The Arc
Montgomery County

We identify, create and sustain ***inclusive communities*** *that embrace and engage individuals and families affected by intellectual and developmental disabilities.*

We support children, youth, adults, seniors and families by providing child care, community living services, work skills training, employment, resources, advocacy and respite care.

Administration
Communications & Outreach, Finance, Human Resources & Staff Development, Information Technology, Quality Assurance, Resource Development
11600 Nebel Street
Rockville, MD 20852
301.984.5777 x1200

Children & Youth Services
AfterAll
4140 Wexford Drive
Kensington, MD 20895
301.984.5777 x3380

Children & Youth Services
KFICCC
10611 Tenbrook Drive
Silver Spring, MD 20901
301.984.5777 x3313

Family & Community Services
11600 Nebel Street
Rockville, MD 20852
301.984.5777 x1262

Family & Community Services
Respite
Suite 150, 11600 Nebel Street
Rockville, MD 20852
301.816.9647

Residential Services
11600 Nebel Street
Rockville, MD 20852
301.984.5777 x1326

Transitioning Youth Retail Project
11600 Nebel Street
Rockville, MD 20852
301.984.5777 x1226

Vocational & Day Services
603 Southlawn Lane
Rockville, MD 20850
301.984.5777 x2210

Urban Thrift
10730 Connecticut Avenue
Kensington, MD 20895
301.933.5666

TheArcMontgomeryCounty.org

Achieve with us.®

Dear Primary Caregiver,

Caregiving is a demanding job and you as a caregiver need occasional breaks ("respite") so you can tend to your own needs and the needs of other family members, and return to your caregiving duties refreshed. If you reside in Montgomery County and are an *unpaid, live-in, primary caregiver* for a child with intellectual/developmental disabilities, challenging behaviors, or functional disabilities (limited activities of daily living which require ongoing support), you may apply for respite care from The Arc Montgomery County.

Our respite services program can provide short-term relief for a few hours, a day, a weekend, or sometimes longer. However, respite care is not a substitute for ongoing child care, school or alternative child care. It's just a way to support families who take care of their loved ones at home. Families can choose from many respite care venues, including the family home, community and recreational programs, camps, and approved respite facilities.

Respite services is an income-based program that may provide a full or partial subsidy to pay a Respite Care Provider (RCP), but it is not an entitlement. Eligibility for a respite care subsidy is based on income and the Maryland Respite Care Services Fee Scale. The subsidy rate for respite care for children and youth age 17 and under is based on the household income, less approved out-of-pocket expenses.

To apply for respite services, complete the application and submit it by mail or secure (password protected) email to our office. If you have questions, please reach out to us directly.

Sincerely,

Julz Abate

Julia "Julz" Abate, Respite Administrator
Respite@arcmontmd.org
301.816.9647 or 301.984.5777

Application Checklist
Please include ALL documents as outlined below; without these documents, your application will be incomplete and cannot be processed.

- ☐ Complete Application for Respite Care Services (Children Age 17 and Under)
- ☐ Statement of Income & Out-of-Pocket Expenses (with required attachments)
- ☐ Physician's Health Form
- ☐ HIPAA Policy & Procedure Acknowledgement
- ☐ Current IEP/IFSP (if applicable; pages 1-2 only)
- ☐ Medicaid/Medical Assistance Card (if applicable)
- ☐ Behavior Plan, Seizure Protocol, and/or Allergen Protocol (if applicable)
- ☐ Current valid Maryland Driver's License or ID for Unpaid, Live-In Primary Caregiver(s) (must show current address; no change of address cards will be accepted)

The Arc
Montgomery County

APPLICATION FOR RESPITE CARE SERVICES

Children Ages 17 and Under with Intellectual, Developmental and/or Functional Disabilities or Challenging Behaviors

Updated 1/2017

A. Complete this section about the child with an intellectual/developmental/functional disability or behaviors.

Name: _____
First *Middle* *Last*

Street Address: _____

City: _____ State: _____ Zip: _____

Race: ☐ White ☐ Black/African American ☐ Asian
☐ American Indian/Alaska Native ☐ Native Hawaiian or Pacific Islander ☐ Two or more races

