RESIDENT'S NAME	DDA NUMBER	RESIDENCE	BIRTHDATE

DEVELOPMENTAL DISABILIITES ADMINISTRATION (DDA)
RESIDENTIAL HABILITATION CENTER (RHC)

Consent and Service Agreement

Contact Information (Family, Guardian, or Legal Representative)

NAME	RELATIONSHIP TO RESIDENT	HOME PHONE (WITH AREA CODE)

WORK PHONE (INCLUDE AREA CODE)	CELL PHONE (INCLUDE AREA CODE)	PAGER

ADDRESS

EMAIL ADDRESS

Private Insurance Information

Complete the following if the resident has medical or dental insurance other than Medicare or Medicaid.

Medical

PRIMARY MEDICAL INSURANCE			
ADDRESS			PHONE (INCLUDE AREA CODE)
SUBSCRIBER'S NAME	SUBSCRIBER NUMBER	EMPLOYER NUMBER	GROUP NUMBER

Dental

PRIMARY DENTAL INSURANCE			
ADDRESS			PHONE (INCLUDE AREA CODE)
SUBSCRIBER'S NAME	SUBSCRIBER NUMBER	EMPLOYER NUMBER	GROUP NUMBER

If the resident has secondary insurance, attach a separate sheet with the information required above.

Service Agreement

I voluntarily agree that the above named person (resident) receive services from the Residential Habilitation Center (RHC). I authorize the RHC to carry out the duties and responsibilities described in the individual habilitation plan or individual plan of care. I understand that I may end this agreement at any time and that receiving services at the RHC is voluntary. I understand the resident may transition out of the RHC at any time, which does not jeopardize the resident's eligibility for services from the Developmental Disabilities Administration.	INITIAL
I understand that I retain the legal authority to authorize, consent, and make decisions for the resident under the applicable laws of the State of Washington. I understand this right varies for parents of minor children, non-guardian parents of adults, guardians, and other legal representatives. I understand the Superintendent is the custodial guardian for the resident. The Superintendent may assume decision making if I do not respond in a timely manner to emergency calls or written requests.	INITIAL

Program Participation

I would like to participate in special program reviews and team meetings, such as Care Plan meetings and meetings about the resident's Individual Habilitation Plan. I understand this does not prevent the RHC from holding planning meetings or informal discussions about the resident without my presence and updating me with any changes being suggested.

Select your preferred method or methods of participation:

☐ In person ☐ By phone ☐ Notify me after each meeting ☐ Participate as needed

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Upon request, you will receive a copy of any plans created or updated at a team meeting.
Select your preferred method or methods of notification:

☐ Phone ☐ Email ☐ Mail

Illness, Injury, and Incident Notification

The RHC notifies the resident's parent or guardian as soon as possible for serious illness, injury, or incident. Approximately 30 days after an incident the RHC will follow up with the resident's parent or guardian.

Indicate below if you wish to receive notice regarding a minor illness, injury, or incident.

