***Please use the full form handout for rights education. Available en Español if needed.***



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**RIGHTS**

The above is a brief listing of your rights. If you would like more information, please contact the program supervisor.

***If you have a concern:***

We want to know if, at any time, you are not satisfied with your services. If you have a concern, please call:

|  |  |  |  |
| --- | --- | --- | --- |
| Supervisor: | Liv Salvador, MA | Phone: | 571-383-7834 |

***If you wish to file a grievance:***

If your concern cannot be resolved locally to your satisfaction, you also call a member of our Quality Management (QM) program:

|  |  |  |  |
| --- | --- | --- | --- |
| QM Staff: | Phyllis Elliot | Phone: | \_\_919-783-8786\_\_\_\_\_\_ |
| Email: | QM@eastersealsucp.com |

Outside of Easter Seals UCP, you can contact your Local Management Entity (CSB) in NC or the Community Service Board (CSB) in VA or any one of the following oversight or advocacy agencies.

|  |  |  |  |
| --- | --- | --- | --- |
| CSB/**CSB**: |       | Phone: |       |

Virginia Office for Protection and Advocacy Phone: 1-800-552-3962

|  |  |  |
| --- | --- | --- |
| VA DBHDS Director of Community Support Services  | Phone: | 804.786.5850 |
| VA DBHDS Office of Human Rights | Phone | 1-877-600-7435 |

**PRIVACY & CONFIDENTIALITY**

You have specific rights regarding privacy, including the right to request:

* With whom we talk about you;
* How we communicate with you;
* To see and receive copies of information contained in your record;
* To request changes or make additions to your record;
* To receive a list of disclosures about you that we have made;
* To receive a full copy of ESUCP’s Notice of Privacy Practices;
* And to request restrictions on disclosures about you.

This is not intended to be a replacement for our full Notice of Privacy Practices—please speak with your ESUCP Representative for the complete document.

***If you wish to file a complaint about our privacy practices:***

Please contact ESUCP’s Privacy Officer at:

|  |  |  |  |
| --- | --- | --- | --- |
| Email:  | HIPAA@eastersealsucp.com | Phone: | 1-800-662-7119 |
|  |  |

To speak with someone outside of Easter Seals UCP NC & VA, you can also contact:

Office for Civil Rights

US Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, DC 20201

**Filing a complaint about ESUCP’s services or privacy practices will not affect your services.**

**GRIEVANCE DOCUMENTATION FORM**

Easter Seals UCP North Carolina & Virginia (ESUCP) is committed to protecting the rights and dignity of the persons we serve at all times. This means always treating you with respect and assuring that your wishes and choices are listened to and honored.

If you believe that wehave fallen short of this goal, we want you to notify us. In the space below, please describe your complaint. Your information will be kept private and will not affect your services or your family member’s services in any way. An Easter Seals UCP representative will contact you to make sure that your concerns have been addressed.

|  |
| --- |
| **Please provide us with your contact information:** |
| Your Name: |  |
| Telephone: |  | (Day) |  | (Eve) |
| Person Served: |  |
| Relationship (circle): | Self | Parent | Other: |  |
| **Please list the staff involved, if applicable, and the services received:** |
| Staff Involved: |  |
| Services Provided: |  |
| **Please describe your complaint or concern in the space below:** |
|  |
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|  |

Signature of Person Filing Complaint or Concern Date

|  |  |  |
| --- | --- | --- |
| *Please mail this form to:* |  | *Or fax to:* |
| ESUCP Quality Management5171 Glenwood Avenue; Ste 400Raleigh, NC 27612 |  | ESUCP Quality Management919-863-3868 |
| For ESUCP Internal Use Only |
| Date Received: |  | Comments:  |
| Received By: |  |

**NOTICE OF PRIVACY PRACTICES Effective April 13, 2003**

Easter Seals UCP NC & VA (ESUCP) has a legal duty to protect private information about you. We are required to protect the privacy of health information about you or the person receiving services. We are required to follow the procedures in this Notice. An ESUCP representative will review the contents of this notice with you on an annual basis; however, we reserve the right to change the terms of this Notice at any time, and to make new notice provisions by first:

* Posting the revised notice in our offices;
* Making copies of the revised notice available upon request (at any of our area offices);
* Posting the revised notice on our website.

