Dear Applicant,

If you are applying for the E-SOL Activity Center program, this is the application you need to fill out. After you have completed this application you must submit it to our office or one of our staff members. If you have any questions about this application or need help filling it out, you may call us at (818) 881-4427. Thank You.

E-SOL

Margie Rhyne

Margie Rhyne

E-SOL
Activity Center
Application Checklist

___1. Regional Center Approval Form

___2. Admission and Agreement Policies Acknowledgment Form

___3. Late Pick-Up Policy

___4. Preplacement Appraisal Form

___5. Identification and Emergency Information

___6. Aquatic Program Release

___7. Consumer Questionnaire

___8. Appraisal/Needs and Services Plan or IPP

___9. Physician's Report

___10. Consent for Emergency Medical Treatment

___11. Authorization to Administer Medication

___12. Functional Capability Assessment

___13. Seizure Procedures

___14. Photographic Release Form

___15. Record of Client's Safeguard Cash Resources

___16. Telecommunication Device Notification

___17. Personal Rights Form

E-SOL
7711 Jellico Ave
Northridge, CA 91325
Activity Center

Admission and Agreement Policies

Adult Activity Program

E-SOL will have all admission policies in writing and available to the public. Please initial each page. The policies shall coincide with the limitations stated on the license, and shall include, but not be limited to, the following:

1. Written admission criteria designating those consumers whose needs can be met by the center's program and its services.
2. The ages of consumers who will be accepted.
3. The program activities.
4. The supplementary services provided, if any.
5. Field trip provisions, if any.
6. Transportation arrangements, if any.
7. Food service provisions.
8. Medical assessment requirement.

Persons accepted for care, including age range and compatibility determination process, when necessary.

E-SOL will be providing care for consumers with special needs and will meet the individual needs of each consumer. Consumers who are at least 21 years old may be eligible for the program. **E-SOL** is specially designed to meet the needs of consumers who have physical and\or developmental disabilities. Case managers, Physicians, schools or friends may make referrals. Each referral will be evaluated on an individual basis to determine whether the applicant is appropriate for our services. Consumers will be evaluated regardless of race, creed, color, national origin or sex. Participants must **NOT** exhibit ongoing assaultive or self-abusive behaviors and must **NOT** require one-to-one or medical staffing. **E-SOL** reserves the right to refuse service or placement to consumers considered inappropriate.

Rates and refund policies

Fees are based upon a daily rate paid by Regional Center. **E-SOL** is a vendor with the Regional Center.

No refunds will be issued for any program after service has been provided by **E-SOL.**

Licensing Authority

E-SOL is licensed to provide care programs through the State Community care Licensing Division.

I. Our Purpose

E-SOL was created with the intent to improve the quality of life for adults with special needs.

Our goals:

- To teach consumers how to work together to attain success as a team
- To create a working relationship between businesses and potential employees with special needs
- To teach consumers the necessary vocational and pre-vocational skills to be an effective employee when given the opportunity to work
- To create a working environment where consumers can feel comfortable learning and working together with each other and with staff as well
- To teach consumers valuable life skills and improve upon previous existing ones that give consumers the best chance for success
- To teach consumers how to generalize their skills to transcend various environments and situations

II. Skills

As a result of their participation in our program, consumers will acquire skills to enhance their performance and\or behavior to the best of their ability. Through daily performance assessments and questionnaires, data from the consumers will be obtained.

1. Each job\task shall be divided into steps.
2. The consumers will be shown each step.
3. The consumers will be supervised at every step.
4. Each consumer will be given individualized training throughout each step.
5. At regular intervals of training, the consumers will demonstrate their proficiency level for each step.

A job\task is mastered when all steps are performed correctly on 3 consecutive trials, 3 consecutive days at 100% efficiency.

III. Program Curriculum

Each consumer's activity schedule will be determined during the interview\screening process. The schedule will reflect his or her individual needs,

concerns. and objectives as expressed in their IPP when considering the most appropriate placement. Each consumer's specific training activities will incorporate the following components:

Sample Schedule

(activities may vary from day to day)

7:30 – 8:00	Arrival and sign in
8:00 – 8:30	Stretching and exercise
8:30 – 9:15	Pre-vocational Training
9:15 – 9:30	Break
9:30 - 11:30	Employee/vocational training
11:30 – 12:00	Lunch prep
12:00 – 12:30	Lunch
12:30 – 1:30	Employee vocational training
1:30 – 2:00	Performance evaluation

Hours of Operation

Daily (Monday - Friday): 7:30 a.m. - 2:00 p.m.

1. **Holidays**

E-SOL will be closed on the following holidays:
New Year's Day
Martin Luther King Jr.'s Birthday
President's Day
Cesar Chavez Day
Memorial Day
4th of July
Labor Day
Columbus Day
Veteran's Day
Thanksgiving Day (Day after Thanksgiving
Christmas Eve

These dates are subject to change based on the Uniform Holiday Schedule published by Regional Center.

2. **Attendance**

Regular attendance is required. Please call and notify **E-SOL** if the consumer is going to be absent for any reason.

3. **Participation**

All consumers will be expected to participate in all activities to the best of their abilities.

4. **Transportation**
E-SOL is not responsible and does not provide transportation to or from the facility. Transportation to and from the facility may be arranged through the consumer's school, Regional Center, or other transportation services. Additionally, consumers\conservators are solely responsible for consumer pick-up.

5. **Conservator Conferences\Observations**
A conference will be arranged to review and\or update goals and objectives upon request by consumer\conservator and in collaboration with the director.

6. **Health and Safety**
Pre-admission Health History form is required for every consumer. Please inform **E-SOL** of any changes regarding physical, emotional or medical issues.

7. **Illness\Injury**
In the best interest of the safety of other consumers as well as staff members we request that sick or injured consumers remain at home until full recovery or a conference can be arranged to assess the best action for the consumer.

8. **Medication**
E-SOL will administer medication **ONLY** with written permission (consent form included in admission packet) from consumer\conservator, care provider, and Physician (Prescription label on medication bottle is mandatory).

9. **Sign in\out Policies**
In compliance with State Licensing requirements, each consumer must be properly signed in and out with a full signature on the **E-SOL** attendance roster.

10. **Personal Belongings**
E-SOL will not be responsible for lost, stolen, or damaged personal belongings. As we understand accidents do occur, please do not send valuable or new items whenever possible. To avoid confusion consumer\conservators should clearly mark all personal items.

11. **Staff training days**
    To ensure the highest quality service, **E-SOL** may be closed for up to five days per calendar year for necessary staff training sessions. Parents will be given ample (written) notification.

E-SOL STAFF

E-SOL staff is selected for their qualifications that exemplify the high standards and principles of our organization. All staff must meet or exceed the state of California Department of Social Services Community Care Licensing criteria for employment.

To ensure the best quality service for participants, the Directors of **E-SOL** have over fifty years of combined experience of working with students and other people with special needs. Our staff currently consists of a Credentialed LAUSD teacher of students with special needs, and (12) LAUSD certified Special Education Assistants. Additionally, we have a certified dance instructor who teaches dance and aerobics on a regular basis. **E-SOL** will continue to expand its community involvement through assemblies, field trips, and incentive programs. All staff members are trained and certified in adult First Aid and CPR. The staff to consumer ratio will be no more than 1:6.

Because we maintain a staff to consumer ratio of only 1:6, consumers applying for the Activity Center:

- Must exhibit appropriate behaviors. Assaulting and\or self-abusive behaviors that may compromise the health and safety of themselves or others are not permitted.
- Must have a neat and clean appearance, good hygiene and good grooming
- Must be able to eat without assistance
- Must follow all rules and guidelines
- Must **NOT** require one-to-one or medical staffing

Additionally, applicants need to do the following:

1. Complete the application intake forms as mandated by both state licensing and\or **E-SOL** policy
2. Complete the interview\screening process conducted by facility directors and administrators.
3. Be approved by the facility director(s) and administrator(s)

Discipline policies

E-SOL will strive to meet the needs of all participants in our program without ignoring the demands of any one individual. It becomes necessary when organizing a group to set limits and guidelines which each member of the group

and program is expected to follow. When those limits are broken, it is essential to provide some form of understanding ensuring safety while providing a high quality and effective program will be the main priority of **E-SOL** and its staff.

Target behaviors deemed "inappropriate" may include:

- Excessive defiance in complying with staff rules and regulations
- Persistent self-abuse
- Disruptive behaviors towards staff or other consumers
- Violent tantrums; tantrums that cannot be controlled

At **NO** time will **E-SOL** staff use corporal punishment to resolve conflicts. The following process will be used to resolve conflicts as they happen:

Types of discipline that will be used

1. **Verbal Communication-** Every effort will be made to help the consumer understand the inappropriateness of his/her actions or behavior. The consumer will then be given a choice between a few acceptable actions or behaviors. When the conflict is consumer-to-consumer, efforts will be made to have them verbally work out their differences with the staff providing facilitator support.
2. **Removal from specific activity-** if verbal communication is not successful removing the consumer from the activity for an appropriate amount of time may be necessary. The denied activity shall be directly related to the inappropriate behavior or action and the removal time shall NOT be excessive.
3. **Consumer-Conservator conference-** if removal from the activity is not successful, the program supervisor will be consulted to meet with the program staff and the consumer to develop an alternate behavior plan.
4. **Consumer\Conservator\Director conference-** if Conservator involvement becomes necessary, specific changes in behavior will be requested and specific consequences for non-success will be defined, as well as specific rewards for successful and positive changes in behavior will be emphasized and promoted. Whenever possible and appropriate, the consumer will participate in these meetings.

Types of discipline not permitted

At **NO** time will **E-SOL** staff use corporal punishment\violation of personal rights to resolve conflicts.

Provisions for contact with Conservators\placement representatives
If Conservator involvement becomes necessary, specific changes in behavior will be requested and specific consequences for non-success will be defined, as well as specific rewards for successful and positive changes in behavior will be emphasized and promoted. Whenever possible and appropriate, the consumer will participate in these meetings.

Grounds for dismissal\eviction\relocation\removal from placement

Consumers are required to maintain an ability development and skill level necessary to perform various jobs and participate in various activities. If for any reason(s), such skills or abilities are lost or significantly diminished, for the safety of our consumers and the integrity of our program, the consumer in question must be considered for removal from the program. Additionally, inappropriate behaviors that warrant a more intense staffing than 1:6 ratio, cannot be accepted. When all measures to positively change inappropriate behaviors have not been successful, or if such behaviors are deemed to represent a danger to others or to the consumer, then the consumer may be removed from the program either on a temporary or on a permanent basis. Also, in the event that a consumer who is already attending the program, develops a condition that requires medical staffing, his or her placement will be re-evaluated. When a consumer has met the necessary criteria and is performing at such a level that exceeds the services that the program has to offer, we will recommend a consultation with a service coordinator to explore the possibility of relocation or placement into a less restrictive program.

Termination Procedures

1. **Verbal communication-** Every effort will be made to help the individual understand the inappropriateness of his/her actions or behavior. Facility directors and/or other staff will meet with and discuss the concerning behavior(s). The individual will be reminded of program rules and guidelines. The consumer will then be given the opportunity to choose an alternate acceptable action(s) or behavior(s). When the conflict is consumer-to-consumer, efforts will be made to have them verbally work out their differences with the staff providing facilitator support.

