CAROLINE COUNTY
HEALTH DEPARTMENT
Caring for Caroline

The Caroline County Health Department

Coordination of Community Services

Individual Plan Booklet

"Supporting individuals with developmental challenges in living a healthy and happy life in their community"

DDA (Developmental Disabilities Services) | 403 S. 7th Street, Denton, Maryland 21629 | (p) 410-479-8075

HEALTH.MARYLAND.GOV/CAROLINECOUNTY

Scott LeRoy, Caroline County Health Officer

Coordination of Community Services
(CCS)

The Caroline County Health Department Developmental Disabilities Program (DDP) is a part of the Caroline County Health Department that supports individuals with developmental disabilities in living a healthy and happy life in their community.

The Coordinators of Community Services (CCSs) assist individuals with developmental disabilities in obtaining the best quality and most appropriate services available within their community. The services are uniquely tailored to meet the individuals' needs.

We are a team of qualified professionals skilled in conducting comprehensive assessment for determining eligibility for Developmental Disabilities Administration (DDA) services and connecting individuals with services that meet their unique needs.

We help people develop an individualized life plan.

Our Goal

To Promote Opportunities for persons with developmental disabilities that produce satisfying quality of life outcomes in the least restrictive environment possible and to assist the individual in achieving as much independence and control over his or her life as possible.

Our Commitment

To support all individuals, with developmental disabilities, in exercising, for themselves, the Four Principles of Self-Determination:

- FREEDOM (to make Choices)
- AUTHORITY (over Services and Supports)
- RESPONSIBILITY (for Organizing Resources)
- SUPPORTS (necessary to live in the Community)

Contents

Your Right to Be Informed

About the Most Integrated Setting

In 2005, a Bill was passed so that the people who receive services funded by DDA have the right to be informed about the Most Integrated Setting – about all the choices you could make about your life and the supports you receive!

CHOICE

You can pick from different things in different parts of your life.

SELF – DIRECTION

You have the RIGHT to make a choice about

The big things in your life like - Where to live, Where to work??

And the little things in your life - What to eat, What to watch on TV??

HOW CAN YOU LET SOMEONE KNOW WHAT YOUR CHOICE IS?

Do you want to ...

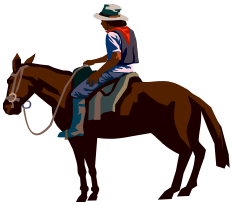
WORK

OWN A BUSINESS

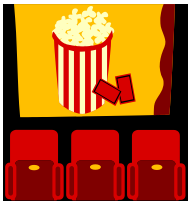
WORK IN A SHELTERED WORKSHOP

Would you like to ...

SWIM



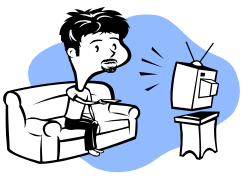
RIDE A HORSE



WATCH MOVIES

What do you like to do at home ...

SLEEP



WATCH TV

PLAY GAMES

Your Right to Be Informed

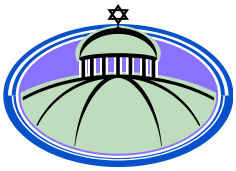
About the Most Integrated Setting

In 2005, a Bill was passed so that the people who receive services funded by DDA have the right to be informed about the Most Integrated Setting – and all the choices you can make about your life and the all the supports you receive !

IT IS YOUR RIGHT TO CHOOSE

Where do you want to worship ?

CHURCH



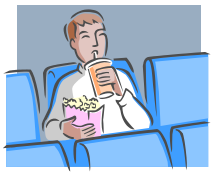
SYNAGOGUE

Your choice

of where

to worship

Where do you want to live - Live alone or with friends or roommates ?



LIVE ALONE

WITH FRIENDS / ROOM MATES

Your own house or an apartment?

RENT APARTMENT

BUY A HOUSE

In the city or country ?

INDIVIDUAL PLAN

Anniversary Date: _____

Date of IP Team Meeting: _____

SIGNATURES

Funding and final approval of DDA services is based on waiver enrollment and/or preauthorized emergency funding and approval from DDA Executive Director or designee. The waiver applicant will receive either an enrollment or denial letter from the Department. People enrolled in the waiver and/or approved for emergency funding have the right to explore licensed DDA service providers to provide the waiver and/or DDA State funded services listed in this plan.

