CIVITAN FOUNDATION

INSTRUCTIONS: This application is to be completed by Parent/Guardian in entirety for all new members. Please ensure all medical forms and releases accompany this application.

Civitan Village Office
12635 N. 42nd St.
Phoenix, AZ 85032

CRITICAL INFORMATION

Member's Name:______________________________ Age:____ Birthdate:___/___/___
Member's Address:______________________________ Assist ID #____________
Guardian(s) Name(s):______________________________ Relationship:______________
Cell Phone:______________ Alt Phone:______________ E-mail:______________________
Guardian's Address:____
Group Home Contact:____
Phone:______________ Alt Phone:______________ E-mail:______________________
Emergency Contact:______________________________ Relationship:______________
Phone:______________ Alt Phone:______________ E-mail:______________________
Insurance:______________________ Policy #:______________ Phone:______________
Primary Care Physician:______________________________ Phone:______________
Other Health Insurance Information:______________________________________
Support Coordinator:______________________________ Phone:______________

HEALTH – MEDICAL

Current Medications and Significant Historical Medication Issues

Diagnosis/Diagnoses:____
Med Log Required: ☐ Yes ☐ No. Special Instructions:______________________

Physical Characteristics of Participant

Height:________ Weight:________ Eye Color:________ Hair Color:________ Unique Marks:____________

Participant has Allergies to: ☐ Medications ☐ Food ☐ Bee Stings ☐ Seasonal
☐ Other:____
Recommended Response to Allergic Reaction:______________________________

Seizures: ☐ Yes ☐ No. **Last Seizure Date**:___/___/___ Triggers/Warning Signs:______________
Type:______________ Frequency:______________ Duration:______________
Description:____
Recommended Response:____
Vagus Nerve Stimulator: ☐ Yes ☐ No. Describe Magnet Use:______________________

Assisted Devices: ☐ Vision ☐ Hearing ☐ Dental ☐ Other:______________________
Describe:____

Protective Devices:____
Instructions for Use:____
Purpose:____
Other Health Care Routines:____

Mobility

Balance While Standing: ☐ Excellent *(not an issue)* ☐ Moderate *(stumbles, etc.)* ☐ Poor *(very unsteady, falls)*
Utilizes Adaptive Aids for Balance: ☐ Yes ☐ No
Independent Mobility: ☐ Crawling/Scooting ☐ Kneeling ☐ Standing ☐ Walking ☐ Running ☐ Climbing
Mobility/Balance Aids: ☐ N/A ☐ Walker ☐ Cane ☐ Crutches ☐ AFOs ☐ Leg Braces ☐ Wheelchair
☐ Other *(Specify)*____
Positioning Instructions:____
Lifting/Carrying Instructions:____

Swim Level: ☐ Non-Swimmer ☐ Beginner ☐ Intermediate ☐ Advanced
Life Vest Required: ☐ Yes ☐ No ☐ Deep water only (i.e. Boating or lakes)

Communication Skills: ☐ Complex Sentences ☐ Simple Sentences ☐ Signs ☐ Nods Yes/No ☐ Gestures
Communication Devices:____

CIVITAN FOUNDATION

INSTRUCTIONS: This application is to be completed by Parent/Guardian in entirety for all new members. Please ensure all medical forms and releases accompany this application.

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12635 N. 42nd St.
Phoenix, AZ 85032

Diet

Food:

Check all that apply	Utensils	Cutting	Drinking	Acquiring	Other:
Independent	☐	☐	☐	☐	☐
Adaptive	☐	☐	☐		☐
Requires limited assistance	☐	☐	☐	☐	☐
Requires significant assistance	☐	☐	☐	☐	☐

Does Food Present a Choking Hazard: ☐ Yes ☐ No.

Required Food Consistency: ☐ Normal ☐ Chopped ☐ Pureed.

Tube Feeding *(Special instructions required)* ☐ Yes ☐ No. ____

Eating Disorder *(Describe on separate sheet)* ☐ Yes ☐ No. ____

Special Diet *((Please attach a separate sheet with further description)*____

Describe special fluids or systems for intake: ____

Personal Care Skills

Check all that apply	Dressing	Toileting	Bathing	Dental	Menses	Shaving	Other*
Independent	☐	☐	☐	☐	☐	☐	☐
Requires prompting	☐	☐	☐	☐	☐	☐	☐
Requires limited assistance	☐	☐	☐	☐	☐	☐	☐
Requires significant assistance	☐	☐	☐	☐	☐	☐	☐

Other* Special Care Needs:____

Diapers/Pull-ups: ☐ Yes ☐ No, If yes ☐ Day ☐ Night.

