Elizabeth Richardson Center

ERC Enhancing lives Removing barriers Creating opportunities

Community Employment
File Access Record

I, the undersigned, give permission for this client's folder to be examined by the following agencies, The Elizabeth Richardson Center (ERC) or Arkansas Rehabilitation Services (ARS). Any other person or agency must have written permission from client or parent/legal guardian.

_____
Client Name (please print)

_____ _____
Signature of Adult client – if own guardian Signature of parent of guardian

The following persons have seen this file:

NAME	RELATIONSHIP/TITLE	PURPOSE	DATE

To comply with the Drug-Free Workplace Act of 1988:

All employees are absolutely prohibited from unlawfully manufacturing, distributing, possessing, or using alcohol or any controlled substances in the workplace. Any employee violating the above policy is subject to discipline, up to and including termination for the first offense.

Alternatively, the Elizabeth Richardson Center, Inc. (ERC) may require any or all employees to successfully complete a drug abuse program at the employee's expense sponsored by an approved private or governmental institution.

The term "controlled substance" means any drug listed in 21 U.S.C. Section 812 and other Federal regulations. Generally, these are drugs which have a high potential for abuse. Such drugs include, but are not limited to: heroin, marijuana, cocaine, PCP, and "crack". They also include "legal" drugs which are used outside the prescribed instructions of a licensed physician.

Each employee of ERC is required by law to inform their supervisor or ERC Human Resources within five (5) working days after he/she is convicted for violation of any Federal or state criminal drug statute where such violation occurred on the agency's premise. A conviction means a finding of guilt (including a plea of nolo contender) or the imposition of a sentence by a judge or jury in any federal court, state court or other court of competent jurisdiction.

As a condition of further employment on any federal governmental contract, the law requires all employees to abide by this policy.

ERC must notify the U. S. Government agency with which the contract was made within ten (10) days after receiving notice from the employee or otherwise receives notice of such a conviction.

ERC shall contact:
Deputy Director (501) 682-6576
Division of Management Services
4th Floor, Donahey Plaza West
PO Box 1437, Slot 3400
Little Rock, AR 72203-1437

I agree to abide by the ERC Drug-Free Agreement.

_____ _____
Client Signature Date

ERC COMMUNITY EMPLOYMENT PROGRAM
GOAL AGREEMENT

I, _____, am participating in the Community Employment Program at the Elizabeth Richardson Center (ERC). I have entered this program because I am interested in working in the community and have a reasonable expectation that I will be successful in a competitive job with the support that I am offered. My purpose is to develop the skills necessary to obtain and maintain a job in the local community. (I understand ERC is a temporary situation and that I will be expected to put forth my best effort at obtaining employment in the community.)

During my time at ERC, I will be required to attend all job clubs and will actively participate in application completions, job site visits, and job-seeking skills training. I will be actively pursuing competitive employment as long as I am a participant in the Community Employment Program at ERC. In this program, I will maintain a professional attitude and follow all ERC rules and regulations. I further understand that failure to comply with this agreement may result in my discharge from this program.

After I find employment in the community, I agree to keep my job for a minimum of ninety (90) days. In the event I have a problem with my job, I will not quit until I discuss the problem with my ERC Employment Case Manager or my counselor at Arkansas Rehabilitation Services (ARS).

By signing this form, I agree to abide by the ERC Goal Agreement:

Signature _____ Date _____

Please print your full name_____

Elizabeth Richardson Center
ERC Enhancing lives Removing barriers Creating opportunities

DOCUMENTATION OF RECEIPT of Program Handbook

Program: Community Employment

I _____ (print name) have received a copy of the Elizabeth Richardson Center (ERC) Consumer Handbook for the Community Employment programs. It has been explained to me and I have had the opportunity to ask questions.