2. **Consumer-Conservator conference-** If necessary, the program supervisor will be consulted to meet with the service coordinator, program staff, and the consumer to develop an alternate plan.

3. **Consumer/Conservator/Director Conference**- If conservator involvement becomes necessary, specific changes in behavior will be requested and specific consequences for non-success will be defined, as well as specific rewards for successful and positive changes in behavior will be emphasized and promoted. The consumer will participate in these meetings.

IX. Assessment Procedures

There are three areas of assessment that **E-SOL** utilizes to assist each consumer to achieve his/her ISP goals; the oral interview, the performance analysis, and the consumer questionnaire.

Oral Interview

Conducted at the initial interview/screening process, this consists of a conversation between the consumer, the service coordinator and the **E-SOL** director to observe the consumer's ability to communicate his or her thoughts and ideas about being involved in a work training program.

Performance Evaluation

On a daily basis consumers will meet and discuss their performance individually and as a group. Consumers will be given the opportunity to evaluate themselves and other consumers. This information will be summarized and recorded on a weekly basis. (See Attachment -A)

Consumer Questionnaire

Conducted initially, and based on the newly developed IPP, a written question and answer form (facilitated by the directors) to determined the most appropriate placement for the consumer. (See Attachment-B)

Based on the data collected from the consumer utilizing the assessment procedures/tools mentioned above, the directors, in collaboration with the service coordinator and the consumer, would determine the most appropriate placement in the program to achieve his/her ISP goals.

A semi-annual evaluation of the consumer's progress will be submitted to the case manager with specific reference to the consumer's needs and goals obtained in their IPP.

E-SOL ACKNOWLEDGEMENT FORM

I have read, understand, and agree with all rules, policies and procedures as stated above in the previous pages.

Signature or Consumer\Conservator_____ Date_____

Signature of Director_____ Date_____

E-SOL
Late pick-up Policy

Participant_____

It is imperative that parents arrange for their children's transportation home from all E-SOL centers. Parents are also responsible for developing a consistent alternative transportation plan to be used, in the event of an emergency, when they are unable to provide transportation.

E-SOL CLOSES PROMPTLY AT 6:30 p.m.
Late pick up charges are $1.00 per minute starting at 6:31 p.m. This covers a six-month period starting with first late pick-up. The payment must be received by the following day.

1st occurrence- late fees apply. _____
2nd occurrence- late fees apply, and a warning regarding penalty charges._____
3rd occurrence- late fees apply, and a penalty charge of $25.00._____
4th occurrence- late fees apply, and a penalty charge of $50.00._____
5th occurrence- late fees apply, and a penalty charge of $100.00. Parents must also attend a mandatory conference with the Center Director._____

Excessive late pick-ups (more than five occurrences within a six-month period) may result in discharge from E-SOL programs.

Signature of Parent/Guardian_____

Date_____

PREPLACEMENT APPRAISAL INFORMATION

Admission - Residential Care Facilities

NOTE: *This information may be obtained from the applicant, or his/her authorized representative. (Relatives, social agency, hospital or physician may assist the applicant in completing this form.) This form is not a substitute for the Physician's Report (LIC 602).*

APPLICANT'S NAME AGE

HEALTH (Describe overall health condition including any dietary limitations)

PHYSICAL DISABILITIES (Describe any physical limitations including vision, hearing or speech)

MENTAL CONDITION (Specify extent of any symptoms of confusion, forgetfulness: participation in social activities (i.e., active or withdrawn))

HEALTH HISTORY (List currently prescribed medications and major illnesses, surgery, accidents; specify whether hospitalized and length of hospitalization in last 5 years)

SOCIAL FACTORS (Describe likes and dislikes, interests and activities)

BED STATUS

OUT OF BED ALL DAY

IN BED ALL OR MOST OF THE TIME

IN BED PART OF THE TIME

COMMENT:

TUBERCULOSIS INFORMATION

ANY HISTORY OF TUBERCULOSIS IN APPLICANT'S FAMILY?

YES NO

ANY RECENT EXPOSURE TO ANYONE WITH TUBERCULOSIS?

YES NO

GIVE DETAILS

DATE OF TB TEST

ACTION TAKEN (IF POSITIVE)

☐ POSITIVE

☐ NEGATIVE

AMBULATORY STATUS *(this person is ambulatory nonambulatory)*

Ambulatory means able to demonstrate the mental and physical ability to leave a building without the assistance of a person or the use of a mechanical device. An ambulatory person must be able to do the following:

YES	NO	
		Able to walk without any physical assistance (e.g., walker, crutches, other person), or able to walk with a cane.
		Mentally and physically able to follow signals and instructions for evacuation.
		Able to use evacuation routes including stairs if necessary.
		Able to evacuate reasonably quickly (e.g., walk directly the route without hesitation).

FUNCTIONAL CAPABILITIES (Check all items below)

YES	NO			
		Active, requires no personal help of any kind - able to go up and down stairs easily		
		Active, but has difficulty climbing or descending stairs		
		Uses brace or crutch		
		Feeble or slow		
		Uses walker. If Yes, can get in and out unassisted?	Yes	No
		Uses wheelchair. If Yes, can get in and out unassisted?	Yes	No
		Requires grab bars in bathroom		
		Other: (Describe)		

SERVICES NEEDED (Check items and explain)

YES	NO	
		Help in transferring in and out of bed and dressing
		Help with bathing, hair care, personal hygiene
		Does client desire and is client capable of doing own personal laundry and other household tasks (specify)
		Help with moving about the facility
		Help with eating (need for adaptive devices or assistance from another person)
		Special diet/observation of food intake
		Toileting, including assistance equipment, or assistance of another person
		Continence, bowel or bladder control. Are assistive devices such as a catheter required?
		Help with medication
		Needs special observation/night supervision (due to confusion, forgetfulness, wandering)
		Help in managing own cash resources
		Help in participating in activity programs
		Special medical attention
		Assistance in incidental health and medical care
		Other "Services Needed" not identified above

Is there any additional information which would assist the facility in determining applicant's suitability for admission? ☐ Yes ☐ No

If Yes, please attach comments on separate sheet.