Bunk Preference: ☐ Top ☐ Bottom

Is there any special training required ☐ Yes ☐ No.

Describe:____

Note: You are responsible for providing supplies for your member's personal care needs (i.e. diapers, pull-ups, wipes, pads, tampons, etc.) Please also send bed pads and extra bedding if needed for your member when sleeping away from home.

Behavioral Concerns

Brief Description	Approximate Frequency	Recommended Intervention
☐ Aggression		
☐ Self-Injurious		
☐ Property Destruction		
☐ Wanders		
☐ Self-Stimulation		
☐ Sexually Active		
☐ Sexual Acting Out		
☐ Other		

Behavior Treatment Plan: ☐ Yes ☐ No. Reason:________________________________

Fears: ☐ Loud Noise ☐ Large Groups ☐ Animals ☐ Bodies of Water ☐ Other____________________

Positive Reinforcers for Member:____

Day Program *(if other than Civitan)*

Day Program:________________________________ Type:____________________

Program Address:________________________________ Phone:____________________

Contact Name:________________________________ E-mail:____________________

SIGNATURE

Guardian's Name:____

Signature: ____ Date: :___/___/___

CIVITAN
FOUNDATION

PARTICIPATION WAIVER

MEMBERS NAME ____**DATE** _________________________

PLEASE AFFIRM EACH STATEMENT BY INITIALING NEXT TO THE NUMBER.

1. _________ I hereby represent that I am the parent or legal guardian of this member.

2. _________ I hereby give my consent for my under age member to attend the Civitan Foundation, Inc.'s programs with adults of all ages, this will include areas such as, but not limited to: all areas of rotation, lunch areas, bathrooms, recreational areas and transportation**.**

3. _________ **Photos/Media:** I grant permission to the Civitan Foundation, Inc. to use likeness, voice, and words of the participant in TV, newspaper, film/video, or other media, for the purpose of promoting Civitan Foundation, Inc. programs. (Choosing not to initial this section will restrict Civitan Foundation, Inc. from utilizing photos or video clips of the member in any videos.)

4. _________ **Search and Seizure:** As a condition of participation and in order to provide a safe environment for all members, Civitan Foundation enforces a policy of reasonable search and seizures of the person and or personal property in situations of suspected theft, illegal drugs, or possession of contraband items such as weapons, fireworks, or alcohol. I hereby consent to such reasonable search and seizure and waive all claims made against Civitan Foundation, Inc.

5. _________ **Contacting Outside Authorities/Agencies:** As a further condition to ensure the safety of all members, I authorize Civitan Foundation, its agents, and employees, to call appropriate agencies, including Child/Adult Protection Services, law enforcement agencies, and mental health providers if my member becomes violent or is a threat to his/her own safety or the safety of others.

6. _________ **Waiver of Responsibilities:** I hereby release and discharge Civitan Foundation, Inc. and any and all of its agents or affiliates, employees or volunteers from any and all claims, liabilities, demands or rights which I (we), or any friends or relatives, may have against said corporation, or any of its agents, affiliates, employees, or volunteers on account of, connected with, or growing out of, any injury, accident, loss, damage or suffering, I (we) may hereafter sustain while on the premises or property owned, leased, or used by Civitan Foundation, Inc., arising out of granting permission for all recreation programs or usage of the said premises, whether said property be known as Civitan Foundation, Inc. or any other named designation or location.

7. _________ **Medication Administration:** I authorize the Civitan Foundation, Inc. staff to administer prescribed medications to my member.

8. _________ **Medical Consent:** In the event I am unable to be reached, I authorize Civitan Foundation, Inc. to seek necessary medical attention for my member in the event of an emergency. I further agree to pay for any prescribed medication or treatment my member may need.

9. _________ **Transportation:** I give permission for a Civitan Foundation, Inc., provider to transport my member on off-campus/out-of-home outings for Attendant Care, Habilitation and Respite purposes, and if so authorized by the Director/Manager/Coordinator or persons in charge.