☐ **Minor illness** ☐ **Minor injury** ☐ **Minor incident**

Medical, Dental, and Behavioral Consent

ROUTINE MEDICAL CARE I understand routine medical care will be provided in accordance with the judgment of the medical staff and contracted consultants as described in the individual habilitation plan or individual plan of care. Routine medical care includes routine physical exams of all body systems. Routine medical care also includes the following: • Lab work; • Preventive treatments; • Vision and hearing exams; • Management of acute and chronic diseases; • Treatment of infections, injuries, and illnesses within available resources including diagnostic testing; • Medication management, such as monitoring for safety and effectiveness; • Referrals and follow-ups from medical specialties occurring on campus; • Nutritional services; • Therapeutic diets; • Weight management; and • Texture-modified diets per assessed nutritional, swallowing, and meal safety needs.	INITIAL
I understand vaccinations will be provided in accordance with current Centers for Disease Control guidelines, unless medically contraindicated. The RHC will send vaccination information to the family, parent or guardian annually. I understand if I wish to be informed of certain aspects of routine medical care regularly, I must discuss this with the health care provider. I understand if I have any specific requests, denials, or instructions regarding routine medical care I must send them to the RHC in writing.	INITIAL
SPECIALIZED MEDICAL CARE I understand that specialized medical care may be sought. I understand that preliminary information will be provided in the event of an emergency. I understand a provider must obtain my consent before performing specialized procedures or treatments.	INITIAL
SPECIALIZED MEDICAL CONSENT I understand my consent is required for any medical or dental procedure that uses sedation or restraint. I understand my consent may be required for use of any hormonal therapy that affects reproduction.	INITIAL
ROUTINE DENTAL I understand routine dental care will be provided when necessary with the judgment of the dental staff and as described in the individual habilitation plan or individual plan of care. Routine dental care includes regular examination, cleaning, scaling, fillings, and topical treatment. I understand my consent is required for extractions and oral surgery, unless an emergency exists as determined by the physician, dentist, or both.	INITIAL
RESTRICTIVE PROCEDURES I understand my consent is required for any ongoing use of a restrictive procedure.	INITIAL

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Emergency Contact for Emergency Care

EMERGENCY CARE

If I cannot be contacted, I authorize the facility to proceed with emergency medical or dental treatment and care as deemed necessary by the attending medical provider. Emergency treatment will not be delayed.

If the RHC cannot contact me, notify the following emergency contact:

NAME	CELL PHONE (INCLUDE AREA CODE)
HOME PHONE (INCLUDE AREA CODE)	EMAIL

I understand the facility may authorize the use of emergency physical, chemical, and mechanical restraints for safety and protection. I understand I will be notified as soon as possible following the use of the emergency physical, chemical, and mechanical restraint.	INITIAL

Social Leave, Finances, Personal Possessions

FRIENDS, FAMILY, AND VISITORS RHC staff may be requested to accompany a resident on visits as determined by the interdisciplinary team. I understand I must notify RHC of any court-ordered protections in place.	INITIAL
FINANCES I understand the RHC will act as the resident's representative payee unless indicated otherwise. I understand the RHC may provide me with quarterly statements of the resident's accounts. Unless determined otherwise, based on assessed need, the resident must have access to their financial account.	INITIAL
PERSONAL MAIL I understand the RHC will review benefit checks, letters that appear to be bills, or legal documents. RHC will ensure appropriate routing of all mail.	INITIAL
PERSONAL POSSESSIONS Restitution may be required for loss of property when deemed appropriate and as identified in the individual habilitation plan or individual plan of care. Personal possessions may be replaced at the expense of the facility if determined to be caused by an employee or volunteer. Notify me of resident's outgrown, broken, or irreparable possessions: ☐ All items ☐ Only items valued over $100 *Disclaimer: Outgrown, broken, or irreparable possessions will be held up to 30 days (unless prior arrangements are made) and then will be disposed or donated at the discretion of the facility.	INITIAL
I understand the resident's guardian may request an inventory of the resident's possessions to assist with guardianship records.	INITIAL
If the resident has limited finances, I would like to be contacted about assisting financially.	☐ Yes ☐ No

Release of Information

FAMILY AND GUARDIAN INFORMATION I authorize the release of my name, address, email, and phone number to the officers and representatives of the Friends of Fircrest, Friends of Rainier, Friends of Yakima Valley School, or Lakeland Village Associates. I understand the RHC must not release my name, address, email, or phone number to other parents or organizations without my permission unless required by law.	☐ Agree ☐ Disagree INITIAL

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Indicate the resident's:

PREFERRED LANGUAGE (REQUIRED)	ETHNICITY (OPTIONAL)	RELIGION (OPTIONAL)

OTHER CULTURAL TRADITIONS AND BELIEFS (OPTIONAL)

Name, photograph, video, and audio recording release:

Where indicated below, I consent to authorized persons photographing, video, or audio recording the resident for the purposes of training RHC staff. Where indicated below, I consent to the use of the resident's name in, or in association with, the photographs, video, or audio.

