



Family Support Services Enrollment Forms Checklist

Name: _____

For Office Use

Forms Needed for In-Home Care:

Scan to: Date:

- | | | |
|---|-----------------------|-------|
| _____ Enrollment Information Form | MIS/CDBG | _____ |
| _____ Information for FSS (4 pgs.) | Room | _____ |
| _____ Picture of Child | | |
| _____ Statement of Responsibility | | |
| _____ Client Indemnity Agreement (If you wish RUI employees to transport child) | | |
| _____ Income Information for FSS | CDBG | _____ |
| _____ Private Insurance Card (Copy) | Acctg. | _____ |
| _____ Payment Agreement | Acctg. | _____ |
| _____ Proof of Income | CDBG | _____ |
| _____ Plan of Care (POC)** | Acctg. If not RUI TCM | _____ |
| _____ Supportive Home Care Schedule (MR-10)** | Acctg. If not RUI TCM | _____ |
| _____ Family Support Documentation** | Coordinator | _____ |
| _____ Authorization for Emergency Medical Care | Room | _____ |
| _____ FSS Client Release Form | Room | _____ |
| _____ Authorization for Release and/or Disclosure (Additional copies available if needed) | | |
| _____ Request to Administer Medication
(Dr. signature required) | Rm./Nurse | _____ |
| _____ Person Centered Support Plan(s)** | Room | _____ |
| _____ Behavior Plan(s)/Info. | Room/Beh. Con. | _____ |

Additional Items Needed for Center-Based Care:

- | | | |
|---|-------------------|-------|
| _____ Media Release | Room | _____ |
| _____ Appointment of Agent | Room | _____ |
| _____ KDHE Medical Record-Page 1 & 2 | Nurse | _____ |
| _____ Child Health Assessment-Page 3 (Dr. signature required) | Nurse | _____ |
| _____ Meal Substitutions
(If Needed for Medical or Dietary Reasons-Dr. signature required) | Dir./Room/Kitchen | _____ |

Additional Items Needed for CAMP WOODCHUCK:

- | | | |
|---------------------------------------|---------------------------|-------|
| _____ Camp Enrollment Form (Schedule) | Dir./Room/If PP to Sched. | _____ |
| _____ Camp Payment Agreement | Acctg./If PP to Sched | _____ |
| _____ Camp Enrollment Fee (\$50) | Acctg. | _____ |

Items it would be helpful to have, but are not mandatory:

- | | | |
|---------------------------------------|------|-------|
| _____ Individual Education Plan (IEP) | Room | _____ |
|---------------------------------------|------|-------|

**You can obtain these items from your Targeted Case Manager. The forms a family needs will depend on the type of funding the client has for services.

Child Information

Full Legal Name		SSN (optional)	
Birthday		Sex	
Child is of Hispanic/ Latino Ethnicity		Y	N
Home address		School District	
City, State, Zip		Phone	
Physician name/phone			
Child lives with	<input type="checkbox"/> Both Parents	<input type="checkbox"/> Mother	<input type="checkbox"/> Father
	<input type="checkbox"/> Grandparent(s)	<input type="checkbox"/> Foster Parent(s)	<input type="checkbox"/> Other _____

Parent/Guardian Information

Full Name		
Address		
City, State, Zip		
Home Phone		
Cell Phone		
Work name and phone		
Opt-Out Statement	<input type="checkbox"/> By checking this box, I choose to opt-out of text message alerts from Rainbows United, Inc.	<input type="checkbox"/> By checking this box, I choose to opt-out of text message alerts from Rainbows United, Inc.
E-mail		
Relationship to Child	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Foster Mother <input type="checkbox"/> Foster Father <input type="checkbox"/> Grand Mother <input type="checkbox"/> Grand Father <input type="checkbox"/> Other: _____	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Foster Mother <input type="checkbox"/> Foster Father <input type="checkbox"/> Grand Mother <input type="checkbox"/> Grand Father <input type="checkbox"/> Other: _____
Education level	<input type="checkbox"/> Did not Graduate HS <input type="checkbox"/> HS Diploma or GED <input type="checkbox"/> Some College <input type="checkbox"/> AA/AS <input type="checkbox"/> BA/BS <input type="checkbox"/> Grad School <input type="checkbox"/> Master's or higher	<input type="checkbox"/> Did not Graduate HS <input type="checkbox"/> HS Diploma or GED <input type="checkbox"/> Some College <input type="checkbox"/> AA/AS <input type="checkbox"/> BA/BS <input type="checkbox"/> Grad School <input type="checkbox"/> Master's or higher

Family Information

Alternate contact's name	Phone	Relationship
Number of people living in home		
# of immediate family living in home	# Adults	# Minors
Yearly household income (estimate to the nearest \$1,000)		
How did you hear about RUI?	<input type="checkbox"/> Family/Friend <input type="checkbox"/> Physician <input type="checkbox"/> Medical <input type="checkbox"/> School <input type="checkbox"/> SRS <input type="checkbox"/> RUI Staff <input type="checkbox"/> Other _____	

Parent/Guardian Signature

Date

Since 1972, Rainbows United, Inc. has served the community as a not-for-profit agency. Rainbows prohibits discrimination in any aspect of the access to, admission, or treatment of consumers in its programs and activities, or in employment and application for employment on the basis of race, color, religion, sex, national origin, age, disability, veteran status, sexual orientation, or any other legally protected characteristics.

RAINBOWSSM

bringing potential to life

FAMILY SUPPORT SERVICES

2258 N. Lakeway Circle

Wichita, KS 67205

(316) 684-7060, Ext. 100

Emergency Cell # 259-9569

INFORMATION FOR FAMILY SUPPORT SERVICES

Date _____

CLIENT INFORMATION

Name _____

I would like my client to be enrolled for the following services as of _____ (date):

_____ In-Home Support Services

_____ Saturday Center (9 am – 3 pm)

_____ Sunday Center (1:30 pm – 5:30 pm)

_____ AM Latchkey (7:00 am – till bus arrival)

_____ PM Latchkey (bus arrival – 5:45 pm)

_____ All Day Latchkey (Preferred Hours are _____ till _____)

_____ Camp Woodchuck (more information to come later)

***Please note there may be a waiting list for one or more of these services.**

Current School: _____ Grade in school: _____

Client has: _____ Behavior Plan From: _____ School, _____ Parsons, _____ Other: _____

_____ Takes medications to alter mood or behavior.

_____ Mental Health Diagnosis (ex. Asbergers, PTSD, Bi-Polar, etc.)

Type of developmental disability/Diagnosis: _____

MR/DD Case Mgr/Agency: _____

Case Manager Phone: _____

Date of last health exam _____

Additional information about your child: _____

Speech Ability: _____

Hearing Ability: _____

Primary Form of Mobility: _____

Activities to be limited or restricted: _____

Special dietary needs or food preparation: _____

Behaviors to be considered: _____

Two great things about your child: _____

Picture of Client

Height _____

Weight _____

ADAPTIVE EQUIPMENT

Mobility equipment includes: _____

How to use it (placement and length of time): _____

Dressing/grooming equipment includes: _____

How to use it: _____

Mealttime equipment includes: _____

How to use it: _____

Bathing/toileting equipment includes: _____

How to use it: _____

Communication equipment includes: _____

How to use it: _____

Other equipment includes: _____

How to use it: _____

HOUSEHOLD EMERGENCY PLANS *(not needed for center only services)*

Fire **Fire Extinguisher is located:** _____

Tornado

Power Outage **Flashlight is located:** _____

Client Becomes Ill/Injured **First Aid supplies are located:** _____

Back-Up Plan in case agency staff not available for a scheduled shift:

SIBLINGS:

<u>Name</u>	<u>DOB</u>	<u>Address</u>	<u>Telephone</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

DUE TO STAFF ALLERGIES:

Pets/Names: _____

Does anyone in the household smoke? yes no

LOCATION OF HOUSEHOLD SUPPLIES *(not needed for center only services)*

Cleaning supplies: _____

Vacuum Cleaner/Broom: _____

Water Shut-off Valve: _____

HOUSEHOLD RULES

Meals/Snacks: _____

Pet care: _____

Family/Visitors: _____

Playtime/Games/TV Watching: _____

Naps/Bedtime Routine: _____

Off-Limits Areas/Items: _____

Outdoor Activities: _____

Behavior Information: _____



FAMILY SUPPORT SERVICES

2258 N. Lakeway Circle
Wichita, KS 67205
(316) 684-7060, Ext. 100
Emergency Cell # 259-9569

STATEMENT OF RESPONSIBILITY

On behalf of _____, my dependent, I wish to receive Family Support services. I have been fully informed of the scope of the Family Support Services program and agree to supply the staff with any and all information deemed necessary to safeguard the welfare of my dependent while being cared for by a Family Support provider.

In the event emergency medical treatment is deemed necessary, and I am not readily available, I authorize such procedures as are necessary to insure the health and well-being of my dependent. I understand that my dependent may become ill or injured during respite services and I agree that if this occurs through no negligence of the Family Support provider, I will not hold Rainbows United, Inc. and/or its employees liable for the illness or injury.

I have fully disclosed to the staff of Family Support Services, Rainbows United, Inc. all pertinent facts about my dependent's needs and problems; and acknowledge full responsibility if I fail to do so.

Signature

Date



Client/Parent Indemnity Agreement

THIS AGREEMENT, dated this ____ day of _____, 20____, is a contract between: _____ (person served hereinafter "Client") and Rainbows United, Inc., and its present and former agents, successors, assigns, employees, officers, directors, representatives, divisions, subsidiaries, parents, affiliated companies, attorneys, and insurers (hereinafter collectively "Rainbows").

WHEREAS, Client strongly desires that Rainbows' employees provide transportation services in personal vehicles for the direct convenience and benefit of Client;

WHEREAS, the primary benefit of such transportation benefits will accrue to Client and not Rainbows; and

WHEREAS, Rainbows' employees would not provide such transportation services unless Client entered into this Agreement.

IN CONSIDERATION of the premises and mutual promises herein contained, the parties agree and acknowledge as follows:

1. Rainbows' employees shall provide transportation services to Client as permissible under any applicable state or federal programs that permit such service and as Rainbows finds acceptable in its sole discretion.

2. To the fullest extent permitted by law, Client shall indemnify and hold harmless Rainbows from and against all claims, damages, losses and expense, including but not limited to attorneys' fees, arising out of or resulting from any performance of the transportation services provided by Rainbows' employees for Client under this Agreement.

3. In signing this Agreement, Client understands that the terms hereof are contractual and not merely a recital, and that Client is not relying upon any statement or representation made by Rainbows, but, instead, Client is relying solely upon Client's own judgment and/or the advice of Client's attorney. Client acknowledges that this Agreement is the entire agreement of the parties regarding this matter.

4. This Agreement is to be interpreted and enforced according to the laws of the State of Kansas, without regard to the principles of conflicts of law, and shall be binding upon Client, Client's heirs, next of kin, executors, administrators, successors, and assigns, and shall inure to the benefit of Rainbows and all other persons and entities released herein.

____ I have read the foregoing Agreement. I understand it and have been given the opportunity to ask questions about it. No one has pressured me or threatened me. I have given the matter adequate thought. After sufficient time to consider it, I want to enter into this Agreement.

____ I do not give permission for Rainbows employees to transport this client in their personal vehicle.

Parent or Guardian

Rainbows United, Inc.

Date: _____

Date: _____



INCOME INFORMATION FOR FAMILY SUPPORT SERVICES

CLIENT NAME: _____

PARENT'S/GUARDIAN'S NAME: _____

Total number in my household is: _____

Household Member Name (First and Last)	Relationship to Parent/Guardian	Date of Birth	Gross Wages (before taxes)	SRS TANF Benefits	SSI / SSDI	Adoption Subsidy or Child Support	Other (specify amount and source)	Total MONTHLY Income
Total Monthly Income								
								X 12
Annual Income								

	<u>YES</u>	<u>NO</u>
My child receives SSI	_____	_____
Medical Card # _____	_____	_____
My child has Medical Insurance	_____	_____

A copy of current insurance card is required.