10. _________ Should it become necessary for my member to be picked up from Camp, or any Civitan Foundation, Inc. function, for any reason, I will make provisions to promptly pick them up from the activity site.

11. _________ I have fully disclosed my member's health conditions, including any propensities towards violent behavior and authorize Civitan Foundation, Inc. to share this information with their staff.

12. _________ I hereby authorize the release of any and all pertinent information regarding my member to Civitan Foundation, Inc.

13. _________ I agree to notify Civitan Foundation, Inc. with any changes that need to be made to this application.

14. _________ I hereby certify that to the best of my knowledge, all of the information provided in the application is true and complete.

I have read and understand the above statements. I agree to the Acceptance Conditions above.

Signature: ____ **Date:** ________________________

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CIVITAN
FOUNDATION

PARTICIPANT MEDICAL EXAM – SIDE A

FORM MUST BE COMPLETED BY A PHYSICIAN

Member Name: ____ Date: ___________
Date of Birth: ____________________ Gender: ____________ Height: ____________ Weight: ____________
Primary Disability: ____
Secondary Disability: ____
If mentally challenged, give functioning age: _________ Are immunizations current? ☐Yes ☐No
Previous illness, conditions, or characteristics (Check all that apply):

☐Asthma
☐Heart Disease/Condition
☐Epilepsy
☐Seizure Type: _______________
Frequency: _______ Duration: ______
☐Emotional/Behavioral Difficulties
☐Diabetes
☐Stroke: When? ___________
☐Cancer: Remission? ________
☐Communicable Disease
☐Other Psych. Disorders
☐Eating Disorder
☐Autism
☐Special Issues ___________
☐Noise Issues ___________
☐OCD
☐ADD/ADHD
☐Recent serious illness/surgery
☐Recent minor illness/ailments
☐In the last 12 months, seen a professional to address mental/emotional concerns?
☐Had a significant life event that continues to affect the participant's life?

*Please explain any checked boxes: ____
____
____
____

Allergies/Sensitivities (including medications):____
Other pertinent diagnoses and/or current treatments:____
Any prescribed meal plan or dietary restrictions: ____
Hearing Capacity: ______________________________ Vision Capacity: ______________________________
Is participant cleared for 7,000 feet elevation? ☐Yes ☐No
ACTIVITY LEVEL ADVISED: I approve supervised camping activities, including participation in, but not limited to, arts and crafts, Go-Karts, recreation, overnight campouts & swimming. ☐Non-strenuous ☐Minimum ☐Moderate ☐Full

CURRENT MEDICATIONS

Current Medication Name	Dosage (How much?)	Frequency (Times given)	What is medication for?

Statement of Physician: I have examined participant ________________________________. I have found no evidence of communicable disease and found him/her to be in satisfactory condition to participate in camp programs to:

A. ______ full extent without restrictions
B. ______ limited extent. Conditions as follows:____

Signature of Physician: ____ Date: ____________________________

Please complete both sides of form in its entirety.

CIVITAN
FOUNDATION

PARTICIPANT MEDICAL EXAM – SIDE B

FORM MUST BE COMPLETED BY A PHYSICIAN

Civitan will not administer any over the counter medications unless this form has been filled out by your physician. The Arizona State Department of Health requires an individualized set of standing orders for each attending member. These standing orders specify which over-the-counter medications may be administered to an individual member and under what conditions. This form pertains to only over-the-counter medications, and must be completed and signed by a physician, physician's assistant, or nurse practitioner. Medications must come with the member in original bottles and containers.

Please fill out all that are relevant.

INDIVIDUALIZED ORDERS FOR:
Name: ____ Age: ________________ Weight: _________________

