

Residential Rights and Responsibilities Agreement

I, _____, an individual of CSC, Inc.'s residential program, understand that in addition to Basic Human Rights, an individual must also understand that all adults have Responsibilities, which include the following:

1. I will either work competitively or attend a day program during the day Monday through Friday.
2. I will help keep the home in which I live clean and orderly.
3. I will participate in the planning of recreational activities and outings for my home. I will follow through with the plans written on the Weekly Activity Schedule.
4. I will not have a weapon in my possession and I will not try to use any object as weapons.
5. I will cooperate with CSC staff members and accept their assistance.
6. I will contribute the designated amount per month to the cost of my room and board, payable on the first day of each month. These payments will come out of my SSI check or other income. I understand that CSC Inc. preserves the right to adjust the room and board contributions as dictated by its budget. If I cannot afford the agreed upon amount, I will make an agreement with CSC, Inc. to determine how much I am able to contribute based upon my income all or part of the expense for the following incurred by CSC, Inc. on my behalf: Medical, Dental, Social/Recreational, Pharmacological, Educational, Legal, Clothing, and Shoes.
7. I will pay for any long distance calls I make out of my personal use funds.
8. If I borrow any money from CSC, Inc., I will enter into an agreement with CSC, Inc. to pay back in monthly installments based upon my income.
9. I will work on the goals established with and for me at my annual IP meeting, and I will be able to access my IP.
10. I will accept the level of supervision I need as determined by my IP team.
11. I will accept the treatment that CSC, Inc. offers me and I will participate in the amount and kind of therapy that I need, as determined by my IP and the medical professionals who care for me.
12. When I go on a visit or leave with family or friends, I will complete a Leave of Absence Form and abide by its terms. When I have visitors in the home that I share with other individuals, I will meet with my visitors in common areas of the house (living room, dining room, club room, etc.) so as not to infringe upon the privacy of my housemates. I will entertain visitors only at reasonable hours that do not conflict with the established routines or scheduled activities. When I am expecting visitors, I will notify my staff and my housemates at the weekly house meeting. I have reviewed the visitation policy in my IP meeting.
13. I will indicate by behavior and attitude that I want to remain in the CSC, Inc. residential program. I understand that certain behaviors are not acceptable, and that CSC staff will call the police if I do any of the following:
 - a. Run away (elope)
 - b. Injure, or threaten to injure, myself or someone else, or seriously damage someone else's property (including CSC Inc. property).
 - c. Bring a weapon or illegal substance onto CSC, Inc. property.
 - d. Lose control of myself and behave in a way that causes other people to fear for their safety.

I understand that if the police are called because of my actions and the police determine that I have broken the law, the police may arrest me and charge me with a crime.

I understand that my records are kept on Therap Online Documentation system and a hard copy is available in my binder. I understand that these records are safe and will be made available upon my request.

14. The right to assert grievances with respect to infringement of guaranteed rights through the appropriate mechanisms including: 1) Human Rights Advisory Committee; 2) Advocates, if available; 3) Protection and Advocacy System. Grievances can be initiated by contacting any member or the committee and that member shall bring the grievances requests to the attention of the committee at the next meeting. If an individual brings a grievance requests that a committee member be excluded from the meeting at which the grievance will be discussed, the Chairperson shall exclude that committee member. I understand that making a complaint will not result in retaliation or barriers to my services.

If an individual exhibits inappropriate behavior, his/her interdisciplinary team will reconvene. If the interdisciplinary team recommends discharge because of the individual's unwillingness to learn adaptive behaviors to conform to reasonable expectations of conduct, the Standing Committee for CSC and/or other approved entity will review the case and may discharge the individual. The individual will then be referred to the Developmental Disabilities Administration.

_____ Initials

**** This consent expires one year from the PCP/Effective Date ****



Center for Social Change, Inc.

Residential Rights and Responsibilities Agreement (cont'd)

I, _____, the individual (or individual's legal guardian), hereby release and hold harmless CSC, Inc. and its agents/representatives/employees from any liability claim except for claims arising from injury to me caused by gross negligence on the part of CSC, Inc. or its agents/representatives/employees.

As determined by my social determinants of health and discussed at my annual IP meeting that CSC, Inc.(held in person , via phone , or virtual) , as my residential provider, has duty to provide with the A clean, safe, well-maintained residence which I will share with other individuals:

