RSA Foundation

H.O.M.E. Hub Program Application

H.O.M.E. Hub is an innovative work-based learning program that promotes success in the workplace and in life.

Our day program and workshops provide structure that will suit each person's needs while promoting self-advocacy skills and personal independence.

Admission Criteria:

The goal of H.O.M.E. Hub is to provide quality work based/skill building learning opportunities that produce outcomes desired by program participants. Intake staff will consider all applications and try to be flexible in meeting individual needs.

Applicants MUST meet the following criteria to begin the intake process:

- Applicant must be 18+ years old
- Be a resident of Macomb County
- A Medicaid Beneficiary

Admission Process:

Referral of applicants should be made to the H.O.M.E. Hub support coordinator/intake staff by calling (586) 806-6455 and by completing the attached application. The intake staffing consists of the support coordinator, program staff, the applicant and referring party. At the intake meeting, the applicant will receive an overview of the H.O.M.E. Hub program and expectations.

The following documents are required before receiving services:

- Individual Plan of Service
- Copy of photo identification
- Signed RSA Authorizations and Releases
- Current Authorization from Macomb County CMH

The intake staff may request one or more of the following:

- Educational History
- Social History
- Other Agency Reports

Application Date:_____
Intake Date:_____

Applicant's Name:

_____
(Last) (First) (Middle)

Current Address:

_____
(Street) (City) (State) (Zip)

Phone Number:_(____)_____ **Cell:**_(___)_____

Date of Birth:___/___/___ **Gender:** [ ] Male [ ] Female

Social Security Number: _____-_____-_____ **Medicaid ID:**_____

Email Address:_____

Legal Guardian's Name (If Applicable):

_____
(Last) (First) (Middle)

Address (if different from above):

_____
(Street) (City) (State) (Zip)

Group Home Name (if applicable):_____

Address (if different from above):

_____
(Street) (City) (State) (Zip)

Referral Source:_____

Why do you want to attend H.O.M.E. Hub?:

_____
_____
_____
_____

Emergency Contacts:

1. Name:

_____

(Last) (First) (Middle)

(____)_____ (_____)_____ (____)_____

(Home) (Work) (Cell)

2. Name:

_____

(Last) (First) (Middle)

(____)_____ (_____)_____ (____)_____

(Home) (Work) (Cell)

3. Name:

_____

(Last) (First) (Middle)

(____)_____ (_____)_____ (____)_____

(Home) (Work) (Cell)

_____

Signature of Applicant Date

_____

Signature of Person Completing Form Date

_____

Signature of Guardian Date

RSA Foundation

AUTHORIZATION FOR PHOTOGRAPHY AND MARKETING

Individual Served Name:_____

I, legal guardian of the above-named Individual Served, hereby give my consent for photographing (including still pictures, motion pictures or videotape, or for transmitting images/voices of the above-named individual for the following purposes: I understand a Mandatory Photo Identification Badge will be made for the above-named Individual Served for safety purposes and dispensing medication if required.

PLEASE CHECK THE APPROPRIATE BOX

Orientation and in-service training programs of RSA Foundation, and other state department of mental health facilities, by RSA Foundation personnel in the creation of videotape film/still pictures/slides for educational purposes with the general public, and for use in newsletters, brochures or annual reports.

YES [ ] NO [ ]

For use with community, school, civic, and service organizations and for use with students and RSA Foundation guardians.

YES [I NO [ ]

For release of photographs/voices for use by the public news, media, including newspapers, website, television and radio.

YES [ ] NO [ ]

I understand that I may revoke this authorization by notifying Creative RSA Foundation in writing of my desire to revoke it. However, I understand that if I revoke this authorization, it will not have any affect of actions taken by RSA Foundation in reliance on this authorization.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect the individual's ability to obtain treatment or eligibility for benefits.

I understand that the person(s) or organization RSA Foundation authorized to use/disclose this information will not receive compensation for doing so.

Signature of legal Guardian or Individual Served if they are their own Guardian Date

Witness Date

THIS CONSENT EXPIRES ONE YEAR AFTER THE DATE SIGNED

RSA Foundation

AUTHORIZATION FOR PARTICIPATION IN COMMUNITY PROGRAMS

Individual Served Name: _____

I, legal guardian for the above-named individual, hereby give my consent for the individual to participate in community programs offered by RSA Foundation. I am aware that community-based activities include risk.

Community Programs may include all or some of the following activities:

1. Daily, weekly or monthly trips to the community at large, to explore and expand the Individual's knowledge and experience of the actual community.
2. To increase social and safety skills in the community.
3. To increase knowledge of what is available to individuals in the community.
4. To increase recreational and social opportunities.
5. To be transported to these community activities via company or staff vehicles.
6. To be given the opportunities available to all citizens including recreational, vocational, educational and tourism.
7. These experiences and activities will be carried out as part of an extension of the
8. Individual Plan of Service and no additional funds will be required from the Individual Served. Individual's Served are permitted to have monies available for personal usage per Individual Plan of Service.
9. To volunteer for community-based skill-building activities, for which the individual will receive no pay but will provide valuable work experience.

