Admission Application

Consumer's Information

Applicant's Name: _____

Living Situation: _____

Address: _____ Zip: _____

D.O.B.: _____ Place of Birth: _____ Gender: _____

Hair Color: _____ Eye Color: _____ Ht:_____ Wt.:_____

Handedness: _____

Residency: _____

Language(s) spoken in the home(s): _____

Language(s) spoken (if different then home): _____

Religious Preference (if any):_____

Consumer's Medical Information

Has the Applicant previously had any of the following illnesses:

Chicken Pox _____ Date _____
Measles _____ Date_____
Mumps _____ Date_____
Scarlet Fever _____ Date _____
Rheumatic Fever _____ Date _____
Whooping Cough _____ Date _____
Dipthria _____ Date _____
Polio _____ Date_____
Tuberculosis _____ Date _____
MRSA _____ Date _____

Does the applicant require the use of mobility aids?: _____

Under what conditions?: _____

Does the applicant require the use of adaptive devices?: _____

Under what conditions?: _____

Has he or she had any operations?: _____ If yes, Please explain:

_____

Does the applicant have any contagious illness(es): _____

If yes, please explain: _____

Does the applicant have a history of seizure disorder: _____

If yes, please describe any triggers, warning signs, and description of seizure

activities:_____

Does the applicant have a special diet: _____

If yes, please describe: _____

Does the applicant have any allergies: _____

If yes, please describe: _____

Consumer's Social Disposition

What would best describe the applicant's personality?_____

…On an average day? _____

…On special occasions?_____

…When frustrated or disappointed? _____

…On days with lots of changes? _____

Does the applicant have any specific fears? _____

If so, please describe:_____

Does the applicant have any unusual habits or behaviors? _____

If so, please describe:_____

Has the applicant hurt him/herself or others, had law enforcement involvement, been on probation, is a registered sex offender? (please provide all information regarding the above question)

Admission Application

Consumer's Day Program/School Placement History

Program/School: _____ Dates Attended:_____

Reason for leaving: _____

Program/School: _____ Dates Attended:_____

Reason for leaving: _____

Program/School: _____ Dates Attended:_____

Reason for leaving; _____

Consumer's Work History

Employer: _____ Dates of Employment: _____

Job Duties:_____ Reason for leaving:_____

Employer: _____ Dates of Employment: _____

Job Duties:_____ Reason for leaving:_____

Employer: _____ Dates of Employment :_____

Job Duties:_____ Reason for leaving:_____

Consumer's Residential Placement History

Residence: _____ Dates of Residence: _____

Reason for leaving: _____

Residence: _____ Dates of Residence: _____

Reason for leaving: _____

Residence: _____ Dates of Residence: _____

Reason for leaving: _____

Admission Application

Parent, Conservator, and/or Family Member Information

Conservator____ Parent ____ Sibling ____ Other Family Member _____

Name: _____

Address: _____ Zip:_____

Phone Number: _____ Alternate Phone: _____

Conservator____ Parent ____ Sibling ____ Other Family Member _____

Name :_____

Address: _____ Zip:_____

Phone Number: _____ Alternate Phone: _____

Conservator____ Parent ____ Sibling ____ Other Family Member _____

Name: _____

Address: _____ Zip:_____

Phone Number: _____ Alternate Phone: _____

Funding Information

Is the Applicant a consumer of the San Diego Regional Center ___ Yes ___No

If so,

Service Coordinator's Name: _____ Phone: _____

Address: _____ Zip: _____

If no,

Name of the person or agency who will be responsible for day program costs:

_____ Phone:_____

Address: _____ Zip: _____

Unyeway, Inc.
Admission Agreement

This admission agreement is authorizing Unyeway, Inc. to provide basic day program service to:

Name:_____ UCI#_____ Birth Date _____

Basic service will be provided by the _____program, vendor # _____.

Basic services include training in Self-Care, Communication, Functional Living, Social Skills, and Appropriate Interactions, as appropriate.