 WE MAY DISCLOSE INFORMATION UNDER THE FOLLOWING CONDITIONS.

**1. We may disclose information about you to provide services.**

This may include communicating with other health care providers regarding your treatment. For example, we may disclose information when you need a referral for other health care services, or to receive authorization to begin services. If you are a Medicaid beneficiary residing in NC, we may contact Community Care of North Carolina/Carolina Access, NC’s Medicaid program. CCNC/CA provides you with a medical home and a primary care provider (PCP).

**2. We may disclose information about you to obtain payment for services.**

Generally, we may disclose your medical information to others to bill and collect payment for the treatment and services provided to you. Before you receive scheduled services, we may share information about these services with your insurer to assure that services are covered.

**3. We may disclose your information for health care operations.**

We may disclose information about you in performing business activities, which we call “health care operations”. These “health care operations” allow us to improve the quality of care we provide and reduce health care costs. Examples of the way we may disclose information about you for “health care operations” include the following:

* Reviewing and improving the quality, efficiency and cost of care that we provide to you or the person receiving services.
* Reviewing and evaluating the skills, qualifications, and performance of health care providers taking care of you.
* Cooperating with outside organizations that assess the quality of the care we and others provide. These organizations might include the NC Division of Mental Health/Developmental Disabilities/Substance Abuse Services; Local Management Entities; or the NC Council of Community Programs.
* Resolving grievances within our organization.
* Reviewing activities and using or disclosing information in the event that control of our organization changes significantly.

**4. We may disclose information to persons involved in your care.**

We may disclose information about you to a relative, or any other person you identify if that person is involved in your care if the information is relevant to your care. If the person receiving services is a minor, for instance, we may disclose information about the minor to a parent, guardian, or other person responsible for the minor except in limited circumstances. We may also disclose information about you to a relative or other person involved in your care if there is an emergency situation, and we need to notify someone of your condition.

You may request that we not disclose information to persons involved in your care. We will generally comply with your request, unless there is an emergency, or if the person is a minor. If the person is a minor, we may or may not be able to comply with your request.

**5. Other circumstances in which ESUCP may disclose information about you.**

We may disclose information about you for a number of circumstances in which you do not have to consent, give authorization or otherwise have an opportunity to agree or object. Those circumstances include:

* When the disclosure is required by law. For example, when a disclosure is required by federal, state or local law or other judicial or administrative proceeding, or when the disclosure relates to victims of abuse, neglect or domestic violence.
* When the disclosure is for health oversight activities. For example, we may disclose information about you to a state or federal health oversight agency which is authorized by law to oversee our operations or to assure the public health.
* When the disclosure is for law enforcement purposes. For example, we may disclose information about you in order to comply with laws that require the reporting of certain types of wounds or other physical injuries, or in reporting of missing persons.
* When the disclosure is to avert a serious threat to health or safety. For example, we may disclose information about you to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
* When the disclosure relates to correctional institutions and in other law enforcement custodial situations. For example, in certain circumstances, we may disclose information about you to a correctional institution having lawful custody of you.

**6. We may disclose information about you with your authorization.**

Under any circumstances other than those listed above, we will ask for your written authorization before we disclose information about you. If you sign a written authorization allowing us to disclose information about you in a specific situation, you can later cancel your authorization in writing. If you cancel your authorization in writing, we will not disclose information about you after we receive your cancellation, except for disclosures which were being processed before we received your cancellation.

YOU HAVE SEVERAL RIGHTS REGARDING PHI ABOUT YOU.

