Avenues to Independent Living
304 South Broad St., Woodbury, NJ 08096
Office: (856) 537-7919, Fax: (856) 537-7914
Email: Intake@AvenuesTIL.com

Dear Parents or Guardians,

First, I would like to thank you for choosing Avenues to Independent Living to serve the needs of your loved one.

Enclosed are the following forms that need to be filled out prior to starting services with Avenues to Independent Living:

1. Intake form
2. Release of Information form
3. Consent forms
4. Medical form by individual's physician
5. Dental Form by individual's dentist
6. Client Rights

Receiving this information and meeting with you and your loved one virtually or in-person before we start services will provide us with a better understanding of which services and staff will best fit your needs.

We have provided a brochure which includes all of the services that Avenues to Independent Living provides.

For your convenience we have listed the following contacts. These are the department heads you may need to contact in the event you need to make requests, or if you have any questions regarding our services:

1. Joan Clark, CEO: JClark@AvenuesTIL.com, ext. 103
2. Stephanie Lundfelt, Assistant Director: SLundfelt@AvenuesTIL.com, 856-430-5391
3. Scheduling Department: scheduling@AvenuesTIL.com ext. 102 or 112
4. Regina Brogan, Finance: RBrogan@AvenuesTIL.com (Finance) ext. 106
5. Kelsey Dominik, Administrative Assistant: ext. 101

If you have any questions or concerns, you can call the office between 8 a.m.-6 p.m.; Monday - Friday.

If you have questions after hours please reach-out to Stephanie Lundfelt at 856-430-5391.

Once again, we thank you for choosing Avenues to Independent Living and we are excited to begin this journey with you.

Sincerely,

Joan Clark
CEO

LOOK FOR US ON FACEBOOK

Avenues to Independent Living
304 South Broad St. Woodbury, NJ 08096
Office: 856-537-7919 Fax 856-537-7914 Email: Intake@AvenuesTIL.com

AVENUES INTAKE

Person to be contacted and responsible for any questions regarding this application:

Name: _____ Phone#: _____

1. **INDIVIDUAL'S PERSONAL INFORMATION** (**Please include a recent photo of the individual with this form)**

First Name: _____ Last Name: _____

Age: Select Age Birth Date: _____ Sex: Select Sex Nickname: _____

Email Address: _____

Mobile Phone #:_____

Home Address: _____

City: _____ State: _____ Zip: _____ County: _____

INDIVIDUAL LIVES IN (CHECK APPROPRIATE BOX)

☐Family Home	☐Own Apartment	☐Group Home	☐Skill Sponsor Home	☐Other:

Who is the contact person in the home: Name:_____ Contact Phone #:_____

2. GUARDIAN INFORMATION

Who is the individual's legal guardian? ☐**Self** ** ☐**Parent(s)** **☐**Other**

****A copy of the court guardianship paperwork must be provided to Avenues included when submitting this application.**

Name(s) of legal guardian(s) and relationship:_____

Guardian Address:

_____

Home #: _____ Best Mobile #: _____

Best Email Address:_____

Name(s) of authorized signer of billing vouchers: ☐**Self** ☐**Others:** _____

Support Coordinator's Name:_____ Phone#: Email:_____

3. EMERGENCY CONTACTS: (PLEASE LIST TWO CONTACTS FOR EMERGENCIES OTHER THAN YOURSELF)

1. Name: _____ Relationship to Individual: _____

Address: _____ City: _____ State: _____ Zip: _____

Mobile # _____ Alternate # _____

2. Name: _____ Relationship to Individual: _____

Address: _____ City: _____State: _____ Zip: _____

Mobile #: _____ Alternate #: _____

INSURANCE INFORMATION: In the event of an accident or injury, your insurance will be used as the primary coverage. Avenues will be used as the secondary coverage.

THIS INDIVIDUAL IS COVERED BY: (Check all that apply)

☐ **Medicaid (M.A.) #: _____ Medicaid #: _____**

☐ **Blue Cross/ Blue Shield Group #: _____**

☐ **Other Insurance: _____ Group #: _____**

☐ **NO INSURANCE COVERAGE**

**** * If individual does not have medical insurance coverage or insurance information is not provided, the person listed below will be responsible for all medical costs.**

Name(s) of Responsible Person(s): _____

PHOTO/IMAGE/LIKENESS PERMISSION:

By signing below, you give permission for the individual to have his/her photograph taken or be filmed by Avenues during activities. The person's name will not be used.

X_____
Guardian Signature

Documents needed:

If the individual is or will be living on their own and/or will be receiving Supported Employment services, copies of the following documents are to be included with this application:

☐ Social Security Card ☐ Medical/Health Insurance Card(s) ☐ Birth Certificate ☐ ID Card

By signing at the X, you are acknowledging that all of the information in this packet is complete and correct to the best of your knowledge.

X_____

If you should have any questions while filling out this intake packet please do not hesitate to call our office during normal business hours and we will be more than willing to help you out. Thank you in advance for your time in filling out this packet.

Revised 11/22

AVENUES TO INDEPENDENT LIVING
AUTHORIZATION TO RELEASE INFORMATION

304 South Broad Street
Woodbury, NJ 08096
(856) 537-7919, Fax (856) 537-7914

Client's Name: _____ Date of Birth: _____

I hereby authorize Avenues to Independent Living (check all that apply):

☑ to obtain from/ provide to the Division of Developmental Disabilities

☑ to obtain from/ provide to my support coordinator and/or my support coordination agency

☑ to obtain from/ provide to potential employers, pre-vocational and volunteer site managers

☐ to obtain from/ provide to the NJ Division of Vocational Rehabilitation

☐ to obtain from/ provide to the Division of Disability Services

☐ to obtain from/ provide to other entities, list:_____

_____

All available documents/information from the records pertaining to services received by me by the entity named above, history of my volunteer activities, employment, relevant health and medical history, services history, information regarding my disability, and other relevant information as needed in order to provide effective and appropriate services as authorized in my individualized service plan.

The records are required for the specific purpose of determining services necessary to provide job support and services associated with the various entities and state divisions as identified above.

I understand that my authorization will be effective from the date of my signature until _____, (if blank, then indefinite) and that the information will be handled confidentially and in compliance with all applicable federal and state laws and regulations.

I understand that I may see the information that is to be sent, and that I may revoke the authorization at any time by written, dated communication.

I have read and understand the nature of this release.

X _____ _____

Signature of Client (if own guardian) or Legal Guardian/Representative **Date**

rev. 11/22

AVENUES TO INDEPENDENT LIVING
INFORMED CONSENT AGREEMENT

Client:_____ **Phone:**_____

• PERSONAL HEALTH INFORMATION DISCLOSURE:

I understand that by giving my consent I am permitting my personal health information to be disclosed to persons who will be involved in my treatment; it may also be used for payment and operational purposes as allowed by law. I have reviewed and received a copy of the "Notice of Privacy Practices" before signing this consent, and that AVENUES reserves the right to change the terms of the notice of privacy practices and make changes available to me.

I may request additional restrictions on access to this information for treatment, payment or health care operations purposes, and I understand that AVENUES may not be able to comply with this request if AVENUES has already acted in reliance on this consent. I request the following special restrictions:

_____

I consent to the use of my identifiable client information necessary for the continuity of my care or which may be of benefit in maintaining or improving my health with the understanding that AVENUES will not provide such information to others for marketing, fundraising, or similar purpose without may specific consent.

I understand that I, or my legal guardian, promptly upon request may inspect, request correction of and obtain information from my patient record.

I may revoke this consent in writing at any time except to the extent AVENUES has already acted in reliance on this consent.

X_____

Client/Legal Guardian Signature (state relationship) **Date**

• CONSENT FOR SERVICE:

I request and agree to have services provided by AVENUES and authorize AVENUES employees to enter my place of residence to assess, supervise, and carry out the agreed upon service.

I understand that my consent is voluntary and I have the right to accept or refuse any service as I choose. I have been informed of the hazards of my choice, such as falls, and that certain other risk and hazards in care are beyond the control of AVENUES.

• AUTHORIZATION TO BILL INSURANCE

If I am eligible and my insurance will cover my care I authorize AVENUES to bill my insurance on my behalf for services provided me. I understand that if my insurance benefits are declined or terminated for any reason, and AVENUES is denied payment for services rendered; I or my legal guardian will be responsible for the outstanding bill.

• CLIENT'S RIGHTS AND RESPONSIBILITIES and GRIEVANCE Statements:

I acknowledge receipt of DDD's Participant Statement of Rights and Responsibilities. I understand these rights and responsibilities as they have been given to me. I have also received AVENUES's Grievance Procedure and understand how to voice a complaint about care, treatment or discontinuation of service and appeal the decisions.

X:_____

Client/ Legal Gaurdian Signature (state relationship) Date

• ADVANCE DIRECTIVES: ☐ NO ☐ YES ☐ A copy has been provided to AVENUES

I acknowledge that Advance Directives have been explained to me and I have received informational material concerning Advance Directives and have informed AVENUES of my decision. I understand that AVENUES does not require that I develop an Advance Directive in order to receive care.

If I have formulated an Advance Directive, I have been advised to give a copy to my Physician and I understand that I can make changes, or cancel my Advance Directive at any time in writing.

• CHOICE OF COMPANION CARE

Based upon my (the client) requested service and an assessment of my physical and health condition:

☐ I have REFUSED or do NOT require nor have I requested assistance with personal care, and instead have chosen to receive companion level service. As such I was informed that the Companion employee from the organization is not permitted by law to provide me with personal care, touching assistance or any hands-on services, nor am I to ask, direct, encourage or permit the Companion to perform personal care, touching assistance or hands on services.

By checking the following, I acknowledge receipt and understanding of each item.

☐ **CONSUMER'S GUIDE** (Click to open link to Guide)

I acknowledge the receipt of the New Jersey Consumer's Guide Home Health Aides.

☐ **DANIELLE'S LAW**

In accordance with Danielle's Law, employees of AVENUES are required to call 911 in life threatening emergencies. Click here to link and learn more about Danielle's Law.

☐ **TARA'S LAW**

In accordance with Tara's Law, employees of AVENUES are mandated reporters of alleged or suspected abuse, neglect and exploitation. Click here to link and learn more about Tara's Law.

☐ **STEPHEN KOMNINOS' LAW**

The Stephen Komninos' Law strengthens protections for participants of any New Jersey DHS funded, licensed or regulated program for adults with developmental disabilities, including State developmental centers and community programs. Click here to link and learn more.

☐ **BUSINESS ETHICS AND CORPORATE COMPLIANCE**

AVENUES stands for the highest level of integrity and ethical standards in relation to business practices and direct service to the people and communities served by the organization. Therefore, it is the policy of AVENUES to deliver service and conduct its business in compliance with all applicable laws, regulations and ethical standards and have established mechanisms to ensure conformity with laws, regulations, program requirements and guidelines, and ethical business practices by its employees.

Should you at any time observe the staff of AVENUES doing anything illegal or fraudulent or be asked to do something you believe to be illegal, fraudulent or unethical by a staff member, please call the AVENUES at (856) 537-7919 and ask to speak with the Chief Executive Operator (CEO) or the Chief Operations Officer (COO).

CERTIFICATION

I certify that I have read and/or had the statements above explained to me, and I understand to the best of my ability the above statements. I am agreeing to and consenting to the conditions, and received a copy thereof. I am the client, or client's legal guardian, and accept the terms herein.

X

Client/Legal Representative Print Name (state relationship)	**Signature**	**Date**
AVENUES Employee Print Name	**Signature**	**Date**

AVENUES TO INDEPENDENT LIVING BUSINESS ETHICS AND CORPORATE COMPLIANCE FOR CLIENTS/FAMILIES

AVENUES TO INDEPENDENT LIVING (AVENEUS) stands for the highest level of integrity and ethical standards in relation to business practices and direct service to the people and communities served by the organization.

Therefore, it is the policy of AVENUES to deliver service and conduct its business in compliance with all applicable laws, regulations and ethical standards and have established mechanisms to ensure conformity with laws, regulations, program requirements and guidelines, and ethical business practices by its employees.

Should you at any time observe the staff of AVENUES doing anything illegal or fraudulent or be asked to do something you believe to be illegal, fraudulent or unethical by a staff member, please call the agency at (856) 537-7919 and ask to speak with the Executive Director.

HOW TO WORK EFFECTIVELY WITH YOUR DIRECT SUPPORT PROFESSIONAL (DSP)

Your DSP is not a Nurse. She/He is a paraprofessional who is functioning according to a written Plan of Care or Service Plan prepared by the Supports Coordinator assigned to your care. The Plan may include such tasks as bathing, shampooing hair, cleaning nails (NO TRIMMING), changing bed linen, light housekeeping other than the clients area, essential errands, and meal preparation.

- DSPs can only do the tasks outlined in the written Plan. Please do not ask them to do things that are not in the Plan such as heavy cleaning, moving furniture, washing windows, or turning mattresses.
- In some assignments, DSPs are not allowed to give hands-on personal care services, they may be assigned to provide companion services only. Please do not ask a DSP to do personal care. This is for your protection.
- Do not provide meals for DSPs.
- Do not loan or give money or give Aides or DSPs gifts or gratuities/tips.
- With permission, the Aide or DSP is allowed to drive you to doctor's visits, necessary shopping or other essential errands as part of the written Plan. Only clients can be driven, family and friends cannot travel in an employee's or Avenue's vehicle.
- **Changes in a DSP's work schedule must be made through the office only by calling 856-537-7919, X102 or X112. Do not make private arrangements with DSP to directly change their schedule.**
- **Do not attempt to hire Avenue's DSPs on a private basis. Any DSP who accepts work on a private basis can be dismissed from the agency.**
- Danielle's Law requires that we call 911 anytime an Avenues employee, including Aides, DSPs and Nurses, believes there is or may be a potential life threatening emergency with a client. **911 will be called even if you and/or your guardian request that 911 is not called**. AVENUES employees are also mandated reporters for alleged abuse, neglect and exploitation.
- Billing for private pay clients is done bi-weekly and must be paid promptly. The person financially responsible for care will be asked to sign a "Terms and Conditions" form before service begins.
- If you have any problems or concerns about the performance or behavior of the DSP, call AVENUES immediately and ask to speak with the supervisor.

My signature below indicates that I have received the information above and agree to and consent to the conditions.

X _____

Client or Client's Legal Guardian Signature **Print Name** **Date**

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES

MEDICAL FORM FOR ADULTS

Name: _____ Age: _____ DOB: _____ ☐ Male ☐ Female

Health Insurance #: _____ SS#: _____ Exam Date: _____

A. ***HISTORY***

1. Indicate any present and past medical condition (include communicable disease history):
   _____
   _____
2. Previous hospitalizations/surgery: _____
   _____
3. Immunizations:
   Adult Diptheria/Tetanus Date: _____
   (Document date of last booster OR administer if more than 10 years ago.)
   Hepatitis B Immunization (if given) Date: (1) _____ (2) _____ (3) _____

B. ***LABORATORY TEST***

1. **Mantoux Test vearlv** if non-reactor or chest x-ray if indicated. Past or current results must be documented.
   Results: Select One: _____ Date: _____
   Tine test is not acceptable. Positive Mantoux reactor should never be retested.
2. Hepatitis B Profile: Initial (repeat at physician's discretion)
   Results: Select One: _____ Date: _____
   (Past or current results must be documented.)
3. Lead Poisoning: Blood Lead Level is required
   a. For individuals with known Pica behavior, test annually, or according to guidelines for elevated lead levels.
   b. Prior to discharge from developmental center (within 3 months of discharge)
   c. For all new admissions to Divisional residential services (within 3 months prior to admission or within 10 days after admission.
   Blood Level: Select µg/dL _____ Date: _____
4. SMAC, initial (repeat at physician's discretion): _____
5. Complete Blood Count, initial (repeat at physician's discretion): _____
6. Urinalysis, initial (repeat at physician's discretion): _____
7. Serology, initial (repeat at physician's discretion): _____
8. Pap Smear (follow American Cancer Society guidelines): _____
9. EKG – initial at age 40 (repeat at physician's discretion): _____

C. ***OTHER MEDICAL CONDITIONS/NEEDS***

1. Seizures: ☐ Yes ☐ No Frequency & Type, if known: _____
   _____
2. Special Dietary Needs: ☐ Yes ☐ No (Attach Prescription): _____
   _____
3. Allergies, Sensitivities (food, drugs, others): _____
   _____
4. Mental Health Problems (behavioral/psychiatric disorders): _____
   _____

D. ***MEDICATION***

Name: _____ Dosage: _____ Frequency: _____ Indication: _____
Name: _____ Dosage: _____ Frequency: _____ Indication: _____
Name: _____ Dosage: _____ Frequency: _____ Indication: _____
Name: _____ Dosage: _____ Frequency: _____ Indication: _____
Name: _____ Dosage: _____ Frequency: _____ Indication: _____

E. ***CLINICAL EXAMINATION***

1. Height: Select ft: Select in: Weight: _____ Temp.: Select Temp Select ° Pulse: Select HR B.P.: Systolic Diastolic
2. Sensory (indicate any impairment and extent):

   Eyes: Vision (glasses, etc.): _____
   Hearing (aids, etc.): _____
3. ENT: _____
4. Teeth & Gums: _____
5. Neck: _____
6. Breast (follow American Cancer Society Guidelines for Mammography): _____
7. Lymphatic System: _____
8. Respiratory System: _____
9. Cardiovascular System: _____
10. Gastrointestinal System (stool for occult blood after age 50): _____
11. Genitourinary System: _____
12. Prostate: _____
13. Muscular System: _____
14. Skeletal System: _____
15. Neurological System: _____

ADDITIONAL INFORMATION/RECOMMENDATIONS

(Please indicate if there are limitations or restrictions regarding physical activities.)

_____
_____

PLEASE ISSUE PRESCRIPTIONS FOR MEDICATION, DIET, ADAPTIVE EQUIPMENT, PROCEDURES AND THERAPIES (Please Print or Type CLEARLY)

Physician's Name: _____ Date: _____

Address: _____ Phone #: _____

Physician's Signature: _____

PLEASE RETURN COMPLETED FORM TO:

NAME: AVENUES TO INDEPENDENT LIVING

ADDRESS: 304 South Broad St.

CITY: WOODBURY **STATE:** NEW JERSEY **ZIP:** 08096 **Email to**: Intake@avenuestil.com

FAX: 856-537-7914 **ATT**: INTAKE

THANK YOU FOR YOUR COOPERATION

ANNUAL DENTAL VISIT

On _____, _____ was examined
(Date) *(Consumer's Name)*

by _____
(Name and Title)

for his/her annual dental visit.

Please initial one of the following:

_____ All necessary treatment has been completed.

_____ Additional treatment is needed.

_____
(Signature)

_____
(Date)

PLEASE RETURN COMPLETED FORM TO:

NAME: AVENUES TO INDEPENDENT LIVING **ADDRESS:** 304 South Broad St.
CITY: WOODBURY **STATE:** NEW JERSEY **ZIP:** 08096 **FAX:** 856-537-7914
ATT: INTAKE **Email to**: Intake@avenuesTIL.com

AVENUES TO INDEPENDENT LIVING
ELECTRONIC SIGNATURE AUTHORIZATION
304 South Broad Street, Woodbury, NJ 08096
T: 856-537-7919, F: 856-537-7914, E: Intake@AvenuesTIL.com

Directions: Please print, sign and email, mail or fax this form to the Main office.
To email (preferred) print, sign and scan to PDF file. Send as PDF document (NOT AS A PHOTO) to: Intake@AvenuesTIL.com

Client's Printed Name:_____ ☐ I Am My Own Legal Guardian

Client's Legal Guardian/ Representative Printed Name:_____

This Electronic Signature Authorization will allow us to use your electronic signature on all important forms and billing vouchers.