Ethnicity: ☐ Non-Hispanic or Latino ☐ Hispanic or Latino

Gender: ☐ Male ☐ Female Date of Birth: _____/_____/_____ (MM/DD/YYYY)

B. Complete this section about the unpaid primary caregivers (parent/guardian) of the person listed in Section A.

Parent/Guardian #1

Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____ Phone: _____

Race: ☐ White ☐ Black/African American ☐ Asian
☐ American Indian/Alaska Native ☐ Native Hawaiian or Pacific Islander ☐ Two or more races

Ethnicity: ☐ Non-Hispanic or Latino ☐ Hispanic or Latino

Gender: ☐ Male ☐ Female Date of Birth: _____/_____/_____ (MM/DD/YYYY)

Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

Parent/Guardian #2

Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____ Phone: _____

Race: ☐ White ☐ Black/African American ☐ Asian
☐ American Indian/Alaska Native ☐ Native Hawaiian or Pacific Islander ☐ Two or more races

Ethnicity: ☐ Non-Hispanic or Latino ☐ Hispanic or Latino

Gender: ☐ Male ☐ Female Date of Birth: _____/_____/_____ (MM/DD/YYYY)

Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

Child Custody: ☐ Joint ☐ Sole ☐ Other (explain): _____

Respite is funded primarily through a grant from the Montgomery County Department of Health and Human Services.

C. Complete this section about other people who live in the same household as the person listed in Section A.

Name *Relationship* *Date of Birth*

_____

_____

_____

_____

D. Provide an emergency contact in case the primary caregiver cannot be reached. Do not list primary caregiver!

Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Relationship to Person Listed in Section A? _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

E. Complete the following information about the person listed in Section A and his/her household environment.

Communication	
Is this person verbal?	☐ Yes ☐ No
What is this person's primary language?	
Does this person understand/speak English?	☐ Yes ☐ No
Does this person speak another language? If yes, which language?	☐ Yes ☐ No
Does this person use an alternate communication method (for example sign language, communication board or other adaptive communication device)? If yes, describe.	☐ Yes ☐ No
Does this person use hearing aids?	☐ Yes ☐ No
Household Environment	
Does this person smoke?	☐ Yes ☐ No
Does anyone else in the home smoke?	☐ Yes ☐ No
Are there pets in the home? If yes, what kind and how many?	☐ Yes ☐ No
Is the entrance to the residence fully handicapped accessible to this person?	☐ Yes ☐ No
Are all the areas of the residence which this individual uses fully handicapped accessible, including the bathroom?	☐ Yes ☐ No
Does this person need physical support to ensure his/her safety in navigating daily life activities?	☐ Yes ☐ No

Activities of Daily Living (provide additional details if needed)	*Manages Independently*	*Needs Supervision*	*Needs Assistance*	*Does Not Apply*
Bathing/Hair Care				
Shaving				
Skin Care				
Teeth Brushing				
Menstrual Care				
Toileting/Depends/Diapers				
Dressing				
Eating/Drinking				
Walking/Ambulating (uses cane, wheelchair or other support?)				
Stair Climbing				
Making Phone Calls				
Cooking/Meal Preparation				
Medication Administration				

Medical Information

Does this person have special dietary requirements or restrictions? ☐ Yes ☐ No
If yes, describe.

Does this person use oxygen? ☐ Yes ☐ No
If yes, describe.

Does this person wear a C-Pap or Bi-Pap while sleeping? ☐ Yes ☐ No

Does this person have a history of seizures? ☐ Yes ☐ No
If yes, describe the type and frequency, and provide a copy of the seizure protocol.

If yes, what is the date of the last seizure?

Does this person have allergies? ☐ Yes ☐ No
If yes, describe the allergen and reaction, and provide a copy of the allergen protocol.

