Employee # _____

EASTER SEALS FLORIDA, INC.
PAYROLL INFORMATION

New Hire: All Information Required **Changes: * Fields Required & Changes Only**

*Name: _____ *Start/Change Date: _____

Address: _____ Gender: ☐ Female ☐ Male

City, State, Zip: _____ Race: _____

Mailing Address: (if different) _____ Date of Birth: _____

Home Phone Number: _____ S.S.#: _____

Cell Phone Number: _____ Email address: _____

Title: _____ Home Location/Service/Grant: _____

(Use only approved job titles from position management sheet) ***(i.e. 0100-00-000)***

Allocation: _____ _____ _____

Location – service – grant % Location – service – grant % Location – service – grant %

Please check one of the following: ☐A-80 ☐A-75 ☐B-75 ☐A-70 ☐A-6O
☐SY70 ☐SY75 ☐SYE75 ☐PT ☐AS NEEDED _____

 # Hours to Work per Week

Salary/Hourly **Range** for position/title: _____ Thru _____

Starting Non-Exempt Salary Information: _____ = _____ per hour

Starting Exempt Salary Information: _____ = _____ biweekly

Supervisor Name: _____

Position Number: _____ Old Position Number (if applicable): _____

Post-Offer Time Off Request (dates): _____ to _____
(Maximum to be approved by supervisor is two weeks. Accrued applied time off must be exhausted, if any)

Comments: _____

_____

_____

***For Easterseals business cards &/or name tag, email the Executive Assistant.**

_____ _____
Vice President Signature Date

HEADQUARTERS USE ONLY

☐ FSOAP ☐ Certipay ☐ TimeCo ☐ NHP ☐ NHL ☐ Ins Pk/Ltr
☐ PMS ☐ LEIE ☐ NSOPW ☐ EVerify ☐ Training ☐ ReviewSnap
☐ MVR ☐ Ins Tracker ☐ Drug Test Results

DIRECT DEPOSIT REQUEST FORM

EMPLOYEE NAME_____ LOCATION_____

Please initiate Direct Deposit to my checking or savings account(s). I am requesting full/partial deposit. (If partial, please indicate amount.)

Checking Account
A voided check is required for checking accounts

Full_____ Partial_____ Amount_____

OR

Savings Account
A Spec Sheet completed by your financial institution is required for credit union and savings accounts.

Full_____ Partial_____ Amount_____

PLEASE READ

By completing this form, I agree to keep Easterseals Florida Human Resources Department informed of changes to my banking relationship, and agree to be responsible for any charges which may occur because of a lapse in information. I understand and agree that any funds deposited in error by Easterseals Florida, or other causes, belong to Easterseals Florida and reimbursement is expected. Easterseals Florida has my authorization to electronically remove funds deposited in error to my account. Easterseals Florida will not re-issue payroll checks until notified in writing from the bank the funds have been returned to Easterseals Florida's account.

The only time a paper check will be issued, is while you are in the bank processing waiting period, which includes: starting, stopping or changing your banking accounts.

_____ _____

Signature Date

Easter Seals Florida, Inc.
Post Offer Voluntary Self-Identification

Name: _____ **Date** _____
Last **First** **M.I.**

Position: _____

To: Employee

Easter Seals Florida is subject to certain government recordkeeping and reporting requirements for administration of civil rights laws and regulations. In order to comply with these laws, we invite you to voluntarily self-identify. All information requested below will be protected as confidential and refusal to provide it will not subject the employee to any adverse treatment. If you would like assistance completing this form, please contact Human Resources for help.

It is the policy of Easter Seals Florida to provide equal employment opportunity for all candidates and employees. Easter Seals Florida does not discriminate on the basis of race, color, religion, sex, sexual orientation, national origin ancestry, age, medical condition, disability, veteran status, marital status, or any other protected class under applicable federal, state, and local laws. Information provided will not be considered in any part of the selection process.

Gender (Sex) Information:

- ☐ Female
- ☐ Male

Please check the applicable box next to your race / ethnic group in Section A. If you identify with more than one of the groups below, please indicate this by selecting the <u>one</u> group you primarily identify with in Section A and checking the box in Section B. A. Individual Race / Ethnicity Information:

Section A: **Individual Race/Ethnicity**

- ☐ **American Indian or Alaska Native (not Hispanic or Latino):** A person having origins in any of the original peoples of North America and South America (including Central America), and who maintains tribal affiliation or community attachment.
- ☐ **Asian (not Hispanic or Latino):** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent. The area includes China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- ☐ **Black or African American (not Hispanic or Latino):** A person having origins in any of the Black racial groups of Africa.
- ☐ **Hispanic or Latino:** A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.
- ☐ **Native Hawaiian/Pacific Islander (not Hispanic or Latino):** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- ☐ **White (not Hispanic or Latino):** A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.

Section B. Two or More Races:

- ☐ **TWO OR MORE RACIAL / ETHNIC GROUPS: (Not Hispanic or Latino)** – All persons who identify with more than one of the racial / ethnic groups (above) except Hispanic or Latino.

Easter Seals Florida, Inc.
Post Offer Voluntary Self-Identification Veterans

Name: _____ **Date** _____
Last **First** **M.I.**

Position: _____

To: Employees

Easter Seals Florida is subject to certain government recordkeeping and reporting requirements for administration of civil rights laws and regulations. In order to comply with these laws, we invite you to voluntarily self-identify. All information requested below will be protected as confidential and refusal to provide it will not subject the employee to any adverse treatment. If you would like assistance completing this form, please contact Human Resources for help.

It is the policy of Easter Seals Florida to provide equal employment opportunity for all candidates and employees. Easter Seals Florida does not discriminate on the basis of race, color, religion, sex, sexual orientation, national origin ancestry, age, medical condition, disability, veteran status, marital status, or any other protected class under applicable federal, state, and local laws.

Information provided will not be considered in any part of the selection process.