To the best of my knowledge; I (the above person) do not need skilled nursing care.

SIGNATURE DATE COMPLETED

APPLICANT (CLIENT) OR AUTHORIZED REPRESENTATIVE

SIGNATURE DATE COMPLETED

LICENSEE OR DESIGNATED REPRESENTATIVE DATE COMPLETED

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION

IDENTIFICATION AND EMERGENCY INFORMATION

This information is required under the H & S Code and the regulations of the Department to be maintained on every person admitted to a community care facility, to be readily available to the person in charge, but not accessible to unauthorized persons. All information must be kept current. See other side for additional information required for residential facilities for children.

A. ALL FACILITIES [EXCEPT CHILD CARE CENTER/FAMILY CHILD CARE HOME COMPLETES LIC 700]

1 NAME OF CLIENT OR CHILD | SOCIAL SECURITY NUMBER (OPTIONAL) | DATE OF BIRTH | AGE | SEX

2 RESPONSIBLE PERSON OR PLACEMENT AGENCY | ADDRESS | TELEPHONE ( )

3 NAME OF NEAREST RELATIVE (OPTIONAL) | RELATIONSHIP | ADDRESS | TELEPHONE ( )

4 DATE ADMITTED TO FACILITY | ADDRESS PRIOR TO ADMISSION

5 DATE LEFT | FORWARDING ADDRESS

6 REASONS FOR LEAVING FACILITY

7 **PERSON(S) RESPONSIBLE FOR FINANCIAL AFFAIRS, PAYMENT FOR CARE, LEGAL GUARDIAN, IF ANY**

NAME	ADDRESS	TELEPHONE
		( )
		( )
		( )

8 **OTHER PERSONS TO BE NOTIFIED IN EMERGENCY**

	NAME	ADDRESS	TELEPHONE
a	PHYSICIAN		( )
b	MENTAL HEALTH PROVIDER, IF ANY		( )
c	DENTIST		( )
d	RELATIVE(S)		( )
e	FRIEND(S)		( )

9 **EMERGENCY HOSPITALIZATION PLAN**

NAME OF HOSPITAL TO BE TAKEN IN AN EMERGENCY | ADDRESS OF HOSPITAL TO BE TAKEN IN AN EMERGENCY

MEDICAL PLAN | MEDICAL PLAN IDENTIFICATION NUMBER

NAME OF DENTAL PLAN (IF ANY) | DENTAL PLAN NUMBER (IF ANY)

10 **OTHER REQUIRED INFORMATION**

a AMBULATORY STATUS

b RELIGIOUS PREFERENCE | NAME AND ADDRESS OF CLERGYMAN OR RELIGIOUS ADVISOR, IF ANY | TELEPHONE ( )

11 COMMENTS

SIGNATURE OF RESIDENT | SIGNATURE OF PERSON COMPLETING FORM | TITLE | DATE

B. RESIDENTIAL FACILITIES FOR CHILDREN

(Additional information is required by regulation for residential facilities for children.)

1 NAME OF CHILD

2. NAME AND ADDRESS OF PERSON TO CONTACT, IF AUTHORIZED REPRESENTATIVE IS NOT AVAILABLE | SPECIFY RELATIONSHIP | TELEPHONE NUMBER

( )

3 NAME AND ADDRESS OF PARENT(S)/PARENT'S DOMESTIC PARTNER, IF KNOWN | TELEPHONE NUMBER

( )

4 CHILD'S COURT STATUS *ATTACH CUSTODY ORDERS AND AGREEMENTS WITH PARENT(S), OR PERSON(S) HAVING LEGAL CUSTODY.* **NOTE:** *OPTIONAL FOR SMALL FAMILY AND FOSTER FAMILY HOMES)*

5 **PERSON(S) WITH WHOM CHILD HAS BEEN LIVING (IF KNOWN)**

NAME AND RELATIONSHIP	ADDRESS	TELEPHONE
		( )
		( )
		( )

6 **VISITATION RESTRICTIONS (BY COURT ORDER OR AUTHORIZED REPRESENTATIVE)**

PERSON(S) NOT AUTHORIZED TO VISIT CHILD		PERSON(S) NOT AUTHORIZED TO VISIT CHILD	
NAME	RELATIONSHIP	NAME	RELATIONSHIP

7 **FAMILY RESIDENCE VISITATION RESTRICTIONS**

SPECIFY, IF ANY

8 **ALL PERSONS AUTHORIZED TO REMOVE CHILD FROM HOME**

NAME	RELATIONSHIP	SPECIFY CONDITIONS

9 **TELEPHONE ACCESS**

IF NO, SPECIFY RESTRICTIONS

MAKE AND RECEIVE CONFIDENTIAL CALLS

YES NO (BY COURT ORDER)

10 COMMENTS

E-SOL

AQUATIC PROGRAM RELEASE

Name_____Birth Date_____

Address_____Phone_____

Medications_____

Can participant participate in water activities in a heated pool (85-90 degrees) with a lifeguard in the water and poolside (non-swimmers supported by an adult in the water)?

