THE COORDINATING CENTER
INSPIRED SOLUTIONS

REM Consents and Assessments

Checklist:

- ❑ Authorization for the Release of Protected Health Information (2)
- ❑ REM Consent to Release Information (2)
- ❑ Consent for Care Management (2)
- ❑ Client Rights and Responsibilities (2)
- ❑ Consent for Community Visits (2)
- ❑ HIPAA Notice of Privacy Practices and Acknowledgement
- ❑ Environmental Assessment
- ❑ Developmental Services Profile (under 60 mo.)
- ❑ Care Management Assessment
- ❑ Client's and Family's Goals Worksheet

SIGNED COPY TO CLIENT OR REP.

The Center's Rep. Initials: _____

THE COORDINATING CENTER
INSPIRED SOLUTIONS

Authorization for the Release of Protected Health Information

CLIENT INFORMATION			
Client's last name: First: Middle:	Date of Birth:	Verification of Identity (type & no.):	
Client's Address:	Phone no.:	Email Address:	Health Record No.:
****Complete the below only if the person authorizing the use or disclosure is not the client****			
Name:	Relationship to Client:	Verification of Identity (type & no.) and Authority:	
Address:	Phone no.:	Email Address:	

I Request and authorize The Coordinating Center to release my/the Client's Protected Health Information (PHI), as follows: ❑ To Me (provide a copy) ❑ To Me (request viewing only) ❑ Release my PHI to: ❑ Discuss my PHI with: ❑ Obtain copies of my PHI from:

❑ Transportation Organizations	❑ Housing Organizations	❑ Community Resource Agencies

Entity or Person:	
Address:	
Contact/Responsible Party:	Phone/Email:
Entity or Person:	
Address:	
Contact/Responsible Party:	Phone/Email:

The following PHI relating to the Client named above may be disclosed: *Check all that apply:*

❑ Abstract ❑ Billing Record ❑ Diagnostic Tests/Results ❑ Discharge Summary ❑ History

❑ Progress Note ❑ Other: _____

❑ Records from other health care providers in Client record

For the date(s) of service from: _____ to _____ (all applicable records may be provided if left blank).

I further authorize the disclosure of the following information about me that may be included in the PHI listed above. *(Check all that are approved):*

❑ Mental Health ❑ Substance Abuse ❑ STD/HIV/AIDS ❑ Genetic Data

Reason for Request:

❑ At my request ❑ For my health care / treatment ❑ For legal purposes ❑ For payment / insurance purposes

❑ Other: _____

I request the copy of PHI be provided (where possible/available):

❑ By paper copy ❑ Electronically on CD ❑ Electronically on flash drive

❑ By unencrypted email to the following email address: _____

I understand that the CD/disc or flash drive is not encrypted or password protected and that it is my responsibility to take extra precautions to protect the data on the device and not to lose or misplace the device. Additionally, I understand that unencrypted e-mail is not secure – that means it could be intercepted and seen by others; in addition, I understand that there are other risks with unencrypted e-mail including misaddressed/misdirected messages; e-mail accounts that are shared; messages forwarded to others; and messages stored on portable devices having no security. By choosing to receive PHI on a CD/disc, flash drive or by unencrypted e-mail, I am acknowledging and accepting these risks.

I understand there may be a fee for a copy of my health information. I understand that all fees will be in compliance with applicable law. I agree to pay this fee.

I understand that The Coordinating Center may not use or disclose protected health information (PHI) without authorization except as provided in The Coordinating Center's Notice of Privacy Practices. By signing this Authorization, I am giving permission for the use or disclosure of the PHI described above for the purpose(s) described.

I understand that I have the right to revoke this Authorization at any time, if I do so in writing and address it to the contact listed in the Notice of Privacy Practices. The revocation will not apply to any information already released as a result of this Authorization.

I understand that I may refuse to sign this Authorization, and I cannot be cannot denied or refused treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign, and that I have the right to receive a copy of this form.

I understand that information disclosed pursuant to this Authorization may no longer be protected by the federal health information privacy laws and could be re-disclosed by the person or entity that receives it.

This authorization expires in 1 year, unless an earlier date is specified here: _____.

Signature of Client or Representative:_____ Date: _____

Attachment P-1 Consent to Release Information

To Families: **We can better serve you if we are able to work with other State and local agencies that know you. When you sign this form you give permission for agencies to share information about you. You will still get services for which you are eligible even if you choose not to sign this form.**

Section I. Identification

Name:_____ Date of Birth: _____

Address:_____

City:_____ State: _____ Zip: _____

Phone:(_____) _____

Social Security Number: _____

Section II. Identification of Parent/Guardian (For Minors Only)

Name:_____

Address:_____

City:_____ State: _____ Zip: _____

Phone:(_____) _____

Relationship to Child: [ ] Self (minor child) [ ] Legal Custodian/Guardian/Surrogate
[ ] Parent [ ] Other caretaker::_____

Section III. Information Release

A. Agencies Sharing Information (Check all that apply)

I, _____, authorize the release of information and records on the above individual between or among the following public agencies.