If you believe you belong to any of the categories of protected veterans listed below, please indicate by checking the appropriate box(es) below:

☐ **DISABLED VETERAN:** A veteran of the U.S. military, ground, naval or air service who is entitled to compensation (or who but for the receipt of military retired pay would be entitled to compensation) under laws administered by the Secretary of Veterans Affairs, or a person who was discharged or released from active duty because of a service-connected disability.

☐ **RECENTLY SEPARATED VETERAN:** A veteran during the three-year period beginning on the date of such veteran's discharge or release from active duty in the U.S. military, ground, naval or air service.

☐ **ACTIVE DUTY WARTIME OR CAMPAIGN BADGE VETERAN:** A veteran who served on active duty in the U.S. military, ground, naval or air service during a war or in a campaign or expedition for which a campaign badge has been authorized, under the laws administered by the Department of Defense.

☐ **ARMED FORCES SERVICE MEDAL VETERAN:** A veteran who, while serving on active duty in the U.S. military, ground, naval or air service, participated in a United States military operation for which an Armed Forces service medal was awarded pursuant to Executive Order 12985.

☐ **I AM NOT A PROTECTED VETERAN.**

If you have a disability, what, if any, accommodation will enable you to perform the position for which you have been hired?

_____

_____

_____

☐ **I DECLINE TO PROVIDE MY SELF-IDENTIFICATION DETAILS.**

Voluntary Self-Identification of Disability

Why are you being asked to complete this form?

Because we do business with the government, we must reach out to, hire, and provide equal opportunity to qualified people with disabilities.[i] To help us measure how well we are doing, we are asking you to tell us if you have a disability or if you ever had a disability. Completing this form is voluntary, but we hope that you will choose to fill it out. If you are applying for a job, any answer you give will be kept private and will not be used against you in any way.

If you already work for us, your answer will not be used against you in any way. Because a person may become disabled at any time, we are required to ask all of our employees to update their information every five years. You may voluntarily self-identify as having a disability on this form without fear of any punishment because you did not identify as having a disability earlier.

How do I know I have a disability?

You are considered to have a disability if you have a physical or mental impairment or medical condition that substantially limits a major life activity, or if you have a history or record of such an impairment or medical condition.

Disabilities include, but are not limited to:

- Blindness
- Deafness
- Cancer
- Diabetes
- Epilepsy
- Autism
- Cerebral palsy
- HIV/AIDS
- Schizophrenia
- Muscular dystrophy
- Bipolar disorder
- Major depression
- Multiple sclerosis (MS)
- Missing limbs or partially missing limbs
- Post-traumatic stress disorder (PTSD)
- Obsessive compulsive disorder
- Impairments requiring the use of a wheelchair
- Intellectual disability (previously called mental retardation)

Please check one of the boxes below:

☐ YES, I HAVE A DISABILITY (or previously had a disability)
☐ NO, I DON'T HAVE A DISABILITY
☐ I DON'T WISH TO ANSWER

_____ _____

Your Name Today's Date

Reasonable Accommodation Notice

Federal law requires employers to provide reasonable accommodation to qualified individuals with disabilities. Please tell us if you require a reasonable accommodation to apply for a job or to perform your job. Examples of reasonable accommodation include making a change to the application process or work procedures, providing documents in an alternate format, using a sign language interpreter, or using specialized equipment.

Footnotes:

[i] Section 503 of the Rehabilitation Act of 1973, as amended. For more information about this form or the equal employment obligations of Federal contractors, visit the U.S. Department of Labor's Office of Federal Contract Compliance Programs (OFCCP) website at www.dol.gov/ofccp.

PUBLIC BURDEN STATEMENT: According to the Paperwork Reduction Act of 1995 no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. This survey should take about 5 minutes to complete.

LOCATION:

Communication Release Form

Yes, I would like to receive information from Easterseals Florida.

_____ _____

Guardian / Caregiver - Print Name Date

_____

Email Address

_____

Signature

Client Name_____

Please list any other family members or friends you would like to invite in receiving information from Easterseals.

Print the persons name below and print their email address:

_____ _____

_____ _____

_____ _____

_____ _____

EASTER SEALS FLORIDA, INC.
INTAKE FORM

DATE: _____

PROGRAM(S):

- ❑ DayBreak
- ❑ Altrusa House
- ❑ ADT Palm Bay
- ❑ Palm Bay (VR)-Employment Svcs
- ❑ Murray Center
- ❑ Amar Center
- ❑ Easterseals Academy Naples
- ❑ Naples LEAP

CLIENT INFO:

Client Name: _____
(Last) (First)

Client DOB: _____ Medicaid# _____

❑ Medicaid HMO: _____

Client SS#: _____ ❑ Part C (Attach IFSP) ❑ School Board (Attach IEP)

Sex: *(circle one)* M F Therapy *(circle one)* : PT OT SPL EI ABA

Race: _____ Diagnosis: _____

Veteran Status: (circle one) Active Military Veteran Family Member (active or veteran) None

PARENT/GUARDIAN INFO:

Parent/Guardian Name: _____
(Last) (First)

Billing Address: _____
(Street address) (City, State, Zip)

Home phone: _____ Cell phone: _____

Work phone: _____ Email: _____

Parent/Guardian SS#: _____ DOB: _____

FUNDER(s) INFORMATION

Funder #1 _____ Funder #2 _____

Funder #3 _____

*Attach authorization documentation for all funders listed.

** If client also has insurance , attach "Insurance Verification" form along with a front and back copy of the insurance card.

