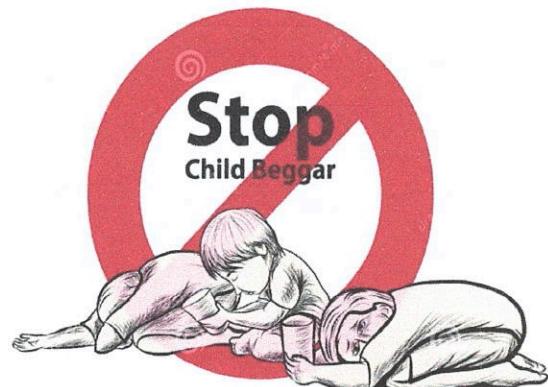
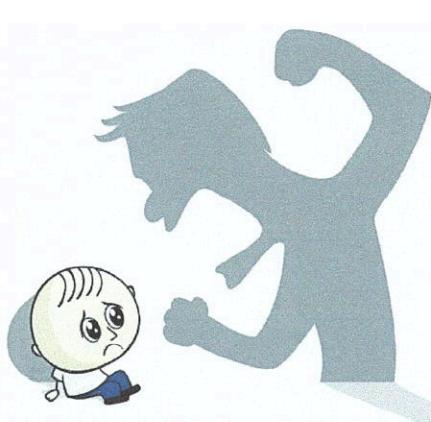




UNITED FAMILY  
HEALTHCARE INC.

## ABUSE, NEGLECT, EXPLOITATION AND REPORTING PROCESS



### There are four ways to make a report:

By Telephone: **1-800-96ABUSE** (1-800-962-2873)

By Fax: 1-800-914-0004

By TDD: 1-800-453-5145

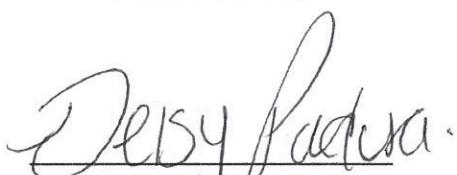
Web Reporting <http://reportabuse.dcf.state.fl.us>

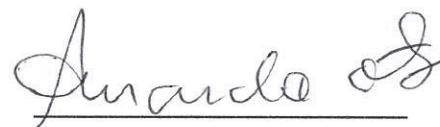
EMERGENCY: **911**

For more information,  
please scan the QR



Date: 07/20/2021

  
Desy Padua  
Individual/Guardian

  
Amanda S.  
Support Coordinator  
Phone: 305/492-5929





## Client Schedule

Client Name	Service Provided	Activities
Erick Pastrana  Diagnosis: Cerebral Palsy, Microcephaly, Encephalopathy and Brain Atrophy.	-Personal Support -Life Skills	<p>Assist Client with the following:</p> <p><b>PS</b></p> <p>1. Personal hygiene in chair, shampoo, nail care, mouth care, &amp; assist with dressing/undressing. 2. Clean, disinfect room, bathroom, and common areas. 3. Bed making, changes lines, pick up dirty clothing and take them to the laundry room, and folding clothes 4. Meal preparation and feeding 5. Incontinent care diapers 6. Lifting &amp; transferring to/from his wheelchair.</p> <p><b>LFSK</b></p> <p>1. Activities in the community 2. Doctor's appointments 3. Park, neighborhood, mall 4. Grocery shopping</p>

**Plan Goal:** PS Assistance with daily living skills, diaper change and lifting/repositioning. Erick is totally dependent also requires constant supervision and care.

**Progress note:** Erick continues to make progress toward achieving his support and services in place. The progress that was possible includes that Erick would like to continue to live his mother at home, which is the most important people for him.

