Delaware County

Office of Services for the Aging

(C.O.S.A.)

Domiciliary Care Program

Consumer Application

RETURN COMPLETED APPLICATION PACKET TO:

ATTENTION:

SHARISSE STANFORD

206 EDDYSTONE AVE

EDDYSTONE, PA 19022

610-499-1965

610-490-1500

stanfords@co.delaware.pa.us

DELAWARE COUNTY OFFICE OF SERVICES FOR THE AGING
C.O.S.A.
DOM CARE CONSUMER OPENING FORM

OPEN DATE: ______________

Consumer Information

LAST NAME: ____________________ FIRST NAME: ____________________

ADDRESS: ____

CITY: ______________ STATE: ______________ ZIP: ______________

PHONE: ______________ SEX: ______________ D.O.B.: ______________

LIVES ALONE: ______YES ______NO SS#: ____________________

INCOME:

SOCIAL SECURITY:__________SSI:__________OTHER:__________

MEDICAL INSURANCE:

MEDICARE #:______________ MA#: ______________ OTHER:______________

BANK ACCOUNT INFORMATION:

CHECKING:___Yes___No BALANCE:______________
SAVING:_____Yes___No BALANCE:______________

LIFE INSURANCE:
COMPANY:______________
AMOUNT: ______________

EMERGENCY CONTACT PERSON:

NAME:____________________ RELATIONSHIP TO CONSUMER:____________________

ADDRESS: ____

CITY:______________STATE:__________ZIP:__________

HOME PHONE:______________ WORK PHONE: ______________

REFERRAL SOURCE: ____________________ RELATIONSHIP TO CONSUMER: ____________

ADDRESS: ____________________ PHONE: ____________________

PHYSICIAN NAME: ____________________ PHONE: ____________________

DIAGNOSIS/ MEDICATIONS:

____

____

____

____

____

____

ASSISTANCE NEEDED:

____

____

____

____

____

____

DELAWARE COUNTY OFFICE OF SERVICES FOR THE AGING
C.O.S.A.
Dom Care Pre-Admission Referral Cover Sheet

CONSUMER INFORMATION:

Name: ____
(Last) (First) (Middle)

Home address: ____
(Town) (Zip)

Phone: ____________________ Social Security #: ____________________

Sex: _______ D.O.B __________ Language: __________ Martial status: __________

CONTACT INFORMATION (family /interested party):

Name: ____________________ Relationship: ____________________

Address: ____

Phone: (home) ______________ (work) ______________ (email) __________

PROFESSIONAL CONTACT (referral source):

Name: ____________________ Phone: ____________________

Facility: ____________________ Admission date: ______________

REFERRING PHYSICIAN

Name: ____________________ Phone: ____________________

Address: ____

INSURANCE: Medicare #______________ MA # ____________________

Other: ______________________________

REASON FOR REFERRAL (CHECK ONE)

_______Access MA nursing home payment (include MA51, PASRR)
_______OBRA...Private and for MA payment (include MA51, PASRR and other documentation)
_______Boarding Home/Dom Care Home new or recert (include MA51 and additional documentation)
_______PDA Waiver program (include MA51)
_______Nursing Home Diversion... under 60 (include Ma 51)

MEDICAL EVALUATION

☐ NEW ☐ UPDATED

1. MA RECIPIENT NUMBER	2. NAME OF APPLICANT (Last, first, middle initial)	3. SOCIAL SECURITY NO.	4. BIRTHDATE	5. AGE	6. SEX

7. ATTENDING PHYSICIAN	8. PHYSICIAN LICENSE NUMBER

9. EVALUATION AT (Description and code) ☐

01 Hospital
02 NF
03 Personal Care/Dom Care
04 Own House/Apartment
05 Other (Specify) ____________

10. For the purpose of determining my need for TITLE XIX INPATIENT CARE, Home and Community Based Services, and if applicable, my need for a shelter deduction, I authorize the release of any medical information by the physician to the county assistance office, Pennsylvania Department of Human Services or its agents.

