Respite Coordination

Short-Term Relief for Caregivers of Adults with Disabilities Ages 18-59

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 adults ages 18-59 with developmental or functional disabilities (like Down syndrome, autism, MS, cancer or stroke) 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 (July 1-June 30), 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. Families may choose the venue, whether it’s the family home, a therapeutic program, summer camp, or a respite facility.

Respite coordination is not an entitlement or a financial assistance program and will not pay the primary caregiver or relatives. Instead, families which meet the eligibility requirements may receive respite care hours at a subsidized rate.

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 **ADULT** 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.

If you have questions, please email Respite@arcmontmd.org or call 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

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Respite Coordination

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

The Arc Montgomery County

FY24 APPLICATION FOR ADULT RESPITE COORDINATION

For Adults Ages 18-59 with Intellectual, Developmental and/or Functional Disabilities

THIS APPLICATION IS VALID JULY 5, 2023 – MARCH 31, 2024.

A. Complete this section about the person with an intellectual/developmental/functional disability.
(Must attach copy of Maryland Driver's License or other MVA issued Maryland identification)

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 person receive Medicaid? Yes ☐ No ☐

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

B. Does this person have a legal guardian/Health Care Proxy/Durable Power of Attorney?

☐ No This person must sign the application and all forms on his/her own behalf.

☐ No—But This person needs assistance completing the application. A signed *Consent to Application for Respite Care* is completed and attached.

☐ Yes A copy of the Guardianship/Health Care Proxy/Durable Power of Attorney paperwork must be attached to this application.

C. Complete this section about the unpaid primary caregiver(s) who lives with the person listed in Section A.

Unpaid, Primary Caregiver #1 ***(Must attach copy of Maryland Driver's License or other MVA-issued Maryland identification)***

Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____ Phone: _____

Relationship to Person Listed in Section A: _____

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

Unpaid, Primary Caregiver #2 ***(Must attach copy of Maryland Driver's License or other MVA-issued Maryland identification)***

Name: _____

Email Address: _____ Phone: _____

Relationship to Person Listed in Section A: _____

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

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

Name	*Relationship*	*Date of Birth*

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

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 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 Reminder (no medication management or medication administration provided)				

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 person require transferring by a support person or support staff? **Please note that home health agencies will not provide total lift and transfer of any individual for safety reasons.**	☐ Yes ☐ No

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

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.

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 (Day/Work/School/Medical Day)

Does this person attend a day/work/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 _____

Agency Name: _____

Mailing Address: _____

Contact Person: _____ Phone: _____

Contact Email: _____

Does this person receive 1:1 support at a day/work/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: _____

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 respite coordination;
2) information how respite coordination operates;
3) information about how, when and where respite coordination is delivered,
4) your affirmation that neither you nor any relative are 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 coordination.

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 care. I understand that respite cannot be used for regular, long-term or continuing care, or to allow the unpaid primary caregiver to regularly 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**. **Respite coordination is not guaranteed** to any particular group or segment of the population.
Caregiver Initials:	I understand that approved eligibility may result in respite hours being available to support my family member. Approved eligibility will not result in a monetary payment to the primary caregiver or relatives.
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 and respite hours are never guaranteed.**
Caregiver Initials:	I understand that respite coordination does not guarantee services based upon my personal scheduling requirements, my family's medical needs, or the ability of the aides to complete their job safely in my home.
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 Respite Coordination Operates

Caregiver Initials:	I understand that The Arc Montgomery County does not directly provide respite care. I must choose a respite provider from among a consortium of pre-screened agencies.

Caregiver Initials:	I understand that I cannot receive respite while the person listed in Section A or Section C 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 and school breaks).
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 hours 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 respite hours cannot be used for camp subsidies for adults (ages 18 and older) who receive Medicaid funding services for vocational and/or day services.

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 person enrolled, a 50% reduced subsidy rate will apply. One caregiver must provide respite for multiple enrolled people at the same time on the same day.
Caregiver Initials:	I understand that I, as the unpaid, primary caregiver living in the same household as the person in Section A, 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 C 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 eligibility for a subsidy does not guarantee respite funds for each occasion, because of limited funding.
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 each fiscal year, which includes ALL required supporting documents annually. Supporting documents must be up-to-date. If I am currently approved for respite coordination, my new application for the following fiscal year will receive priority review if submitted between May 15 and June 15. Otherwise, my application may not be considered until after the following fiscal year.
Caregiver Initials:	I understand that even if income eligibility requirements have been waived (i.e. do not apply at the time of this application), **these requirements may be reinstated,** which could impact my eligibility for respite coordination.

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:

1) **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**
2) **No other relative or family member 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 household members or parents/guardians, 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 Adult with ID/DD/FD _____ Date _____

(Unless Consent for Respite Services Application/Guardianship/Health Care Proxy/Durable Power of Attorney papers are provided)

Signature of Unpaid, Primary Caregiver #1 _____ Date _____

Signature of Unpaid, Primary Caregiver #2 _____ Date _____

STOP!