Drug Name	**Route** Please circle preferred	**Dosage**	**Schedule and Indications**	**Camper Health-Care Provider Order**		**Comments**
Tylenol (Acetominophen)	PO (Chewable Tabs, Elixir)	Per Label Instructions by Age/Weight	Q 4 hr prn for Pain or Fever > _____°F	Yes	No	
Motrin (Ibuprofen)	PO (Chewable Tabs, Sus-)	Per Label Instructions by Age/Weight	Q 6 hr prn for Pain or Fever > _____°F	Yes	No	
Robitussin	PO (Syrup)	Per Label Instructions by Age/Weight	Q 4 hr prn for Cough	Yes	No	
Mylanta	PO (Chewable Tabs, Liquid)	Per Label Instructions by Age/Weight	TID-QID prn for Stomach Upset	Yes	No	
Tums	PO (Chewable Tabs)	Per Label Instructions by Age/Weight	BID-TID prn for Stomach Upset	Yes	No	
Benadryl (Diphenhydramine HCL)	PO (Elixir or Tabs)	Per Label Instructions by Age/Weight	Q 4-6 hr prn for Allergy	Yes	No	
Sudafed (Pseudoephedrine)	PO (Tabs)	Per Label Instructions by Age	Q 4-6 hr prn for Sinus Congestion	Yes	No	
Midol	PO (Chewable Tabs)	Per Label Instructions by Age/Weight	Q 4-6 prn for Menstrual Symptoms	Yes	No	
Aleve (Naproxen)	PO (Tabs)	Per Label Instructions by Age/Weight	Q 12 hr prn for Pain or Arthritis	Yes	No	
Imodium AD (Loperamide)	PO (Tabs)	Per Label Instructions by Age/Weight	1 caplet after 1st BM, and ½ caplet after each subsequent loose BM	Yes	No	
Prune Juice/ Prunes	PO	4 oz or 5-10 prunes	No BM in 2 days	Yes	No	
Milk of Magnesia	PO (Liquid)	1 oz @ AM/HS	No BM in 3 days	Yes	No	
Glycerin Suppository	PR	1/HS		Yes	No	
Vitamin ______	PO (tabs, gummies)	Age/Weight		Yes	No	
Vitamin ______	PO (tabs, gummies)	Age/Weight		Yes	No	
Other				Yes	No	

Doctor'sName:____Phone#: ____________________

Signature:____Date:______________________

In case of medical emergencies we will contact 911 or transport to the nearest urgent care facility or hospital.

CIVITAN FOUNDATION

CONSENT TO ADMINISTRATION OF PSYCHOTROPIC MEDICATIONS

I, (myself or the guardian) of: ______________________________, give consent
(*Member's name)*

1. To the administration of: ____
   (Name of medication)
   For the prescribed purpose of: ____

   Prescribed by: ____
   (Prescribing Physician/Agent)

   With a maximum dosage of ______________, for a time period not to exceed 12 months.

2. To the administration of: ____
   (Name of medication)
   For the prescribed purpose of: ____

   Prescribed by: ____
   (Prescribing Physician/Agent)

   With a maximum dosage of ______________, for a time period not to exceed 12 months.

3. To the administration of: ____
   (Name of medication)
   For the prescribed purpose of: ____

   Prescribed by: ____
   (Prescribing Physician/Agent)

   With a maximum dosage of ______________, for a time period not to exceed 12 months.

4. To the administration of: ____
   (Name of medication)
   For the prescribed purpose of: ____

   Prescribed by: ____
   (Prescribing Physician/Agent)

   With a maximum dosage of ______________, for a time period not to exceed 12 months.

It is my understanding that such medication has been prescribed by a licensed physician who has made careful diagnosis and evaluation and is committed to the monitoring and possible future reduction or elimination of the medication as future needs indicate.

I have received information on the possible side effects and it is my understanding that any possible side effects will be reported by myself or Civitan Foundation Staff to the physician immediately.

Member/ Guardian Signature: ____Date:_________________________

CONSENT TO ADMINISTRATION OF PSYCHOTROPIC MEDICATIONS

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CIVITAN FOUNDATION

NOTICE OF PRIVACY PRACTICES

Effective: June 13, 2013

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

PLEASE REVIEW CAREFULLY.

This notice will tell you how we may use and disclose protected health information about you.
Protected health information means any health information about you that identifies you or for which there is a reasonable basis to believe the information can be used to identify you. In the header above, that information is referred to as "medical information." In this notice, we simply call all of that protected health information, "health information."

This notice also will tell you about your rights and Civitan's duties with respect to health information about you. In addition, it will tell you how to complain to us if you believe we have violated your privacy rights. If you have any questions about this Notice, please contact our Privacy Officer at 12635 N. 42nd St., Phoenix, AZ 85032.

How We May Use and Disclose Health Information About You

- **For Treatment**
  We may use and disclose health information about you so we can be paid for the services we provide to you. This can include billing a third party payee, such as Medicaid or other state agency (for example, the state's Office of Mental Retardation), or your insurance company. For example, we may need to provide the state Medicaid program information about the services we provide to you so we will be reimbursed for those services. We also may need to provide the state Medicaid program with information to ensure you are eligible for the medical assistance program.

