Accessible Space, Inc. (ASI)

Dear Prospective Service Consumer,

The mission of Accessible Space, Inc. (ASI) is to provide accessible, affordable, independent and supportive living opportunities for persons with physical disabilities and brain injuries, as well as seniors. This mission is accomplished through the development and cost-effective operation of cooperatively managed housing, supportive living and rehabilitation services. Although ASI offers both accessible housing and supported living services, it is important to note that these options must be applied for separately.

The core of ASI's philosophy is self-reliance. ASI believes that its residents with physical disabilities are best able to judge, direct and manage the services they need. Individuals with brain injuries who participate in ASI's services are likewise supported in their efforts to achieve greater self-sufficiency and independence.

Enclosed is an application for ASI's Assisted Living and Community Residential Services (Adult Foster Care) program. Although the application is lengthy, we encourage you to complete it in its entirety. Please check the appropriate type of service on the front of the application. If you have questions about which services you are eligible for, please contact the Intake Specialist.

Your special attention is requested on the Authorization for Release of Information forms. Please note that these release forms must be signed, dated, and list complete mailing addresses as directed. Failure to complete these forms could result in a delay in processing your application.

ACCESSIBLE SPACE, INC. ACCEPTS MINNESOTA MEDICAID (MEDICAL ASSISTANCE) AS PAYMENT FOR SERVICES. IF YOU ARE NOT CURRENTLY RECEIVING MEDICAL ASSISTANCE BENEFITS, PLEASE CONTACT THE INTAKE SPECIALIST BEFORE PROCEEDING WITH THE FOLLOWING APPLICATION.

IF YOU HAVE A LEGAL GUARDIAN, CONSERVATOR OR POWER OF ATTORNEY, YOU MUST ENCLOSE COPIES OF THESE LEGAL DOCUMENTS.

Once the completed application is returned (via mail, fax, or email), you will be contacted to set up an initial intake screening. This is an opportunity for ASI to describe our services and better understand your needs.

Thank you for your interest in Accessible Space, Inc. If you have any questions or need assistance filling out this application, please contact the Intake Specialist at 651-645-7271 or (800) 466-7722.

Sincerely,

Intake Specialist
Phone: 651-645-7271
Fax: 651-645-0541

ASSISTED LIVING SERVICE – ELIGIBILITY CRITERIA

A person must:

- Be 18 years old or older
- Have a physical disability, brain injury or similar disability requiring 24 Hour Assisted Living services. Applicants must be approved for 24 Hour Assisted Living services through the CADI, BI or EW waiver or be able to pay for services privately.
- Required to have a level of care that meets a need for 24 Hour Assisted Living Services. To be eligible you must have 3 or more dependencies in the following ADLs (eating, walking, mobility, dressing, grooming, bathing, toileting, transfers and cues/prompting/behavioral intervention.)
- Be able to communicate their needs and advocate for themselves either verbally, by writing or using a communication device.
- Be willing and able to follow prescribed treatments and orders by a medical or mental health professional. Be willing and able to follow treatment prescribed by a physician and universal precaution procedures with any communicable disease.
- The individual must recognize their medications, and be willing to safely control their medication supply or accept medication administration and assistance from ASI staff.
- Recognize safety issues and be able to access assistance in an emergency situation.
- Be able to navigate independently within the community or be willing to accept assistance from staff if needed.
- Have the ability to manage their finances, either independently or with the assistance of a third party.
- Be willing to work with all available staff; ASI is proud of our diverse workforce and proud to be an equal opportunity, affirmative action employer.
- Not have serious incidents of physical or verbal aggression, sexually inappropriate behavior or any behavior which may lead to health or safety risks for any persons or disrupt the peaceful enjoyment of the residence
- Be at least 6 months free of any chemical abuse or dependence
- Be medically/mental health stable. An individual's care needs must be within the scope of care that is authorized for the individual and appropriate for the Resident Assistant Staff to provide
- Be eligible for housing and maintain housing (with or without assistance) as determined by the Landlord's screening criteria

COMMUNITY RESIDENTIAL SERVICES (ADULT FOSTER CARE) – ELIGIBILITY CRITERIA

Applicants are approved for Community Residential Services program if they have the potential to live in a cooperative living setting and if they meet the following criteria:

- Be 18 years of age or older.

- Have a diagnosis of physical disability, brain injury or similar disability requiring services provided in the Community Residential Services (Adult Foster Care) Program

- Be cooperative with Accessible Space, Inc (ASI)'s staff regarding personal care schedules and work toward goals to increase self-reliance. Applicants are strongly encouraged to participate in day activities.