Does this person use special or adaptive equipment? ☐ Yes ☐ No
(Include walker, wheelchair, assistive technology, hearing aids, etc.) If yes, describe.

Does this person require transferring by a support person or support staff? ☐ Yes ☐ No

Has this person been hospitalized in the last year? ☐ Yes ☐ No
If yes, describe the reason(s) for hospitalization and/or the situation which required hospitalization.

Behavior Information
Does this person have a behavior plan? ☐ Yes ☐ No
If yes, provide a copy of the plan.
Does this person exhibit behaviors that endanger himself/herself or other people? ☐ Yes ☐ No If yes, describe behaviors.
Has this person attempted suicide in the last year? ☐ Yes ☐ No If yes, provide date(s) and details.

Behaviors Exhibited	*Yes*	*No*	*Frequency*	*Additional Description*
Yelling/Shouting/Screaming				
Biting				
Hitting				
Scratching				
Pinching				
Pushing				
Hair pulling				
Spitting				
Throwing/ Breaking Objects				
Pica				
Body Slamming				
Bullying/Intimidation				
Theft				
Fearfulness				
Restlessness				
Pacing				
Wandering/Elopement/Night Walking				
Aggression				
Self-Injurious Behavior				
Forgetfulness (especially showering/eating)				
Inappropriate Sexual Behavior				

Please Indicate Person's Overall Support Level	**Minimal** (needs little supervision)	**Moderate**	**Extensive** (needs close supervision)

F. Complete the following information about other support services provided to the person listed in Section A.

Out of Home Support (Child Care/School)

Does this person attend a child care or school program? ☐ Yes ☐ No
If yes, provide the following information.

Days Attending and Number of Hours Each Day *(mark all)* : ☐ Saturday _____ ☐ Sunday _____

☐ Monday _____ ☐ Tuesday _____ ☐ Wednesday _____ ☐ Thursday _____ ☐ Friday _____

Child Care/School Name: _____

Mailing Address: _____

Contact Person: _____ Phone: _____

Contact Email: _____

Does this person receive 1:1 support in a child care or school program? ☐ Yes ☐ No

In Home Services or Programs (Personal Support/Personal Care Attendant/Nursing)

Does this person receive additional support services (including those provided at home)? ☐ Yes ☐ No
If yes, provide the following information.

Days Receiving Support and Number of Hours Each Day *(mark all)* : ☐ Saturday _____ ☐ Sunday _____

☐ Monday _____ ☐ Tuesday _____ ☐ Wednesday _____ ☐ Thursday _____ ☐ Friday _____

Agency Name: _____

Mailing Address: _____

Contact Person: _____ Phone: _____

Contact Email: _____

Coordination of Community Services/Case Management (REM/New Directions/Community Pathway/CFC/Community Options, Etc.)

Do you work with a Coordinator of Community Services or Case Manager? ☐ Yes ☐ No
If yes, provide the following information.

Agency Name: _____

Mailing Address: _____

Contact Person: _____ Phone: _____

Contact Email: _____

Additional Supports
Are there any other federal, state or county agencies not listed above that are helping to support your, or are you on any kind of waiting list for additional services (MCITP, My Turn, LISS, LEAP, etc.)? If yes, please provide all relevant information.

G. Please describe any additional family information that impacts your needs.

H. What is your written plan in the event of an emergency that requires this child to be evacuated from the home? How are physical restrictions accommodated during evacuation? Note: This plan must also be posted in the home.

Certification of Acknowledgement and Understanding

The following statements include:

1) information how the respite services program operates;
2) information about how, when and where respite care services are delivered,
3) your duties and obligations with regard to the respite services program;
4) your affirmation that you are not receiving payment to support the person listed in Section A; and
5) your consent to release information for the purpose of determining eligibility for respite services.

Please read each statement carefully, then initial beside each statement to indicate your understanding and acknowledgement. Then sign and date the application where indicated.