During the development of the Individual Plan and/or its annual review, it is the individual's right to participate in, develop and modify the IP at any time, have access to it and to request a modification of the information contained therein at any time.

Individual's Name (Print): _____

Signature:_____

The team is in agreement that the individual is receiving services in the most integrated setting possible and team consensus is obtained on all services documented within this plan: ☐ YES ☐ NO

In accordance with **C.O.M.A.R.10.22.05.05) (A) (1) (2),**

This **INDIVIDUAL PLAN** has been reviewed and approved by:
(1) The Executive Officer/Administrative head of the Licensee or a Qualified Developmental Disabilities Professional whom he/she designates; and (2) One other professional who is responsible for carrying out a major program but does not participate in the IP.

Program Coordinator : _____ Date : _____

Provider Agency Director/Designee : _____ Date : _____

Coordinator of Community Services : _____ Date : _____

CCS Director/Designee : _____ Date : _____

INDIVIDUAL RIGHTS POLICY

It is the policy of the Caroline County Health Department CCS DD Program to comply with the Developmental Disabilities Law, Subtitle 10.22.04, Values, Outcomes and Fundamental Rights.

Individual Rights:

1. To have the same rights and protection as all other citizens under the laws and Constitution of Maryland and the United States;
2. To have religious and cultural beliefs respected;
3. To be free from abuse, neglect, and mistreatment;
4. To have personal information kept in confidence;
5. To live, work, and receive services in a manner that is not unnecessarily restrictive;
6. To have one's money and belongings secured; and
7. To have access to one's money and belongings.

In addition, individuals should be informed that they have the following rights:

1. The right to receive a timely, interdisciplinary assessment of support service needs;
2. The right to refuse evaluations, assessments, and services,
3. The right to be notified in advance, and to participate in all meetings in which a decision regarding a proposal to change one's eligibility status;
4. The right to have an advocate accompany him / her in any meeting;
5. The right to have complaints mediated by a Coordinator of Community Services.

During the development of the Individual Plan and Annual Review of the Individual Plan:

1. The right to participate in, develop, and change the Individual Plan at any time;
2. The right to have access to one's Individual Plan;
3. The right to examine and request amendment of information contained in the Individual Plan.
4. The right to be informed of the MOST INTEGRATED SETTING.

Signature and Date of:

_____

Individual (or Individual's Representative) Date

GRIEVANCE FORM

If your rights have been violated or if you feel discriminated against, you can file a grievance. Filing a grievance is a way to settle a disagreement. If you have a complaint about how you have been treated by a Coordinator of Community Services, you can complete this form verbally and if not resolved in writing.

Date: _____

Coordinator of Community Services Name: _____

Your Name:_____

Address:_____

Telephone Number: _____- _____- _____

What is the complaint?

_____
_____
_____
_____
_____

What do you want to happen?

_____
_____
_____

You can give it to your CCS or his/her Supervisor. Your CCS must answer this within five business days of receiving it. If you do not hear from the CCS or his/her Program Supervisor within five business days, you can send your grievance to the CCS Program Director.

If you need assistance with registering the grievance, you may also contact the CCS Program Director.

Date received:_____

Received by: _____

CCS Supervisor review:

Signature _____ Date _____

HOW TO FILE A GRIEVANCE

1. The individual presents the grievance **verbally to the CCS for informal discussion.** If the grievance is not resolved within 5 business days through this mechanism, the grievant may appeal to the next level in writing within the next 5 business days.
2. The individual presents the grievance **in writing to the CCS Supervisor**, or a designated representative. Within 5 business days of receipt of the grievance, the Supervisor conducts a conference with the grievant and renders a written decision within the next 10 business days. If not satisfied with the decision, the grievant may appeal to the next level in writing within the next 5 business days.
3. The individual presents the **written grievance to the Program Director**, or a designated representative. Within 10 business days of receipt of the grievance, the Program Director conducts a conference with the grievant, and renders a written decision within the next 15 business days. If the grievant is still not satisfied with the decision, he/she may appeal to the next level within the next level in writing within the next 10 business days.
4. The individual presents the **written grievance to the Health Officer, Deputy Health Officer,** or a designated representative. Within 10 business days of receipt of the grievance the Health Officer or Deputy Health Officer conducts a conference with the grievant and renders a written decision within the next 15 business days. If not satisfied with the decision, the consumer may grieve to the **Developmental Disabilities Administration (DDA), State of Maryland.**
5. Since the Caroline County Health Department's CCS DD program is licensed by the DDA Maryland, individuals have the right to proceed with their grievance if they are not satisfied after following the above procedures.
6. **Services continue throughout grievance**
7. Nothing in these rules prevents a grievant from continuing to work together to solve the underlying grievance, or to solve new problems as they may arise. During the time a grievance is pending at any stage, services the person is receiving shall continue unless safety or health reasons, as determined by the person's physician or planning team, suggest otherwise.

APPEALS PROCEDURE

Appeal Procedure for Participant Differences with Service Planning Team Recommendations

- **The Individual Plan is based on a wide range of individual choices and opportunities.**
- **Participants are encouraged to identify their own goals of independence, integration, and productivity.**
- **Each Individual Plan is developed to reflect the participant's interest and desires, and to provide the highest level of personal satisfaction**

Any participant for whom an Individual Plan is developed has the right to request a review of the plan at any time. Individuals receiving services may initiate appeal on the contents of his / her Individual Plan. A review of the Individual Plan must take place within 10 working days of the request of the individual. The request may be made verbally or in writing.

The CCS and the team will review the completed Individual Plan with the individual and attempt to accommodate any changes the individual desires. When negotiations to accomplish this fail, the CCS is responsible for notifying his / her supervisor and forwarding the appeal to the Regional Office. The request must be made in writing within 10 working days. When receiving a request from an individual to review his / her Individual Plan, the Coordinator of Community Services is required to document the request in the individual's record.

The following personnel will be available to assist any individual who would like to appeal decisions made in the Individual Plan:

- *Coordinator of Community Services (CCS)*
- *The team responsible for developing the Individual Plan*
- *CCS Supervisor for his / her respective county*
- *DDA Regional Director / Representative*

INDIVIDUAL CHOICE

All services that are provided reflect the individual's choice and respects each individual's right to make their own decisions.

Coordinators of Community Services do not recommend or influence an individual's choice of a service provider.

A. During the IP meeting the option for a choice of services and providers has been reviewed with the individual and/or their representative. The discussion is noted on the IP document and signed by all the team members.

B. For those individuals new to service, the verification of choice memo is completed and signed by the individual and/or their representative.

C. When community referrals are discussed the CCS will provide the individual / authorized representative with a list of providers and help the individual make an informed choice. When an individual or representative is not able to select a provider the team will decide on consensus.

Signature & Date: _____

Date

MARYLAND DEPARTMENT OF HEALTH AND YOUR HEALTH INFORMATION

NOTICE OF PRIVACY PRACTICES

FOR MENTAL HYGIENE AND DEVELOPMENTAL DISABILITIES FACILITY RESIDENTS

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW CAREFULLY.

Introduction

The Maryland Department of Health (MDH) is committed to protecting your health information. MDH is required by law to maintain the privacy of Protected Health Information (PHI). PHI includes any identifiable information that we obtain from you or others that relate to your physical or mental health, the health care you have received, or payment for health care. As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of PHI. In order to provide treatment or to pay for your healthcare, MDH will ask for certain health information and that health information will be put into your record. The record usually contains your symptoms, examination and test results, diagnoses, and treatment. That information, referred to as your health or medical record, and legally regulated as health information, may be used for a variety of purposes.
MDH and its Business Associates are required to follow the privacy practices described in this Notice, although MDH reserves the right to change our privacy practices and the terms of this Notice at any time. You may request a copy of the new Notice from any MDH agency. It is also posted on our website at http://MDH.maryland.gov.

PERMITTED USES & DISCLOSURES

MDH employees will only use your health information when doing their jobs. For uses beyond what MDH normally does, MDH must have your written authorization unless the law permits or requires it, and you may revoke such authorization with limited exceptions. The following are some examples of our possible uses and disclosures of your health information:

USES AND DISCLOSURES *WITHOUT CONSENT* RELATING TO TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS:

- **For treatment:** MDH may use or share your health information to approve, deny treatment, and to determine if your medical treatment is appropriate. For example, MDH health care providers may need to review your treatment with your healthcare provider for medical necessity or for coordination of care.
- **To obtain payment:** MDH may use and share your health information in order to bill and collect payment for your health care services and to determine your eligibility to participate in our services. For example, your health care provider may send claims for payment of medical services provided to you.
- **For health care operations:** MDH may use and share your health information to evaluate the quality of services provided, or to our state or federal auditors.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION REQUIRED OR PERMITTED BY LAW:

- **Information purposes:** Unless you provide us with alternative instructions, MDH may send appointment reminders and other materials about the program to your home.
- **Required by law:** MDH may disclose health information when a law requires us to do so.
- **Public health activities:** MDH may disclose health information when MDH is required to collect or report information about diseases, injuries, or to report vital statistics to other divisions in the department and other public health authorities.

- **Health oversight activities:** MDH may disclose your health information to other divisions in the department and other agencies for oversight activities required by law. Examples of these oversight activities are audits, inspections, investigations, and licensure.
- **Coroners, Medical Examiners, Funeral Directors and Organ Donations:** MDH may disclose health information relating to a death to coroners, medical examiners or funeral directors, and to authorized organizations relating to organ, eye, or tissue donations or transplants.
- **Research purposes**: In certain circumstances, and under the supervision of our Institutional Review Board or other designated privacy board, MDH may disclose health information to assist medical research.
- **Avert threat to the health or safety:** In order to avoid a serious threat to health or safety, MDH may disclose health information as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.
- **Abuse and neglect:** MDH will disclose your health information to appropriate authorities if we reasonably believe that you may be a possible victim of abuse, neglect, domestic violence, or some other crime. MDH may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
- **Specific government functions:** MDH may disclose health information of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government benefit programs relating to eligibility and enrollment, and for national security reasons, such as protection of the President. .
- **Family, friends, or others involved in your care:** MDH may share your health information with people as it is directly related to their involvement in your care or payment of your care. MDH may also share your health information with people to notify them about your location, general condition, or death.
- **Worker's compensation:** MDH may disclose health information to worker's compensation programs that provide benefits for work-related injuries or illnesses without regard to fault.
- **Patient directories:** MDH entities generally do not maintain directories for disclosures to callers or visitors who ask for you by name. However, if a MDH entity does maintain a directory, you will not be identified to an unknown caller or visitor without authorization, and the limited information we disclose may include your name, location in the entity, your general condition (e.g., fair, stable, etc.) and your religious affiliation.
- **Lawsuits, disputes and claims:** If you are involved in a lawsuit, a dispute, or a claim, MDH may disclose your health information in response to a court or administrative order, subpoena, discovery request, the investigation of a complaint filed on your behalf, or other lawful process.
- **Law enforcement:** MDH may disclose your health information to a law enforcement official for purposes that are required by law or in response to a subpoena.
- **Other parties for conducting permitted activities:** MDH may conduct the above-described activities ourselves, or we may use non-MDH entities (known as Business Associates) to perform those operations. In those instances where we disclose your PHI to a third party acting on our behalf, we will protect your PHI through an appropriate privacy agreement.
- **Fundraising Activities:** MDH may use information about you to contact you in an effort to raise money for MDH and its operations. The information we release about you will be limited to your contact information, such as your name, address and telephone number and the dates you received treatment or services at MDH.