- Must not require 24-hour skilled nursing care.

- Must not pose a threat to others or require a locked house to maintain safety.

- Must demonstrate appropriate social behavior or behavior which is manageable with a behavior modification program.

- Be at least 6 months free of any chemical abuse or dependency.

- Be willing and able to follow prescribed treatments and orders by a medical or mental health professional.

- Be willing to follow universal precaution procedures with any communicable disease. A physical examination is required within 30 days of moving in

- Must be eligible for low income HUD housing and must be approved through Property Management's housing intake process. Service applicants must be approved for CADI, BI or EW waiver or be able to pay for services privately.

Accessible Space, Inc. (ASI)

For ASI Use Only

Application for Services
MINNESOTA

Date: _____

Setting Type:

- **Assisted Living (own apartment):** Consumer self-directed services for persons with a physical disability and/or a BI or similar cognitive disability in an apartment setting with access to staff 24 hours per day.
- **Assisted Living (shared house):** Consumer self-directed services for persons with a physical disability and/or BI or similar cognitive disability in a shared house with private bedroom, access to staff 24 hours per day.
- **Community Residential Services (Adult Foster Care Home):** Supportive services for persons with a physical disability, BI and/or severe cognitive disability in a shared home with private bedroom. Both asleep and awake overnight staffing options.

√	24-Hour Assisted Living (own apartment)	√	24-Hour Assisted Living (shared house)	√	Community Residential Services (Corporate Adult Foster Care)
	Minneapolis		Minneapolis House		St. Anthony
	St. Paul		Grand Rapids House		Falcon Heights
	Roseville				Coon Rapids
	New Brighton*				Blaine
	Mounds View*				White Bear Lake
	Champlin*				
	Brooklyn Park*				
	Bloomington*				
	Rochester				
	Duluth				
	Sites with a * indicate NHHI owned properties, applicant must have mobility impairment				

APPLICANT INFORMATION

Name: _____

Address: _____

_____

Telephone: _____

If above address is a Health/Nursing /Rehab Facility or Group Home, please complete the following:

Facility Name: _____

Please list a staff person at the facility that we may contact:

Name: _____ Title: _____

Telephone: _____

Date of Birth: _____ Age: _____ Gender: _____

Height: _____ Weight (Approximate): _____

Diagnosis:_____

_____

_____

Date of Onset : _____ Circumstances of Injury/Condition: _____

_____

Are you currently receiving MN Medicaid (Medical Assistance/MA) Benefits? ___ YES ___NO

Are you currently receiving one of these county waiver services? ___ BI ___CADI ___ EW

COMMUNITY SUPPORT SERVICES (Provide name and telephone number for any applicable)

Waiver Case Manager: _____ #: _____

Relocation Service Coordinator: _____ #: _____

ARMHS/Mental Health Case Manager: _____ #: _____

ILS Worker: _____ #: _____

Applicant's contact person (Secondary contact in case we are unable to contact applicant directly):

Name:_____Relationship to Applicant:_____

Telephone #: (Day) _____

Provide name and daytime telephone number for any of the following that are applicable.
(Enclose copies of legal documentation)

Guardian or Power of Attorney: _____ #: _____

INSURANCE / INCOME INFORMATION

Social Security #: _____

Medical Assistance (MA) #: _____

Other Insurance: _____

Gross Monthly Income: $_____ Monthly Spenddown: $_____

How did you hear about us?

Name:_____ #:_____ Email:_____

FAMILY COMPOSITION - List number of persons who will live in the unit with you.

Spouse/Partner: _____ Children (17 or younger): _____ Other Adults:_____

HOUSING HISTORY – List current and former housing settings using codes listed below.

Setting Code: (1) Parent's Home (2) Rental Apt/House (3) Hospital
(4) Group Home (5) Nursing Home (6) Rehabilitation Facility

Current Housing: Setting Code: _____ How Long Resided Here? _____

Name of Facility or Property: _____

Reason for Moving: _____

Former Housing: Setting Code: _____ How Long Resided Here? _____

Name of Facility or Property: _____

Reason for Moving: _____

SERVICE NEEDS

Mobility

- Ambulatory without aid: _____
- Ambulatory with aid of device (list device): _____
- Manual wheelchair: _____
- Power wheelchair: _____

Please check any of the following that you require assistance with. ASI does not guarantee that all of these services are available through our service program.