[**X**] _____Dept. of Social Services
(Name of Jurisdiction)

[ ] _____Local Health Department
(Name of Jurisdiction)

[ ] _____Public School System
(Name of Jurisdiction)

[ ] _____
Local Planning Entity Designated by Article 49D §11

[ ] Maryland State Dept. of Education

[ ] Maryland Dept. of Health and Mental Hygiene

[ ] Maryland Dept. of Juvenile Service (DJS)

[ ] Other Public Agencies:_____

B. Information to be Released (Check all that apply)

[ ] Reports/records about psychological or cognitive abilities

[ ] Early intervention reports/records

[ ] Recommendation for intervention or treatment

[ ] Assessment of family situation

[**X**] Other (specify): **R1 Authorized Representative Valid ONLY for Medical Assistance representative to receive notices**

REM Case Manager Name:_____

REM Case Manager Address:_____

_____

REM Case Manager Phone:_____

[ ] Educational reports or records

[ ] Medical health needs/treatment/history

[ ] Mental health needs/treatment/history

[ ] Alcohol/drug treatment (Identify information to be shared[1]):

_____

[1]Information from drug and alcohol abuse patient records can be obtained only when the patient signs this form and specifically designates how much and what kind of information is to be released, in accordance with 42 CFR Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records. A general authorization for the release of medical or other information is not sufficient for this purpose.

For Minor Children:

[ ] yes [ ] no If consenting to release of protective services records collected prior to October 1, 1993, do you wish to review the Child Protective Services' records, if any exist, at the local department prior to release of the information? I understand that I may cancel this consent in whole or in part after reviewing any existing pre-October 1, 1993, Child Protective Services' record.

Section IV. Signature

I understand that the purpose of this authorization is to allow agencies to share information and records to provide services to me in a coordinated and effective way. I agree that the agencies above may share and exchange information about me. Information and records released under this authorization shall remain confidential and may not be disclosed to any party not identified on this form without specific written consent in accordance with state and federal law. Criminal penalties may apply to illegal disclosure. This authorization can be cancelled in writing at any time. I understand that the cancellation will not affect any information that was already released before the cancellation. I approve the release of this information. I understand what this agreement means. I am signing on my own and have not been pressured to do so.

_____ _____ _____

Signature Date Signature (Parent/Guardian Signature for Minors only) Date

For Worker Use:
This authorization is good for one year from the date it is signed: _____
(Expiration Date)

1. Fill out this form for any individual for whom information is requested.

2. Be specific about why you need information released to you. You may want to use a cover letter to explain your request. The clearer you are in your request, the more likely you are to receive a prompt and accurate response. Do not ask for information you do not need.

3. Alcohol/Drug, Mental Health and Medical Records include all aspects of diagnosis, treatment and prognosis. Education Records include both behavioral and progress reports.

4. **CANCELLATION**. If the authorization is cancelled by a person having authority to cancel, write "cancelled" and date of the cancellation letter boldly across the CONSENT TO RELEASE INFORMATION form. Date and initial it and keep it in the file.

5. **DURATION**. The authorization is valid for one year unless otherwise specified. Check to be sure that the release you are using is current.

6. **PERSON-IN-INTEREST FOR THE MINOR CHILD**
The requesting agency should seek consent to share information from the person-in-interest as defined in Article 49D§20. If there is more than one reasonably available person-in-interest, the requesting agency should approach one of the following persons in the following descending order of priority:

   (1) minor child if the child is allowed to consent;
   (2) a parent with legal custody;
   (3) a noncustodial parent, if the custodial parent is not available;
   (4) a guardian, custodian or a representative of the minor designated by the court;
   (5) an individual authorized to act as a surrogate for the parents or guardian pursuant to the Individuals with Disabilities Education Act, 20 USC §1415 (b)(1)(B) and § 1480(5).

   If a person-in-interest affirmatively refuses consent, the requesting agency may not seek consent for the release of the same information from another person-in-interest.

7. **IF THE PERSON-IN-INTEREST IS THE MINOR CHILD**
Under certain circumstances, minors can consent to treatment. If the minor has consented to the advice or treatment as described in paragraphs (a) through (e) below, then only the minor child may consent to the release of the information. Parents may not consent to release of information, which the minor child consented, to the advice or treatment. Below is a listing of the appropriate authority for a minor to consent to release of the minor's own medical information.

   (a) Health Gen. Code § 20-101: -Blood donations

   (b) Health Gen. Code § 20-102: If the minor is married or the parent of a child, the minor may consent to release of information concerning medical treatment provided.

   (c) Health Gen. Code §20-102(b) : A minor may consent to release of information concerning the following provided that the minor gave consent to the treatment itself; Emergency medical treatment, Treatment for or advice about drug abuse, alcoholism, venereal disease, pregnancy, contraception other than sterilization; Physical examination and treatment of injuries from an alleged rape or sexual offense, physical examination to obtain evidence of an alleged rape or sexual offense.

