CARING PATHWAYS
of Carrollton

Caring is our PASSION

Client Application

Towards a better quality of life for all

Client Name:_____D.O.B._____

Residing address:_____

City:_____Zip:_____

Phone Number:_____Second Number:_____

Request Full Time (M-F): _____ or if Part Time: Days Requesting:_____

Guardian Information

Is the client their own guardian?: yes/no

If no, Name(s) of Guardian(s):_____

Guardian Phone Number:_____Second Number:_____

Address (if different from above):_____

City:_____Zip:_____

Special guardian contact instructions :_____

Primary Caregiver Information:

Name (if different from above): _____ Phone: _____

Address (if different from above):_____

City:_____Zip:_____

Living Situation: Parent(s)/guardian:_____ Foster Care:_____ Group Home:_____

Emergency Contact Information

Name: _____ Phone: _____

Address: _____ Email: _____

2nd Emergency Contact information

Name: _____ Phone: _____

Address: _____ Email: _____

HCS or TxHmL Medicaid Waiver Provider Information; (if applicable)

Name of Provider:_____

Provider main phone number:_____

Provider emergency contact name: _____

Provider emergency phone number: _____

Case Manager Name:_____

Case Manager Email:_____

Case Manager Phone Number:_____

Provider Nurse Name: _____

Provider Nurse Phone Number:_____

Provider's Nurse's Email: _____

Program (check): _____HCS _____TxHmL

Billing address:_____

Billing Email: _____ Billing phone # _____

Waiver program (circle type): HCS TxHmLiving other:_____

Please include the Personal Directed Plan (PDP), IPC, implementation plan and behavioral support plan if applicable

Private Pay: Email for invoicing: _____

Medical Information

Client name: _____

Primary Disability:_____Additional Diagnoses: _____

Medication Allergies:_____

Special Dietary Concerns:_____

Will the client need medications given during Individualized Skills & Socialization programing hours? ___No ___Yes

If an individual cannot or chooses not to self-administer his or her medications, (including over-the-counter medications such as Tylenol, Pepto-Bismol, etc.), Caring Pathways of Carrollton will provide assistance with such medications and the performance of related tasks **if:**

- A registered nurse has delegated such to Caring Pathways of Carrollton in accordance with state law and rules; or
- A physician has delegated the assistance and related tasks

When sending prescription medications to CPoC, they must be in a current prescription bottle from the pharmacy with the label intact. Over-the-counter medications must be in the original manufacturer's container with the label intact.

For safety reasons, caregivers are to bring the medication directly to the manager.

Current Medications – Please list **ALL** daily medications, PRN medications, supplements, etc.

Medication	Dose/Amount	Frequency	Reason

General Information

How does the client navigate their space?_____

_____

Does the client use any adaptive aids such as a cane, walker, communication device?_____

Functional Skills

Method of Communication: verbal / non-verbal / signs

Does your child use a communication device? eg: an IPAD? yes/no

If yes, what type of device/program? _____

Food likes:_____

Food dislikes:_____

Food allergies:_____

Eating habits and needed assistance while eating:_____

_____

Bathroom habits and needs:_____

_____

Preferred client activities and hobbies:_____

_____

Non-preferred activities (dislikes): _____

_____

Behavioral supports

We welcome all clients, however we want all guardians/providers to be aware that we are not able to accept clients who have a history of:

- aggression toward self - aggression toward others (clients or staff)

- physical destruction - history of elopement

If a client has displayed any of the above within the last 12 months, a clear explanation must be provided.

Does the client have a behavioral support plan or guidelines? YES/NO

If yes, please attach

Behaviors exhibited in the last 12 months: (please check all that apply)

___tantrums ___scratches ___steals ___hyperactive ___destructive

___screams ___pulls hair ___withdrawn ___runs away ___bites (self/others)

___kicks ___moody ___pinches ___hits ___head bangs

___ self abuse ___aggresion ___spitting ___slapping ___talks to self

___uses foul language ___other

Explain all behaviors checked: frequency, antecedents:

_____

_____

_____

_____

Are there things that upset him/her? sensitivities?