- **For Payment**
  We may use health information about you to provide, coordinate or manage the services, supports, and health care you receive from us and other providers. We may disclose health information about you to doctors, nurses, qualified mental retardation professionals (QMRPs), psychologists, social workers, direct support staff and other agency staff, volunteers and other persons who are involved in supporting you or providing care. We may consult with other health care providers concerning you and, as part of the consultation, share your health information with them. For example, staff may discuss your information to develop and carryout your individual service plan. Staff may share information to coordinate needed services, such as medical tests, transportation to a doctor's visit, physical therapy, etc.

- **For Health Care Operations**
  We may use and disclose health information about you for our own operations. These are necessary for us to operate CIVITAN and to maintain quality for our patients. For example, we may use health information about you to review the services we provide and the performance of our employees supporting you. We may disclose health information about you to train our staff and volunteers. We also may use the information to study ways to more efficiently manage our organization, for accreditation or licensing activities, or for our compliance.

- **How Will We Contact You**
  Unless you tell us otherwise in writing, we may contact you by either telephone or by mail at either your home or your workplace. At either location, we may leave messages for you on the answering machine or voice mail. If you want to request that we communicate to you in a certain way or at a certain location, see "Right to Receive Confidential Communications" in this Notice.

- **Civitan's Directory**
  We may include your name, your location in our facility, your condition described in general terms in our directory while you receive services. This information may be released to people who ask for you by name. If you do not want to be included in our facility directory, or you want to restrict the information we include in the directory, you must notify our Privacy Officer at 12635 N. 42nd St., Phoenix, AZ 85032.

- **Disclosures to Family and Others**
  We may disclose to a parent/guardian, personal representative, family member, other relative, a close personal friend, or any other person identified by you, health information about you that is directly relevant to that person's involvement with the services and supports you receive or payment for those services and supports. If there is a family member, other relative or close personal friend that you do not want us to disclose health information about you too, please notify our Privacy Officer at 12635 N. 42nd St., Phoenix, AZ 85032.

- **Disaster Relief**
  We may use or disclose health information about you to a public or private entity authorized by law or by its charter to assist in disaster relief efforts. This will be done to coordinate with those entities in notifying a parent/guardian, personal representative, family member, other relative, close personal friend, or other person identified by you of your location, general condition or death.

- **Public Health Activities**
  We may disclose health information about you for public health activities and purposes. This includes reporting health information to a public health authority that is authorized by law to collect or receive the information for purposes of preventing or controlling disease.

- **Victims of Abuse, Neglect or Domestic Violence**
  We may disclose health information about you to a government authority authorized by law to receive reports of abuse, neglect, or domestic violence, if we believe you are a victim of abuse, neglect, or domestic violence. This will occur to the extent the disclosure is: (a) required by law; (b) agreed to by you or your personal representative; or (c) authorized bylaw and we believe the disclosure is necessary to prevent serious harm to you or to others.

- **Health Oversight Activities**
  We may disclose health information about you to a health oversight agency for activities authorized by law, including audits, investigations, inspections, licensure or disciplinary actions. These and similar types of activities are necessary for appropriate oversight of the health care system, government benefit programs, and entities subject to various government agencies.

- **Disclosures for Law Enforcement Purposes, Judicial and Administrative Proceedings**
  We may use or disclose health information about you when we are required to do so by law. We may disclose health information about you in the course of any judicial or administrative proceeding in response to an order of the court or administrative tribunal. We also may disclose health information about you in response to a subpoena, discovery request, or other legal process. We may also disclose health information about you to a law enforcement official for law enforcement purposes:
  a) As required by law;
  b) In response to a court, grand jury or administrative order, warrant or subpoena;
  c) About crimes that occur at our facility.

- **To Avert Serious Threat to Health or Safety**
  We may use or disclose protected health information about you if we believe the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public. We also may release information about you if we believe the disclosure is necessary for law enforcement authorities to identify or apprehend an individual who admitted participation in a violent crime or who is an escapee from a correctional institution or from lawful custody.

- **Inmates and Persons in Custody**
  We may disclose health information about you to a correctional institution or law enforcement official having custody of you. The disclosure will be made if the disclosure is necessary: (a) to provide health care to you; (b) for the health and safety of others; or (c) the safety, security and good order of the correctional institution.

