UCP United Cerebral Palsy™
of Berkshire County
Life without limits for people with disabilities™

FAMILY SUPPORT INTAKE APPLICATION

Main Office: 208 West Street Pittsfield, MA 01201 Phone (413) 442-1562 Fax (413) 499-4077
North County Office: 535 Curran Highway, North Adams MA 01247 Phone (413) 664-9345 Fax (413) 663-5019

Name: _____ **Date of Birth:** _____

Residence Address: _____

_____

Phone: _____ **(Home)** **Email:** _____

_____**(Cell)**

Legal Guardian:Yes _____ **No** _____ **Name:** _____
(Only if you are legal guardian)

Identification of Individual or Parent/Guardian: _____
(State ID, DL, etc.) **(Please include a copy of ID with Intake)**

Medical History: _____

Diagnosis: _____

Physician's Name: _____ **Phone:** _____

Fax: _____

LIFE SKILLS AFFECTED BY DISABILITY:

____ Speech ____ Fine Motor Skills
____ Vision ____ Reading Skills
____ Mobility ____ Writing
____ Hearing ____ Other _____

_____

DO YOU USE ANY ADAPTIVE EQUIPMENT:

Mobility: _____ **Computer:** _____
Other: _____

WHAT TYPE OF SERVICES ARE YOU IN NEED OF FROM UCP?

_____

_____

_____

REFERRED BY: _____
INTAKE COMPLETED BY: _____ **DATE:** _____

Record Location
535 Curran Highway
North Adams, MA 01247

UCP of Berkshire County

EMERGENCY INFORMATION RECORD

Commonwealth of Massachusetts
Area: Berkshire

Name: _____

Nickname(s): _____

Birthdate: _____

Phone Numbers: _____(home)

_____(work)

_____(cell)

Gender: _____ **Race:** _____ **Height:** _____ **Weight:** _____

Hair Color: _____ **Eye Color:** _____

Distinguishing Marks: _____

Physician's Name: _____

Physician's Address: _____

_____

Physician's Phone Number: _____

Health Insurance: _____

Insurance Number: _____

Health Care Proxy (if applicable)

Name: _____

Address: _____

Phone Number(s): _____

Guardian Information (if applicable)

Name: _____

Address: _____

Phone Number(s): _____

Language/Communication Skills Needed:

_____

_____

_____

Ability to protect self without assistance: _____

Significant behavior characteristics: _____

_____

_____

Photo Last Updated:

Work/Day Program:

Agency:

Phone #:

Address:

Job Site:

Phone #:

Address:

Current Medications:

Allergies:

Likely to respond to search efforts: _____ **Pattern of Movement if previously lost:** _____

Places Frequented: _____

Special Needs/Relevant Capabilities/Limitations/Preferences:

_____

_____

_____

EMERGENCY CONTACTS:

Name: **Relationship:** **Phone Number(s):**

_____

_____

_____

_____

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Demographic/Financial Information

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Member Name: _____

Gender: _____

Age:

- o **Under 2**
- o **2-5**
- o **6-11**
- o **12-17**
- o **18-24**
- o **Over 25**
- o **Over 50**
- o **Unknown**

Race: (check all/any that apply)

- o **Afro-American**
- o **Asian**
- o **Asian-American**
- o **Caucasian**
- o **Caucasian/Afro-Amer.**
- o **Caucasian/Hispanic**
- o **Hispanic/Afro-Amer.**
- o **Hispanic/Lebanese**
- o **Native Amer./Caucasian**
- o **Native American**
- o **Vietnamese**
- o **Unknown**

Ethnicity: (check all/any that apply)

- o **Asian**
- o **Chinese**
- o **Croatian**
- o **Dutch**
- o **English**
- o **French**
- o **German**
- o **Hispanic/Latino**
- o **Irish**
- o **Italian**
- o **Native American**
- o **Norwegian**
- o **Pacific Islander**
- o **Polish**
- o **Scotch-Irish**
- o **Scottish**
- o **Other**
- o **Unknown**

Origin of Birth:

- o Born in the USA

Location _____

- o Born outside USA

Location _____

Family Living Configuration: **Family Size:** _____

- o Two Parents
- o Mother Only
- o Father Only
- o Joint Custody
- o Neither Parent
- o Unknown

Household Yearly Gross Income:

Wages: _____ SSI: _____ SSDI: _____ TAFDC: _____

Member/Parent/Guardian:

I hereby affirm under the pains and penalties of perjury, that the information provided is accurate and complete to the best of my knowledge.

Signature of Member/Parent/Guardian: _____ **Date:** _____

Staff Signature: _____ **Date:** _____

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Demographic/Financial Form

Explanation

This form was developed to mimic the information that our grants and funding sources require when we, the agency, receive funding, apply for funding, and/or when being audited by our funding source.

This form and the information you give does not affect services provided or offered to you by the agency.

Thank you for your cooperation and in helping us to fulfill the goal of United Cerebral Palsy Association of Berkshire County, Inc. and to continue to make a difference in the lives of individuals with disabilities and their families.

Thank You

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Disclosure Authorization Form

For the use/disclosure of Heath Information

By signing this Authorization, I authorize the use/disclosure of my individually identifiable health information maintained by:

Provider/Physician Name (please print) _____

Organization/Practice providing the Information _____

Address _____

_____

My Health Information may be disclosed under this Authorization to:

The Recipient (please print) _____

Organization receiving the information UCP of Berkshire County

Address _____

_____

Health information that may be used or disclosed through this Authorization is as follows: (check all that apply)

- o All health information about me, including my clinical records, created of received by the provider. Information pertaining to the identity, diagnosis, prognosis or treatment for alcohol or drug abuse maintained by a federal assisted alcohol or drug abuse program.
- o Specific information regarding AIDS, ARC and HIV including, for example, a test for the presence of HIV antibodies or antigens, regardless of weather (a) this test is ordered, performed, or reported and (2) the test results are positive or negative.
- o Specific information regarding the results of a genetic test.
- o All health information including only the following:

  _____
- o Specific health information **excluding only** the following:

  _____

Note: Describe the health information to be excluded or included in a specific meaningful fashion.