1. Furnishings for the home including furniture, a television in the living room or club room, linens, towels, decorations, etc.
2. Decorate my room in the manner I prefer
3. A telephone which I may use in private, provided I use it responsibly (keeping calls to a reasonable length, allowing staff and housemates to have reasonable access to the phone, etc.)
4. Legal representation and the ability to communicate with that person in an area in which communication cannot be seen or heard. If I do not have legal representative and I choose to/need to have one, CSC will help me secure one.
5. The right to be free from chemical restraints, except for minimal restraints that a physician authorizes, in writing for a clearly indicated medical need and made a permanent part of the individual's record.
6. Food and household items such as cleaning supplies and basic hygiene items (soap, toothpaste and toothbrushes, shampoo, shaving cream, and razors, deodorant, etc.)
7. All utilities for the residence except for my personal long-distance calls and individually elected non-necessary utilities.
8. The right to access my records.
9. Formal counseling/therapy as determined at my IP meeting or recommended by a physician/psychiatrist/psychotherapist who is treating me.
10. Any medical or dental services that I need as determined by my IP or recommended by medical/dental professionals who are treating me.
11. Mobility training and assistances needed and determined by my IP.
12. Opportunities for recreational/social activities as planned at the weekly house meeting.
13. Whatever training and assistance I need to develop appropriate social skills, safety skills, housekeeping skills (i.e., cooking, cleaning, laundering clothes), personal care skills (i.e. hygiene skills, choosing and buying clothes, getting haircuts, etc.), and money management/budgeting skills.
14. Any other services that I need, as determined by my IP and that CSC, Inc., as my residential provider, has duty to provide.
15. To live in an environment free from abuse, neglect, humiliation, and exploitation of any kind.
16. If I disagree with the recommendations, decisions, or actions of Center for Social Change, Inc., I may appeal to my Program Director, request an I.T.M. or contact the Developmental Disabilities Administration. A meeting to address my concerns must be arranged within 30 days of my request.
17. Access to my funds as agreed in my IP meeting and access to my financial records.
18. Adherence to research guidelines and ethics, when persons served are involved (if applicable).

I, _____, the individual (or individual's guardian on individual's behalf), understands that I am voluntarily an individual of CSC, Inc., and that my continued participation in CSC, Inc. programs/services is based upon my desire to remain in the program and my behavior. Should I decide to leave, a thirty day notice of intent is expected. During this thirty day notice, contributions to cost of care and room and board will continue regardless of the individual's participation in the program I understand that CSC, Inc. provides services to all of its individuals on the basis of need, without regard for and without discrimination on the basis of race, color, creed, age, sex, sexual orientation, national origin, marital status, or physical or mental disability. By signing below I agree that I have received my individual rights and responsibilities handbook.

Individual's Name (Printed)

Signature of Individual/Legal Guardian

Signature of Witness

Meeting Date

PCP/Effective Date

**** This consent expires one year from the PCP/Effective Date ****



Center for Social Change, Inc.

Created Material and Photograph Release Form

I, _____, hereby authorize Center for Social Change to use, reproduce, and/or publish any written or created materials, such as letters or drawn pictures, and/ audio or visual materials, including photographs, which may pertain to me. I understand that this material may be used in various promotional publications and recruitment materials, such a brochures, press releases and annual reports and in the event that I am missing (e.g., away without leave) and it is necessary to notify the police. This material may also appear on the CSC Web page and social media pages affiliated with Center for Social Change, such as Facebook. This authorization is continuous and may only be withdrawn upon my request. Consequently, Center for Social Change may publish materials, organization deems appropriate in order to promote/publicize its service opportunities.

(Initial)

_____ I agree to all the above.

_____ I only agree for emergency release of my picture.

Authorization to Release/ Obtain Information

I hereby authorize the Center for Social Change, Inc. to obtain and release, (initial all that apply)

- _____ Medical _____ Educational (IEP) _____ Psychological
- _____ Dental _____ Employment/Vocational _____ Psychiatric
- _____ Service Coordination/Resource Coordination/Case Management
- _____ Masters Recommendations _____ Family members/Legal Guardians

_____ Other _____

I understand that the information contained within these records is for professional use and will remain confidential. This authorization is effective until such time that I am discharged from the Center for Social Change, Inc. I authorize Center for Social Change staff to obtain medical/hospital treatment for the above participant in the event of an emergency or for ongoing care.

Individual's Name (Printed) Signature of Individual/Legal Guardian

Signature of Witness Meeting Date PCP/Effective Date

*** This consent expires one year from the PCP/Effective Date ***



Visitation Policy

- All visits must be scheduled at least 48 hours in advance with the program coordinator.
- Family/Guardian/Visitors shall visit with the individuals:
 - Monday through Friday between 4:30 p.m. - 8:00 p.m.
 - Saturday and Sunday between 10:00 a.m. - 6:00 p.m.
- Family/Guardian/Visitors shall meet with the individuals in common areas of their residential setting. Visits that take place in the home versus going out for an activity should be limited as to not disrupt others in the home.
- Any outside food has to be pre-approved by the coordinator, and should meet the nutritional plan requirement for the individual.
- All Visitors must be approved by the individual’s treatment team.
- All Visitors must respect the privacy of the other individuals living in the house.

Individual’s Name (Printed)

Signature of Individual/Legal Guardian

Signature of Witness

Meeting Date

PCP/Effective Date



Center for Social Change, Inc.

Annual Person Centered Plan Sign-In Sheet

Name of Person Served :		Date:	
Individual's Address:		Time:	
Purpose of Meeting:	<u>Annual Person Centered Planning (Social Determinants of Health)</u>		

Name	Title	Agency	Signature	Email Address

*** This consent expire one year from the PCP/Effective date. ***