No _____ Yes_____

Can participant participate in the following pool activities:

pool	no _____	yes _____
Wading pool	no _____	yes _____
Jacuzzi	no _____	yes _____

Has participant ever been in a large pool? no _____ yes _____

Is participant afraid of the water? no _____ yes _____

Will participant put his/her face in the water? no _____ yes _____

Has participant ever experienced seizures or other difficulties during swimming?

No _____ Yes _____

If yes, please describe _____

_____

_____

Has participant been given organized swim lessons? No _____ Yes _____

If yes: 1) Where were the lessons given? _____

2) What was the highest level achieved? _____

Does participant require any special equipment (i.e., ear plugs, nose plugs, swim cap, water shoes, etc.?): No _____Yes _____

If yes, please list items _____

Does participant require assistance dressing? No _____ Yes _____

If yes, please explain_____

_____

_____

_____

Signature Date

Consumer Questionnaire

Do you want to work? _____Yes _____No

Why do you want to work? _____

_____

_____

I want to work _____Indoors _____Outdoors

Comments_____

_____

_____

What kinds of jobs have you done?

_____

_____

_____

I want to work in a: ____quiet environment ____temp-controlled environ

Comments_____

_____

_____

I would like to make friends at work? _____yes _____No

What do you like to do when you're not working? ____listen to music

_____watch T.V. _____play video games _____computer

____read _____exercise _____other (explain)_____

I want to work with: ___Materials/things ___People ___Alone

When I'm working I like to: ___sit _____stand _____move around

Comments_____

_____

_____

Attachment B

APPRAISAL/NEEDS AND SERVICES PLAN

CLIENT'S/RESIDENT'S NAME | DATE OF BIRTH | AGE | SEX ☐ MALE ☐ FEMALE | DATE

FACILITY NAME | ADDRESS | CHECK TYPE OF NEEDS AND SERVICES PLAN: ☐ ADMISSION ☐ UPDATE

PERSON(S) OR AGENCY(IES) REFERRING CLIENT/RESIDENT FOR PLACEMENT | FACILITY LICENSE NUMBER | TELEPHONE NUMBER ( )

Licensing regulations require that an appraisal of needs be completed for specific clients/residents to identify individual needs and develop a service plan for meeting those needs. If the client/resident is accepted for placement the staff person responsible for admission shall jointly develop a needs and services plan with the client/resident and/or client's/resident's authorized representative referral agency/person, physician, social worker or other appropriate consultant. Additionally, the law requires that the referral agency/person inform the licensee of any dangerous tendencies of the client/resident.

NOTE: *For Residential Care Facilities for the Elderly, this form is not required at the time of admission but must be completed if it is determined that an elderly resident's needs have not been met.*

BACKGROUND INFORMATION: *Brief description of client's/resident's medical history/ emotional, behavioral, and physical problems; functional limitations; physical and mental; functional capabilities; ability to handle personal cash resources and perform simple homemaking tasks; client's/resident's likes and dislikes.*

NEEDS	OBJECTIVE/PLAN	TIME FRAME	PERSON(S) RESPONSIBLE FOR IMPLEMENTATION	METHOD OF EVALUATING PROGRESS
SOCIALIZATION — Difficulty in adjusting socially and unable to maintain reasonable personal relationships				
EMOTIONAL — Difficulty in adjusting emotionally				

(Continued on Reverse)

PHYSICIAN'S REPORT FOR COMMUNITY CARE FACILITIES

For Resident/Client Of, Or Applicants For Admission To, Community Care Facilities (CCF).

NOTE TO PHYSICIAN:
The person specified below is a resident/client of or an applicant for admission to a licensed Community Care Facility. These types of facilities are currently responsible for providing the level of care and supervision, primarily nonmedical care, necessary to meet the needs of the individual residents/clients.

THESE FACILITIES DO NOT PROVIDE PROFESSIONAL NURSING CARE.
The information that you complete on this person is required by law to assist in determining whether he/she is appropriate for admission to or continued care in a facility.

FACILITY INFORMATION (To be completed by the licensee/designee)

NAME OF FACILITY: TELEPHONE: 4321134

ADDRESS: NUMBER STREET CITY

LICENSEE'S NAME: TELEPHONE: FACILITY LICENSE NUMBER:

RESIDENT/CLIENT INFORMATION (To be completed by the resident/authorized representative/licensee)

NAME: TELEPHONE:

ADDRESS: NUMBER STREET CITY SOCIAL SECURITY NUMBER:

NEXT OF KIN: PERSON RESPONSIBLE FOR THIS PERSON'S FINANCES:

PATIENT'S DIAGNOSIS (To be completed by the physician)

PRIMARY DIAGNOSIS:

SECONDARY DIAGNOSIS: LENGTH OF TIME UNDER YOUR CARE:

AGE: HEIGHT: SEX: WEIGHT: IN YOUR OPINION DOES THIS PERSON REQUIRE SKILLED NURSING CARE? ☐ **YES** ☐ **NO**

TUBERCULOSIS EXAMINATION RESULTS: DATE OF LAST TB TEST:

ACTIVE INACTIVE NONE

TYPE OF TB TEST USED: TREATMENT/MEDICATION: ☐ **YES** ☐ **NO** If YES, list below:

OTHER CONTAGIOUS/INFECTIOUS DISEASES:

A) ☐ **YES** ☐ **NO** If YES, list below:

TREATMENT/MEDICATION:

B) ☐ **YES** ☐ **NO** If YES, list below:

ALLERGIES

C) ☐ **YES** ☐ **NO** If YES, list below:

TREATMENT/MEDICATION:

D) ☐ **YES** ☐ **NO** If YES, list below:

Ambulatory status of client/resident:

1. This person is able to independently transfer to and from bed: ☐ Yes ☐ No

2. For purposes of a fire clearance, this person is considered:

Ambulatory Nonambulatory Bedridden

Nonambulatory: A person who is unable to leave a building unassisted under emergency conditions. It includes any person who is unable, or likely to be unable, to physically and mentally respond to a sensory signal approved by the State Fire Marshal, or to an oral instruction relating to fire danger, and persons who depend upon mechanical aids such as crutches, walkers, and wheelchairs.
Note: A person who is unable to independently transfer to and from bed, but who does not need assistance to turn or reposition in bed, shall be considered non-ambulatory for the purposes of a fire clearance.