I hereby certify that all of the above information is true and correct. I understand that this information is being given in connection with the receipt of Federal Funds; that Rainbows United officials may, for cause, verify information; and that deliberate misrepresentation may subject me to prosecution under applicable State and Federal criminal statutes.

When there is a change in family size or income, I will notify the Family Support Services office.

Signature of Parent/Guardian

Date



**FAMILY SUPPORT SERVICES
SLIDING FEE SCALE**

The fee schedule is based on the total household income of the person receiving support services. An "enrolled" person is an individual with one or more developmental disabilities. Persons receiving family support may access the sliding fee scale once this funding source has been utilized at the \$12.24 per hour rate.

SLIDING FEE SCALE FOR IN-HOME CARE, LATCHKEY, OR WEEKEND CENTER:

<u>Household Income</u>	<u>Service Rate</u>
\$0.01 to \$20,000.00	\$3.55/hour
\$20,000.01 to \$30,000.00	\$4.75/hour
\$30,000.01 to \$40,000.00	\$5.85/hour
\$40,000.01 to \$50,000.00	\$7.10/hour
\$50,000.01 to \$75,000.00	\$8.85/hour
\$75,000.01 and above	\$12.24/hour
Trust Fund	\$12.24/hour

SLIDING FEE SCALE FOR CAMP WOODCHUCK:

<u>Household Income</u>	<u>Rate Per Hour</u>
\$0.01 to \$25,000.00	\$3.40/hour
\$25,000.00 to \$50,000.00	\$4.25/hour
\$50,000.01 to \$75,000.00	\$5.05/hour
\$75,000.01 to \$100,000.00	\$5.90/hour
\$100,000.01 to \$150,000.00	\$7.00/hour
\$150,000.01 to \$200,000.00	\$8.40/hour
\$200,000.00 and above	\$11.60/hour
Trust Fund	\$12.24/hour

*If child attends half-days, divide the above rates by two.

Additional Information

- * Rainbows cannot provide care for a sibling of a child with HCBS-MR/DD funding.
- * Rainbows cannot provide care for a typical sibling in a group setting such as the Weekend Center, Latchkey Program or Camp Woodchuck.
- * Rainbows can provide care for a sibling at \$2.25 per hour per sibling if the child with disabilities receives an allocation from Family Support OR you are privately paying for the care and the team agrees it is appropriate.
- * Families using private or Family Support funds for camp will be charged for all days scheduled. Credit will not be given for days client does not attend.
- * Rainbows charges a late fee of \$5 for every 15 minutes past the scheduled time of pick-up.
- * Sliding Fee Scale rate will not be ratio'd.

This fee schedule may be revised at Rainbows' discretion.



FAMILY SUPPORT SERVICES
PAYMENT AGREEMENT

This Agreement is entered between Rainbows United, Inc. and _____, the parent(s) and/or legal guardians(s) of _____.

As the parent/legal guardian of the above named person, I have asked Rainbows United, Inc. to provide services for him/her. I agree to pay Rainbows United, Inc. for services rendered by a person acting on behalf of this Agency.

I understand that the rate for care is based on the income of my household which may include but is not limited to wages, child support, SSI payments, subsidies (such as Adoption), and any direct financial assistance. Furthermore, I will provide Rainbows with proof of my household income before accessing the sliding fee scale. Please submit proof of your total household income, for one month, with your application, i.e., pay check stubs, court order for child support, SSI letter showing monthly amount, food stamp notice showing monthly amount. (Sliding fee scale does not apply to agencies funding a service i.e. foster care agencies.)

Please check the option that applies:

_____ My child receives HCBS-MR/DD or HCBS/Autism Waiver services, I understand that Medicaid will pay Rainbows for the service provided according to the approved hours of the Plan of Care. _____ I understand that Medicaid requires the Agency to bill private insurance before billing Medicaid. I will ensure that Rainbows has a copy of the Plan of Care and the Prior Authorization. After the approved hours are used, I can access the sliding fee scale for additional hours. My rate for additional hours, according to the sliding fee scale will be \$_____ per hour. This rate will not be altered by the staff to child ratio.