I understand that it contains the following information:

- ERC Mission Statement
- Core Values
- Client Rights
- ERC's Grievance Procedures
- Transportation Procedures
- ERC procedures including:
    - Descriptions of ERC programs
    - Outcome expectations
    - Guidelines for behavior
- List of the ERC Board of Directors
- Equal Opportunity laws
- Americans with Disabilities Act

Handbook received on (date): _____

_____

Signature of individual/guardian

Elizabeth Richardson Center
ERC Enhancing lives Removing barriers Creating opportunities

NOTICE OF PRIVACY PRACTICES
ELIZABETH RICHARDSON CENTER
Effective September 2013

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

PLEASE REVIEW IT 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 this notice, we call all of that protected health information, "health information."

This notice also will tell you about your rights and our 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.

HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU

We use and disclose health information about you for a number of different purposes. Each of those purposes is described below.

- **For Treatment.** We may use or disclose health information about you to provide, coordinate or manage the services, supports and care you receive from ERC and other providers. For example, we may disclose health information about you to doctors, nurses, case managers, therapists, teachers, psychologists, social workers, direct support 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. We may share information to coordinate needed services, such as medical tests, doctor visits, therapy appointments, etc.

- **For Payment.** We may use or disclose health information about you so we can be paid for the services we provide to you. This can include billing a third party payor or other state agency, 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 may also need to provide the state Medicaid program with information to ensure you are eligible for the medical assistance program.

- **For Health Care Operations.** We may also use and disclose health information about you for our day-to-day operations. For example, we may use health information about you that review and evaluate 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 may also use your health information to study ways to more efficiently manage our organization, for accreditation or licensing activities, auditing, or for our compliance program.

- **Individuals Involved in Your Care.** We may disclose to a 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. We also may use or disclose health information about you to notify, or assist in notifying, those persons of your location, general condition, or death. In the event of your death, we may disclose to any of those persons who were involved in your care for payment for health care prior to your death, health information about you that is relevant to that person's involvement, unless doing so is inconsistent with any prior expressed preference of you that is known to us.

  If there is a family member, other relative, or close personal friend that you do not want us to disclose health information about you to, please notify ERC's Privacy Officer or tell our staff member who is providing care to you.

- **Health Plan.** We will not use or disclose your genetic information for underwriting purposes, which includes determination of eligibility (including enrollment and continued eligibility) or benefits under the plan; the computation of premium or contribution amounts under the plan (including discounts, rebates, etc. for participating in a health risk assessment or a wellness program); and the application of any pre-existing condition under the plan.

- **Disaster Relief.** We may disclose health information about you to an entity assisting in a disaster relief effort so that your parents/guardian, family, relatives or close personal friends can be notified about your condition, status, and location.

- **As Required By Law.** We will disclose health information about you when required to do so by federal, state or local law.

- **Public Health Activities.** We may use or 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. It also includes reporting for purposes of activities related to the quality, safety or effectiveness of a United States Food and Drug administration regulated product or activity.

- **Proof of Immunization.** We may use or disclose immunization information to a school about you: (a) if you are a student or prospective student of the school; (b) the information is limited to proof of immunization; (c) the school is required by State or other law to have the proof of immunization prior to admitting you; and, (d) we obtain and document the agreement to the disclosure from either: (1) your parent, guardian, or other person standing *in loco parentis* of you if you are an un-emancipated minor, or (2) from you if you are an adult or an emancipated minor.

- **Reporting 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. We will only make this disclosure if you agree or when it is authorized by law.

- **Health Oversight Activities.** We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities may include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

- **Judicial and Administrative Proceedings.** If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also discuss health information about you in response to a subpoena, discover request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

- **Law Enforcement.** We may also disclose health information about you to a law enforcement official for law enforcement purposes:
    - As required by law.
    - In response to a court, grand jury or administrative order, warrant or subpoena.
    - To identify or locate a suspect, fugitive, material witness or missing person.
    - About an actual or suspected victim of a crime and that person agrees to the disclosures. If we are unable to obtain that person's agreement, in limited circumstances, the information will be disclosed.
    - To alert law enforcement officials to a death if we suspect the death may have resulted from criminal conduct.
    - About crimes that occur at our facility.
    - To report a crime in emergency circumstances.

