FOUNDATIONS GROUP OF MN, INC.

IDT Signature Page

Consumer Name: _____ Date of Meeting: _____

Reason for Meeting *(please check appropriate box):*

☐ 45 day Review ☐ Annual ☐ Semi-Annual ☐ Initiation of Services

☐ Other: _____

I have participated in the completion of, and am in agreement with, this
(please check appropriate box):

☐ Risk Management Assessment ☐ Outcome Achievement Plan ☐ Care Plan

☐ Respite Care Needs Assessment

and cannot identify any additional areas of concern at this time.

Name	Signature	Date	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

☐ Verbal approval was given by _____*(name)* on _____*(date)*
Reason unable to attend:

_____

Meeting was held outside specified time line due to:

FOUNDATIONS GROUP OF MN, INC.

Self-Sufficiency Scale

Annual Outcome Indicator

Consumer Name:_____ Date:_____

Consumers A & B

Indicate functioning level:

A = appropriate use of skill
WA = appropriate use with assistance needed
U = Unable to complete skill

Self-Preservation

- [ ] Able to dial 911 in an emergency
- [ ] Appropriate response to fire drill
- [ ] Follows directions during emergency
- [ ] Knowledge of surroundings
- [ ] Able to identify when assistance is needed and who to ask for assistance
- [ ] Knowledge of internal reporting procedures
- [ ] Able to lock/unlock doors
- [ ] Able to remain home alone

Community Orientation

- [ ] Carries personal identification
- [ ] Community/pedestrian safety
- [ ] Recites phone number and address
- [ ] Ambulates Safely

Grooming and Clothing

- [ ] Dresses appropriately for weather
- [ ] Appropriate grooming and hygiene

Social/Emotional

- [ ] Demonstrates appropriate personal space and privacy
- [ ] Exhibits socially acceptable behavior

Health

- [ ] Cooperates with medical/medication plans
- [ ] Reports injury or illness

Food/Nutrition

- [ ] Consumes Edible Foods

Financial

- [ ] Recognizes monetary value

FOUNDATIONS GROUP OF MN, INC.

Transitional Scale

Annual Outcome Indicator

Consumer Name:_____ Date:_____

Consumers C & D

Indicate functioning level:

A = appropriate use of skill
WA = appropriate use with assistance needed
U = Unable to complete skill

Self-Preservation
☐ Displays ability to use emergency contact #'s
☐ Responds appropriately to emergency warnings
☐ Demonstrates use of fire extinguisher
☐ Exhibits use of internal reporting procedure
Community Orientation and Leisure
☐ Accesses community and streets safely
☐ Attends employment/school on a regular basis
☐ Recites phone number and address
Sexuality
☐ Knowledge of sexual safety
Housing and Domestic
☐ Exhibits home maintenance skills
☐ Appropriate use of appliances
Grooming and Clothing
☐ Demonstrates appropriate grooming/hygiene
Social/Emotional
☐ Exhibits socially acceptable behavior
☐ Understands and demonstrates personal space and privacy
Health
☐ Communicates healthcare needs
☐ Ability to identify need for emergency health care and administer basic first aid
☐ Ability to schedule and attend medical appointments
☐ Identifies and administers medication independently
Food/Nutrition
☐ Prepares and stores meals safely
☐ Demonstrates identification and danger of spoiled food
Financial
☐ Safely manages finances

FOUNDATIONS GROUP OF MN, INC.

Responsible Party

Minnesota law requires the presence of a responsible party (RP) when a person cannot direct their own care and Personal Care Assistant (PCA) services are used. The intent of having a responsible party is to assure health and safety for the person who cannot direct their own care. The responsible party is to determine if the person can safely live alone with services available. If at any time the person cannot safely live alone with the services being provided, the responsible party must act to assure health and safety.

Criteria

The responsible party must be at least 18 years old; capable of providing the support necessary to assist the person who cannot direct their own care to live in the community; may or may not live with the person receiving services; and is **not** the PCA.