_____ My child has supplemental funding from: _____ _____ I understand that this funding will be billed at the rate of \$12.24 per hour until the funding is no longer available. I will then be able to access the sliding fee scale. My rate according to the sliding fee scale will be \$_____ per hour. This rate will not be altered by the staff to child ratio.

_____ I choose to private pay as my child does not receive any MR/DD funding to supplement the cost of services. My rate according to the sliding fee scale will be \$_____ per hour. This rate will not be altered by the staff to child ratio.

_____ I choose to private pay the full rate of \$12.24 per hour. This rate will not be altered by the staff to child ratio.

Payments are due no later than 20 days from date of invoice. I understand as the parent/guardian, I have a responsibility to track the number of hours used and/or amount of funding spent.

I understand Rainbows United, Inc. may terminate services for the following reasons:

- * I do not complete a new application upon request; or
* I do not schedule care through the Family Support Services office; or
* I provide false and/or inadequate information regarding the above named person's care; or
* I refuse to comply with a request for verification of my household income; or
* I do not pay for the services received.

I understand Rainbows United, Inc. will not continue services beyond the services listed on the Plan of Care without this signed Payment Agreement on file. The same will apply if payments are not up to date. It is the responsibility of the family and/or guardian to ensure that this signed Payment Agreement has been returned and that payments are made on time.

Choose one of the following options:

_____ My dated signature on this form signifies my acceptance of this agreement until I revoke it in writing. I understand that all hours of services through Rainbows United must be scheduled with the Rainbows Scheduler. I have enclosed verification of my household income with this Agreement.

Signature

Date

_____ My dated signature on this form signifies my acceptance of this agreement until I revoke it in writing. I understand that all hours of services through Rainbows United must be scheduled with the Rainbows Scheduler. I choose not to enclose proof of total household income. Therefore, I may not access the Sliding Fee Scale, and my rate will be \$12.24 per hour.

Signature

Date

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FSS CLIENT RELEASE FORM (Regular and Emergency)

Client Name: _____

Client Lives With: Mother Father Other (specify) _____

Parent/Guardian Information

Please circle which one applies to you: Single Married

Mother/Guardian

Father/Guardian

Name: _____

Name: _____

Address: _____

Address: _____

City, State, Zip: _____

City, State, Zip: _____

Home Phone: _____

Home Phone: _____

Cell Phone: _____

Cell Phone: _____

E-Mail: _____

E-Mail: _____

Employer: _____

Employer: _____

Address: _____

Address: _____

City, State, Zip: _____

City, State, Zip: _____

Work Phone: _____ Work Hrs: _____

Work Phone: _____ Work Hrs: _____

Working Days (circle): M Tu W Th F Sa Su

Working Days (circle): M Tu W Th F Sa Su

I authorize those persons listed below to pick up my client from Rainbows United, Inc. Rainbows' staff is authorized to take this client off the USD 259 bus, if applicable.

Authorized persons: you should indicate **at least two other than parent/guardian**. Please include transportation companies. This form will serve as a list for emergency notification as well as pick up. List in order of preference.

NAME	ADDRESS	PHONE NUMBER	RELATIONSHIP
1.			
2.			
3.			
4.			
5.			
6.			

I understand that I am responsible for the following:

- 1) Notifying Rainbows in writing if any person on this list no longer has my permission to pick up this client.
- 2) Advising all persons listed above about the need to provide a picture ID, and that the identification must be presented in order to pick up this client.

Signed _____

Date _____



AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE OF INFORMATION

Child's Name: _____ Date of Birth: _____
Address: _____

AUTHORIZATION

I hereby authorize Rainbows United to:

_____ Disclose information to _____ Request information from

The following person or entity:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ FAX: _____ Email: _____

For date(s) of: _____

For the following purpose(s):

_____ Eligibility Evaluation _____ Case Planning
_____ Observation and Consultation _____ Behavior Planning _____ Case Coordination
_____ Other (specify) _____

This authorization shall remain in effect until _____ at which time this authorization to disclose information expires. If this item is left blank, the authorization shall remain effective for 90 days after the date listed below.