- **Workers Compensation**
  We may disclose health information about you to the extent necessary to comply with workers' compensation and similar laws that provide benefits for work-related injuries or illness without regard to fault.

- **Other Uses and Disclosures**
  Other uses and disclosures will be made only with your written authorization. Disclosures of psychotherapy notes, marketing disclosures and sale of protected health information require authorization. You may revoke such an authorization at any time by notifying the local Privacy Officer in writing at 12635 N. 42nd St., Phoenix, AZ 85032.

  If there is a breech and your protected health information is disclosed without consent, you will be notified of the breech.

Your Rights With Respect to Health Information About You

- **Rights to Request Restrictions**
  You have the right to request that we restrict the uses or disclosures of health information about you to carry out treatment, payment, or health care operations. You also have the right to request that we restrict the uses or disclosures we make to: (a) a family member, other relative, a close personal friend or any other person identified by you; or (b) to public or private entities for disaster relief efforts. To request a restriction, you may do so at any time. If you request a restriction, you should do so to us and tell us: (a) what information you want to limit; (b) whether you want to limit use or disclosure or both; and (c) to whom you want the limits to apply (for example, disclosures to your spouse). However, we are not required to agree to any requested restriction.

- **Right to Receive Confidential Communications**
  You have the right to request that we communicate health information about you to you in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at an alternative phone number. If you want to request confidential communication, you must do so in writing. Your request must state how or where you can be contacted.

- **Right to Inspect and Copy**
  With a few very limited exceptions, such as psychotherapy notes, you have the right to inspect and obtain a copy of health information about you. To inspect or copy health information about you, you must submit your request in writing. Your request should state specifically what health information you want to inspect or copy. If you request a copy of the information, we may charge a fee for the costs of copying and, if you ask that it be mailed to you, the cost of mailing.

- **Right to Amend**
  You have the right to ask us to amend health information about you. To request an amendment, you must submit your request in writing. Your request must state the amendment desired and provide a reason in support of that amendment. If we deny your request, we will inform you of the basis for the denial. You will have the right to submit a statement of disagreeance with our team.

- **Right to an Accounting of Disclosures**
  You have the right to receive an accounting of disclosures of health information about you. Certain types of disclosures are not included in such an accounting:

  A) Disclosures to carry out treatment, payment and health care operations;
  B) Disclosures of your health information made to you;
  C) Disclosures that are incident to another use or disclosure;
  D) Disclosures that you have authorized;
  E) Disclosures for our facility directory or to persons involved in your care;

  To request an accounting of disclosures, you must submit your request in writing. Your request must state a time period for the disclosures.

- **Right to a Copy of this Notice**
  You have the right to obtain a paper copy of our Notice of Privacy Practices. You may obtain the most current version of our Notice of Privacy Practices over the Internet at our web site, www.civitanfoundationaz.org. To obtain a paper copy of this notice, please contact our Privacy Officer at 12635 N. 42nd St., Phoenix, AZ 85032.

Our Duties

- **Generally**
  We are required by law to maintain the privacy of health information about you and to provide individuals with notice of our legal duties and privacy practices with respect to health information. We are required to abide by the terms of our Notice of Privacy Practices in effect at that time.

- **Our Right to Change Notice of Privacy Practices**
  We reserve the right to change this Notice of Privacy Practices. We reserve the right to make the new notice's provisions effective for all health information that we maintain, including that created or received by us prior to the effective date of the new notice.

- **Complaints**
  You may complain to us and to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by Civitan. To file a complaint with us, contact us. All complaints should be submitted in writing.

  To file a complaint with the United States Secretary of Health and Human Services, send your complaint to him or her in care of: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue SW, Washington, D.C. 20201. You will not be retaliated against for filing a complaint.

- **Questions and Information**
  If you have any questions or want more information concerning this Notice of Privacy Practices, please contact our Privacy Officer at 12635 N. 42nd St., Phoenix, AZ 85032.

CIVITAN
FOUNDATION

NOTICE OF PRIVACY PRACTICES
Effective: June 13, 2013

By signing below, I acknowledge that I have been provided a copy of Civitan Foundation Inc.'s Notice of Privacy Practices statement and have thereby been advised of how health information may be used and disclosed by Civitan, and how I may obtain access to and control this information.