Responsibilities and requirements for the responsible party and/or delegated responsible party

1. Actively participates in planning and directing of PCA service
2. Must be accessible to the person and the PCA when PCA services are being provided (This could be accomplished in different ways and needs to be determined by the responsible party and the provider).
3. Must monitor the services at least weekly according to the plan of care to assure care outcomes are met
4. Report suspected abuse/neglect of the person to the local county human service agency
5. May delegate some or all of the responsibility to another adult who is not the PCA but is still responsible to assure that the delegate performs the functions of the responsible party, as identified in the care plan

Process & Procedure

The responsible party must be identified at the time of assessment

The county PHN documents the name on the person's service agreement and MA Home Care Service Plan
The PCA Agency and the responsible party document the name on the person's care plan The role of responsible party may be delegated to another person who meets the criteria and provides the necessary support
Delegate may be identified at the time of assessment and listed on the service agreement and MA Home Care Service Plan by the county PHN
The PCA Agency and the responsible party document the delegate name on the person's care plan
In the event that no delegate was named at the time of the assessment and one is currently needed; the responsible party is asked to notify the provider of the delegate's name. The PCA care plan should reflect any changes in responsible party.

Signing states that you agree to the above duties and responsibilities and are willing to act as the responsible party on behalf of _____(NAME OF RECIPIENT)

SIGNATURE OF RESPONSIBLE PARTY:	DATE

DELEGATE

Signing states that you agree to the above duties and responsibilities and are willing to act as the responsible party on behalf of _____(NAME OF RECIPIENT)

SIGNATURE OF DELEGATE RESPONSIBLE PARTY	DATE

Form used when responsible party is required

Copy to responsible party, provider, and county file

FOUNDATIONS GROUP OF MN, INC.

1FINANCIAL AUTHORIZATION/CONSENT

Name of Consumer: _____

I _____authorize the license holder to assist me in the management and safekeeping of my funds and/or property. All financial records kept by the license holder are available to me and my case manager at any time. I authorize the license holder to assist me in the following areas:

(Check yes/no):

Yes	No		Boundaries (if any)
___	___	Cash	_____
___	___	Checking Acct.	_____
___	___	Savings Acct.	_____
___	___	Property	_____
___	___	Other_____	_____

The license holder will complete itemized financial statements that include the receipts and disbursements of funds. These itemized financial statements will be mailed out to me and my case manager according to our preference. The preferences for receiving itemized financial statement(s) are:

(Circle one):

Consumer/Legal Guardian

Monthly Quarterly Semi-Annually Annually Other:_____

Case Manager

Monthly Quarterly Semi-Annually Annually Other:_____

This consent is time-limited, needing to be reviewed and re-signed on an annual basis. I may revoke or revise this consent at any time.

_____

Consumer/Legal Guardian *Date*

_____

Case Manager *Date*

_____

Foundations Group of Mn, Inc. *Date*

FOUNDATIONS GROUP OF MN, INC.

CONSUMER BILL OF RIGHTS

You have several rights when you are receiving services from a licensed provider. They must give you a copy of these rights on your first day of service. The provider must then explain these rights to you within 5 working days of providing service to you.

SERVICE RELATED RIGHTS

THE RIGHT TO TERMINATE OR REFUSE SERVICES - You have the right to refuse or end services. If you choose either of those options, the service provider will inform you of the results of ending or refusing services.

THE RIGHT TO KNOW SERVICE LIMITS - You have the right to know, in advance, any limits to the services you are to receive. Those limits to service are:

_____

THE RIGHT TO KNOW INITIATION/DISCHARGE TERMS - You have the right to know the provider's policy on service starting services. You also have a right to know why the provider could discharge you. A discharge is when the provider stops giving you services and asks you to get services somewhere else. If a provider wants to stop giving you services, they must give you written notice in advance.