Additional basic service specific to each individual component include:

Behavior Management Program BMP 1:3 Vendor # H90182 (Lakeside), Vendor # HQ0707 (Oceanside), & Vendors # HQ0766(Chula Vista) provides proactive behavior management techniques, behavior intervention strategies, work activities- as available, boundaries and relationship training, and anger management, as appropriate.
Psych/Social Programs – ADC 1:3 Vendor # HQ0120 (Lakeside), Vendors # HQ0765(Chula Vista), & Vendor # HQ0699 (Oceanside), provides boundaries and relationship training, community interaction training, abuse prevention, assertiveness training and coping skill, while taking advantage of paid work opportunities, as appropriate.
Community Based Programs – Work Focused – CBP 1:4 Vendor # H85697 (Lakeside) and Vendor # HQ0767 (Chula Vista), provides work and volunteer opportunities throughout the day, focuses on independent work and achievement, and the skills necessary to advance in a work setting, as appropriate.
Community Cased Programs – Community Integration Focused – CBP 1:3 Vendor # H85698 (Lakeside), Vendors # HQ0764 (Chula Vista), & Vendor # HQ0700 (Oceanside), provides community integration training and support in the community, uses public transportation frequently, develops natural resources in the community, works towards community consumer skills, such as: purchasing, pricing, getting assistance, and community interaction. The groups also practice safety skills and emergency response in the community, as appropriate.
Nursing Programs – ADC 1:3 Vendor # HQ0120 (Lakeside), Vendors # HQ0765(Chula Vista), & Vendor # HQ0699 (Oceanside), provides traditional day program services with the added support of nursing staff based directly out of the program. Additional services include Range of Motion, G & J Tube feeding and hydration, seizure monitoring, injectable PRNs, diabetes monitoring, suctioning, tracheotomy care, catheter care, Alzheimer and dementia

monitoring, administration of restricted medications such as: eye drops, otic solutions, suppository PRNs, epi-pens injections, etc…, as appropriate.

Rascals Program – ADC 1:4 Vendor # H14696 (Lakeside) ,Vendors # HQ0768(Chula Vista), & Vendor #HQ0701 (Oceanside), provides retirement and leisure activities to people who attend at a slower more relaxed pace. Arts and Crafts, Music Appreciation, Get Up and Move Exercises, and Maintenance Programs are emphasized, as appropriate.

Activities Centers OAC 1:6 Vendor #HQ0698 (Oceanside Only), provides activities within a center site located in Lakeside, which emphasizes appropriate social interaction with peers, work activities as available, learning skills which are barriers to movement to a habilitiation program, appropriate work behaviors and relationships.

Activities Centers CVAC 1:6 Vendor #HQ0763 (Chula Vista Only), provides activities within a center site located in Lakeside, which emphasizes appropriate social interaction with peers, work activities as available, learning skills which are barriers to movement to a habilitiation program, appropriate work behaviors and relationships.

Activities Centers LAC 1:8 Vendor # H27417 (Lakeside Only), provides activities within a center site located in Lakeside, which emphasizes appropriate social interaction with peers, work activities as available, learning skills which are barriers to movement to a habilitiation program, appropriate work behaviors and relationships.

Adult Development Center 1:4 Vendor #H14696 (Lakeside), Vendors # HQ0768(Chula Vista), & Vendor #HQ0701 (Oceanside), provides traditional site based training, with an emphasis on increasing independence in self-care, functional living, and communication.

Day Program Rates are as Follows:

Regional Center Funded: The monthly rate is established in conjunction with the Department of Developmental Services and the San Diego Regional Center. The established rate for basic services is $_____per day. The rate is billed at the end of the month in which services are provided. The basic monthly rate does not include optional funds, such as P & I money used for special activities and purchasing individual equipment. Since the funded rates are prescribed by the Department of Developmental Services, basic rate changes will be effective on the operative date of any rate changes made in that program without prior notice. In the event that a rate change is made retroactive, the difference in rates will be either billed for or refunded

Private Pay: The monthly rate is established by the Unyeway, Inc. Administration based upon the most current cost statement for the program which the person will be attending. The rate for basic services is $_____per day. The rate is billed at the end of the month in which services are provided and must be paid Net 15. The basic monthly rate does not include optional funds, such as P & I money used for special activities and purchasing individual equipment.

Additional Augmentative Unyeway, Inc. Services:

Unyeway, Inc. currently provides the below listed additional service with no additional charge for people who attend our program, as available and appropriate. Unyeway, Inc. may end augmentative services without notice:

Physical Therapy
Speech Therapy
Family Life Education

Additional Funds for Consumers Provided by their Authorized Representative or Conservator

The consumer, their residential care providers, or family can send P & I money to the program so that it is accessible for the consumer to use on outings, for purchases, etc… (Checks may be made payable to Unyeway, Inc. and mailed to the Administrative Offices located at: 2330 Main St. Ramona, CA. 92065- please indicate the consumer's name on the check). Please do not send more than $20.00 each month.

In Order For The Consumer To Attend One Of Unyeway, Inc.'s Programs The Following Conditions Must Be Met By The Person Or Agency Responsible For The Consumer's Residential Services:

An emergency phone number must be on file with Unyeway, Inc., Unyeway, Inc. must be able to reach an emergency contact person within 15 – 30 minutes of being called. An emergency contact must be able to pick a consumer up at program, upon request by Unyeway, Inc, within 15-30 minutes.

A current emergency medical treatment consent form must be on file with Unyeway, Inc. for a consumer to attend one of the Unyeway, Inc. programs. Other forms of consent may also be requested, such as: photo/publicity consent, release of information consent, etc…

A physician report must be on file with Unyeway, Inc prior to or within 30 calendar days following the acceptance of a consumer into one of Unyeway, Inc.'s programs. A current negative PPD/TB or clear chest x-ray must be on file prior to the consumer's first day of program (Current is within 1 year for PPD or chest x-ray).

A copy of a current Hepatitis Screening indicating a person's current hepatitis status and a complete immunization record.

Prior to attending program, a physician's prescription is needed for all: medications/injections treatments, specialized equipment, range of motion, and an

incontinence/bowel schedule (if applicable). A physician's order must be on file prescribing the use of diapers or depends if they are to be worn at program.

Any medications prescribed to be delivered at program (routine or P.R.N.) must be delivered to the program on a schedule to ensure that the medication is available each day.

A care plan will be written prior to the consumer attending program if a restricted health condition is to be addressed. The care plan will be written by a licensed medical professional.

In order to discontinue a medication/injection/treatment delivered at program, a physician's order must be received by the program (if the medication/injection/treatment is given at program) stating when the program is to discontinue the medication.

Unyeway, Inc. must be notified if a consumer attending our program has or has had a contagious infection or condition during the time that they are enrolled with Unyeway, Inc. No person with a contagious infection or condition is permitted to attend Unyeway, Inc. A physician's note, indicating that a person is no longer contagious, must be received by Unyeway, Inc. prior to a person returning to program.

The consumer, their residential staff and family members are required to cooperate with all general policies and procedures of Unyeway, Inc.

The consumer must arrive no earlier than 8:45 a.m. and be picked up no later than 3:15 p.m. each program day.

Consumers are prohibited from bringing items to program which may be harmful to others.

A 30-day written notice is required by Unyeway, Inc,, when a consumer is intending to end their attendance at Unyeway, Inc., unless an emergency residential placement out of our area of service is necessary.

The consumer must bring a lunch and drink to program each day. The lunch must be prepared as prescribed by a nutritionist or physician (if special diet or food prep is required). Lunch money can be sent in lieu of a lunch if arrangements are made ahead of time or scheduled.

All applicable reporting requirements will be made by Unyeway, Inc. if a concern arises at Unyeway, Inc.

Any specialized equipment and personal items, which will be the responsibility of Unyeway, Inc. to safeguard, must be pre-approved by the Director of the program.

Upon discharge from the program, any personal property, money, medications will be returned to the consumer and/or his/her representative whenever possible on their last day of attendance and no later than 30 days after discharge, if arrangements need to be made.

With the consent of the consumer visitors can come to the program. While the consumer's privacy is important, visitors will be accompanied by a manager unless the visitor is the person's legal conservator or an authorized representative of an agency such as; Community Care Licensing or the San Diego Regional Center who is responsible for the consumer.

A person may be discharged by Unyeway, Inc. for the following reasons with a 30-day notice unless otherwise indicated:

Non-payment of the rate for basic services within sixty days of the due date.

Failure to comply with local, state, and federal laws may result in discharge.

Failure to comply with Unyeway, Inc. general policies or a lack of cooperation which results in Unyeway, Inc.'s ability to abide by regulations, guidelines, and policies may result in discharge.

If a person poses a clear and present danger to others and demands frequently or consistently, a ratio greater than is prescribed by the component they attend may result in discharge (3-day notice – 30 day depending on the severity).

If a person has medical needs which go beyond the scope of medical care available at the component they attend and/or the person develops a C.C.L. prohibited medical condition (3-day notice).

If a person uses hate or harassing speech or actions which create a hostile work environment (3-day notice – 30 day notice depending on the severity).

Thirty-day notices given by Unyeway, Inc. are communicated in writing to the San Diego Regional Center. All 3-day notices given by Unyeway, Inc. require the notification of Community Care Licensing in addition to the San Diego Regional Center

My signature represents my agreement to abide by Unyeway, Inc.'s Admission Agreement. Please have any questions or concerns clarified before signing below.

_____

Individual to be provided services by Unyeway, Inc.

_____

Residential Care Provider of the Individual to be provided services by Unyeway, Inc.

_____

Parent or Conservator of the Individual to be provided services by Unyeway, Inc.

_____

Unyeway, Inc. Case Manager

_____

Unyeway, Inc. Director

Unyeway, Inc.
11440 Riverside Dr. Ste D
Lakeside, CA. 92040
(619) 562-6330 p
(619) 562-6547 f

Unyeway, Inc.
4065 Oceanside Blvd. Ste J
Oceanside, CA. 92056
(760) 643-9394 p
(760) 643-9616 f

Unyeway, Inc.
1261 3rd Ave. Ste G
Chula Vista, CA. 91911
(619) 691-6346 p
(619) 691-6963 f

UI NO: A-005
RVSD 1/09

Unyeway Inc

An Equal Opportunity Employer

2330 Main Street, Suite E **Ramona. CA 92065-2595** **(760) 789-5960**

EMPLOYMENT APPLICATION

Please type or print clearly, answer all questions, and sign and date the Applicant Agreement.

Date: _____

Name:_____ **Social Security # :** _____

Present Address:_____**City** _____ **State** _____ **Zip Code** _____

Telephone Number: (Home) _____ **(Business)** _____

Position(s) Applying For: _____ **Referred by:** _____

Are you at least 18 years old? Yes ☐ **No** ☐ **Indicate Availability: Part Time** ☐ **Full time** ☐

Have you ever been employed by Unyeway, Inc.? Yes ☐ **No** ☐

Have you ever applied for a position with Unyeway, Inc.? Yes ☐ **No** ☐ **If yes, when?**

Do you have a legal right to work in the U.S.? Yes ☐ **No** ☐ **NOTE: If hired, proof must be provided.**

Have you ever been convicted of a felony crime? Yes ☐ **No** ☐ **If yes, list:** _____

NOTE: A felony conviction will not necessarily disqualify you for employment.

If hired, you will be required to have fingerprints filed with the Department of Justice.

Name and relationship of any relatives presently working for Unyeway:

_____

Are you able to perform the essential functions of the job for which you are applying, either with or without reasonable accommodations? Yes ☐ **No** ☐

If necessary, please describe the functions that cannot be performed:

_____

_____

EDUCATION/TRAINING

NOTE: Only include education/training that demonstrates your qualifications for this job, beginning with the most recent and work back. Education/Training may be full time or part time.

Circle highest grade completed: 1 2 3 4 5 6 7 8 9 10 11 12 **GED Exam: Yes** ☐ **No** ☐

College: 1 2 3 4 **Post Graduate: 1 2 3 4**

College or University Attended	Location	Did you graduate?	Course of Study	No. of Years Completed	Degree or Diploma
College					
High School Attended					
Vocational/Other Training					

Employment History:

List below all previous employers starting with your present or most recent position **(last 10 years is sufficient). Start with your most recent employer**. Please account for any periods of unemployment. Since we make effort to contact previous employers, the correct telephone numbers of past employers are critical.

NOTE: You must complete this section even if attaching a resume.