   (d) Health Gen. Code §20-103: Abortion, if; the minor is married or the un-married minor consented to the procedure.

   (e) Health Gen. Code §20-104: If the minor is 16 years old or older, the minor may consent to release of information concerning consultation, diagnosis, and treatment of a mental or emotional disorder by a physician or a clinic provided that the minor consented to the treatment.

8. **TERMINATION OF PARENTAL RIGHTS FOR THE MINOR CHILD**. If the parent's rights have been terminated, the parent may not consent to the release of information.

9. **IF THE PERSON-IN-INTEREST IS NOT A NATURAL OR ADOPTIVE PARENT OF THE MINOR CHILD,** then attach to this form a copy of one of the following:

(a) A copy of the court order appointing the person as guardian, custodian or legal representative of the minor with authority to act on behalf of or in lieu of a parent; or
(b) Documentation appointing the person giving consent the authority to act as a surrogate for the parent or guardian in accordance with the Individuals With Disabilities Act, 20 U.S.C. §1415(b)(1)(B) and §1480(5).

10. **IF THE PERSON-IN-INTEREST IS NOT AVAILABLE TO GIVE WRITTEN CONSENT FOR THE MINOR CHILD** The requesting agency must attach a court order or provide a written explanation why the parent, legal custodian/guardian or surrogate was unavailable to authorize this disclosure and what reasonable efforts were made by the requesting agency to contact the person in interest.

Substituted consent may be given by:

(1) A person having care and control of the minor, but who is not merely a babysitter or a teacher;

(2) A court that has jurisdiction over a suit affecting the parent-child relationship of which the minor is the subject (attach a copy of any court order/other document describing the nature of court proceeding and the information sought by the court); or

(3) The Department of Health and Mental Hygiene, Department of Juvenile Services or a local Department of Social Services when the minor is in that agency's care and custody.

If an agency requests information and has not been able to secure the signature/authorization from a parent or legal guardian/surrogate, an explanation must accompany the request as to why an adult having care or control, or why the public agency, is authorizing consent.

11. **DISCLOSURE.** Information received under this authorization shall not be disclosed to any party not identified on this form without specific written consent. Criminal penalties may apply to illegal disclosure. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of alcohol and drug information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

12. **CANCELLATION**. If the authorization is cancelled by a person having authority to cancel, write "cancelled" and date of the cancellation letter boldly across the CONSENT TO RELEASE INFORMATION form. Date and initial it and keep it in the file.

13. **DURATION**. The authorization is valid for one year unless otherwise specified. Check to be sure that the release you are using is current.

14. **COURT ORDER.** A copy of the court order must accompany this form in the following situations:

(a) If the signer is a guardian/legal custodian appointed by the court;

(b) If a public agency has custody and the agency's representative signs; or

(c) If a court has jurisdiction over a suit affecting the parent-child relationship in which the minor is the subject.

15. **CHILD PROTECTIVE SERVICES (CPS).** If a person-in-interest consents to the release of CPS records collected prior to October 1, 1993, the person-in-interest must have an opportunity to review the CPS record on the minor at the local department. Upon receipt of a request for the release of information concerning a CPS record collected prior to October 1, 1993, the local department shall contact the person-in-interest and advise the person of his or her right to review the record on the child prior to sending the information to the requesting agency. The local department shall provide access to the information to the person-in-interest without disclosing information about the reporter, or any other person whose life or safety is likely to be endangered by disclosure. If the consenting person is not a person-in-interest, he or she may not review the record.

THE COORDINATING CENTER
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CONSENT FOR CARE MANAGEMENT SERVICES

I hereby consent to participate in care management services as delivered by The Coordinating Center. I understand that

- Care management is a comprehensive, family centered, collaborative process that assesses, plans, implements, coordinates, and monitors and evaluates options and services to meet an individual's health care needs.
- Care management services seek to partner professionals with client/families to identify and access necessary benefits, as well as community resources for individuals.
- Care management services may yield the benefits of greater access to services, more cost efficient and effective utilization of funds and services, as well as a more coordinated and comprehensive approach to the provision and utilization of health care and related services.
- My participation in care management services does not pose any significant risk to me or my access to health care benefits.
- I have the right to refuse to participate in care management services understanding that such refusal could limit my access to certain health care benefits.
- I may request a change in the Care Coordinator assigned to me.
- If more than one care management agency is providing service to my health care plan, I may ask to change agencies without citing a reason.
- I may revoke my Consent for Care Management at any time.

*Signed this*_____ *day of* _____, 2____ .

_____ _____

Client's Name Witness

_____ _____

Signature (Parent/Guardian if under age 18) Print Name of Signatory

THE COORDINATING CENTER
INSPIRED SOLUTIONS

RIGHTS AND RESPONSIBILITIES

Your care team is committed to helping you receive the highest quality of services available. One important way to achieve this level of excellence is for you to understand and exercise your rights and responsibilities.