√	Grooming/Personal ADLs		Financial Needs	√
	Bathing		Retrieving Mail	
	Hair Care		Organizing Mail	
	Skin Care		Writing out Bill Payments	
	Oral Care (Including Dentures)		Set Up Household Budget	
	Nail Care (Fingers/ Toes)		Completing Forms/Applications	
	Foot Care (Ointments, Lotions, Powders, Etc)		**Supportive Needs**	
	Dressing		Assistance with Communication/Telephone	
	Toileting (Including Bowel Program)		Making Appointments	
	Repositioning		Arranging Transportation	
	Transfers		Protecting Self from Abusive Situations	
	ROM / Exercise Program		Staff Support in Community/Escort Services	
	Mobility inside the Home		**Vocational Needs**	
	Opening Doors		Identifying Volunteer Options	
	Meal Preparation		Seeking Day Activities	
	Menu Planning		**Social Skills**	
	Cooking		Cues/Prompting to Initiate Tasks	
	Eating/Drinking		Maintaining Appropriate Social Behavior	
	Grocery Shopping		Maintaining Verbal Appropriateness	
	Health		Maintaining Appropriate Sexual Conduct	
	Medication Management (set up, pass, reminders)		Controlling Physical Aggression	
	Applying Topical Medications		Maintaining Sobriety	
	Wound Care		Following Directions	
	Monitoring Blood Sugar		**Other (Please List)**	
	Self-Injections			
	Catheter or Colostomy Care			

MEDICAL HISTORY

List Hospitals, Rehabilitation Centers, Nursing Homes, etc. from which you have received recent medical treatment. **IMPORTANT! Please fill out a corresponding "Authorization for Release of Protected Information" form (attached) for each vendor/provider/contact you list below.**

1

Facility Name: _____ Date: _____ To: _____

Address: _____

_____

Telephone: _____ Fax: _____

2

Facility Name: _____ Date: _____ To: _____

Address: _____

_____

Telephone: _____ Fax: _____

3

Hospital Name: _____ Date: _____ To: _____

Address: _____

_____

Telephone: _____ Fax: _____

4

Name of Primary Physician: _____

Address: _____

_____

Telephone: _____ Fax: _____

5

Name of Counselor, Psychiatrist, or Psychologist: _____

Address: _____

_____

Telephone: _____ Fax: _____

6

Name of Personal Care Service Agency: _____

Address: _____

_____

Telephone: _____ Fax: _____

Please contact ASI's Intake Specialist if you require additional Authorization for Release of Protected Information forms at 651-645-7271.

Accessible Space, Inc. 2550 University Avenue, Suite 330N, St. Paul, MN 55114

Authorization for Release of Protected Information

Individual's Name: _____ **Individual's Phone #:** _____

Individual's Address: _____ **Date of Birth:** _____

_____

I authorize the disclosure and use of health information as described below:

1. Who may disclose (give out) this information: Name: _____
(Print name, address and phone number of facility, provider, agency or individual you are authorizing to release information)

Address: _____

_____

Phone: _____

2. Information to be disclosed: **Time Period of stay:** _____ **to** _____

_____ Entire medical record (includes all listed below)
_____ Verbal communication (includes all records listed below)
_____ Behavior records
_____ Most recent physical & history
_____ Chemical health records
_____ Most recent discharge summary records
_____ Psychology / Psychiatric records
_____ Medication information
_____ Neuropsychological evaluation records
_____ Daily narratives and progress notes
_____ Other: _____

3. This authorization expires on the following date: _____
(Note: If date is not specified, this authorization expires twelve (12) months from the date this form is signed)

4. The purpose for which this information may be disclosed:

_X_ At the request of the individual listed above
_X_ Provision of service
_X_ Determining care needs
_X_ Developing Care Plan
_X_ Care Coordination

5. Who may receive and use this information:
(Print name, address, and phone number)

Accessible Space, Inc.
2550 University Avenue West, Suite 330 North
St. Paul, MN 55114
651-645-7271

I understand that:

- I may revoke this authorization at any time by notifying, in writing, the facility listed above
- Revoking this authorization does not apply to information that has already been released under this authorization
- I have the right to inspect or request a copy of the health information to be disclosed
- If the disclosed information goes to a health care provider or a health plan covered by federal privacy laws, it will be protected by federal privacy laws
- Information that goes to other persons or entities may not be protected by state of federal privacy laws and may be re-disclosed.
- I do not have to sign this form.

