The FREEDOM CENTER

For Independent Living, Inc.

People Empowering People

Consumer Intake Packet

Freedom Center for Independent Living, Inc.

400 North Broad Street · Middletown · Delaware · 19709

(302)376-4399 F(302)376-4395

www.fcilde.org

11/12/2020

Freedom Center for Independent Living, Inc.

Intake Form

Consumer Name: _____

Address : _____

County: New Castle ☐ Kent ☐ Sussex ☐ Out of State ☐

Ethnicity: African-American ☐ Asian Pacific ☐ Hispanic ☐

Native-American Indian ☐ Caucasian ☐ Other ☐

How Did You Find Out About Freedom Center : _____

Disability(s):_____

Limiting Factors of Disability(s) : _____

_____

Telephone Number(s):

Home: _____ Work _____

Fax _____ TDD _____

Email _____

Contact By: Phone ___ Fax ___ Email ___ Mail ____ Other ____

Needs/Potential Goals: _____

_____

_____

Freedom Center for Independent Living, Inc.

Follow-up Action taken: _____

_____

_____

Independent Living Specialist_____ Date _____

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Emergency Contact Form

Name: _____

Home Address: _____

Home Phone: _____ Cell Phone: _____

Primary Emergency Contact

Name: _____ Relationship : _____

Contact Number: _____ Type: _____

Secondary Emergency Contact

Name: _____

Relationship: _____

#2 Contact Number: _____ Type:_____

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Primary Care Physician:_____ Phone#: _ _ _ _ _ _ _

Medical Conditions:_____

Current Medications:_____

Allergies:_____

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Consumer Profile

Consumer Name: _____

Address: _____

Telephone Number(s): Home _____ Work_____

Fax _____ TDD _____

Email: _____

Date of Birth:_____ Sex: Male [ ] Female [ ]

Age: _____

Are you a military veteran? Yes [ ] No [ ]

What is your level of education? Elementary [ ] High School [ ] GED [ ]

College [ ] Special Education [ ]

What is your marital status? Single [ ] Married [ ]

Divorced [ ] Separated [ ] Widowed [ ]

What do you consider to be your ethnicity? African-American [ ] Caucasian [ ]

Asian-Pacific Islander [ ] Hispanic [ ] Native American -Indian [ ] Other [ ]

Have you applied for Vocational Rehabilitation Services? Yes [ ] No [ ]

If YES: When? _____ Current Status: Active [ ] Inactive [ ]

If ACTIVE: Vocational Rehabilitation Counselor: _____

1. What is your employment status? Full-Time [ ] Part-Time [ ]
   Retired [ ] Not Working/Have Worked [ ] Supported [ ]
   Never Worked [ ]

What mode of transportation can you use? Public [ ] Personal [ ] DART [ ]

What are your current living arrangements? Live Alone ☐ live with Spouse ☐

2. Live with Parent/Guardian ☐ Live with Primary Caregiver ☐
3. live in a Supervised Residence ☐ Other ☐ _____
4. Do you have an attendant? Yes ☐ No ☐
5. What is your annual income?

   $0-$5,000 ☐ $5,001-$10,000 ☐ $10,001-$15,000 ☐

   $15,001-$20,000 ☐ Over $20,000 ☐
6. Are you registered to vote? Yes ☐ No ☐
7. If No, would you like to Register at Freedom Center? Yes ☐ No ☐
8. What is your primary disability? _____
9. What other disabilities do you have? _____
10. How did you learn about the Freedom Center?_____
11. Were you referred by another organization? Yes ☐ No ☐
12. If yes, what is the name of the organization? _____
13. COMMENTS:

_____

_____

_____

_____

_____

_____

Consumer's Signature: _____ Date: _____

Independent Living Specialist Signature: _____ Date:_____

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Consumer Significant Disability Statement

Consumer Name: _____

Address: _____

Phone: _____ County of residence: _____

Consumer Stated Significant Disability(s) [Optional): _____

_____

I acknowledge that I_____ am a person with a significant disability which limits my ability to perform at least two activities of daily living. *Due to my disability I am eligible for services from Freedom Center for Independent Living. I understand that the Freedom Center for Independent Living provides services to individuals with significant disabilities. As a person with a significant disability, I request assistance in my effort to live independently in the community.

Consumer's Signature: _____ Date: _____

Independent Living Specialist Signature: _____ Date: _____

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*13.1 Eligibility for Receipt of Services (secs.7 (15) (B) and 703 of the Act; 34 CFR 364.51 (a) Individuals with significant disabilities are eligible for services provided under SPIL. (B) To be eligible, an individual is one: (1) Who has a significant physical, mental, cognitive, or sensory impairment; (2) Whose ability to function independently in the family or community or whose ability to obtain, maintain or advance in employment is substantially limited; and (3) For whom the delivery of independent living services will improve the ability to function, continue functioning, or move towards functioning independently in the family or community or to continue in employment.