Bedridden: For the purpose of a fire clearance, this means a person who requires assistance with turning or repositioning in bed.

I. PHYSICAL HEALTH STATUS: GOOD FAIR POOR	COMMENTS: YES NO (Check One)	ASSISTIVE DEVICE	COMMENTS:
1. Auditory impairment			
2. Visual impairment			
3. Wears dentures			
4. Special diet			
5. Substance abuse problem			
6. Bowel impairment			
7. Bladder impairment			
8. Motor impairment			
9. Requires continuous bed care			

II. MENTAL HEALTH STATUS: GOOD FAIR POOR	COMMENTS: NO PROBLEM	OCCASIONAL	FREQUENT	IF PROBLEM EXISTS, PROVIDE COMMENT BELOW:
1. Confused				
2. Able to follow instructions				
3. Depressed				
4. Able to communicate				

III. CAPACITY FOR SELF CARE: YES NO	COMMENTS: YES NO (Check One)	COMMENTS:
1. Able to care for all personal needs		
2. Can administer and store own medications		
3. Needs constant medical supervision		
4. Currently taking prescribed medications		
5. Bathes self		
6. Dresses self		
7. Feeds self		
8. Cares for his/her own toilet needs		
9. Able to leave facility unassisted		
10. Able to ambulate without assistance		
11. Able to manage own cash resources		

PLEASE LIST OVER-THE-COUNTER MEDICATION THAT CAN BE GIVEN TO THE CLIENT/RESIDENT, AS NEEDED, FOR THE FOLLOWING CONDITIONS:

CONDITIONS	OVER-THE-COUNTER MEDICATION(S)
1. Headache	
2. Constipation	
3. Diarrhea	
4. Indigestion	
5. Others *(specify condition)*	

PLEASE LIST CURRENT PRESCRIBED MEDICATIONS THAT ARE BEING TAKEN BY CLIENT/RESIDENT:

1. _____ 4. _____ 7. _____
2. _____ 5. _____ 8. _____
3. _____ 6. _____ 9. _____

PHYSICIAN'S NAME AND ADDRESS: TELEPHONE: DATE:

PHYSICIAN'S SIGNATURE

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION (TO BE COMPLETED BY PERSON'S AUTHORIZED REPRESENTATIVE)
I hereby authorize the release of medical information contained in this report regarding the physical examination of:

PATIENT'S NAME:

TO (NAME AND ADDRESS OF LICENSING AGENCY):

SIGNATURE OF RESIDENT, POTENTIAL RESIDENT AND/OR HIS/HER AUTHORIZED REPRESENTATIVE ADDRESS: DATE:

CONSENT FOR EMERGENCY MEDICAL TREATMENT

AS THE PARTICIPANT (OR CONSERVATOR IF NECESSARY), I HEREBY GIVE MY CONSENT TO

_____TO PROVIDE ALL EMERGENCY OR DENTAL CARE PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR _____

THIS CARE MAY BE GIVEN UNDER WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF PERSON NAMED ABOVE.

PARTICIPANT HAS THE FOLLOWING MEDICATION ALLERGIES:

_____ _____

DATE SIGNATURE OF PARTICIPANT OR CONSERVATOR

HOME ADDRESS

HOME PHONE WORK PHONE

E-SOL

Authorization to Administer Medication

Participants name_____

Program_____

Medication_____

Generic Name (if applicable)_____

Dosage_____

Times to be administered_____

Doctors name (printed)_____

Doctors' signature_____

Date_____

FUNCTIONAL CAPABILITY ASSESSMENT

Licensees of Adult Residential and Social Rehabilitation Facilities must obtain the following information prior to placement. The Licensee can obtain this assessment information from the applicant or his/her authorized representative. Adult Day Care Facilities and Adult Day Support Centers may use this form to identify the functional ability of the applicant as required. The licensee must maintain this information in the client's file as a part of the Needs and Services Plan.

Note: Residential Care Facilities for the Elderly may use this form to assess the person's functional capabilities as required in Section 87584 of the regulations.

CLIENT'S NAME	DATE OF BIRTH	AGE	SEX
			☐ MALE ☐ FEMALE

Check the box that most appropriately describes clients ability:

BATHING:
- ☐ Does not bathe or shower self.
- ☐ Needs help with bathing or showering.
- ☐ Bathes or showers without help.

DRESSING:
- ☐ Does not dress self.
- ☐ Needs help with dressing.
- ☐ Dresses self completely.

TOILETING:
- ☐ Not toilet trained.
- ☐ Needs help toileting.
- ☐ Uses toilet by self.

TRANSFERRING:
- ☐ Unable to move in and out of a bed or chair.
- ☐ Needs help to transfer.
- ☐ Is able to move in and out of a bed or chair.

CONTINENCE:
- ☐ No bowel and/or bladder control.
- ☐ Some bowel and/or bladder control.
- ☐ Use of assistive devices, such as a catheter.
- ☐ Complete bowel and/or bladder control.