SIGNATURE - APPLICANT OR PERSON ACTING FOR APPLICANT ____________ DATE ____________

11. HEIGHT	WEIGHT	BLOOD PRESSURE	TEMPERATURE	PULSE RATE	CARDIAC RHYTHM

12. MEDICAL SUMMARY

13. IN EVENT OF AN EMERGENCY THE PATIENT CAN VACATE THE BUILDING

☐ 1. Independently ☐ 2. With Minimal Assistance ☐ 3. With Total Assistance

14. PATIENT IS CAPABLE OF ADMINISTERING HIS/HER OWN MEDICATIONS

☐ 1. Self ☐ 2. Under Supervision ☐ 3. No

15. ICD DIAGNOSTIC CODES

	PRIMARY (Principal)
	SECONDARY
	TERTIARY

16. PROFESSIONAL AND TECHNICAL CARE NEEDED - CHECK ✓ EACH CATEGORY THAT IS APPLICABLE

☐ Physical Therapy ☐ Speech Therapy ☐ Occupational Therapy ☐ Inhalation Therapy ☐ Special Dressings ☐ Irrigations
☐ Special Skin Care ☐ Parenteral Fluids ☐ Suctioning ☐ Other (Specify) ____________

17. PHYSICIAN ORDERS

Medications ____________

Treatment ____________

Rehabilitative and Restorative Services ____________

Therapies ____________

Diet ____________

Activities ____________

Social Services ____________

Special Procedures for Health and Safety or to Meet Objectives ____________

18. PROGNOSIS - CHECK ✓ ONLY ONE

☐ 1. Stable ☐ 2. Improving ☐ 3. Deteriorating

19. REHABILITATION POTENTIAL - CHECK ✓ ONLY ONE

☐ 1. Good ☐ 2. Limited ☐ 3. Poor

20A PHYSICIAN'S RECOMMENDATION

To the best of my knowledge, the patient's medical condition and related needs are essentially as indicated above. I recommend that the services and care to meet these needs can be provided at the level of care indicated - check ✓ only one

☐ Nursing Facility Clinically Eligible Services to be provided at home or in a nursing facility
☐ Personal Care Home Services provided in a Personal Care Home
☐ ICF/MR Care Services to be provided at home or in an intermediate care facility for the mentally retarded
☐ ICF/ORC Care Services to be provided at home or in an intermediate care facility for consumers with ORCs
☐ Inpatient Psychiatric Care
☐ Other (Please Specify) ____________

20B. COMPLETE ONLY IF CONSUMER IS NURSING FACILITY CLINICALLY ELIGIBLE AND WILL BE SERVED IN A NURSING FACILITY.

ON THE BASIS OF PRESENT MEDICAL FINDINGS THE PATIENT MAY EVENTUALLY RETURN HOME OR BE DISCHARGED. ☐ YES ☐ NO If Yes, Check ✓ Only One ☐ 1. Within 180 days ☐ 2. Over 180 days

20C. PHYSICIAN'S SIGNATURE

PHYSICIAN (PRINTED NAME) ____________ TELEPHONE ____________ PHYSICIAN SIGNATURE ____________ DATE ____________

FOR DEPARTMENT USE

Medical and other professional personnel of the Medicaid agency or its designee MUST evaluate each applicant's or recipient's need for admission by reviewing and assessing the evaluations required by regulations.

21A. MEDICALLY ELIGIBLE ☐ Yes ☐ No ☐ Medically Appropriate for Waiver Services

21B. Length of Stay ☐ Within 180 days ☐ Over 180 days

22 Comments. Attach a separate sheet if additional comments are necessary.

REVIEWER'S SIGNATURE AND TITLE ____________ DATE ____________

INSTRUCTIONS FOR COMPLETING
MA-51 MEDICAL EVALUATION

NOTE: THE MA-51 IS VALID AS LONG AS IT REFLECTS THE CURRENT CONDITIONS FOR THE APPLICANT

At the top of the page, mark if this is a new or updated MA-51.

Questions 1-7 are self-explanatory.