YOUR RIGHTS

You Have a Right to:

- **Request restrictions:** You have the right to request a restriction or limitation on the health information MDH uses or discloses about you. MDH will accommodate your request if possible, but is not legally required to agree to the requested restriction. Except as otherwise required by law, MDH must accommodate your request if the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full.
- **Request confidential communication:** You have the right to ask that MDH send you information at an alternative address or by alternative means. MDH must agree to your request as long as it is reasonably easy for us to do so.
- **Inspect and copy:** With certain exceptions (such as psychotherapy notes, information collected for certain legal proceedings, and health information restricted by law)**,** you have a right to see your health information upon your written request. If you want copies of your health information, you may be charged a reasonable and cost-based fee for copying, postage, and preparing an explanation or summary of the protected health information. You have a right to choose what portions of your information you want copied and to have prior information on the cost of copying. If MDH maintains your health information using electronic health records, we will provide access in electronic format and transmit copies of the health information to an entity or person designated by you, provided that any such choice is clear, conspicuous, and specific.
- **Request amendment:** You may request in writing that MDH correct or add to your health record. MDH will respond to your request within 60 days, with up to a 30-day extension, if needed. MDH may deny the request if MDH determines that the health information is: (1) correct and complete; (2) not created by us and/or not part of our records; (3) not permitted to be disclosed. If MDH approves the request for amendment, MDH will change the health information and inform you, and MDH will tell others that need to know about the change in the health information.
- **Require authorization:** You have the right to require your authorization for most uses and disclosures of psychotherapy notes, for receiving marketing communication and for the sale of your PHI**.**
- **Receive accounting of disclosures:** You have a right to request a list of the disclosures made of your health information after April 14, 2003, and in the six years prior to the date on which the accounting is requested. Exceptions are health information that has been used for treatment, payment, and health care operations. In addition, MDH does not have to list disclosures made to you, based on your written authorization, provided for national security, to law enforcement officers, or correctional facilities. There will be no charge for up to one such list each year**.** Additionally, MDH will provide an accounting for disclosures made through an electronic health record for treatment, payment, and health care operations, but information is limited to three years prior to date of request.
- **Opt-Out:** You have the right to receive fundraising communication and the right to request to opt-out of fundraising communication. You also have a right to request to opt-out of a MDH facility's patient directory.
- **Receive notice:** You have the right to receive a paper copy of this Notice and/or an electronic copy by mail upon request.
- **Receive breach notification:** You have the right to receive notification whenever a breach of your unsecured PHI occurs.
- **Receive protection of genetic information:** If any of MDH's health care components is considered a health plan, the health plan is prohibited from using or disclosing your genetic information for certain underwriting purposes.
- **Receive protection of mental health records:** If a medical record that is developed in connection with you receiving mental health services is disclosed without your authorization, MDH will only release the information in your record that is relevant to the purpose for which the disclosure is sought.

FOR MORE INFORMATION:

This document is available in other languages and alternative formats that meet the guidelines for the Americans with Disabilities Act. If you have questions and would like more information, you may contact your Care Coordinator or CSS worker.

TO REPORT A PROBLEM ABOUT OUR PRIVACY PRACTICES:

If you are a resident of a MDH facility and believe that your privacy rights have been violated, you may file a complaint.

- You can file a complaint with the Department of Health and Mental Hygiene, Resident Grievance System Central Office at 1-800-RGS-7454.
- You can file a complaint with the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights. You may call the Department of Health and Mental Hygiene for the contact information.

MDH will take no retaliatory action against you if you make such complaints.

Effective Date: This notice is effective on August 19, 2013.

(PROVIDER PROGRAMS MUST ENSURE THAT THEY TRY TO GET THIS ACKNOWLEDGEMENT SIGNED)

Acknowledgement of receipt of this notice:

_____ _____

Patient or Authorized Representative Date

_____ _____

Signature of MDH representative Date

If unable to get acknowledgement, specify why:

CAROLINE COUNTY
HEALTH DEPARTMENT
Caring for Caroline

INDIVIDUAL'S AUTHORIZATION

Purpose: This form is used to confirm the direction of an individual to authorize the Caroline County Health Department to request, to use, or to disclose the individual's health information.

Please type or print neatly; we are not able to process incomplete or illegible forms.

☐ **Check if this authorization for Psychotherapy notes.**

If this authorization is for Psychotherapy notes, MDH will not use it as an authorization for any other type of health information. If the individual seeks to authorize the use and disclosure of other health information as well, an additional form must be submitted.

SECTION A : Individual's Health Information authorized for Use and Disclosure.