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Confidentiality Policy - Consumer Sign-Off

All Freedom Center records and information relating to Freedom Center or its Consumers are to be held strictly confidential. Therefore, every Freedom Center employee is mandated to treat all related matters accordingly. No Freedom Center, or Freedom Center related information, including, without limitation, documents, notes, files, records, oral information, computer files or similar materials (except in the ordinary course of performing duties on behalf of Freedom Center) may be removed from Freedom Center's premises without permission of the Executive Director. Additionally, the contents of Freedom Center's records or information otherwise obtained in regard to the Freedom Center or its Consumers may not be disclosed to anyone, except where required for a Freedom Center related business purpose. Employees must not disclose any confidential information, purposefully or inadvertently through casual conversation, or to any unauthorized person inside or outside Freedom Center. Employees who are unsure about the confidential nature of specific information must ask the Executive Director for clarification. Employees will be subject to appropriate disciplinary action, up to and including dismissal, for knowingly revealing information of a confidential nature.

It is the policy of Freedom Center for Independent living (Freedom Center) to keep all Consumers' information confidential. Discussion of Consumer information outside the office is forbidden and grounds for dismissal. The only reason information may be discussed in the office is to have authorized colleagues offer suggestions regarding issues with which an employee may be concerned and to better serve the Consumer.

_____ _____

Signature of Freedom Center Representative Date

_____ _____

Consumer's Signature Date

Freedom Center for Independent Living, Inc.
WRITTEN GOAL PLAN

First Name _____ **Last Name** _____

IL PLAN (704 Req.)	☐ Waived ☐ Accepted	**Goal Outcome:** (704 Req.)	☐ Ongoing ☐ Achieved ☐ Dropped
Date Defined:	_____	**Outcome Date:** (704 Req.)	_____
Goal Category:	☐ Communication ☐ Consumer Rights ☐ Education & Training ☐ Employment/Vocational ☐ Equip/Assistive Devices ☐ Finance/Benefits ☐ Health Care/Nutrition ☐ Housing		☐ Mobility ☐ Other ☐ Personal Assistance ☐ Self-Care/IL Skills ☐ Self-Help/Personal Growth ☐ Social/Recreation ☐ Transportation

Goal Type:

_____

_____

_____

Goal Notes:

_____

_____

_____

Goal Action Worksheet

1. _____

_____

_____

Start Date_____	**Anticipated Completion Date**_____	**Completion Date**_____

Person Responsible: Consumer ☐ Staff ☐ Consumer & Staff ☐ Other ☐

_____

2. _____

_____

_____

Start Date_____	Anticipated Completion Date_____	Completion Date_____

Person Responsible: Consumer ☐ Staff ☐ Consumer & Staff ☐ Other ☐

3. _____

_____

_____

Start Date_____	Anticipated Completion Date_____	Completion Date_____

Person Responsible: Consumer ☐ Staff ☐ Consumer & Staff ☐ Other ☐

4. _____

_____

_____

Start Date_____	Anticipated Completion Date_____	Completion Date_____

Person Responsible: Consumer ☐ Staff ☐ Consumer & Staff ☐ Othe ☐

Consumer Signature_____ Date _____

Staff Signature _____ Date _____

FUNDERS			
DHOH/Dane Co	Fee for Service	PVA	Transportation
DHOH/United Way	ILS/DHFS	SAP	USF
Donations	ILS/RSA	SILC/Youth	WisLoan
ILS/United Way	ILS/	SSDI-EP	WisTech
	Part D	Telework	

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Personal Empowerment Plan Waiver

I, _____understand that it is the policy of Freedom Center for Independent Living (Freedom Center) to have a written Personal Empowerment Plan with every Consumer receiving services. As specified in the Reauthorization Act of 1993, I now have the right to waive this requirement. I hereby waive my right to have a Personal Empowerment Plan written at this time.

The services I am requesting from Freedom Center are: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I understand, however, that I retain the right to request a Personal Empowerment Plan be developed if I so desire.

