EMERGENCY FORM

Client Name: _____
Facility Name: _____
Address: _____
Facility Tel #: _____
Care Provider: _____
Job Title: _____
Tel #: _____
Admission Date: _____
Date of Birth: _____
SS #: _____

CLIENT PHOTO
HERE
(Must be a current close-up!)

Responsible Person/Placement Agency: _____
Address: _____ Tel #: _____
SARC UCI #: _____ MEDI-CAID Waiver: ___ Y ___ N
Diagnosis: _____
Language Spoken: _____
Is Client Conserved? ____ Y _____ N Marital Status: _____
Conservator's Address: _____ Tel #: _____
Name of Nearest Relative: _____
Relative's Address: _____ Tel #: _____

PHYSICAL DESCRIPTION:
Eye Color: _____ Weight: _____ Sex: ___ M ___ F
Hair Color: _____ Height: _____
Ambulatory Status: ___Ambulatory ___ Non-ambulatory

INSURANCE INFORMATION:
MEDI-CAL #: _____ Medicare #: _____
Dental Plan: _____ Own Insurance (if any): _____

MEDICAL PROVIDERS:
Physician: _____ Tel #: _____ Address: _____
Dentist: _____ Tel #: _____ Address: _____
Psychologist: _____ Tel #: _____ Address: _____
Psychiatrist: _____ Tel #: _____ Address: _____
Pharmacy: _____ Tel #: _____ Address: _____
Name of hospital to be taken in emergency: _____
Hospital Address: _____ Tel #: _____

ALLERGIES: _____
SEIZURES: _____ TYPE: _____
CURRENT LIST OF MEDICATIONS: (See Centrally Medication Chart)

Completed by: _____ Signature: _____ Title: _____

Signature of Resident: _____ Date: _____

PHYSICIAN'S REPORT FOR COMMUNITY CARE FACILITIES

For Resident/Client Of, Or Applicants For Admission To, Community Care Facilities (CCF).

NOTE TO PHYSICIAN:
The person specified below is a resident/client of or an applicant for admission to a licensed Community Care Facility. These types of facilities are currently responsible for providing the level of care and supervision, primarily nonmedical care, necessary to meet the needs of the individual residents/clients.

THESE FACILITIES DO NOT PROVIDE PROFESSIONAL NURSING CARE.
The information that you complete on this person is required by law to assist in determining whether he/she is appropriate for admission to or continued care in a facility.

FACILITY INFORMATION (To be completed by the licensee/designee)

NAME OF FACILITY: | TELEPHONE:

ADDRESS: NUMBER STREET CITY

LICENSEE'S NAME: | TELEPHONE: | FACILITY LICENSE NUMBER:

RESIDENT/CLIENT INFORMATION (To be completed by the resident/authorized representative/licensee)

NAME: | TELEPHONE:

ADDRESS: NUMBER STREET CITY | SOCIAL SECURITY NUMBER:

NEXT OF KIN: | PERSON RESPONSIBLE FOR THIS PERSON'S FINANCES:

PATIENT'S DIAGNOSIS (To be completed by the physician)

PRIMARY DIAGNOSIS:

SECONDARY DIAGNOSIS: | LENGTH OF TIME UNDER YOUR CARE:

AGE: | HEIGHT: | SEX: | WEIGHT: | IN YOUR OPINION DOES THIS PERSON REQUIRE SKILLED NURSING CARE? ☐ YES ☐ NO

TUBERCULOSIS EXAMINATION RESULTS: ☐ ACTIVE ☐ INACTIVE ☐ NONE | DATE OF LAST TB TEST:

TYPE OF TB TEST USED: | TREATMENT/MEDICATION: ☐ YES ☐ NO If YES, list below:

OTHER CONTAGIOUS/INFECTIOUS DISEASES:
A) ☐ YES ☐ NO If YES, list below:

TREATMENT/MEDICATION:
B) ☐ YES ☐ NO If YES, list below:

ALLERGIES
C) ☐ YES ☐ NO If YES, list below:

TREATMENT/MEDICATION:
D) ☐ YES ☐ NO If YES, list below:

Ambulatory status of client/resident: ☐ Ambulatory ☐ Nonambulatory

Health and Safety Code Section 13131 provides: "Nonambulatory persons" means persons unable to leave a building unassisted under emergency conditions. It includes any person who is unable, or likely to be unable, to physically and mentally respond to a sensory signal approved by the State Fire Marshal, or an oral instruction relating to fire danger, and persons who depend upon mechanical aids such as crutches, walkers, and wheelchairs. The determination of ambulatory or nonambulatory status of persons with developmental disabilities shall be made by the Director of Social Services or his or her designated representative, in consultation with the Director of Developmental Services or his or her designated representative. The determination of ambulatory or nonambulatory status of all other disabled persons placed after January 1, 1984, who are not developmentally disabled shall be made by the Director of Social Services, or his or her designated representative.

