EVEREST HOME HEALTH
109 DEWALT AVE SUITE 201B PITTSBURGH PA 15227
EMAIL: - everestopd2025@gmail.com
PHONE: - 412-484-6298, FAX: - 412-207-8661

HAB Consumer Packet – Checklist of Required Documents:

Row #	Documents/Assessment	Completed
1	Consumer Face Sheet (Demographics)	
2	Copy of ISP (Individual Support Plan)	
3	Habilitation Goals and Outcomes (from ISP)	
4	Habilitation Daily/Monthly Progress Notes Template	
5	Service Note Log Sheet	
6	Consent for Services	
7	HIPAA Acknowledgment & Consent Form	
8	Emergency Contact Information Form	
9	Emergency Medical Plan	
10	Medication Administration Record (if applicable)	
11	Doctor's Orders (if required for services)	
12	Behavior Support Plan (if applicable)	
13	Incident Management Acknowledgment	
14	Rights of Individuals Receiving Services	
15	Grievance Policy Acknowledgment	
16	Orientation Acknowledgment	
17	Staff Signature Sheet (who provides services)	
18	Training Verification for Staff Assigned to Consumer	
19	Photo Consent/Refusal Form	
20	Copy of Insurance Card and State ID	
21	Copy of Social Security Card	
22	Emergency Evacuation Plan (home specific)	
23	ODP Required Assessments (like SIS, if available)	
24	Backup Plan / Contingency Plan	
25	Service Location & Community Integration Preferences	
26	Most Recent ISP Signature Page	

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27	Team Contact List	

1. **Consumer Face Sheet (Demographics)**

- Consumer Name: _____
- DOB: _____
- MA #: _____
- Phone: _____
- Address: _____
- Primary Contact: _____
- Emergency Contact (Name/Phone/Relationship):_____
- Support Coordinator: _____
- Diagnosis: _____
- Insurance Information: _____
- MCO: _____
- Preferred Language: _____

2. **ISP**

3. **Habilitation Goals and Outcomes (from ISP)**

- Goal #1: _____
- Objective: _____
- Staff Support Instructions: _____
- Frequency: _____
- Measurement Method: _____

(Repeat for each goal)

4. **Habilitation Daily/Monthly Progress Notes Template**

- Date: _____
- Time In: _____

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- Time Out: _____
- Summary of Activities: _____
- Progress Toward Goals: _____
- Staff Initials: _____

5. **Service Note Log Sheet**

Date Time In Time Out Service Provided Staff Signature

6. Consent for Services Agreement

This Consent for Services ("Agreement") is entered into between the Provider and the Consumer named below for the purpose of delivering Habilitation (HAB) services as outlined in the Individual Support Plan (ISP) authorized by the Office of Developmental Programs (ODP).

Consumer Information

- Full Name of Consumer: _____
- Date of Birth: _____
- MA Number: _____

Provider Information

- Provider Name: _____
- Contact Phone: _____
- Address: _____

---

1. Purpose of Services

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The Provider agrees to deliver habilitation services that promote independence, skill-building, and inclusion in accordance with the Consumer's ISP. These services are person-centered and will be implemented in accordance with the policies and procedures outlined by ODP.

---

2. Nature of Services

Habilitation services may include, but are not limited to:

- Skill acquisition and support
- Community integration
- Self-help and adaptive skills training
- Communication and socialization supports
- Health and safety education

---

3. Consumer Rights

The Consumer has the right to:

- Be treated with dignity and respect
- Refuse services at any time
- Receive services in the least restrictive environment
- File grievances or complaints without retaliation
- Confidentiality of records and information

---

4. Risks and Responsibilities

The Consumer understands:

- Participation in services is voluntary.
- The Provider will take reasonable precautions to ensure safety during services.
- The Consumer and/or legal guardian is responsible for providing accurate and updated medical and emergency information.

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5. Confidentiality

All personal and medical information will be kept confidential in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and ODP requirements.

---

6. Consent to Treatment and Services

By signing this document, the Consumer (or their legal guardian) acknowledges and consents to:

- Participation in services as outlined in the ISP
- Communication between the Provider, Support Coordinator, and other ISP team members
- Documentation of services and progress by the Provider

---

7. Duration and Termination of Consent

This consent remains in effect until:

- Services are discontinued or terminated by either party
- The Consumer or legal guardian withdraws consent in writing
- The ISP changes significantly, requiring updated consent

Acknowledgment and Agreement

I, the Consumer (or legal guardian), acknowledge that I have read and understand the information above. I have had the opportunity to ask questions, and all questions have been answered to my satisfaction. I voluntarily give consent for the provision of habilitation services by the Provider.