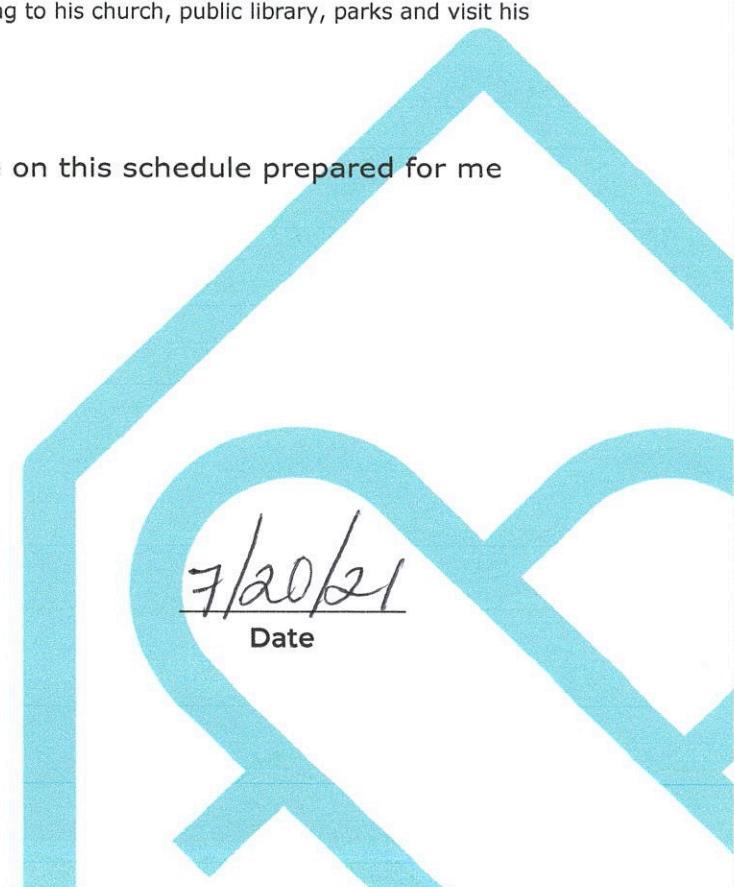
**Plan Goal:** LFSK Take and involve Erick to the Community. Erick was meaningful day activities and wishes to attend community activities. Erick need going to the grocery store, the park, the doctor's appointments and going to various places in the community. Erick totally need assistance around the community.

**Progress note:** Continues integrated in the community by going to his church, public library, parks and visit his friends and family his mother side.

I agree with these services and activities state on this schedule prepared for me and the Agency.



Client/Guardian Signature



7/20/21

Date



UNITED FAMILY  
HEALTHCARE INC.

## Annual Medical Appointments Log

Client Name: Erick Pastrana.

	<b>Physician Name</b>	<b>Last Visit</b>	<b>Next Visit</b>	<b>Other Information</b>
PRIMARY PHYSICIAN	Rene Andino .	Sept 28.	6 months.	
OPTOMETRIST/OPTHAM				
NEUROLOGIST	Christina Valdés .	Agosto 3	Next year.	
GYNCOLOGIST				
PSYCHOLOGIST/PSYCHIAT				
PODIATRIST				
DERMATOLOGIST				
ENDOCRINOLOGIST				
GASTROENTEROLOGIST				
DENTIST				
ANNUAL PHYSICAL				
ANNUAL LABS/X-RAY				
ANNUAL PSYCHIATRIC FORM				
ANNUAL NEUROLOGICAL FORM				
OTHER DOCTOR VISIT <i>Orthopedic: John Asghar.</i>		July 26		
OTHER DOCTOR VISIT				
OTHER DOCTOR VISIT				
OTHER DOCTOR VISIT				
OTHER DOCTOR VISIT				

*Mallum*  
Contractor Signature \_\_\_\_\_

Date 7/20/2021





## HIPAA COMPLIANCE PATIENT CONSENT FORM

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

**By signing this form, I understand that:**

	Yes	No
May we phone, email, or send a text to you to confirm appointments or other information?	X	
May we leave a message on your answering machine at home or on your cell phone?	X	
May we use photos and videos for use in our advertising campaigns or health information content?	X	
May we mention the didactic advances that the patient shows thanks to our teaching techniques?	X	
May we discuss your medical condition with any member of your family?	X	

\* Select Yes or No using an X

The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

This consent was signed by: Deysi Pastrana  
(PRINT NAME PLEASE)

Signature: Deysi Pastrana Date: 7/20/2021

WSC Signature: Auranda S





UNITED FAMILY  
HEALTHCARE INC.