Last Name: _____ First Name: _____MI:_____

Street Address: _____ Apt # _____

City: _____ State: _____ Zip: _____

Phone (home):_____ (Work):_____ Date of Birth: ____ / ____ / ____

SECTION B : The Use and / or Disclosure being authorized.

Provide a detailed description of the health information you are authorizing us to use and/or disclose.

The purpose of the Disclosure (Optional): _____

Who is authorized to ☐ Disclose / ☐ Receive and Use your health information:

NAME (S): Developmental Disabilities Program Caroline County Health Department

ADDRESS: 403 S. 7th Street Denton, MD 21629

TELEPHONE NUMBER: 410-479-8075_____ FAX : 410-479-5383_____

Who is authorized to ☐ Disclose / ☐ Receive and Use your health information:

NAME (S): _____

ADDRESS:_____

TELEPHONE NUMBER: _____ FAX :_____

If the information which the program has includes records or information from another entity, I ___ do or ____do not wish to have that information released under this authorization.

SECTION C: Expiration and Revocation:

Expiration: This authorization will expire (complete one):

☐ On _____/ _____/ _____ ☐ On occurrence of the following event (which must relate to the individual or to the purpose of the use and/or disclosure being authorized): _____

Right to Revoke: *I understand that I may revoke this authorization at any time by giving written notice of my revocation to MDH. In order to obtain a revocation form to revoke this authorization, I understand that I may contact* ***Caroline County Health Department****. I understand that revocation of this authorization will not affect any action that MDH or others named or unnamed took in reliance on this authorization before MDH received my written notice of revocation.*

SECTION D : Signature.

To the individual: Please read the following:

- *I authorize the use and/or disclosure of my health information as described in Section B above. I understand this authorization is voluntary.*
- *I understand that if the persons or organizations I authorize to receive and/or use my health information are not subject to the federal or state health information privacy laws, they might further disclose the health information, and it may no longer be protected by the health information privacy laws.*
- *I have had full opportunity to read and consider the contents of the authorization, and I confirm that the contents are consistent with my intent.*

Signature: _____ *Date:* _____

If a ***personal representative*** *is making this request, please attach a copy of any document granting legal authority and complete the following:*

Personal Representative's Signature & Name (Printed): _____

Relationship to the Individual: _____

****

CAROLINE COUNTY
HEALTH DEPARTMENT
Caring for Caroline

Caroline County Health Department Developmental Disabilities Program

TEAM DISCUSSION HIGHLIGHTS :

PREVIOUS YEAR'S OUTCOMES & GOALS

PROGRESS SUMMARY :

CAROLINE COUNTY
HEALTH DEPARTMENT
Caring for Caroline

Team Meeting Sign-in Sheet:

Date of Meeting:

Coordination of Community Services Developmental Disabilities Program

Phone : 410-470-8075 Fax: 410-479-5383 Toll Free: 855.236.3079

Name	*Signature*	*Agency*	*Relationship*

Individual Plan Reporting Form

Individual's Name: _____ CCS : _____

IP Anniversary Date: _____ Team Meeting Date: _____

FINANCIAL STATUS REVIEW:

Waiver Eligibility :	Categorical	Optional	MA Redet.Dt.	Representative Payee :	Agency	Family
Medicaid #				SS #		
Medicare #						
SSI	SSDI	SSA				

ASSURANCE	Y	N	PLEASE EXPLAIN /SPECIFY REASON
1. IP being developed within 30 days of service initiation/365 days of the previous IP (as applicable) ?			
2. IP include outcome oriented goals that reflect the strengths, needs, preferences and interests of the individual?			
3. Progress made on IP outcomes & goals documented in the IP at least quarterly?			
4. Individual has the authority and supports to directly manage own services?			
5. Individual was informed of self-directed services?			
6. Offered choice in Service Providers including CCS services ?			
7. Individual was informed of their fundamental rights and responsibilities with regards to services?			
8. Was a request made to change CCS / CCS Agency ?			W/in calendar days #
9. Supports / strategies in place for seeking and maintaining work in competitive integrated settings (if so desired) ?			
10. IP identifies natural supports and community supports?			
11. Was an alternative communication method requested?			ASL / Assistive Tech. / Interpreter
12. If yes, was the requested communication method provided?			
13. Does the team agree that all Health and Safety issues have been addressed?			
14. Specific health concerns, if any?			HRST Score #
15. Please specify if the Individual is not willing to discuss health issues?			
16. Individualized Emergency Plan discussed at the IP meeting?			
17. Were there any Reportable Incidents during the IP year / in the interim?			
18. Did the CCS follow up on the IR's to determine the status and potential need for additional supports and/or services?			
19. Any requests for service change developed during the IP year to meet any changes in service needs?			
20. Willing to participate in Customer Satisfaction Survey (CSS)?			
21. Meeting is at a convenient time and place for all team members?			
22. Team agreement on Outcomes/goals ?			