Consumer/Legal Guardian Name: _____
Signature: _____
Date: _____

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Provider Representative Name: _____
Signature: _____
Date: _____

---

7. **HIPAA Acknowledgment & Consent Form**

(Health Insurance Portability and Accountability Act of 1996)

Consumer Information

Full Name of Consumer: _____

Date of Birth: _____

MA Number: _____

Provider Information

Provider Name: _____

Provider Phone Number: _____

1. Purpose of This Form

This form serves as an acknowledgment that the Consumer (or legal guardian) has received, reviewed, and understands the Notice of Privacy Practices from the Provider in compliance with the Health Insurance Portability and Accountability Act (HIPAA). This form also provides consent for the Provider to use and disclose protected health information (PHI) for purposes related to treatment, payment, and healthcare operations.

2. Acknowledgment of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have received and reviewed a copy of the Provider's Notice of Privacy Practices which describes how my personal health information may be used and disclosed, and how I may access this information.

3. Consent to Use and Disclosure of Health Information

I understand and consent that the Provider may use and disclose my PHI:

To provide treatment and coordinate care

To obtain payment for services rendered

To carry out administrative and healthcare operations

To communicate with other members of my ISP team including doctors, support coordinators, therapists, and other providers

As required or permitted by law (e.g., for mandated reporting, audits, or court orders)

4. Consumer Rights Under HIPAA

I understand that I have the right to:

Request restrictions on how my PHI is used or shared

Request confidential communications

Inspect and obtain a copy of my PHI

Request corrections to my PHI

Receive a record of disclosures made

File a complaint with the Provider or the U.S. Department of Health and Human Services (HHS) if I believe my privacy rights have been violated

5. Revocation of Consent

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I understand that I have the right to revoke this consent at any time by submitting a written request to the Provider. I understand that revocation will not apply to actions already taken in reliance on this consent.

6. Duration of Consent

This consent will remain in effect for the duration of services unless revoked in writing or otherwise required by law.

7. Additional Disclosure Authorizations

(Optional – check any that apply):

☐ I authorize the Provider to communicate with my emergency contact in the event of a health or safety concern.

☐ I authorize the Provider to share relevant health information with other providers for care coordination.

☐ I do not authorize any additional disclosures beyond those required for treatment, payment, and healthcare operations.

Acknowledgment and Consent

I, the Consumer (or legal guardian), certify that I have read and understood this document, and that I voluntarily consent to the use and disclosure of my health information as outlined above.

Consumer/Legal Guardian Name: _____

Signature: _____

Date: _____

Provider Representative Name: _____

Signature: _____

Date: _____

---

8. **Emergency Contact Information Form**

- Name: _____
- Relationship: _____
- Phone Number: _____
- Secondary Contact: _____
- Preferred Hospital: _____

---

9. **Emergency Medical Plan**

- Allergies: _____
- Medical Conditions: _____
- Medications: _____
- Emergency Instructions: _____
- Hospital Preference: _____

---

10. **Medication Administration Record (if applicable)**

Date	Medication Dose	Time	Administered By	Notes

11. **Doctor's Orders (if required for services)**

(Attach signed physician orders if applicable)

12. **Behavior Support Plan (if applicable)**

(Attach latest plan with review dates and signatures)

---

13. **Incident Management Acknowledgment Form**

For Habilitation Services under the Office of Developmental Programs (ODP)

Consumer Information

- Full Name of Consumer: _____
- Date of Birth: _____

- MA Number: _____

Provider Information

- Provider Name: _____
- Provider Representative: _____

---

1. Purpose of this Form

This form serves as documentation that the Consumer (or legal guardian) has been informed about the Incident Management Policy and Procedures of the Provider, as required by the Pennsylvania Office of Developmental Programs (ODP). The Consumer acknowledges understanding their rights, protections, and the responsibilities of the Provider regarding incident identification, reporting, and response.