- **Coroners, Medical Examiners and Funeral Directors.** We may disclose health information to a coroner or medical examiner. This may be necessary to identify a deceased person to determine cause of death. We may also disclose health information to funeral directors as necessary to carry out their duties.

- **Organ, Eye or Tissue Donation.** To facilitate organ, eye or tissue donation and transplantation, we may disclose health information about you to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs, eyes or tissue.

- **To Avert Serious Threat to Health or Safey.** We may use or disclose 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.

- **Military and Veteran.** If you are a member of the armed forces, we may disclose health information about you as required by military authorities. We may also disclose health information about foreign military personnel to the appropriate foreign military authority.

- **National Security and Intelligence.** We may disclose health information about you to authorized federal officials for the conduct of intelligence, counter-intelligence, and other national security activities authorized by law.

- **Protective Services for the President.** We may disclose health information about you to authorized federal officials so they can provide protection to the President of the United States, certain other federal officials, or foreign heads of State, or to conduct investigations authorized by certain federal laws.

- **Correctional Institution.** Should you be an inmate of a correctional institution, we may disclose to the institution or its agents health information necessary for your health and the health and safety of others.

- **Worker's Compensation.** We may disclose health information about you for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness.

- **Fundraising Activities.** We may use and disclose health information about you to contact you to raise funds for ERC. We may disclose health information to a business associate of ERC, so that business associate may contact you to raise money for the benefit of ERC. We will only release: (a) demographic information relating to you, including your name, address, other contact information, age, gender and date of birth; (b) dates of health care provided to you; (c) department of service information; (d) treating physician; (e) outcome information; and, (f) health insurance status.

  You have the right to opt out of receiving fundraising communications. If you do not want ERC to contact you for fundraising, please notify ERC's Privacy Officer.

CERTAIN USES AND DISCLOSURES THAT REQUIRE YOUR WRITTEN AUTHORIZATION

- **Psychotherapy Notes.** Your authorization is required before we may use or disclose psychotherapy notes unless the use or disclosure is: (a) by the originator of the psychotherapy notes for treatment; (b) for our own training programs for students, trainees, or practitioners in mental health; (c) to defend ourselves in a legal action or other proceeding brought by you; (d) when required by law; or, (e) permitted by law for oversight of the originator of the psychotherapy notes.

- **Marketing.** We will not disclose your health information for marketing purposes without your written authorization.

- **Sale of Information.** Your authorization is required for any disclosure of your health information when the disclosure is in exchange for direct or indirect remuneration from or on behalf of the recipient of the health information. However, your authorization may not be required under certain conditions if the disclosure is: (a) for public health purposes; (b) for research purposes; (c) for treatment and payment; (d) if we are being sold, transferred, merged or consolidated; (e) to a business associate of ours for activities undertaken on our behalf; (f)

  to you when requested by you; (g) required by law; (h) when permitted by applicable law where the only remuneration received by us is a fee permitted by law.

- **Employers.** We will not disclose your personal health information to potential or current employers without your written authorization.

OTHER USES AND DISCLOSURES

Other uses and disclosures will be made only with your written authorization. You may revoke such an authorization at any time by notifying ERC's Privacy Officer in writing of your desire to revoke it. However, if you revoke such an authorization, it will not have any effect on actions taken by us in reliance on it.

YOUR RIGHTS WITH RESPECT TO HEALTH INFORMATION ABOUT YOU

Although your records are the property of ERC, the information belongs to you. You have the following rights regarding your health information:

- **Right 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) for no 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 ERC's Privacy Officer 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.

  With one exception, we are not required to agree to any requested restriction. The exception is that we will always agree to a request to restrict disclosures to a health plan if: (a) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and, (b) the information relates solely to a health care item or service for which you, or someone on your behalf (other than the health plan), has paid us in full.

  If we agree to a restriction, we will follow that restriction unless the information is needed to provide emergency treatment. Even if we agree to a restriction, either you or we can later terminate the restriction. However, we will not terminate a restriction that falls into the exception stated in the previous paragraph.