____
Name of Member

____
Name of Responsible Person

____
Signature of Responsible Person

____
Date

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CIVITAN
FOUNDATION

STATEMENT OF MEMBER RIGHTS

You have the right to be free from personal and financial exploitation;
You have the right to a safe, clean, and humane physical environment;
You have the right to own and have free access to your personal belongings;
You have the right to have your friends;
You have the right to participate in social, religious, educational, cultural, and community activities;
You have the right to manage your personal finances and to be taught to do so;
You have the right to accomplish tasks with the least amount of assistance;
You have the right to privacy;
You have the right to choose the person to best assist you as indicated by your ISP;
You have the right to be treated with dignity and respect;
You have the right to be provided with choices and to express preferences which will be honored;
You have the right to make decisions about medical care, including the right to accept or refuse medical care;
You have the right to carry out an advance directive;
As a person with developmental disabilities, you have the rights, benefits and privileges guaranteed by the Constitution of the United States and the State of Arizona;
You have the right to be presumed legally competent regarding guardianship proceedings;
You have the right to be protected from exploitation and abuse;
You have the right to live in the least restrictive environment;
You have the right to receive a public education;
You have the right to fair and equitable employment;
You have the right to buy, lease, and rent real property without discrimination;
You have the right to be evaluated to receive the most appropriate services;
You have the right to receive a written ISP in which you have provided input, along with people you chose to participate to create an outcome based on the evaluation of your skills;
You have the right to review and/or change your ISP;
You have the right to participate in your initial evaluation, with your parent/guardian, and to be informed of your progress. In addition, you have the right to alternative service choice;
You and/or your parent/guardian have the right to remove services, except if services are assigned by the juvenile court;
You have the right to be free from mistreatment, neglect, and abuse;
You have the right to be free from unnecessary and excessive medication;
You and your parent/guardian have the right for these rights to be explained to you so that you fully understand;
You have the right as a "child" to appropriate services that are consistent with an ISP; services do not require the relinquishment or restriction of your parents/guardians rights;

________________	________________	__________
Member Name	Member Signature	Date
Parent/Guardian Name	Parent/Guardian Signature	Date

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CIVITAN FOUNDATION

MEMBER DEMOGRAPHIC INFORMATION

DISCLAIMER
All information that you provide on this sheet will be recorded anonymously, and will in no way impact your services or eligibility for financial aid.

This information is critical to our ability to retain and seek out funding contracts from private, corporate and government sources to enhance our programs and facilities for your loved ones, and keep our services affordable. **Please fill out the form in its entirety.**

The Civitan Foundation, Inc. will not sell, trade or transfer your personal information to any third party or entity. If you have any questions regarding the information requested below, please call 602-953-2944.

Member: ____ Date: _______________

MEMBER DEMOGRAPHIC INFORMATION
Please answer all questions as they pertain to your MEMBER.

Age: ________

Gender: ☐ Male ☐ Female

Race: ☐ Caucasian ☐ Black ☐ Asian ☐ American Indian/Alaskan Native ☐ Hawaiian/Pacific Islander

Is he/she Hispanic/Latino? ☐ Yes ☐ No *(Includes Mexican, Cuban, Puerto Rican, Central & South American or other Spanish culture or origin regardless of race).*

City of Residence: ___________________________________ Zip code: _____________

HOUSEHOLD DEMOGRAPHIC INFORMATION
This information is required for federal funding and reporting purposes only. Please answer all questions as they pertain to YOU and YOUR FAMILY.

Total number of persons living in household:__________

Total Annual Household Income:
(Combined gross annual income of all persons in the house regardless of whether they assist with household expenses)

(Check one box)

☐ Less than $25,000
☐ $25,000 to $34,999
☐ $35,000 to $49,999
☐ $50,000 to $74,999
☐ $75,000 to $99,999
☐ $100,000 to $149,999
☐ $150,000 to $199,999
☐ $200,000 or more

What is the highest degree or level of education you have completed?

☐ Less than high school
☐ High school graduate (includes equivalency)
☐ Some college, no degree
☐ Associate's degree
☐ Bachelor's degree
☐ Ph.D.
☐ Graduate or professional degree

Your Relationship to the Member: ☐ Parent ☐ Legal Guardian ☐ Custodian ☐ Caregiver