**New Admission Packet**

Please complete the information below; it is required to help populate the form. The form will re-align itself once this information is provided.

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AUTHORIZATION TO DISCLOSE INFORMATION

I, (LRP) hereby authorize to disclose specific informationfrom the records of the above named client to: WesCare Professional Services, LLC. Located at 2704 N. Church Street · Greensboro, NC 27405 and in addition authorize WesCare Professional Services, LLC to disclose specific information to the provider named above for the specific purpose(s) of:

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|  | Making a placement decision for admission |  |  | Work Related or volunteer related opportunities |
|  | Psychological/Psychiatric Assessments |  |  | Medical/Vision/Dental Health |
|  | Current Medications |  |  | Social Networking (Coach, Pastor, Friend’s Parents, etc.) |
|  | School Academic Achievement |  |  | Evaluations reflecting current level of functioning |
|  | Behavior Concerns |  |  | Other Purposes listed below (Please be sure to detail these purposes below) |

Other purposes:

Specific information to be disclosed:

***EXCEPTION:*** Only the information indicated above will be released/disclosed with this signed consent unless it is an emergency or for other exceptions as detailed in the General Statutes or in 45 CFR 164.512 of HIPAA. Some exceptions include reporting neglect/abuse, criminal activity or other legal proceedings.

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| This authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the *Revocation form*. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.  I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.  I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.  I further understand that I may request a copy of this signed authorization. |

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| *NOTE: This Authorization was revoked on* |  |  |  |
|  | Date |  | Signature of Staff |

FACE SHEET

IDENTIFICATION PAGE

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| CLIENT NAME: | | | | |  | | | | | | | | | |  | | | | | | | | | |  | | | | | | | | | |
|  | | | | | | | First | | | | | | | | Middle | | | | | | | | | | Last | | | | | | | | | |
| ADDRESS: | |  | | | | | | | | | | | | | | | | | | | | | | | Legal Guardian:  Check If Client is Guardian | | | | | | | | | |
| CITY: | |  | | | | | | | | | | | STATE: | | |  | | ZIP: | | | |  | | | Name: | | | | |  | | | | |
| COUNTY: | |  | | | | | | | | | | | | | | | | | | | | | | | Phone: | | | | |  | | | | |
| RACE: | | White | | | | | | | | | ETHNICITY: | | Non-Hispanic | | | | | | | | | | | | Email: | | | | |  | | | | |
| PHONE 1: | |  | | | | | | | | | | PHONE 2: | | | |  | | | | | | | | | PHONE 3: | | | | | | |  | | |
| MARITAL STATUS: | | | | | |  | | | | | | | | SOCIAL SECURITY: | | | | | |  | | | | | | | | | | |  | | |  |
| DIAGNOSIS: | | | | | | AXIS I | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | AXIS II | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | AXIS III | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | AXIS IV | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | AXIS V | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | Allergies: | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| PHYSICIAN: | | |  | | | | | | | | | | | | | | | | | | PHONE: | |  | | | | | | | | | | | |
| ADDRESS: | | |  | | | | | | | | | | | | | | | | | | | | | | | | | EMAIL: | | | | |  | |
| ALTERNATE PHYSICIAN: | | | | | | | |  | | | | | | | | | | | | | PHONE: | |  | | | | | | | | | | | |
| ADDRESS: | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CITY: |  | | | | | | | | | | | | | | | | STATE: | | | | |  | | | | | ZIP: | |  | | | | | |
| AMBULANCE: | | | |  | | | | | | | | | | | | | | | | | | PHONE: | |  | | | | | | | | | | |
| FIRE DEPT: | | | |  | | | | | | | | | | | | | | | | | | PHONE: | |  | | | | | | | | | | |
| POISON CONTROL CENTER: | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| IN CASE OF EMERGENCY, NOTIFY: The person(s) listed below will be notified in addition to the guardian if an emergency occurs | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name | | | | | | | | | | | | | Relationship | | | | | | Email | | | | | | | Phone | | | | | | | | |  |
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| LIST INSURANCES THAT COVER THIS PERSON: (Use a separate page for more than two policies) | | | | |
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| Address: |  | | | Address: |  | |
|  |  | | |  |  | |
| Policy Holder: |  | | | Policy Holder: |  | |
|  |  | | |  |  | |
| Insurance# |  | | | Insurance# |  | |
| DATE OF ADMISSION | |  | DATE FORM COMPLETED | | |  |