Name of Company: _____
Name of Supervisor: _____
Address: _____
Street City State Zip Code
Telephone Number: _(_____)_____
Position and Duties: _____
_____
_____
Starting Date of Employment: _____ Ending Date of Employment: _____
Starting Rate of Pay: _____ Ending Rate of Pay: _____
Reason For Leaving: _____

Name of Company: _____
Name of Supervisor: _____
Address: _____
Street City State Zip Code
Telephone Number: _(_____)_____
Position and Duties: _____
_____
_____
Starting Date of Employment: _____ Ending Date of Employment: _____
Starting Rate of Pay: _____ Ending Rate of Pay: _____
Reason For Leaving: _____

Name of Company: _____
Name of Supervisor: _____
Address: _____
Street City State Zip Code
Telephone Number: _(_____)_____
Position and Duties: _____
_____
_____
Starting Date of Employment: _____ Ending Date of Employment: _____
Starting Rate of Pay: _____ Ending Rate of Pay: _____
Reason For Leaving: _____

Name of Company: _____
Name of Supervisor: _____
Address: _____
Street City State Zip Code
Telephone Number: _(_____)_____
Position and Duties: _____
_____
_____
Starting Date of Employment: _____ Ending Date of Employment: _____
Starting Rate of Pay: _____ Ending Rate of Pay: _____
Reason For Leaving: _____

May we contact the above employers for reference? Yes _____ No _____

- It is Unyeway, Inc.'s policy to employ, promote, terminate, and otherwise treat any and all employees, volunteers, and job applicants on the basis of merit, qualifications, and competence. This policy shall be applied without regard to any individual's race, color, religious creed, national origin, ancestry, physical or mental disability, medical condition, marital status, sex, gender, sexual orientation, veteran status, and political activity.
- It is Unyeway, Inc.'s policy to not retaliate against anyone who files a discrimination complaint.
- It is Unyeway, Inc.'s policy to promote and encourage cultural diversity and sensitivity.
- In accordance with applicable federal and state law protecting qualified individuals with known disabilities, Unyeway, Inc. will attempt to reasonably accommodate those individuals needing accommodations to perform their position unless doing so would create an undue hardship on Unyeway, Inc.
- Unyeway, Inc. is an at-will employer and conducts pre-employment drug screening.

APPLICANT AGREEMENT

_____ Initials

I hereby certify that I have not knowingly withheld any information that might adversely affect my chances for employment and that the answers given by me are true and correct to the best of my knowledge. I further certify that I, the undersigned applicant, have personally completed this application. I understand that any omission or misstatement of material fact on this application or any document used to secure employment shall be grounds for rejection or for immediate discharge if I am employed, regardless of the time elapsed before discovery.

_____ Initials

I hereby authorize Unyeway, Inc. to thoroughly investigate my references, work record, education and other matters related to my suitability for employment and, further, authorize the references I have listed to disclose to Unyeway, Inc. any and all letters, reports and other information related to my work records without giving me prior notice of such disclosure. In addition, I hereby release Unyeway, Inc., my former employers and all other persons, corporations, partnerships and associations from any and all claims, demands or liabilities arising out of or in any way related to such investigation or disclosure. I also understand that if I am hired for a position at Unyeway, Inc. my employment will be contingent upon passing a fingerprint clearance and a pre-employment drug screen.

_____ Initials

I understand that nothing contained in the application or conveyed during any interview which may be granted or during my employment, if hired, is intended to create an employment contract between me and Unyeway, Inc. In addition, I understand that my employment at Unyeway, Inc. is at will, and agree that if I am employed, my employment is for no definite or determinable period and may be terminated at any time, with or without prior notice, at the option of either myself or Unyeway, Inc., and that no promises or representations contrary to the foregoing are binding on Unyeway, Inc. unless made in writing and signed by me and Unyeway's designated representative.

_____
Applicant's Signature Date

PROFESSIONAL REFERENCES

List below the names of three persons not related to you, whom you have known for at least one year, who could tell us about your qualifications.

Name	Address	Occupation	Phone Number	Years Known
1.				
2.				
3.				

DMV CHECK

ANY OFFER OF EMPLOYMENT MAY BE CONDITIONAL UPON A SUCCESSFUL DMV CHECK.

CA DRIVER'S LICENSE NUMBER: _____ EXP. DATE: _____

IS THERE ANY REASON YOU WOULD NOT BE ABLE TO TRANSPORT UNYEWAY PERSONNEL AND/OR EQUIPMENT IF REQUIRED? YES ____ N0 ____ IF YES, PLEASE EXPLAIN:

_____

_____

_____

_____

_____

_____

_____

_____

APPLICANT'S SIGNATURE **DATE**

Consumer's Face Sheet Information

Consumer's Information

Name:_____ D.O.B.: _____ Gender: _____

Height:_____ Weight:_____ Eye Color:_____ Hair Color:_____

Ambulatory Status: _____ Conserved By:_____

Diagnosis / Medical Concerns:

Allergies or Precautions:

Residence

Home: _____ Home #: _____

Address:_____ Zip:_____

Primary Contact:_____ Cell #:_____ Other#:_____

Secondary Contact:_____ Cell #:_____ Other#:_____

Other Contact:_____ Cell #:_____ Other#:_____

Other Contacts

Emergency Contact: _____ Relationship:_____

Address: _____ Zip:_____

Home #: _____ Cell #:_____ Other#:_____

Emergency Contact: _____ Relationship:_____

Address: _____ Zip:_____

Home #: _____ Cell #:_____ Other#:_____

Transportation Company: _____Contact:_____

Address: _____ Zip:_____

Home #: _____ Cell #:_____ Other#:_____

Continued Next Page

Consumer's Face Sheet Information

Medical Provider Information

UCI # _____ Medi-Cal #_____ Medi-Care #_____

Specialty Equipment or Medical Supplies Needed:

Doctors

Name: _____ Specialty: _____

Address: _____ Zip:_____

Office #: _____ Other # _____

Physicians

Doctor's Name: _____ Specialty: _____

Address: _____ Zip:_____

Office #: _____ Other # _____

Doctor's Name: _____ Specialty: _____

Address: _____ Zip:_____

Office #: _____ Other # _____

Doctor's Name: _____ Specialty: _____

Address: _____ Zip:_____

Office #: _____ Other # _____

Pharmacy

Name: _____

Address: _____ Zip:_____

Office #: _____ Other # _____

Continued Next Page

Consumer's Face Sheet Information

ID Team Members

Unyeway, Inc. Case Manager: _____

Instructor/Coach: _____ Site: _____

Component: _____ Date of Admission: _____

Component: _____ Date of Transfer: _____

Component: _____ Date of Transfer: _____

Component: _____ Date of Transfer: _____

San Diego Regional Center Service Coordinator: _____

Location: _____ Phone #: _____ Fax #:_____

Address: _____ Zip:_____

Conservator: _____ Relationship:_____

Address: _____ Zip:_____

Home #: _____ Cell #:_____ Other#:_____

Residential Administrator: _____

Office Address: _____ Zip:_____

Home #: _____ Cell #:_____ Other#:_____

Residential Nurse: _____

Office Address: _____ Zip:_____

Home #: _____ Cell #:_____ Other#:_____

Behavior Specialist: _____

Location: _____ Phone #: _____ Fax #:_____

Address: _____ Zip:_____

Other: _____ Relationship:_____

Address: _____ Zip:_____

Home #: _____ Cell #:_____ Other#:_____

INDIVIDUAL FACT SHEET

NAME:

COMMUNICATION SKILLS:

MEDS:

HEALTH/ALLERGIES:

BEHAVIORS:

BEH. INTERVENTIONS:

LUNCH:

CONCERNS:

LIKES:

DISLIKES:

TOILETING:

DO'S:

DONT'S:

Medication and Allegry Information Sheet

Individual's Name: _____ Medical #:_____

Medication:_____Reason:_____ Side Effects:_____

Medication:_____Reason:_____ Side Effects:_____

Medication:_____Reason:_____ Side Effects:_____

Medication:_____Reason:_____ Side Effects:_____

Medication:_____Reason:_____ Side Effects:_____

Medication:_____Reason:_____ Side Effects:_____

Medication:_____Reason:_____ Side Effects:_____

Medication:_____Reason:_____ Side Effects:_____

Medication:_____Reason:_____ Side Effects:_____

Medication:_____Reason:_____ Side Effects:_____

Medication:_____Reason:_____ Side Effects:_____

Medication:_____Reason:_____ Side Effects:_____

Medication:_____Reason:_____ Side Effects:_____

Medication:_____Reason:_____ Side Effects:_____

Medication:_____Reason:_____ Side Effects:_____

Medication:_____Reason:_____ Side Effects:_____

Medication:_____Reason:_____ Side Effects:_____

Allergy:_____Reaction:_____

Allergy:_____Reaction:_____

Allergy:_____Reaction:_____

Allergy:_____Reaction:_____

PRN Authorization Letter

Dear Dr. Date:

Unyeway Inc. is the day program provider for some of your patients who reside at _____. Community Care Licensing Title 22 regulation 82075 is mandating that we have the consumer's physician determine which consumers are able to communicate their own need for PRN medication and those consumers who are able to clearly communicate symptoms indicating a need for a PRN medication.

In order to continue to administer PRN medications we must receive this form back signed by you. Please check the appropriate box(es) pertaining to _____

- ☐ My Patient can determine and clearly communicate his/her need for prescribed PRN medications.
- ☐ My Patient cannot determine his or her own need for a PRN medication, but can communicate symptoms indicating a need for prescribed PRN medications.
- ☐ My Patient cannot determine his or her own need or the symptoms for a PRN medication. (CCL regulations require that in such cases the consumer's physician, physician's assistant, or nurse practitioner be contacted prior to the administration of each dose, even with a prescription order on file.) *Though my patient cannot communicate a need or symptoms for a prescribed PRN medication, when **non-subjective physical symptoms** occur such as a fever, repeated seizures, anaphylactic signs, etc… my prescribed PRN orders pertaining to these signs and symptoms should be followed without the need to contact my office.

Physician's Signature _____ Date_____

If you have any questions please call the location indicated below:

- ☐ Unyeway, Inc. East County – 11440 Riverside Dr. Suite D. Lakeside, CA. 92040.
  Phone (619) 562-6330 Fax (619) 562-6547.
- ☐ Unyeway, Inc. South Bay – 1261 3rd Ave. Suite G. Chula Vista, CA. 91911.
  Phone (619) 691-6346 Fax (619) 691-6963.
- ☐ Unyeway, Inc. North County – 4065 Oceanside Blvd. Suite J. Oceanside, CA. 92056.
  Phone (760) 643-9394 Fax (760) 643-9616.

Available and Unavailable Immunization Records

SECTION I – IMMUNIZATION RECORDS

Please send immunization records for _____ to the address of the program site he or she will be attending (addresses listed below). If you are unable to provide immunization records please fill out Section II at the bottom of this form.

Unyeway, Inc. Lakeside	Unyeway, Inc. Oceanside	Unyeway, Inc. Chula Vista
11440 Riverside Dr. Suite D.	4065 Oceanside Blvd. Suite J	1261 3rd Ave. Ste G
Lakeside, CA. 92040	Oceanside, CA. 92056	Chula Vista, CA. 91911
(619) 562-6330 p	(760) 643-9394 p	(619) 691-6346 p
(619) 562-6547 f	(760) 643-9616 f	(619) 691-6963 f

SECTION II – UNAVAILABLE IMMUNIZATION RECORDS

Immunization records for _____ are not available.

_____ _____

Signature Date

_____ _____

Printed Name Relationship

_____

Contact Phone Number

Consent for Emergency Medical Treatment

Emergency Medical Care Release

As the consumer, authorized representative or conservator, I hereby give consent to Unyeway, Inc. to provide all emergency medical or dental care Prescribed by a duly licensed physician (m.d.) osteopath (d.o.) or dentist (d.d.s.) for_____ . This care may be given under whatever conditions are necessary to preserve the life, limb or well being of the individual named above.

_____
Consumer/Authorized Representative/Conservator signature
(circle appropriate title)

Print Name _____

Address_____ Zip:_____

Phone_____ Alternate Phone _____

Consumer has the following medication allergies:

Consent for Release of Information to Family Members From Unyeway, Inc.

I _____ authorize Unyeway, Inc.
(self or conservator)

to release information pertaining to _____.
(Consumer's Name)

Information To Be Released:

Medical, Psychological, Payroll/P&I, Assessments/Evaluations conducted by Unyeway, Inc. or Consultants of Unyeway, and Individual Program Plan information and progress.

_____ _____
Signature of Consumer or Conservator **Date**

Authorization becomes invalid one year after the date of Signature.

If you do not wish information to be release please fill out below

☐ **No Information May Be Released to anyone listed**

☐ **All Information may be release except _____.**

☐ **All Information may be released except to _____.**

Authorization becomes invalid one year after the date of Signature

_____ _____
Signature of Consumer or Conservator **Date**

Consent for Release of Information to Residential Care Providers From Unyeway, Inc.

I _____ authorize Unyeway, Inc.
(self or conservator)

to release information pertaining to _____.
(Consumer's Name)

Information To Be Released:

Medical, Psychological, Payroll/P&I, Assessments/Evaluations conducted by Unyeway, Inc. or Consultants of Unyeway, and Individual Program Plan information and progress.

_____ _____
Signature of Consumer or Conservator **Date**

Authorization becomes invalid one year after the date of Signature.

If You do not wish information to be release please fill out below

☐ **No Information May Be Released to anyone listed**

☐ **All Information may be release except _____.**

☐ **All Information may be released except to _____.**

Authorization becomes invalid one year after the date of Signature

_____ _____
Signature of Consumer or Conservator **Date**

Consent for Release of Information to San Diego Regional Center From Unyeway, Inc and From SDRC to Unyeway, Inc.

I _____ authorize Unyeway, Inc. and San
(self or conservator)

Diego Regional Center to share information pertaining to _____.
(Consumer's Name)

Information To Be Released:

Medical, Psychological, Payroll/P&I, Assessments/Evaluations conducted by Unyeway, Inc. or Consultants of Unyeway, and Individual Program Plan information and progress.

_____ _____
Signature of Consumer or Conservator **Date**

Authorization becomes invalid one year after the date of Signature.

If you do not wish information to be release please fill out below

_____ No Information May Be Released to anyone listed

_____ All Information may be release except _____.

_____ All Information may be released except to _____.

Authorization becomes invalid one year after the date of Signature

_____ _____
Signature of Consumer or Conservator **Date**

Consent for Release of Photographs.

I _____ authorize Unyeway, Inc.
(self or conservator)

to use for distribution, publication, posting, or other media related described below:

the picture(s) of _____ . The picture(s) depicts
(Consumer's Name)
this person:

_____ _____
Signature of Consumer or Conservator **Date**

Comments:

_____ _____
Signature of Consumer or Conservator **Date**

Grievance Procedure Acknowledgment

The following is taken directly from the Unyeway, Inc. Participant Handbook. The entire handbook is written in a question and answer format. “We” refers to Unyeway, Inc. and “You” addresses the participant.

This procedure is presented to each participant upon his or her enrollment into the program and annually thereafter. Please sign below to acknowledge the receipt of this procedure.

What can I do if I do not like my program schedule or job?

We understand if you do not like your program schedule or job. If you have made this decision after your 30-day introductory trial enrollment period, talk with your supervisor. That person will see what can be done to help you advocate for yourself, you will also be encouraged to contact your Service Coordinator throughout the grievance procedure.

Who do I talk to if I have a problem?

The first person you should talk to is your immediate supervisor. This person is the person who works with you every day and is most familiar with your program and work situation. This person can usually help you solve a problem right away.

If I do not agree with my immediate supervisor, who do I talk to?

If you disagree with what your supervisor has told you about how to solve the problem, the next person to talk to is your Case Management Specialist (Your supervisor’s supervisor). This person will discuss the issue with the supervisor and the Director to see if things can be worked out within 10 days of your initial complaint.

If you still do not agree with that person, who do I talk to?

If you still have concerns after talking with your supervisor and the Case Management Specialist and the Director’s solution, you can request a meeting with the Executive Director. She will schedule a meeting with you within 10-days of receiving your request, listen to your problem, and help you develop a plan for what to do next. A resolution will be suggested within 5 days of your meeting.

Then what?

Sometimes, no matter how hard we try, there are certain concerns that cannot be solved. If you still are not happy with the solution recommended by your supervisor, the Case Management Specialist, Director, and Executive Director we will call an ID Team meeting to decide the next step.

I _____have received a copy of the grievance policy.
(Name of Consumer)

_____ _____

Consumer/Conservator’s Signature Date Unyeway, Inc. Representative’s Signature Date