The purpose(s) of this authorization is (are): (check one)

- o Specifically, the following purposes: Service Application
- o The request for information to be used or disclosed has been initiated by the individual and the individual does not elect to disclose its purpose. Note this box may NOT be checked if the information to be used or disclosed pertains to alcohol or drug abuse identity, diagnosis, prognosis or treatment.

This Authorization expires: _____ **(event or date)**

Note: If an expiration event is used, the event must relate to the individual or the purpose of the discloser.

I have read and understand the terms of this Authorization. I have had an opportunity to ask questions about the use or disclosure of my health information.

Individual's Signature: _____ **Date of Signature:** _____

Print Individual's full name: _____ **Date of Birth:** _____

When individual is unable to give the consent, the signature of a parent, guardian, health care agent (proxy) or other representative is required.

Signature of representative: _____ **Date of Signature:** _____

Print Full Name: _____ **Relationship to individual:** _____

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Important Information about your Disclosure

1. Health information includes information collected from you or created by the Provider, or information received by the provider from another health care provider, a health plan, your employer or a health care clearing house. Health information may relate to your past, present or future physical or mental health condition, and the provision of your health care or the payment of your health care services.
2. Any provider that operates a federally assisted alcohol or drug abuse program is prohibited from disclosing information about treatment for alcohol or drug abuse without your specific written authorization unless a disclosure is otherwise authorized by federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR, Part 2)
3. Under the state law the Provider is prohibited from disclosing information about HIV status without your specific written authorization. The Provider is prohibited under state law from disclosing the results of a genetic testing (including the identity of a person being tested) without first obtaining an authorization that constitutes "informed written consent," except when the test results disclosed will be used only as confidential research information for use in epidemiological or clinical research conducted for the purpose of generating scientific knowledge about genes or learning about the genetic basis of disease or for developing pharmaceutical and other treatments of disease.
4. The provider cannot guarantee that the recipient will not re-disclose your health information to a third party. The recipient may not be subject to federal laws governing privacy of health information. However, if the disclosure consists of treatment information about a client in a federally assisted alcohol or drug abuse program, the recipient is prohibited under federal from making any further disclosure of such information unless further disclosure is expressly permitted by written consent of the client or as otherwise permitted under federal law governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFP, Part 2)
5. You may refuse to sign this authorization and that your refusal to sign will not affect your ability to obtain treatment (or payment if applicable) from United Cerebral Palsy Association of Berkshire County, Inc. except when receiving research-related treatment or receiving health care solely for the purpose of creating information for the disclosure to a third party. If either of these exceptions applies, your refusal to sign authorization will result in your ability to obtain treatment (or payment, if applicable) from the Provider.
6. You may revoke this authorization in writing at any time, except that the revocation will not have any effect on any action taken by the Provider in reliance on this authorization before the provider receives written notice of revocation. Understand that you must provide any notice of revocation in writing to the Privacy Officer at United Cerebral Palsy Association of Berkshire County, Inc. The officer will receive written notices at **208 West St. Pittsfield, MA 01201**
7. This paragraph is only applicable to certain authorizations to disclose the health information for marketing purposes. Understand that United Cerebral Palsy Association of Berkshire County, Inc. may directly or indirectly, receive remuneration from a third party in connection with the marketing activities undertaken by United Cerebral Palsy Association of Berkshire County, Inc.

The individual/member should be provided with a copy of the signed authorization

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Authorization for Release of Information

To Whom It May Concern:

I hereby authorize United Cerebral Palsy Association of Berkshire County, Inc. (UCP) or its representatives to have access to inspect and copy part or all of any record information concerning _____.

I also request that you cooperate with UCP and provide them with and relevant information you may have concerning these records or other documents. I further authorize UCP to discuss that information with third parties with which the need to consult regarding services.

This release is authorized for _____ months.

_____
Individual/Parent/Guardian Signature

_____
Individual/Parent/Guardian Name

_____
Date

_____
Staff Signature

_____
Staff Title

_____
Date

Form Revised 2/20/2018

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Individual Transportation Release

I authorize United Cerebral Palsy Association of Berkshire County, Inc. (UCP) and its representatives to transport _____ whenever deemed necessary for his/her participation within the UCP program. It is my understanding that UCP or its representatives will not be held responsible or liable for injuries due to an accident.

_____
Individual/Parent/Guardian Signature

_____
Individual/Parent/Guardian Name

_____
Date

_____
Staff Signature

_____
Staff Title

_____
Date

Form Revised 2/20/2018

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Medical/Emergency Room Release

Individual: _____

I hereby authorize United Cerebral Palsy Association of Berkshire County, Inc. to seek necessary Medical/Emergency Room treatment. In an emergency, every effort will be made to contact the parent/guardian as soon as possible.

_____
Individual/Parent/Guardian Signature

_____
Individual/Parent/Guardian Name

_____
Date

_____
Staff Signature

_____
Staff Title

_____
Date

Form Revised 2/20/2018

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Name: _____ **DOB:** _____

Address: _____

_____

_____

Physician's use only:

Physician's Name: _____

Physician's Address: _____

_____

_____

Physician's Phone Number: _____

Please certify that _____ has a disability as described below.

Name of Disability: **Please state diagnosis/disability with ICD 10 codes.**

_____

_____

_____

_____

_____

Signature of Physician: _____ Date: _____