Caregiver Initials:

I have attached all necessary supporting documents to this application. I understand that if the supporting documents are not attached, my application will not be processed and will be returned to me by email or US mail. I understand there is no guarantee that respite services will be provided to me simply because I have submitted this application. I understand that I must submit a new application with supporting documents annually (12 months after approval), and that all supporting documents must be current or updated. I have made a copy of my application and supporting documents for my own records.

Caregiver Initials:

I understand that respite care is designed to give the live-in, unpaid primary caregiver short-term relief. It is not a substitute for ongoing child care. I understand that respite care cannot be used for regular, long-term or continuing care, or to allow the live-in, unpaid primary caregiver to go to work. I understand that, as the live-in, unpaid primary caregiver, I cannot be paid by an agency or vendor while receiving respite services and that I cannot be a respite provider to another family in the respite program.

Caregiver Initials:

I understand that respite services operated by The Arc Montgomery County is not an entitlement program and does not guarantee benefits to a particular group or segment of the population. I understand that respite care is based upon eligibility for respite services subsidies and dependent on income and other criteria, and that eligibility will result in respite care hours, not financial assistance.

Caregiver Initials:

I understand that eligibility for a subsidy does not guarantee respite funds for each occasion, because there is limited funding available. I understand that The Arc Montgomery County has limited funding available, therefore respite care cannot be used with the following waiver/grant funding in the same 24/hour period:

- Personal Supports through DDA under the Community Pathway waiver or New Directions;
- In-home support/personal care/nursing under any Medicaid waiver (REM, Community Options, Traumatic Brain Injury, Community First Choice, etc.);
- Any program or services paid for by Montgomery County or the State of Maryland, including full or partial payments for camp, therapeutic programs, LISS or LEAP.

Caregiver Initials:

I understand that respite care cannot be used in lieu of any child care, school or alternative child care program, including days/times when those programs are closed. I understand that I cannot receive respite care while the person listed in section A is in a hospital, rehabilitation center, or residential program.

Caregiver Initials:

I understand that respite care is limited to 10 hours per day in the home (between 6 am and midnight only) or at a therapeutic program and that respite providers will not be paid by The Arc Montgomery County for more than 10 hours per day. I understand that in-home respite care is limited to a total of 40 hours per month.

Caregiver Initials:

I understand that overnight respite care must be provided at an approved respite care facility. Respite hours used at an approved respite care facility are limited to a maximum of 164 hours per fiscal year.

Caregiver Initials:	I understand that only the approved respite facilities, therapeutic programs and in-home support providers on The Arc Montgomery County consortium list may be utilized when payment is authorized through respite care subsidies. If I choose to utilize a respite care provider not on this list, I am personally responsible for any and all payments to that respite care provider. I understand that the approved list of consortium members for The Arc Montgomery County changes frequently, and that I may be required to change respite care providers as a result of changes to this list.
Caregiver Initials:	I understand that respite services has two levels of care (Level I and Level II), and that the information provided on the Physician's Health Form determines the level of care required.
Caregiver Initials:	I understand that if I select a respite care provider for Level I care who is not on The Arc Montgomery County consortium list (i.e. family members, relatives, friends), this respite care provider may not have all the experience, skills, abilities and necessary trainings, certificates and licenses to deliver respite care to my family member. I assume full responsibility for my choice of respite care provider.
Caregiver Initials:	I understand that in-home Level II respite care must be provided by a licensed health care practitioner, such as a Licensed Practical Nurse (LPN) or Registered Nurse (RN).
Caregiver Initials:	I understand that I must obtain an authorization form from The Arc Montgomery County prior to any respite occasion, and that failure to follow this procedure will compromise the payment to the respite provider. If this happens, I will be liable for payment to the respite provider. I also understand that I will be responsible for payment to the respite care provider for any hours worked beyond what is approved and allowed by The Arc Montgomery County.
Caregiver Initials:	I understand that changes to the respite program may occasionally occur based upon state, county and agency requirements, and I agree to comply with those changes or withdraw or cancel my application. I understand that all respite applications are subject to audit, with changes in status or approval based upon audit findings.
Caregiver Initials:	**I affirm that as the unpaid, live-in, primary caregiver(s), I do not work for or receive payments (including foster parent payments) from any agency, company or organization that pays me to support the person listed in section A of this application.**

This application provides information about your eligibility for respite care services and benefits. These benefits are provided at public expense and you must provide true, accurate information. This information may be verified with public and private agencies and businesses. You must report any changes to the information provided on this form within 10 days of the change. If you knowingly give false information, impersonate another person, or willfully fail to report changes, you will be subject to disqualification and denial of services.