_____ _____
Signature of Resident or Resident's Legal Representative: Date:
If Signed by Resident's Representative:

_____ _____
Print Representative's Name Relationship to Resident

Witness Signature: _____ Date: _____

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   X Developing Care Plan

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SERVICE INTAKE
NOTICE OF PRIVACY PRACTICES--*MINNESOTA*

For Your Protection	THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU AND INFORMATION ABOUT YOUR ELIGIBILITY FOR ASI SERVICES MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
Private Health Information	When you apply for ASI services, you need to give ASI personal information about you. The law says that: 1 ASI must keep your health information from others who do not need to know it. 2 You can tell us if there is some health information you do not want ASI to share. In some cases, we may not be able to agree to your request.
Who Sees and Shares my Medical Information?	Your private medical information may be used by ASI to determine eligibility for the service programs and to determine additional services needed. We may use your information to contact you about appointments. We only share information about you that is needed at that time by that provider or agency to do their job. You may limit the health information we disclose about you to someone who is involved in your care or payment for your care.
How is Payment Made?	When your service begins, ASI sends a bill to your health plan (insurance company or Medical Assistance) to receive payment for health care services you receive. Your health plan may require information about the services, your diagnosis or supplies used in order for payment to be made. Your health plan may be contacted before the start of service to determine if they will cover the planned services. We may also release information to other health care providers who may be entitled to receive a payment for services provided to you. With your signed authorization, we may release payment information about you to a family member or a friend who is involved in your health care.
May I See My Medical Information?	You are allowed to see your personal information generated by ASI unless it is the private notes taken by a mental health provider, part of a legal case, or if ASI decides it would be harmful for you to see the information. Most of the time you can receive a copy if you ask. You have the right to see your information by giving notice to the Intake Specialist. You may be charged a small amount for the copying costs. If you think some of the information is wrong, you may ask in writing that it be changed or new information be added. ASI's Privacy Official will decide if this change is possible. You may ask that the changes be sent to others who have received your personal information from us. You can get a list of where your personal information has been sent to be sure that the laws are being followed.

What if My Medical Information Needs to Go Somewhere Else?	You will be asked to sign a separate form, called an authorization form, allowing ASI to collect your medical or service information, or to send information somewhere else. This would be used if ASI needs to send it to another person or healthcare provider for you. The form tells us what, where and whom this information will be collected from or sent. Your authorization is good for 12 months or until the date you put on the form. You can cancel or limit the amount of information sent at any time by letting us know in writing. You may be charged a small amount for the copying costs.
Could My Medical Information Be Released Without My Authorization?	We follow laws that tell us when we have to share medical information, even if you do not sign an authorization form. We report the following as required by regulations: 1 contagious diseases to the health department; 2 reactions and problems with medicines; 3 to the police when required by law or when the courts order us to; 4 to a state or federal health oversight agency to review our programs; 5 to a provider or insurance company who needs to know if you are enrolled in one of our programs; 6 to Adult Protection and/or the Ombudsman's Office if we have a serious concern for your health or safety or to prevent a serious threat to you or another person; 7 to Workers' Compensation for work related injuries; 8 birth, death and immunization information; 9 to the federal government when they are investigating something important to protect our country, the President and other government workers; 10 suspected victims of abuse or neglect.
May I Have A Copy of This Notice?	This notice is yours. If anything changes, you will get a new one. If you have questions about this notice, please ask the Intake Specialist. If this person cannot answer your questions, call Ken Berry, Director of Housing and Program Services, at (651) 645-7271 ext. 284. You may file a privacy complaint by following ASI's Grievance Procedure. You can complain to the state government by writing to the State Privacy Official at the Minnesota Department of Human Services, 444 Lafayette Road North, Saint Paul, MN 55155 or calling 651-296-5764. You can complain to the federal government by writing to the Region V Office of Civil Rights at 233 N. Michigan Avenue, Suite 240, Chicago, IL 60601 or phoning 312-886-2359 (TDD: 312-353-5693). This needs to be done within 180 days of when the problem happened. **Your eligibility for services will not be affected by a complaint made to our Privacy Official or to the state or federal government.**

Accessible Space, Inc. (ASI)

ACKNOWLEDGEMENT OF RECEIPT OF *SERVICE INTAKE* NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I was given a copy of this notice and had a chance to ask questions about how my personal health information will be used. I know that I can contact Ken Berry, Director of Housing and Program Services, at (651) 645-7271 or 1-800-466-7722 ext. 284 if I have further concerns.

_____
Print Name

_____ _____
Signature **Date**

_____
Guardian if applicable

ASI shares information with these professionals:

Screening Nurse: _____

Physician/Clinic: _____

Case Manager: _____

You will be asked to sign separate authorization forms for your current healthcare professionals.

Please return this form to the Intake Specialist with your Service Application and keep the Notices of Privacy Practices for your reference.