CAROLINE COUNTY
HEALTH DEPARTMENT
Caring for Caroline

Developmental Disabilities Program

To:

Date:

CONSUMER SATISFACTION SURVEY

Dear Sir or Madame:.

We are happy to provide you with a tool so you can let us know how we are doing and how we can improve our services. Enclosed please find a **Customer Satisfaction Survey** where you can rate your experience with your Coordinator and give us your feedback on how we can provide you with better services.

Our goal is to not only fulfill but to exceed your expectations and there is no better way to ensure this than by your feedback. Please complete the attached survey and mail it directly to me in the self-addressed envelope marked CONFIDENTIAL.

Please seal the envelope before sending it back. I assure you that your responses will be kept confidential and any information will be used strictly for Quality Assurance purposes.

Thank you!

With best regards,

Quality Assurance Review Committee

Developmental Disabilities Program

Caroline County Health Department

Email : cchd.qa@gmail.com

Customer Satisfaction Survey – Coordinator of Community Services

Date:

My Living Arrangements

☐ I live with family ☐ have staff help ☐ I have room-mates ☐ I live on my own ☐ other

My Work or Other Day Arrangements

☐ I am employed ☐ I volunteer ☐ I go to a day program ☐ I go to school ☐ I stay home ☐ other

1. My(DDA)Community Coordinator's name is: [] Ann McGarrity [] Joy Patchett [] Samantha Ward [] Shantwan Dowell
   [] Other: _____

- or -

☐ I have a new Coordinator of Community services and don't know the name
☐ I know who it is but not their name
☐ I don't know

My (DDA) Coordinator of Community Services:

	☺	😐	☹	?
2. Returns my calls and comes to meetings on time	Yes	Some	No	I don't know
3. Talks to me before my annual /IP meeting about my services	Yes	Some	No	I don't know
4. Sees me more than just at my annual /IP meeting	Yes	Some	No	I don't know
5. Helps me figure out my goals (what I want in my IP)	Yes	Some	No	I don't know
6. Is always respectful and professional	Yes	Some	No	I don't know
7. Are you satisfied with your Coordinator of Community Services?	Yes	Some	No	I don't know

I answered these questions: ☐ by myself ☐ with family ☐ with a friend ☐ with staff ☐ other

Notes & Suggestions:

The information from this survey is private. We will not share it with anyone. You may give us your name if you want to, but you don't have to. You can also add your own comments.

We will be using your answers to help us improve our services.

Thank you for taking time to share your thoughts!

EMERGENCY ACTION PLAN

Plan 9

You can do this!

Collect these nine essential items to help you shelter-in-place in the event of an emergency.

Start here

1 Water

One gallon per person, per day for three days.

2 Food

Non-perishables such as canned or packaged food.

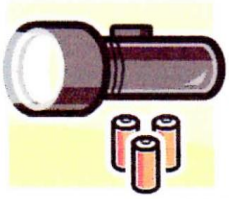
3 Clothes

One change of clothes and footwear per person.

4 Medications

Three days' worth of prescription medications.

5 Flashlight

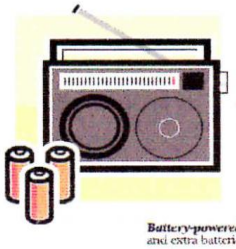


A bright flashlight and extra batteries.

6 Can Opener

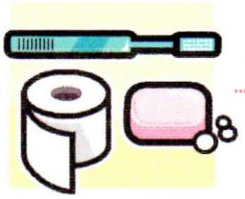
***Manual* can opener** in case there's no electric power.