---

2. What Is an Incident?

According to ODP regulations, an *incident* is any suspected or actual event that:

- Puts the health or safety of the Consumer at risk
- Results in or has the potential to result in abuse, neglect, injury, or violation of rights
- Requires immediate response, investigation, and documentation in HCSIS (Home and Community Services Information System)

Examples of reportable incidents include (but are not limited to):

- Abuse (physical, sexual, verbal, emotional)
- Neglect
- Misuse of funds
- Death or serious injury
- Missing person
- Rights violations
- Restraints or restrictive procedures

---

3. Incident Reporting Responsibilities

The Provider is responsible for:

- Recognizing and identifying reportable incidents
- Reporting incidents to ODP via HCSIS within 24 hours of discovery
- Notifying the Consumer and their team (including guardians and support coordinators as appropriate)
- Taking immediate actions to ensure the safety of the Consumer
- Conducting a thorough investigation and resolution process
- Maintaining confidentiality throughout the process

---

4. Consumer Rights Regarding Incidents

The Consumer has the right to:

- Be informed of any incident involving them
- Be protected from retaliation if they report or are involved in a report
- Receive support services during and after the incident
- Request a meeting to review the incident and next steps
- File complaints or grievances about how the incident was handled
- Have incidents reviewed by the Provider's Incident Management Committee and/or Human Rights Committee, if applicable

---

5. Reporting Channels

The Consumer (or guardian) can report incidents to:

- Provider Staff or Management
- ODP Regional Office
- Support Coordinator or Service Coordination Entity
- Protective Services or Law Enforcement, as needed

Emergency Contact (Provider): _____
ODP Complaint Hotline: 1-888-565-9435

---

6. Training and Policy Review

I acknowledge that:

- I have been provided a copy and/or explanation of the Provider's Incident Management Policy.
- I understand the procedures that will be followed in the event of an incident.
- I know how and where to report concerns, suspicions, or known incidents.

Acknowledgment and Consent

I, the Consumer (or legal guardian), confirm that I have received and understand information about Incident Management procedures. I have had the opportunity to ask questions, and I understand that I have the right to be protected and informed if any incident occurs.

Consumer/Legal Guardian Name: _____
Signature: _____
Date: _____

Provider Representative Name: _____
Signature: _____
Date: _____

---

14. **Rights of Individuals Receiving Services**

Acknowledgment Form
Office of Developmental Programs (ODP) – Habilitation Services

---

Consumer Information

- Full Name of Consumer: _____
- Date of Birth: _____
- MA Number: _____

Provider Information

- Provider Name: _____
- Provider Representative: _____

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1. Purpose of this Form

This form documents that the Consumer (or legal guardian) has been informed of their rights as an individual receiving Habilitation services under the Pennsylvania Office of Developmental Programs (ODP). These rights are protected under state and federal laws, including the Americans with Disabilities Act (ADA), the HCBS Final Rule, and ODP regulations.

---

2. Rights of Individuals Receiving Services

As a Consumer receiving services through ODP, you have the right to:

Dignity, Respect, and Privacy

- Be treated with dignity and respect at all times
- Have your personal values, cultural background, and religious beliefs honored
- Receive services in a manner that respects your privacy and promotes your independence

Freedom and Choice

- Make decisions about your life, services, and supports
- Choose who provides your services, where they are delivered, and how they are delivered
- Participate in creating and updating your Individual Support Plan (ISP)

Informed Consent

- Be fully informed of your rights, the risks and benefits of services, and any changes to your care
- Consent to or refuse services without fear of retaliation

Freedom from Abuse and Exploitation

- Be free from physical, emotional, verbal, and sexual abuse
- Be protected from neglect, financial exploitation, and unnecessary restraint
- Report abuse without fear of retaliation

Access to Services and Supports

- Receive services that help you achieve your personal goals and outcomes
- Access services in the most inclusive, least restrictive setting appropriate to your needs

Community Integration

- Participate in your community to the fullest extent possible

- Seek employment, education, recreation, and social opportunities in typical community settings

Confidentiality

- Have your personal and health information kept private in accordance with HIPAA and state regulations
- Decide who has access to your records and information

Grievance and Complaint Process

- File complaints or grievances about services, staff, or provider practices
- Have complaints reviewed promptly without discrimination or retaliation
- Request assistance from your Support Coordinator or the ODP Regional Office if needed