Consent to release information: By signing below, I hereby authorize the Montgomery County Department of Health and Human Services and The Arc Montgomery County to contact, review and obtain records maintained by any person, partnership, corporation, association or governmental agency for the purpose of establishing proof of my eligibility for respite care benefits. A photocopy of this form is as valid as the original.

_____ _____

Signature of Unpaid, Live-In, Primary Caregiver Date

_____ _____

Signature of Unpaid, Live-In, Primary Caregiver Date

If you need assistance completing this application, please call our office at 301.816.9647.

The Arc
Montgomery County

STATEMENT OF INCOME & OUT-OF-POCKET EXPENSES

Children Ages 17 and Under with Intellectual, Developmental and/or Functional Disabilities or Challenging Behaviors

Updated 1//2017

Please print clearly.

Child's Name: _____
First *Middle* *Last*

Household Income: Proof of all combined household income is required.

Please attach all documents which apply and check the box to indicate the documents are attached.

Source of Income	*Document Attached*
SSI, SSDI, Social Security for CHILD	☐
SSI, SSDI, Social Security for PRIMARY CAREGIVER(S)	☐
Earned Income for Primary Caregiver(s)	☐
Child Support Payments	☐
HOC Voucher Payments	☐
Temporary Cash Assistance Payments	☐
Income or Income Support for Other Household Members	☐
Other Income or Income Support	☐

Out-of-Pocket Expenses: Proof of all out-of-pocket expenses is required.

Please attach all documents which apply and check the box to indicate the documents are attached.

Out-of-pocket expenses include medical co-payments, prescriptions, physical and occupational therapy, psychiatry or individual therapy, dietary items deemed necessary for medical conditions, adaptive equipment, and incontinence supplies. Out-of-pocket items must be recurring and deemed medically necessary by a healthcare professional. Account statements are not acceptable proof.

The following are **not eligible** as out-of-pocket expenses: duplicate services, expenses paid by state and county government, child care fees, groceries, utilities, transportation and group therapy.

Source of Out-of-Pocket Expenses	*Monthly Amount*	*Document Attached*
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐

_____ _____
Signature of Unpaid, Live-In, Primary Caregiver(s) Date

FOR RESPITE SERVICES USE ONLY

Total Household Income	$_____	Total Net Income	$_____
Total Out-of-Pocket Expenses	$_____	Approved Subsidy	$_____

Respite is funded primarily through a grant from the Montgomery County Department of Health and Human Services.

The Arc
Montgomery County

PHYSICIAN'S HEALTH FORM

Must be completed and signed by a licensed physician

Updated 1//2017

Please print clearly; use additional paper if needed.

Patient's Name: _____
First *Middle* *Last*

Date of Birth: _____/_____/_____ (MM/DD/YY) Height: _____ Weight: _____

Date of TB Screening: _____/_____/_____ (MM/DD/YY) Skin Test Result: _____ X-ray Result: _____

1. Primary Diagnosis (please check all that apply).

☐ Autism
☐ Allergies
☐ Behavioral problems
☐ Blindness/Severe visual impairment
☐ Cancer
☐ Cerebral Palsy
☐ Cystic Fibrosis
☐ Deafness/Severe hearing impairment
☐ Dementia/Alzheimer's Disease
☐ Diabetes
☐ Epilepsy/Seizure disorder
☐ Head injury
☐ Heart Conditions
☐ Intellectual/Developmental Disability
☐ Lupus
☐ Mental illness
☐ Multiple Sclerosis
☐ Neurological impairment
☐ Parkinson's Disease
☐ Seizures
☐ Sickle Cell
☐ Speech/Language impairment
☐ Spinal Bifida
☐ Spinal cord injury
☐ Stroke
☐ Other _____
☐ Other _____