Signature of legal Guardian or Individual Served if they are their own Guardian Date

Witness Date

THIS CONSENT EXPIRES ONE YEAR AFTER THE DATE SIGNED

RSA Foundation

AUTHORIZATION TO RELEASE AN INDIVIDUAL SERVED

Individual Served Name: _____

I, legal guardian for the above-named individual, will provide up to six names and telephone numbers to whom the Individual Served may be released in the care of, while attending RSA Foundation with 'the exception of medical personnel in case of an emergency and assigned personnel from the contracting agency. In addition, the direct caregivers employed with _____are authorized.

Authorized Names and Telephone Numbers:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

_____

Signature of legal Guardian or Individual Served if they are their own Guardian Date

_____

Witness Date

THIS CONSENT EXPIRES ONE YEAR AFTER THE DATE SIGNED

RSA Foundation

AUTHORIZATION FOR RELEASE PROTECTED HEALTH INFORMATION

Individual Served Name: _____Date _____
INFORMATION IS AUTHORIZED TO BE RELEASED TO THE FOLLOWING AGENCY:
RSA FOUNDATION

AGENCIES AUTHORIZED TO RECEIVE INFORMATION AND CONTRACTING AGENCY

CENTER FOR MEDICARE & MEDICAID SERVICES
COMMISSION ON ACCREDITATION FOR REHABILITAION FACILITIES
COMMUNITY LIVING SERVICE
CONSUMER LINK
DEPARTMENT OF LABOR
DESIGNATED RESIDENTIAL PROVIDER
FAMILY INDEPENDENCE AGENCY
MACOMB COUNTY COMMUNITY MENTAL HEALTH
MACOMB-OAKLAND REGIONAL CENTER
MICHIGAN COMMISSION FOR THE BLIND
MICHIGAN REHABILITATION SERVICES
OFFICE OF RECIPIENT RIGHTS
SOCIAL SECURITY ADMNISTRATION
STATE OF MICHIGAN
OTHER _____

SPECIFIC INFORMATION TO BE DISCLOSED:
Current plan of care outlining training components and treatment needs; relevant health information (reason for admission, significant illnesses, medical evaluations, physical limitations and/or health care plan); and known allergies; speech, hearing and adaptive behavioral evaluations; information regarding medication (type, dosage and frequency, potential side effects); current psychological profile and program evaluation reports; name, address and telephone number of parent or guardian, and payroll information. This release is sought for the purpose of ensuring coordinated planning and delivery of vocational, educational and employment services to Individual Served, and also may be used to ensure continuation of funding or services to the individual served.

I understand that the information used or disclosed may be subject to redisclosure by the person(s) or class of person(s) receiving it and no longer protected by the federal privacy regulations.

I understand that I may revoke this authorization by notifying RSA Foundation in writing of my desire to revoke it. However, I understand that if I revoke this authorization, it will not have any effect on actions taken by RSA Foundation before I revoked it. I understand that I may refuse to sign this authorization and that my refusal to sign will not permit the contracting agency to authorization services.

Further release of information so disclosed is prohibited unless consistent with the authorized purpose stated above. Any persons receiving such information shall be so advised (Section 748 {3} of Act 258, Public Acts of 1974, as amended).

RSA Foundation has provided me with their Notice of Privacy Practices document and I understand that this document explains my rights and how my pertinent medical information is managed A copy is available at the RSA Foundation location. I understand that if I have a question or concern, I should contact the Privacy Officer Angela Stirling at (586) 806-6455.

Signature of legal Guardian or Individual Served if they are their own Guardian Date

Witness Date

THIS CONSENT EXPIRES ONE YEAR AFTER THE DATE SIGNED

RSA Foundation

AUTHORIZATION FOR RSA FOUNDATION SERVICES

Individual Served Name: _____

I, legal guardian for the above-named individual hereby give my consent for the above individual to receive vocational services from RSA Foundation. I understand that vocational services may be provided in any or all of the following services as written in the Individual Plan of Service.

- Facility Based Skill Development
- Community Employment Skill Development
- Community Based Skill Development
- Transition to Employment
- Transportation

The above individual or guardian is aware that there are potential health and safety risks in the community. The individual or guardian can make the decision to decline any of the above activities.

Signature of legal Guardian or Individual Served if they are their own Guardian Date

Witness Date

THIS CONSENT EXPIRES ONE YEAR AFTER THE DATE SIGNED

RSA Foundation

AUTHORIZATION FOR SECURING MEDICAL TREATMENT

Individual Served Name: _____ Date _____
Individual Served DOB:_____
Home Name: _____ Address: _____

This person is an Individual Served of RSA Foundation

I, legal guardian, hereby give RSA Foundation my permission to secure emergency medical treatment and consent to the administration of anesthetics and to the performance of any emergent operation upon the above-named recipient at any licensed medical facility,

MEDICAID:_____

The above-named individual served is included in a hospitalization plan (other than Medicaid): Yes or No (circle one)

If yes please list:

Name of Insurance Co: _____

Policy Number: _____

Family group: _____

Place Photo Here

_____
Signature of legal Guardian or Individual Served if they are their own Guardian Date

THIS CONSENT EXPIRES ONE YEAR AFTER THE DATE SIGNED

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▶ **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See Specific Instructions on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–		–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here **Signature of U.S. person** ▶ **Date** ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*