I understand information in my health records may include information about alcohol or drug abuse, psychiatric treatment, mental status information, HIV testing, HIV results, or AIDS information, and I hereby consent to the release of such information.

I understand if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I understand that reasonable fees may be charged for preparing and sending copies of records. I understand I may revoke this authorization at any time (except to the extent that action has been taken in reliance upon it) by providing written notification to Rainbows United.

Date Signature of Individual/Individual's Representative

Printed Name of Representative and Relationship Representative's address and telephone number

A photocopy of this Authorization shall be effective and valid as the original.

Rainbows United, Inc.
3223 N. Oliver / Wichita, KS 67220
(316) 260-4673



**Family Support Services
Request To Administer Medication**

FOR THE PHYSICIAN Please provide all requested information:

Name of Child: _____ Birth Date: _____

Weight: _____ Height: _____ Diagnosis: _____

Medication Allergies: _____

The above named client is to receive the following medication during his/her regular day. Please complete this form for *all* medications given at home, school and center. A physician's signature is required *prior* to nursing staff administering any medications, and to verify medications given to client.

Medication: Tylenol (Acetaminophen) **Dosage:** Weight/Age Appropriate

Purpose: _____

Requested Starting Date: Now **Expected Duration:** 1 year from start date

When to Administer: As Needed **Special Consideration:** _____

Special Instructions to Administer Medication: _____

Medication: _____ **Dosage:** _____

Purpose: _____

Requested Starting Date: _____ **Expected Duration:** _____

Times to Administer: _____ **Special Consideration:** _____

Special Instructions to Administer Medication: _____

Medication: _____ **Dosage:** _____

Purpose: _____

Requested Starting Date: _____ **Expected Duration:** _____

Times to Administer: _____ **Special Consideration:** _____

Special Instructions to Administer Medication: _____

FOR THE PARENT/GUARDIAN Please complete the following:

I hereby certify that (*Child's Name*) _____ has previously had at least one dose of the above prescribed medication and did not have an adverse reaction from it. I request that this medication be administered at school as directed above. I understand that Rainbows United, Inc. and any employee of Rainbow United, Inc. who administers this prescription to my child in accordance with written instructions from the physician or dentist shall not be liable for damages as a result of an adverse drug reaction suffered by the student because of administering such drug or because of mislabeled or altered product. I hereby authorize Rainbows United, Inc. personnel to exchange information regarding this request with the above named attending physician and with the pharmacy as identified on the affixed pharmacy label.

Signature: _____ Date: _____

Lawful Custodian

Please note: Physician's signature required on both sides of form if additional medications are listed on other side.

PHYSICIAN'S SIGNATURE: _____ **Date:** _____

Medications Cont'd

Medication: _____ **Dosage:** _____

Purpose: _____

Requested Starting Date: _____ **Expected Duration:** _____

Times to Administer: _____ **Special Consideration:** _____

Special Instructions to Administer Medication: _____

Medication: _____ **Dosage:** _____

Purpose: _____

Requested Starting Date: _____ **Expected Duration:** _____

Times to Administer: _____ **Special Consideration:** _____

Special Instructions to Administer Medication: _____

Medication: _____ **Dosage:** _____

Purpose: _____

Requested Starting Date: _____ **Expected Duration:** _____

Times to Administer: _____ **Special Consideration:** _____

Special Instructions to Administer Medication: _____

Medication: _____ **Dosage:** _____

Purpose: _____

Requested Starting Date: _____ **Expected Duration:** _____

Times to Administer: _____ **Special Consideration:** _____

Special Instructions to Administer Medication: _____

Medication: _____ **Dosage:** _____

Purpose: _____

Requested Starting Date: _____ **Expected Duration:** _____

Times to Administer: _____ **Special Consideration:** _____

Special Instructions to Administer Medication: _____

Medication: _____ **Dosage:** _____

Purpose: _____

Requested Starting Date: _____ **Expected Duration:** _____

Times to Administer: _____ **Special Consideration:** _____

Special Instructions to Administer Medication: _____

PHYSICIAN'S SIGNATURE: _____ **Date:** _____