A-1 Community Choice LLC
"Where Individuals Come First"

Weekly Schedule

Recipient Name: _____Date:_____

Circle Service Provided: Personal Supports Life Skills Level 1 Respite

Services are provided at a mutually agreed upon time:

Times are approximate based on recipient's choices. They are subject to change.

Saturday	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday

Services are provided at a mutually agreed upon setting:

Check areas that apply:

At clients home	
In the community	

350 N. Washington Ave
Suite B
Titusville, FL 32796
Phone 321-269-8563
Fax 1-321-267-5708
a1communitychoice@hotmail.com

A-1 Community Choice LLC
"Where Individuals Come First"

Health and Welfare

Name: _____ Sex: _____Male
_____Female

Date Completed:_____

Date of Birth: _____ Medicaid ID Number: _____

Doctor: _____ Phone: (_____)_____

Dentist: _____ Phone: (_____)_____

Current Medications:

Name of Medication:	Amount:	Time:	Taken For:

Please record Behavioral/Emotional & Physical. If it does not apply record N/A!!

- Behavioral: _____
  _____
- Emotional: _____
  _____
- Physical: _____
  _____
- Others: _____
- Allergies:_____

Emergency Contacts:

	Name:	Relationship:	Phone:
1st:			
2nd:			

350 N. Washington Ave
Suite B
Titusville, FL 32796
Phone 321-269-8563
Fax 321-267-5708
a1communitychoice@hotmail.com

A-1 Community Choice LLC
"Where Individuals Come First"

Recipients Rights and Responsibilities

Below is a list of rights and responsibilities for recipients receiving services with A-1 Community Choice LLC. If you have any questions at any time please ask your provider or office staff.

1. To have access to all records pertaining to my welfare.
2. To participate in programs designed to afford substantial opportunities to have access to the community.
3. To be suitably dress and given assistance in maintaining body hygiene and reasonable grooming.
4. To be fully informed of my Medial Conditions and the right to refuse treatment.
5. To be treated with consideration, respect and full recognition of my dignity and individuality.
6. If Adjudicated incompetent in accordance with Florida State law,(this can only be done by a judge; documentation is necessary) to have my advocate or guardian act on my behalf in order to be sure that my rights are implemented according to Florida State law.
7. To be permitted to have the choice of available physicians or any other health care provider.
8. To participate in activities, social, religious, and community groups at my discretion.
9. To associate and communicate privately with persons of my choice.
10. To refuse services or care without fear or restraint, reprisal, interference, coercion, or discrimination.
11. To have confidential treatment of my case-files and records therein.
12. To be free from emotional and physical abuse and from chemical and physical restraints except in emergencies; justification by a doctor for a specified and limited period of time may occur; this will be documented in the case file.
13. I am aware that I may express dissatisfaction and make recommendations for changes in delivery of services and or policies.
14. I am encouraged and assisted to learn to exercise my rights as a consumer and a citizen. “Assistance with voting procedures is available from several sources upon request”.
15. **I have the right to be transferred to another available service location or another provider at my request.**
16. I and/or my guardians shall be given reasonable notice of changes in Support Coordinators, unless deemed an emergency.
17. I and/or my guardians have the right of file complaints using the established “Grievance Policies”.
18. I and/or my guardians shall be informed of their rights via the written “Due Process Pamphlet” published by DCF.
19. To be fully informed of all services that are available to me and in writing of services I actually receive.
20. Any person with a developmental disability has the right to be free from Abuse, Exploitation, and/or Neglect. “Zero Tolerance”. Abuse hotline 1-800-96-ABUSE. * All providers are “Mandatory Reporters” for suspected incidents of abuse, neglect, and/or exploitation.

RECIPIENT ACKNOWLEDGEMENT

I have had the above rights reviewed to me. I understand its contents to the best of my ability. I have received The Bill of Rights of Persons Who Are Developmentally Disabled from A-1 Community Choice LLC. It has been explained to me and I understand its contents to the best of my ability.

Recipient Name_____
(please print)

Recipient Signature _____Date_____

Parent and/or Guardian Signature_____ Date_____

A-1 Community Choice LLC
"Where Individuals Come First"

Grievance Policy & Procedure

PURPOSE: To develop a consistent method in which any problem, complaint, suggestion, or question receives a timely response from A-1 Community Choice LLC supervisors and management.