2. Does the patient require skilled care that should be delivered by a skilled health care professional (such as medication administration, G-tube feeding, injections, catheter care, etc.)? ☐ Yes ☐ No

If yes, provide details. _____

_____

3. Please list any and all medications prescribed to patient.

_____

_____

4. Please list any and all dietary modifications required for patient.

_____

_____

5. Please provide details and treatment protocols for allergens and seizures.

_____

_____

_____ _____
Signature of Physician or Other Licensed Health Care Practitioner Date
Include Physician's or LHCP's Stamp with Address

Respite is funded primarily through a grant from the Montgomery County Department of Health and Human Services.

The Arc
Montgomery County

HIPAA POLICY & PROCEDURE ACKNOWLEDGEMENT

For People Receiving Respite Services

Updated 1//2017

The Arc Montgomery County Summary of Notice of Privacy Practices

This notice describes how protected health information (PHI) about you may be used and disclosed and how you can get access to this information. Please review it carefully.

- The collection, use and disclosure of protected health information is protected by law. The Arc Montgomery County maintains physical, electronic, and procedural safeguards that comply with federal standards to protect personal health information.
- The Arc Montgomery County discloses protected health information for the purposes of treatment, payment, and health care operations, and, when required to do so, by law or regulation.
- People receiving services from The Arc Montgomery County have a right to request access to their records.
- People receiving services from The Arc Montgomery County have a right to know to whom their protected health information was disclosed.
- People receiving services from The Arc Montgomery County have a right to review a detailed copy of The Arc Montgomery County's Notice of Privacy Practices.
- Any questions regarding The Arc Montgomery County's privacy practices should be directed to the Director of Quality Assurance, who acts as The Arc Montgomery County's designated privacy officer. Any questions regarding the electronic storage and transmission of protected health information should be directed to the Director of Information Technology, who acts as The Arc Montgomery County's designated security officer.

I have received a copy of The Arc Montgomery County's Notice of Privacy Practices on HIPAA (Health Information Portability and Accountability Act) regulations, and I have read the summary notice above. I understand that I am fully responsible for complying with these policies, practices and regulations. I also understand that it is my responsibility to seek clarification should I require further explanation.

Individual's Printed Name: _____

Individual's Signature: _____

Parent/Guardian Signature: _____
If applicable; required for children under age 18 or individuals subject to guardianship.

Telephone: _____

Street Address: _____

City, State, Zip Code: _____

Date: _____

Respite Services is funded primarily through a grant from the Montgomery County Department of Health and Human Services.

Keep this page for your records!

THE ARC MONTGOMERY COUNTY NOTICE OF PRIVACY PRACTICES
For People Receiving Respite Services

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION MAY BE USED AND DISCLOSED BY THE ARC MONTGOMERY COUNTY AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

Guarding Protected Health Information for People Receiving Services

The Arc Montgomery County is committed to protecting the health information of people receiving services. In order to provide treatment or pay for health care, or for other purposes listed below, The Arc Montgomery County may ask for certain health information and that health information will be put into the record of the person receiving services. The record may contain symptoms, examination and health results, diagnoses, treatment, Individual Plans and Personal Assistance (behavior management) information for the person. That information, referred to as medical records for the person, and legally regulated as health information, may be used for a variety of purposes, as listed below.

The Arc Montgomery County is required to follow the practices described in this Notice of Privacy Practices, although The Arc Montgomery County reserves the right to change our privacy practices described in this Notice at any time. A copy of the new notice may be requested at any time from The Arc Montgomery County privacy officer, 11600 Nebel Street, Rockville, MD 20852, 301.984.5777 x1250.