Rights Regarding Finances and Property

- Control your own finances or receive assistance from a representative payee if needed
- Have your belongings respected and protected
- Be informed about how your funds are used if the Provider handles them

Due Process

- Appeal decisions that affect your eligibility or services
- Receive assistance in navigating appeals and administrative processes

---

3. Additional Rights in Residential or Shared Living Settings

If you live in a residential setting licensed or funded by ODP, you also have the right to:

- Lock your bedroom door (with exceptions for health/safety)
- Decorate your space to reflect your personality
- Have access to food, visitors, and personal communication (phone/internet)
- Be free from unnecessary restrictions on movement, schedule, or routines

---

4. Staff Responsibilities

Provider staff are required to:

- Know and respect each Consumer's rights

- Ensure services do not infringe upon these rights
- Immediately report any observed or suspected violation of rights

---

Acknowledgment of Rights

I, the Consumer (or legal guardian), have received a copy of the "Rights of Individuals Receiving Services" and have had the opportunity to ask questions. I understand my rights and know whom to contact if I believe my rights are not being respected.

Consumer/Legal Guardian Name: _____
Signature: _____
Date: _____

Provider Representative Name: _____
Signature: _____
Date: _____

I received and understand my rights.

- Signature: _____
- Date: _____

---

15. **Grievance Policy Acknowledgment Form**

For Consumers Receiving Habilitation Services under the Office of Developmental Programs (ODP)

Consumer Information

- Full Name of Consumer: _____
- Date of Birth: _____
- MA Number: _____

Provider Information

- Provider Name: _____
- Provider Representative: _____

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1. Purpose of This Form

This form documents that the Consumer (or their legal guardian) has been informed of the Provider's Grievance Policy and Procedures and understands how to file a complaint or grievance regarding services received under the Office of Developmental Programs (ODP).

---

2. What Is a Grievance?

A grievance is a formal or informal complaint made by the Consumer, their guardian, family member, or advocate regarding dissatisfaction with:

- Services provided
- Staff behavior or professionalism
- Service quality or frequency
- Policy violations
- Rights violations
- Any action or inaction that affects the Consumer's well-being

Grievances may also include complaints about how the Provider responds to incidents, implements the ISP, or treats the Consumer.

---

3. Consumer Rights Regarding Grievances

The Consumer has the right to:

- File a grievance at any time
- Receive help in understanding and submitting a grievance
- Be free from retaliation, punishment, or reduction in services
- Have the grievance addressed in a timely, respectful, and confidential manner
- Receive a written or verbal response about the resolution
- Request further review if unsatisfied with the outcome

---

4. How to File a Grievance

Grievances may be submitted:

- Verbally or in writing to any Provider staff member

- Directly to a supervisor, manager, or director
- Through a Grievance Form (available upon request)
- To the Support Coordinator or Service Coordination Entity
- To the ODP Regional Office at any time

The Provider will respond to all grievances within 7 business days and maintain a written record of the complaint and actions taken.

---

5. Additional Assistance

If the Consumer needs help filing or understanding the grievance process, they may request assistance from:

- Support staff
- Support Coordinator
- Independent advocate
- ODP Representative

---

6. Policy Availability

A copy of the full Grievance Policy is available at the Provider's office and will be provided upon request. Staff are trained to assist Consumers and guardians with the grievance process.

Acknowledgment

I, the Consumer (or legal guardian), acknowledge that:

- I have been informed of my right to file a grievance or complaint
- I understand the process to submit a grievance
- I have been provided access to the Provider's Grievance Policy or had it explained to me
- I understand that I will not be penalized for making a complaint

---

Consumer/Legal Guardian Name: _____
Signature: _____
Date: _____

Provider Representative Name: _____
Signature: _____
Date: _____

I received and understand the grievance policy.

- Signature: _____
- Date: _____

---

16. **Orientation Acknowledgment Form**

For Individuals Receiving Habilitation Services Under ODP

Consumer Information

- Full Name of Consumer: _____
- Date of Birth: _____
- MA Number: _____

Provider Information

- Provider Name: _____
- Provider Representative: _____

---

1. Purpose of This Form

This form documents that the Consumer (or legal guardian) has completed an orientation session provided by the Provider. Orientation is required by the Office of Developmental Programs (ODP) and is designed to ensure the Consumer is informed, supported, and empowered when beginning or continuing Habilitation services.