EATING:
- ☐ Does not feed self.
- ☐ Feeds self with help from another person.
- ☐ Feeds self completely.

GROOMING:
- ☐ Does not tend to own personal hygiene.
- ☐ Needs help with personal hygiene tasks.
- ☐ Handles own personal hygiene.

Check the box that most appropriately describes clients ability:

REPOSITIONING:
- ☐ Unable to reposition.
- ☐ Repositions from side to side.
- ☐ Repositions from front to back and back to front.

WHEELCHAIR:
- ☐ Unable to sit without support.
- ☐ Sits without support.
- ☐ Uses wheelchair.
- ☐ Needs help moving wheelchair.
- ☐ Moves wheelchair by self.

VISION:
- ☐ Severe vision problem.
- ☐ Mild/moderate vision problem.
- ☐ Wears glasses to correct vision problem.
- ☐ No vision problem.

HEARING:
- ☐ Severe hearing loss.
- ☐ Mild/moderate hearing loss.
- ☐ Wears hearing aid(s).
- ☐ No hearing loss.

COMMUNICATION:
- ☐ Does not express verbally.
- ☐ Expresses by facial expressions or gestures.
- ☐ Expresses by sounds or movements.
- ☐ Expresses self verbally.

WALKING:
- ☐ Does not walk.
- ☐ Walks with support.
- ☐ Uses walker.
- ☐ Walks well alone.

Describe client's medical history and/or conditions:

List prescription medicine:

List non-prescription medicine:

Describe mental and/or emotional status:

Able to follow instructions? YES NO

Confused/disoriented? YES NO

Participates in social activities? YES NO | Active | Withdrawn

Is there a history of behaviors resulting in harm to self or others that require supervision? YES NO
If YES, provide date _____ and describe last occurrence:

Does he/she have ability to manage own finances and cash resources? YES NO

Is there any additional information that would assist the facility in determining client's suitability for admission? If YES, describe: YES NO

SIGNATURE OF APPLICANT OR AUTHORIZED REPRESENTATIVE

DATE COMPLETED

SIGNATURE OF LICENSEE OR FACILITY REPRESENTATIVE

DATE COMPLETED

E-SOL

SEIZURE PROCEDURES

1. Current medical information on a consumer's seizure condition must be provided by a Physician. This medical information must be updated at least annually.

2. If a consumer has any type of seizure, parents will receive a repot of the incident.

3. If a consumer has a partial seizure that lasts more than 15 minutes, the parents, or the emergency contact, will be called in order to remove the consumer from the program so medical attention can be obtained. In the event neither parent or the emergency contact can be reached, staff will attempt (as situation demands) to take consumer to the ER, or 911 will be called.

4. The staff will follow Emergency First Aid and Care Procedures of the Red Cross.

5. If a consumer has repeated or frequent seizures, parents may be asked to obtain medical attention in order for the consumer to continue in the program.

I agree with the above procedures

_____

Signature of Parent/Guardian Date

E-SOL

PHOTOGRAPHIC RELEASE FORM

We do hereby give our consent to E-SOL to photograph, and without limitation, to use such pictures in connection with any of the work of the organization, and/or purposes of publication in printing matters. Such pictures will always appear in good taste and will not be used to exploit.

PARTICIPANT_____

PARENT/GUARDIAN_____

SIGNATURE_____

DATE_____

If above named participant is over age 18 and unconserved, he or she must sign for themselves.

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

RECORD OF CLIENT'S/RESIDENT'S SAFEGUARDED CASH RESOURCES

Client/resident: Your signature below indicates you have received the following amount of money from the facility on the date indicated.

Facilities that handle client's/resident's cash resources must maintain accurate records of all money received and disbursed.

NAME OF CLIENT/RESIDENT:

INSTRUCTIONS:

1) *The date of the transaction shall be noted under Date.*
2) *Use a separate line for each transaction.*
3) *Supporting receipts for purchases shall be filed in order of dates of purchases.*
4) *The client's/resident's (or client's/resident's representative) signature on this form may serve as a receipt for cash distribution to the client/resident. (Sec. 80026(h)(1)(A) and 87227(g)(1)(A).*
5) *The facility representative's signature is necessary to be able to verify a cash transaction.*

FACILITY NUMBER:

YEAR

DATE	DESCRIPTION	AMOUNT RECEIVED	AMOUNT SPENT OR WITHDRAWN	BALANCE	SIGNATURE FOR CASH TRANSACTIONS	
					FACILITY REPRESENTATIVE	CLIENT/RESIDENT OR REPRESENTATIVE

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

TELECOMMUNICATIONS DEVICE NOTIFICATION

- ☐ ADULT RESIDENTIAL FACILITY
- ☐ RESIDENTIAL CARE FACILITY FOR THE ELDERLY
- ☐ FOSTER FAMILY HOME
- ☐ SOCIAL REHABILITATION FACILITY
- ☐ SMALL FAMILY HOME
- ☐ GROUP HOME
- ☐ ADULT DAY SUPPORT CENTERS
- ☐ ADULT DAY CARE FACILITIES

NOTICE

Any deaf or hearing impaired, or otherwise impaired resident of any community care facility is entitled to equipment and service by the telephone company, pursuant to Section 2881 of the Public Utilities Code, to improve the quality of their telecommunications. Any resident who has a declaration from a licensed professional or a state or federal agency pursuant to Section 2881 of the Public Utilities Code, that he or she is deaf or hearing impaired, or otherwise disabled should contact the local telephone company and ask for assistance in obtaining this equipment and service.

This section shall not be construed to require, in any way, the licensee to provide a separate telephone line for any resident.

