Respite Coordination

Short-Term Relief for Primary Caregivers of Children with Disabilities

The Arc Montgomery County

Caregiving is a demanding job and caregivers need occasional breaks so they can return to their duties refreshed. These breaks are called “respite.” Respite can be provided for a few hours, a day, or sometimes longer.

Unpaid, primary caregivers of children age 17 and under with disabilities or challenging behavior who live in the same Montgomery County residence can apply for coordination of respite. Approved families are eligible for up to 140 hours of respite care per fiscal year, with some restrictions.

The Arc Montgomery County does not directly provide respite care. Instead, families choose the respite provider from among a consortium of pre-screened agencies and individuals. Families also choose the venue, whether it’s the family home, a therapeutic program, camp, or a respite facility.

Respite coordination is not an entitlement or a financial assistance program and will not pay the primary caregiver. Instead, families which meet the eligibility requirements may receive respite care hours at a subsidized rate. An application is required and eligibility is based on total family income less certain out-of-pocket expenses.

Please note that families receiving any county, state or federal funding for in-home supports/services, DDA personal supports, or other Medicaid-waiver funding are NOT eligible for respite.

To apply, complete the CHILD respite application and submit it by mail or secure (password protected) email to our office. Please be advised that due to the large number of applications received, any applications with missing documentation or unanswered questions will **not** be processed and will be returned by email.

Due to the COVID-19 pandemic and corresponding closures of schools, camps and other services which typically support families who have children with disabilities, income eligibility requirements for respite have been waived (do not apply) for in-home respite for children, through August 31, 2020. However, individuals who receive any county, state or federal funding for in-home support services are not eligible for respite.

For applications with waived income eligibility requirements, all respite care must be delivered by an approved home health care agency which is already a member of The Arc’s Respite Consortium.

If you have questions, please reach out to us directly by calling 301.984.5777 x1204.

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

7362 Calhoun Place, Rockville, MD 20855
301.984.5777 x1204 | www.TheArcMontgomeryCounty.org

7/2020

Respite

Short-Term Relief for Unpaid, Live-In, Primary Caregivers

The Arc Montgomery County

APPLICATION FOR CHILD RESPITE CARE

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

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 ☐ Other _____

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

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

Does the child receive Medicaid? Yes ☐ No ☐

Does the child receive Social Security Benefits? Yes ☐ No ☐ *(If yes, attach benefits documentation)*

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

Parent/Guardian #1 (*Attach copy of Maryland Driver's License or other **MVA**-issued Maryland identification)*

Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____ Phone: _____

Race: ☐ White ☐ Black/African American ☐ Asian
☐ American Indian/Alaska Native ☐ Native Hawaiian or Pacific Islander ☐ Other _____

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

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

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

Parent/Guardian **#2** (*Attach copy of Maryland Driver's License or other **MVA**-issued Maryland identification)*

Name: _____

Email Address: _____ Phone: _____

Race: ☐ White ☐ Black/African American ☐ Asian
☐ American Indian/Alaska Native ☐ Native Hawaiian or Pacific Islander ☐ Other _____

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

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

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

www.TheArcMontgomeryCounty.org/what-we-do/Respite
Phone 301.984.5777 x1204 | Fax 301.881.3383 | 7362 Calhoun Place, Rockville, MD 20855

C. Custody arrangements for the child listed in Section A.

☐ Joint ☐ Sole ☐ Other (explain): _____

(If applicable, attach copy of custody agreement)

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

Name	*Relationship*	*Date of Birth*

E. Complete the following information about the child 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 anyone 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 the 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? If yes, describe.	☐ 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 Cycle				
Toileting/Depends/Diapers				
Dressing				
Eating/Drinking				
Walking/Ambulating (uses cane, wheelchair or other support?)				
Stair Climbing				
Making Phone Calls				
Cooking/Meal Preparation				
Medication Administration				
Other (specify)				

Medical Information	
Does this person have special dietary requirements or restrictions? If yes, describe.	☐ Yes ☐ No
Does this person use oxygen? If yes, describe.	☐ Yes ☐ No
Does this person wear a C-Pap or Bi-Pap while sleeping?	☐ Yes ☐ No
Does this person have a history of seizures? 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?	☐ Yes ☐ No
Does this person have allergies? If yes, describe the allergen and reaction, and provide a copy of the allergen protocol.	☐ Yes ☐ No
Has this person been hospitalized in the last year? If yes, describe the reason(s) for hospitalization and/or the situation which required hospitalization.	☐ Yes ☐ No
Does this person use special or adaptive equipment? If yes, describe (include walker, wheelchair, assistive technology, hearing aids, etc.)	☐ Yes ☐ No
Does this require transferring by a support person or support staff?	☐ Yes ☐ No

Behavior Information
Does this person have a behavior plan? ☐ Yes ☐ No **If yes, attach 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 child listed in Section A.