Easterseals Florida

Adult Day Training Program Application for Services

Section I - Participant Information

Name (Last):_____ (First): _____ (Middle):_____

Address: _____

Email Address: _____ Phone: _____

Date of Birth: _____ Age: ___ Place of Birth: _____

Legally Competent: _____

Primary Disability:_____Secondary Disability: _____

Medicaid Waiver: _____

Private Pay: _____ If private pay, are you on the Medicaid Waiver waitlist: _____

Transportation: SCAT Bus_____ ES Van: _____ Private: _____

Days Attending ADT Program: _____ Arrival Time_____ Departure Time_____

Section II— Family/Guardian Information

Father's Name: _____ Mother's Name: _____

Address: _____

Phone: _____ Email Address: _____

Legal Guardian (if applicable): _____ Relationship: _____

Address: _____

Phone: _____ Email Address: _____

Emergency Contact (other than parent or guardian)

Name: _____ Phone: _____

Relationship: _____

Persons authorized to remove consumer from ADT program:

Section III - Medical Information

Medical Coverage: _____

Primary Physician: _____ Phone: _____

Hospital Preference: _____

Allergies: _____

Medical Conditions (please list all): _____

_____

Current Medications: _____

_____

Date of last physical: _____

Physician: _____ Phone: _____

Assistive Devices: _____

Additional Medical Concerns: _____

_____

Section IV - Vocational History

Previous Work Experience (if applicable):
_____

_____

Section V- Reason for Referral

Please indicate training needs expressed by individual:

Additional Information:

Section V- Support Coordinator Information (if applicable)

Name: _____

Address: _____

Phone: _____ Cell: _____ Fax:_____

Email: _____

Easterseals Florida Vocational Services Agreement
Self-pay/Medicaid Waiver/iBudget/CDC

Name: _____

Address:_____

Home Phone:_____ **Cell Phone**:_____

I, _____request the following services from Easterseals Florida:

☐ **Adult Day Training** ☐ **Transportation** ☐ **Community Employment**

I have received a Vocational Services Adult Day Training Program Handbook, a copy of this agreement, a copy of SCAT/ES Van Rules and completed all required forms before admission. I do hereby agree to the following terms and conditions for the admission of:
Name _____

Private pay consumers: **PAYMENT IS DUE ONE WEEK IN ADVANCE** and payable weekly unless other arrangements have been made. Established ADT rate is $_____per day but may be subject to change upon written notice. The ADT Program is a daily rate regardless of the number of hours spent in the program. The consumer will not be retained in the program if she/he requires services beyond ability of the program. If you would like to use Easterseals transportation services, the cost will be $_____per one-way trip. Use of van will be contingent on space. Pick-up and drop-off times **may change** based on transportation needs. Payment is due **ONE WEEK IN ADVANCE** and payable weekly unless other arrangements have been made.

PLEASE NOTE: Any delinquency in payments will result in consumer suspension from program and/or transportation services until outstanding balance is paid.

Medicaid Waiver/iBudget/CDC consumers: I understand I am financially responsible for services not covered by the iBudget/CDC Program.

Consumer: _____**Date:** _____

Parent/Guardian/Caregiver: _____ **Date:** _____

Easterseals Florida - Adult Day Training Program
DATE:_____
Updated: _____

Health/Behavioral/Emotional Information

Consumer Name: _____

Sex: _____ Date of Birth:_____

Home address:

_____

_____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Parent/Guardian(s):_____

Address, if different:_____

_____

Phone:_____ Email:_____

Contact Person: _____

Address: _____

Phone: _____ Cell number: _____

Email Address: _____

Emergency Contact Person: _____

Phone number:_____ Cell number: _____

Doctor/Physician Name: _____

Phone: _____

Primary Diagnosis: _____

Allergies: _____

_____

Seizures_____ **How Often?**_____

Cancer_____**Glaucoma**_____

Lung Condition_____ **Diabetes**_____ **Multiple Sclerosis**_____

High Blood Pressure_____ **Arthritis**_____**Heart condition** _____

Other: _____

_____

Surgery within the past 5 years: (describe) _____

_____

Diet Restrictions: _____

_____

_____

Hospital Preference: _____

_____

IDENTIFY ALL CURRENT MEDICATIONS

Will consumer be taking any medications during his/her day at Easterseals Programs?_____

Please list all current medications:

Medication Name: _____ **Dosage and Schedule:** _____

Purpose: _____ **Side effects noted:** _____

Medication Name: _____ **Dosage and Schedule:** _____

Purpose: _____ **Side effects noted:** _____

Medication Name: _____ **Dosage and Schedule:** _____

Purpose: _____ **Side effects noted:** _____

Medication Name: _____ **Dosage and Schedule:** _____

Purpose: _____ **Side effects noted:** _____

Medication Name: _____ **Dosage and Schedule:** _____

Purpose: _____ **Side effects noted:** _____

Medication Name: _____ **Dosage and Schedule:** _____

Purpose: _____ **Side effects noted:** _____

Describe any current behavioral and emotional health concerns and/or issues that program staff should be aware of:

Authorization – Use of Disclose Protected Health Information Media and Testimonial Release for Adult

Date: _____

Name: _____

Birth Date: _____ Last 4 Numbers Social Security # | | | | |

_____
Street Address Apt #

_____
City State ZIP

We appreciate the fact that you would like to provide information, a testimonial or comment about your experience or care received from us. With your permission and authorization we may use your information in printed materials, on our web site, on social media we create (e.g. Twitter, Facebook, Instagram), and we may release it to the media. We may send text messages e.g. photos internally to other Easterseals Florida staff to obtain approval prior to use. Please understand this may involve the use or disclosure of information protected by federal health privacy law that requires your authorization first. We will use or disclose only information you authorize. We may respond to a comment you post on social media we maintain or thank you for your testimonial. If we respond or thank you we will not use or disclose any information you have not previously authorized. Any narratives, depictions, pictures, film, photographs, audio-visual or sound recordings or testimonials of you made by Easterseals Florida or its respective employees and agents may be used by Easterseals Florida, and those acting with its permission, for the purpose of illustration, broadcast, or testimonial in connection with the work of Easterseals Florida and these materials may be released to the general public. You assign to Easter Seals Florida all of your rights to these materials. This form explains your authorization. Please use it to authorize Easterseals Florida to use or disclose your information. We will give you a copy.

Authorization

I authorize Easterseals Florida to use and disclose information described in Section 1 of this form to publish information, a testimonial or comment about my experience or care I have received. This includes posting my comment on social media maintained by or for Easterseals Florida. My authorization to use my information extends to any persons working on behalf of Easterseals Florida to create or maintain materials in any format that may include my information, testimonial or comment including but not limited to printed materials, web sites and social media. I authorize Easterseals Florida to respond to any comment or testimonial I provide to the extent that its response does not use or disclose any protected health information other than the information described in this authorization.

