Magic City Enterprises, Inc. Admissions Packet

1780 Westland Rd. Cheyenne, WY 82001

Phone: 307-637-8869 Fax: 307-638-0467

Website: www.mcewyo.org

"Supporting Individuals with Disabilities to Live Successfully"

Admissions into MCE, Inc. is a three step process. We are here to help you along the way.

1. Introduction: Explore our services and fill out an application, which you may turn into our admissions coordinator.
2. Acceptance: our interdisciplinary team reviews your application and additional materials to make a decision as to whether MCE would be able to serve you.
3. Welcome! We may ask you to fill out additional forms to enroll you in the different supports and services at MCE.

Magic City

Thank you for your interest in Magic City Enterprises. If you have any questions throughout the application process, please call us at 307-637-8869 and ask to speak with someone regarding an application for services.

In order to process your application, please make sure to include the following:

- ☐ Copy of your Medicare, Medicaid, or other insurance cards
- ☐ Copy of your social security card
- ☐ Copy of your drivers license or state ID.
- ☐ Completed application with current demographic information.
- ☐ All releases included in this admissions packet are signed.
- ☐ Documentation of an intellectual disability from a doctor or psychologist
- ☐ Medical and psychological evaluation (completed in the last 12 months for medical).
- ☐ Reports and program plans from referring agencies.
- ☐ Sponsorship by fee-paying agency or appropriate private source (such as the Medicaid Home and Community Based Waiver, Department of Vocational Rehabilitation, or School District.)

Please check the services you are applying for:

- ☐ Community Living
- ☐ Adult Day Services
- ☐ Supported Employment
- ☐ DVR

Signature: _____ Date:_____

Magic City Enterprises Services

Magic City Enterprises (MCE) offers a variety of supports and services designed to meet your individual needs and desires. For more detailed information about MCE services and how they can best support you in becoming the most independent individual possible, you can contact our Admissions Coordinator at 307-637-8869 or by email at (can we create an email address that is something like application@mcewyo.org who will discuss our individualized services, paperwork required, applications and funding information. You may also visit the MCE web page at www.*mcewyo.org*.

If you are a private paying individual, a fee schedule will be provided to you upon request.

The following criteria must be met for Admission into MCE programs:

- An intellectual, developmental disability Acquired Brain Injury or other disability which results in significant restriction in employment and/or independent living skills.
- Sponsorship by a fee-paying agency or appropriate private source.
- Funding appropriate for the level of care needed to serve you.
- Do not exhibit behaviors which may cause physical damage to yourself or others.
- Psychological report within the last 5 years
- Results of physical evaluation within the past 12 months
- Current Plan of Care
- Reports and program plans from referring agencies.
- A person should be able to benefit from MCE services.
- Medical care that does not require surgical medical procedures be performed.

If at any time you feel that the introduction, acceptance, or enrollment phase is problematic, please contact the program director and MCE at 307-637-8869

Magic City Enterprises

Application for Services

Personal Information

Social Security Number: _____

Last Name: _____ First Name:_____MI:_____

Date of Birth: _____ Sex: Male ___ Female____

Address: _____

City: _____ State: _____ Zip:_____

Phone: Home: _____ Work: _____ Cell:_____

Legal Status: _____

(Own guardian, Legally Authorized Representative, conservatorship) *need copy of court order

Legal Guardian Name: _____

Address: _____

Phone:_____

Who is your payee: _____

Ethnic Origin: _____

(White, Black, Native American, Hispanic, Asian American, Other)

Referred By: _____ Contact Name: _____

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Educational Information

School or program Attended: _____

Programs or grade last completed: _____

Disability Information

Primary: _____ Secondary: _____ Other: _____

(Please enter disability numbers)

1. ASD
2. Seizure Disorder
3. Mental Illness
4. Hearing Impairment
5. Intellectual Disability (mild)
6. Intellectual Disability (severe)
7. Specific Learning Disability
8. Speech Language Impairment
9. ABI/TBI Injury
10. Orthopedically Impaired
11. Behavior Disorder
12. None
13. Cerebral Palsy
14. Personality Disorder
15. Visual Impairment
16. Diabetes
17. Intellectual Disability (moderate)
18. Intellectual Disability (profound)
19. Speech Language Disability
20. Spina Bifida
21. Organic Brain Syndrome
22. Other (specify)

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Medical Information

Primary Physician: _____

Address: _____

Phone: _____

Medicaid #: _____ Medicare #: _____

Insurance Company and Policy #: _____

Adaptive Equipment: (Circle all that apply)

Walker Wheelchair Glasses Dentures Hearing Aid Eating Devices Cane
Communication Board Other: _____

Medications: _____

Emotional Problems/Physical Limitations/Allergies: _____

_____

_____

_____

Likes/Hobbies

My interests: _____

_____

My dislikes: _____

_____

Magic City

Employment and Financial Information

Current Employer: _____ Position: _____

Past Employer: _____ Position: _____

Income Sources: _____

(Wages, SSI, Social Security, Railroad, Trusts, Other)

Total Monthly Income: _____

Emergency Contact

Name: _____

Address: _____

Phone: _____ Relationship: _____

Contact Type: (Circle One) E=emergency, P=primary, G=guardian, C=conservator, O=other

Name: _____

Address: _____

Phone: _____ Relationship: _____

Contact Type: (Circle One) E=emergency, P=primary, G=guardian, C=conservator, O=other

****Please Read Carefully and Sign****

I, _____, hereby request admission to the Magic City Enterprises: Community Living _____Adult Day Services____ Supported Employment_____, DVR_____ Program(s). I agree to abide by MCE policies and procedures and to voluntarily participate in the goals and objectives in my Individual Plan of Care to best meet my needs. I understand that my goals will be collaboratively decided by my Individual Plan of Care Team, of which I will be an active participant.

Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Magic City Enterprises

Public Relations Release

I, _____, give my permission for Magic City Enterprises to use my name, picture, or video of me for public relations purposes. This may include printing my name or picture in the following Magic City Enterprises publications *(check each item to give permission for that usage*):

___ Annual Report ___ Brochures ___ Web site ___ Other PR materials___ Facebook
___ Twitter___ Instagram ___ Pinterest ___ YouTube

If, in the future, I change my mind about allowing Magic City Enterprises to print my name or picture for public relations, I can request that this release be turned over to me for destruction.

_____ _____

Date of release
(Expires 5 years from date signed)

Individual signature

_____

Guardian signature

_____ _____

Witness title

Witness signature

Magic City Enterprises
Release of Personal Information

Individuals Name: _____

Social Security #: _____

Please initial the form in which the information can be released:

Verbal____ Written____ Audio____Video____ Electronic____

This is to authorize: _____
_____
_____

To disclose and release the following information only: _____
_____
_____

To: _____
(Agency or Person's name)

Address: _____
(Who is authorized to receive such information)

This information will be kept strictly confidential and used for: _____
_____
_____

This release is valid until: _____

Individuals signature: _____ Guardian's signature: _____

Date of Release: _____ (*Valid for 1 year from signature*)

1780 Westland Road ** Cheyenne, WY ** Phone: 307-637-8869 ** Fax: 307-638-0467

Magic City Enterprises Medical Release

(Required by M.C.E.)

I hereby authorize personnel of Magic City Enterprises, as required by the state of Wyoming, to admit to a medical treatment facility and/or obtain emergency medical treatment for_____ in the event that any medical and/or psychiatric treatment is recommended by a licensed professional. I also authorize the release of information concerning my medical/psychiatric diagnosis, treatment, and discharge directives to MCE personnel. In the event that I am unreachable and medications for immediate treatment and/or health and safely are necessary, (i.e. antibiotics), I give permission for MCE to fill and administer these prescriptions until I am contacted and can consult about the treatment.

Release effective dates:

This authorization will be in effect for the duration of the current Individual Plan of care.

Plan of Care dates: _____/_____/_____ through _____/_____/_____.

Signature of Individual: _____ Date: _____

Signature of Guardian: _____ Date: _____

Magic City Enterprises, Inc. - Notice of Privacy Practices Outline and Receipt

A federal regulation, known as the "HIPAA Privacy Rule requires that we provide detailed notice, in writing of our privacy practices. A hard copy of our Notice of Privacy Practice is available for you to review at your request. An outline of the topics covered in the MCE Notice of Privacy Practice is as follows:

1. Our commitment and obligation to protecting health information about you.
2. How we may use and disclose protected health information about you
    - Uses and disclosures for treatment, payment, and health care operations.
    - Other uses and disclosures we can make without written authorization for which you have the opportunity to agree or object.
    - You have the right to object to us disclosing protected health information about you to a family member, close friend, or any other person identified by you that is involved in your care or payment for your care.
    - Other uses and disclosures we can make without your written authorization or opportunity to agree or object.
    - Other uses and disclosures of protected health information require your authorization.
3. Your rights regarding protected health information about you
4. Complaints and questions

I acknowledge that I was provided with the MCE Notice of Privacy Practices.