## Acknowledgment of Receipt of the Agency for Persons with Disabilities HIPAA Notice of Privacy Practices

I hereby acknowledge receipt of the HIPAA Notice of Privacy Practices published by the Florida Agency for Persons with Disabilities (APD). This brochure explains how APD uses and protects the personal health information of its clients.

Print Name: Deisy Pastrana

Guardian Signature: Jun Patron Date: 7/20/2021





# UNITED FAMILY HEALTHCARE INC. CHOICES AND PREFERENCES

(Human Values Along with ethical and professional values)

It is important to know that an individual with a developmental disability values the same things in life as everyone else. Just like everyone, people with disabilities value:

- Love  
Amor
- Friendship  
Amistad
- Being respected and treated with dignity  
Ser respetado y tratado con dignidad.
- Accessing information to make choices  
Acceder a información para tomar decisiones
- Safe place to live  
Lugar seguro para vivir
- Community participation and civic responsibilities  
Participación comunitaria y responsabilidades cívicas
- Freedom from poverty and abuse  
Libertad de pobreza y abuso
- Ability to exercise rights  
Capacidad para ejercer derechos
- Meaningful employment  
Empleo significativo
- Learning opportunities and the ability to grow personally  
Oportunidades de aprendizaje y capacidad para crecer personalmente.
- Intimate relationships  
Relaciones íntimas
- Remaining connected with family  
Permanecer conectado con la familia
- Advocacy and support to pursue life choices  
Promoción y apoyo para buscar opciones de vida.

For More information,  
please scan the QR



## Promoting Choice:

Ensure that individuals make their own choices as much as possible.

Decisions related Visit Places

Decisions related Clothing

Decisions related Communication

Decisions related Entertaining

Activities to engage in, or health and dietary decisions.

**Ensure that individuals have enough information to understand their options and the potential impact of their decisions.**

Asegurarse de que las personas tengan suficiente información para comprender sus opciones y el impacto potencial de sus decisiones.

**This is known as "informed choice."** (See Document Attached, Preference and Choice with Service Log Form)

Esto se conoce como "elección informada". (Ver documento adjunto, preferencia y elección Junto al formulario de registro de servicio)

## Promoting Self-Advocacy:

Is to help individuals be self-advocates. Self-advocacy includes

speaking up for oneself, making decisions, and exercising one's own rights.

I ERRICK Pastrana, have been informed and educated regarding These rights and I feel free to ask United Family Health Care inc. About any questions.

Clients Name: ERRICK Pastrana Date: 7/20/2021

Signature (Client/Parent's/Guardian): Errick Pastrana

[www.unitedfamilyinc.com](http://www.unitedfamilyinc.com)





UNITED FAMILY  
HEALTHCARE INC.

## CHOICE AND EMPOWERMENT

As a provider, I recognize the need for individuals to be encouraged to make their own decision. I view individuals I serve and their families as partners in meeting the person's service needs. I am committed to creating opportunities for individuals to make choices throughout the services I provide.

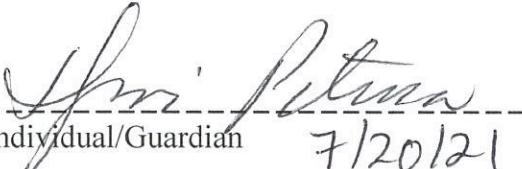
The choice making ability of each individual served by me will be reviewed at the time of the first meeting with the person, throughout the support plan year, and annually thereafter during the individual's support plan meeting. Training will be provided in those areas that are identified as needed.

The individual is encouraged to identify his/her choices and needs and to share them with me. Through meetings with the person, and other individuals they wish to invite, priority outcomes are determined. An implementation plan is developed within 30 days of beginning a new service and within 30 days of the effective date of the service authorization for ongoing services. This plan directly relates with the stated outcomes from the support plan for the service I provide. The implementation plan will include specific plans of how to assist the person in meeting their stated outcomes as well as those that ensure health and safety. The implementation plan may be changed throughout the support plan year as personal outcomes are met, the person's preferences change, or if a different approach should be used to ensure achievement of the outcome.

All individuals receiving services are expected to fully participate in the community training activities and are given chances to choose where they would like to go, what they would like to purchase, etc.