1. Description of information to be used or disclosed
   For your convenience you may check one or more boxes describing information to be used or disclosed in your comment or testimonial.

☐ Client's photograph	☐ Client's name	☐ Client's initials only
☐ a comment I write	☐ recording (video or audio) of client	
☐ client story		
☐ any other information described in the box below		

2. Identification of persons to whom use or disclosure of the information described in Section 1 may be made
   The information described above may be used or disclosed to the general public who may view or read the information on materials created by or for Easterseals Florida including but not limited to photographs, videos, printed materials, web sites and social media.
3. Purpose
   The purpose of this Authorization is to permit Easterseals Florida to use or disclose the information described in Section 1 for public relations and marketing purposes by publication in any medium it creates or is created on its behalf including but not limited to its web site, social media, social media web site, newsletters, printed materials and press releases. Easterseals Florida will not receive any payment or financial remuneration from anyone for use or disclosure of this information. The materials created by Easterseals Florida, its employees and agents are owned by Easterseals Florida. The materials do not need to be submitted to me for further approval.
4. Expiration Date of this Authorization
   This authorization shall be valid - unless I revoke it earlier in writing - for ten (10) years following the date of the authorization.

I understand

1. I may revoke this authorization at any time by giving Easterseals Florida notice of my revocation in writing to Rikesha Blake, Corporate Compliance Officer, 520. N. Semoran Blvd., Orlando, FL 32746
2. My revocation of this authorization will not apply to information used or disclosed as permitted by this authorization before I give Easterseals Florida written notice of my revocation.
3. Easterseals Florida may not condition my treatment or payment, enrollment or eligibility for benefits on whether I sign this authorization.
4. Information disclosed as permitted by this authorization may be re-disclosed by persons who receive it and is no longer protected by federal health information privacy law.
5. I have a right to request and receive a copy of this authorization.
6. I will not receive any payment or financial remuneration for the information I am authorizing Easterseals Florida to use and disclose by this authorization.

I understand this Authorization to Use or Disclose Protected Health Information for Testimonials and Social Media, signed it voluntarily and received a copy.

Signature, Individual/ Personal Representative _____

Name, Personal Representative (if any) _____

Personal Representative's Authority to Act _____

☐ Identity of the Individual verified

or

☐ Identity, Authority to Act of Personal Representative verified

Received and confirmed for Easterseals Florida
by:

_____

Signature Printed Name and Title

AUTHORIZATION AND CONSENT FORM

Client Name: _____Date: _____

GUARANTEE OF PAYMENT: For and in consideration of services rendered or to be rendered to this client by EASTER SEALS FLORIDA, I/WE, individually and jointly, here to agree to pay any and all bills rendered for said client which are not covered by insurance and/or third party payers, or otherwise paid. I understand and agree that all bills are payable and become due upon presentation.
X _____

ASSIGMENT OF INSURANCE BENEFITS: I/WE authorize and direct payment of the medical benefits arising from insurance or other coverage through which the client is insured and covered, any and all other proceeds from any insurance and/or settlement or judgment, or out of a claim or lawsuit, directly to EASTER SEALS FLORIDA, but not to exceed the regular charges for services provided. I understand that I am responsible for all charges not paid through the above sources. I understand that I am responsible for any insurance deductible, co-pay and co-insurance.
X _____

AUTHORIZATION TO RELEASE INFORMATION: I/WE authorize EASTER SEALS FLORIDA to release medical and all other information as required for collection of benefits from insurance carriers or other third party sources of payment in connection with the illness or injury of the client, and I/WE authorize benefits be made in my behalf to EASTER SEALS FLORIDA. I/WE authorize release of medical information regarding client's care and treatment at the center to referring physicians and other I/WE may determine.
X _____

SIGNATURE ON FILE: I authorize use of this form on all my insurance submissions, I authorize EASTER SEALS FLORIDA to act as my agent in helping me obtain payment directly to EASTER SEALS FLORIDA. I permit a copy of this authorization to be used in place of the original.
X _____

I CERTIFY THAT I FULLY UNDERSTAND THE NATURE OF THE ABOVE STATEMENTS.

Signature: _____ Date: _____
Client:_____
Witness: _____

EASTERSEALS FLORIDA

Adult Day Training Program

EMERGENCY MEDICAL RELEASE

I grant permission to Easterseals Florida to secure emergency medical treatment for myself, or son/daughter, in the event it is needed.

Signature of Program Participant: _____

Date: _____

Signature of Legal Guardian, if applicable: _____

Date: _____

Signature of Witness: _____

Date: _____

Is the individual above legally competent? _____ yes _____ no

Easterseals Florida

PARTICIPANT'S CIVIL AND ABUSE RIGHTS

Easterseals Florida agrees that it will comply with Title VI of the Civil Rights Act of 1964, as amended, 42 U.S.C. 2000d et seq., prohibiting discrimination on the basis of race, color, or national origin in programs and activities receiving or benefiting from federal financial assistance.

Easterseals Florida agrees that it will comply with Section 504 of the Rehabilitation Act of 1973, as amended 29 U.S.C. s.794(a), et.seq., in regard to employees or applicants for employment.

Easterseals Florida agrees that it will comply with Title XI of the Education Amendments of 1972, as amended, 29 U.S.C. 2000e, et seq., which prohibits discrimination on the basis of sex in education programs and activities receiving or benefiting from federal financial assistance.

Easterseals Florida agrees that it will comply with the Omnibus Budget Reconciliation Act of 1981, P.L. 97-35, prohibiting discrimination on the basis of sex or religion in programs and activities that receive or benefit from federal financial assistance.

Easterseals Florida agrees that it will comply with Chapter 415.1034, F.S. stating that an employee of the provider who knows, or has reasonable cause to suspect, that a individual receiving services from Development Disabilities is being abused, neglected, or exploited, shall immediately report such knowledge or suspicion to the central abuse registry and tracking system of DCF using the statewide toll-free telephone number (1-800-96ABUSE).