I. PHYSICAL HEALTH STATUS: ☐ GOOD ☐ FAIR ☐ POOR	COMMENTS:			
	YES (Check One)	NO (Check One)	ASSISTIVE DEVICE	COMMENTS:
1. Auditory impairment				
2. Visual impairment				
3. Wears dentures				
4. Special diet				
5. Substance abuse problem				
6. Bowel impairment				
7. Bladder impairment				
8. Motor impairment				
9. Requires continuous bed care				

II. MENTAL HEALTH STATUS: ☐ GOOD ☐ FAIR ☐ POOR	COMMENTS:			
	NO PROBLEM	OCCASIONAL	FREQUENT	IF PROBLEM EXISTS, PROVIDE COMMENT BELOW:
1. Confused				
2. Able to follow instructions				
3. Depressed				
4. Able to communicate				

III. CAPACITY FOR SELF CARE: ☐ YES ☐ NO	COMMENTS:		
	YES (Check One)	NO (Check One)	COMMENTS:
1. Able to care for all personal needs			
2. Can administer and store own medications			
3. Needs constant medical supervision			
4. Currently taking prescribed medications			
5. Bathes self			
6. Dresses self			
7. Feeds self			
8. Cares for his/her own toilet needs			
9. Able to leave facility unassisted			
10. Able to ambulate without assistance			
11. Able to manage own cash resources			

PLEASE LIST OVER-THE-COUNTER MEDICATION THAT CAN BE GIVEN TO THE CLIENT/RESIDENT, AS NEEDED, FOR THE FOLLOWING CONDITIONS:

CONDITIONS	OVER-THE-COUNTER MEDICATION(S)
1. Headache	_____
2. Constipation	_____
3. Diarrhea	_____
4. Indigestion	_____
5. Others *(specify condition)*	
_____	_____
_____	_____

PLEASE LIST CURRENT PRESCRIBED MEDICATIONS THAT ARE BEING TAKEN BY CLIENT/RESIDENT:

1. _____	4. _____	7. _____
2. _____	5. _____	8. _____
3. _____	6. _____	9. _____

PHYSICIAN'S NAME AND ADDRESS:	TELEPHONE:	DATE:

PHYSICIAN'S SIGNATURE

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION (TO BE COMPLETED BY PERSON'S AUTHORIZED REPRESENTATIVE)

I hereby authorize the release of medical information contained in this report regarding the physical examination of:

PATIENT'S NAME:

TO (NAME AND ADDRESS OF LICENSING AGENCY):

SIGNATURE OF RESIDENT/POTENTIAL RESIDENT AND/OR HIS/HER AUTHORIZED REPRESENTATIVE	ADDRESS:	DATE:

IMMUNIZATION RECORDS

CONSUMER NAME: _____ DATE OF BIRTH: _____

☐ NO IMMUNIZATION RECORD PRIOR TO PLACEMENT AT THIS FACILITY AVAILBALE

IMMUNIZATIONS AND TESTS

DATE OF EACH IMMUNIZATION														
POLIO (TYPE)					TETANUS					MEASLES				
DPT					FLU					MUMPS				
DT										RUBELLA				

DATE, REACTION OR RESULTS

	DATE	REACTION	DATE	REACTION	DATE	REACTION
TUBERCULIN						
CHEST X-RAY						
OTHER (specify)						

SPECIAL MEDICAL PROBLEMS

_____

_____

_____

☐ NO ALLERGY INFORAMTION PRIOR TO PLACEMENT AT THIS FACILITY AVAILABLE

ALLERGY	REACTION
_____	_____
_____	_____
_____	_____

DRUG	REACTION
_____	_____
_____	_____
_____	_____

APPRAISAL/NEEDS AND SERVICES PLAN

CLIENT'S/RESIDENT'S NAME	DATE OF BIRTH	AGE	SEX ☐ MALE ☐ FEMALE	DATE
FACILITY NAME	ADDRESS			CHECK TYPE OF NEEDS AND SERVICES PLAN: ☐ ADMISSION ☐ UPDATE
PERSON(S) OR AGENCY(IES) REFERRING CLIENT/RESIDENT FOR PLACEMENT			FACILITY LICENSE NUMBER	TELEPHONE NUMBER ( )

Licensing regulations require that an appraisal of needs be completed for specific clients/residents to identify individual needs and develop a service plan for meeting those needs. If the client/resident is accepted for placement the staff person responsible for admission shall jointly develop a needs and services plan with the client/resident and/or client's/resident's authorized representative referral agency/person, physician, social worker or other appropriate consultant. Additionally, the law requires that the referral agency/person inform the licensee of any dangerous tendencies of the client/resident.

NOTE: *For Residential Care Facilities for the Elderly, this form is not required at the time of admission but must be completed if it is determined that an elderly resident's needs have not been met.*

BACKGROUND INFORMATION: *Brief description of client's/resident's medical history/ emotional, behavioral, and physical problems; functional limitations; physical and mental; functional capabilities; ability to handle personal cash resources and perform simple homemaking tasks; client's/resident's likes and dislikes.*

NEEDS	OBJECTIVE/PLAN	TIME FRAME	PERSON(S) RESPONSIBLE FOR IMPLEMENTATION	METHOD OF EVALUATING PROGRESS
SOCIALIZATION — Difficulty in adjusting socially and unable to maintain reasonable personal relationships				
EMOTIONAL — Difficulty in adjusting emotionally				

(Continued on Reverse)

NEEDS	OBJECTIVE/PLAN	TIME FRAME	PERSON(S) RESPONSIBLE FOR IMPLEMENTATION	METHOD OF EVALUATING PROGRESS
MENTAL — Difficulty with intellectual functioning including inability to make decisions regarding daily living.				
PHYSICAL/HEALTH — Difficulties with physical development and poor health habits regarding body functions.				
FUNCTIONING SKILLS — Difficulty in developing and/or using independent functioning skills.				

We believe this person is compatible with the facility program and with other clients/residents in the facility, and that I/we can provide the care as specified in the above objective(s) and plan(s).

TO THE BEST OF MY KNOWLEDGE THIS CLIENT/RESIDENT DOES NOT NEED SKILLED NURSING CARE.

LICENSEE(S) SIGNATURE ▶	DATE

I have reviewed and agree with the above assessment and believe the licensee(s) other person(s)/agency can provide the needed services for this client/resident

CLIENT'S/RESIDENT'S AUTHORIZED REPRESENTATIVE(S)/FACILITY SOCIAL WORKER/PHYSICIAN/OTHER APPROPRIATE CONSULTANT SIGNATURE ▶	DATE

I/We have participated in and agree to release this assessment to the licensee(s) with the condition that it will be held confidential.

CLIENT'S/RESIDENT'S OR CLIENT'S/RESIDENT'S AUTHORIZED REPRESENTATIVE(S) SIGNATURE ▶	DATE

San Andreas Regional Center
Semi-Annual & Quarterly Report on Consumer Progress on IPP Objectives
Level _____

Part One
Per Title 17, Section 56026 (c) The Administrator shall be responsible for ensuring the preparation and maintenance of the written report of consumer progress toward achievement of each IPP objective for which the facility is responsible.

Please keep a copy in consumer file and send a copy to San Andreas Regional Center Service Coordinator within 30 days following the end of the quarter.

Consumer Name:	UCI#	Date of Birth:
Admission Date:	Facility:	Report Prepared by:
Report Date:	Months Covered:	

Medications (Name/Dosage)	Physician's Name	Reason for the Medication

Medication Changes_____
_____

Health Status (concerns, changes, referrals or health related issues) _____
_____
_____
_____

Weight:	Height:	P&I Balance:

San Andreas Regional Center
Semi-Annual & Quarterly Report on Consumer Progress on IPP Objectives
Level _____

IPP Objective #1_____

Summary of data and progress:

_____
_____
_____
_____

Identification of barriers to consumer progress and action taken in response to these barriers:

_____
_____
_____
_____

IPP Objective #2_____

Summary of data and progress:

_____
_____
_____
_____

Identification of barriers to consumer progress and action taken in response to these barriers:

_____
_____
_____
_____

IPP Objective #3_____

Summary of data and progress:

_____
_____
_____
_____

San Andreas Regional Center
Semi-Annual & Quarterly Report on Consumer Progress on IPP Objectives
Level _____

Identification of barriers to consumer progress and action taken in response to these barriers:

_____
_____
_____
_____

IPP Objective #4_____

Summary of data and progress:

_____
_____
_____
_____

Identification of barriers to consumer progress and action taken in response to these barriers:

_____
_____
_____
_____

IPP Objective #5_____

Summary of data and progress:

_____
_____
_____
_____

Identification of barriers to consumer progress and action taken in response to these barriers:

_____
_____
_____
_____

_____ _____
Facility Administrator **Date**

San Andreas Regional Center
Semi-Annual & Quarterly Report on Consumer Progress on IPP Objectives
Level _____

Part Two: (To be completed by Service Coordinator during the quarterly face to face visit)

Consumer Name:	Date of Birth:
Date of Review:	Location:

Present at Meeting:

_____
_____
_____

Consumer Progress Report on IPP Objectives - if not addressed in Part One:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

I _____concur with assessment of progress toward achievement of the IPP objectives as described in Part I, and have reviewed this information with the consumer.

_____

Service Coordinator
San Andreas Regional Center

Date

RECORD OF MEDICAL / DENTAL CARE

RESIDENT'S NAME: _____

Date of Visit:

Name of Physician / Dentist / Psychiatrist / Other: _____

Problem:

Treatment and/or Medication Prescribed:

_____

(Signature of person making entry)

Date of Visit:

Name of Physician / Dentist / Psychiatrist / Other: _____

Problem:

Treatment and/or Medication Prescribed:

_____

(Signature of person making entry)

Date of Visit:

Name of Physician / Dentist / Psychiatrist / Other: _____

Problem:

Treatment and/or Medication Prescribed:

_____

(Signature of person making entry)

SPECIAL INCIDENT REPORT FOR ALL VENDORS
TO BE E-MAILED OR FAXED TO SAN ANDREAS REGIONAL CENTER
(Within 24 hours of the incident)

Consumer's Name:	UCI #:
Consumer's Address:	Date of Birth: Sex: _____Male _____Female
Vendor or Agency Name:	Date of Report:
If in Residential facility, date of admission:	Service Coordinator:
Conservator/Guardian name (if applicable):	CCL Facility Number:
Name of person reporting:	Position at agency:

TYPE OF INCIDENT
(Check all that apply)

☐ Suspected Abuse/Exploitation *(Limited to that which has occurred while under care/supervision of a vendor.)* Check type:
- ☐ Sexual
- ☐ Fiduciary
- ☐ Emotional/Mental
- ☐ Physical and/or Chemical Restraint

☐ Serious Injury/Accident Which Occurs While the Consumer is Under the Care and Supervision of Any Vendor and Results in One or More of the Following Check type:
- ☐ Lacerations requiring sutures or staples
- ☐ Puncture wounds requiring medical treatment beyond first aid
- ☐ Fractures
- ☐ Dislocations
- ☐ Bites that break the skin and require medical treatment beyond first aid
- ☐ Internal bleeding
- ☐ Medication errors/reactions that require intervention by licensed medical personnel
- ☐ Burns that require medical treatment beyond first aid

☐ Victim of Crime *(Regardless of consumer's living arrangement or perpetrator.)* Check type:
- ☐ Personal Robbery
- ☐ Aggravated assault
- ☐ Burglary
- ☐ Forcible rape
- ☐ Larceny
- ☐ Other (specify)

☐ Suspected Neglect *(Limited to that which has occurred while under care/supervision of a vendor.)* Check type:
- ☐ Failure to Assist in Personal Hygiene, Provision of Food, Clothing, Shelter
- ☐ Failure to Prevent Malnutrition or Dehydration
- ☐ Failure to Provide Medical Care
- ☐ Failure to Protect from Health & Safety Hazards

☐ Any Unplanned or Unscheduled Hospitalization Due to the Following Conditions. Check type:
- ☐ Respiratory illness
- ☐ Seizure-related
- ☐ Cardiac related
- ☐ Internal infections
- ☐ Diabetes related
- ☐ Wound/skin care
- ☐ Nutritional deficiencies
- ☐ Involuntary psychiatric admission

☐ Missing Person *(Complete only when reported to law enforcement and if consumer was under care/supervision of a vendor.)*

☐ Death *(Regardless of living arrangement, cause or perpetrator)*
See page 3

☐ Serious Injury/Accident Which Occurs While the Consumer is Under the Care and Supervision of Any Vendor and Results in One or More of the Following: Check type:
- ☐ Injury-Accident
- ☐ Injury-Unknown origin
- ☐ Injury from seizure
- ☐ Injury from another consumer
- ☐ Injury from behavior episode

☐ Aggression Displayed by Consumer. Check type:
- ☐ Aggressive act to self
- ☐ Aggressive act to another consumer
- ☐ Aggressive act to staff
- ☐ Aggressive act to family/visitor

☐ Other Check type:
- ☐ Violation of Rights
- ☐ Pregnancy
- ☐ Disease outbreak
- ☐ Fire
- ☐ Suicide attempt
- ☐ Threatened suicide
- ☐ Medical emergency
- ☐ Property damage
- ☐ Other sexual incident—Not rape
- ☐ Unauthorized absence–law enforcement not notified
- ☐ Other:

Incident date ☐ Definitive ☐ Approximate	Time of incident ☐ Definitive ☐ Approximate
Date incident reported to RC	Medical Care/Treatment Required? ☐ Yes ☐ No

Relationship of alleged perpetrator to consumer
- ☐ Unknown
- ☐ Self
- ☐ Vendor or Employee of Vendor
- ☐ Non-Vendor or Employee of Non-Vendor
- ☐ Another Consumer
- ☐ Relative/Family Member
- ☐ Individual known to consumer (Not a provider or another consumer)
- ☐ Not applicable

Incident location (Check only one)		
☐ Acute hospital–not ER ☐ Acute hospital–ER ☐ Day care/ Intervention program ☐ Psychiatric treatment center ☐ SNF ☐ Other	☐ Job site ☐ Out of home respite ☐ Community setting ☐ Home of family ☐ In transit ☐ Sub acute or pediatric sub acute	☐ Day program ☐ Consumer's residence ☐ Hospice ☐ Jail or related setting ☐ Pubic school ☐ Rehabilitation facility

Person/Agency responsible for consumer at time of incident	
☐ Vendor Vendor Number: ☐ Self/Spouse ☐ Residential ☐ Parent/Family ☐ Day Program ☐ Other	Name: Address: City/Zip: Telephone:

Other agencies notified by person/agency making this report	
☐ Community Care Licensing	☐ DHS Licensing & Certification
☐ Child Protective Services	☐ Adult Protective Services
☐ Parent/Guardian/Conservator	☐ Long-Term Care Ombudsman
☐ Police/Law Enforcement	☐ Other
☐ Coroner	☐ Other Specify

Description of incident

Attending Physician's name, findings, and treatment, if any:

Specific preventative action taken or planned:

Disposition:

Complete Only if Incident Type is Death	
Describe the circumstances of the consumer's death	
Describe nature of medical treatment and where administered	
Other comments or information regarding death	
Type of Death ☐ *Disease Related* ☐ *Unknown*	☐ ***Non-Disease Related*** ☐ Homicide ☐ Suicide ☐ Accident ☐ Alleged Abuse/Neglect ☐ Suspected Substance Abuse ☐ Catastrophic Event (Fire, Flood) ☐ Other (specify)

Residential Care Home

Ongoing Progress Notes

Per Title 17, Section 56026 (a) (1) - (6)

The administrator for each Service Level 2, 3, or 4 facility shall be responsible for ensuring preparation and maintenance of on-going, written consumer notes which shall include: community and leisurely activities, overnight visits away from the facility, illness, Special Incident Reports, and medical and dental visits. The date and signature of the staff person making the entry must also be recorded.

Consumer Name: _____

Date: _____ Staff Person: _____

Medical/Dental Visits: _____

Illnesses: _____

Community Outings: _____

Leisurely Activities: _____

Overnight Visits: _____

Special Incidents: _____

Date: _____ Staff Person: _____

Medical/Dental Visits: _____

Illnesses: _____

Community Outings: _____

Leisurely Activities: _____

Overnight Visits: _____

Special Incidents: _____

Date: _____ Staff Person: _____

Medical/Dental Visits: _____

Illnesses: _____

Community Outings: _____

Leisurely Activities: _____

Overnight Visits: _____

Special Incidents: _____

CONSENT TO RELEASE INFORMATION

This release is provided pursuant to California Welfare and Institution Code. Section 4514 et.esq., & California Civil Code, Section 56 et.esq.

_____
_____
_____

I, the consumer/parent/guardian/conservator of _____
(Date of Birth)_____, hereby authorize_____
_____
to release and /or receive from_____
(Address)_____
_____

_____All information/records _____Educational _____Social
_____Medical/Dental _____Vocational _____Psychological
_____Others (specify) _____

This information shall be valid for one year from the date signed or until_____ unless revoked in writing. This information shall be utilized only for the purpose of:_____
_____

The person signing this release has a right to receive a copy:___Copy offered ___Copy given

A photostatic copy off my signature is as valid as the original.

Signed: _____ Date: _____

Address: _____ Relationship to Consumer_____
_____ _____
_____

Witness: _____ Date: _____

Notice to Providers of information
All information you supply to us is subject to Section 4514. Welfare & Institutions Code, Confidentiality & Disclosure. Regulations allows for inspection and copying of all records by the consumer, his/her parent/guardian/conservator.

Notice to Receivers of Information
The information being released to you is Confidential and subject to Section 4514, Welfare and Institution Code. You are prohibited from making any further disclosure of this information with out the informed, written consent of the person to whom this information pertains or his/her parent/guardian or conservator.

Documentation of Method Used to Explain Consumer Rights, House Rules, and Complaint Procedure to Consumer

Facility Name: _____

Consumer Name: _____

Consumer Rights	House Rules	Complaint Policy	Staff Name	Date	Manner of Explanation

_____
Signature of Consumer or Parent/Guardian
(If consumer in conserved, conservator must also sign!)

_____
Signature of Staff Person

Legend:

Verbal = Explained through ordinary conversation, can include question and answer
Signs = Explained with the use of sign language or gestures
Picture = Explained using Picture Icons, Drawings, or Visual Graphics

State of California—Health and Human Services Agency

Department of Developmental Services

RIGHTS OF INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

DSP 304 (English) (Rev. 1/2000)

Each person residing or receiving services in this facility has the following rights:

1. To wear his/her own clothes, to keep and use his/her own personal possessions including his/her toilet articles, and to keep and be allowed to spend a reasonable sum of his/her own money for canteen expenses and small purchases.
2. To have access to individual storage space for his/her private use.
3. To see visitors each day.
4. To have reasonable access to telephones, both to make and receive confidential calls.
5. To have ready access to letter writing materials, including stamps, and to mail and receive unopened correspondence.
6. To refuse electroconvulsive therapy.
7. To refuse behavior modification techniques which cause pain or trauma.
8. To refuse psychosurgery.
9. Other rights, as specified by regulations *(see e.g., Titles 17 and 22, California Code of Regulations)*.

Pursuant to Title 17, California Code of Regulations, Section 50530, the professional person in charge of the facility or his/her designee may for good cause deny a person any of the rights above under (1) through (5), inclusive.

If you believe that there was not a good reason for denying one of your rights, you may call the local clients' rights advocate who must respond to your complaint.

Name of Advocate	Address/Location of Office	Telephone
Arthur Lipscomb	300 Orchard city Dr., Suite 170, Campbell, CA 95008	(408) 374-2470

It is the advocate's responsibility to investigate and resolve your complaint to your satisfaction. If the advocate is unable to do so, the complaint must be referred by the advocate to the developmental center or regional center director. After that, if the problem is still not resolved, it must be referred to the Office of Human Rights, State Department of Developmental Services.

Address/Phone # of Area Board:

Area Developmental Disabilities Board VII
359 Northlake Drive
San Jose, CA 95117-1261 (408) 246-4355

Office of Human Rights
Department of Developmental Services
Sacramento, CA 95814
(916) 654-1888
TDD: (916) 654-2054

Address/Phone # of Regional Center:

San Andreas Regional Center
300 Orchard City Drive, Suite 170
Campbell, CA 95008 (408)374-9960

This Notice must be posted, as well as distributed to each person with a developmental disability receiving services in any developmental center, licensed community care or health facility.

In addition to the above rights, persons with developmental disabilities also have the following rights:

1. A right to treatment and habilitation services and supports in the least restrictive environment. Treatment and habilitation services and supports should foster the developmental potential of the person and be directed toward the achievement of the most independent, productive, and normal lives possible. Such services shall protect the personal liberty of the individual and shall be provided with the least restrictive conditions necessary to achieve the purposes of the treatment, services or supports.
2. A right to dignity, privacy, and humane care.
3. A right to participate in an appropriate program of publicly supported education, regardless of degree of disability.
4. A right to prompt medical care and treatment.
5. A right to religious freedom and practice.
6. A right to social interaction and participation in community activities.
7. A right to physical exercise and recreational opportunities.
8. A right to be free from harm, including unnecessary physical restraint, or isolation, excessive medication, abuse, or neglect.
9. A right to be free from hazardous procedures.
10. A right to make choices in their own lives, including, but not limited to, where and with whom they live, their relationships with people in their community, the way they spend their time including education, employment, and leisure, and pursuit of their personal future, and program planning and implementation.

Resident/Resident Representative Signature	Date

NOTE: Authority Cited: Sections 4502, 4503, and 4731, Welfare and Institutions Code

State of California—Health and Human Services Agency

Department of Developmental Services

DERECHOS DE LAS PERSONAS CON DISCAPACIDADES DEL DESARROLLO

DSP 304 (Spanish) (Rev. 1/2000)

Todas las personas que viven en o reciben servicios en esta instalación tienen los siguientes derechos:

1. Usar su propia ropa, mantener y usar sus pertenencias personales, incluyendo sus artículos de aseo, conservar y que se les permita gastar una cantidad razonable de su propio dinero para los gastos en la tienda y para pequeñas compras.
2. Tener acceso a espacio individual de almacenamiento para su uso privado.
3. Recibir visitas todos los días.
4. Tener un acceso razonable a los teléfonos, tanto para hacer como para recibir llamadas confidenciales.
5. Tener acceso a implementos para escribir cartas, incluyendo estampillas, y enviar y recibir correspondencia cerrada.
6. Rehusar la terapia electroconvulsiva.
7. Rehusar técnicas de modificación del comportamiento que causen dolor o trauma.
8. Rehusar la psicocirugía.
9. Otros derechos, según se hallan especificados en las reglamentaciones *(ver, por ejemplo, los Títulos 17 y 22 del Código de Reglamentaciones de California).*

En cumplimiento de la Sección 50530 del Título 17 del Código de Reglamentaciones de California, el profesional a cargo de la instalación, o la persona que designe para ese fin, podrán denegar, con motivo suficiente, cualesquiera de los derechos (1) a (5), inclusive, que anteceden.

Si usted cree que no hubo motivo suficiente para negarle alguno de sus derechos, puede llamar al defensor local de los derechos de los clientes, que debe responder a su queja.

Nombre del defensor	Dirección/ubicación de la oficina	Teléfono
Arthur Lipscomb	300 Orchard City Dr, Ste. 170, Campbell,	(408) 374-2470

Es responsabilidad del defensor investigar y resolver sus quejas a su plena satisfacción. Si el defensor no puede hacerlo, la queja debe ser remitida por el defensor al centro de desarrollo o al director del centro regional. Después, si el problema todavía no se ha resuelto, se lo debe remitir a la Oficina de derechos humanos del departamento de servicios de desarrollo del Estado.

Dirección y teléfono del Consejo de la zona:
Area Developmental Disabilities Board VII
359 Northlake Drive,
San Jose, CA 95117-1261 (408)246-4355

Office of Human Rights
Department of Developmental Services
Sacramento, CA 95814
(916) 654-1888
TDD: (916) 654-2054

Dirección y teléfono del Centro regional:
San Andreas Regional Center
300 Orchard City Drive, Suite 170
Campbell, CA 95008 (408)374-9960

Este Aviso se debe exhibir y, además, distribuir a todas las personas con una discapacidad del desarrollo que reciban servicios en cualquier centro de desarrollo o instalación de atención comunitaria o instalación de salud autorizadas.

Además de los derechos que anteceden, las personas con discapacidades del desarrollo también tienen los siguientes derechos:

1. Derecho a servicios de tratamiento, de habilitación y de apoyo en un entorno de mínima restricción. Los servicios de tratamiento, de habilitación y de apoyo deben propiciar el desarrollo latente de la persona y tener por objetivo que la persona lleve la vida más independiente, productiva y normal posible. Esos servicios deben proteger la libertad personal del individuo y deberán prestarse en las condiciones de mínima restricción posibles necesarias para alcanzar los objetivos del tratamiento, de los servicios o del apoyo.
2. Derecho a la dignidad, a la privacía y a la atención humanitaria.
3. Derecho a participar en un programa adecuado de educación con financiamiento público, independiente del grado de incapacidad.
4. Derecho a atención y tratamiento médico puntual.
5. Derecho a la libertad religiosa y su práctica.
6. Derecho a la interacción social y a la participación en actividades de la comunidad.
7. Derecho al ejercicio físico y a las oportunidades de esparcimiento.
8. Derecho a estar libre de daños, incluyendo las restricciones físicas innecesarias, el aislamiento, la medicación excesiva, el maltrato o el abandono.
9. Derecho a estar libre de intervenciones peligrosas.
10. Derecho a tomar decisiones sobre su propia vida, incluyendo, pero no limitado a, dónde y con quiénes vivir, su relación con personas en su comunidad, la manera en que pasa su tiempo, incluyendo educación, empleo y ocio, y la búsqueda de su futuro personal, así como la planificación y la puesta en práctica de los programas.

Firma del residente o del representante del residente	Fecha

NOTA: Autoridad citada: Secciones 4502, 4503 y 4731 del Código de Bienestar e Instituciones

PERSONAL RIGHTS
ADULT COMMUNITY CARE FACILITIES

EXPLANATION: The California Code of Regulations, Title 22 requires that any person admitted to a facility must be advised of his/her personal rights. Facilities are also required to post these rights in areas accessible to the public. Consequently, this form is designed to meet both the needs of persons admitted to facilities and the facility owners who are required to post these rights.

This form describes the personal rights to be afforded each person admitted to an adult community care facility. The form also provides the complaint procedures for the client and representative/conservator. The facility staff or client representative must communicate these rights in a manner appropriate for client's ability.

This form is to be reviewed, completed and signed by each client and/or each representative/conservator upon admission to the facility. The client and/or representative/conservator also has the right to receive a completed copy of the originally signed form. The original signed copy shall be retained in the client's file which is maintained by the facility.

TO: CLIENT OR AUTHORIZED REPRESENTATIVE:

Upon satisfactory and full disclosure of the personal rights as explained, complete the following acknowledgment:

ACKNOWLEDGMENT: At the time of admission I have been personally advised of, and have received a copy of the personal rights contained in the California Code of Regulations, Title 22.

(PRINT THE NAME OF THE FACILITY) (PRINT THE ADDRESS OF THE FACILITY)

(PRINT THE NAME OF THE CLIENT)

(SIGNATURE OF THE CLIENT) (DATE)

(SIGNATURE OF THE REPRESENTATIVE/CONSERVATOR)

(TITLE OF THE REPRESENTATIVE/CONSERVATOR) (DATE)

THE CLIENT AND/OR THE REPRESENTATIVE/CONSERVATOR HAS THE RIGHT TO BE INFORMED OF THE APPROPRIATE LICENSING AGENCY TO CONTACT REGARDING COMPLAINTS. THIS AGENCY IS:

NAME

ADDRESS

CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER
		( )

PERSONAL RIGHTS
ADULT COMMUNITY CARE FACILITIES

Each client shall have rights, which include, but are not limited to the following:

(1) A right to be treated with dignity, to have privacy and to be given humane care.

(2) A right to have safe, healthful and comfortable accommodations, including furnishings and equipment to meet your needs.

(3) A right to be free from corporal or unusual punishment, infliction of pain, humiliation, intimidation, ridicule, coercion, threat, mental abuse, or other actions of a punitive nature. To be free from restraining devices, neglect or excessive medication.

(4) A right to be informed by the licensee of provisions in the law regarding complaints, including the address and telephone number of the licensing agency, and of information regarding confidentiality.

(5) A right to attend religious services and activities . Participation in religious services and other religious functions shall be on a completely voluntary basis.

(6) A right to leave or depart the facility at any time, and to not be locked into any room or building, day or night. This does not prohibit the development of house rules, such as the locking exterior doors or windows, for the protection of the consumer.

(7) A right to visit a facility with a relative or authorized representative prior to admission.

(8) A right to have communications between the facility and your relatives or authorized representative answered promptly and completely, including any changes to the needs and services plan or individual program plan.

(9) A right to be informed of the facility's policy concerning family visits. This policy shall encourage regular family involvement and provide ample opportunities for family participation in activities at the facility.

(10) A right to have visitors, including advocacy representatives, visit privately during waking hours provided the visits do not infringe upon the rights of other consumers.

(11) A right to possess and control your own cash resources.

(12) A right to wear your own clothes, to possess and use your own personal items, including your own toilet articles.

(13) A right to have access to individual storage space for your private use.

(14) A right to have access to telephones, to make and receive confidential calls, provided such calls do not infringe on the rights of other clients and do not restrict availability of the telephone in emergencies.

(15) A right to promptly receive your unopened mail.

(16) A right to receive assistance in exercising your right to vote.

(17) A right to receive or reject medical care or health-related services, except for those whom legal authority has been established.

(18) A right to move from a facility in accordance with the terms of the admission agreement.

Reference:

California Code of Regulations, Title 22, Division 6 - General Licensing Regulations, Section 80072; Section 81072, Social Rehabilitation Facilities; Section 85072, Adult Residential Facilities; Section 87872, Residential Care Facilities for the Chronically Ill.

PERSONAL RIGHTS
Children's Residential Facilities

EXPLANATION: The California Code of Regulations, Title 22 requires that any child admitted to a home/facility must be advised of his/her personal rights. Homes/Facilities are also required to post these rights in areas accessible to the public. Consequently, this form is designed to meet both the needs of children admitted to homes/facilities and the home/facility owners who are required to post these rights.

This form describes the personal rights to be afforded each child admitted to a home/facility. This form also provides the complaint procedures for the child and authorized representative.

This form is to be reviewed, completed and signed by each child and/or each authorized representative upon admission to the home/facility. The child and/or authorized representative also has the right to receive a completed copy of the originally signed form. The original signed copy shall be retained in the child's file which is maintained by the home/facility.

TO: CHILD OR AUTHORIZED REPRESENTATIVE:

Upon satisfactory and full disclosure of the personal rights as explained, complete the following acknowledgment:

ACKNOWLEDGMENT: I/We have been personally advised of, and have received a copy of the personal rights contained in the California Code of Regulations, Title 22, at the time of admission to

(PRINT THE NAME OF THE HOME/FACILITY) (PRINT THE ADDRESS OF THE HOME/FACILITY)

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE CHILD) (DATE)

(SIGNATURE OF THE AUTHORIZED REPRESENTATIVE)

(TITLE OF THE AUTHORIZED REPRESENTATIVE) (DATE)

THE CHILD AND/OR THE AUTHORIZED REPRESENTATIVE HAS THE RIGHT TO BE INFORMED OF THE APPROPRIATE LICENSING AGENCY TO CONTACT REGARDING COMPLAINTS, WHICH IS:

NAME

ADDRESS

CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER
		( )

PERSONAL RIGHTS
Children's Residential Facilities

YOU HAVE THE RIGHT:

- To live in a safe, healthy, and comfortable home and to be treated with respect.
- To be free from physical, sexual, emotional or other abuse, or corporal punishment.
- To be free from discrimination, intimidation, or harassment based on sex, race, color, religion, ancestry, national origin, disability, medical condition or sexual orientation or perception of having one or more of those characteristics.
- To receive adequate and healthy food and adequate clothing.
- To wear your own clothing.
- To possess and use personal possessions, including toilet articles.
- To receive medical, dental, vision, and mental health services.
- To be free of the administration of medication or chemical substances, unless authorized by a physician.
- To contact family members (unless prohibited by court order) and social workers, attorneys, foster youth advocates and supporters, Court Appointed Special Advocates (CASA), and probation officers.
- To visit and contact brothers and sisters, unless prohibited by court order.
- To contact Community Care Licensing Division of the State Department of Social Services or the State Foster Care Ombudsperson regarding violations of rights, to speak to representatives of these offices confidentially and to be free from threats or punishments for making complaints.
- To be informed by the caregiver of the provisions of the law regarding complaints.
- To make and receive confidential telephone calls and send and receive unopened mail (unless prohibited by court order).
- To attend religious services and activities of your choice.
- To maintain emancipation bank account and manage personal income, consistent with your age and developmental level, unless prohibited by the case plan.
- To not be locked in any room, building, or facility premises, unless placed in a community treatment facility.
- To not be placed in any restraining device, unless placed in a postural support and if approved in advance by the licensing agency or placement agency.
- To attend school and participate in extracurricular, cultural, and personal enrichment activities, consistent with your age and developmental level.
- To work and develop job skills at an age appropriate level that is consistent with state law.
- To have social contacts with people outside of the foster care system, such as teachers, church members, mentors, and friends.
- To attend Independent Living Program classes and activities if you are 16 or older.
- To attend court hearings and speak to the judge.
- To have storage space for private use.
- To review your own case plan if you are over 12 years of age and to receive information regarding out-of-home placement and case plan, including being told of changes to the plan.
- To be free from unreasonable searches of personal belongings.
- To have all your juvenile court records be confidential (consistent with existing law).

Reference: California Code of Regulations - Foster Family Homes Regulations, Section 89372; Group Homes Regulations, Section 84072; Small Family Homes Regulations, Section 83072.