8. **Physician License Number.** Enter the physician license number, not the Medical Assistance number.
9. **Evaluation At.** Enter 1-5 to describe where evaluation took place. If 5 is used, specify where evaluation was completed.
10. **Signature.** Applicant should sign if able. If unable, legal guardian or responsible party may sign.
11. **Essential Vital Signs.** Self-explanatory.
12. **Medical Summary.** Include any medical information you feel is important for determination of level of care. **Please list patient's known allergies in this section.**
13. **Vacating of building.** How much assistance does the patient require to vacate the building?
14. **Medication Administration.** Is the patient capable of being trained to self-administer medications?
15. **Diagnostic Codes and Diagnoses.** ICD diagnostic codes should be put in the blocks, then written by name in the space next to the block. List diagnoses starting with primary, then secondary, and finally tertiary. There is room for any other pertinent diagnoses.
16. **Professional and Technical Care Needs.** Indicate care needed. Examples of "other" include mental health and case management.
17. **Physician Orders.** Orders should meet needs indicated in box 16. Medications should have diagnoses to support their use.
18. **Prognosis.** Indicate patient's prognosis based on current medical condition.
19. **Rehabilitation Potential.** Indicate based on current condition. Should be consistent with box 18.

20A. **Physician's Recommendation.** Physician must recommend patient's level of care. If the box for "other" is checked, write in level of care. In order to provide assistance to a physician in the level of care recommendation, the following definitional guidelines should be considered:

Nursing Facility Clinically Eligible (NFCE)	Personal Care Home	ICF/MR Care	ICF/ORC Care	Inpatient Psychiatric Care
Requires health-related care and services because the physical condition necessitates care and services that can be provided in the community with Home and Community Based Services or in a Nursing Facility.	Provides Personal Care services such as meals, housekeeping, & ADL assistance as needed to residents who live on their own in a residential facility.	Provides health-related care to MR individuals. More care than custodial care but less than in a NF.	Provides health-related care to ORC individuals. More care than custodial care but less than in a NF.	Provides inpatient psychiatric services for the diagnoses and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.

20B. **Complete only if Consumer is NFCE and will be served in a Nursing Facility.** Check whether the patient will be eventually be discharged from facility based on current prognosis. If yes, check expected length of stay.

20C. **The physician must sign and date the MA-51. A licensed physician must sign the MA-51.** It may not be signed by a "physician in training" (a Medical Doctor in Training [MT] or an Osteopathic Doctor in Training [OT].

Questions 21 and 22 completed by the OPTIONS Unit in the Area Agency on Aging.

MA-51 Attachment

This form is to be used when the applicant is physically and/or mentally incapacitated to the extent that signing his/her name is not possible.

Medical Evaluation Applicant Signature Waiver

______________________________ is unable to sign MA-51 (#10) because of
(Applicant)

the following reason (s):

____

____

____

____

______________________________ ______________________

(Signature /Relationship to Applicant) (Date)

FORM APPROVED
OMB NO. 0960-0095

PUBLIC ASSISTANCE AGENCY INFORMATION REQUEST

This report is authorized by section 402(a) of the Social Security Act.
Requested information cannot be provided without a submittal of this form

SOCIAL SECURITY WAGE EARNER INFORMATION

WAGE EARNER'S NAME	b. SEX	c. DATE OF BIRTH (Mo., Day, Yr.)	d. DATE OF DEATH (Mo., Day, Yr.)	e. SOCIAL SECURITY NUMBER (If unknown see instructions)	f. CLAIM SYMBOL
	☐ MALE ☐ FEMALE				

TO:
SOCIAL SECURITY ADMINISTRATION

3. PUBLIC ASSISTANCE CLAIMANT INFORMATION

a. CLAIMANT'S NAME

b. SOCIAL SECURITY NUMBER

c. DATE OF BIRTH (Mo., Day, Yr.)

d. CASE NUMBER

e. ADDRESS (include ZIP Code)

f. TELEPHONE NO. (include area code)

g. RELATIONSHIP TO WAGE EARNER

PUBLIC ASSISTANCE AGENCY REQUEST

Is the requested information available on BENDEX, SDX, BUY-IN? ☐ Yes ☐ No
If no, explain.

Information is needed for:
Dates: ______
Program:

Title IV ______ Title XIX ______
Title XVI ______ Food Stamps ______
Title XVIII ______ Other ______

Purpose:
Entitlement ______ Referral ______
Fraud ______ Other ______
QA ______

Please complete the checked blocks for the individuals whose names, dates of birth and SSN are given below:

FOR REQUESTING AGENCY USE		FOR SSA USE						
NAME AND SOCIAL SECURITY NUMBER OF BENEFICIARY	DATE OF BIRTH (Mo., Day, Yr.)	TYPE OF BENEFIT	DATE OF ENTITLEMENT	AMOUNT OF BENEFIT Gross	AMOUNT OF BENEFIT Net	EFFECTIVE DATES	PAYMENT STATUS	SMIB EFFECTIVE DATE
SSN								
SSN								
SSN								
SSN								
SSN								