**MEDICATION AUTHORIZATION**

I understand that the medication(s) listed below have been prescribed for me or the person for whom I am legally responsible by a medical professional. I have been informed of the potential side effects of these medications and understand that while this authorization is in effect, I will be updated when new medications are prescribed. I further understand that pharmacy information explaining the side effects of the new medications will be made available at the main office by request.

Medication(s):

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You may request additional information about the medication(s) listed through the QP assigned to your case.

I, , give permission for certified staff of WesCare, to administer the above mentioned prescribed medication for treatment purposes. I have been notified of the possible adverse side effects that could occur.

I, , will self-administer medication, therefore, there are no prescriptions written and there is no medication administration record in the client file.

I hereby acknowledge that this consent will expire automatically after 1 year from the date on which it is signed.

**Client Finances**

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| **Personal Funds** | **Client Fees** |
| Consumers of WesCare Professional Services, LLC., hereafter referred to as WesCare, will be required to use their personal funds for the following:   1. Pocket money for outings 2. Clothing, accessories and personal equipment (i.e., private radio, TV, etc.) 3. Any beauty and/or barber shop trip over $10.00 4. Money needed for school/educational outings 5. Personal video tapes, cassette tapes, or magazines for the resident’s enjoyment. 6. Dry cleaning of clothing items. 7. Premiums for personal insurance policies. 8. Fees for camps, vacations, etc. | As a Provider of residential and periodic services, State and Federal regulations bind WesCare Professional Services, LLC., in the area of client fees.  As a consumer or Parent / Legal Guardian of a consumer who is served by WesCare Professional Services, LLC., you may expect the following in relation to client fees:   * Most of our clients are eligible for Medicaid funded services. In these cases, there shall be no fees charged for services allowed and reimbursed by Medicaid. * In those rare cases of a private-pay consumer, the person legally responsible for the client will be billed monthly, in arrears, for services provided. * The private-pay daily rate for services will be equal to the Medicaid daily rate for the service provided, i.e., residential or periodic. * Those personal items and services not covered in the Medicaid daily rate include such items as toothpaste, cosmetics, hair care products, haircuts, etc. These items are generally covered by SSI. It may be necessary to bill the consumer or person legally responsible person for the consumer for these items if sufficient SSI funds are not available.   If you have any questions about these issues, please contact the supervising QP. |

I have reviewed the above list and understand personal funds of the client named above will be used toward this end.

**EXPLANATION OF CLIENT RIGHTS**

Basic Human Rights are assured to each client/consumer served by WesCare Professional Services, LLC. These rights include the right to dignity, privacy, humane care, and freedom from mental and physical abuse, neglect, and exploitation. Each client/consumer is assured the right to live as normally as possible while receiving care and age-appropriate treatment.

Each client/consumer has the right to:

* Have an individualized written treatment or habilitation plan setting forth a program to maximize the development of her/his capabilities.
* Be free from unnecessary or excessive medication. Medication shall not be used for punishment, discipline, or staff convenience.
* Have medication administered in accordance with accepted medical standards and only upon the order of a physician as documented in the consumer’s record. If the client/consumer refuses to take the medication, staff may not force her/him to take the medication.
* Consent to or refuse any treatment offered. Consent may be withdrawn at any time by the person who gave consent. If treatment is refused, the qualified professional shall determine whether treatment in some other modality is possible.
* Keep the same rights (as age permits) as any other citizen to exercise their rights, unless the exercise of that right has been disallowed by an adjudication of incompetence, including the right to:

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| > | Dispose of property | > | Keep and spend money |
| > | Execute instruments | > | Enter into contractual relationships |
| > | Make purchases | > | Bring civil actions |
| > | Register and vote | > | Contact and consult with:  legal counsel  private physicians  other professionals |
| > | Marry and get a divorce |
| > | Send and receive sealed mail |
| > | Make/receive confidential telephone calls |
| > | Make visits and receive visitors | > | Be out of doors daily and have access to physical exercise |
| > | Communicate with individuals of his/her own choice | > | Participate in religious worship |
| > | Keep and use personal possessions | > | Retain a driver’s license as appropriate |

My signature below acknowledges that I have received a copy of WesCare’s Consumer Handbook and my rights and the handbook have been explained to me. I further understand that for a full description of all my rights, I should refer to my copy of the Consumer Handbook. I understand and agree to comply with the contents of this guide. In addition, I understand that this is only a guide and additional placement agreements and consent forms will contain more specific information. These forms will be reviewed with me, and signed by me or my guardian at the time of admission into the home or new service.

Client Name

Client Signature (If possible)

**SCREENING/REFERRAL FORM**

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| Date: | **2/5/2014** | | |  | | | | Referring Agency: | Click here to enter text. | | |
|  |  | |  | | | | | Contact Name: | Click here to enter text. | | |
|  |  | |  | | | | | Contact Phone: | Click here to enter text. | | |
|  |  | |  | | | | | Email: | Click here to enter text. | | |
| **DSM IV Diagnoses** Check one **ICD 9  ICD 10** | | | | | **Medication(s):** | | | | | **Dosage** | |
| **Axis 1** | |  | | | **1** | |  | | |  | |
| **Axis 2** | |  | | | **2** | |  | | |  | |
| **Axis 3** | |  | | | **3** | |  | | |  | |
| **Axis 4** | |  | | | **4** | |  | | |  | |
| **Axis 5** | |  | | | **5** | |  | | |  | |
| **Current Status/Issues:** | | | | | | | | | | | |
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| **Educational Status/Needs:** | | | | |  | **Family History:** | | | | |
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| **Vocational Status/Needs:** | | | | |  | **Physical Concerns or Problems:** | | | | |
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| **Previous Placement History:** | | | | |  | **Recommendations:** | | | | |
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| **Disposition (For Office Use Only)** | | | | | | | | | | |
| WesCare has agreed to provide the following service(s): | | | | | | | | | | |
| WesCare has declined to provide services because: | | | | | | | | | | |
| Recommendations: | | | | | | | | | | |

**VISITATION REPORT**

Individuals who have permission to visit the consumer, by a pre-arranged meeting or can remove the consumer from the agency premises for day visits or overnight visits.

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Individuals who only have permission to visit the consumer, by a pre-arranged meeting or can remove the consumer from the agency premises for day visits. These are not to be overnight visits.

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Individuals who only have permission to visit this person at their agency managed residence.

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| Comments: |
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I understand that WesCare Professional Services, LLC., its personnel will NOT be held responsible for any accidents or for any deterioration while the consumer is not at their residence in any of the above-referenced person’s care. I further understand that I can rescind this permit at any time by notifying the supervising QP, the Clinical Director, or the Operations Manager in writing.

RESTRICTIVE INTERVENTION CONSENT

Our company’s policy requires all staff to complete a restrictive interventions course, as there are times when the behavior of our consumers calls for physical/restrictive intervention by staff. Therefore, WesCare Professional Services, LLC. requires consent to use restrictive interventions, if needed, if continuous behaviors exist, namely:

* Consumer is causing or attempting to cause injury to another consumer, staff, or other individual
* Consumer is causing or attempting to cause injury to himself or herself
* Consumer is causing or attempting to cause excessive property damage

WesCare will not use time outs, isolation, or seclusion. Nor does WesCare use mechanical devices or medication regimen protocols as a means to control the behaviors of a consumer. WesCare will only use prescribed medications from a licensed physician, and only for its intended purpose.

