HISway, LLC
8590 W. Fairview
Boise, ID 83704
www.hiswayidaho.com

Thank you for your interest in HISway, LLC. We at HISway are dedicated to assisting individuals with disabilities to increase their independence. We will encourage individuals to advocate for themselves, and we will advocate for those who are not able. We will strive to provide the highest quality of service by providing consistency, professionalism, creativity, and teamwork.

Enclosed is an intake application packet for services. Please fill it out completely and return it as soon as possible; when received the application and releases will be processed to determine eligibility. We will be gathering a current IEP/ISP and Psychological evaluation, a copy of the most current History Physical, Doctor's referral, and any other documentation to support a Developmental Disability. If you have any of these documents, please submit them with the application; this will help expedite the process. Once the needed information is received, a professional from HISway will schedule a planning meeting to discuss the participant's needs, interests, and choices.

Thank you again for choosing HISway as your Residential Habilitation or Developmental Disability Agency. We look forward to serving you.

Sincerely,

Ellen Hampton, Administrator
HISway, LLC

HISway, LLC
Application for Services

I. General Information

Applicant Full Name: _____ Application Date:_____

Address: _____

Mailing Address (If different):_____

Applicant E-mail:_____ Applicant Telephone_____

Date of Birth (DOB): _____ Gender: Male❑ Female❑

Social Security #: _____Medicaid Number: _____

Healthy Connections Number:_____

Guardian Full Name: _____

Guardian Address:_____

Guardian Phone Number: _____Guardian E-Mail: _____

Targeted Service Coordinator/Service Coordinator:

Name: _____ Agency:_____

Phone Number:_____ E-Mail:_____

Fax Number:_____Address:_____

Please attach copies of the following for service application:

1.	Birth Certificate	❑(check if attached)
2.	Medicaid Card	❑(check if attached)
3.	Medicare Card	❑(check if attached)
4.	Photo ID/School Photo ID	❑(check if attached)
5.	Social Security Card	❑(check if attached)
6.	Guardianship Documentation	❑(check if attached)
7.	Medical Documentation	❑(check if attached)

Please attach medical documentation identifying the primary diagnosis:

Primary Diagnosis:_____

Secondary Diagnosis:_____

Current Living Arrangement:

❑ ICF-ID	❑ Certified Family Home (CFH)	❑ Family Residence
❑ Supported Living	❑ PCS Home	❑ Correctional Facility
❑ Group Home	❑ Foster Home	❑ Other:_____

Marital Status: ❑ Married ❑ Single ❑ Divorced

Religious Preference:_____

Additional Information:_____

_____

_____

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II. Medical History

Has the applicant had or does he/she currently suffer from seizures or seizure disorder?

❑ Yes ❑ No If Yes, What type? ❑ Grand Mal ❑ Petit Mal ❑ Focal Motor ❑ Other

How frequent are seizures occuring?_____

Are seizures controlled by medication?_____

Does the applicant suffer from any chronic medical conditions? ❑ Yes ❑ No

If yes please list conditions:_____

Is the applicant ambulatory? ❑ Yes ❑ No

Are there any physical disabilities or limitations? ❑ Yes ❑ No

If yes please explain:_____

Does the Applicant use any assistive devices? ❑ Yes ❑ No

If yes please explain:_____

Please list all known allergies, including medication allergies:_____

_____

Please list any recurring illnesses:_____

_____

_____

Please list any hospitalizations and surgeries: _____

_____

_____

Please list any additional relevant medical information: _____

_____
_____

Medical Contact Information

Primary Care Physician:

Name:_____Telephone Number:_____E-Mail_____

Address:_____ Fax number:_____

Counselor/Psychotherapy:

Name:_____Telephone Number:_____E-Mail_____

Address:_____ Fax number:_____

Medication Management:

Name:_____Telephone Number:_____E-Mail_____

Address:_____ Fax number:_____

Dentist:

Name:_____Telephone Number:_____E-Mail_____

Address:_____ Fax number:_____

PT/OT/Speech:

Name:_____Telephone Number:_____E-Mail_____

Address:_____ Fax number:_____

Specialist:

Name:_____Telephone Number:_____E-Mail_____

Address:_____ Fax number:_____

Specialist:

Name:_____Telephone Number:_____E-Mail_____

Address:_____ Fax number:_____

III. Service History

Has the applicant received Developmental Disability Agency (DDA) services in the past?