CLIENT SIGNATURE | DATE

CONSERVATOR/RESPONSIBLE PARTY/AUTHORIZED REPRESENTATIVE SIGNATURE | DATE

FACILITY NAME | FACILITY ADDRESS

FACILITY REPRESENTATIVE SIGNATURE | DATE

CALIFORNIA PUBLIC UTILITIES CODE
SECTION 2881 (a) and (c)

2881. (a) The commission shall design and implement a program whereby each telephone corporation shall provide a telecommunications device capable of serving the needs of individuals who are deaf or hearing impaired, together with a single party line, at no charge additional to the basic exchange rate, to any subscriber who is certified as an individual who is deaf or hearing impaired by a licensed physician and surgeon, audiologist, or a qualified state or federal agency, as determined by the commission, and to any subscriber that is an organization representing individuals who are deaf or hearing impaired, as determined and specified by the commission pursuant to subdivision (e). A licensed hearing aid dispenser may recommend an individual to a licensed physician and surgeon or audiologist for purposes of participation in the program.

(c) The commission shall also design and implement a program whereby specialized or supplemental telephone communications equipment may be provided to subscribers who are certified to be disabled at no charge additional to the basic exchange rate. The certification, including a statement of medical need for specialized telecommunications equipment, shall be provided by a licensed physician and surgeon acting within the scope of practice of his or her license, or by a qualified state of federal agency as determined by the commission.

DISTRIBUTION:
White: CLIENT
Yellow: CLIENT FILE
Pink: CLIENT REPRESENTATIVE

LIC 9158 (2/00)

PERSONAL RIGHTS
ADULT COMMUNITY CARE FACILITIES

Each client shall have rights, which include, but are not limited to the following:

(1) A right to be treated with dignity, to have privacy and to be given humane care.

(2) A right to have safe, healthful and comfortable accommodations, including furnishings and equipment to meet your needs.

(3) A right to be free from corporal or unusual punishment, infliction of pain, humiliation, intimidation, ridicule, coercion, threat, mental abuse, or other actions of a punitive nature. To be free from restraining devices, neglect or excessive medication.

(4) A right to be informed by the licensee of provisions in the law regarding complaints, including the address and telephone number of the licensing agency, and of information regarding confidentiality.

(5) A right to attend religious services and activities . Participation in religious services and other religious functions shall be on a completely voluntary basis.

(6) A right to leave or depart the facility at any time, and to not be locked into any room or building, day or night. This does not prohibit the development of house rules, such as the locking exterior doors or windows, for the protection of the consumer.

(7) A right to visit a facility with a relative or authorized representative prior to admission.

(8) A right to have communications between the facility and your relatives or authorized representative answered promptly and completely, including any changes to the needs and services plan or individual program plan.

(9) A right to be informed of the facility's policy concerning family visits. This policy shall encourage regular family involvement and provide ample opportunities for family participation in activities at the facility.

(10) A right to have visitors, including advocacy representatives, visit privately during waking hours provided the visits do not infringe upon the rights of other consumers.

(11) A right to possess and control your own cash resources.

(12) A right to wear your own clothes, to possess and use your own personal items, including your own toilet articles.

(13) A right to have access to individual storage space for your private use.

(14) A right to have access to telephones, to make and receive confidential calls, provided such calls do not infringe on the rights of other clients and do not restrict availability of the telephone in emergencies.

(15) A right to promptly receive your unopened mail.

(16) A right to receive assistance in exercising your right to vote.

(17) A right to receive or reject medical care or health-related services, except for those whom legal authority has been established.

(18) A right to move from a facility in accordance with the terms of the admission agreement.

Reference:

California Code of Regulations, Title 22, Division 6 - General Licensing Regulations, Section 80072; Section 81072, Social Rehabilitation Facilities; Section 85072, Adult Residential Facilities; Section 87872, Residential Care Facilities for the Chronically Ill.

PERSONAL RIGHTS
ADULT COMMUNITY CARE FACILITIES

EXPLANATION: The California Code of Regulations, Title 22 requires that any person admitted to a facility must be advised of his/her personal rights. Facilities are also required to post these rights in areas accessible to the public. Consequently, this form is designed to meet both the needs of persons admitted to facilities and the facility owners who are required to post these rights.

This form describes the personal rights to be afforded each person admitted to an adult community care facility. The form also provides the complaint procedures for the client and representative/conservator. The facility staff or client representative must communicate these rights in a manner appropriate for client's ability.

This form is to be reviewed, completed and signed by each client and/or each representative/conservator upon admission to the facility. The client and/or representative/conservator also has the right to receive a completed copy of the originally signed form. The original signed copy shall be retained in the client's file which is maintained by the facility.

TO: CLIENT OR AUTHORIZED REPRESENTATIVE:

Upon satisfactory and full disclosure of the personal rights as explained, complete the following acknowledgment:

ACKNOWLEDGMENT: At the time of admission I have been personally advised of, and have received a copy of the personal rights contained in the California Code of Regulations, Title 22.

(PRINT THE NAME OF THE FACILITY) _____ (PRINT THE ADDRESS OF THE FACILITY) _____

(PRINT THE NAME OF THE CLIENT) _____

(SIGNATURE OF THE CLIENT) _____ (DATE) _____

(SIGNATURE OF THE REPRESENTATIVE/CONSERVATOR) _____

(TITLE OF THE REPRESENTATIVE/CONSERVATOR) _____ (DATE) _____

THE CLIENT AND/OR THE REPRESENTATIVE/CONSERVATOR HAS THE RIGHT TO BE INFORMED OF THE APPROPRIATE LICENSING AGENCY TO CONTACT REGARDING COMPLAINTS. THIS AGENCY IS:

NAME _____

ADDRESS _____

CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER
		( )