Coordination of Community Services/Case Management (REM/Family Support/Community Pathway/CFC/Community Services, Etc.)

Do you work with a Coordinator of Community Services or Case Manager? ☐ Yes ☐ No
(i.e. The Coordinating Center, Service Coordination, Optimal Health, MMARS, Total Care, DHHS, Other)
If yes, provide the following information.

Agency Name: _____

Mailing Address: _____

Contact Person: _____ Phone: _____

Contact Email: _____

Out of Home Support (Child Care/School)

Does this child 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/school program? ☐ Yes ☐ No

Does this person have an IEP/IFSP? If yes, attached pages 1 and 2 of that document. ☐ Yes ☐ No

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

Does this child 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: _____

Medicaid Services

Does this person receive ANY Medicaid services? ☐ Yes ☐ No
If yes, attach a copy of the service plan for ALL Medicaid services received.

Certification of Acknowledgement and Understanding

The following statements include:

1) your duties and obligations with regard to the respite services program;
2) information how the respite services program operates;
3) information about how, when and where respite care services are delivered,
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 final page of this application where indicated.

1. Your Duties and Obligations With Regard To Respite Coordination

Caregiver Initials:	I have attached all necessary supporting documents to this application. **I understand that if the supporting documents are not attached, and/or if the application is incomplete, IT WILL NOT BE PROCESSED and will be returned to me by email or mail.**
Caregiver Initials:	I understand there is no guarantee that respite will be provided to me simply because I have submitted this application. I have made a copy of my application and supporting documents for my own records.
Caregiver Initials:	I understand that respite is designed to give the unpaid, primary caregiver living in the same residence short-term relief. It is not a substitute for ongoing child care. I understand that respite cannot be used for regular, long-term or continuing care, or to allow the unpaid primary caregiver to go to work.
Caregiver Initials:	I understand that the respite program coordinated by The Arc Montgomery County **is not an entitlement** program or a financial assistance program. **Benefits are not guaranteed** to any particular group or segment of the population.
Caregiver Initials:	I understand that respite is based upon eligibility and subsidies are dependent on income and other criteria. Approved eligibility may result in respite care hours being available to support my family member. Approved eligibility will not result in a monetary payment to the primary caregiver.
Caregiver Initials:	I understand that the respite program 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 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).

2. How The Respite Services Program Operates

Caregiver Initials:	I understand that if I select a respite care provider for Level I care who is a family member, relative, or friend, 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 I cannot receive respite while the person listed in Section A or Section B is in a hospital, rehabilitation center, or residential program. I understand that respite cannot be used in lieu of any child care, school or alternative child care program, including days/times when those programs are closed (with the exception of holidays, school breaks, and public health emergencies).
Caregiver Initials:	I understand that I may be required to obtain an updated Physician's Health Form for the person(s) receiving respite care if a hospitalization occurs.
Caregiver Initials:	I understand that if the person listed in Section A of this application is eligible for hospice services, Level I respite care can be delivered in the home by an approved, licensed home health care agency.

Caregiver Initials:	I understand that I cannot be a respite provider to another family in the respite program, and that no other person in my household can be a respite provider to another family in the respite program.
Caregiver Initials:	I understand that the respite provider will provide care ONLY for the person(s) enrolled in the respite program. The respite provider is not allowed to care for other children or adults who are in the home. If this happens, all respite services will be immediately, and potentially permanently, discontinued.
Caregiver Initials:	I understand that only the approved respite facilities, therapeutic programs and in-home support providers on The Arc Montgomery County respite consortium may be utilized when payment is authorized through respite care subsidies.
Caregiver Initials:	If I choose to utilize a respite care provider not on The Arc Montgomery County Respite Consortium, I am personally responsible for any and all payments to that respite care provider. I understand that the Respite 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.

3. How, When and Where Respite is Delivered

Caregiver Initials:	I understand that **I must contact Respite@arcmontmd.org or 301.984.5777 x1204 before using respite hours, to request and receive the appropriate authorization.** Failure to follow this procedure will prevent payment to the respite provider. *If this happens, I will be liable for payment to the respite provider.*
Caregiver Initials:	I 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 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 (which includes respite provided between midnight and 6 am). Respite hours used at an approved respite care facility are limited to a maximum of 140 hours per fiscal year.
Caregiver Initials:	I understand that I may not be approved for respite hours if the agency I select to provide respite care is not part of The Arc Montgomery County Respite Consortium. The Arc of Montgomery County and DHHS reserve the right to limit the number of consortium members.
Caregiver Initials:	I understand that if I receive IHAS (In-Home Aide Services), I must use my IHAS provider to deliver respite care. IHAS and Respite cannot be used in the same 24 hour period.
Caregiver Initials:	I understand that camps and therapeutic programs will be limited to MD, DC and VA only. The cost of the camp/therapeutic program, dates of attendance, and hours of attendance must be provided when requesting hours. *Approval of respite hours for camps/therapeutic program will occur only one month in advance (i.e. respite hours will not be approved for multiple months at the same time).*
Caregiver Initials:	I understand that if I have more than one child enrolled in respite, a 50% reduced subsidy rate will apply when one caregiver provides respite for multiple enrolled siblings at the same time.
Caregiver Initials:	I understand that eligibility for a subsidy does not guarantee respite funds for each occasion, because of limited funding.
Caregiver Initials:	I understand that, as the unpaid, primary caregiver living in the same household as the person in Section A, I cannot receive payments from any federal, state or county agency, vendor or program (including Medicaid, foster care, respite, etc.) to provide support services to anyone in my household. I also understand that no other person in my household can receive payments from any federal, state or county agency, vendor or program (including Medicaid, foster care, respite, etc.) to provide support services to anyone in my household.