1. ***You have the right to request restrictions on disclosures of information about you.*** We are not required to agree to your requested restrictions. However, even if we agree to your request, in certain situations your restrictions may not be followed. These situations include emergency treatment, disclosures to the Department of Health and Human Services, and disclosures described in the previous section of this Notice. You may request a restriction by notifying ESUCP’s Local Manager.
2. ***You have the right to request different ways to communicate with you.*** You have the right to request how and where we contact you. For example, you may request that we contact you at your work address or phone number or by email. You may request alternative communications by notifying ESUCP’s Site Manager in your area in writing.
3. ***You have the right to request to see and receive a copy of information created by ESUCP contained in ESUCP's clinical record.*** There are certain situations in which we are not required to comply with your request. In this case, we will respond to you in writing, stating why we will not grant your request and describing any rights you may have to request a review of our denial. You may request to see and receive a copy by notifying ESUCP’s Site Manager by using the included form titled “Protected Health Information (PHI) Individual Request”.
4. ***You have the right to request amendments or changes to clinical, billing and other records used to make decisions about you.*** If you believe that we have information that is either inaccurate or incomplete, we may add information to indicate the problem and notify others who have copies of the inaccurate or incomplete information. If you wish to add an amendment to the clinical record, complete the “Protected Health Information (PHI) Individual Request” form and give it to your Site Manager. Any amendments made must be done in the presence of an ESUCP representative. The ESUCP representative may add an additional response to your amendment, but only in your presence. We may deny your request to change or delete entries in the clinical record. If we deny your request, we will explain our reasons for doing so in writing.
5. ***You have the right to receive a written list of disclosures about you.*** You may ask for disclosures made up to six (6) years before your request (not including disclosures made prior to April 14, 2003). We are not required to include disclosures:
	* For your treatment;
	* For billing and collection of payment for your treatment;
	* For our health care operations;
	* Authorized by you, or which are made to individuals involved in your care;
	* Allowed or required by law when the use and/or disclosure relates to certain specialized government functions;
	* As part of a limited set of information which does not contain certain information which would identify you.

The list will include the date of the disclosure, the name (and address, if available) of the person or organization receiving the information, a brief description of the information disclosed, and the purpose of the disclosure. You may request a listing of disclosures by notifying ESUCP’s Site Manager in your area in writing.

1. ***You have the right to request a paper copy of this Notice at any time by notifying ESUCP’s Site Manager in your area.*** We will provide a copy of this Notice on the date you begin receiving services from us.
2. ***You have the right to request restrictions on uses and disclosures.*** You have the right to request that we limit the disclosure of information about you for treatment, payment and health care purposes. We are not required to comply with your request, however, such requests can be made in writing by completing the “Protected Health Information (PHI) Individual Request” form. Give this form to your ESUCP Site Manger and they will guide you through the process.

YOU MAY FILE A COMPLAINT ABOUT OUR PRIVACY PRACTICES.

If you think your privacy rights have been violated by us, or you want to complain to us about our privacy practices, you can contact the ESUCP Representative listed below, or use the Privacy Complaint Form. Filing a complaint will not affect your services.

|  |  |
| --- | --- |
| Privacy Officer—ESUCP NC5171 Glenwood Avenue; Ste 400Raleigh, NC 27612919-783-8898HIPAA@eastersealsucp.com | Office for Civil RightsUS Department of Health and Human Services200 Independence Avenue, SWRoom 509F, HHH BuildingWashington, DC 20201 |

**PROTECTED HEALTH INFORMATION—INDIVIDUAL REQUESTS**

***Please note that Easter Seals UCP North Carolina & Virginia (ESUCP) is not required in all instances to comply with requests regarding Protected Health Information (PHI).*** If we deny any of your requests, however, we will provide an explanation of this denial in writing. Please see the ESUCP Notice of Privacy Practices.

Name of Person Served:

Name of Person Making Request:

Daytime Ph): Evening Ph): Circle Primary #

[ ]  Request for Restriction of Disclosure of Information

You have the right to request specific restrictions about disclosure of your personal information in day to day operations (i.e., not to share information with a particular person). Please use the space below to describe what information should be restricted, and from whom.