7 Radio



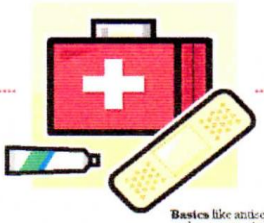
***Battery-powered* radio** and extra batteries.

8 Hygiene Items



Basics like soap, toilet paper and a toothbrush.

9 First Aid



Basics like antiseptic, bandages, and non-prescription medicines.

Done!

For more information about emergency preparedness, contact some of the following organizations:

American Red Cross	redcross.org
Centers for Disease Control	cdc.gov
Disaster Help	disasterhelp.gov
Federal Emergency Management Agency	fema.gov
U.S. Department of Homeland Security	ready.gov

APC
Advanced Practice Centers

Federal Emergency Management Agency (FEMA)

EMERGENCY PREPAREDNESS

Make sure your family has a plan in case of an EMERGENCY!

Before an emergency happens,

- **Sit down together**
- **Decide how you will contact each other**
- **Where you will go & What you will do**
- **Keep a copy of this plan in the Emergency Supply Kit or in a safe place where you can access it in the event of a disaster.**

BASIC DISASTER SUPPLIES KIT

A Basic Emergency supply Kit could include the following recommended items:

- **Water,** one gallon of water per person per day for at least three days, for drinking and sanitation
- **Food,** at least a three-day supply of non-perishable food
- **Battery-powered or hand crank radio** and a NOAA Weather Radio with tone alert and extra batteries for both
- **Flashlight** and **extra batteries**
- **First aid kit**
- **Whistle** to signal for help
- **Dust mask** to help filter contaminated air and **plastic sheeting and duct tape to shelter-in-place**
- **Moist towelettes, garbage bags and plastic ties** for personal sanitation
- **Wrench or pliers** to turn off utilities
- **Manual can opener** for food
- **Local maps**
- **Cell phone with chargers, inverter or solar charger**

ADDITIONAL ITEMS to consider:

- Prescription medications and glasses
- Infant formula and diapers
- Pet food and extra water for your pet
- Cash or traveler's checks and change
- Important family documents such as copies of insurance policies, identification and bank account records in a waterproof, portable container. You can use the Emergency Financial First Aid Kit - EFFAK (PDF - 977Kb) developed by Operation Hope, FEMA and Citizen Corps to help you organize your information.
- Emergency reference material such as a first aid book or free information from this web site. (See Publications)
- Sleeping bag or warm blanket for each person. Consider additional bedding if you live in a cold-weather climate.

EMERGENCY PREPAREDNESS cont.….

- Complete change of clothing including a long sleeved shirt, long pants and sturdy shoes. Consider additional clothing if you live in a cold-weather climate.
- Household chlorine bleach and medicine dropper – When diluted, nine parts water to one part bleach, bleach can be used as a disinfectant. Or in an emergency, you can use it to treat water by using 16 drops of regular household liquid bleach per gallon of water. Do not use scented, color safe or bleaches with added cleaners.
- Fire extinguisher
- Matches in a waterproof container
- Feminine supplies and personal hygiene items
- Paper and pencil
- Books, games, puzzles or other activities for children
- Mess kits, paper cups, plates, paper towels and plastic utensils

Remember being prepared is the best way to assure you will make it safely through an unforeseen event.
Don't leave this to the last minute, it will be too late.

Fill out an **EMERGENCY CARD** & Give These to All Family Members

FAMILY EMERGENCY PLAN

EMERGENCY CONTACT NAME: ……...…… Phone……..……..……..

OUT-OF-TOWN CONTACT NAME: …… Phone……

NEIGHBORHOOD MEETING PLACE: ……..……..…

OTHER IMPORTANT INFORMATION & PHONE NOS: ……..

……

Thank you for allowing us to be a part of your decision making process.

We promise to strive to provide the best guidance, oversight, and assurance that all your choices are being implemented in a manner that is acceptable to you.

Our Mission, as part of the State Health Department, is to assure that you, along with all county residents, live a longer and healthier life.

Thank you again

The Care Coordination Team at The Caroline County Health Department.

Reviewed & Revised: October 5, 2017