Consumer's Signature: _____ Date: _____

Independent Living Specialist Signature: _____ Date: _____

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Consent for Release of Information

_____ _____ _____
Person's Full Name Last 4 digits of S.S. # DOB

The following agency(s) and/or individual(s) have my permission to exchange/give/ receive/share/re-disclose information regarding service delivery planning for the purpose of securing coordination and/or providing services for the above named person (please identify all agencies that apply):

_____ _____ _____

_____ _____ _____

I authorize exchanging, giving, receiving/sharing, and re-disclosing of the following information if needed by the receiving agency to secure, coordinate, and provide services to the individual:

Circle One	Initial	
☐ Yes ☐ No	____	**Identifying Information:** Name, Birth Date, Sex, Race, Address, & Phone#
☐ Yes ☐ No	____	**Social Security Number**
☐ Yes ☐ No	____	**Case Information:** Only information that is generated by the Freedom Center will be released. The Freedom Center cannot release information obtained from other agencies.

I understand the Consent for Release of Information expires 1 year from the date it is signed unless otherwise indicated herein by the Consumer. I also understand that I may cancel the Consent for Release of Information at any time by stating so in writing with the date and my signature and delivering it to Freedom Center for Independent Living. The revocation does not include any information, which has been shared between the time that I gave permission to share information and the time that it was canceled.

I understand that my signing or refusing to sign this consent will not affect the public benefits or services that I am eligible for.

This consent expires on the _____ day of_____,20____

Signature of Person _____ Date: _____

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Signature of Parent/Guardian (if applicable) _____ Date: _____

Witness/ Agency Representative_____ Date: _____

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Consent for Release of Information: Page 2

_____
Person's Full Name

Violation of Federal Law by a program is a crime. Suspected violations may be reported to the United States Attorney in the district where the violation occurs.

TO ALL AGENCIES RECEIVING INFORMATION DISCLOSED AS A RESULT OF THIS SIGNED CONSENT:

1. If the records released include information of any diagnosis or treatment or drug or alcohol abuse, the following statement applies:

   Information disclosed pursuant to this consent has been disclosed to you for records whose confidentiality is protected by Federal Law.

   Federal regulations (42 CFR Part 2) prohibit you from making any future disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

2. If the records released include information on an HIV - related diagnosis or test results, the following statement applies:

   This information had been disclosed to you from confidential records protected from disclosure by state law. You shall make no future disclosures of this information without the specific, written and informed release of the individual to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is NOT sufficient for the purpose of the release of HIV test results or diagnoses.

3. This information has been disclosed to you from records protected by federal and/or state confidentiality rules. Any further release of it is prohibited unless the person to whom it pertains, Juvenile Court/DYS in the case of Youth records, or applicable federal and/or state law expressly permits the further disclosure.

Client Assistance Program

NEW CASTLE COUNTY

United Cerebral Palsy Center

700-A River Road, Wilmington, DE 19809

(302) 764-6216; (800) 640-9336; Fax (302) 764-6218

KENT & SUSSEX COUNTIES - MAIN OFFICE

3249 Midstate Road, Felton, DE 19943

{302)335-3739

Fax(302)335-5716

CAP is a place to turn to with questions or problems about rehabilitation programs.

CAP provides:

- Information on available services from such providers as Vocational Rehabilitation, Division for the Visually Impaired, Centers for Independent Living, Independent Living Inc., other agencies providing rehabilitation services, and ADA - Title 1.
- Information about your rights and responsibility as an applicant or client of the rehabilitation agencies.
- Information services about Vocational Rehabilitation Services and Benefits.
- Information/Referral
- Assistance with resolving any concerns that you may have while seeking or receiving rehabilitation services.

What Rights Do I Have As A Vocational Rehabilitation Client?

- Help pursuing appeals or other legal remedies to ensure protection of your rights under the Rehabilitation Act.

You have the right to:

- Apply or reapply for vocational rehabilitation services. This includes the right to an evaluation to find out if you are eligible for services.
- Be involved in planning your own rehabilitation program.
- Be consulted about changes in, or decisions about, your program.
- Appeal decisions with which you do not agree.

All services of CAP are free of charge & are provided on a non-discriminatory basis.

Freedom Center for Independent Living
MEDIA RELEASE FORM

I, _____, grant permission to Freedom Center for Independent Living Inc, to use my image (photographs and/or video) for use in Media publications including:

(Check All That Apply)

☐ Videos ☐ Photography ☐ Recruiting Brochures ☐ Newsletters ☐ Magazines ☐ General Publications ☐ Website and/or Affiliates ☐ Email Blasts ☐ Social Media ☐ Other: _____

I hereby waive any right to inspect or approve the finished photographs or electronic matter that may be used in conjunction with them now or in the future, whether that use is known to me or unknown, and I waive any right to royalties or other compensation arising from or related to the use of the image.