[ ]  Request to Amend Method of Contact

I understand that one of my rights as a person served is to choose how I am contacted. I *DO/DO NOT* *(please circle one)* give permission for ESUCP representative to contact me at work. Furthermore, I *DO/DO NOT* *(please circle one)* give permission for ESUCP representatives to leave voice messages for me at *HOME/WORK/BOTH/NEITHER* *(please circle one).*

[ ]  Request to Inspect and Copy Protected Health Information

I am financially responsible for the following fees associated with my request and may be charged up to $5.00 for the first three pages and $0.15 per each additional page. I understand that and ESUCP representative must first explain to me the contents of the clinical record before providing access and/or copies.

[ ]  Request for Correction/Amendment of Protected Health Information (PHI)

Entry to be amended:

[ ]  Service note [ ]  History [ ]  Correspondence [ ]  Other:

Please explain what changes you would like made in the record.

[ ]  Request an Accounting of Disclosures of PHI

You have the right to receive an accounting of certain non-routine disclosures of identifiable, protected health information made by ESUCP. Your request must state a time period below no longer than (6) years, not including dates before 4-14-03. The first request within a 12-month period will be provided at no cost. Additional requests during the same 12-month period may require payment for copying expenses; however, we will notify you of the cost involved in advance, should you wish to modify or withdraw your request.

Accounting requested from: to: .

 *Start Date End Date*

[ ]  Request for Copy of Notice of Privacy Practices

We will provide a copy of this Notice on the date you begin receiving services from us, and whenever you request an updated copy.

[ ]  Request for Limitation and Restriction of PHI for Treatment, Payment or Healthcare Operations

Please check items for limitation/restricted access and explain limitations.

|  |  |
| --- | --- |
| **Information Set** | **Restrictions on Use** |
| [ ]  Personal Contact Information |  |
| [ ]  Family Information |  |
| [ ]  Family Contact Information |  |
| [ ]  Employer/School Information |  |
| [ ]  Service Documentation |  |
| [ ]  Other: |  |

Signature of Individual or Legal Representative Date

|  |
| --- |
| *Please deliver this form to your ESUCP Representative or Local Manager.* |
|  |  |  |
| For ESUCP Internal Use Only |
| Date Received: |  | Comments:  |
| Received By: |  |
| **If Amendment/Change has been requested:** |
| [ ]  Accepted  | [ ]  Partially denied/accepted  | [ ]  PHI: accurate & complete |
| [ ]  Denied  | [ ]  PHI: exclude record set  | [ ]  PHI not available by law  |
| [ ]  Other: |  |

**PRIVACY COMPLAINT FORM**

Easter Seals UCP values the privacy of the people we serve and are committed to operating in a manner that preserves your confidentiality while providing high quality services.

If you believe that wehave fallen short of this goal, we want you to notify us. In the space below, please describe your complaint. Your information will be kept private and will not affect your services or your family member’s services in any way. An Easter Seals UCP representative will contact you to make sure that your concerns have been addressed.

|  |
| --- |
| **Please provide us with your contact information:** |
| Your Name: |  |
| Telephone: |  | (Day) |  | (Eve) |
| Person Served: |  |
| Relationship (circle): | Self | Parent | Other: |  |
| **Please list the staff involved, if applicable, and the services you receive:** |
| Staff Involved: |  |
| Services Provided: |  |
| **Please describe your complaint or concern in the space below:** |
|  |
|  |
|  |
|  |
|  |
|  |

Signature Date

|  |  |  |
| --- | --- | --- |
| *Please mail this form to:* | *Or fax to:* | *Or email us at:* |
| ESUCP Privacy Officer5171 Glenwood Avenue; Ste 400Raleigh, NC 27612 | ESUCP Privacy Officer919-863-3868 | HIPAA@eastersealsucp.com |
| For ESUCP Internal Use Only |
| Date Received: |  | Comments: |
| Received By: |  |

**VOTER REGISTRATION INFORMATION**

GACPD is a division of the N.C. Department of Administration and is guided by a 21-member board of volunteers appointed by the state´s top leaders in government.