THE RIGHT TO KNOW SERVICE CHARGES - You have the right to know what the charges are for your services. The charges are as follows:

_____

THE RIGHT TO KNOW FUNDING SOURCE - You have the right to know who pays for your services and if you or your family has to pay any amount. Service payment is covered by:

_____

THE RIGHT TO TRAINED/COMPETENT STAFF - The staff who work with you must have the training necessary to do a good job. If you and your case manager think these staff need added training and write this in your service plan, the provider must make sure that staff have this training.

PROTECTION RELATED RIGHTS

THE RIGHT TO PRIVATE RECORDS - People can only look at your records or talk about you to others if you or your legal representative gives permission. You have a right to know your service provider's policy about keeping your information private.

THE RIGHT TO SEE YOUR RECORDS - You have a right to look at your records.

THE RIGHT TO BE FREE FROM MALTREATMENT - Staff must do all they can to prevent you from being hurt by others. If someone mistreats you, tell a staff person, your case manager, or some other advocate.

THE RIGHT TO BE TREATED WITH RESPECT - Staff must treat you respectfully. They must allow you to do the things you enjoy, speak with you in a way you can understand, and be respectful of your cultural background.

THE RIGHT TO REFUSE TO PARTICIPATE IN AN EXPERIMENT - You do not have to participate in any experiment or research unless you want to. Staff must give you information about this in a way you that are able to understand it and put your choice in writing.

THE RIGHT TO A PHONE - You have the right to use a phone privately on a daily basis to make free local calls. You may have to pay for long distance calls or call collect.

THE RIGHT TO PRIVATE MAIL - No one can open your mail or tell you who you can or can't write to, or what you can write.

THE RIGHT TO PRIVACY WHEN MARRIED - If your husband or wife visits you, you have a right to private visits. If you both live at the service site, you have a right to share a bedroom and a bed.

THE RIGHT TO FRIENDS - You can choose your own friends. You have the right to talk to your family and friends, and they can visit when they want.

THE RIGHT TO PERSONAL PRIVACY - You have the right to be alone in the bathroom and bedroom.

THE RIGHT TO PLAN ACTIVITIES - You have a right to choose, plan, and participate in activities you enjoy.

I have read, been explained, and received a copy of the Consumer Bill of Rights

_____

Consumer/Legal Guardian Date

_____

Person Explaining Rights *Date*

FOUNDATIONS GROUP OF MN, INC.

Reporting Maltreatment of Minors and Vulnerable Adults Policy

- If you know or suspect that a minor or vulnerable adult has been maltreated, you must report it immediately (within 24 hours).

- If the individual is a minor, you must report to the child protection department in which the child resides:

Anoka County	(763)422-7125
Chisago County	(651)213-0324
Isanti County	(763)689-1711
Pine County	(800)450-7463

**A list of all other Minnesota Counties may be listed in Foundations Group of MN, Inc. Policies and Procedures handbook, as well as posted in the main office. The list will be provided to mandated reporters as requested.

If the individual is a vulnerable adult, you must report to the Common Entry Point for the county in which the suspected maltreatment has occurred:

Anoka County	(763)422-7168
Chisago County	(651)213-0375
Isanti County	(763)689-1711
Pine County	(320)245-2268

** A list of all other Minnesota Counties may be listed in Foundations Group of MN, Inc. Policies and Procedures handbook, as well as posted in the main office. The list will be provided to mandated reporters as requested.

Or, you can report internally to the Supervisory Coordinator. If the Supervisory Coordinator is involved in the alleged or suspected maltreatment, you may report to the Program Director.

When an internal report is received, the Program Director is responsible for deciding if the report must be forwarded to the Common Entry Point. If that person is involved in the suspected maltreatment, the Executive Director will assume responsibility for deciding if the report must be forwarded to the Common Entry Point. The report must be forwarded within 24 hours.

If you have reported internally, you will receive, within two working days, a written notice that tells you whether or not your report has been forwarded to the Common Entry Point. The notice will be given to you in a manner that protects your identity. It will inform you that, if you are not satisfied with the facility's decision on whether or not to report externally, you may still make the external report to the Common Entry Point yourself. It will also inform you that you are protected against any retaliation if you decide to make a good faith report to the Common Entry Point.

An internal review of the report must be completed if the facility has reason to know that an internal or external report of alleged or suspected maltreatment has been made. The review will be completed by the Program Director.

If this individual is involved in the alleged or suspected maltreatment, the Executive Director will be responsible for completing the internal review.

The internal review must include: whether related policies and procedures were followed; whether the policies and procedures were adequate; whether there is a need for additional staff training; and whether further action is necessary to protect the health and safety of vulnerable adults.

The internal review must be documented, and made available to the Commissioner of the Department of Human Services upon request.

I have received a copy of FGMI VA/MOM Reporting Policy

_____ _____

Legal Representative Signature Date

Data Practices

The "Minnesota Government Data Practice Act" Minnesota Statutes 13.01 through 13.88 as amended, provides you with a variety of rights.

You have the right to:

Receive this notice, outlined below, which explains certain considerations concerning any data, which is collected from you.

Have access to all data maintained about you by this office without charge to you.

Receive copies of that data if you pay the actual cost of preparing the copies; and,

Challenge the accuracy or completeness of any data we maintain about you.

Pursuant to Minnesota Statutes 13.04, subdivision 2, you are further informed of the following:

6. The data that Foundations Group of MN, Inc. is collecting from you, if in forms we ask you to fill out, or in the course of interviewing you, is private data, and will be collected for the purpose of assisting you.

7. You are NOT legally required to provide this office with any information about yourself.

8. Should you not provide certain data to us, the result may be that we will not be able to properly and completely assist you. If you provide data to us, there will be no adverse consequences. Your employing agency and personnel therein will not receive any of this information.

9. The data we collect from you will be available only to:

employees of FGMI and individuals under contract with it who must have access to the data in order to assist you;
parties to Judicial proceeding's pursuant to court order;
auditing agencies of the State and Federal Government, but only for the purpose of assuring that public funds are being properly spent;
other individuals or agencies that may be specifically authorized by State Statute or Federal Law or State Commissioner ofAdministration which authorize the use or sharing of the information after this notice was given.

FOUNDATIONS GROUP OF MN, INC.

Policy on Plan File Maintenance and Data Practices

Individual records will be maintained for all consumers admitted to Foundations Group of MN, Inc. programs. Records will be sufficient to determine service needs, plan, implement and evaluate programming, protect the legal rights of consumer, employees and the program, and to meet the requirements of licensure.

Maintenance of records will be in accordance with the Minnesota Data Protections Act and will be available only with the written consent of the client and/or the client's legal representative, Foundations Group of MN, Inc. staff, or licensing personnel. Such consent shall be on an original form. Photocopies or facsimiles are not acceptable authorization. This provision applies only to self-generated material (Foundations Group). Foundations Group of MN, Inc. will not release materials received at our request from other agencies with the exceptions as applicable by law.

The plan file includes all records maintained pertaining to a particular consumer. The plan file will be maintained at the Foundations Group offices, historical files will also be maintained as Foundations Group controlled property.

All client records will be maintained for at least three years after the termination of services. Records will not be maintained for longer than seven years.

-

I have read, understand, and received a copy of FGMI's Data Practices Policy, including MN Government Data Practices Act

_____

Consumer or Legal Representative Signature *Date*

1*P.O. Box 247*
31100 Forest Blvd, Suite B
Stacy, MN 55079
Office (651) 408-1433 Fax: (651) 408-1434

FOUNDATIONS GROUP OF MN, INC.

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: _____ Intake Date: _____

Previous Names:_____ Date of Birth: _____

Phone Numbers (Home) _____ (Work) _____ (Other)_____
This will authorize _____ to release information to Foundations Group of MN.

_____
Name of Organization
_____
Street Address
_____
City State Zip Code

This will authorize Foundations Group of Mn, Inc. to release records to:

The following information is to be released (check appropriate boxes):

Discharge Summary	Monthly/Annual Reviews	Medication Administration Records
Individual Treatment Plan	Risk Management Assessment	Health Progress Notes
Consultation Reports	UA Screens	Psychological Tests
Client Progress Notes	Incident Reports	Other (specify)_____

For the following dates of treatment or condition:_____

I am requesting this information to be released for the following purpose:

Continued care by another provider	Insurance claim purposes	Personal use
Legal review	Other _____	

! With the exception of psychotherapy notes, all records pertaining to psychiatric/mental health testing will be released unless otherwise indicated by a checkmark here: _____ Please indicate any restrictions: (specify) _____
_____
! I understand I may revoke this authorization by written request at any time to the address listed at the top form. I understand that the revocation will not apply to information that has already been release in response to this authorization.
! This authorization will expire one year from the date of my signature, or a lesser period of time as specified here:_____
_____. The expiration period noted here may exceed one year only incertain situations as specified by law.
! I understand there may be a retrieval and copy charge associated with the release.
! I understand that once information is release pursuant to this authorization, FGMI cannot guarantee the re-disclosure of the information to a third party.
! I understand this authorization must be filled out completely and signed in order to be considered valid. A signed original copy is required.
! Foundations Group of MN will only release internally generated materials.

_____ _____ _____
Signature of Consumer/Authorized Person (If authorized person is signing, please print name) | Authorized Person's authority to sign (Parent, guardian, power of attorney, etc) | Date

Reason consumer is unable to sign: Minor Child Deceased Other: _____

P.O. Box 247
31100 Forest Blvd, Suite B
Stacy, MN 55079
Office (651) 408-1433 Fax: (651) 408-1434

FOUNDATIONS GROUP OF MN, INC.

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: _____ Intake Date: _____

Previous Names:_____ Date of Birth: _____

Phone Numbers (Home) _____ (Work) _____ (Other)_____
This will authorize _____ to release information to Foundations Group of MN.

_____
Name of Organization
_____
Street Address
_____
City State Zip Code

This will authorize Foundations Group of Mn, Inc. to release records to:

The following information is to be released (check appropriate boxes):

Discharge Summary	Monthly/Annual Reviews	Medication Administration Records
Individual Treatment Plan	Risk Management Assessment	Health Progress Notes
Consultation Reports	UA Screens	Psychological Tests
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_____

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! I understand this authorization must be filled out completely and signed in order to be considered valid. A signed original copy is required.

! Foundations Group of MN will only release internally generated materials.

_____ _____ _____
Signature of Consumer/Authorized Person (If authorized person is signing, please print name) | Authorized Person's authority to sign (Parent, guardian, power of attorney, etc) | Date

Reason consumer is unable to sign: Minor Child Deceased Other: _____

P.O. Box 247
31100 Forest Blvd, Suite B
Stacy, MN 55079
Office (651) 408-1433 Fax: (651) 408-1434

FOUNDATIONS GROUP OF MN, INC.

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: _____ Intake Date: _____

Previous Names:_____ Date of Birth: _____

Phone Numbers (Home) _____ (Work) _____ (Other)_____
This will authorize _____ to release information to Foundations Group of MN.

_____
Name of Organization
_____
Street Address
_____
City State Zip Code

This will authorize Foundations Group of Mn, Inc. to release records to:

The following information is to be released (check appropriate boxes):

Discharge Summary	Monthly/Annual Reviews	Medication Administration Records
Individual Treatment Plan	Risk Management Assessment	Health Progress Notes
Consultation Reports	UA Screens	Psychological Tests
Client Progress Notes	Incident Reports	Other (specify)_____

For the following dates of treatment or condition:_____

I am requesting this information to be released for the following purpose:

Continued care by another provider	Insurance claim purposes	Personal use
Legal review	Other _____	

! With the exception of psychotherapy notes, all records pertaining to psychiatric/mental health testing will be released unless otherwise indicated by a checkmark here: _____ Please indicate any restrictions: (specify) _____
_____
! I understand I may revoke this authorization by written request at any time to the address listed at the top form. I understand that the revocation will not apply to information that has already been release in response to this authorization.
! This authorization will expire one year from the date of my signature, or a lesser period of time as specified here:_____
_____. The expiration period noted here may exceed one year only incertain situations as specified by law.
! I understand there may be a retrieval and copy charge associated with the release.
! I understand that once information is release pursuant to this authorization, FGMI cannot guarantee the re-disclosure of the information to a third party.
! I understand this authorization must be filled out completely and signed in order to be considered valid. A signed original copy is required.
! Foundations Group of MN will only release internally generated materials.

_____ _____ _____
Signature of Consumer/Authorized Person (If authorized person is signing, please print name) | Authorized Person's authority to sign (Parent, guardian, power of attorney, etc) | Date

Reason consumer is unable to sign: Minor Child Deceased Other: _____

FOUNDATIONS GROUP OF MN, INC.

Policy on Consumer Grievances

Consumers and their representatives will be encouraged to make suggestions regarding all aspects of service, and to submit grievances.

Grievances will receive response in a timely manner, and anyone stating a grievance will be free from reprisal. Consumers have the right to appeal any suspension, reduction or termination of services; such appeal will be made to the Commissioner of Human Services. A copy of the grievance policy and procedure will be given to each consumer and legal representative upon admission, and at any time requested thereafter.

Consumer _____

I have received and reviewed a copy of FGMI policy and procedures on consumer grievances.

Consumer Signature _____ Date _____

Legal Representative Signature _____

Witnessed By _____ Date _____

FOUNDATIONS GROUP OF MN, INC.

Authorization to Facilitate Services Outside of the Home

I, _____ hereby authorize FGMI employees to facilitate services outside of my residence as normal life activities may require. This may be necessary to achieve program goals through community activities, medical appointments, or meetings. FGMI maintains applicable insurance and requires staff to provide proof of insurance prior to transporting consumers in their own vehicles. Staff will follow plan as outlined in individual's Risk Management Assessment.

Consumer Name_____

Signed _____
(consumer/legal guardian/conservator)

Date _____

FOUNDATIONS GROUP OF MN, INC.

Medication Assistance Approved:

Personal Care Assistants or In-Home Support Persons may assist in administering **prescribed medications** when:

10. The Responsible Party pre-measures the medication into a container other than that which the medication is prescribed in;
11. the medication is labeled with the date and time to administer; and
12. any instructions (ex. Must be taken with food) are written by the Responsible Party or included in the Care Plan.

Personal Care Assistants or In-Home Support Persons may assist in administering **PRN (as needed) medications** when:

The Responsible Party pre-measures the medication into a container other than that which the medication is purchased in; and
the staff is given general directions as to signs or symptoms which would lead to staff contacting the Responsible Party, at which time the Responsible Party will advise staff if medication should be administered.

Medication Assistance Not Approved:

Personal Care Assistants or In-Home Support Persons may **not assist** in the following procedures:

- Sterile Procedures
- Injections of fluids into veins, muscles, or skin.

Signed _____
(Client, responsible party, legal guardian, conservator)

Date:_____

Witness: _____

Date: _____

FOUNDATIONS GROUP OF MN, INC.

Authorization to Provide Emergency Intervention

I, _____ authorize Foundations Group of MN employees to provide emergency intervention on my behalf for those situations that require immediate action to prevent or minimize bodily injury to myself or to others. I understand that staff will utilize only those procedures for which they have been trained and that staff will seek other trained professionals to provide care if the care required exceeds their level of training (such as basic life support provided by ambulance personnel, emergency room staff etc.)

I understand that my family members and case manager will be notified within 24 hours of my receiving emergency intervention.