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 Coordination (Adults 18-59 with ID/DD/FD)
- ☐ Physician's Health Form (must be signed AND stamped)
- ☐ Behavior Plan, Seizure Protocol, and/or Allergen Protocol (if applicable)
- ☐ HIPAA Policy & Procedure Acknowledgement
- ☐ Consent to Application for Respite Coordination **AND** Copy of the Guardianship/Health Care Proxy/ Durable Power of Attorney paperwork
- ☐ Current valid Maryland Driver's License or other **MVA**-issued Maryland identification for Person in Section A. A copy of social security award letter or income tax return with all financial information redacted may be accepted.
- ☐ Current valid Maryland Driver's License or other **MVA**-issued Maryland identification for Person(s) in Section C. Passports, utility bills and lease agreements are not acceptable forms of identification.
- ☐ Current IEP/IP (if applicable/approved; for adults 18-22, only first two pages required)
- ☐ Plan of Care for any Medicaid services such as CFC, REM, Community Pathways, etc. (if applicable)

How did you learn about Respite Coordination?

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

☐ Montgomery County Agency (specify) _____

☐ Home Health Care Agency (specify) _____

☐ Other (specify) _____

If you need assistance completing this application, please call our office at 301.984.5777 x1204.
Completed applications should be emailed in a single PDF file to Respite@arcmontmd.org.
If you cannot scan/email, please mail your application to the following address:
The Arc Montgomery County-Respite Coordination
7362 Calhoun Place, Rockville, Maryland 20855
PLEASE DO NOT USE FEDERAL EXPRESS, UPS, OR PRIORITY MAIL.
FAXED APPLICATIONS WILL NOT BE ACCEPTED.

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

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Respite Coordination

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

The Arc Montgomery County

FY24 CONSENT TO APPLICATION FOR ADULT RESPITE COORDINATION

For Adults Ages 18-59 with Intellectual, Developmental and/or Functional Disabilities

Name of Adult with ID/DD/FD listed in Section A of the Application *(please print clearly):*

_____
First *Middle* *Last*

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

I give my consent for the individual(s) named below to prepare and submit, on my behalf, an application to The Arc Montgomery County for the purpose of determining if I am eligible to receive respite care to support my unpaid, live-in, primary caregiver(s). I understand that this application includes:

1) personal medical information, which may include assessments, treatment plans, diagnoses, evaluations, service summaries, lab results, medication records and other medical information;
2) information about other people who live in my household;
3) information about my household environment and activities of daily living;
4) information about my communication and behavior;
5) Information about out-of-home and in-home support services I receive;
6) Information about my income, including Medicaid funding, Social Security, SSI/SSDI/HOC and food stamps.

Individual(s) who may prepare, submit and discuss an application on my behalf to The Arc Montgomery County:

Primary Caregiver as listed in Section C of the Application:

_____

Street Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____ Phone: _____

Relationship to Person listed in Section A: _____

Additional Individual: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____ Phone: _____

Relationship to Person listed in Section A: _____

This authorization is valid for one year from the date of signature.

I understand that I can revoke this authorization at any time by submitting a request in writing to The Arc Montgomery County. The revocation will become effective on the date it is received by The Arc Montgomery County and does not apply to information that has already been used or disclosed with this consent.

_____ _____
Signature of Adult with ID/DD/FD (listed in Section A of the Application) Date

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Respite Coordination

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

The Arc Montgomery County

FY24 PHYSICIAN'S HEALTH FORM

*Must be completed, signed **and stamped** by a licensed physician, nurse practitioner, or registered nurse.*

Please print clearly; use additional paper if needed.

Patient's Name:

_____

First *Middle* *Last*

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

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

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

Respite Coordination does not provide medication administration or management.

2. Does the patient have any of the following?

   G-Tube ☐ Yes ☐ No Catheter ☐ Yes ☐ No Wound Management ☐ Yes ☐ No

   If yes, provide details. _____

   _____

3. Please list any and all dietary restrictions/requirements required for the patient.

   _____

4. Please provide details and treatment protocols for allergens and seizures, including PRN medications for these protocols.

   _____

   _____

   _____

_____

Printed Name of Physician, Nurse Practitioner, or Registered Nurse

_____

Signature of Physician, Nurse Practitioner, or Registered Nurse

_____

Date

MD/NP/RN Stamp with Address
Physician's License # _____

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FY24 HIPAA POLICY & PROCEDURE ACKNOWLEDGEMENT

For People Receiving Respite Coordination

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 healthcare 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.

Printed Name of Person listed in Section A of the Application: _____

Signature of Person listed in Section A of the Application: _____

Telephone: _____

Street Address: _____

City, State, Zip Code: _____

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

Date Signed: _____

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Keep this page for your records!

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

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 healthcare, 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 healthcare 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.

Healthcare 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 Coordination

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.