---

2. Orientation Topics Covered

The Provider has reviewed the following topics with the Consumer (or guardian), either verbally or in writing:

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Overview of Habilitation (HAB) Services
Individual Support Plan (ISP) roles and responsibilities
Consumer Rights (including dignity, privacy, and choice)
Grievance and complaint procedures
Incident reporting policies and protections
Health and safety expectations
Emergency procedures and evacuation plan
Medication management (if applicable)
Staff roles and supervision
Confidentiality and HIPAA privacy protections
Community participation and integration
Service schedule, location, and documentation
Procedures for service interruptions or cancellations
Provider policies regarding conduct, communication, and boundaries

---

3. Opportunity for Questions

The Consumer (or legal guardian) was given the opportunity to ask questions about services, rights, and provider procedures during orientation. All questions were answered to their satisfaction.

---

4. Acknowledgment

By signing below, I, the Consumer (or legal guardian), acknowledge that I:

- Participated in or received the required orientation
- Understand the policies, procedures, and expectations of the Provider
- Know whom to contact with concerns or questions about my services
- Have received a copy of the Consumer Handbook and/or other orientation materials (if applicable)

Consumer/Legal Guardian Name: _____
Signature: _____
Date: _____

Provider Representative Name: _____
Signature: _____
Date: _____

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17. **Staff Signature Sheet (who provides services)**

Staff Name	Title	Signature	Date

---

18. **Training Verification for Staff Assigned to Consumer**

Staff Name	Training Type	Date Completed	Verified By

---

19. **Photo Consent/Refusal Form**

For Consumers Receiving Habilitation Services under the Office of Developmental Programs (ODP)

Consumer Information

- Full Name of Consumer: _____
- Date of Birth: _____
- MA Number: _____

Provider Information

- Provider Name: _____
- Provider Representative: _____

---

1. Purpose of This Form

This form allows the Consumer (or legal guardian) to indicate whether they give permission for the Provider to take, use, and share photographs, video, or audio recordings of the Consumer. These images may be used for documentation, training, promotional materials, newsletters, events, or social media purposes.

---

2. Use of Photos/Media

If consent is granted, photos or video may be used in the following contexts:

- Documentation of service delivery for recordkeeping
- Training or professional development of staff

- Marketing and outreach materials (print or digital)
- Organization's website or social media platforms
- Recognition events, celebrations, or program displays

No photographs or recordings will be sold or used for any commercial gain.

---

3. Consent Options (Check One)

☐ I GIVE CONSENT
I hereby authorize the Provider to take and use photographs, video, or audio recordings of me/my child for the purposes listed above. I understand that these may be shared publicly and that no personal identifying information will be disclosed without further consent.

☐ I DO NOT GIVE CONSENT
I do not authorize the Provider to take or use any photographs, video, or audio recordings of me/my child. I understand this choice will not affect the quality or delivery of services in any way.

---

4. Right to Withdraw Consent

I understand that I may revoke this consent at any time by submitting a written request to the Provider. Any images already published or used before the withdrawal will not be recalled or destroyed.

Acknowledgment

By signing below, I confirm that I have read and understood this form. I am aware that participation is voluntary and that refusal to consent will not affect access to services or supports.

Consumer/Legal Guardian Name: _____
Signature: _____
Date: _____

Provider Representative Name: _____
Signature: _____
Date: _____

---

20. **Copy of Insurance Card and State ID**

(Attach copies front and back)

---

21. **Copy of Social Security Card**

(Attach copy)

---

22. **Emergency Evacuation Plan (home specific)**

- Evacuation Procedure: _____
- Meeting Point: _____
- Responsible Staff: _____
- Transportation Plan: _____

---

23. **ODP Required Assessments (like SIS, if available)**

(Attach latest SIS or other required assessments)

---

24. **Backup Plan / Contingency Plan**

- Staff Backup Plan: _____
- Emergency Contact Protocol: _____
- Service Interruption Plan: _____

---

25. **Service Location & Community Integration Preferences**

- Preferred Locations: _____
- Activities of Interest: _____
- Transportation Method: _____

---

26. **Most Recent ISP Signature Page**

(Attach latest signed ISP page)

---

27. **Team Contact List**

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Name	Role	Phone	Email