

*Welcome to ACCENT on Family!*

*Our mission is to offer our families the information, services and support they need in a friendly and timely manner and to ensure that all are treated with dignity and respect.*

*Our website, accentonfamily.com, is designed to be a resource for both families and providers. Any forms you may need will be found on both the Forms page and the Employment page. An outline of our training is found on the Resource pages along with helpful links regarding such things as videos of sign language and CPR as well as other educational tools.*

*We encourage you to stay in contact with us to keep us informed of how we can best meet your needs.*

*Thank you for choosing ACCENT on Family Care Services!*

*Sincerely,*

*Deborah Belnap*

*President, ACCENT on Family Care Services, LLC*

*Phone: 480-518-2285*

*Fax: 480-677-3477*

*Email: Debbielee@accentonfamily.com*



***GENERAL CONSENT AND AUTHORIZATION***

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, certify that I am the

 Parent or Guardian’s name (print)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Relationship to client Name of client

And I consent to the following for \_\_\_\_ him/ \_\_\_\_ her during the time the client is with ACCENT on Family Care Services, llc (Check all that have your authorization)

\_\_\_ Necessary Emergency Treatment(s)

\_\_\_ Necessary educational, vocational, and therapeutic evaluation/assessments with the exception(s) of:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Routine Medical Care

\_\_\_ Administration of over-the-counter medications and prescription medication (as prescribed by a physician or dentist and not to exceed the maximum dosage), except for:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Participation in routine routing recreational/leisure activities

I also give permission for the release of the following information (check all that apply).

\_\_\_ Medical records

\_\_\_ Social

\_\_\_ Educational

\_\_\_ Psychological

\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I certify that I understand the above information. I also understand that my consent may be withdrawn at any time by my written notification to ACCENT on Family Care Services, llc.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Guardian’s signature Date



***Family Information Form***

To better serve you, please fill out this form entirely.

Name of Client \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diagnoses \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Areas client needs to work on: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian’s full names and relationship to the child:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address with Zip code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Support Coordinator’s Name & Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved monthly hours of: HAB: \_\_\_\_\_\_\_\_\_\_ Respite: \_\_\_\_\_\_\_\_\_\_ Att. Care: \_\_\_\_\_\_\_\_\_\_

Days and Times you need a provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Qualities of a provider that you want: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



***Transportation Waiver***

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, give my permission for

 (parent or legal Guardian’s full name)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to transport in his/her own vehicle

 (provider’s full name)

my child, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, born on, \_\_\_\_\_\_\_\_\_\_\_\_\_.

 (client’s/child’s full name) (birth date)

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (provider’s full name)

Verify that my driver’s license, auto insurance and auto registration for the vehicle used to transport said client is valid and current and meets all state laws and requirements and is on file with ACCENT on Family Care Services, LLC. I also verify that the vehicle used to transport said client is in safe condition and passes state safety requirements. I also swear that no harmful substances will be in the vehicle when transporting client and that I will be of sound mind and not be under the influence of alcohol, illegal drugs or other substances that my impair my judgment. I swear to uphold all traffic regulations while transporting said client. I will only transport client to places that are agreed to with parent or legal guardian prior to transporting the client.

Parent or Legal Guardian’s Signature Date

Parent or Legal Guardian’s Address

Provider’s Signature Date

 

This is a reminder of some requirements set forth by the Division of Developmental Disabilities and ACCENT.

The State will not fund or allow habilitation, respite or attendant care services to be performed when the individual is admitted into the hospital **or** during an emergency room visit. The Division of Developmental Disabilities performs yearly audits with hospitals and will know if this happens.

No services can be worked when the individual receiving services is out of the country.

Services cannot be done during school hours if the individual attends a publicly paid school including charter schools or if the district or state is paying tuition for a private school.

The ISP states specifically how many habilitation and attendant care hours can be worked in a week. Make sure that the hours the provider performs habilitation and attendant care services stays within the weekly allotment. And remember that respite must be worked less than 12 hours daily.

Providers are not permitted to work for ACCENT on Family Care Services more than 40 hours per week.

If a parent has a provider work in a manner that is inconsistent with DDD's rules and regulations, they can be held responsible for the payment to the provider or can be held responsible to reimburse the agency if DDD will not cover the costs.

Please keep in mind your providers' strength and abilities when asking them to do heavy lifting or moving items. Do not ask providers to do something that is not within the scope of the individual's ISP.

Please contact ACCENT on Family Care Services if you would like to have access to your child's service hours through a website called dddclaims.com. This will help you keep track of how many hours each provider has worked over the course of the year and help you keep up with the balance of your child's hours each month.

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, understand and agree to the regulations stated in this letter.

 (Guardian’s printed name)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Guardian’s signature)



Employee Client Orientation Agreement

Employee Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing this form, I agree to comply with the confidentiality standards and practices as set out by the Division of Developmental Disabilities as well as by ACCENT on Family Care Services. I have been oriented on my consumer’s care and services. I agree to follow all guidelines as set forth in ACCENT’s Policy and Procedures and keep all certifications and trainings updated.

Complete each row for every individual you serve and return the completed signed form to ACCENT.

|  |  |  |
| --- | --- | --- |
| Date | Consumer Name  | Provider Signature |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |