RSA Foundation

H.O.M.E. Hub Program Application

H.O.M.E. Hub is an innovative work-based learning program that promotes success in the workplace and in life.

Our day program and workshops provide structure that will suit each person's needs while promoting self-advocacy skills and personal independence.

Admission Criteria:

The goal of H.O.M.E. Hub is to provide quality work based/skill building learning opportunities that produce outcomes desired by program participants. Intake staff will consider all applications and try to be flexible in meeting individual needs.

Applicants MUST meet the following criteria to begin the intake process:

- Applicant must be 18+ years old
- Be a resident of Macomb County
- A Medicaid Beneficiary

Admission Process:

Referral of applicants should be made to the H.O.M.E. Hub support coordinator/intake staff by calling (586) 806-6931 and by completing the attached application. The intake staffing consists of the support coordinator, program staff, the applicant and referring party. At the intake meeting, the applicant will receive an overview of the H.O.M.E. Hub program and expectations.

The following documents are required before receiving services:

- Individual Plan of Service
- Copy of photo identification
- Signed RSA Authorizations and Releases
- Current Authorization from Macomb County CMH

The intake staff may request one or more of the following:

- Educational History
- Social History
- Other Agency Reports

Application Date: _____
Intake Date: _____

Applicant's Name:

_____
(Last) (First) (Middle)

Current Address:

_____
(Street) (City) (State) (Zip)

Phone Number: (____)_____ **Consumer's Cell:** (___)_____

Date of Birth:___/___/___ **Gender:** [ ] Male [ ] Female

Social Security Number: _____-_____-____ **Medicaid ID:**_____

Consumer's Email Address:_____

Legal Guardian Information (if applicable):
Guardian Name: _____
Address: _____
Phone: _____
Email: _____

Caseworker Information:
Caseworker Name: _____ Agency Name: _____
Phone: _____ Email: _____

Group Home Information (if applicable):
Group Home Name: _____ Group Home Contact: _____
Group Home Phone: _____

Referral Source:_____

Why do you want to attend H.O.M.E. Hub?

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Emergency Contacts:

1. Name:

_____
(Last) (First) (Middle)

(____)_____ (_____)_____ (____)_____
(Home) (Work) (Cell)

2. Name:

_____
(Last) (First) (Middle)

(____)_____ (_____)_____ (____)_____
(Home) (Work) (Cell)

3. Name:

_____
(Last) (First) (Middle)

(____)_____ (_____)_____ (____)_____
(Home) (Work) (Cell)

_____
Signature of Applicant Date

_____
Signature of Person Completing Form Date

_____
Signature of Guardian Date

RSA Foundation

VIDEO/PHOTOGRAPHY RELEASE

Individual Serviced Name: _____

I, legal guardian of the above-named Individual Served, hereby give my consent for photographing (including still pictures, motion pictures, security videotape, or for transmitting images/voices) of the above-named individual the following purposes:

PLEASE MARK THE APPROPRIATE CHOICE:

Orientation and in-service training programs of RSA Foundation and other state department of mental health facilities, by RSA Foundation personnel in the creation of videotape film/still pictures/slides for educational purposes with the general public, and for use in newsletters, brochures or annual reports.

Yes _____ No _____

For use with community, school, civic, and service organizations and for use with students and RSA Foundation guardians.

Yes _____ No _____

For release of photographs/voices for use by the public news, media, including newspapers, website, television and radio.

Yes _____ No _____

- I understand that I may revoke this authorization by notifying RSA Foundation in writing of my desire to revoke it. However, I understand that if I revoke this authorization, it will not have any affect of actions taken at RSA Foundation in reliance on this authorization.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect the individual's ability to obtain treatment or eligibility for benefits.
- I understand that the person(s) or organization RSA Foundation authorized to use/disclose this information will not receive compensation for doing so.

Signature of legal guardian or Individual Served if they are their own guardian:

_____ Date: _____

Witness: _____ Date: _____

RSA Foundation

AUTHORIZATION FOR PARTICIPATION IN COMMUNITY PROGRAMS

Individual Served Name: _____

I, legal guardian for the above-named individual, hereby give my consent for the individual to participate in community programs offered by RSA Foundation. I am aware that community-based activities include risk.

Community Programs may include all or some of the following activities:

1. Daily, weekly, or monthly trips to the community at large, to explore and expand the Individual's knowledge and experience of the actual community.
2. To increase social and safety skills in the community.
3. To increase knowledge of what is available to individuals in the community.
4. To increase recreational and social opportunities.
5. To be transported to these community activities via company or staff vehicles.
6. To be given the opportunities available to all citizens including recreational, vocational, educational, and tourism.
7. These experiences and activities will be carried out as part of an extension of the Individual Plan of Service and no additional funds will be required form the Individual Served. Individual's Served are permitted to have monies available for personal usage per the Individual Plan of Service.
8. To volunteer for community-based skill-building activities, for which the individual will receive no pay but will provide valuable work experience.

Signature of legal guardian or Individual Served if they are their own guardian:

_____ Date: _____

Witness: _____ Date: _____

RSA Foundation

AUTHORIZATION TO RELEASE AN INDIVIDUAL SERVED

Individual Served Name: _____

I, legal guardian for the above-named individual, will provide up to three names and telephone numbers to whom the Individual Served may be released in the care of while attending RSA Foundation with the exception of medical personnel in case of an emergency and assigned personnel from the contracting agency. In addition, the direct caregivers employed with _____ are authorized.