Please review your rights and responsibilities below:

It is your right to:

1. Be part of the decision-making process regarding your care.
2. Participate in the development of your plan of care and receive a copy of that plan.
3. Receive assistance in obtaining information about programs or services for which you may be eligible.
4. Request a change in your Care Coordinator to best meet your needs.
5. Voice concerns or grievances about care coordination services and receive a timely response to address your concerns.
6. Be treated with respect and dignity by your Care Coordinator.
7. Refuse care coordination services understanding that such refusal may have an impact on your eligibility for programs or services.
8. Request and obtain notice of any changes in your care coordination services.

It is your responsibility to:

1. Notify your Care Coordinator about changes in address, name, or other important information including information that may affect your health or services.
2. Inform the Care Coordinator if you are hospitalized or go to the Emergency Room for any reason.
3. Actively participate with providers and the Care Coordinator working with you to develop your Plan of Care.
4. Discuss any problems for which you desire assistance or express concerns about services with the Care Coordinator.
5. Contact the Care Coordinator if you need to make a change in your Plan of Care or have questions about your Plan of Care., Attend all care meetings and notify your Care Coordinator if you need to reschedule or will not be able to attend.
6. Attend all plan of care meetings and notify your Care Coordinator if you need to reschedule or won't be able to attend.
7. Notify the Care Coordinator of any cancelled clinic or doctor's visits, or any pre-arranged transportation, if you are not going to be able to keep the scheduled appointment.

8. Cooperate in the scheduling of home visits/site visits at a time that is convenient for both you and the Care Coordinator.
9. Voice any concerns or ask for clarification about program and care activities that may affect your care or your ability to participate in that care.

I have read these client rights and responsibilities and understand their scope and intent.

_____
Client's Name

_____ _____
Signature (Parent/Guardian if under age 18) Date of Signature

_____
Print Name of Signatory

THE COORDINATING CENTER
INSPIRED SOLUTIONS

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

This HIPAA Notice of Privacy Practices (Notice) contains important information regarding your medical information. Our current Notice is posted at https://www.coordinatingcenter.org/. You also have the right to receive a paper copy of this Notice and may ask us to give you a copy of this Notice at any time. If you received this Notice electronically, you are entitled to a paper copy of this Notice. If you have any questions about this Notice, please contact the person listed below in Part 8.

The Health Insurance Portability and Accountability Act of 1996 (**HIPAA**) imposes numerous requirements on certain health care providers regarding how certain individually identifiable health information – known as protected health information or PHI – may be used and disclosed. This Notice describes how The Coordinating Center (The Center), and any third party that assists in the administration of The Center, may use and disclose your protected health information for treatment, payment or health care operations and for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your protected health information. "Protected health information" is information that is maintained or transmitted by The Center, which may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. This Notice applies to all of the medical records we maintain.

We are required by law to abide by the terms of this Notice to:

- Make sure that medical information that identifies you is kept private.
- Give you notice of our legal duties and privacy practices with respect to medical information about you.
- Follow the terms of the Notice that is currently in effect.

1. How We May Use and Disclose Medical Information About You.

HIPAA generally permits use and disclosure of your health information without your permission for purposes of health care treatment, payment activities and health care operations. These uses and disclosures, and others, are more fully described below. Please note that this Notice does not list every use or disclosure, instead it gives examples of the most common uses and disclosures.

- **Treatment:** We may use or disclose medical information about you to provide and facilitate medical treatment or services. We may disclose medical information about you to health care providers, including doctors, nurses, technicians, and medical students who are involved in taking care of you. For example, we might disclose information about you with physicians who are treating you.
- **Payment:** When and as appropriate, we may use and disclose medical information about you to determine your eligibility for benefits, to facilitate payment for the treatment and services you receive from us, to determine benefit responsibility and coverage, or to coordinate your coverage. For example, we may disclose information about your medical history to your health insurance company or third party. Additionally, we may share medical information with another entity to assist us in collecting payments due for services provided.
- **Health Care Operations:** When and as appropriate, we may use and disclose medical information about you for The Center operations, as needed. For example, we may use medical information in connection with: conducting quality assessment and clinical improvement; conducting or arranging for medical review, legal services, audit services and fraud and abuse detection programs; business planning and development such as cost management; and business management and general administrative activities of The Center. For example, we may use your information to review the effectiveness of programs.
- **Health Information Exchange:** We may share information that we obtain or create about you with other health care providers or health care entities through the **Chesapeake Regional Information System for our Patients, Inc. (CRISP)**, a regional health information exchange serving Maryland and D.C. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care, and assist providers and public health officials in making more informed decisions. **You may "opt out" and disable all access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at www.crisphealth.org.** Public Health reporting and Controlled Dangerous Substances information as part of the Maryland Prescription Drug Monitoring Program (PDMP), will still be available to providers, even if you opt-out.

- **Fundraising Activities:** we may use or disclose medical information about you to contact you about our fundraising activities to benefit The Center. Information we may use includes demographic information (for example, your name, address, contact information, age, gender, and birthdate), when your received services, which program or department you received services under, who provided your services, and your services outcome. You may "opt out" of receiving fundraising communications by following the instructions to opt out (or be removed from a mailing list) which are included in all fundraising communications involving The Center.