POLICY: When a recipient, their family and/or guardian, disagrees with established rules of conduct, policies, or practices, they can express their concern through the grievance procedure. No recipient will be penalized, formally or informally, for voicing a complaint with A-1 Community Choice LLC or for using the grievance procedure.

PROCEDURE: When a situation occurs where the recipient, their family and/or guardian, believes that a decision affecting them is unjust or inequitable, they are encouraged to make use of the following steps. The recipient, their family and/or guardian, may discontinue the procedure at any step.

1. The recipient, their family and/or guardian, presents the problem to management. If management is unavailable or the recipient, their family and/or guardian, believes it would be inappropriate to contact that person, they may present the problem to the owner.

2. The manager responds to problem during discussion or after consulting with appropriate parties and documents discussion.

3. If the recipient, their family and/or guardian is not satisfied with the results of the discussion with the manager, the recipient, their family and/or guardian, can present the problem to the owner.

4. The owner responds to problem during discussion or after consulting with appropriate parties, when necessary. The discussion will be documented.

5. The owner reviews and considers problem. The owner has the full authority to make any adjustment deemed appropriate to resolve the problem.

6. If the recipient, their family and/or guardian is still not satisfied with the results of the final disposition by the owner, a hearing may be requested in accordance with Florida Statues or they must request a change in services and/or provider.

These grievance procedures will be reviewed annually and signed by the recipient, family and/or guardian. These procedures will be communicated in clear, understandable language to the recipient, family and/or guardian.Responses to grievances will be provided verbally and in writing at the recipient's level of comprehension and in the language understood.

A log of all grievances filed by the recipient, family and/or guardian, will be maintained and will include the following information:

a) The name of the recipient making the complaint and his/her relationship to the recipient receiving services;
b) The date the complaint is received;
c) A clear description of the complaints. Oral complaints will be documented in writing. All complaints should be retained in the recipient's file and a copy retained with the grievance log.
d) The date of the final disposition of each complaint.

RECIPIENT ACKNOWLEDGEMENT

I have received a copy of the A-1 Community Choice LLC Grievance Policy for Recipients served. It has been explained to me and I understand its contents.

Recipient Name_____
(please print)

Recipient Signature _____Date_____

Parent and/or Guardian Signature_____ Date_____

A-1 Community Choice LLC
"Where Individuals Come First"

SATISFACTION SURVEY

Recipients Name:_____

Date Completed:_____

Name of Provider (s): _____

_____

The following Satisfaction Survey may be completed by the recipient or with the recipient's primary caregiver.

	YES	NO	DON'T KNOW	COMMENT
Are you satisfied with the services that you are receiving?				
Do you feel you are treated with dignity and respect?				
Do you feel that all of your needs are being met?				
Are your goals being addressed?				

Recipient Signature: _____

Parent/ Guardian Signature :_____

Office Use Only	
Completed By Phone:	
Spoke to:	
Completed In Person:	
Spoke to:	
Notes:	

A-1 Community Choice LLC
"Where Individuals Come First"

Recipient Choices

Recipient Name: _____

Date Completed:_____

It is important for us as providers to know your interests and dislikes. This helps us to better serve you. Please list as many things you would like to share and we will be sure to keep them in mind when providing services. This also gives the caregiver the opportunity to increase community participation based on your interests. You can make changes to this document at any time by contacting the office or sharing with your caregiver.

INTERESTS

1._____ 4._____

2._____ 5._____

3._____ 6._____

DISLIKES

1._____ 4._____

2._____ 5._____

3._____ 6._____

Additional Requests:_____

_____

Recipient Signature: _____

Parent/ Guardian Signature:_____

350 N. Washington Ave
Suite B
Titusville, FL 32796
Phone 321-269-8563
Fax 321-267-5708
a1communitychoice@yahoo.com

A-1 Community Choice LLC
"Where Individuals Come First"

Photograph/Video Release Form

I, _____
(Recipient's name)
a recipient of A-1 Community Choice LLC authorize my caregiver and agency to release information and photographs/video of myself for publications *. I understand that this information and the photographs / video may be printed in newsletters, newspapers and other written publications. I may be posted to the agency Facebook and website of any outside media group photographing/ videoing me.

_____
Signature

_____
Date

*This form does not expire unless agency is advised otherwise. At which time a new form will be filled out and recorded.

If you wish to ***NOT*** have your photo released please check here ☐

350 N. Washington Ave
Suite B
Titusville, FL 32796
Phone 321-269-8563
Fax 321-267-5708
a1communitychoice@hotmail.com