SLS Program Design Requirements
Service Code 896

“Support Living Service(s) (SLS) means those services and supports referenced in Section 54349(a) through (e), and specified as SLS service support components in Title 17, Section 58614, which are provided by a SLS vendor, paid for by the regional center, and support consumers’ effort to: (A) Live in their own home, as defined in Title 17, Section 58601(a)(3); (B) Participate in community activities to the extent appropriate to each consumer’s interests and capacity; and (C) Realize their individualized potential to live lives that are integrated, productive, and normal.” (Title 17 Section 54302(a)(71))

“Supported Living Arrangement means the full array of regional center-funded services and supports received by a SLS consumer, including SLS, day program, transportation, and all other regional center services and supports.” (Title 17 Section 58601(a)(7))

“Generic Support(s) means voluntary service organizations, commercial businesses, non-profit organizations, generic agencies, and similar entities in the community whose services and products are regularly available to those members of the general public needing them.” (Title 17 Section 54302(a)(32))

“Natural Supports means, pursuant to Welfare and Institutions Code, Section 4512(e), personal associations and relationships typically developed in the family and community that enhance or maintain the quality and security of life for people.” (Title 17 Section 54302(a)(48))

You are required to ensure that you are familiar with Alta California Regional Center’s (ACRC) expectations for a Supported Living Services (SLS) provider. You should have a copy of and be familiar with any regulations relating to SLS as well as vendorization in general. To view Title 17, go to the Department of Developmental Services’ (DDS) website at www.dds.ca.gov

ACRC Services Coordinators (SC) will read your program design which enables them to gain information as well as increase their sense of your program, its mission and service goals. Through this informed understanding, an SC can more easily assist their consumers and families in their process towards choosing an SLS program.

An SLS service program is a program vendored by ACRC. SLS services directly provide those services detailed in the consumer’s Supported Living component of his/her Individual Program Plan (IPP). All services directly provided to the consumer shall be in accordance with the provider’s SLS service design and in compliance with Title 17 Section 58600-58680. **The program design, the SLS contract and these regulations compile the vendor’s contract with ACRC.**

Title 17: Browse - California Code of Regulations AND Laws & Regulations : CA Department of Developmental Services

Title 17 Section 56710-56756: Browse - California Code of Regulations

Review definitions as outlined in Title 17 Section 54302(a)(16)(17)(30)(35): View Document - California Code of Regulations

Composition and Efficiency

Requirements of the program design:

- The program design is to be typed with a header or footer on each page.
- Pages of the program design are to be numbered in sequential order.
- The potential vendor is responsible for all content of the program design; the program design shall be composed by the potential vendor.
- Use present tense when writing the program design (as if provider is in operation)
- The number of pages for the program design shall not exceed 40 pages.
- Title 17 regulations may be referenced but not copied and pasted within the program design.

40 Page Max- Limit

Please limit your submission to no more than 40 pages (including Appendix/Attachments). All Program Designs submitted outside of the 40-page max will be returned.

Instructions: Copy/paste the following into your program design and address each prompt with your business information. This format must be used.

<u>1 page max.</u>

SLS Name

Business Address
Mailing Address (if any)

SLS Director's Name with Title
SLS Director's Email with Label
SLS Director's Phone Number with Label

Referral Email with Label (if different)
Referral Phone Number with Label (if different)

Instructions: Copy/paste the following into your program design and add page numbers. This section must follow the format as shown below.