We will always try to ensure that the medical information used or disclosed will be limited to a "Designated Record Set" and to the "Minimum Necessary" standard, including a "limited data set," as defined in HIPAA. We may also contact you to provide information about treatment options or alternatives or other health-related benefits and services that may be of interest to you.

OTHER PERMITTED USES AND DISCLOSURES

- **Disclosure to Others Involved in Your Care:** We may disclose medical information about you to a relative, a friend or to any other person you identify, provided the information is directly relevant to that person's involvement with your health care or payment for that care. For example, if a family member or a caregiver calls us with prior knowledge of a claim and asks us to help verify the status of a claim, we may agree to help them confirm whether or not the claim has been received and paid.
- **Workers' Compensation:** We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work related injuries or illness.
- **To Comply with Federal and State Requirements:** We will disclose medical information about you when required to do so by federal, state or local law. For example, we may disclose medical information when required by the U.S. Department of Labor or other government agencies that regulate us; to federal, state and local law enforcement officials; in response to a judicial order, subpoena or other lawful process; and to address matters of public interest as required or permitted by law (for example, reporting child abuse and neglect, threats to public health and safety and for national security reasons). We are required to disclose medical information about you to the Secretary of the U.S. Department of Health and Human Services if the Secretary is investigating or determining compliance with HIPAA or to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law. We may disclose your medical information to a health oversight agency for activities authorized by law (such as audits, investigations, inspections and licensure).
- **To Avert a Serious Threat to Health or Safety:** We may use and disclose medical information about you when necessary to prevent a serious threat to your health

and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose medical information about you in a proceeding regarding the licensure of a physician.

- **Military and Veterans:** If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.
- **Business Associates:** We may disclose your medical information to our business associates. We have contracted with entities (defined as "business associates" under HIPAA) to help us in our operations. We will enter into contracts with these entities requiring them to only use and disclose your health information as we are permitted to do so under HIPAA.
- **Other Uses:** If you are an organ donor, we may release your medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation. We may release your medical information to a coroner or medical examiner. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your information to the correctional institution or law enforcement official.

Uses and disclosures other than those described in this Notice will require your written authorization.

Your written authorization is required for:

- most uses and disclosures of psychotherapy notes;
- uses and disclosures of PHI for marketing purposes; and
- disclosures that are a sale of PHI.

You may revoke your authorization at any time, but you cannot revoke your authorization if The Center has already acted on it.

The privacy laws of a particular state or other federal laws might impose a stricter privacy standard. If these stricter laws apply and are not superseded by federal preemption rules, The Center will comply with the stricter law.

2. Your Rights Regarding Medical Information About You.

You have the following rights regarding medical information we maintain about you:

Your Right to Inspect and Copy: You have the right to inspect and obtain a copy of your medical information in a designated record set, as long as that information is maintained in the designated record set.

- If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.
- We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. If The Center does not maintain the health information, but know where it is maintained, you will be informed of where to direct your request.

Your Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for The Center.

In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend any of the following information:

- Information that is not part of the medical information kept by or for The Center.
- Information that was not created by us, unless the person or entity that created the information is no longer available to make the amendment.
- Information that is not part of the information which you would be permitted to inspect and copy.
- Information that is accurate and complete.

Your Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" (that is, a list of certain disclosures The Center has made of your health information). Generally, you may receive an accounting of disclosures if the disclosure is required by law, made in connection with public health activities, or in similar situations as those listed above as "Other permitted uses and disclosures". You do not have a right to an accounting of disclosures where such disclosure was made:

- For treatment, payment, or health care operations.
- To you about your own health information.
- Incidental to other permitted disclosures.
- Where authorization was provided.

- To family or friends involved in your care (where disclosure is permitted without authorization).
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances.
- As part of a limited data set where the information disclosed excludes identifying information.

To request this list or accounting of disclosures, you must submit your request, which shall state a time period, which may not be longer than six years and may not include dates before **April 14, 2003**. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Notwithstanding the foregoing, you may request an accounting of disclosures of any "electronic health record" (that is, an electronic record of health-related information about you that is created, gathered, managed and consulted by authorized health care clinicians and staff), provided that you must submit your request and state a time period which may be no longer than three years prior to the date on which the accounting is requested. In the case of any electronic heath record created on your behalf on or before January 1, 2009, this paragraph shall apply to disclosures made on or after January 1, 2014. In the case of any electronic health record created on your behalf after January 1, 2009, this paragraph shall apply to disclosures made on or after the later of January 1, 2011 or the date we acquired the electronic health record.

Your Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

We are not required to agree to your request. If The Center does agree to a request, a restriction may later be terminated by your written request, by agreement between you and The Center (including orally), or unilaterally by The Center for health information created or received after The Center has notified you that they have removed the restrictions and for emergency treatment.