Easterseals Florida agrees that it will comply with the Americans with Disabilities Act of 1990 P.L.101-336, prohibiting discrimination, based on disability, in employment, public accommodations, transportation, state and local government services and telecommunications.

Easterseals Florida agrees that it will comply with Title 42, Code of Federal Regulations (CFR) 431.51, which states that each individual served will be afforded freedom of choice within the scope of available funding levels.

Easterseals Florida will uphold the rights and privileges of recipients with developmental disabilities as specified in Chapter 393.13, F.S. "The Bill of Rights of Persons Who Are Developmentally Disabled".

I have been informed (verbally and in writing) and understand my civil and abuse rights.

_____ _____

Date Consumer Signature or Authorized Representative

Easterseals Florida
VOCATIONAL SERVICES

CONSUMER GRIEVANCE PROCEDURE

Procedure- To Resolve any Issues that the Consumer has regarding their Program
And involve all Resources (Family, Guardians, and/or Provider)

Grievance: – If you feel that you have been treated unfairly or disagree with any element of your program at Easterseals, you should contact your Group Supervisor or a LEAD Activities Trainer. You can make contact verbally or in writing. It is important to contact someone immediately (or at least within two (2) weeks of the occurrence). A copy of all complaints will be kept in the Center Director's office.

If you feel more comfortable discussing your concerns with your family or Support Coordinator, they can assist you and participate in the problem solving process with your Supervisor or Lead Activities Trainer.

You may also report your concerns anonymously by calling the Easterseals Compliance Hotline at 407-588-7133, open 24 hours a day.

Resolution- A meeting with the Consumer Services Coordinator will be scheduled to discuss and resolve the problem. You may invite anyone you wish to attend this meeting with you. The Consumer Services Coordinator will respond to your problem verbally and in writing within five (5) days. A copy of the written response will be kept in the Center Director's office.

Appeals- If the Consumer Services Coordinator is unable to solve your grievance, the next step in the process is to meet with the Center Director. You may invite anyone you wish to attend this meeting with you. The Center Director will respond to your problem verbally and in writing within five (5) days. If there is still no resolution, your grievance will be heard by the Vice President of Programs and within ten days, will make the final decision.

==========

I have read (or have had someone read to me) and understand the procedure that is in place to resolve any problem that I have with my Easterseals Vocational Program

I also understand that Easterseals Florida does not allow any form of retaliation (negative actions, ignoring, laughing at, termination) against employees who file a grievance or who participate in an investigation.

_____ _____
Consumer Date

_____ _____
Parent/Guardian Date

Easterseals Florida
Adult Day Training Program

Consumer Safety Agreement

As a condition of participation, I do hereby agree to comply with the following safety procedures:

1. I agree to follow established departmental safety procedures as outlined in the Vocational Services ADT Program Handbook.

2. I agree to report any accident or injury to my supervisor or closest available staff member as soon as it occurs, prior to seeking medical attention but no later than the end of the program day.

3. If I require medical treatment due to an illness or injury during program hours, I agree to the following procedure:

    a. If illness or injury requires immediate medical attention, Easterseals staff will call 911 and consumer's parent or emergency contact person. Staff will accompany consumer to the hospital in the event that parent of emergency contact person is not present. Staff will remain with consumer at the hospital until family is present.

    b. If illness or injury does not require immediate medical attention, Easterseals staff will contact consumer's parent or emergency contact person to remove the consumer from program if necessary.

I understand that failure to comply with the above procedures could result in disciplinary action.

_____ _____
Consumer Signature Date

_____ _____
Witness/Guardian, if applicable Date

Easterseals Florida
Adult Day Training Program - Rockwell Collins Enclave
Eligibility Form

Consumer Name: _____

Is Consumer Eligible: _____YES _____NO

Date of Eligibility: _____

Name/Title of Person (s) making determination of eligibility or non-eligibility:

_____

_____

Eligibility Criteria - Check all statements that apply to this consumer:

- An adult, at least 18 years of age or older
- Demonstrates maturity level necessary to participate at enclave setting
- Is free from violent or disruptive behavior and profane language
- Demonstrates respect for the property of others
- Demonstrates socially appropriate behavior in public places
- Communicates a desire to participate in the program
- Is medically stable and has adequate stamina
- Is able to independently feed and toilet him/herself
- Is able to function in a one (1) to three (3) trainer to consumer ratio
- Dresses appropriately in workplace attire
- Is able to independently understand simple directions
- Is able to communicate effectively with ES trainer, Rockwell staff and peers either verbally, using sign language or with the use of assistive technology

Consumers who do not satisfy 100% of the above criteria will not be considered eligible for participation in the enclave. Any failure to demonstrate adherence to the above criteria will result in removal from the enclave program. Keep in mind that Rockwell Collins has its own rules and policies that our consumers must follow. These are the same rules and policies that apply to their own employees.

Eligibility to participate will be reviewed annually.

I have read or have read to me the above eligibility criteria necessary to participate in the Rockwell Collins enclave program. I understand that if I do not adhere/follow the above criteria, I will be removed from the enclave program.

_____ _____

Consumer signature **Date**

_____ _____

Parent/Guardian signature **Date**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY

Notice to patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

Please print your name here

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this client but it could not be obtained because:

- o The client refused to sign
- o Other *(please provide specific details)*

_____

_____

_____

_____

_____ _____

Employee signature *Date*

ACUSE DE RECIBO DEL AVISO DE PRIVACIDAD

Aviso a los pacientes:

Estamos obligados a proporcionarle una copia de nuestro Aviso de prácticas de privacidad, que establece cómo podemos usar y / o divulgar su información de salud. Por favor firme este formulario para acusar recibo de la notificación. Usted puede negarse a firmar este reconocimiento, si lo desea.

Reconozco que he recibido una copia del Aviso de esta oficina de prácticas de privacidad.