- Photograph: .... ☐ Agree ☐ Disagree
- Videotape: .... ☐ Agree ☐ Disagree
- Recording: .... ☐ Agree ☐ Disagree
- Use of full name: .... ☐ Agree ☐ Disagree
- Use of first name only: ...... ☐ Agree ☐ Disagree
- No name use allowed:....... ☐ Agree ☐ Disagree

News media release:

Where indicated below, I consent to the release of photographs, video, or audio recordings of the resident to the new media if authorized by the RHC Superintendent. Where indicated below, I consent to the use of the resident's name in, or in association with, the photographs, video, or audio recordings.

- Photograph: .... ☐ Agree ☐ Disagree
- Videotape: .... ☐ Agree ☐ Disagree
- Recording: .... ☐ Agree ☐ Disagree
- Use of full name: .... ☐ Agree ☐ Disagree
- Use of first name only: ...... ☐ Agree ☐ Disagree
- No name use allowed:....... ☐ Agree ☐ Disagree

RHC newsletter release:

Where indicated below, I consent to including the resident's visual media, name, or artwork in the RHC newsletter or other communications.

- Visual media: .... ☐ Agree ☐ Disagree
- Use of name:................... ☐ Agree ☐ Disagree
- Use of artwork: .... ☐ Agree ☐ Disagree

Photos for personal use:

Where indicated below, I consent to including the resident in photos taken during field trips, friend exchanges, or for the resident to display.

- Field trips:....................... ☐ Agree ☐ Disagree
- Friend exchanges: .... ☐ Agree ☐ Disagree
- Personal display: .... ☐ Agree ☐ Disagree

INDIVIDUAL RIGHTS AND RESPONSIBILITIES	INITIAL
I have received a written copy of the RHC Client / Resident Rights and Responsibilities (attached). I understand if I have any questions or concerns I can contact an RHC Supervisor, the Habilitation Plan Administrator, the Case Manager Resource Nurse, or the Resident Care Coordinator.	
PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST)	
Does the resident have a POLST / advance directive? If interested in obtaining a POLST or to get more information on advance directives, contact the resident's medical provider.	☐ Yes ☐ No INITIAL
ADVOCACY INFORMATION	INITIAL
If you have concerns about abuse or neglect reporting, or have concerns related to resident's rights, there are advocacy agencies not affiliated with the RHC you can contact for assistance. These include: Disability Rights Washington, DD Ombudsman, Nursing Home Ombudsman program, or Complaint Resolution Unit (CRU) Hotline. CRU Number: 1-800-363-4276 To file a grievance, see the attached Grievance Policy.	

SIGNATURE	DATE	RELATIONSHIP
		☐ Parent ☐ Guardian ☐ Relative (relationship): ____________ ☐ Superintendent / Custodial Guardian

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Disclaimer: Services at this RHC are based on the resident's assessed needs and if you request services outside the interdisciplinary team determination, you are responsible for payment, transportation, and setup for that service.

If you feel the resident needs a service not provided by the facility, contact the Habilitation Plan Administrator, Case Manager Resource Nurse, or Resident Care Coordinator so they can facilitate a team meeting to discuss the recommendation.

