**SUPERVISOR/COORDINATOR IP PAPERWORK PACKET**

|  |  |
| --- | --- |
| **Individual Name:** |  |

|  |  |
| --- | --- |
| **Date of IP Meeting:** |  |

|  |  |
| --- | --- |
| **Coordinator/Supervisor Name:** |  |

**PRE-IP DOCUMENTS**:

* The following documents are due two weeks before the IP meeting.
* Email these documents to the Case Manager and make sure that a copy of each is saved on the G-Drive. Check off each item to confirm that you have sent it to the Case Manager and saved it to the G-Drive.

**[ ]** Residential Summary

**[ ]** Health and Safety Assessment and Plan

**[ ]** Life Skills Assessment

**[ ]** Inventory

**[ ]** Person-Centered Description

**[ ]** Person-Centered IP Planner

**[ ]** Pre-IP PAR Packet

**AT THE IP MEETING**:

Innovations documents that need to be signed:

* Please bring blank versions the following documents to the IP meeting to be signed by the Consumer or their Guardian.
* All of the following documents need to be filed in the Consumer’s home book, and a copy of each needs to be routed to Linda Saenz to be scanned into Qwestys. In addition, a copy of the Personal Needs Money Agreement needs to be routed to Innovations Accounting Clerk Debbie Watson.
* Check off each item to confirm that you have filed the following documents and routed them to the correct person.

[ ]  Innovations IP Acknowledgement (attached to this document)

* Also attached are the Innovations Complaint and Grievance Policy, and the Innovations Dispute Resolution Procedures, which are referenced in the IP Acknowledgement

[ ]  Imagine! Innovations Photo Release (optional, attached to this document)

[ ]  Personal Needs Money Agreement (either “PNF-1”, “PNF-2”, or “PNF-3”, all attached)



**Innovations IP Acknowledgement**

|  |  |
| --- | --- |
| **Individual Name:** |  |

**My signature below indicates the following:**

1. I have received a copy of the Innovations Grievance/Complaint Procedures
2. I have received a copy of the Innovations Dispute Resolution Procedures

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| **Individual/Guardian Name** |  | **Individual/Guardian Signature** |  | **Date** |



**Complaint and Grievance Policy**

|  |  |
| --- | --- |
| **Date Implemented:** | 10/1/12 |

|  |  |
| --- | --- |
| **Date(s) Updated:** | 5/22/14, 9/15/14 |

|  |  |
| --- | --- |
| **Regulation(s) supporting the need for this policy:** | 10 CCR 2505-10 8.605.5 |

**POLICY:**

Innovations will address all complaints and grievances promptly and will ensure that each complaint and grievance is resolved.

**PROCEDURE:**

1. **Filing a complaint**
	1. **Who can file a complaint**
		1. Complaints can be filed by the consumer receiving services or by anyone on the consumer’s IDT.
		2. Filing a complaint will never cause a consumer to lose his or her services and the consumer cannot be coerced, intimidated, threatened, or retaliated against because he or she has filed a grievance/complaint or been participated in the grievance/complaint process.
	2. **When to file a complaint**
		1. Complaints should be filed when the person does not agree with a decision made by Innovations.
		2. Complaints should be filed as soon as possible so that a solution can be reached promptly.
	3. **How a complaint is filed**
		1. The person filing the complaint will notify the consumer’s Program Manager that they wish to file a complaint. This can be done either:
			1. Face-to-face
			2. Over the phone
			3. In writing either by email or postal mail.
		2. If the person filing the complaint needs help talking to the Program Manager about the complaint, then assistance can be provided by anyone on the individual’s IDT, and/or by an advocate.
2. **Resolving complaints**
	1. Within 15 days an Innovations Representative will schedule an informal meeting with everyone. This meeting gives everyone a chance to come together to work on a solution acceptable to all the people involved. The person filing the complaint can ask that anyone be invited to this meeting.
	2. If a solution cannot be reached at this meeting, the Program Manager will schedule another meeting with the Director of Innovations or someone appointed by the Director of Innovations to help in finding a solution. This could include mediation if that is what everyone wishes to do. This meeting will be scheduled within 30 days of the informal meeting.
	3. The Director of Innovations or representative will come to a decision and inform everyone of the decision within 30 days of the 2nd meeting.
	4. If anyone is still not happy with the decision that has been made, the Director of Innovations or an appointee will review the decision. If more information is needed the Director of Innovationscan ask for additional information or schedule another meeting. If another meeting is needed it must be scheduled within 30 days.
	5. The Director of Innovations will make a decision and inform the parties of that decision within 10 daysof the request for review, or within 10 days after the meeting, whichever pertains. The decision of the Director of Innovations is final.
	6. If the person filing the complaint thinks that their complaint was not resolved in a satisfactory manner at the agency level, he or she may submit a complaint to the State of Colorado Health Facilities and Emergency Medical Services Division (HFEMSD). Contact information for filing a complaint with the state is listed below.