I fully inform individuals that they have a right to due process should they be unhappy with the services being provided and have the right to choose a new provider should we not be able to work out any problems between us. A person's ability to make choices as described in this policy will be reviewed with the person each year.

This policy related to choice and empowerment has been fully explained to the individual/guardian.

  
Individual/Guardian

7/20/21

  
Support Coordinator



UNITED FAMILY  
HEALTHCARE INC.

## GRIEVANCE PROCEDURE

I hope that you will always be satisfied with the service I provide to you. If, however, you have any complaints, I would ask that you abide by the following procedures.

I will sit down with you and/or your guardian and attempt to resolve the problem. Sometimes problems can be worked out simply by sitting down and discussing them. Should this not solve the problem within 7 days, your concern will be forwarded to this agency's director for potential resolution. If this matter cannot be resolved to your satisfaction within 30 days, I will assist you in contacting the Developmental Disabilities district office. The resolution of the grievance will be provided to you/your guardian both verbally and writing. You may invite anyone you wish to assist you in resolving your grievance.

A separate log of grievance will be maintained. This log will include the following:

- Name of the person making the compliant.
- The provider's relationship to the person receiving services
- Date the complaint is received
- A clear description on the complaint
- Date of the final disposition of the complaint

In addition to the log, this information will also be maintained in the individual's file.

This procedure will be reviewed with the individual/guardian within 30 days of beginning services with the individual and annually thereafter.

This acknowledge that the policy related to the grievance procedure has been fully explained to the individual/guardian.

Date: 07/29/21

  
\_\_\_\_\_  
Individual/Guardian

  
\_\_\_\_\_  
Support Coordinator



**UNITED FAMILY  
HEALTHCARE INC.**

## THE BILL OF RIGHTS FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

1. The right to dignity, privacy, human care.
2. The right to religious freedom and practice.
3. The right to receive services, within available sources, which protects the personal liberty of the individual and which are provided in the least restrictive conditions necessary to achieve the purpose of treatment.
4. The right to participate in an appropriate program of quality education and training services.
5. The right to social interaction and to participate in community activities.
6. The right to physical exercise and recreational opportunities.
7. The right to be free from harm, including unnecessary physical, chemical or mechanical restrain, isolation, excessive medication, abuse or neglect.
8. The right to consent to or refused treatment, subject to guardianship provisions.
9. No person having a developmental Disability shall be excluded from participation in, or denied benefits of, or be subject to discrimination under any program or activity which receives public funds.
10. No person having a Developmental Disability shall be denied the right to vote in public elections.
11. The right to communicate.
12. The right to possession and use of his/her own clothing and personal effects.
13. Each individual will receive prompt and appropriate medical treatment and care for physical and mental ailments and for the preventions of any illness or disability.
14. Each individual shall have access to individual storage space for private use.
15. No individual shall receive a treatment program to eliminate bizarre or unusual behavior without first being examined by physician to determine if there is any organic cause for these behaviors.
16. Each individual in work programs which require compliance with federal wage and hour laws shall be provided with minimum wage protection and compensation for labor in accordance with the federal wage per hour regulations.
17. Each individual shall have a central record; the record shall include admission information, historical summaries, a summary of the individual's present condition and all other required information under the regulations.



## UNITED FAMILY HEALTHCARE INC.

I have been given a copy of the Bill of Rights for People with Developmental Disabilities. A representative has verbally interpreted the document for me, and how to exercise it. I understand what an individual who is receiving services from this agency can expect from its staff. I further understand that should I question compliance of any of these rights, I may discuss the issue with any administrative staff from this agency or The Agency for Person with Disabilities.

These rights and responsibilities will be discussed with the individual on an annual basis.

This policy related to rights and responsibilities has been fully explained to the individual/guardian.

Date 07/20/21

  
\_\_\_\_\_  
Individual/Guardian

  
\_\_\_\_\_  
Support Coordinator



UNITED FAMILY  
HEALTHCARE INC.

## CONFIDENTIALITY

As a provider of services, I understand that any information I have regarding a person must be kept confidential. Before providing information, either verbally or in writing, I will complete consent for information for the individual/guardian to sign. This consent will include specific information to be provided, to whom the information will be provided and will be time limited, not to exceed one year. Furthermore, I understand that no information about the individual may be publicly displayed without express consent from the individual/guardian and any records on the individual will be stored in a secured setting.