❑ Yes ❑ No

If Yes, Please list previous DDA(s):_____

_____

IV. Educational History

Current School or last school attended:_____

Current Grade:_____Contact Name:_____

Last Grade Completed:_____Current Teacher:_____

V. Service Needs

Current Behavioral Issues or Concerns:

❑ Verbal Assaults ❑ Physical Assaults ❑ Self-Injurious Behaviors

❑ Stealing ❑ Property Destruction ❑ Sexual Misconduct

❑ Eating Disorders ❑ Lying ❑

Other:_____

Past Behavior Issues or Concerns:

❑ Verbal Assaults ❑ Physical Assaults ❑ Self-Injurious Behaviors

❑ Stealing ❑ Property Destruction ❑ Sexual Misconduct

❑ Eating Disorders ❑ Lying ❑

Other:_____

What areas do you feel need to be focused on to address the applicant's needs?

_____

_____

_____

HISway Developmental Disabilities Program (DDA)

Requested Services:

❑ ***Adult Developmental Therapy:***

❑ Community-Based Developmental Therapy

❑ Home-Based Developmental Therapy

❑ Center-Based Developmental Therapy

❑ ***Adult Day Health***

❑ Community-Based ADH

❑ Center-Based ADH

❑ ***Children's Services (Ages 3-17)***

❑ Habilitative Supports (HS) ❑ Habilitative Intervention (HI)

If receiving Habilitative supports or Intervention are you interested in receiving:

❑ Family Training

❑ Interdisciplinary Training

Please select the day and indicate times you are requesting services:

- ❑ Monday:_____
- ❑ Tuesday:_____
- ❑ Wednesday:_____
- ❑ Thursday:_____
- ❑ Friday:_____
- ❑ Saturday:_____
- ❑ Sunday:_____

Residential Habilitation/Supported Living

Services and Supports Requested:

- ❑ **Supported Living (24-Hour Supports)**
- ❑ **Hourly Residential Habilitation**
- ❑ **Representative Payee Supports**

Please select the day and indicate times you are requesting services:

- ❑ Monday:_____
- ❑ Tuesday:_____
- ❑ Wednesday:_____
- ❑ Thursday:_____
- ❑ Friday:_____
- ❑ Saturday:_____
- ❑ Sunday:_____

HISway, LLC
Rights & Responsibilities

Any person receiving services or supports from HISway LLC shall be ensured the following rights as mandated by the Idaho Department of Health and Welfare Standards. Upon admission to HISway LLC and as appropriate thereafter, any person receiving services from HISway LLC will be informed of their rights and responsibilities as individuals in a manner that will best promote individual understanding of these rights. These rights include but are not limited to the following:

1.. Humane care and treatment.
2. Not to be put in isolation.
3. Be free from mechanical restraints, unless necessary for the safety of that person or for the safety of others.
4. Be free of mental and physical abuse.
5. Communicate by sealed mail, telephone or otherwise and to have access to private area to make telephone calls and receive visitors.
6. Receive visitors at all reasonable times and to associate freely with persons of his/her own choice.
7. Reside in the least restrictive environment or setting.
8. Voice grievances and to recommend changes in policies and /or services.
9. Practice his/her religion.
10. Ensure that Participants have the opportunity to participate in social, religious and community group activities.
11. Wear his/her own clothing and to retain and use own personal possessions.
12. Be informed of his/her own medical and habilitative condition, of services available with HISway LLC and the charges for services.
13. Reasonable access to all records concerning him/herself.
14. Refusal of services.
15. Exercise all civil rights unless limited by prior court order.
16. Privacy and confidentiality of records.
17. Be treated in a courteous manner.
18. Be treated with dignity and respect.
19. Receive a response from HISway LLC to any request made within a reasonable time frame.
20. Receive services which enhance the person's social image and personal competencies and whenever possible, promote inclusion in the community.
21. Refuse to perform services for HISway LLC if he/she is hired to perform services for HISway LLC the wage shall be paid consistent with State and Federal Law.