- **Right to Receive Confidential Communications.** You have the right to request that we communicate heath 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 work or that we cannot leave appointment reminders on your answering machine. We will not require you to tell us why you are asking for the confidential communication.

  If you want to request confidential communication, you must do so in writing to ERC's Privacy Officer. Your request must state how or where you can be contacted.

  We will accommodate your request. However, we may, when appropriate, require information from you concerning how payment will be handled. We also may require an alternate address or other method to contact you.

- **Right to Inspect and Copy.** With some exceptions, you have the right to review and copy your health information. *You must submit your request in writing to the Privacy Officer for ERC. We may charge a fee for the cost of copying, mailing or other supplies associated with your request.* Your request should state specifically what health information you want to inspect or copy. Your request should also state the form of access and copy you desire, such as in paper or in electronic media. We will act on your request within thirty (30) days after we receive your request. If we grant your request, in whole or in part, we will inform you of our acceptance of your request and provide access and copying. We may deny your request if the health information involved is psychotherapy notes or is information compiled in anticipation of, is use in, a civil, criminal or administrative action proceeding. If we deny your request, we will inform you of the basis for the denial, how you may have our denial reviewed, and how you may

complain. If you request a review of our denial, it will be conducted by a licensed health care professional designated by us who was not directly involved in the denial. We will comply with the outcome of the review.

- **Right to Amend.** If you feel that health information in your record is incorrect or incomplete, you may ask us to amend the information. You have this right for as long as the information is kept by ERC. *You must submit your request in writing to the Privacy Officer for ERC. In addition, you must provide a reason for your request.* We will act on your request within 60 days after we receive your request. If we grant your request, in whole or in part, we will inform you of our acceptance of your request and provide access and copying and we will seek your identification and agreement to share the amendment with relevant other persons. We also will make the appropriate amendment to the health information by appending or otherwise providing a link to the amendment. 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 information that was not created by us, unless the person or entity that created the information is no longer available to make the amendment; is not part of the health information kept by us; or is accurate and complete.

  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 disagreement with our denial. Your statement may not exceed five (5) pages. We may prepare a rebuttal to that statement. Your request for amendment, or denial of the request, your statement of disagreement, if any, and our rebuttal, if any, will then be appended to the health information involved or otherwise linked to it. All of that will then be included with any subsequent disclosure of the information, or, at our election, we may include a summary of any of that information. If you do not submit a statement of disagreement, you may ask that we include your request for amendment and our denial with any future disclosures of the information. We will include your request for amendment and our denial with any subsequent disclosures of the health information involved. You will also have the right to complain about our denial of your request.

- **Right to an Accounting of Disclosures.** You have the right to receive an accounting of disclosures of health information about you. The accounting may be for up to six (6) years prior to the date on which you request the accounting but not before April 14, 2003.

  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 disaster relief purposes;
  f. Disclosures for national security or intelligence purposes;
  g. Disclosures to correctional institutions or law enforcement officials having custody of you;
  h. Disclosures that are part of a limited data set for purposes of research, public health, or health care operations (a limited data set is where things that would directly identify you have been removed).
  i. Disclosures made prior to April 14, 2003.

  Under certain circumstances your right to an accounting of disclosures to a law enforcement official or a health oversight agency may be suspended. Should you request an accounting

during the period of time your right is suspended, the accounting would not include the disclosure or disclosures to a law enforcement official or to a health oversight agency.

To request an accounting of disclosures, you must submit your request in writing to ERC's Privacy Officer. Your request must state a time period for the disclosures. It may not be longer than six (6) years from the date we receive your request and may not include dates before April 14, 2003.

Usually, we will act on your request within sixty (60) calendar days after we receive your request. Within that time, we will either provide the accounting of disclosures to you or give you a written statement of when we will provide the accounting and why the delay is necessary.

There is no charge for the first accounting we provide to you in any twelve (12) month period. For additional accountings, we may charge you for the cost of providing the list. If there will be a charge, we will notify you of the cost involved and give you an opportunity to withdraw or modify your request to avoid or reduce the fee.

