

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

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 frail senior citizen, 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 care or adult day 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, adult medical day programs, and approved respite facilities.

Respite services may provide a subsidy to pay a Respite Care Provider (RCP), but it is not an entitlement. To apply for respite services for a frail senior citizen, 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 (Senior Citizens Ages 60+)
- Physician's Health Form
- Consent for Respite Services Application **OR** Guardianship Papers (if applicable)
- HIPAA Policy & Procedure Acknowledgement
- Current valid Maryland Driver's License or ID
- Medicaid/Medical Assistance Card (if applicable)
- Current valid Maryland Driver's License or ID **for Unpaid, Live-In Primary Caregiver** (must show current address; no change of address cards will be accepted)

A. Complete this section about the senior citizen for whom respite care is being requested.

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)

Receives: Medicaid Social Security

B. Does this person have a legal guardian?

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 for Respite Services Application* is completed and attached.

Yes A copy of the guardianship papers 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.

Name #1: _____

Name #2: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____ Phone: _____

Relationship(s) to Person Listed in Section A: _____

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

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. 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: _____

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

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

<i>Activities of Daily Living (provide additional details if needed)</i>	<i>Manages Independently</i>	<i>Needs Supervision</i>	<i>Needs Assistance</i>	<i>Does Not Apply</i>
Bathing/Hair Care				
Shaving				
Skin Care				
Teeth Brushing				
Menstrual Care				
Toileting/Depends/Diapers				

<i>Activities of Daily Living (provide additional details if needed)</i>	<i>Manages Independently</i>	<i>Needs Supervision</i>	<i>Needs Assistance</i>	<i>Does Not Apply</i>
Dressing				
Eating/Drinking				
Walking/Ambulating (uses cane, wheelchair or other support?)				
Stair Climbing				
Making Phone Calls				
Cooking/Meal Preparation				
Medication Administration				
Other (specify)				

<i>Medical Information</i>	
Does this person have special dietary requirements or restrictions? If yes, describe.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does this person use oxygen? If yes, describe.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does this person wear a C-Pap or Bi-Pap while sleeping?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does this person have a history of seizures? If yes, describe the type and frequency, and provide a copy of the seizure protocol.	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what is the date of the last seizure?	
Does this person have allergies? If yes, describe the allergen and reaction, and provide a copy of the allergen protocol.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does this person use special or adaptive equipment? (Include walker, wheelchair, assistive technology, hearing aids, etc.) If yes, describe.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does this person require transferring by a support person or support staff?	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No

<i>Behavior Information</i>	
Does this person exhibit behaviors that endanger himself/herself or other people? If yes, describe behaviors.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has this person attempted suicide in the last year? If yes, provide date(s) and details.	<input type="checkbox"/> Yes <input type="checkbox"/> No

<i>Behaviors Exhibited</i>	Yes	No	Frequency	<i>Additional Description</i>
Yelling/Shouting/Screaming				
Biting				
Hitting				
Scratching				
Pinching				
Pushing				
Hair pulling				
Spitting				
Throwing/ Breaking Objects				
Theft				
Fearfulness				
Restlessness				
Pacing				
Wandering/Elopement/Night Walking				
Aggression				
Self-Injurious Behavior				
Forgetfulness (especially showering/eating)				
Inappropriate Sexual Behavior				
Other (describe)				
Other (describe)				
Other (describe)				

<i>Please Indicate Person's Overall Support Level</i>	Minimal (needs little supervision)	Moderate	Extensive (needs close supervision)
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G. Complete the following information about other support services provided to the person listed in Section A.

Out of Home Support (Adult Day/Medical Day)

Does this person attend an adult day/medical day 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: _____

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: _____

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

I. What is your written plan in the event of an emergency that requires this person 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 adult 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 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.

Caregiver Initials:

I understand that respite care cannot be used with the following waiver/grant funding in the same 24-hour period:

- In-home support/personal care/nursing under any Medicaid waiver (Community Options, Traumatic Brain Injury, Community First Choice, etc.);
- Any medical support funding program;
- Any program or services paid for by Montgomery County or the State of Maryland.

Caregiver Initials:

I understand that I cannot receive respite care while the person listed in section A or the unpaid, live-in primary caregiver is in the 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 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 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 Adult for Whom Respite Care Is Requested
(Unless Consent for Application to Respite Services or Guardianship Papers are also provided)

Date

Signature of Unpaid, Live-In, Primary Caregiver

Date

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

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).

- | | | |
|---|--|---|
| <input type="checkbox"/> Autism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Epilepsy/Seizure disorder | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Behavioral problems | <input type="checkbox"/> Head injury | <input type="checkbox"/> Sickle Cell |
| <input type="checkbox"/> Blindness/Severe visual impairment | <input type="checkbox"/> Heart Conditions | <input type="checkbox"/> Speech/Language impairment |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Intellectual/Developmental Disability | <input type="checkbox"/> Spinal Bifida |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Lupus | <input type="checkbox"/> Spinal cord injury |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Deafness/Severe hearing impairment | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Dementia/Alzheimer's Disease | <input type="checkbox"/> Neurological impairment | <input type="checkbox"/> 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
Include Physician's or LHCP's Stamp with Address

Date



CONSENT FOR RESPITE SERVICES APPLICATION

Senior Citizens Ages 60+

Updated 1/2017

Please print clearly.

Name of Senior Citizen:

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, 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:

Name #1: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Relationship to Me: _____

Name #2: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Relationship to Me: _____

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 staff. 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 Senior Citizen

Date



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: _____

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.

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.

Keep this page for your records!

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 offices, 11600 Nebel Street, Rockville, MD 20852, 301.984.5777 x1264.

KEEP THIS PAGE
FOR YOUR RECORDS