22. Review the results of the most recent survey conducted by the Department of Health and Welfare and the accompanying plan of correction.

HISway, LLC

Rights & Responsibilities – cont.

23. Be protected from harm:
    a. HISway LLC will ensure all individuals hired do not have a conviction or prior employment history of child abuse, neglect, mistreatment, or exploitation of an individual with whom he/she has worked and;
    b. All confirmed or suspected incidents of mistreatment, neglect, exploitation or abuse of individuals shall be reported to the Adult and Child protection authority.
24. All other rights established by law.
25. Inform each Participant, or legal guardian, of the services to be received, the expected benefits and attendant risks of receiving those services, and of the right to refuse services, and the alternate forms of services available.
26. Provide each Participant with the opportunity for personal privacy and ensure privacy during provision of services.
27. Upon admission to HISway LLC and as appropriate thereafter, any person receiving services with HISway LLC will be informed of their rights and responsibilities as individuals in a manner that will best promote individual understanding of these rights.
28. Inform each Participant, or legal guardian of the Participant's rights and rules of the agency.
29. Allow and encourage individual Participants to exercise their rights as Participants of the agency and as citizens of the United States, including the right to file complaints, and the right to due process.
30. Participants have the right of free choice of provider.

I acknowledge by signing below that I have read and received a copy of my Rights and

Responsibilities along with HISway LLC Participant Grievance Procedure.

Participant's Signature: _____ Date: _____

Guardian's Signature: _____ Date: _____

Representative of HISway LLC: _____ Date: _____

HISway, LLC
8590 W. Fairview
Boise, ID 83704
Phone: (208) 322-0262
Fax: (208) 672-0238
www.hiswayidaho.com

Advocacy and Protection resources available in this area:

Advocacy Resources:

ACCESS Unit	(208) 344-0900
Blind commission	(208) 334-3220
Family Advocacy	(208) 345-3344
Idaho Coalition for Advocacy	(208) 336-5353
Idaho Parents unlimited	(208) 342-2884
LINK	(208) 336-3335
Women's Crisis Center	(208) 343-7025

Protection Resources:

Area Agency on Aging- Adult Protection Services

Boise	(208) 489-6909

Health & Welfare- Child Protection Services:

Regular Hours	(208) 334-0800
24-Hour Emergency	(208) 334-0808

HISway LLC

Release of Records Exchange Form

This form is to authorize the exchange of information for:

Participant: _____ Birth Date: _____

Information is to be exchanged between:

HISway, LLC
8590 W. Fairview
Boise, ID 83704
Phone: (208) 322-0262
Fax: (208) 672-0238

_____
_____
_____
_____
_____
_____

Attn: _____

The following Information is being requested:

- O Medical
- O Social Evaluation
- O Current Physical
- O Developmental Evaluation
- O Psychological Evaluation
- O Functional Assessment
- O SIB-R Results
- O Speech/Communication Evaluation
- O Physical Therapy Evaluation
- O Occupational Therapy Evaluation
- O IEP
- O School Related Records
- O Healthy Connections Information
- O Other: _____

All information exchanged will be maintained confidentially. This release expires one year from the date signed by Participant of guardian. The Participant or guardian has the right to revoke this release at any time in writing, but not retroactive to the release of information made in good faith at the date indicated below or prior to the date consent is revoked.

Participant's Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Representative of HISway LLC: _____ Date: _____

Media Release Policy

I hereby give my permission to be photographed and my photograph be used by HISway, LLc on printed media such as brochures, flyers, banners, and HISway, LLC website. It is my understanding that this photograph will be used for public view.

I agree to participate without financial remuneration, and I understand that this releases HISway, LLC from any future claims, as well as from any liability, arising from the use of the said photograph,

Name:_____
_____

Address:_____
_____

City, State,
Zip:_____

Signature:_____Date:_____
_____

Parent/Guardian
Signature:_____Date:_____

This form expires one year from the signed date.