Mail:

Complaint Intake Coordinator

Health Facilities and Emergency Medical Services Division

4300 Cherry Creek Drive South

Denver, Colorado 80246

Phone:

303-692-2910 / 800-842-8826

Email:

healthfacilities@state.co.us



**Dispute Resolution Procedures**

|  |  |
| --- | --- |
| **Date Implemented:** | 1/10/13 |

|  |  |
| --- | --- |
| **Date(s) Updated:** | 9/11/13, 12/3/13, 5/22/14 |

|  |  |
| --- | --- |
| **Regulation(s) supporting the need for this policy:** | 10 CCR 2505-10 8.605 |

**PROCEDURE:**

Innovations will provide written notice 15 days before making changes in a consumer’s program or services through the Innovations Notifications of Actions to be Taken form. A dispute may be filed if the consumer or guardian disagrees with any of the following decisions made by Innovations:

1. That the consumer is not eligible for services or supports
2. That the consumer is no longer eligible for services or supports
3. That services or supports are going to end
4. That services written in the Individualized Plan (IP) are going to be changed, reduced or denied

The use of the dispute resolution procedure shall not prejudice the future provision of appropriate services or supports to the individual in need of and/or receiving services. An individual shall not be coerced, intimidated, threatened or retaliated against because that individual has exercised his or her right to file a complaint or has participated in the dispute resolution process. Innovations will not terminate services to an individual during an appeal.

**How to file a dispute**

1. The consumer, guardian or authorized representative should tell the Program Manager that there is a disagreement with an Innovations decision in one of the four categories noted above.
2. The notification can occur either verbally, face-to-face, over the phone, by email or in writing.
3. If everyone agrees, an informal meeting will be scheduled within 15 days of receiving the dispute to try to resolve the issue with the Innovations Director. Or, if both parties agree, mediation can be used to try to solve the issue.
4. If the problem is not taken care of at the informal meeting or in mediation, or if the consumer, guardian, authorized representative or Innovations do not wish to use the informal process, any party may request that the formal dispute resolution process be started.

**The formal dispute resolution process**

1. Innovations will schedule a meeting within 10 business days of asking for the formal dispute resolution process.
2. The Innovations Director will appoint an individual to listen to the dispute. This person is considered an impartial decision maker, which means someone who listens to everyone, cannot take sides with anyone and has not been directly involved with the specific decision at issue.
3. The meeting is to give everyone time to tell what they think is the right answer to the problem; this is called presenting information and evidence.
4. The consumer, guardian, counsel, or authorized representative is allowed to speak at this meeting. This should include what the decision is and why the consumer, guardian or authorized representative disagree with the decision. The person speaking for Innovations will also talk about the decision that was made and what Innovations believes is the right answer to the problem. Everyone will be allowed to ask questions and answer questions asked by others.
5. The meeting may be recorded by audio or video, or there may be someone there who will take notes about the meeting.

**Final Steps**

1. Within 15 days after the meeting, all parties will receive a written decision in the mail from the impartial decision maker.
2. If any party does not like the decision, the Executive Director of the Colorado Department of Health Care Policy and Financing (HCPF) can be asked to review the decision. This request must be made within 15 days from the date postmarked on the letter of the written decision.
3. The Executive Director of HCPF, or someone appointed by the Executive Director (called a designee), will be told about the problem and what has been done about the problem so far. The Director, or designee, can ask for more information or another meeting to help make a final decision about the issue. The Executive Director or designee may request oral argument or a hearing if deemed necessary by the Executive Director or designee to render a decision.
4. The Executive Director or designee will make a final decision based on all of the information within 10 working days of receiving all relevant information. This decision is final.
5. The consumer’s services and supports will not stop during the dispute resolution process unless the Executive Director decides that it is an emergency situation. An emergency situation is one that could result in harm to the consumer or someone else.

Authorization for Release of Information
*For Non-Specific Media/Public Relations and Marketing Purposes*

Revised June 2015

I give my permission to Imagine! to take photographs, films, audio and/or video, interview, or publish article(s) or information about:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Individual’s Name (Please print)**

These records may be used for promotional or publicity purposes and may be published in the following Imagine! marketing, public relations, and external communication materials, including:

|  |  |
| --- | --- |
| * Imagine! newsletters
* Imagine! brochures and reports;
* On an Imagine! display board used at community fairs, presentations, events, and/or on display in Imagine! buildings
* Newspapers and other published materials
 | * Imagine! websites and social media sites, including Facebook, Twitter, and Imagine! blogs *(Note: This material will be accessible to anyone who is connected to the Internet and may be downloaded by any computer user.)*
 |

|  |  |
| --- | --- |
| Other: (specific use) |  |
|  |
|  |

By signing below, I acknowledge that I do not require information on the specific photo, video, or information that is to be shared. Therefore, this permission is consistent with protections provided by rules for the Colorado Division for Developmental Disabilities at 2 CCR 503-1 and ***will be in effect for no more than two years*** ***from the date signed*** unless I cancel my permission before then. If I cancel my permission, no additional copies of marketing literature will be printed after that date and already printed copies may be used until that literature is replaced.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signed *(Legal guardian, or if under age 18, parent or legal guardian)* Relationship to Authorized Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Printed name of legal guardian Date

***Imagine! will use this information to acknowledge, recognize, and promote the many contributions individuals with intellectual and developmental disabilities are bringing to their communities every day***. ***All images used for marketing or public relations will be respectful and dignified. If an individual or guardian does not believe a picture to respectful or dignified, s/he may ask for the image to be removed.***

***For Imagine! Administrative Use Only***

­­­­­­­Name of Imagine! Staff Soliciting Release:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**[ ]** Updated in NetSuite

**[ ]** Scanned in Questys

**COLORADO DEPARTMENT OF HUMAN SERVICES**

# DIVISION FOR DEVELOPMENTAL

**DISABILITIES**

**OFFICE OF LONG TERM CARE**

EXCLUSION AGREEMENT

I, ­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, who live at

 (Name of Person in Services)

­­­­­­­­­­­­­­­­­­­­­­ (Address)

do not want to have provider staff take care of my money or personal things.

 I will take care of my own money and personal things.

or

 I will let the person named below take care of my money and personal

 things for me.

I have made this choice on my own. No one told me to or made me say it.

­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **(Signature of Person in Services) (Date)**

 **or**

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 **(Signature of Legally Authorized Representative) (Date)**

**(This authorization expires and must be renewed annually at the IP Staffing)**

I have let the person named below take care of my money and personal things for me. I have, or will have, this person become my representative payee so that they can receive and take care of my money for me and make sure it is spent on things for me.

**NAME AND ADDRESS OF AUTHORIZED REPRESENTATIVE:**

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**PNF-1**

**2011**

COLORADO DEPARTMENT OF HUMAN SERVICES

# DIVISION FOR DEVELOPMENTAL

**DISABILITIES**

**OFFICE OF LONG TERM CARE**

**AUTHORIZATION OF PROVIDER FOR**

**PERSONAL NEEDS FUNDS ADMINISTRATION**

I, ­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, want to let

 (Name of Person in Services)

­­­­­­­­­­­­­­­­­­­­­­ (Name and Address of Provider)

receive and take care of my money and personal things for me and to make sure that my money is used to meet my needs. The provider agrees to keep a correct record of:

* the receipts for the things I buy or someone buys for me with my money;
* the bills paid with my money:
* my personal things;
* how much money and personal things I have at all times; and,
* if I or my legally authorized representative ask, to tell us how my money has been spent.

­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Signature of Person in Services) (Signature of Legally Authorized Representative)

­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Signature of Provider Representative) (Title)

 Dated this \_\_\_\_\_\_\_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_\_\_, 20\_\_\_\_\_\_\_

 **(This authorization expires and must be renewed annually at the IP staffing)**

**PNF-2**

**2011**

# DIVISION FOR DEVELOPMENTAL

**DISABILITIES**

**COLORADO DEPARTMENT OF HUMAN SERVICES**

**OFFICE OF LONG TERM CARE**

**LIMITED AUTHORIZATION OF PROVIDER FOR**

PERSONAL NEEDS FUNDS ADMINISTRATION

I, ­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, want to let

 (Name of Person in Services)

­­­­­­­­­­­­­­­­­­­­­­ (Name and Address of Provider)

receive and take care of the following personal needs for me and to make sure that my money is used to meet my needs.

 Supplemental Security Income

Wages

 Social Security Administration Benefits (SSA)

 Social Security Disability Income (SSDI)

 Other Income Sources: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

All other income shall be received directly by my legally authorized representative or me and shall not be handled by the agency.

The provider agrees to keep a correct record of:

* The receipts for the things I buy or someone buys for me with my money;
* The bills paid with my money;
* My personal things;
* How much money and personal things I have at all times; and,
* If I or my legally authorized representative ask to tell us how my money has been spent.

I also agree to allow my provider to withdraw from my account, without further authorization, my monthly room and board payment.

­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **(Signature of Person in Services) (Signature of Legally Authorized Representative**)

­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **(Signature of Provider Representative) (Title)**

 **Dated this \_\_\_\_\_\_\_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_\_\_, 20\_\_\_\_\_\_\_**

 **(This authorization expires and must be renewed annual at the IP Staffing)**

**PNF-3**

**2011**

**PNF-2**

**2011**