Signed _____

(client/legal guardian/conservator)

Date _____

Choice for Supervision

You (Responsible Party) have the choice to supervise your own PCA or to request supervision from a Qualified Professional.

QP Supervision Levels:

Level 0

13. Review and approve Recipient Care Plan upon intake, revisions, and annually thereafter

Level 1

14. Review and approve Recipient Care Plan upon intake, revisions, and annually thereafter
15. Consultation with service recipient within 14 days of service initiation and annually thereafter
16. Review PCA Documentation regularly regarding essential observation of the recipient's health, and about any conditions that should be immediately brought to the attention of either the nurse or attending physician

Level 2

17. Review and approve Recipient Care Plan upon intake, revisions, and annually thereafter
18. Consultation with service recipient within 14 days of service initiation and annually thereafter
19. Review PCA Documentation regularly regarding essential observation of the recipient's health, and about any conditions that should be immediately brought to the attention of either the nurse or attending physician
20. Contact Responsible Party and conduct Service Evaluation and review of Care Plan once every 30 days during the first 90 days of services, then once every 120 days

Level 3

Review and approve Recipient Care Plan upon intake, revisions, and annually thereafter
Consultation with service recipient within 14 days of service initiation and annually thereafter
Review PCA Documentation regularly regarding essential observation of the recipient's health, and about any conditions that should be immediately brought to the attention of either the nurse or attending physician
Contact Responsible Party and conduct Service Evaluation and review of Care Plan once every 30 days during the first 90 days of services, then once every 120 days
Train PCA to provide hands on assistance with special health care tasks

Level 4

Review and approve Recipient Care Plan upon intake, revisions, and annually thereafter
Consultation with service recipient within 14 days of service initiation and annually thereafter
Review PCA Documentation regularly regarding essential observation of the recipient's health, and about any conditions that should be immediately brought to the attention of either the nurse or attending physician
Contact Responsible Party and conduct Service Evaluation and review of Care Plan once every 30 days during the first 90 days of services, then once every 120 days
Train PCA to provide hands on assistance with special health care tasks
Provide additional services as requested by Responsible Party. Those services are:

_____

_____

_____

_____

I have reviewed QP supervision levels offered by Foundations Group of MN, Inc. and have chosen Level _____ . I understand that any supervision not chosen is my (Responsible Party's) responsibility.

_____
Consumer Name

_____
Responsible Party Signature

_____
Date

FOUNDATIONS GROUP OF MN, INC.

Automobile Waiver of Liability for Employees:

For your protection, the employees of Foundations Group of MN, Inc. are covered under our Worker's Compensation and General Liability Policies. However, Foundations Group of MN, Inc. does not carry policies to cover our employee's vehicles as is would be beyond our ability to control the safety of the vehicle or driver.

Therefore, if one of our employees is transporting you, or the person you are responsible for, in his/her vehicle, whether owned or rental, we are asking that you agree to accept full responsibility for bodily injury which may be caused by any accident resulting from such transportation.

Permission for our employee to transport you, or the person you are responsible for, in his/her vehicle is granted when we receive this form signed by you.

Thank You.

☐ I, the undersigned, hereby agree to accept full responsibility for any bodily injury to myself, or the person I am responsible for, incurred while riding in a Foundations Group of MN, Inc. employee's vehicle.

Signed _____Patient's Name:_____
(Client, responsible party, legal guardian, conservator)

Date:_____

Witness: _____Date:_____

☐ I, the undersigned, grant permission to the below named Foundations Group of MN, Inc. employee(s) to drive my insured automobile to transport myself, or the person I am responsible for, to destinations I have authorized.

Employee(s): _____

_____

Signed _____Patient's Name:_____
(Client, responsible party, legal guardian, conservator)

Date:_____

Witness: _____Date:_____

Important Note: ***Employee(s) must provide Foundations Group of MN, Inc. with a copy of a current driver's license as well as automobile insurance when consumer/family requests the employee to provide transportation.***