_____

Por favor escriba su nombre aquíse

_____

Firma

_____

Fecha

PARA USO DE LA OFICINA

Hemos hecho todos los esfuerzos para obtener el reconocimiento de recibo por escrito de nuestro Aviso de Privacidad de este cliente, pero no se pudo obtener debido:

- El cliente se negó a firmar
- Otro (indique los detalles específicos)

_____

_____

_____

_____

_____

_____

Firma del Empleado *Fecha*

WELCOME TO EASTERSEALS!

This handbook is designed to help you get to know our Adult Day Training Program, act as a general guide for you to follow and to answer any questions or concerns you might have.

The staff is here to help you do your very best and want you to succeed in whatever tasks you choose.

The rules in this handbook are for you to know and follow. Please read them over carefully and discuss them with your parents/guardians, support coordinator, support staff or a member of our Adult Day Training Program staff. These rules are not meant to restrict your activities but are in place to make sure your work areas are safe, pleasant and a productive place for you and for all of us at Easterseals.

ADMISSIONS

Applicants are reviewed on an individual basis to ensure criteria fulfillment. All admissions forms and other requested information must be complete, accurate, and on file before services begin. Each new consumer, upon admission, will serve a **90-day probationary period -** a trial period to make sure you, as a consumer, can follow the program rules. The ADT program retains the right, when warranted, to limit or remove you from the program.

Upon entering the ADT program, you will be evaluated on your abilities and skills. We also want to learn about your interests and job preferences. During this initial 90-day period, you will be paid for the work you do.

ATTENDANCE

As with any good employee, we expect that you attend the program on all your scheduled days. However if you are sick, we hope that you will stay home so as not to make others ill. If you cannot come to work, please call your staff and your bus/van to cancel your ride. It is your responsibility to call us as you would any employer.

If you stop coming to the ADT program without previously notifying your staff, you may be considered to have abandoned your slot in our program. Your slot may be given to another consumer. It is very important that you let us know of your plans during long absences.

HOURS OF OPERATION

Easterseals ADT Program is open Monday- Friday. The center opens daily at 8am and **closes promptly at 4pm.** A late fee will be charged a one dollar per minute penalty charge for every minute after 4:00 p.m. *(e.g., 4:01 p.m., late fee is $1.00, 4:02 p.m.; late fee is $2.00 and so on).* These fees are due at pick-up time. If the fees are not paid at pick-up, they must be paid before the consumer will be allowed to return to the program.You will be provided with a calendar of holiday closures upon registration into the program, annually thereafter.

PROPER DRESS

All consumers are expected to dress neatly and appropriately in clean clothes suitable for a work setting. This is a place of business and your appearance is important. Clothes should not be overly revealing (no halter tops, tube tops, etc.). Clothes and accessories shall not convey messages that are crude; vulgar/profane; violent/ death-oriented; sexually suggestive; and/or promote alcohol, drugs, or tobacco. Open-toed shoes, high heels, crocs and "flip-flops" are not to be worn. Please bring to work and keep in your locker a spare set of clothing in case of accidents.

GENERAL BEHAVIOR

Good manners and courteous conduct make being together both pleasant and safe. Running, pushing, yelling, stealing, banging on furniture, fighting, the use of profanity and making a mess of

the program areas or bathrooms is not appropriate behavior. Speaking quietly with your co-workers and keeping your workspace clean and neat is appreciated and expected. Consumers should also respect each other's right to privacy. It is also not appropriate to gossip or spread rumors.

PAY POLICY

Consumers are paid for the work they perform. ADT consumers are paid on piece-rate basis or sometimes an hourly wage. Each consumer will be paid in accordance with the federal guidelines applying to the Department of Labor regulations. Paydays are every other week. Your check will be directly deposited in your bank. All appropriate income and Social Security taxes will be withheld in accordance with federal laws.

HEALTH AND SAFETY

Each consumer will report any accident or injury to their supervisor or the nearest available staff member.
If you become ill or are injured in the ADT program, immediately notify the nearest staff member. If emergency medical assistance is needed, your parent/guardian/caregiver will be notified and you will be transported to the nearest medical facility. Consumers who arrive ill or become ill during the day will have arrangements made to allow them to return home as soon as possible. In the case of a serious or contagious illness, permission from the doctor will be required to return to work.
To insure your safety in the case of fire or other emergencies, Easterseals conducts both announced and unannounced

fire/evacuation/disaster drills. All consumers will be expected to participate in these drills. Consumers will leave the building in an orderly fashion and report to a designated area until the drill is complete. At all times you must follow the directions of staff members. If you have any questions about our emergency procedures, please ask your supervisor.
Staff and consumers must always be alert to any potential dangers. Practicing safety precautions at all times is extremely important. Consumers should report any real or potential danger to the first staff member they see. All consumers will obey safety rules. Any necessary safety equipment will be worn at appropriate times.

EMERGENCY OR FIRE

In an emergency or fire, you will be directed by staff members to go to the nearest exit in an orderly fashion. Be considerate of others, especially those who may have difficulty walking or using wheelchairs or walkers. Never run to the exit. You will be directed to a specific gathering place where you will remain until the "all clear" is given.

VISITORS AND PHONES

While Easterseals has an "open door policy" regarding visits, we encourage you to keep them to a minimum to avoid frequent disruptions in the workplace.
Easterseals will **not be liable** for the loss of cellular phones, iPads, or other personal items brought into the workplace. Excessive personal calls during the workday, regardless of the phone used (personal or company), can interfere with work productivity and be distracting to others. Any phone calls a

consumer needs to make while in the program, should be of high importance or an emergency. Consumers are asked to make personal calls during non-work time (i.e. break time, lunch time) when possible and to ensure that friends and family members are aware of the policy.

DIGITAL MEDIA DEVICES

Due to privacy matters and HIPAA regulations, the use of personal camera phones, cameras, and other digital media devices are prohibited without written consent from each participating consumer. Easterseals will **not be liable** for the loss of personal digital media devices or personal items brought into the workplace.