- **Right to Copy of This Notice.** You have the right to a paper copy of this Notice of Privacy Practices even if you have agreed to receive the Notice electronically. You may ask us to give you a copy of this Notice at any time.

  You may obtain a copy of this Notice at our website, www.ercinc.org.

  To obtain a paper copy of this Notice, contact the Privacy Officer of ERC.

OUR DUTIES

- **Generally.** We are required by law to maintain the privacy of health information about you, to provide individuals with notice of our legal duties and privacy practices with respect to health information, and to notify affected individuals following a breach of unsecured protected health information. We are required to abide by the terms of our Notice of Privacy Practices in effect at the 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.

- **Availability of Notice of Privacy Practices.** A copy of our current Notice of Privacy Practices will be posted at each ERC facility in a common area. A copy of the current notice also will be posted on our web site, www.ercinc.org.

  At any time, you may obtain a copy of the current Notice of Privacy Practices by contacting ERC's Privacy Officer.

- **Effective Date of Notice.** The effective date of the notice is stated on the first page of this 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 us.
  To file a complaint with us, contact ERC's Privacy Officer. 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/her in care of: Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue SW, Washington, D.C. 20201. Complaints also may be filed online. Go to: http://www.hhs.gov/ocr.

  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:

  Cathy Obana, ERC Privacy Officer
  3917 S. Old Missouri Rd., Springdale, AR 72764
  479-799-2935
  cobana@ercinc.org

NOTICE OF PRIVACY PRACTICES
ELIZABETH RICHARDSON CENTER
Effective September, 2013

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This is to acknowledge my receipt of ERC's Notice of Privacy Practices (effective date September, 2013) on the date stated below.

_____
Date of Individual's or Personal Representative's Signature

_____
Signature of Individual or Personal Representative

_____
Individual's Name (Please print)

_____

_____
Individual's Address

_____
Name of Personal Representative (If applicable)

_____

_____
Description of Representative's Authority to Act for the Individual (If applicable)

Elizabeth Richardson Center
Enhancing lives
Removing barriers
Creating opportunities

ERC Community Employment Program
Informed Consent Form

The Community Employment Department is designed to assist adults with disabilities who are 18 years of age or older learn about the world of work, acquire job searching skills, interview skills, and other skills that are important to obtaining employment. Your goal is to obtain and maintain integrated employment in the community that will increase your independence. It is important that you understand both the possible benefits and risks of being in the ERC CE Program.

You Can Expect Us To:

- Keep your information private. It will only be given out with permission from you or your guardian.
- Help you understand you legal rights and responsibilities.
- Give you information about advocacy groups that can help you if your rights are not respected.
- Give you information about the grievance policy so you will know what to do if you have a complaint.
- Search for and assist you in locating appropriate employment that meets your employment goals.

We Expect You To:

- Help pick out your goals and to work on your goals
- Stay in contact with the Employment Team.
- Follow rules for the program(s) you attend.

Planned Benefits (the good parts):

Based on your IPE (your goals), the Community Employment Team may help you learns the follow specific skills through formal goals as well as other skills as a part of general programming.

- Proper health and hygiene skills
- Correct work behavior
- Computer skills
- Personal safety
- Self-administration of medication if needed during the day
- Following the chain of command
- Follow rules, procedures, and instructions
- On the job communication skills
- Appropriate workplace attire
- Employer/workplace expectations
- Staying on task
- Social skills and how to interact with other people on the job (coworkers and supervisors)
- Building and understanding your resume and references
- How to fill out an application
- Interview skills

- How to find a job
- What types of jobs would be best for you
- Other benefits: _____

It is your choice to participate in the CE Program. If you choose to not be in the program, you might not receive the support you need to achieve your goals.

Possible Risks (the bad parts):

If you choose to be in the Community Employment Program, you will be interacting with many other people. ERC does its best to provide a safe learning environment, but being in the community may have these risks.