To request restrictions, you must make your request in writing and must tell us the following information:

- What information you want to limit.
- Whether you want to limit our use, disclosure or both.
- To whom you want the limits to apply (for example, disclosures to your spouse).

Effective February 17, 2010 (or such other date specified as the effective date under applicable law) we will comply with any restriction request if: (1) except as otherwise required by law, the disclosure is to The Center for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out-of-pocket in full.

Your Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted, and we ask that your request be made in writing.

You must make any of the requests described above, to the person listed in Part 8, below.

3. Breach Notification.

We understand that medical information about you and your health is personal and we are committed to protecting your medical information. Furthermore, we will notify you following the discovery of any "breach" of your unsecured protected health information as defined in the HITECH Act (the "**Notice of Breach**"). Your Notice of Breach will be in writing and provided via first-class mail, or alternatively, by e-mail if you have previously agreed to receive such notices electronically. If the breach involves:

- 10 or more individuals for whom we have insufficient or out-of-date contact information, then we will provide substitute individual Notice of Breach by either posting the notice on the web site of The Center or by providing the notice in major print or broadcast media where the affected individuals likely reside.
- Less than 10 individuals for whom we have insufficient or out-of-date contact information, then we will provide substitute Notice of Breach by an alternative form.

Your Notice of Breach shall be provided without unreasonable delay and in no case later than 60 days following the discovery of a breach and shall include, to the extent possible:

- A description of the breach.
- A description of the types of information that were involved in the breach.
- The steps you should take to protect yourself from potential harm.
- A brief description of what we are doing to investigate the breach, mitigate the harm, and prevent further breaches.
- The Center's relevant contact information.

Additionally, for any substitute Notice of Breach provided via web posting or major print or broadcast media, the Notice of Breach shall include a toll-free number for you to contact us to determine if your protected health information was involved in the breach.

4. Changes to This Notice.

We can change the terms of this Notice at any time. If we do, the new terms and policies will be effective for all of the medical information we already have about you as well as any information we receive in the future. We will post any revised notice on the web address listed on page 1 of this Notice, and you may request a copy of the revised notice.

5. Complaints.

If you believe your privacy rights have been violated, you may file a complaint with The Center or with the Secretary of the Department of Health and Human Services. To file a complaint with The Center, contact the person listed below in Part 8.

All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

6. Other Uses of Medical Information.

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you grant us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. We are unable to take back any disclosures we have already made with your permission.

7. Effective Date.

The effective date of this Notice is August 1, 2016.

8. Contact Information.

All correspondences relating to the contents of this Notice should be directed as follows:

The Coordinating Center
Privacy Officer
8531 Veterans Highway, 3rd Floor
Millersville, Maryland 21108
(410) 987-1048
privacy@coordinatingcenter.org

THE COORDINATING CENTER
INSPIRED SOLUTIONS

ACKNOWLEDGEMENT OF THE COORDINATING CENTER
HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received the Notice of Privacy Practices (Notice) from The Coordinating Center (The Center) and that I have been provided an opportunity to review it. I understand that:

- I have certain rights to privacy regarding my protected health information.
- The Center can and will use my health information for purposes of my treatment, payment for treatment, and health care operations.
- The Notice explains in more detail how The Center may use and share my protected health information for other purposes.
- I have rights regarding my protected health information, which are listed in the Notice.
- The Center has the right to change the Notice from time to time and I can obtain a current paper copy of the Notice by contacting the person listed in the Notice, and I can also view the current Notice posted at https://www.coordinatingcenter.org/

Client Name: _____ Date: _____

Signature: _____ Date of Birth: _____

Relationship to Patient: _____

Good Faith Effort to Obtain Acknowledgment (*for office use only*):

Client Name: _____ Date of Birth: _____

I attempted to obtain the Client's (or Client Representative's) signature on this HIPAA Notice of Privacy Practices Acknowledgement Form, but was unable to do so as documented below:

Reason: _____

TCC Representative Name: _____ Date: _____

TCC Representative Signature: _____

THE COORDINATING CENTER
INSPIRED SOLUTIONS

REM PROGRAM ENVIRONMENTAL ASSESSMENT

Client Name:_____

HOME EXTERIOR		CORRECTIVE ACTION /DESCRIPTION
Entrance well lit/visible?	Y / N / NA	
Secure handrails?	Y / N / NA	
Address visible from street?	Y / N / NA	
Handicap parking space	Y / N / NA	
Ample parking?	Y / N / NA	
HOME INTERIOR		**CORRECTIVE ACTION /DESCRIPTION**
Functional smoke detector, each level?	Y / N / NA	Advise of local fire dept as resource?
Fire extinguisher?	Y / N / NA	
Two (2) means of exit?	Y / N / NA	
Walkways clear?	Y / N / NA	
Functional electricity?	Y / N / NA	Name of Utility Company:
Functional heat?	Y / N / NA	
Functional air conditioning?	Y / N / NA	
Gas odor/malfunction?	Y / N / NA	
Functional telephone?	Y / N / NA	Contact EMS? / 911 access/ Name of Phone Company:
Functional plumbing?	Y / N / NA	
Running water?	Y / N / NA	
Functional refrigerator?	Y / N / NA	
Functional stove?	Y / N / NA	
Paint/plaster flakes on wall / floor / window?	Y / N / NA	Report notify PCP?
Pets? Type: Number:	Y / N / NA	Precautions:
Insects?	Y / N / NA	
Rodents?	Y / N / NA	
MEDICAL EQUIPMENT		**CORRECTIVE ACTION /DESCRIPTION**
Equipment functional?	Y / N / NA	
Client/caregiver instructed in use?	Y / N / NA	
Back-up batteries charges & functional?	Y / N / NA	
Oxygen in use? Amount:	Y / N / NA	
Oxygen location?		
Signs posted?	Y / N / NA	
Oxygen tanks properly stored?	Y / N / NA	
No smoking signs posted?	Y / N / NA	
Flashlights?	Y / N / NA	
ACCESSIBILITY		**CORRECTIVE ACTION /DESCRIPTION**
Ground level or accessible entrance?	Y / N / NA	
Exterior ramping/lift?	Y / N / NA	
Entry door 32″ width?	Y / N / NA	
Bedroom:		
Child has own bed? Infant has own crib?	Y / N / NA	
Caregiver aware of Safe sleep recommendations (if age appropriate)?	Y / N / NA	
Toilet/Bathing:		
Toilet?	Y / N / NA	
Sink?	Y / N / NA	
Kitchen:		
Sink accessible?	Y / N / NA	
Stove accessible?	Y / N / NA	
Low pile carpeting?	Y / N / NA	
Levered doorknobs?	Y / N / NA	
Adaptation for phone?	Y / N / NA	

THE COORDINATING CENTER
INSPIRED SOLUTIONS

REM PROGRAM ENVIRONMENTAL ASSESSMENT

Client Name:_____

Alternative Living Units		CORRECTIVE ACTION /DESCRIPTION
Meds locked?	Y / N / NA	
Emergency Contact info accessible?	Y / N / NA	
Emergency Protocol accessible?	Y / N / NA	
Staff/client ratio?	Y / N / NA	
Evidence of restraints?	Y / N / NA	

Safety Issues Discussed: _____

_____

Care Coordinator Signature: _____ Date: _____

THE COORDINATING CENTER
INSPIRED SOLUTIONS

Developmental Services Profile

Child's Name:	
Key #:	
Date of Birth:	
Assessment Date:	

County	✓
Anne Arundel	
Baltimore City	
Baltimore	
Frederick	
Prince George's	
Howard	
Other, Specify:	

□ Child exhibits a delay in one or more areas of development

□ Child is currently receiving developmental services through:

□ Infants ***and Toddlers,*** services provided:
□ Special Instruction □ Speech Therapy □ Physical Therapy □ Occupational Therapy
□ Other _____

Name of Service Coordinator/Contact: _____

□ ***School,*** services are provided: □ in school □ home-based

Name of School/Contact _____

□ Private ***rehabilitation service provider,*** services provided:
□ Physical Therapy □ Speech Therapy □ Occupational Therapy

□ Child is not receiving developmental/rehabilitation services at this time AND

□ Child needs referral for: □ Infants/Toddlers □ Educ. Serv. □ Rehab. Serv.

□ Child does not exhibit a developmental delay at this time.

□ Child at high risk for delay and will need to be monitored ongoing.

REM Participant Name
Current MA#
DOB
CM Name
Report Date mm/dd/yyyy
Agency Code
REM Enrollment Date
REM End Date
REM LOC

ATTACHMENT H: REM ASSESSMENT REPORT

Demographic Data

Aliases				
Address1				
Address2				
City	**State**	**Zip**	**County**	
DOB	**Age**	**Sex**	**SSN#**	
E-mail Address:				
Primary Language Spoken:			**Interpreter services required ☐ YES ☐NO**	
Caregiver Name		**Relationship**	**Phone #**	**Phone Type (Home, Work, Cell, etc.)**
			Phone #	
			E-mail Address	
Emergency Contact Name		**Relationship**	**Phone #**	**Phone Type**
			Phone #	
			E-mail Address	

REM Intake Information (from REM Intake Form)

Referring Physician	**Phone**	**Specialty**
Primary Care Physician	**Phone**	**Specialty**
Immunizations received this year	**Date(s):**	
Flu vaccine	**Date:**	

ATTACHMENT H: ASSESSMENT REPORT

REM Participant Name
Current MA#
DOB
CM Name
Report Date mm/dd/yyyy
Agency Code
REM Enrollment Date
REM End Date
REM LOC

REM Qualifying Dx	**REM Qualifying ICD-10 Code**
Additional diagnoses	**ICD-10 (if known)**

Health Profile

Current Health Status
1. Recent illness: **2. Changes in symptoms:**
Significant Past Health History
1. Surgeries: **2. Major illnesses, traumas:**
Routine Care
Growth and Development
Observations of Physical Status
Observations of Cognitive Functioning
Physician Notification and Emergency Plan