Please **initial** the paragraph below which is applicable to your present situation:

_____ - I am 18 years of age or older and I am competent to contract in my own name. I have read this release before signing below, and I fully understand the contents, meaning and impact of this release. I understand that I am free to address any specific questions regarding this release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this release.

_____ - I am the parent or legal guardian of the below named child. I have read this release before signing below, and I fully understand the contents, meaning and impact of this release. I understand that I am free to address any specific questions regarding this release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this release.

Signature: _____ Date: _____

Date of Birth: _____

Name (please print): _____

Address: _____

Signature of parent or legal guardian: _____
(if under 18 years of age)

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Consumer Satisfaction Survey

Consumers are important to us. Our goal is to provide services that will strengthen and empower people with disabilities so that they become more self - sufficient in maintaining their independence within the community. To this end, we are requesting your help to improve our services to people with disabilities. Please take the time to answer the following questions. All answers will remain confidential. Thank you.

Consumer Name: _____

Part 1: What types of assistance are you requesting from the Freedom Center?
(circle all that apply)

Advocacy	Equip/Assist Devices	Personal Assistance
Mentoring	Finance/Benefits	Health Care/Nutrition
\Self-Help	Social/Recreation	Information & Referral
Transportation	Housing	Education & Training
Employment	Mobility	Peer Support

Part 2: Rate these statements about your experience working with Freedom Center.
(l=Strongly Agree 2=Agree 3=Neutral 4=Disagree S=Strongly Disagree)

I was able to discuss my needs with staff and develop a plan to help me become more independent.	1	2	3	4	5
Staff assisted me in developing the goals in my plan and the steps I needed to take to attain those goals.	1	2	3	4	5
The staff helped me understand the choices and options I may have available to me.	1	2	3	4	5
	1	2	3	4	5

The staff treated me with respect and encouraged me to make my own decisions.	1	2	3	4	5
I believe the information I received from the staff will be helpful.	1	2	3	4	5
I feel more in control over my life than I did before coming to the Freedom Center.	1	2	3	4	5

Part 3: Please identify the staff person that helped you the most _____

Did you receive the assistance you requested? Yes No _____

Are you satisfied with the services you were provided? Yes No _____

Part 4: Rate the following statements about the Freedom Center.
(l=Strongly Agree 2=Agree 3=Neutral 4=Disagree S=Strongly Disagree)

The receptionist was helpful & respectful.	1	2	3	4	5
The overall services provided were appropriate.	1	2	3	4	5
The staff treated me with respect.	1	2	3	4	5
The staff returned my calls promptly.	1	2	3	4	5
The information provided to me was appropriate.	1	2	3	4	5
The staff was supportive and understanding.	1	2	3	4	5
I found it easy to make an appointment.	1	2	3	4	5
I would recommend Freedom Center to others.	1	2	3	4	5

Part 5: We encourage you to tell us how we can better assist you and others. Please take the time to tell us what you think we should be doing, not doing or anything else you feel we should know.

_____

_____

_____

_____

_____

_____

Part 6: If other agencies were involved in providing services to you, please tell us how helpful they were. This will aid us in future work with other consumers.
(l=No Help 2=Some Help 3=Neutral 4=Helpful 5=Great Help)

Agency Name:_____	1	2	3	4	5
Agency Name:_____	1	2	3	4	5
Agency Name:_____	1	2	3	4	5
Agency Name:_____	1	2	3	4	5
Agency Name:_____	1	2	3	4	5
Agency Name:_____	1	2	3	4	5

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Peer Support Group Membership Application

Purpose: To provide opportunities for socialization, peer-support, and peer-counseling for persons with disabilities as they work toward and/or maintain an independent lifestyle within their community. Peers tend to serve as excellent role models, often providing the motivation in others to envision the possibilities and develop the strategies to obtaining those visions. Information, one-on-one peer mentoring, and group interactions helping people with disabilities develop mutual support, assistance, and understanding.

Consumer Name:_____ Date_____
Mailing Address: _____

Telephone Number(s)_____ Type:_____

Email Address(es):_____

Best Contact Method: Phone___Fax:___ E-mail:___ Mail:___Other:_____

Describe your experience/background related to persons with disabilities. (i.e., a person with a disability, a parent or family member of a person with a disability, professional, educator, etc.)

_____

_____

_____

Please describe the reasons for your interest in becoming a Peer Support Group member and what you hope to contribute to the group.

_____

_____

_____

What are some areas that you would be interested in as a Peer Support Group Meeting Topic, Independent Living Skills Training, or just something you are interested in learning more about?

_____

_____

_____

Thank you for your interest in becoming a Peer Support Group member!
Please feel free to contact us if you need additional information or would like to discuss your possible membership.