PERSONAL RIGHTS
RESIDENTIAL CARE FACILITIES FOR THE ELDERLY

EXPLANATION: The California Code of Regulations, Title 22 requires that any person admitted to a facility must be advised of his/her personal rights. Facilities licensed for seven (7) or more are also required to post these rights in areas accessible to the public. Consequently, this form is designed to meet both the needs of persons admitted to facilities and the facility owners who are required to post these rights.

This form describes the personal rights to be afforded each person admitted to a facility. This form also provides the complaint procedures for the resident and the resident's responsible person. The facility staff, resident's responsible person or conservator must explain these rights in a manner appropriate to the resident's ability.

This form is to be reviewed, completed and signed by each resident, and/or responsible person (if any), or conservator upon admission to the facility. The resident and/or responsible person or conservator also has the right to receive a completed copy of the originally signed form. This originally signed copy shall be retained in the resident's file, which is maintained by the facility.

RESIDENT OR CONSERVATOR AND RESPONSIBLE PERSON

Upon satisfactory and full disclosure of the personal rights, complete the following:

I/we have been personally advised and have received a copy of the personal rights contained in the California Code of Regulations, Title 22.

(PRINT THE NAME OF THE FACILITY) (PRINT THE ADDRESS OF THE FACILITY)

(PRINT THE NAME OF THE RESIDENT)

(SIGNATURE OF THE RESIDENT) (DATE)

(SIGNATURE OF THE RESPONSIBLE PERSON OR CONSERVATOR)

(TITLE OF THE RESPONSIBLE PERSON OR CONSERVATOR)

THE RESIDENT AND/OR THE RESPONSIBLE PERSON OR CONSERVATOR HAS THE RIGHT TO BE INFORMED OF THE APPROPRIATE LICENSING AGENCY TO CONTACT REGARDING COMPLAINTS, WHICH IS:

NAME

ADDRESS

CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER
		( )

To report known or suspected elder abuse, contact the Statewide Ombudsman Toll Free 24-hour CRISIS line at 1-800-231-4024. Local Ombudsman's Office Telephone Number _____.

PERSONAL RIGHTS

RESIDENTIAL CARE FACILITIES FOR THE ELDERLY

Explanation: Each resident shall have rights which include, but are not limited to, the following:

(1) To be accorded dignity in his/her personal relationships with staff, residents, and other persons.

(2) To be accorded safe, healthful and comfortable accommodations, furnishings and equipment.

(3) To be free from corporal or unusual punishment, humiliation, intimidation, mental abuse, or other actions of a punitive nature, such as withholding of monetary allowances or interfering with daily living functions such as eating or sleeping patterns or elimination.

(4) To be informed by the licensee of the provisions of law regarding complaints and of procedures to confidentially register complaints, including, but not limited to, the address and telephone number of the complaint receiving unit of the licensing agency.

(5) To have the freedom of attending religious services or activities of his/her choice and to have visits from the spiritual advisor of his/her choice. Attendance at religious services, either in or outside the facility, shall be on a completely voluntary basis.

(6) To leave or depart the facility at any time and to not be locked into any room, building, or on facility premises by day or night. This does not prohibit the establishment of house rules, such as the locking of doors at night, for the protection of residents; nor does it prohibit, with permission of the licensing agency, the barring of windows against intruders.

(7) To visit the facility prior to residence along with his/her family and responsible persons.

(8) To have his/her family or responsible persons regularly informed by the facility of activities related to his/her care or services including ongoing evaluations, as appropriate to the resident's needs.

(9) To have communications to the facility from his/her family and responsible persons answered promptly and appropriately.

(10) To be informed of the facility's policy concerning family visits and other communications with residents. This policy shall encourage regular family involvement and provide ample opportunities for family participation in activities at the facility.

(11) To have his/her visitors, including ombudspersons and advocacy representatives permitted to visit privately during reasonable hours and without prior notice, provided that the rights of other residents are not infringed upon.

(12) To wear his/her own clothes; to keep and use his/her own personal possessions, including his/her toilet articles; and to keep and be allowed to spend his/her own money.

(13) To have access to individual storage space for private use.

(14) To have reasonable access to telephones, to both make and receive confidential calls. The licensee may require reimbursement for long distance calls.

(15) To mail and receive unopened correspondence in a prompt manner.

(16) To receive or reject medical care, or other services.

(17) To receive assistance in exercising the right to vote.

(18) To move from the facility.

Reference: California Code of Regulations - Title 22, Section 87572, Residential Care Facilities for the Elderly

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

RECORD OF CLIENT'S/RESIDENT'S SAFEGUARDED CASH RESOURCES

Client/resident: Your signature below indicates you have received the following amount of money from the facility on the date indicated.

Facilities that handle client's/resident's cash resources must maintain accurate records of all money received and disbursed.

INSTRUCTIONS:

1) *The date of the transaction shall be noted under Date.*
2) *Use a separate line for each transaction.*
3) *Supporting receipts for purchases shall be filed in order of dates of purchases.*
4) *The client's/resident's (or client's/resident's representative) signature on this form may serve as a receipt for cash distribution to the client/resident. (Sec. 80026(h)(1)(A) and 87227(g)(1)(A).*
5) *The facility representative's signature is necessary to be able to verify a cash transaction.*

NAME OF CLIENT/RESIDENT:	FACILITY NUMBER:	YEAR

DATE	DESCRIPTION	AMOUNT RECEIVED	AMOUNT SPENT OR WITHDRAWN	BALANCE	SIGNATURE FOR CASH TRANSACTIONS	
					FACILITY REPRESENTATIVE	CLIENT/RESIDENT OR REPRESENTATIVE