Hospitalization/ER visits Within Past Year

Facility	**Date**	**LOS**	**Reason For Admission**

ATTACHMENT H: ASSESSMENT REPORT

REM Participant Name
Current MA#
DOB
CM Name
Report Date mm/dd/yyyy
Agency Code
REM Enrollment Date
REM End Date
REM LOC

Support Systems

Family Composition **1. Individuals living in household:** **2. Family members living outside household (brothers, sisters, parents):**
Caregiver/Support Systems **1. Adult caregiver in home:** **2. Supports to caregiver:** **3. Supports to patient:** **4. Legal/CPS/APS supports:** **5. Finance/Income:**

Home and Community Based Waiver Services

Name of Waiver or Service	☐ **CO Waiver** ☐ **DDA Waiver** ☐**CFC** ☐ **AW** ☐ **BI** ☐ **Other**
Contact Person:	**Contact Phone/Email:**
Services Provided:	
Contact Person:	**Contact Phone/Email:**
Services Provided:	
Assessment of Services and Recommendations:	

ATTACHMENT H: ASSESSMENT REPORT

REM Participant Name
Current MA#
DOB
CM Name
Report Date mm/dd/yyyy
Agency Code
REM Enrollment Date
REM End Date
REM LOC

Primary Care Provider

Name	Address	Phone Number	Last Appt	Next Appt	D/S	Assessment of Services & Recommendations

Specialist/Specialty Clinic

Name and Location	Phone Number	Type of Clinic	Frequency of visits	Last Appt	Next Appt	D/S	Assessment of Services & Recommendations

Dental Care

Name and Location	Phone Number	Type of Clinic	Frequency of visits	Last Appt	Next Appt	D/S	Assessment of Services & Recommendations

Home Care

Provider Name	Provider Contact	Phone Number	Type of Service	Frequency	Assessment of Services & Recommendations (goals met/unmet)

ATTACHMENT H: ASSESSMENT REPORT

REM Participant Name
Current MA#
DOB
CM Name
Report Date mm/dd/yyyy
Agency Code
REM Enrollment Date
REM End Date
REM LOC

Therapies

Provider Name	Provider Contact	Phone Number	Type of Service	Frequency	Assessment of Services & Recommendations (goals met/unmet)

Equipment and Supplies

Provider Name	Provider Contact	Phone Number	Equipment/ Supplies	Rent or Purchase	Assessment of Service & Recommendations

Medications/Nutritionals

Provider Name	Provider contact	Phone Number	Drug/Nutritional Product	Assessment of Services and Recommendations

Lab and Diagnostic Outpatient Technology Services

ATTACHMENT H: ASSESSMENT REPORT

REM Participant Name
Current MA#
DOB
CM Name
Report Date mm/dd/yyyy
Agency Code
REM Enrollment Date
REM End Date
REM LOC

Provider Name	Provider contact	Type of Service	Frequency of Service	Last Service	Next Service

Optional Services

Provider Name	Provider Contact	Phone Number	Type of Service	Frequency	Assessment of Services and Recommendations

Environment

Current Living Arrangements
1. Type of Housing:
2. Limitations:
3. Safety Issues:
4. Accessibility Issues:
5. Health Issues:
6. Housing Issues:

Education

ATTACHMENT H: ASSESSMENT REPORT

REM Participant Name
Current MA#
DOB
CM Name
Report Date mm/dd/yyyy
Agency Code
REM Enrollment Date
REM End Date
REM LOC

School Name	**School Address**	**Phone Number**	**County**
Contact	**Phone Number**	**Position**	
IFSP/IEP/Transition plan	**Date of last IFSP/IEP**	**Next Review Due Date**	

Occupation, Vocation, Day Program

Employer Name	**Phone Number**	**Position**	**Assessment of Services & Recommendations**
Contact			
Vocation Plan	**Date**	**Next Review**	

Transportation

Social, Cultural, Language, and Community Issues

Non-Medicaid Reimbursed Services

REM Qualifying Diagnosis

ATTACHMENT H: ASSESSMENT REPORT

REM Participant Name
Current MA#
DOB
CM Name
Report Date mm/dd/yyyy
Agency Code
REM Enrollment Date
REM End Date
REM LOC

Does participant still meet the criteria for their REM qualifying diagnosis? Yes___ No___ If no, please explain and Report to the Department.

Case Management Interaction with Interdisciplinary Team/Outcomes

Summary of CM activities and results:

Issues and Opportunities Identified From Assessment Report

1. **2.** **3.**

THE COORDINATING CENTER
INSPIRED SOLUTIONS

Client's/Family's Goals

Initial _____ Annual_____

Client Name:_____ Interview With: _____

Date: _____ Coordinator: _____

What are your concerns regarding _____?
(program participant's name**)**

_____

_____

_____

_____

_____

_____

_____

_____

_____

What are your goals for _____?
(program participant**)**

_____

_____

_____

_____

_____

_____

_____

_____