_____

_____

_____

Please provide any other vital information about him/her that would be helpful for us to know how to best serve the client. _____

_____

_____

Acknowledgement

Abuse, Neglect and Exploitation

To Report Allegations of Abuse, Neglect, and/or Exploitation DFPS

Report to: 800-458-9858

Caring Pathways of Carrollton

February 2023

You must report suspected abuse, neglect, or exploitation to DFPS (Texas Department of Family Protective Services) **immediately**, but no later than one hour after having knowledge or suspicion that an individual has been or is being abused, neglected or exploited.

I, _____ acknowledge that on this date I understand that Caring Pathways Of Carrollton must ensure that all personnel (including but not limited to: all individuals, guardians, legally authorized representatives, employees and contracted service providers) understand and have been instructed to report abuse, neglect or exploitation immediately. By signing below, I am stating that I have been provided the toll-free telephone number (1-800-458-9858) in writing, and that I understand the importance of reporting immediately, but no later than one hour after having any knowledge or suspicion. I have received training and had the opportunity to ask questions.

_____ _____

Signature Date

Relationship: _____ (Specify if Family member, Client or Staff)

If you have complaints, questions or need to contact Caring Pathways of Carrollton, please contact Kathy Owens, Director of Operations at operations@caringpathways.org or call 469-758-0063 to speak with Jake Davis, Director.

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Client's Name: _____ Date of Birth: _____

Guardian's Name: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: Caring Pathways of Carrollton

Address: 2150 North Josey Lane #318

City: Carrollton State: TX Zip Code: 75006

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates:_____

☐ All healthcare information

☐ Other:_____

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Guardian Signature:_____ Date Signed:_____

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED.

Emergency Medical Treatment

In the event of an emergency, I authorize Caring Pathways of Carrollton to give consent for medical treatment.

Preferred Hospital in case of emergency: _____

_____

Guardian Signature:_____ Date Signed:_____

Printed Name: _____

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED.

Off-Site Consent Form

This consent is in regard to: _____(client name).

Consent for Off-Site Services

As part of Individualized Skills and Socialization regulations, Caring Pathways of Carrollton is required to offer all clients Off-Site services. Clients will go into the community for walking trips to parks, businesses, and community services in the area. Some Off-Site services will be at no cost, such as lunch in the park, a visit to the police or fire station or taking a walk when the weather permits. Clients/Caregivers pay the cost of other outings, which may include lunch in a nearby restaurant, grocery shopping, running errands, etc.

____ I give permission for my son/daughter to participate in Off-Site services.

____ I DO NOT give permission for my son/daughter to participate in Off-Site services.

I do not hold Caring Pathways of Carrollton, its staff, or board members liable for accidents or other unfortunate events that occur during an Off-Site activity.

If the client uses a wheelchair, can they transfer to a regular seat? ___Yes ____No

Guardian Signature:_____ Date Signed:_____

PERMISSION TO PHOTOGRAPH

I, _____ (individual/parent/guardian's name) hereby authorize Caring Pathways of Carrollton, to photograph _____

_____ (name of individual). I acknowledged that since my participation with Caring Pathways of Carrollton is voluntary, I will receive no financial compensation. I waive the right to inspect or approve the finished product, including the written or electronic copy, wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of the photography.

	Please Check	
Type of Use	**Grant Permission**	**Decline Permission**
Still Photography		
Video		
Display in center		
Show to current and prospective clients		
Display on center website		
Display on center Instagram and Facebook		
Use in promotional material		
Text		
First Name		
Last Names *	n/a	n/a

*Only first names and possibly last initial in the event of two or more individuals with the same first name will be displayed.

I understand it is my responsibility to update this form in the event that I no longer wish to authorize one or more of the above uses. I agree that this form will remain in effect during the term of my enrollment.

_____ _____

Individual/Parent/Guardian/LAR Date