- Being exposed to illnesses or diseases; you could get sick.
- Being injured while at the jobsite.
- Being injured traveling to and from your jobsite.
- Being around other people who may not understand your disability and may treat you unkindly by yelling at you or calling you names.
- You could have other risks due to your health or other needs.
- My Risks: _____
- My Risks: _____
- My Risks: _____

Risk Interventions

An Individual Plan of Protection (I-PoP) will be developed for you. It will be kept in your records.

Additional Information:

- Please ask us questions. We will be happy to answer your questions about the CE Program and your plan for services.
- If you ask, we will give you a copy of any information we have created and placed your file. We cannot give you anything from your file that was created by another agency or professional.
- You may be able to receive additional services from ERC and other agencies while you are in the CE Program at ERC.
- You do not have to take part of any research if you do not want to.
- We will refer you to legal experts for representation if needed.

The People Who Will Help You With Services:

You are the most important person!

_____Your Employment Specialist

_____Your Community Employment Case Manager: _____

_____Other: _____

I understand the ERC CE Program and the risks and benefits (good and bad parts) of being in this program as explained in this form and by signing this form I agree to participate fully in this program.

Please print your name: _____

_____ _____

Your signature *Date*

_____ _____

Signature of Parent/Guardian (if applicable) *Date*

Signatures of Applicable Service Delivery Team Members:

_____ _____

Signature of Case Manager *Date*

_____ _____

Signature of Employment Specialist *Date*

Community Employment Intake Form

1. INFORMATION REQUIRED TO BE PROTECTED.
2. The privacy of identifiable health information must be protected at all times. Information relating to a client's health care history, diagnosis, condition, treatment, or evaluation shall be considered individually identifiable health information. Confidentiality of this health information must be maintained at all times, and may only be disclosed with the express written consent of the client.
3. Non-individually identifiable health information, (e.g. health information that cannot be linked to a specific client) is not included within the definition of protected health information.
4. BOUNDARIES ON HEALTH INFORMATION USE AND RELEASE:
5. An individual's health information can be used for health purposes only.
6. Protect individually identifiable health information. ERC shall not publish or otherwise make generally available any information or data that identifies a client for purposes other than treatment, payment or other health care operations, without his or her express written consent. This does not restrict the internal use.
7. Ensure that health information is not used for non-health purposes. Patient information can be used or disclosed only for purposes of treatment, payment and health care operations. Health information cannot be used for purposes not related to health care without explicit authorization from the patient. For example, ERC may not access the personal health information obtained by an ERC affiliate for any purpose other than to perform the services for which we were engaged, unless ERC first obtains the explicit authori9zation of the patient.
8. Maintain health information in a manner to protect confidentiality. All individually identifiable health information shall be maintained by ERC in a confidential manner that prevents unauthorized use or disclosure to third parties. For example, ERC may share confidential information with a third party under contract or affiliated with ERC for the same purpose of performing the services for which we were engaged, provided that the information shall remain confidential at all times and shall be shared with only those persons that have authority to receive such information.
9. Penalties for Misuse of Personal Health Information
10. 10. There are serious penalties for violation of the confidentiality of health information. Please be advised of the following:
    - State Penalties. Various state laws impose criminal and civil penalties on individuals who misuse or disclose individually identifiable health information without explicit consent by the patient.
    - Federal Penalties. HIPAA (Health Insurance Portability and Accountability Act) is a piece of federal legislation that directly addresses the privacy and security protection of individually identifiable health information. HIPAA calls for civil and criminal penalties for privacy and security violations, including:
        - Fines up to $25,000 for multiple violations of the same standard in a calendar year.
        - Fines up to $250,000 and/or imprisonment up to 10 years for knowing misuse of individually identifiable health information.
    - ERC Penalties. Any employee who violates the privacy and confidentiality of patient health information, through disclosure or otherwise, may be subject to disciplinary action, including termination of his or her employment with ERC.

By signing this form you verify that you understand that ERC employees will safe guard your private information.