LEAVING THE PROGRAM AREA

No consumer should leave the program building without notifying a staff member. Even when someone is here to pick you up early, please make sure you let a staff member know so you can be "checked out". Do not assume a staff member saw you leave. ADT staff members need to know where you are at all times when you are in our program.

HARASSMENT

Easterseals will not tolerate any forms of harassment. It is our intent to investigate all complaints and encourage fair and full processing of any harassment allegations. Appropriate disciplinary action will be taken if determined that harassment has occurred.

GRIEVANCE PROCEDURE

As a consumer at Easterseals, you have the right to tell your supervisor if you do not like the way you have been treated or do not agree with something in the program. It is important to tell someone right away. If you feel more comfortable, you may talk to your family or support coordinator. If your supervisor and Lead Activities Trainers cannot solve your problem, you can meet with the Consumer Services Coordinator. If they cannot solve your problem, you can meet with the Center Director for a meeting and invite whomever you would like to attend. The Center Director will respond to your problem in writing and by talking to you within five (5) days. If this does not solve the problem, you can take your problem to the Vice President of Programs. She will give you a decision within ten (10) days, and this will be the final decision.

* Easterseals Florida does not allow any form of retaliation (negative actions, ignoring, laughing at, termination) against employees who file a grievance or who participate in an investigation.*

EQUAL EMPLOYMENT OPPORTUNITY POLICY

It is Easterseals policy that no person shall, on the basis of race, color, religion, national origin, sex, age or disability be excluded from participation in, be denied the benefits of, or be subject to unlawful discrimination under any program or activity receiving or benefiting from federal financial assistance and administered

by the Agency for Persons with Disabilities/DCF or other such programs.
Our Equal Employment Policy provides that job opportunities are afforded to all and that applications and employees are evaluated on the basis of job qualifications. In this policy is the commitment to maintain a place of employment and work environment that is safe, productive and free of harassment and intimidation based on such things as religion, sex, national origin or age.

PARTICIPANT'S CIVIL AND ABUSE RIGHTS

Easterseals Florida agrees that it will comply with:

- Title VI of the Civil Rights Act of 1964, which prohibits discrimination on the basis of race, color, or national origin in programs and activities receiving or benefiting from federal financial assistance.
- Section 504 of the Rehabilitation Act of 1973, in regard to employees or applicants for employment.
- Title XI of the Education Amendments of 1972, which prohibits discrimination on the basis of sex in education programs and activities receiving or benefiting from financial assistance.
- Omnibus Budget Reconciliation Act of 1981, which prohibits discrimination on the basis of race, creed, color, national origin, sex, handicap, political affiliation or beliefs in programs and activities receiving or benefiting from federal financial assistance.
- Americans with Disabilities Act of 1990, which prohibits discrimination based on disability in employment, public accommodations, transportation, state and local government services and telecommunications.
- Title 42, Code of Federal Regulations (CFR) 431.51, which states that each individual served will be afforded freedom of choice within the scope of available funding levels.

- Chapter 415, Florida Statues, that states: An employee of the provider who knows, or has reasonable cause to suspect, that a child, aged person or disabled adult is or has been abused neglected, or exploited, shall immediately report such knowledge or suspicion to the central abuse registry and tracking system of the Department on the single-wide toll-free telephone number (1-800-96ABUSE).

CONSUMER BILL OF RIGHTS

Every consumer has rights that are followed every day in our Vocational Services Programs. The Consumer Bill of Rights was a law passed to protect and give importance to rights for individuals with disabilities.

- The right to dignity, privacy and humane care.
- The right to religious freedom and practice.
- The unrestricted right to communication.
- The right to personal possessions and effects.
- The right to education and training.
- The right to participate in community activities and to social interaction.
- The right to prompt and appropriate medical care and treatment.
- The right to behavioral and leisure time activities.
- The right to physical exercise.
- The right to humane discipline.
- The right to physical examination prior to subjection to a treatment program to eliminate bizarre or unusual behaviors.

- The right to minimum wage protection and fair compensation.
- The right to vote.
- The right to be free from physical restraint.
- The right to a central record.

CONSUMER RECORDS ACCESS

Consumer records/files are confidential and only certain people may look at your files:

- The consumer may have access at any time. Staff may be used to help a consumer understand information in their file.
- The consumer's legal guardian will have access to the consumer's file.
- APD or other directly involved contract-related staff would have access to a consumer's file for monitoring or other purposes.
- A written release signed by a consumer or a legal guardian would allow access by other individuals.

MEDICATIONS

All consumers are encouraged to take care of medication needs outside of program hours if at all possible. However, if it is required that a consumer take medication (prescribed or over-the-counter) during program hours, arrangements will be made for you to take them after all necessary paperwork has been

submitted to the center as defined in Florida Administrative Code Chapter 65G-7.
This paperwork is required to be updated annually or medications will not be administered to the consumer while in the center.

PROGRAM AREAS AND OPPORTUNITIES

The ADT program will offer you opportunities to be involved in some of the following activities and programs: regularly scheduled exercise, arts and crafts activities, contract work fulfillment, the Life, Employment & Community (LEC) Skills Program, off-site work enclaves, the ES cleaning crew, community outings and community employment services if you have been referred for this service.

CONSUMER GOVERNMENT

Within our ADT program, is a consumer-run government. It is formed by and for the consumers benefit and needs and is made up of program participants without direct staff involvement. Staff is available for help and guidance if it is requested. The Consumer Government meets monthly, and officers are nominated and elected annually from and by the consumers.

STAFF MEMBER ROLES

In our Vocational Services Programs, different staff members do different things. They work together to give you the help you need to reach your goals. These are the staff working in the ADT program:

- Center Director – is in charge of the overall program and related program areas, supervises other staff members and helps ensure you are treated with respect and dignity and also achieve your goals at Easterseals.
- ADT Supervisor – is responsible for getting contract work into the workshop and will make sure you are paid fairly for the work you do. The ADT Supervisor also directly oversees the Activities Trainers.
- Consumer Services Coordinator – is here to help staff members train you to reach your goals. The Coordinator will help the Center Director provide important trainings, help you set up your goals every year, and write reports on your progress in our program.
- Transportation Supervisor – is responsible for keeping the Easterseals vans in good and safe condition. The Transportation Supervisor will help set up your transportation on our vans should you decide to use them. This person supervises the van drivers.
- LEC Teacher – If you choose to attend LEC classes, the teacher will help you work on goals of your choice. In LEC, you can learn computer, personal/social, life, employment-readiness, literacy and community skills.
- Activities Trainers – These are the staff members who work directly with you in the workshop areas. They are here to train you in all skill areas and keep track of your progress towards meeting your goals.