Board members bring personal insight to the needs of people with disabilities either through experiencing a disability themselves or through having a close family member who has a disability.

How Can GACPD Help?

If you are a person with a disability and need help speaking or acting to protect your rights, GACPD may be able to help by providing information, advocacy services or legal representation.

Priorities

Due to limited resources and a high demand for services, GACPD establishes priorities which are reviewed annually by its Board after input from the public. The priorities dictate what type of issues GACPD will pursue during that year. Cases are accepted on the basis of established case selection criteria and in accordance with current priorities as well as resources available at the time of the request.

Intake Procedures

When you first contact GACPD, you will talk with an intake specialist who will take details of your concerns. Even if your problem is not accepted as a case, Intake may continue to provide you technical assistance as you work to re-solve your situation.

Information and Referral Service

GACPD can provide information about laws that protect the rights of people with disabilities, as well as provide someone to help you develop a plan of action in your case. If the GACPD is unable to help you, you will be referred to another appropriate resource or re-sources from our extensive information and referral data bank.

Advocacy services may be provided when you are negotiating for your equal rights under the law. GACPD advocates know state and federal laws concerning the rights of people with disabilities and they are experienced negotiators.

GACPD staff may also advocate for assistive technology devices in a number of settings, including school, work, and nursing homes. These devices may be low or high tech, and include communication devices for non-speaking per-sons, hearing devices,

WHAT YOU SHOULD KNOW…

The National Voter Registration Act requires service providers, such as Easter Seals UCP North Carolina and Virginia (ESUCP), which work with people with disabilities and receive ANY state or federal funds to ask people they serve if they would like to register to vote. When someone says, “YES”, the agency must then register that person on the spot.

ESUCP is excited about the opportunity to empower people, the people with disabilities and their family members by offering them the opportunity to register to vote. The following information will help your ESUCP representative as they provide the opportunity for individuals who receive services from ESUCP to register to vote.

ESUCP will assist you if you desire in completing the North Carolina Voter Registration Application if you want to register to vote where you live now. Once the application is completed, it should be mailed to the Board of Elections where the person lives. The person registering may wish to mail the Voter Application to the Board of Elections themselves or request the ESUCP representative to mail it for them. Either way the application form must be mailed to the local Board of Elections within five business days. A directory of County Board of Election Offices with addresses is included in this handout.

In order to register to vote a person must:

* be at least 18 years of age
* be a U.S. Citizen, whether by birth or Naturalization
* be a resident of North Carolina and the county in which you are registering for 30 days
* NOT be a felon or, if you have been a felon, had your citizenship rights restored.

You may decline the opportunity to register to vote. Declining will in no way affect the service or benefits you might receive.

All voter registration service must be non-partisan. Your ESUCP representative should not attempt to influence you in your choice of political preference or party registration.

If you have questions that your ESUCP representative is unable to answer, contact your local County Board of Elections Office which can be found on the included handout.

**MISSION**

Easter Seals UCP creates opportunities, promotes individual choice and changes the lives of children and adults with disabilities by maximizing their individual potential for living, learning and working in their communities.

**DISCHARGE POLICY**

**Policy:** Easter Seals UCP discharges individuals served when they no longer desire, need or are eligible for continued services, via a decision-making process that involves appropriate stakeholders.

**Purpose:** To establish consistent discharge criteria guidelines around discharges.

**Procedure**: Preparing the person for discharge is an on-going process that begins during the admission assessment and the development of the personal centered plan and continues throughout the relationship. The treatment team works with the person and/or family to determine when discharge is appropriate and what additional supports may be needed.