OTHER

REMARKS *(If additional space is needed use reverse of this sheet)*

I wish to apply for Dom-Care Allowance
Signature: Date:

RETURN TO:

NAME AND ADDRESS OF AGENCY *(include ZIP Code)*

6. Signature of Requesting Official

Title | Date:

7. Signature of SSA Official

Title | Date:

APPLICATION FOR DOMICILIARY CARE SUPPLEMENT

CASE IDENTIFICATION				
Co.	Case Number	Cst.	Ctr.Dig.	Dist.
CASEWORKER				

1. IDENTIFYING INFORMATION

Name (*Last, First, Middle*)	Sex ☐ M ☐ F	BIRTHDATE	SOCIAL SECUIRTY NUMBER
ADDRESS (*Street, Town or City, Zip Code*)	MARITAL STATUS ☐ Never Married ☐ Separated ☐ Divorced ☐ Married ☐ Widowed		

2. APPLICANTS AFFIRMATION

I herby request a State Supplement to SSI to enable me to pay for my care in an approved Domiciliary Care Facility of my choice.

For the purpose of determining my need for domiciliary care, I authorize the Department of Public Welfare or its agent to obtain such medical and social facts about my situation as may be essential.

SIGNATURE (*Client or Authorized Representative*)

DATE

3. APPLICANT'S REASONS FOR SEEKING DOMICILIARY CARE

(Give Brief Description of Client's View of His Need for Care)

4. FUNCTIONAL LEVEL

ACTIVITY	DOES INDEPENDENTLY	DOES WITH ASSISTANCE	TYPE OF ASSISTANCE REQUIRED	CANNOT DO WITH ASSISTANCE
Transportation				
Shopping				
Meal Preparation				
Laundry				
Medication Usage				
Managing Finances				
Telephone				
House Keeping				
Bathing				
Dressing and Undressing				
Eating				
Personal Grooming				

5. SOCIAL FACTORS

DESCRIBE RECENT MAJOR CHANGES IN CLIENT'S LIFELEADING TO NEED FOR DOMICILIARY CARE. *(e.g. Death of Spouse, Friend or Family Member: Change in Marital Status: Change in Living Arrangement: Major Illness: Self, Spouse, Friend or Family Member.)*

6. COMMUNITY RESOURCES

Are the Necessary Supports for Independent Living Available in the Community? ☐ YES ☐ NO *(Explain)*

7. PLACEMENT AGENCY CERTIFICATION

Having Reviewed all Relevant Social and Medical Information on the Above Named Individual, I Certify That the Applicant:

☐ NEEDS DOMICILIARY CARE IN AN APPROVED DOMICILIARY CARE FACILITY AND IS RESIDING

☐ NEEDS DOMICILIARY CARE IN AN APPROVED DOMICILIARY CARE FACILITY AND WILL BE RESIDING

EFFECTIVE DATE:

NAME OF FACILITY
ADDRESS

☐ DOES NOT NEED DOMICILIARY CARE *(Explain)*

SIGNATURE DATE

AGENCY	PHONE NUMBER
ADDRESS	

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

*SSA will not honor this form unless all required fields have been completed (*signifies required field).*

TO: Social Security Administration

*Name ____ *Date of Birth ____ *Social Security Number ____

I authorize the Social Security Administration to release information or records about me to:

*NAME ____ *ADDRESS ____

*I want this information released because: ____

There may be a charge for releasing information.

*Please release the following information selected from the list below:

You must check at least one box. Also, SSA will not disclose records unless applicable date ranges are included.

- [ ] Social Security Number
- [ ] Current monthly Social Security benefit amount
- [ ] Current monthly Supplemental Security Income payment amount
- [ ] My benefit/payment amounts from ____ to ____
- [ ] My Medicare entitlement from ____ to ____
- [ ] Medical records from my claims folder(s) from ____ to ____
  If you want SSA to release a minor's medical records, do not use this form but instead contact your local SSA office.
- [ ] Complete medical records from my claims folder(s)
- [ ] Other record(s) from my file (e.g. applications, questionnaires, consultative examination reports, determinations, etc.) ____

I am the individual to whom the requested information/record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury in accordance with 28 C.F.R. § 16.41(d)(2004) that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that any applicable fees must be paid by me.