I, , hereby give consent for WesCare Professional Services, LLC. to use restrictive interventions, as needed, if the aforementioned conditions exist. I further understand that this consent is valid for six months from the date that it is signed. This consent may be revoked with written notice at any time prior to the six month expiration date.

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Person Completing Form Date WesCare Representative Date

#### For office use only

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| NCI INSTRUCTOR’S TEMP APPROVAL DATE (good for 30 days): \_\_\_\_\_\_\_\_\_\_\_\_\_\_NCI INSTRUCTOR’S SIGNATURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_--------------------------------- CLIENT RIGHTS COMMITTEE USE BELOW --------------------------------------------CRC REVIEW DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  APPROVED  DENIEDREASON FOR DENIAL:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CRC APPROVAL DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CRC EXPIRATION DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_NCI INSTRUCTOR SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CRC CHAIR SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**STANDING ORDERS**

The following orders are good for 1 year from the date signed. Strike through any orders you do not want applied to this consumer. Age and weight are taken into consideration, and dosages may be administered according to age/weight if different than directions listed below.

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| **PAIN**: | Tylenol (Acetaminophen) 650mg – As directed by package prn for minor pain/headache x 48 hrs (may give tablet, Cap or liquid). Notify M.D. of continued minor pain or headache. | | | | |
| **COUGH**: | Robitussin D.M. (Guaifenesin w/Dextromorphan) 10ml – po as directed by package prn for cough x 48 hrs. Notify M.D. of continued cough. (DO NOT TAKE WITH TYLENOL COLD.) | | | | |
| **SORE THROAT**: | Chloraseptic spray/lozenges – 5 sprays or dissolve 1 lozenge Q 2 hrs prn for sore throat x 48 hrs. Notify M.D. of continued sore throat. | | | | |
| **RUNNY NOSE**: | Tylenol Cold Tabs every 6 hrs, not to exceed 8 tabs in 24 hrs. Do not take other Tylenol or any ANSAIDS while on this. | | | | |
| **INDIGESTION**: | Mylanta (antacid) susp. – 30ml po Q 4 hrs prn indigestion/stomach upset x 48 hrs. Notify M.D. of continued symptoms. | | | | |
| **CONSTIPATION**: | MOM – 30ml po Q day x 1 prn for constipation. If no results within 24 hrs, may give Dulcolax (bisacodyl) supp. PR x 1 prn for constipation. If no bowel movement in 24 hrs. check for impaction. If impacted, remove impaction. If not impacted, give Fleets Enema PR x 1. If not effective, notify M.D. | | | | |
| **DIARRHEA**: | If 3 loose stools in 24 hrs, hold all laxatives and stool softeners. Kaopectate 30 cc po after 1st loose stool, then every 2 hrs prn – no more than 6 doses in 24 hrs. | | | | |
| **NAUSEA**: | Dramamine (dimenhydrinate) 50mg po Q 4 hrs prn for nausea x 48 hrs. Or Phenergan 25mg supp. Q 4 hrs prn for nausea x 48 hrs. If not effective, notify M.D. | | | | |
| **MINOR CUTS or SCRATCHES**: | Cleanse area with peroxide and apply Neosporin (triple antibiotic ointment), and then apply non-adhering dressing Q day until healed. | | | | |
| **RASH**: | Benadryl (diphenhydramine) 25mg bid prn for rash x 24 hrs. Do not overlap with other antihistamine medications. If not resolved in 24 hrs, call M.D. | | | | |
| **Allergies:** |  | **Height:** |  | **Weight:** |  |

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| Other Orders / Modifications: |
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Signature of Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