Authorized Names and Telephone Numbers:

1. _____
2. _____
3. _____

Signature of legal guardian or Individual Served if they are their own guardian:

_____ Date: _____

Witness: _____ Date: _____

RSA Foundation

AUTHORIZATION FOR RELEASE PROTECTED HEALTH INFORMATION

Individual Served Name: _____ Date: _____

INFORMATION IS AUTHORIZED TO BE RELEASED TO THE FOLLOWING AGENCY:
RSA FOUNDATION

AGENCIES AUTHORIZED TO RECEIVE INFORMATION AND CONTRACTING AGENCY

CENTER FOR MEDICARE & MEDICAID SERVICES
COMMISSION ON ACCREDITATION FOR REHABILITATION FACILITIES
COMMUNITY LIVING SERVICE
CONSUMER LINK
DEPARTMENT OF LABOR
DESIGNATED RESIDENTIAL PROVIDER
FAMILY INDEPENDENCE AGENCY
MACOMB COUNTY COMMUNITY MENTAL HEALTH
MACOMB-OAKLAND REGIONAL CENTER
MICHIGAN COMMISSION FOR THE BLIND
MICHIGAN REHABILITATION SERVICES
OFFICE OF RECIPIENT RIGHTS
SOCIAL SECURITY ADMINISTRATION
STATE OF MICHIGAN
OTHER _____

SPECIFIC INFORMATION TO BE DISCLOSED:

Current plan of care outlining training components and treatment needs; relevant health information (reason for admission, significant illnesses, medical evaluations, physical limitations and/or health care plan); and known allergies; speech, hearing and adaptive behavioral evaluations; information regarding medication (type, dosage and frequency, potential side effects); current psychological profile and program evaluation reports; name, address and telephone number of parent or guardian, and payroll information. This release is sought for the purpose of ensuring coordinated planning and delivery of vocational, educational, and employment services to Individual Service, and also may be used to ensure continuation o funding or services to the individual served.

I understand that the information used or disclosed may be subject to redisclosure by the person(s) or class of person(s) receiving it and no longer protected by the federal privacy regulations.

I understand that I may revoke this authorization by notifying RSA Foundation in writing of my desire to revoke it. However, I understand that if I revoke this authorization, it will not have any effect on actions taken by RSA Foundation before I revoked it. I understand that I may refuse to sign this authorization and that my refusal to sign will not permit the contracting agency to authorization services.

Further release of information so disclosed is prohibited unless consistent with the authorized purpose stated above. Any persons receiving such information shall be so advised (Section 748 {3} of Act 258, Public Acts of 1974, as amended).

RSA Foundation has provided me with their Notice of Privacy Practices document and I understand that this document explains my rights and how my pertinent medical information is managed. A copy is available at the RSA Foundation location. I understand that if I have a question or concern, I should contact Home Hub at 586-806-6931.

Signature of legal guardian or Individual Served if they are their own guardian:

_____ Date: _____

Witness: _____ Date: _____

RSA Foundation

AUTHORIZATION FOR RSA FOUNDATION SERVICES

Individual Served Name: _____

I, legal guardian for the above-named individual, hereby give my consent for the above individual to receive vocational services from RSA Foundation. I understand that vocational services may be provided in any or all of the following services as written in the Individual Plan of Service:

- Facility Based Skill Development
- Community Employment Skill Development
- Community Based Skill Development
- Transition to Employment
- Transportation

The above individual or guardian is aware that there are potential health and safety risks in the community. The individual or guardian can make the decision to decline any of the above activities.

Signature of legal guardian or Individual Served if they are their own guardian:

_____ Date: _____

Witness: _____ Date: _____

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AUTHORIZATION FOR SECURING MEDICAL TREATMENT

Individual Served Name: _____ Date: _____
Individual Served Date of Birth: _____
Group Home Name: _____
Group Home Address: _____

This person is an Individual Served of RSA Foundation.

I, legal guardian, hereby give RSA Foundation my permission to secure emergency medical treatment and consent to the administration of anesthetics and to the performance of any emergent operation upon the above-named recipient at any licensed medical facility.

MEDICAID:

The above-named individual served is included in a hospitalization plan (other than Medicaid):

Yes _____ No _____

PLACE PHOTO HERE

If yes, please list:

Name of Insurance Co: _____

Policy Number: _____

Family Group: _____

Signature of legal guardian or Individual Served if they are their own guardian:

_____ Date: _____

Witness: _____ Date: _____

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Process for attending the H.O.M.E. Hub Program

Macomb County: Call Access Center at (586) 948-0222 if you do not already have a Supports Coordinator.

Oakland County: Call Access Center at (248) 464-6363 if you do not already have a Supports Coordinator. Please be aware that only Community Living Services (CLS) in Oakland County will approve individuals to attend the RSA Foundation program.

You will be asked questions to confirm that you or your student or the Individual Served are eligible for services. You will then be provided a list of agencies to choose from as your Supports Coordinator.

Once the above is set up, you will have to inform your Supports Coordinator that you would like to attend the RSA Foundation for Skill Building. Your student/Individual Served will need 22 units per day if they wish to attend the RSA Foundation program.

If you have any questions, please contact Home Hub at 586-806-6931 or at homehub@rsaonline.org.