*Signature: ____ *Date: ____

Relationship *(if not the individual)*: ____ *Daytime Phone: ____

Social Security Administration
Consent for Release of Information

Form Approved
OMB No. 0960-0566

Instructions for Using this Form

Complete this form only if you want us to give information or records about you, a minor, or a legally incompetent adult, to an individual or group (for example, a doctor or an insurance company). If you are the natural or adoptive parent or legal guardian, acting on behalf of a minor, you may complete this form to release only the minor's non-medical records. If you are requesting information for a purpose not directly related to the administration of any program under the Social Security Act, a fee may be charged.

NOTE: Do not use this form to:

- Request us to release the medical records of a minor. Instead, contact your local office by calling 1-800-772-1213 (TTY-1-800-325-0778), or
- Request information about your earnings or employment history. Instead, complete form SSA-7050-F4 at any Social Security office or online at www.ssa.gov/online/ssa-7050.pdf.

How to Complete this Form

We will not honor this form unless all required fields are completed. An asterisk (*) indicates a required field. Also, we will not honor blanket requests for "all records" or the "entire file." You must specify the information you are requesting and you must sign and date this form.

- Fill in your name, date of birth, and social security number or the name, date of birth, and social security number of the person to whom the information applies.
- Fill in the name and address of the individual (or organization) to whom you want us to release your information.
- Indicate the reason you are requesting us to disclose the information.
- Check the box(es) next to the type(s) of information you want us to release including the date ranges, if applicable.
- You, the parent or legal guardian acting on behalf of a minor, or the legal guardian of a legally incompetent adult, must sign and date this form and provide a daytime phone number where you can be reached.
- If you are not the person whose information is requested, state your relationship to that person. We may require proof of relationship.

PRIVACY ACT STATEMENT

Section 205(a) of the Social Security Act, as amended, authorizes us to collect the information requested on this form. The information you provide will be used to respond to your request for SSA records information or process your request when we release your records to a third party. You do not have to provide the requested information. Your response is voluntary; however, we cannot honor your request to release information or records about you to another person or organization without your consent.

We rarely use the information provided on this form for any purpose other than to respond to requests for SSA records information. However, in accordance with 5 U.S.C. § 552a(b) of the Privacy Act, we may disclose the information provided on this form in accordance with approved routine uses, which include but are not limited to the following: 1. To enable an agency or third party to assist Social Security in establishing rights to Social Security benefits and/or coverage; 2. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; 3. To comply with Federal laws requiring the disclosure of the information from our records; and, 4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

Additional information regarding this form, routine uses of information, and other Social Security programs are available from our Internet website at www.socialsecurity.gov or at your local Social Security office.

PAPERWORK REDUCTION ACT STATEMENT

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U.S. Government agencies in your telephone directory or you may call 1-800-772-1213 (TTY 1-800-325-0778).** *You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***

Commonwealth of Pennsylvania
Department of Public Welfare

AUTHORIZATION FOR RELEASE OF INFORMATION

APPLICANT'S NAME	SOCIAL SECURITY NUMBER
ADDRESS	ZIP CODE

I give my permission to the Department of Public Welfare to act as my representative in connection with the verification requirements for age, citizenship, income and resources pertaining to the eligibility requirements for health care coverage under the Medicaid Program. This authority grants permission for the release and disclosure of information to the Department of Public Welfare. The information obtained will be used only for the purposes directly related to eligibility for health care coverage.

Signature of Applicant or Authorized Representative (Applying on Behalf of Applicant) ____________ Date ____________

Signature of Witness (if applicant signed with a mark) ____________ Date ____________

Name of Authorized Representative	Telephone Number
Address of Authorized Representative	Relationship to Applicant

PA-4 LTC

DELAWARE COUNTY OFFICE OF SERVICE FOR THE AGING
C.O.S.A.
DOM CARE PROGRAM
CONSUMER RIGHTS

1. THE RIGHT TO BE ACCEPTED AND TREATED AS A MEMBER OF THE FAMILY, A CONSUMER MAY NOT BE KEPT FROM THE FAMILY OR MADE TO FEEL INFERIOR.