This policy related to confidential information will be reviewed with the person on an annual basis or more frequently as needed.

I acknowledge that the policy related to confidential information has been fully explained to the individual/guardian.

Date 07/20/21

  
Pri Batina  
Individual/Guardian

  
Amanda S.  
Support Coordinator



# UNITED FAMILY HEALTHCARE INC.

## EMERGENCY / DISASTER MEDICATION / EQUIPMENT / SUPPLY NEEDS ASSESSMENT

PATIENT NAME: Enriche Pastana DATE: 07/2021

### Priority Code:

- I = Totally dependent with skilled care and/or on Life Support.
- II = Mod. to Min. dependence with skilled care or totally dependent with non-skilled care.
- III = Minimum dependence with non-skilled care and/or lives alone.

MEDICATIONS	EQUIPMENT	SUPPLIES
Miralax	bath chair wheelchair. Stroller. hospital bed.	Pampers Wipes. underpads.

Client/Caregiver Signature:

Name: Duyse Pastana



# UNITED FAMILY HEALTHCARE INC.

## EMERGENCY PLAN

Client's Name: Enri Padura, Phone: 717125195  
Address: 2765 West 61 Place Apt 101 Hialeah 33016.

### GENERAL INSTRUCTIONS TO CLIENT ON USE OF THIS FORM:

This information is provided to you as quick reference source in case any emergency occurs. Keep this document where it can easily be found. Inform other persons close to you (relative, neighbor, etc.) of this location.

1.- UNITED FAMILY HEALTH CARE INC. Is available 24/7. You can contact us at (786)747-8002, after office hours and on weekends, our answering services will be accessible for non-emergency purposes. The agency will return your call and will visit the client if is necessary.

2.- In case of a serious medical emergency, client should be taken to the hospital, UNITED FAMILY HEALTH CARE INC. Does not operate as an emergency service, therefore valuable time may be lost by contacting the Agency for a serious emergency.

3.- Emergency service number is **911**

4.- Name of close relative: Helen Padura.

Address: \_\_\_\_\_

Telephone Relationship to Client: \_\_\_\_\_

5.- Doctor's Name: Rehe Andino Telephone: (305)826-9449

Address: \_\_\_\_\_

6.- In the event of a Hurricane or other natural disaster I plan to take the following action:

- Remain in the Home
- Go to a local shelter
- Evacuate to safe area (Remember to call Agency with the new location)
- Go to relative/Other location

A copy of this document was left and explained to Client/Caregiver on:

DATE: 07/20/21

CLIENT/CAREGIVER SIGNATURE:

PROVIDER SIGNATURE:



## EMERGENCY PLAN INFORMED CONSENT

This information is provided to you as a quick reference source in case of an emergency/disaster before approaching or occurring.

As part of the Emergency Plan that United Family Health Care Inc. Has approved by the Florida Department of Health and renewed annually, withing the steps the Agency takes when an emergency or a disaster occurs, the Agency contacts consumers/caregivers to inform them the activation of the Plan and from that very moment begins an unfolding of actions among which is to confirm if consumers will be going to a shelter, local hospital or remain home.

It is very important for you to know that, in addition to the information that you can get from the 311 Contact Center, which provides a fast, simple and convenient way for residents to get information on local government services, it is also exists the Emergency and Evacuation Assistance Program (EEAP), that is designed for individuals living at home that need assistance with evacuation and sheltering.

To qualify for this Program, individuals should be in some of the categories to be eligible for assistance from the County. This information as well as the application that have to be submitted to the EEAP, you can find it in the web site:

<https://www.miamidade.gov/global/emergency/home.page>

Or you can also contact the office of Emergency and Evacuation Assistance Program at 9300 NW 41 St, Doral Fl, 33178

**Consumers/Caregivers** wishing to apply for the Program will have to complete the application process prior to an emergency/disaster, not when the event is approaching or occurring.

Please note that the hurricane season is currently defined as the time frame from June 1 though November 30. Consumers have to be prepared before this period of time with their own safety plan or to be active with the EEAP.