ATTACHMENT: RHC Client / Resident Rights and Responsibilities

RHC Client / Resident Rights and Responsibilities

General Rights for All Clients / Residents

- The right to exercise his/her civil rights as guaranteed to all other individuals by the US Constitution, Federal laws, and State laws, with support, and without interference, coercion, discrimination, or retaliation from the facility.
- The right to be free from sexual, physical, and mental abuse, corporal punishment, involuntary seclusion, and financial exploitation.
- The right to be free from discrimination based on race, color, creed, national origin, religion, sex, age, disability, marital and family status, gender identity, or sexual orientation.
- The right to a safe, clean, comfortable and homelike environment with appropriate treatment and support.
- The right to self-determination, and communication with and access to persons and services inside and outside the facility.
- The right to be free from restraints (physical, chemical, mechanical) imposed for purposes of discipline or convenience, and not required to treat the client / resident's medical symptoms.
- The right to treatment to reduce dependency on restraints (physical, chemical, mechanical).
- The right to receive full Title XIX services and benefits for which the client / resident is eligible.
- The right to designate and revoke designation of a representative in accordance with State law.
- The right to be notified of any changes in client/resident rights under Federal or State law.
- The right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.
- The right to receive notices orally and in writing and in a format and language he/she understands.
- The right to be offered growth experiences to promote independence within the concept of reasonable risk and to be held accountable for personal decisions and actions based upon level of capability.
- The right to receive a free and appropriate public education, if under 22 years of age.
- The right to be informed of these rights and responsibilities and the facility will protect and promote those rights.
- The right to vote, participate in the democratic process, and help people with getting elected to office.
- Right of access to the courts, right to counsel, and the right to obtain private legal representation.

Reporting and Grievance Rights

- The right to file a grievance according to the Facility Grievance policy by contacting the Grievance Official / designee. Grievances can be made anonymously.
- The right to be free from discrimination.

Privacy and Confidentiality Rights

- The right to the opportunity for personal privacy; right to privacy during treatment, care of personal needs and discussions.
- The right to express concerns and complaints without fear of retribution.
- The right to communicate, associate and meet privately with individuals of his/her choice.
- The right that all information contained in personal records will be kept confidential and discussed in a confidential manner in a private area. Right of access to personal and medical records for review with translation upon request. Records may be received electronically or as a hard copy.

Care and Services Rights

- The right to participate in the planning process of the person-centered plan.
- The right to appropriate medical treatment including the right to be free from unnecessary medication, restraints, and restrictions.
- The right to be informed of their medical condition, developmental and behavioral status, which includes information provided to their representative, if requested. Each individual has the right to be notified of any changes in their current treatment planning prior to the change which includes helping to plan how the treatment will be implemented.

RHC Client / Resident Rights and Responsibilities

- The right to informed consent any potential risks of treatment as well as benefits and goals of treatment.
- The right to consent to, refuse, or withdraw from research projects.
- The right to refuse medical treatment.
- The right to housing, food, clothing, and furnishing in the bedroom that meets their needs, and addresses preferences whenever possible.
- The right to retain and use appropriate personal possessions and clothing; right to dress in one's own clothing each day.
- The right to decline search of person or personal belongings or premises.

Transfer, Discharge, and Roommate Rights

- The right to be transferred or discharged only for good cause and with proper notice. When discharging from the Nursing Facility, the right to notification to the Ombudsman Program.
- The right for a married couple, who both reside at the facility, to share a room.

Financial, Insurance, and Vocational Rights

- The right to be compensated at prevailing wages, and commensurate with abilities for any work performed for the facility. The right to pursue vocational interests.
- The right to manage personal financial affairs and to be taught to do so to the extent of his/her capabilities.

Social, Activity, and Self-Determination Rights

- The right to self-determination through choice, activities, lifestyle and interaction with individuals in the community.
- The right to a person centered plan, which identifies needs; and in the design of programs or approaches that meet those needs; and to participate in the selection of alternatives to the program(s) he/she rejects.
- The right to send and receive unopened mail and packages regardless of method of delivery.
- Right to access telephones with privacy for incoming and outgoing calls as well as use of TDD and TTY upon request.
- Right to have and use cell phone at personal expense.
- The right of opportunity to participate in social, religious and community group activities including Advocacy Groups, as well as the right to organize a client / resident group.
- The right to sexual expression based upon capabilities and legal status.

Disclaimer: If the client / resident presents a danger to themselves or others, these rights may be abridged to protect health and safety.