2. THE RIGHT TO THE ENJOYMENT OF REASONABLE PRIVACY WITHIN THE HOUSEHOLD, INCLUDING PRIVACY OF SELF AND POSESSIONS.

3. THE RIGHT NOT TO BE PHYSICALLY OR PSYCHOLOGICALLY ABUSED OR PUNISHED BY THE PROVIDER, THE FAMILY, OTHER CONSUMERS, OR OTHERS IN THE HOUSEHOLD.

4. THE RIGHT TO LIVE FREE FROM PHYSICAL RESTRAINT, INVOLUNTARY CONFINEMENT, AND FINANCIAL EXPLOITATION AND REQUEST AND RECEIVE ASSISTANCE IN RELOCATING.

5. THE RIGHT TO FULL ENJOYMENT OF THE HOME, INCLUDING FREEDOM TO USE THE LIVING ROOM, DINNING ROOM, AND RECREATION AREAS, AS IN COMPLIANCE WITH THE DOCUMENTED HOUSE RULES; AND THE RIGHT TO VOICE GRIEVANCES AND RECOMMEND CHANGES IN POLICIES AND SERVICES OF THE HOME.

6. THE RIGHT TO COMMUNICATE PRIVATELY BY MAIL OR TELEPHONE WITH ANYONE, INCLUDING RELATIVES, FRIENDS, CARE MANAGERS, MEDICAL AND PSYCHIATRIC FACILITIES, AND MEMBERS OF PUBLIC AGENCIES. THE RIGHT TO REASONABLE USE OF TELEPHONE WHICH DOES NOT INCLUDE TOLL CALLS UNLESS AN ARRANGEMENT IS WORKED OUT WITH THE PROVIDER.

7. THE RIGHT TO HAVE VISITORS, PROVIDED THE VISITS ARE PRE-ARRANGED, CONDUCTED AT REASONABLE HOURS, AND THE VISITORS ARE NOT ACTIVELY DISRUPTIVE TO OTHERS WITHIN THE FAMILY OR HOUSEHOLD.

8. THE RIGHT TO MAKE ANY VISITS OUTSIDE THE HOME. HOWEVER, THERE IS A SHARED RESPONSIBILITY ON THE PART OF BOTH THE PROVIDER AND THE CONSUMER TO MAKE MUTUAL ARRANGEMENTS FOR KEEPING IN TOUCH WITH EACH OTHER.

9. THE RIGHT TO MAKE HIS / HER OWN DECISIONS AND CHOICES IN MANAGING HIS / HER PERSONAL AFFAIRS IN ACCORDANCE WITH HIS / HER ABILITIES.

10. THE RIGHT TO EXPECT THE COOPERATION OF THE PROVIDER IN ACHIEVING THE MAXIMUM DEGREE OF BENEFIT FROM PLACEMENT IN THE HOME.

11. IS FREE TO EXERCISE HIS / HER RIGHTS WEATHER OR NOT TO ATTEND AND PARTICIPATE IN RELIGIOUS ACTIVITIES.

12. THE CONSUMER SHALL BE MADE AWARE OF THE GOVERNOR'S ACTION LINE (TOLL FREE 1-800-932-0784) AND OTHER ADVOCACY AGENCIES TO WHICH THE CLIENT MAY ADDRESS GRIEVANCES WHEN HE / SHE FEELS THEY HAVE NOT BEEN PROPERLY RESOLVED THROUGH HOME'S GRIEVANCE PROCEDURE. ATTEMPTS TO RESLOVE ANY GRIEVANCES SHOULD FIRST BE MADE THROUGH THE DOMICILIARY CARE CARE MANAGER.

13. THE RIGHT TO LIVE ACCORDING TO THE (WOLF WOLFENSBURG) "PRINCIPALS OF NORMALIZATION." SIMPLY STATED, THE CONSUMER HAS THE RIGHT TO BE ALLOWED AND ENCOURAGED TO DEVELOP TO HIS / HER FULLEST POTENTIAL AND NOT BE HELD BACK IN HIS / HER OWN PERSONAL, SOCIAL, EDUCATIONAL, OR VOCATIONAL GOALS.

*NOTE THE LIST OF CONSUMER'S RIGHT IS NOT INTENDED TO EXCLUDE ANY OTHER RIGHTS AND PRIVILEDGES NOT MENTIONED HERE THAT ARE ENJOYED BY ADULT CITIZENS ANYWHERE IN THE UNITED STATES OF AMERICA.