WAITING LIST

The ADT Program will make every effort to serve all qualified individuals. There may be times when a waiting list must be

established to assure an orderly intake of consumers. Individuals will be placed on a list in order of their application to the ADT Program. As openings occur, the next person on the list will be moved into the ADT Program.

SUSPENSION

In accordance with the Agency for Persons with Disabilities (APD) policy, you may be temporarily suspended for up to three (3) days due to violation of program rules or behaviors that place you or others at risk.

TERMINATION

If the Center Director determines that due to misconduct or health reasons your continued participation is inappropriate or does not meet program guidelines, and all steps have been taken in accordance with APD regulations, you may be terminated. Misconduct would include destructive, unsafe, threatening or otherwise hazardous behaviors, which place the consumer or other consumers or staff at risk.

Adult Day Training Program
Consumer Handbook Acknowledgement

I, _____,
have read/or have had read to me and understand the contents of the ADT Program Handbook. I have received a copy of the handbook upon admission to the Adult Day Training Program.

_____ _____
Date **Consumer Signature**

_____ _____
Date **Parent/Caregiver/Guardian Signature**

Consumer Choices & Preferences

Name: _____ **Date:** _____

I like to:	Yes	No	Comments
Work alone			
Work in a group			
Other			
What kinds of jobs do you like to do?			
Assembly			
Recycling			
Sorting			
Packaging			
Labeling			
Other			
What activities would you like to participate in?			
Volunteering			
Arts & Crafts			
Exercise			
Community outings			
Other			
Things I would like to learn about:			
Computer skills			
Money skills			
Community employment			
Other			

Consumer Signature: _____ **Date:** _____

Guardian Signature, if applicable: _____

Assisted by, if necessary: _____

Staff Signature & Title

PERSON-CENTERED PLANNING OUTLINE

Do you have an Implementation Plan?

- Yes. Every year or when you would like to make changes, Easterseals staff will help you develop an Implementation Plan

How is your Implementation Plan developed? How are you involved in the development of your Implementation Plan?

- Your IP will be developed with you to help you meet your support plan goals
- You select the people you would like to be present at your IP meeting and the day/time you would like to have your meeting
- You will be involved in the development of your plan and everything will be explained to you in a clear and understandable manner

How are your goals developed? Who helps you with your goals and outcomes?

- You will choose options and choices that are based on your needs and preferences
- Your Consumer Services Coordinator, your Support Coordinator, your family or friend or anyone you choose can assist you with developing your goals and outcomes

Can you make changes/ updates to your plan and goals if you want too? How do you make changes/ updates to your IP Plan and/or goals?

- Yes! You can make changes at any time to your IP
- You can talk with your Support Coordinator, parents/family or Easterseals staff about making changes to your IP Plan or goals
- You will have another IP meeting to talk about and make these changes

Will anyone talk to you about your progress on your plan/ goals?

- Yes, your Easterseals "Supervisor", Consumer Services Coordinator or ADT Supervisor will talk to you on a regular basis about your progress on your goals
- You have an annual Support Plan and IP meeting in which you can talk about your progress on your goals and if you would like to keep working on them or choose new goals

How is it decided what staff will provide your services? How do you select a different service / staff if you want it?

- It is your choice to decide who will provide your services – you decide!
- If you have an issue with an Easterseals staff, you can talk to your supervisor or Consumer Service Coordinator or Support Coordinator and they will help you select a different staff
- If you would like to select a different service, your Support Coordinator or Easterseals staff can help you do this and provide you with other options

Person-Centered Planning has been reviewed with consumer upon admission to ADT Program:

Date read or reviewed with consumer: _____ Consumer Name:_____

Staff name/title:_____ Consumer Signature:_____

EASTERSEALS FLORIDA

Adult Day Training Program

Annual Orientation on Competitive Employment Opportunities

Supported Employment- Provides training and assistance in a variety of activities to support the individual in sustaining employment.

Activities could include training to assist the person to learn, retain or improve specific job skills, and to successfully adapt and adjust to a particular work environment.

Competitive Employment- Work performed by a person with a disability in an integrated setting at minimum wage or higher and at a rate comparable to non-disabled workers performing the same tasks.

Orientation conducted by: _____ _____

Signature **Title**

I have read (or have had someone read to me) and understand Easterseals Adult Day Training program is not my only option for employment.

I understand that I can choose to work in the community and may be able to receive help in finding work through an agency such as Vocational Rehabilitation or the Agency for Persons with Disabilities.

_____ _____

Consumer Signature Date

_____ _____

Parent/Guardian Signature Date

VOCATIONAL SERVICES Index: 1309
OPERATIONAL PROCEDURES Issued: 2/18

SECTION: CONSUMER RIGHTS

SUBJECT: REASONABLE MODIFICATIONS

Purpose: To ensure Easterseals Florida Palm Bay programs and services are accessible to individuals with disabilities.

Responsibility: The Center Director and Supervisors will have primary responsibility for ensuring all consumers are provided safe, reliable, efficient and accessible services.

Procedure:

1. Easterseals Florida will make reasonable modifications to its policies and procedures to avoid discrimination and ensure individuals with disabilities have equal access to all services.
2. Reasonable modifications exceptions would include those that:
    - Cause a direct threat to the health and/or safety of others
    - Result in a fundamental alteration of the nature of the service
    - Are not necessary in order for the individual with a disability to fully utilize Easterseals services
3. Requests for reasonable modifications in an Easterseals program or service should contact the Associate Vice President of Programs at 561-471-1688.