Signature _____ Date _____

Elizabeth Richardson Center
ERC Enhancing lives Removing barriers Creating opportunities

Community Employment Intake Form

☐ SE ☐ TTW ☐ E1 ☐ Placement

Interviewer:

_____

Interview Date & Time:

_____

Personal Information

Name: _____

Address (Street, Apt. #, City, State, Zip and County)

_____

_____

Phone Number: _____ **Cell or alternate:**_____

Date of Birth:_____ **Social Security #:**_____

Email address: _____**ARS Counselor**_____

Primary Disability:_____

Race:_____ ☐ **Male** ☐ **Female** **Family Size:** _____

Current Source(s) of Income: _____

Monthly Income Amount from all sources: $_____

Are you your own guardian? ☐ **Yes** ☐ **No** **If no, who is?**_____

Emergency Contact: _____

Emergency contact phone: _____ **Relationship:**_____

Any allergies?_____

Current Medications_____

_____

Have you ever been convicted of a felony? ☐ **No** ☐ **Yes** **(If yes, please explain below)**

_____

What is your main mode of transportation/How are you planning on getting to work?

_____

_____

Do you have any physical limitations that we should know about that would affect your ability to work in a job with or without a reasonable accommodation, including but not limited to lifting, bending, reaching, crawling, standing, walking, sitting, climbing or crouching. If so, what is your limitation? _____

_____

_____

_____

_____

Employment Preferences

Employment Goal (preference)_____

What hours do you prefer to work? How many hours per week? _____

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Start							
End							

What are your work preferences? (Example: working alone, noise, temperature, etc.)

☐ **Indoors** ☐ **Outdoors** ☐ **With others** ☐ **Alone** ☐ **In quiet** ☐ **Around noise**

☐ **With Animals** ☐ **Doing the same thing repeatedly** ☐ **Doing different things**

☐ **Fast pace** ☐ **Slow pace** ☐ **In hot** ☐ **In cold** **Other preference: _____**

_____

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School or Training History

Do you have a high school diploma or GED? ☐ Yes ☐ No

Name of High School Attended_____

City and State _____

Year graduated or received diploma?_____

Do you have any further training (vocational training, college, etc.) ☐ Yes ☐ No
If yes,

Name of School _____ years attended _____

Program studied_____ Type of certificate_____

Employment History or Volunteer Experience

Starting with the most current

Name of Employer_____ Start date_____ to _____

Address_____ City _____ State_____

Phone number _____ Supervisor's Name_____

Type of work performed_____

_____

Likes / Dislikes _____

_____

Would you like to return to this type of work? ☐ Yes ☐ No

Name of Employer_____ Start date_____ to _____

Address_____ City _____ State_____

Phone number _____ Supervisor's Name_____

Type of work performed_____

_____

Likes / Dislikes _____

_____

Would you like to return to this type of work? ☐ Yes ☐ No

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Name of Employer_____ Start date_____ to _____

Address_____ City _____ State_____

Phone number _____ Supervisor's Name_____

Type of work performed_____

_____

Likes / Dislikes _____

_____

Would you like to return to this type of work? ☐ Yes ☐ No

Name of Employer_____ Start date_____ to _____

Address_____ City _____ State_____

Phone number _____ Supervisor's Name_____

Type of work performed_____

_____

Likes / Dislikes _____

_____

Would you like to return to this type of work? ☐ Yes ☐ No

<u>Personal References:</u> please list three (3) individuals you would like to use as personal references on your resume.

1) Name: _____ Years known: _____

Phone:_____ Email:_____

Relationship:_____

2) Name: _____ Years known: _____

Phone:_____ Email:_____

Relationship:_____

3) Name: _____ Years known: _____

Phone:_____ Email:_____

Relationship:_____

<u>Business References:</u> please list three (3) individuals you would like to use as business references on your resume.

1) Name: _____ Years known: _____

Phone:_____ Email:_____

Relationship:_____

2) Name: _____ Years known: _____

Phone:_____ Email:_____

Relationship:_____

3) Name: _____ Years known: _____

Phone:_____ Email:_____

Relationship:_____