I agree to use my electronic signature to establish my identity and sign electronic documents and forms.

I further agree that, for the purposes of authorizing and authenticating Avenues electronic records, billing vouchers, authorizations and consents, health information, and other related documents, my electronic signature has the full force and effect of a signature affixed by hand to a paper document.

I understand and agree that I will be held legally bound, obligated, or responsible for any electronically signed submission I make.

I agree that my electronic signature is the legal equivalent of my manual signature on any and all forms for the duration of Avenues services. By signing this agreement, I consent to be legally bound by the terms and conditions of this agreement. Legal Guardian, please sign below:

X

LEGAL GUARDIAN AUTHORIZED SIGNATURE ABOVE **DATE:**_____

NEW JERSEY DEPARTMENT OF HUMAN SERVICES
Division of Developmental Disabilities

PARTICIPANT STATEMENT OF RIGHTS AND RESPONSIBILITIES

The rights and responsibilities of an individual with an intellectual or developmental disability receiving supports and services through the New Jersey Division of Developmental Disabilities (Division) include, but are not limited to, the following:

RIGHTS

I have the right to exercise my rights as a citizen.

I have the right to privacy and to be treated with dignity and respect.

I have the right to be believed to have the ability to make my own decisions.

I have the right to live as I choose, free from judgment, interference, or threat.

I have the right to protection from physical, verbal, psychological, or sexual abuse, neglect or punishment.

I have the right to equal employment opportunities, to work in the community and fair payment for my work.

I have the right to own, rent, or lease property.

I have the right to live and receive services/supports in the least restrictive environment and to be free from restraint.

I have the right to express human sexuality and receive appropriate training/education.

I have the right to marry and have children.

I have the right to presumption of legal competency in guardianship proceedings.

I have the right to be free from unnecessary and excessive medication.

I have the right to privacy during treatment and care of my personal needs.

I have the right to confidentiality/privacy of my information and medical records.

I have the right to access my personal resources and be free from personal and financial misuse/abuse.

I have the right to utilize my New Jersey Individualized Service Plan (NJISP) and budget to meet my needs within Waiver program guidelines.

I have the right to decide how to choose my services or to have someone I choose help me with decisions within the guidelines of the Waiver program.

I have the right to identify and invite who I want to participate in my service plan meetings.

I have the right to a fair hearing if for any reason my waiver services are denied, reduced, suspended or terminated. An initial appeal shall be made in writing to:

Division of Medical Assistance and Health Services (DMAHS) Fair Hearing Unit
PO Box 712
Trenton, NJ 08625

When living in a community residence licensed by the New Jersey Department of Human Services Office of Licensing, I have the right to have a key to lock/unlock my home and bedroom door, to have visitors of my choosing, make and receive phone calls, make my own schedule and access food at any time, unless otherwise determined in a documented person-centered process that I am a part of.

RESPONSIBILITIES

I am responsible for maintaining/keeping Medicaid coverage to continue services on my Waiver program.

I am responsible for making sure that I can meet with my support coordinator and provide all information necessary to ensure that my NJISP can be created within 30 days of my support coordination agency selection.

I am responsible for participating in the development of my NJISP and sharing in any decision making associated with the plan.

I am responsible for what is included in my NJISP and for following my budget according to Waiver guidelines.

I am responsible for all required paperwork and following all Waiver program policies and procedures.

I am responsible to contact my support coordinator in the event that I want to change any of the service providers listed in my NJISP.

I am responsible to contact my support coordinator if anything changes in my life that may require a change to my NJISP or services that I receive.

I am responsible for participating in monthly phone contacts and quarterly face-to-face visits with my support coordinator. I understand these visits are mandatory and may occur in my home, day program or place of employment as agreed upon with my support coordinator. I understand that at least one of these face-to-face quarterly visits per year must take place inside my home.

I have read and /or understand these rights and responsibilities.

_____ _____

Participant/Representative Signature Date