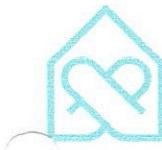
This Document has been left and explained to the client.

By signing this, the information has been officially known.

Date: 07/29/21

Client/Caregiver Signature:

Name: Daisy Rodriguez



HEALTH OBSERVATION CHECK LIST

Health Questions	Yes	No	Comments
Have you seen your doctor in the past year?	✓		/
Have seen the dentist?	✓		
Have you being in the ER in the past year?		✓	
Have you being hospitalized?		✓	
Do you have any health problems?	✓		constipation
Do you take prescription medicines?	✓		miralax
Do you need help to take your medicines? who help?	✓		
Do you take anti-seizures medicines?	✓		
Do you take behavior/psychiatric medicines?		✓	
Do you have any special diet?	✓		
Do you drink alcohol?		✓	
Do you smoke?		✓	
Do you have swallowing problems?	✓		
Do you have dentures?		✓	
Do you have bladder/blower incontinence?	✓		
Do you have any adaptive equipment?	✓		
Do you require any special equipment in case of emergencies? Which one?		✓	

Client Name: Eric Pastrana

Client/Guardian Signature: Eric Pastrana

Staff Signature: Teisha Padua 07/20/21



UNITED FAMILY  
HEALTHCARE INC.

BEHAVIOR OBSERVATION CHECKLIST

Client's Name: Eric Pasternak Date: 07/20/21

Behavior Observed	Yes	No	Comments
Attentive	✓		
Cooperative	✓		
Demanding		✓	
Dependent		✓	
Following Instruction		✓	
Helping Others		✓	
Participating		✓	
Inappropriate		✓	
Independent		✓	
Recalls Routine		✓	
Initiative Activities		✓	
Making Choices		✓	
Requesting Help		✓	
Uncooperative		✓	
Unsafe Activities		✓	
Using Appropriate Manners		✓	
Waiting		✓	

Consumer/Guardian Signature: Jeri Pasternak

Staff Signature: Jeri Pasternak



# UNITED FAMILY HEALTHCARE INC.

## ASSESSMENT FOR CLIENT VULNERABILITY TO ABUSE AND/OR NEGLECT

Client Name: ENK Pashana  
Date Client Assessed for Vulnerability: 07/20/21  
Client Vulnerability risk exist? ✓ Yes \_\_\_\_\_ No

VULNERABILITY RISK FACTOR	YES	NO
Demonstrates orientation to time, place and person Demuestra orientacion en tiempo, espacio y persona		✓
Demonstrates ability to follow directions consistently Demuestra habilidad para seguir indicaciones		✓
Demonstrates assertiveness Demuestra ser assertivo		✓
Demonstrates ability to give accurate information consistently Demuestra habilidad para dar información correcta		✓
Demonstrates interest in environment activities Demuestra interés en actividades a su alrededor		✓
Demonstrates ability to walk without assistive devices Demuestra habilidad para caminar sin ningún equipo		✓
Demonstrates full range of motion Demuestra movimientos completos		✓
Demonstrates adequate endurance Demuestra adecuada Resistencia		✓
Demonstrates pain-free condition/illness Demuestra condición o enfermedad sin dolor		✓
Demonstrates freedom from communicable disease Libre de enfermedades contagiosas	✓	
Demonstrates adequate auditory perception Demuestra Buena audición	✓	
Demonstrates adequate visual perception Demuestra Buena visión	✓	
Demonstrates adequate speech Demuestra adecuada habla		✓
Demonstrates adequate touch sensation Demuestra adecuada sensación al tacto	✓	
Demonstrates adequate communication Demuestra adecuada comunicación		✓
Demonstrates cooperative behavior Demuestra comportamiento cooperativo		✓
Demonstrates ability to adhere to safe precaution consistently Sigue instrucciones de precauciones adecuadamente		✓
Demonstrates ability to report abuse and/or neglect Tiene habilidad para comunicar abuso o negligencia		✓

Signature of Client/Guardian: Jeri L. Lewis

Date: 07/20/21

Provider Signature: [Signature]

Date: 07/20/21

- This form will be reviewed at least annually with the individual/guardian.