Caregiver Initials:	I understand that if the person listed in Section A or Section B of this application receives any county, state, federal or veteran funding for **in-home** supports or services, he/she is NOT ELIGIBLE for respite. This includes services provided through Community First Choice, REM, Community Pathways, Family Supports Waiver, Maryland Community Support, Autism Waiver, etc.
Caregiver Initials:	I understand that respite hours cannot be used with grant-funded programs or services paid for by Montgomery County or the State of Maryland, including full or partial payments for Adult Day/Medical Day, camp, therapeutic programs, LISS or LEAP.
Caregiver Initials:	I understand that in order to ensure respite funding is available to eligible people and their families who have little or no services, limits will be placed on the number of respite hours available. I understand that these limits may change at any time.
Caregiver Initials:	I understand that changes to the respite program will 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 understand that I must submit a NEW application which includes ALL required supporting documents annually. Supporting documents must be up-to-date. If I am currently approved for respite care, my application for the next fiscal year will receive priority review if submitted between April 15 and June 15. Otherwise, my application may not be considered until the following fiscal year.
Caregiver Initials:	I understand that for applications submitted between April 1 and August 31, 2020 and for which the income eligibility and other requirements have been waived, all respite care must be delivered in-home by an approved home health care agency which is already a member of The Arc's Respite Consortium.

4. Affirmation That You Are Not Receiving Payment to Support the Person In Section A

Caregiver Initials:	**I affirm that, as the unpaid, primary caregiver living in the same household as the person in Section A, I do not work for or receive payments from any federal, state or county agency, vendor or program (including Medicaid, foster care, respite, etc.) that pays me to support the person listed in Section A of this application, AND that no other person in my household works for or receives payments from any federal, state or county agency, vendor or program (including Medicaid, foster care, respite, etc.) 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, omit Medicaid services or any other funding sources, or willfully fail to report changes, you will be subject to disqualification and denial of services.

5. 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. See attached document.

Signature of Parent/Guardian #1 _____ Date _____

Signature of Parent/Guardian Caregiver #2 _____ Date _____

If you need assistance completing this application, please call our office at 301.984.5777 x1204

Completed applications should be returned by email to Respite@arcmontmd.org or by US mail to The Arc Montgomery County, Attn: Respite, 7362 Calhoun Place, Rockville, MD 20855.

Please note: The Arc Montgomery County may take up to 30 days after receipt to process a completed application.

How did you learn about Respite Coordination by The Arc Montgomery County?

☐ Internet Search ☐ Community Outreach ☐ Website ☐ Family/Friend

☐ Montgomery County Agency (specify) _____

☐ Home Health Care Agency (specify) _____

☐ Other (specify) _____

Application Checklist

Please include ALL documents as outlined below; without these documents, your application is incomplete and WILL NOT BE PROCESSED.

☐ Completed Application for Respite Care (Children Age 17 and Under)

~~☐ Statement of Income & Out-of-Pocket Expenses (with required attachments)~~ ***Waived through 8/31/2020***

~~☐ Physician's Health Form (must be signed AND stamped)~~ ***Waived through 8/31/2020; will be completed by home health care agency in advance of service***

☐ HIPAA Policy & Procedure Acknowledgement

Additional External Documents:

☐ Custody or Guardianship Documents (if applicable)

☐ Current IEP/IFSP (if applicable; pages 1 and 2 only)

☐ Current valid Maryland Driver's License or other **MVA**-issued Maryland identification for Person(s) in Section B

☐ Plan of Care for any Medicaid services such as CFC, REM, Community Pathways, etc. (if applicable)

☐ Behavior Plan, Seizure Protocol, and/or Allergen Protocol (if applicable)

HIPAA POLICY & PROCEDURE ACKNOWLEDGEMENT

For People Receiving Respite Services

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: _____

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, 7362 Calhoun Place, Rockville, MD 20855, 301.984.5777 x1250.

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, 7362 Calhoun Place, Rockville, MD 20855, 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, 7362 Calhoun Place, Rockville, MD 20855, 301.984.5777 x1264.