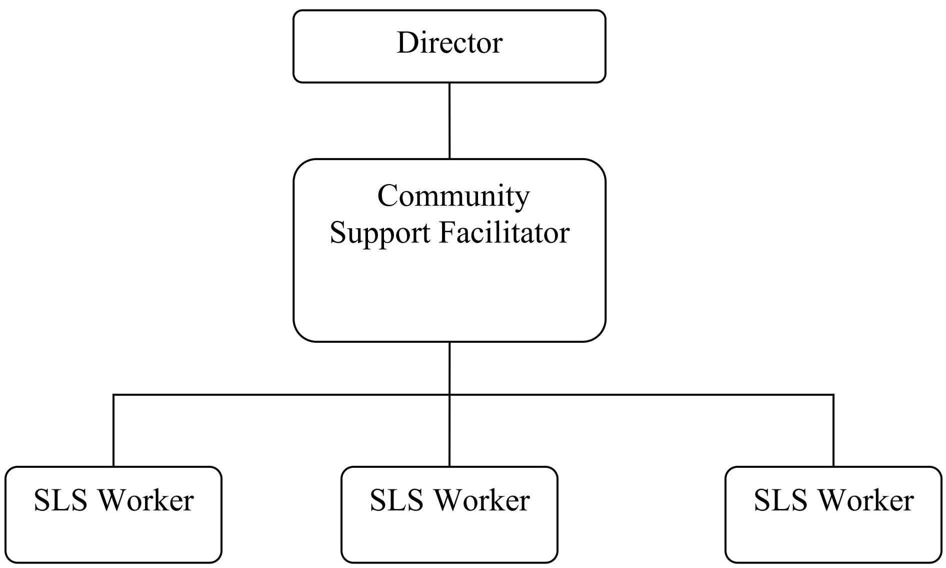
Table of Contents

Instructions: Copy/paste the following into your program design and address each prompt with your business information. You are required to specifically identify the Director and Supervisor, but direct care staff do not need to be specified. If you do not have a Supervisor, remove box. This section must follow the format as shown below.

<u>1 page max.</u>

Organizational Chart

Name of Agency
Address
Telephone Number



Instructions: Include the following section into your program design and address each prompt. Pursuant to Title 17 §58631, describe the SLS's mission statement, Purpose and goals. This section must follow the format as shown below. <u>4 sentences max each section.</u>

Mission Statement

The program design is required to have a mission statement which outlines how the provider is providing services that match the goals and objectives for a SLS provider.

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Purpose and Goals

The purpose and goals of the program design should support the mission statement.

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Instructions: Include the following section into your program design and address each prompt. Pursuant to Title 17 §58632, describe the implementation of SLS Philosophy. Also, pursuant to Title 17 §58631(b) vendor will also describe whether and to what extent each of the services is available through the vendor. This section must follow the format as shown below. <u>4 sentences max each prompt.</u>

Implementation of SLS Philosophy

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Discuss the 5 principles of SLS and how the program will support those principles.

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Instructions: Include the following section into your program design and address each prompt. The SLS vendor will review Title 17 §58614(b) and describe how the vendor will support the consumer in each of the areas. This section must follow the format as shown below. <u>16 sentences max each prompt.</u>

Implementation of Service and Support Components

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Instructions: Copy/paste the following section into your program design. Address each prompt. If your program only offers 1:1, do not copy/paste the 1:2 and 1:3 information below. This section must follow the format as shown below. <u>Half a page max.</u>

Staffing Ratio

☐ I understand and agree that this program will be vendored for:

- ☐ 1:1 (the service is conducted on an individual basis)
- ☐ 1:2 (the service is provided to two clients)
- ☐ 1:3 (the service is conducted on a group basis)

☐ I understand and agree that if this program is vendored for 1:1 or 1:2 or 1:3 ratio

- The Program Director or CFS will ensure the staffing ratio is maintained during routine supervision (see Staff Supervision section).
- Services and Support Components, as outlined in Title 17 Section ***58614(b***) will be maintained regardless of ratio.

☐ I understand and agree that in order to meet HCBS guidelines, this program will maintain person-centered practices:

- This program will assess and document how the additional ratio of 1:2 or 1:3 best meets the needs of the individual clients, vs the convenience of the provider.
- This program will assess each individual client to determine which participants will receive services together.

- This program will have a process in place if a client wants a change of staff, peer, or ratio.
- This program will maintain an individual's privacy when offering services to more than one participant at a time (i.e. financial, medical, other personal information, etc.).
- Before 1:2 and/or 1:3 can begin, a planning team will be held to ensure there is agreement amongst the clients and their planning teams and to also ensure the IPP and ISP are updated and submitted to all members of the planning teams.

☐ I understand and agree that this program will bill services hourly based on ratio of employee to supported individuals.

☐ I understand and agree that rates have been established for ratios: 1:1, 1:2 and 1:3.

Providers initials: ______

By initialing here, I understand what is expected and will follow Title 17 Section 58631(a)-(g).

Instructions: Include the following section into your program design. Copy/paste the first prompt as written. Address the second prompt with the ACRC areas you will serve. This section must follow the format as shown below.

Description of Geographic Area Served

1. The counties <u>and</u> cities this program will offer services in:
   a.
   b.
   c.

Instructions: Include the following section into your program design and describe the characteristics of a consumer served by the vendor. <u>4 sentences max</u>

Description of the Consumers Served

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Instructions: Copy/paste the following section into your program design. This section must follow the format as shown below. 1 and a half pages max.

Intake Procedure

☐ I understand and agree with the following Screening Procedure:

Screening Procedure for New Clients

- Referral is received from ACRC.
- Referral to include the current IPP, CDER, ISP reports from any day program or SLS agencies, etc.
- Program Director will review referrals to ensure clients meet the program's entrance criteria.
- It takes approximately 2 weeks before a POS can begin for any service.

☐ I understand and agree with the following Assessment Procedure:

Assessment Procedure

- The Assessment POS will be a total of 50 hours over the course of two-month max authorized transitional period.
- Once the POS is effective, the Program Director will complete the assessment procedure.
- Assessment will include a meeting with the client. Example: in-person interview at the referred client's home.
- Different instruments will be used to assess the need for all 16 functional skills as outlined in Title 17 Section 58614(b) as well as to measure and collect data related to the client's wants, needs, and interests.
    - Instruments to be used:
        -
        -
    - How each instrument will assess the client's needs:
        -
        -
- Only the functional skills agreed upon <u>with</u> the client will be determined as the client's SLS goals.
- Assessment data will be used to determine the specific activity and program services the client receives.
- The ISP will be written by the designated staff and submitted to the Service Coordinator by the end of the 30-day POS timeframe.
- The assessment report will identify whether this program can provide ongoing SLS training for the client based on their needs and wants assessed for SLS.
- The assessment report will identify the number of hours for <u>each</u> assessed SLS goal – the total will be the monthly SLS hours requested for the ongoing Purchase of Services (POS).
- The monthly POS hours cannot exceed 744 hours per month and will be agreed upon with the client and planning team

Monthly summaries will be completed and submitted to the client's service coordinator by the tenth of each month. These reports are used to determine the extent of a client's progress toward achieving the specific outcomes in each IPP objective for which the program is responsible.

First Day of Ongoing Services

☐ I understand and agree to review and have the client/authorized representative sign the following forms on the first day of services: Attendance Policy Acknowledgement Form, Exit Criteria and Grievance Procedure Acknowledgement Form, Authorization to Release or Exchange Information and Records Form, etc.

☐ I understand and agree to complete an Initial Individual Service Plan (ISP) within 30 days of the start of ongoing services.

Providers initials: _______

By initialing here, I understand what is expected and will follow Title 17 Section 58632 and Section.

Instructions: Copy/paste the following section into your program design. Address each prompt. This section must follow the format as shown below. 1 in a half pages max.

Entrance & Exit Criteria

Entrance Criteria

1) Ages of consumer to be served: must be 18 with a diploma or age 22.
2) Other prerequisites required for participation in the program: ___________
3) Self-care skills: ___________
4) Physical and medical conditions: ___________
5) Behavioral characteristics: ___________
6)

Exit Criteria

1) Self-care skills: ___________
2) Physical and medical conditions: ___________
3) Behavioral characteristics: ___________
4) Failure to meet attendance requirements (See Attendance Policy)
5) The level of skills and ability development which would indicate that placement in the vendor's program may no longer meet the consumer's needs: ___________

☐ I understand and agree with the following Exit Procedure:

Exit Procedure – 30-Day Notice to Exit

- Program will schedule planning team meeting to discuss barriers that are occurring and the SLS program will propose resolutions, such as changing SLS Instructors, reducing SLS hours, etc.
- After exhausting measures to prevent exit, the SLS Director will submit a written 30-day notice to the client, their authorized representative, and their Service Coordinator via email and mail. This notice will include a written statement of reasons for the termination which must be supported by the Exit Criteria listed above.
- The SLS remains responsible for providing services during this 30-day period – SLS must identify an alternative SLS Instructor if the current one can no longer work with the client.

Exit Criteria
☐ I understand and agree to maintain an Exit Criteria Form.
☐ I understand and agree that the Exit Criteria Form will be provided to the client and any authorized representative, upon start of services and annually.

Providers initials: _______
By initialing here, I understand what is expected and will follow Title 17 Section 58613(a)-(b) and 58672(a)-(c).

Instructions: Copy/paste the following section into your program design. Address each prompt. This section must follow the format as shown below. Half a page max.

Participation Policy
☐ I understand and agree the Program Director will notify the Regional Center on or before the client's 10th consecutive day of unplanned absence.

Attendance requirements for clients to remain enrolled in your program:
1.
2.
3.

The efforts the program will make to assure attendance at the program as frequently as determined necessary by the ID team:
1. Schedule and host a planning team meeting to discuss barriers and propose resolutions.
2.
3.

☐ I understand and agree to create and maintain an Participation Policy Acknowledgement Form.
☐ I understand and agree that the Participation Policy Acknowledgement Form will be provided to the client and any authorized representative, upon start of services and annually.

Providers initials: _______
By initialing here, I understand what is expected and will follow Title 17 Section 58614.

Instructions: Copy/paste the following section into your program design. This section must follow the format as shown below. Half page max.

Internal Grievance Procedure

☐ I understand and agree with the following procedure:
- Client and their planning team members can file a written grievance using the Grievance Form.
- The Grievance Form is to be submitted to the Community Support Facilitator.

- Within 5 business days of receiving the Grievance Form, the Community Support Facilitator will propose a resolution, in writing, to the client and/or person who submitted the grievance.
- If the proposed resolution is not sufficient, a planning team meeting, which will include the Service Coordinator, will be scheduled for further discussion and resolution.
- If an agreement for resolution cannot be reached, the client and/or person who submitted the grievance will be notified of their rights to contact the Office of Clients Rights Advocate and/or the ACRC Client Advocate for further support.

☐ I understand and agree that the Grievance Procedure Acknowledgement Form will be provided to the client and any authorized representative, upon start of services and annually.

☐ I understand and agree to explain to the client grievances are not always a major issue but that a grievance may be when they have a complaint or feel they have been wronged.

Providers initials: ______

By initialing here, I understand what is expected and will follow Title 17 Section 58631(d)

Instructions: Include the following section into your program design and address each prompt. The SLS vendor will review Title 17 § 58653 and describe how the vendor will support the training to the consumer in each of the areas. This section must follow the format as shown below. <u>4 sentences max each prompt.</u>

Consumer Training

1. Philosophy of SLS
2. Consumers' rights
3. Identification and reporting of suspected abuse or exploitation of the consumer
4. Internal grievance procedure of the SLS vendor
5. Strategies for building and maintaining an effective circle of support

Instructions: Copy/paste the following section into your program design. Address each prompt. If you do not have a Supervisor, the job description for the Supervisor must be included in the Director's job description. This section must follow the format as shown below. <u>3 pages max.</u>

Job descriptions/qualifications

SLS Director

Qualifications per Title 17 Section 58641:

1. Director shall have the ability, as a result of any combination of relevant training and experience, to competently and consistently organize and supervise the provision of services in accordance with the SLS vendor's established policies, including:
    a. Selecting, and exercising general supervision over, assigned staff; and

    b. Overseeing discharge of the vendor's contractual obligations, budgeting, service design and implementation, project planning, staff development, training, evaluation, and the direction of the SLS.
2. Education:_______________
3. Experience:_______________

Job Descriptions:
1. Organizing and supervising the program in accordance with the program's established policies.
2. Overseeing the areas of budgeting, program design and implementation, project planning, staff development and training, evaluation and the direction of program services.
3. Organizing and monitoring the intake and continuing assessment process.
4. The program is authorized to delegate to the director additional functions which are directly related to the overall administration of the program.
5. _______________
6. _______________

Duty statement: _______________
Work hours: _______________
Positions supervised: Program Supervisor, SLS Instructor

Community Support Facilitator (CSF)
Qualifications per Title 17 Section 58642:
1. The SLS vendor shall assign direct service supervisory staff to supervise the delivery of SLS by direct service personnel.
2. All direct service supervisory staff shall have the ability, as a result of any combination of relevant training and experience, to competently and consistently organize and supervise the direct provision of services to consumers in accordance with the SLS vendor's established policies, under the general supervision of the director.
3. Three years of experience in a human services delivery system, including at least one year in a comparable program or a bachelor's degree in a human services related field; and
4. The demonstrated ability to provide staff training, supervision and planning.
4. Education:_______________
5. Experience:_______________

Job Descriptions:
1. Selection, training, and supervision of assigned staff.
2. Planning, managing, coordinating and evaluating, assigned staff efforts to achieve the program's objectives and consumer outcomes.
3. Coordinating with the regional center the implementation of consumer IPP objectives for which the vendor is responsible.
4. Assessing the program's effectiveness in achieving consumer IPP objectives.
5. Identifying barriers to consumer success in obtaining the IPP objective(s) and how those shall be overcome pursuant to section Title 17 Section 58620(e).
6. The program is authorized to delegate to the supervisor additional functions which are directly related to the supervision of the program.
7. _______________
8. _______________

Duty statement: _______________
Work hours: _______________
Positions supervised: SLS Instructor
Reporting supervisor: Program Director

SLS Instructor
Qualifications per Title 17 Section 58643:
1. The SLS vendor shall, subject to Section 58620(c), assign direct service staff to provide SLS directly to consumers. Such direct service staff shall have:
    a. The skill, training, or education necessary to:
        i. Establish and maintain a constructive and appropriate personal relationship with consumers;
        ii. Minimize risks of endangerment to the health, safety, and well-being of consumers;
        iii. Perform first aid and cardiopulmonary resuscitation (CPR), and operate 24-hour Emergency Assistance systems, as appropriate to the need with respect to any specific consumer; and
        iv. Achieve the intended results of the service being performed.
    b. Current and valid licenses, certificates, or registrations that may be legally required to provide the service.
2. Education: _______________
3. Experience: _______________
4. The ability to perform the functions required in the program design.
5. _______________
6. _______________

Job Descriptions:
1. Implementing program curricula.
2. Directly delivering individual and group learning experiences to assist each consumer served in obtaining his/her IPP objective(s) for which the vendor is responsible.
3. Maintaining data regarding consumer progress.
4. Participating in consumer assessment, planning and evaluation processes.
5. The program is authorized to assign staff to operate a motor vehicle for the purpose of carrying out assigned functions. The program shall assure that such staff possess a current valid driver's license which is appropriate for the type of vehicle to be driven.
6. _______________
7. _______________

Duty statement: _______________
Work hours: _______________
Reporting supervisor: Program Supervisor

Providers initials: _______
By initialing here, I understand what is expected and will follow Title 17 Section 58641, Section 58642, and Section 58643.

Instructions: Copy/paste the following section into your program design – do not copy/paste the examples into your program, those are included here for further support. Address each prompt. This section must follow the format as shown below. <u>Half a page max.</u>

Staff Screening and Supervision

The program design will describe the procedures and practices the program will use to screen paid staff, consultants, and volunteers who have direct contact with consumers. (Title 17 Section 58631(g))

The level of Supervision of Staff provided to ensure that the services are being provided as outlined in each client's IPP:

- ______________
- ______________
- ______________

Examples:

1. *The Program Director will conduct unannounced visits to 5 different clients every 6 months; these visits will occur during scheduled SLS training sessions which should match with the SLS Instructor's weekly schedule.*
2. *The Community Support Facilitator will make unannounced calls to 3 different clients every quarter and ask them about their current SLS goals and the most recent SLS training session which should match what is written in the most recent internal report: daily notes which were composed by the SLS Instructor.*
3. *GPS Location Tracking app to track location of where staff clock-in prior to their SLS training session which should match what's written in the most recent internal report: daily notes which were composed by the SLS Instructor; the Community Support Facilitator will check the GPS Location Tracking app on a bi-monthly basis when daily notes are reviewed.*

What will occur if it is determined the staff is not meeting with the client and providing services in accordance with the client's IPP: ___________

☐ I understand and agree that it is important to monitor staff who are providing direct services to clients as often as possible.
☐ I understand and agree that if staff falsely report service hours and this program improperly bills the Regional Center, the program is responsible for notifying the ACRC Accounting Dept. immediately to make necessary corrections.
☐ I understand and agree that improperly billing ACRC may lead to a financial audit of this vendorization.

Providers initials: ______
By initialing here, I understand what is expected and will follow what is outlined above.

Instructions: Copy/paste the following section into your program design. Add additional topics as appropriate and address the on-going staff training prompt. This section must follow the format as shown below. 1 page max.

Staff Training

1. **New employee orientation – *Occurs within the first 2 weeks of employment***
    - Welfare and Institutions Code 4502, 4504, 4518, 4646.5, 4648, 4655, 4705, 4710, 4710.5
    - Consumer's rights as defined in Title 17 Section 58620
    - The developmental disabilities service system
    - The policies, procedures and practices of the vendor's program
    - Specific job requirements for that employee
    - Training in client safety procedures to be used in the event of an emergency
    - Zero Tolerance Policy – upon hire & annually
    - CPR and First Aid- every two years
    - CPS, APS, Law Enforcement – mandated reporter requirements
    - SIR
    - IPP, ISP, other required reports
    - Program Design
    - HIPAA
    - Person Centered Planning and Thinking
    - _______________
    - _______________

2. **On-going staff training – *Occurs*** ________
    - Curriculum as outlined in Title 17 Section 58652
    - Instructional methodology and techniques used in training consumers to meet their IPP objectives
    - _______________
    - _______________

Providers initials: _______
By initialing here, I understand what is expected and will follow Title 17 Section 58651 & 58652.

Performance Evaluation

☐ I understand and agree with the following procedure:

- Each fiscal year this program shall conduct an annual review of its effectiveness in relation to the program design.
    - This shall include a documented review of the anticipated client outcomes resulting from participation in the program stated in measurable terms.
    - This shall include a documented review of aggregate data on progress in relation to the IPP objectives for which this program is responsible.
- The evaluation review will result in a written program evaluation report.
- The written program evaluation report will include:

- The purpose of the evaluation
    - The type of data to be collected and used
    - The frequency of data collection
    - Data collection and analysis methods
    - A description of the distribution, communication of, and actions taken upon the results of the evaluation
    - The frequency of evaluations
    - The reason this particular evaluation design was selected and how it relates to program objectives
- The program will submit to the vendoring regional center, user regional centers and the Department a written summary of the annual program evaluation which shall be maintained in the vendor file at the vendoring regional center and at the Department.
- The program shall maintain the program evaluation for review by the regional center and the Department.
- Program will provide written notification to ACRC's Community Services and Supports department <u>at least 30 days prior</u> to any change in ownership, location, license, certificate, registration, credential, or permit.
- Termination requires sixty (60) days' written notice of the intent to terminate, consistent with Title 17, Section 58672(3)(B).

Providers initials: _______
By initialing here, I understand what is expected and will follow Title 17 Section 58671(c) and Section 58631(b)(e).

Appendix:

All documents cited in the program design should be included as appendices. Likewise, every item included as an appendix should be cited within the body of program design. Identify when that document is used, by whom, for what purpose, etc.

Addendum 1: Practice

Include examples for the following reports:

1. SLS Assessment Report:
    a. ***Instructions: Copy/paste the template into your program design. This section must follow the format as shown below. Address each prompt using sample information. <u>5 pages max.</u>***
2. Annual / Monthly Progress Report
    a. ***Instructions: Copy/paste the template into your program design. This section must follow the format as shown below. Address each prompt using sample information. <u>4 pages max.</u>***
        1. Monthly– 1 page max.
        2. Client information
        3. Timeframe for the report
        4. Monthly Report: January 2024
        5. Summary of progress and barriers made for each goal in ISP for the timeframe the report is for
        6. SIR

7. Medication changes
8. Total # of hours provided in the timeframe the report is summarizing
9. Staff name, signature, date

3. Any internal report your program will complete.
    a. ***Instructions: Provide a sample of your internal report. See below for required information based on the type of internal report you may choose from.***
        i. Daily or Session Notes/Report – ***1 page max.***
            1. Client information
            2. Date of session
            3. Time in/start and time out/end
            4. Total # of hours provided in the single session
            5. Client signature
            6. Staff name and signature
            7. Medical Appointments/ Medication if applicable

NAME OF VENDOR / LOGO
ADDRESS
TELEPHONE NUMBER

SLS Assessment Report

Client Name: **Service Coordinator:**

Date of Birth: **Date of Report:**

UCI Number: **Date Report was Submitted to SC:**

Report Composer and Title:

....

Client Information:

Address the following areas, as applicable, in a narrative format

- Name and contact information of client, to include address and phone number
- Age of client
- Ethnicity of client
- Eligible ACRC condition and all diagnoses
- Ambulatory/non-ambulatory
- Verbal/non-verbal (communication)
- Likes and dislikes (i.e., social, play skills)
- Client's reported strengths and barriers in relation to SLS functional skills
- Strengths and deficits of ADLs
- Additional relevant information

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Functional Skill 1: Cooking
Assessment summary of this goal:

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Objectives:

1.

Services and Supports:

1.

Client has agreed to receive SLS training on this goal: **Yes/No**

Training hours per month for Cooking: 5

Functional Skill 2: Cleaning

Assessment summary of this goal:

-

Objectives:

1.

Services and Supports:

1.

Client has agreed to receive SLS training on this goal: **Yes/No**

Training hours per month for Cleaning: 5

Functional Skill 3: Shopping in natural environments

Assessment summary of this goal:

-

Objectives:

1.

Services and Supports:

1.

Client has agreed to receive SLS training on this goal: **Yes/No**

Training hours per month for Shopping: 5

Functional Skill 4: Menu planning

Assessment summary of this goal: N/A

Client has agreed to receive SLS training on this goal: **Yes/No**

Training hours per month for Money Management: 0

Functional Skill 5: Meal preparation

Assessment summary of this goal: N/A

Client has agreed to receive SLS training on this goal: **Yes/No**

Training hours per month for Meal Preparation: 0

Functional Skill 6: Money management, including check cashing and purchasing activities

Assessment summary of this goal: N/A

Client has agreed to receive SLS training on this goal: **Yes/No**

Training hours per month for Money Management: 0

Functional Skill 7: Use of public transportation in natural environments
Assessment summary of this goal: N/A
Client has agreed to receive SLS training on this goal: **Yes/No**

Training hours per month for Money Management: 0

Functional Skill 8: Personal health and hygiene
Assessment summary of this goal: N/A
Client has agreed to receive SLS training on this goal: **Yes/No**

Training hours per month for Money Management: 0

Functional Skill 9: Self-advocacy training
Assessment summary of this goal: N/A
Client has agreed to receive SLS training on this goal: **Yes/No**

Training hours per month for Money Management: 0

Functional Skill 10: Independent recreation and participation in natural environments
Assessment summary of this goal: N/A
Client has agreed to receive SLS training on this goal: **Yes/No**

Training hours per month for Money Management: 0

Functional Skill 11: Use of medical and dental services, as well as other community resources
Assessment summary of this goal: N/A
Client has agreed to receive SLS training on this goal: **Yes/No**

Training hours per month for Money Management: 0

Functional Skill 12: Community resource awareness such as police, fire, or emergency help
Assessment summary of this goal: N/A
Client has agreed to receive SLS training on this goal: **Yes/No**

Training hours per month for Money Management: 0

Functional Skill 13: Home and community safety
Assessment summary of this goal: N/A
Client has agreed to receive SLS training on this goal: **Yes/No**

Training hours per month for Money Management: 0

Assessed SLS Goals:

1. Cooking
2. Cleaning
3. Shopping

Ongoing SLS Services:

Overall, this agency **can/cannot** meet the client's needs for SLS. This program **is/is not** requesting to provide ongoing services to this client.

Total training SLS hours per month: 15

Client signature: ____________________ Date: _______________

Program Director: ____________________ Date: _______________

NAME OF VENDOR / LOGO
ADDRESS
TELEPHONE NUMBER

☐ **Initial ISP** ☒ **Annual ISP**

Client Name: **Service Coordinator:**

Date of Birth: **Date of Report:**

UCI Number: **Date Report was Submitted to SC:**

SLS Instructor:

....

Current SLS Goals:
1. Cooking
2. Cleaning
3. Shopping

....

Goal 1: Cooking
Objectives:
1.

Services and Supports:
1.

Performance and progress:
-

Barriers to the client's success in achieving the IPP objective:
-

How barriers shall be overcome in the future:
-

Can this program continue to meet the client's needs for this goal: **Yes/No**

Training hours for per month goal 1: 5

Goal 2: Cleaning
Objectives:
1.

Services and Supports:
1.

Performance and progress:
-

Barriers to the client's success in achieving the IPP objective:
-

How barriers shall be overcome in the future:
-

Can this program continue to meet the client's needs for this goal: **Yes/No**

Training hours per month for goal 2: 5

Goal 3: Shopping
Objectives:
1.

Services and Supports:
1.

Performance and progress:
-

Barriers to the client's success in achieving the IPP objective:
-

How barriers shall be overcome in the future:
-

Can this program continue to meet the client's needs for this goal: **Yes/No**

Training hours per month for goal 3: 5

Ongoing SLS Goals:
1. Cooking
2. Cleaning
3. Shopping

Ongoing SLS Services:
Overall, this agency **can/cannot** continue to meet the client's needs for SLS. This program **is/is not** requesting to provide ongoing services to this client.

Total training SLS hours per month: 15

Client signature: ____________________ Date: _______________
Program Director: ____________________ Date: _______________

Instructions: Copy/paste the following templates into your program design. This section must follow the format as shown below.

Addendum #2: Forms

Exit Criteria and Exclusion Acknowledgement Form

Exit Criteria

1. Self-care skills: ___________
2. Physical and medical conditions: ___________
3. Behavioral characteristics: ___________
4. Failure to meet attendance requirements (See Attendance Policy)
5.

Exit Procedure – 30-Day Notice to Exit

- Measures this agency will take prior to providing a written 30-day notice to exit the program: planning team meeting will occur in a timely manner. The team will discuss barriers that are occurring and the SLS program will propose resolutions, such as changing SLS Instructors, reducing SLS hours, etc.
- After exhausting measures to prevent exit, the Program Director will submit a written 30-day notice to the client, their authorized representative, and their Service Coordinator via email and mail. This notice will include a written statement of reasons for the termination which must be support by the Exit Criteria listed above.

Exclusion Procedure

- A vendor may <u>exclude</u> a consumer from participation in the program <u>during periods when the vendor determines that the consumer is a threat to the health and safety</u> of other individuals in the program, per T17 Section 56718(g).
- Once a decision is made to exclude the client from the program a written notification is to be provided to the client, Service Coordinator and authorized representative via email.
  - This written notification will specify details of the health and safety concern (ex: client engaged in physical aggression toward their SLS Instructor).
  - This written notification will specify how long the exclusion will last.
- A meeting will be scheduled by the Program Director or Supervisor within three working days of determination.
- To be included in this meeting: client, Service Coordinator, Program Director or Supervisor, and authorized representative.
- Purpose of the meeting: to discuss the basis of the exclusion and any program changes that may be required.
- If no resolution can be agreed upon, or if it is the program's understanding that the period, in which the client is a threat to the health and safety of others, is not temporary and is believed to be ongoing then the Exit Criteria procedure will be followed by the program, which includes providing a written 30-day notice.

Client signature: ____________________ Date: _______________
Program Director: ____________________ Date: _______________

Grievance Procedure Acknowledgement Form

- Client and their planning team members can file a written grievance using the Grievance Form.
- The Grievance Form is to be submitted to the Program Director.
- Within 5 business days of receiving the Grievance Form, the Program Director will propose a resolution, in writing, to the client and/or person who submitted the grievance.
- If the proposed resolution is not sufficient, a planning team meeting, which will include the Service Coordinator, will be scheduled for further discussion and resolution.
- If an agreement for resolution cannot be reached, the client and/or person who submitted the grievance will be notified of their rights to contact the Office of Clients Rights Advocate and/or the ACRC Client Advocate for further support.

Client signature: ____________________ Date: _______________
Program Director: ____________________ Date: _______________

Grievance Form

Date of report: ________

Date the grievance occurred: _________

Grievance summary:

____
____
____

Proposed resolution:

____
____
____

Agreed upon resolution:

____
____
____

If resolution cannot be reached, next steps:

____
____
____

Client signature: ____________________ Date: _______________
Program Director: ____________________ Date: _______________

AUTHORIZATION TO RELEASE OR EXCHANGE INFORMATION AND RECORDS

Client Name		Date of Birth:
Other Names		

I or my legally authorized representative request that confidential information and records about me be released or exchanged as set forth on this form:

☐ Unilateral Release (Steps 1 – 3) ☐ Mutual Exchange (Steps 1 – 6)

1. **NAME AND ADDRESS OF PERSON, CLASS OF PERSONS, OR ENTITY AUTHORIZED TO *RELEASE* INFORMATION AND RECORDS:**

2. **SPECIFIC INFORMATION AND RECORDS TO BE RELEASED:**
   - ☐ All Information/records
   - ☐ Educational
   - ☐ Social
   - ☐ Medical/Dental
   - ☐ Vocational
   - ☐ Psychological
   - ☐ Regional Center
   - ☐ Other (specify):

3. **NAME AND ADDRESS OF PERSON, CLASS OF PERSONS, OR ENTITY AUTHORIZED TO *RECEIVE* INFORMATION AND RECORDS:**

4. **NAME AND ADDRESS OF PERSON, CLASS OF PERSONS, OR ENTITY AUTHORIZED TO *RELEASE* INFORMATION AND RECORDS:**

5. **SPECIFIC INFORMATION TO BE RELEASED:**
   - ☐ All Information/records
   - ☐ Educational
   - ☐ Social
   - ☐ Medical/Dental
   - ☐ Vocational
   - ☐ Psychological
   - ☐ Regional Center
   - ☐ Other (specify):

6. **NAME AND ADDRESS OF PERSON, CLASS OF PERSONS, OR ENTITY AUTHORIZED TO *RECEIVE* INFORMATION AND RECORDS:**

7. **PURPOSE:**

☐ Requested by client, applicant or legally authorized representative
☐ Other (specify):

I understand that the information released may also include the medical history, physical or mental condition, and services rendered or treatment received.

8. RIGHT OF REVOCATION. I understand that I have the right to revoke this authorization at any time, provided that my revocation is in writing.

9. LIMITS TO REVOCATION. I understand that my revocation will be effective upon its receipt by the person, class of persons or entity I authorized in Section 1, but would not be effective to the extent that such person, class of persons, or entity has acted in accordance with this Authorization and in reliance thereon. With request to the person, class of persons or entity I authorized to receive information in Section 3, if I (or legally authorized representative) requested this Authorization, any revocation will be effective only when I (or legally authorized representative) communicate the revocation directly to them.

10. REDISCLOSURE. I understand that if a recipient of my information or records identified in Section 3 is not a healthcare provider, a health plan or health care clearing house or not an entity required to comply with federal or state privacy laws and regulations, my information may be further disclosed by such recipient and my information may no longer be protected by state and federal laws.

11. CALIFORNIA/ARIZONA RESTRICTION. I understand that a recipient of medical information in California or Arizona may not further disclose medical information about the patient unless a new Authorization form is signed by me or my legally authorized representative or unless disclosure is specifically required or permitted by law.

12. RIGHT TO REFUSE TO SIGN. I understand that I do not have to sign this authorization and that my failure to sign this authorization will not affect my ability to obtain treatment, payment or benefits.

13. DURATION. This authorization will automatically expire one (1) year from the date of signing unless a different end date or event date is specified below.

14. I understand that I must be provided a signed copy of this Authorization.

End date:	Event Name:

Signature of client/applicant or legally authorized representative	Date
If signing on behalf of client, relationship to client:	

Addendum #3: Qualifications

- Include a copy of the Program Director's resume – ***<u>2 pages max.</u>***
- Include a copy of the Program Supervisor's resume – ***<u>2 pages max.</u>***