Easter Seals UCP may discharge persons at the request of the individual and/or the legally responsible person or emancipated minor for reasons including, but not limited to the following:

1. The organization no longer meets the medical needs of the person.
2. Non-payment of fees; except as prohibited by Medicaid or other funding source.
3. The program no longer reasonably meets the needs of the person with the resources available to safely meet the needs of the person or others.
4. The person moves out of the service area.
5. The person dies.
6. The person’s funding source no longer requires Easter Seals UCP services.
7. The person no longer meets the minimum continued need requirements.
8. The individual fails to appear (without calling to reschedule) for three consecutive scheduled appointments. In this event, the second missed appointment will be followed up with a letter notifying the individual that her/his services will be terminated. If the individual does not keep the third appointment, the program will discharge the individual with notification via certified mail to the last known address. Notification will include information on how to access intake services, crisis services and local government oversight (if applicable), should they wish to reinstate services.

**Exception**

**Supported Employment:** Persons receiving employment supports in the community may be discharged or terminated for:

1. The use and abuse of drugs, alcohol or other controlled substances.
2. Threatening to verbally or physically assault another co-worker, SET employee or others.
3. Committing verbal or physical assault against another.
4. Possession of weapons (including knives, guns, explosives or other items).
5. Threatening to destroy property or destruction of property.
6. Theft of property.

Easter Seals UCP will not discharge a voluntarily admitted minor from treatment or services without consulting with the legally responsibility person.

Upon receiving notification by the individual, legally responsible person, or emancipated minor that they desire services to end, the Easter Seals UCP representative will share this information with the case manager, primary clinician and, if appropriate, the attending physician. The physician shall forward discharge orders, per service requirements. These contacts will be documented in the person’s record.

**Discharge Plan:** To ensure continuity of care, if possible, prior to discharge the appropriate Easter Seals UCP representative shall work with the person and/or their legally responsible person to prepare a discharge plan identifying and recommending service options that enable the person to meet their personal outcomes. The Easter Seals UCP representative shall meet with the person and their legally responsible person to review the discharge plan and answer any questions. The Easter Seals UCP representative shall provide a copy of the discharge plan to the person or the legally responsible person. For service specific discharge requirements see service specific policies.

**Discharge Summary:** The Easter Seals UCP representative shall complete a discharge summary form to document the circumstances and place in the person’s file.

**Inactive Status:** There are times when a person is not authorized for services or supports but could be eligible in the future. A person is considered inactive after twelve months of not receiving services. An inactive summary sheet is completed and filed in the person’s record and the CSB notified.

|  |  |
| --- | --- |
|  | **VERIFICATION OF PROVIDER CHOICE****VIRGINIA START SERVICES** |
| Service(s) Desired | Crisis Prevention and Intervention |
|  |
| Information Received | [ ]  | In Person | [ ]  | Telephonically | [ ]  | Other: |  |
|  |
| *I, the undersigned, am seeking services through the above named CSB. I have been informed of my right to select the eligible provider of my choice based upon the care for the person to be served. I have been provided with objective information about provider choices, including, when applicable, those with experience in the areas required for care. I understand that my range of choices includes physicians, nurses, case managers, therapists and support staff. I understand that my selection of providers is based upon my preferences, and that I may change my choice of providers at any time. I also understand that there may be times when medically unsuitable choices cannot be honored.* |
| *Requests to change providers will be shared with my service team, or I may contact the Care Management Unit of my local CSB, by calling:* |
|  |
| CSB/County |       | Phone # |       |
|  |
| *I have selected the following provider for the above-named service(s):* |
|  |
| Provider |       | Contact Info |       |
|  |  |  |  |
| *I confirm that I have been given choices for providers for care that is medically necessary for me/child/person in my legal care. The choice has been made from a selection of appropriate providers and I feel best suits the care needs for me/my family member or ward. A copy of this form is available upon request.* |
|  |
| Signature |  | Date |  |
| Relationship to Person Served | [ ]  | Self | [ ]  | Parent | [ ]  | Legal Representative |
|  |
| Witness |  | Date |  |