KEEP THIS PAGE FOR YOUR RECORDS

How The Arc Montgomery County May Use and Disclose Protected Health Information for People Receiving Services

The Arc Montgomery County discloses protected health information (PHI) of people receiving services for the purposes of treatment, payment, and health care operations, and when required to do so by law or regulation.

Treatment

The Arc Montgomery County shares PHI with all members of the interdisciplinary team and medical services providers for the person. We share PHI with other services providers as identified in the Individual Plan (IP), Individual Education Plan (IEP), and/or Individual Family Service Plan (IFSP).

Payment

The Arc Montgomery County shares PHI with organizations that provide payment for services received by the person, including insurance companies and state and county government.

Health Care Operations

The Arc Montgomery County shares PHI with state and county regulatory bodies, accrediting agencies, organizations that provide payroll services to The Arc Montgomery County, support groups associated with the agency, and other agencies necessary for the day to day operations of The Arc Montgomery County.

Regulation and Law Enforcement

The Arc Montgomery County shares PHI with public health agencies, courts, legal counsel to the agency, law enforcement agencies, the Maryland Disability Law Center, coroners, medical examiners, and funeral directors, and state, county, and federal government agencies.

Business Associates

The Arc Montgomery County will provide a copy of the agency's Notice of Privacy Practices to all its business associates. All of The Arc Montgomery County's business associates will be expected to comply with The Arc Montgomery County's Notice of Privacy Practices. All business associates will be required to sign a form stating that they have received The Arc Montgomery County's Notice of Privacy Practices and are willing to comply with these practices.

THE ARC MONTGOMERY COUNTY NOTICE OF PRIVACY PRACTICES
For People Receiving Respite Services

Training
People receiving services have the right to have their PHI treated as confidential by all the employees and business associates of the agency. Therefore, all employees of The Arc Montgomery County will receive the agency's Notice of Privacy Practices and will be trained on HIPAA regulations and The Arc Montgomery County's privacy policies. Agency employees will be required to sign a form stating they received a copy of The Arc Montgomery County's Notice of Privacy Practices, have received training on HIPAA, and the agency's privacy policies, and understand that they are required to comply with these regulations and policies. The employee training will include confidentiality and disclosure requirements of the law, specific requirements regarding electronic transmission of PHI, and all other aspects of HIPAA regulations.

Rights of People Receiving Services from The Arc Montgomery County
People receiving services have the right to request access to their files, as discussed in detail in The Arc Montgomery County's Policies and Procedures Manual, Section 2.1.4 (Individual Rights—Records Access).

People receiving services have the right to request and amendment to their file, as discussed in detail in The Arc Montgomery County's Policies and Procedures Manual, Section 2.1.4 (Individual Rights—Records Access).

People receiving services have the right to know with whom The Arc Montgomery County is sharing their PHI. People receiving services may also request a copy of the log of individuals/agencies with whom their PHI was shared *for purposes other than* treatment, payment, healthcare operations, and regulation and law enforcement. That log will be maintained in their permanent file. People receiving services have the right to request a restriction or limitation on the disclosure of PHI. The Arc Montgomery County will accommodate such a request, if possible, but is not legally required to agree to the requested restriction.

People receiving services have a right to review a detailed copy of The Arc Montgomery County's Notice of Privacy Practices. The Notice of Privacy Practices is maintained in the agency Policies and Procedures Manual. These manuals are maintained at all permanent program sites as well as the administrative offices. A summary of The Arc Montgomery County's Privacy Practices will be posted at all permanent program sites.

The Arc Montgomery County has designated a privacy officer and a security officer for the agency. The Director of Quality Assurance will act as the agency's privacy officer and may be reached at The Arc Montgomery County's administrative offices, 11600 Nebel Street, Rockville, MD 20852, 301.984.5777 x1250. The Director of Information Technology will act as the agency's security officer and may be reached at The Arc Montgomery County's administrative officers, 11600 Nebel Street, Rockville, MD 20852, 301.984.5777 x1264.

KEEP THIS PAGE FOR YOUR RECORDS