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| The following consents are granted or denied for the person named above, who is or will be receiving supports and services from WesCare. Please check the appropriate boxes below.  **MEDICAL CONSENTS** | | | | |
| Granted |  | Denied |  | **EMERGENT AND/OR ROUTINE HEALTHCARE** |
|  |  |  |  | To ensure that necessary medical, dental, and psychiatric care may be more readily available, WesCare is authorized to seek, consent to, and obtain emergent and routine health, dental, and psychiatric care for the above individual on an as needed basis, and to implement any medication or treatment recommended by the healthcare provider(s). |
|  |  |  |  | MEDICAL/SURGICAL |
|  |  |  |  | The parent/legal guardian of the above-named person has granted limited power of attorney to act on behalf of this person in case of a medical emergency or condition requiring immediate medical/surgical intervention when attempts to contact the parent/legal guardian have been unsuccessful for the purpose of gaining signed consent for treatment. (***For parents/legal guardians who prefer not to grant this consent, please document your preferred protocol in the notes section below.)*** |
|  |  |  |  | **SELF-ADMINISTRATION OF MEDICATION** |
|  |  |  |  | This consent is for adult consumers over the age of 18 that have demonstrated the ability and willingness to self-administer. It can also be used for consumers under 18 who require medications that: **1**. can be more effectively self-administered and only monitored by staff, **2.** create an uncomfortable situation for the consumer, and **3.** can more effectively be used or applied by the consumer. (Some examples of these medications include topicals, enemas, and some injections. **If there are only certain meds this consent applies to, please indicate those medications in the notes section below. Otherwise the consent will apply to all medications**)   |  |  |  |  |  | | --- | --- | --- | --- | --- | | 1 | Click here to enter text. |  | 5 | Click here to enter text. | | 2 | Click here to enter text. |  | 6 | Click here to enter text. | | 3 | Click here to enter text. |  | 7 | Click here to enter text. | | 4 | Click here to enter text. |  | 8 | Click here to enter text. |   WesCare will not administer these medications (unless requested by the client); staff will, however, be available to assist with reading prescriptions/directions as prescribed by the physician. |

Notes:

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I understand that all of the above consents will remain in effect until the consumer is discharged from WesCare, the consent is revoked, or 1 year from the date the consent was signed. Any of the above consents may be revoked in writing by the undersigned at any time except to the extent that action has already been taken that cannot be reversed.

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| The following consents are granted or denied for the person named above, who is or will be receiving supports and services from WesCare. Please check the appropriate boxes below. Be advised, some of our facilities have surveillance systems installed. Regardless of your choices below, residents in these houses will be recorded in common areas only. These systems are installed to help keep all our residents safe.  **NON-MEDICAL CONSENTS** | | | | |
| Granted |  | Denied |  | **CONSENT TO PHOTOGRAPH** |
|  |  |  |  | WesCare has consent to take photographs, video and/or audio by film or other electronic means for identification purposes, provide supporting documentation of medical conditions, training, or for marketing/business purposes. Any materials produced are the exclusive property of WesCare, giving them exclusive rights and title therein to reproduce and use the materials in the future except for the following exclusions or limitations: |
|  |  |  |  | **SERVICE/PROVIDER SELECTION** |
|  |  |  |  | The parent/legal guardian of the above-named person has been provided a list of service providers. The parent/legal guardian of this person has granted consent to WesCare to provide the following service(s):   |  |  | | --- | --- | | Residential/Supported Living | Community Networking | | Day Supports - Individual | Respite | | Personal Care Services/Personal Assistance | Supported Employment |   The signature below confirms that the parent/legal guardian has selected WesCare as their service provider freely, without influence, pressure or coercion, direct or indirect, from anyone affiliated with WesCare or anyone who may stand to gain from this action. |
|  |  |  |  | **TRANSPORTATION** |
|  |  |  |  | The parent/legal guardian of the above-named person has given consent to WesCare to provide and/or arrange general transportation services for this person. |

Notes:

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I understand that all of the above consents will remain in effect until the consumer is discharged from WesCare, the consent is revoked, or 1 year from the date the consent was signed. Any of the above consents may be revoked in writing by the undersigned at any time except to the extent that action has already been taken that cannot be reversed.