Printed Name of Individual: _____

Signature of Individual: _____

Date: _____ Individuals Date of Birth: _____

For Guardian of Individual (If Applicable)

Printed Name of Guardian: _____

Signature of Guardian: _____

Date: _____

Signature of MCE Witness: _____ Date:_____

Magic City Enterprises, Inc.

Individual Rights Pictorial Manual

Know Your Rights

Know Your Rights

Individuals with intellectual disabilities have the same basic human and legal rights of the United Sates as everyone else. MCE is dedicated to protecting your rights and to providing a safe and healthy environment for you. It is important to know your rights.

<u>Individuals with intellectual disabilities have the right to:</u>

Services and Supports:

- Teaching on how to be safe.
- Freedom from restraint, neglect, abuse, and exploitation.

- Choose your service providers and support team.

- Accept or refuse services.

- Choose your own medical services.

- Have Services Designed for your needs and desires.

- Say “no thank” to being part of research or other treatment

- Know about your treatments and program, exam, test, and treatment results
- Apply for any entitlements you may have.

- Receive services in the lease restrictive environment.

- The right to eat when and what you want, choose who you eat with and have access to food at all times.
    - Request a preferred staff person,
        - Control your daily schedule.

Education:

- Educational services developed just for you as long as you meet state and federal standards.
- An education provided by qualified people.

Own Property

- Keep and use personal possessions.

- Have a choice in what you wear.

- Keep and spend your own money.

- Have visitors and talk to the people you choose at any time.

- Say “NO” to unnecessary drugs and medications

- Choose where you live and who you live with

- Right to keep your records and information private
- Protection from state intrusion except to protect yourself and others.

Due Process

- Police Protection

- To make complains without fear of being treated badly

- Vote in elections

- Practice your religion and go to the place of worship you choose

- The right to send and receive unopened mail.

You may be denied one or more of the above rights only as a part of your individual plan of care (IPC.) You will be informed in writing and orally of the grounds for denial. The grounds of denial will be entered into the plan of care and require approval of the Wyoming Department of Health.

Freedom from Discrimination

You have the right to be free from discrimination because of race, age, national origin, sex, religion, sexual orientation, veteran status, and disability.

MAGIC CITY ENTERPRISES, INC.
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice, please contact our Privacy Officer, Mandy Liley at (307-771-2811.)

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by contacting MCE and requesting that a revised copy be sent to you in the mail.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

We may disclose health information about you to doctors, nurses, psychologists, social workers, direct support staff and other agency staff, volunteers and other persons who are involved in providing health and rehabilitation services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of Magic City Enterprises, Inc.

The following are examples of the types of uses and disclosures of your protected health information that Magic City Enterprises, Inc. is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a physician's office that provides care to you. We will also disclose protected health

information to other providers who may be also providing services to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (*e.g.*, a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services, we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Service Operations: We may use and disclose health information about you for our own operations. These are necessary for us to operate Magic City Enterprises, Inc. and to maintain quality health for our participants. For example, we may use health information about you to review the services we provide and the performance of our employees supporting you. We may disclose health information about you to train our staff and volunteers. We also may use the information to study ways to more efficiently manage our organization or for accreditation or licensing activities.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the

information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally established programs.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then Magic City Enterprises, Inc. may, using professional judgement, determine whether the disclosure is in your best interest.

Others Involved in Your Health Care or Payment for your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition, or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

1. **YOUR RIGHTS**

The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your record that contains services provided, medical and billing records and any other records that Magic City Enterprises, Inc. uses for making decisions about you.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer, Heather Raimondo-O'Brien if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Magic City Enterprises, Inc. is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected

health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with our Privacy Officer, Mandy Liley.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have Magic City Enterprises, Inc. amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer, Heather Raimondo-O'Brien if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for example to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

2. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer, Mandy Liley of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer, Mandy Liley at (307) 307-771-2811 **mliley@mcewyo.org** for further information about the complaint process.

This notice was published and becomes effective on **10/10/2023**