STEPPING STONES CARE

15255 N Frank Lloyd Wright Blvd. 2123
Scottsdale, AZ. 85260

New Member Intake Packet and Respite Care and Habilitation Handbook

An introduction for Parents and Guardians

Stepping Stones Care contracts with the State of Arizona to provide care and learning tools for those with disabilities. Care is provided in your home or in the community and is monitored by the DDD Division.

OUR PROGRAMS

Respite:

Our respite worker's primary job is to provide care in your home for your loved ones with special needs. Respite care services provide parents or guardians with a break from caring for the special needs member. These hours are used at the parent's request. Parents or guardians can also stay in the home during Respite Care hours.

We assign a respite worker who best match your particular needs. Some workers may be more experienced with physically handicapped members, while others have strong skills for handling difficult behaviors. Who we assign also depends upon the city you live in and the times during which you need assistance. All of our workers are carefully screened based upon positive employment experience in the care-giving field. Applicant screening also includes criminal background check through the Department of Justice.

Respite Care workers, with your consent, are allowed to transport your loved ones in the community to engage in activities outside your home. In many cases our staff are regularly driving between your home, therapies, educational settings, and other activities in the community.

Respite Care workers can prepare basic meals for clients, however workers are not allowed to eat the client's food.

Respite care workers do not perform medical services such as shots and enemas. However, they are trained in First Aid and CPR, which may be used in an emergency situation.

Respite Care is scheduled mutually between the guardians and caregivers, with respect to each of their schedules, but may not exceed hours allocated by the DDD Division. Stepping Stones Care is an Agency With Choice (AWC).

To cover all needed hours some families use multiple respite workers. Call the Stepping Stones Care office to see how multiple workers can complete your schedule.

Respite Care may be billed up to 12 hours per day as long as the hours don't exceed the total allocated by the DDD Division for that period.

Habilitation:

Habilitation services are focused on achieving the goals set for each member during their annual ISP. These goals are focused on preparing members to live more independently in the future and often include the development of safety skills, communication skills, problem-solving skills, and other areas that will increase the members' independence and quality of life.

Care staff will record progress made for each of the personalized goals on the provided habilitation sheets every time they are providing Habilitation Services to the member.

OUR STAFF

All staff members at Stepping Stones Care are required by the State of Arizona to possess up-to-date training certification before providing any services to members. Training requirements include CPR, First Aid, Article IV (client rights), and for those providing Habilitation a certificate of Habilitation and Support is required. In addition, all service providers are screened for criminal records, obtain fingerprint clearance, and pass through Central Registry. Stepping Stones Care, as well as the DDD Division monitors these qualifications regularly.

Remember when selecting a caregiver for your loved ones that you have a choice and no staff will be authorized to provide care until you have decided it is a good fit for you and your loved one. If you have someone in mind who you would like to provide care for your loved one, Stepping Stones Care can train that person to become a paid employee, as long as they meet the requirements set forth by the DDD Division.

Clients over the age of 18 may also select a qualifying family member to provide care services as long as they meet the requirements set forth by the DDD Division.

RESPITE AND HABILITATION HOURS

Respite and Habilitation hours are decided by the members case manager with input from families and support staff. Any services that are performed by the caregiver must remain within those hours and any overages will not be paid. Therefore, it is important for the guardian, as well as the caregiver, to closely monitor hours of services provided. Keep in mind that respite hours may roll over if not used. However, Habilitation hours are lost if not used within the allotted time period.

TRACKING

We pay employees bi-weekly. You will need to sign the caregiver's time sheets and track your hours. The caregiver is required to submit hardcopies containing original signatures to Stepping Stones Care. In order to track the hours worked by the care worker, they need to present a time sheet for you to initial on a daily basis, and sign at the end of the pay period. The signature of the parent/ guardian on the time sheet is considered proof that the provider worked the hours indicated on the time sheet. Please be sure to not sign a time sheet containing hours that were not worked by the provider, or is containing hours for future services that have not been provided at the time of signing, as this constitutes fraud and is punishable by law.

ABSENCES OR GAP IN SERVICE

If your caregiver is more than fifteen minutes late to a scheduled visit, call the caregiver to verify that they are coming. If tardiness or absences become a pattern, call the Stepping Stones Care office so we can assist in addressing this situation. We have staff available on call 24 hours to assist you in the event of an emergency.

If you are planning a vacation please notify your caregiver as well as the office. If your caregiver is planning an absence they must first approve it with you as well as notify the office. If a substitute caregiver is necessary please notify the office and Stepping Stones Care will do everything possible to fill the gap while still maintaining the integrity of the training and requirements.

FORMS

In order to make sure all relevant information regarding emergency instructions, medications, and allergies is available to your care provider, please fill out the emergency sheet information.

The forms included in this packet need to be completed and returned to Stepping Stones Care:

Client and Responsible Person Information
Pre-service Provider Information
Transportation Waiver
Photo Waiver
Pairing Questioner
Authorization for Medical Treatment

Agency With Choice (AWC)

Stepping Stones Care L.L.C. is proud to be an Agency With Choice (AWC).

Agency With Choice is a new model of home care services developed by the Division of Developmental Disabilities to encourage participant/member-directed care. Specifically, this model encourages members and their advocates to be directly involved in the planning, scheduling, hiring, and maintenance of their support workers.

In the Agency With Choice model, Stepping Stones Care is considered a joint employer with the member or the member's guardian. Stepping Stones Care's primary functions are to conduct vetting of employees, monitoring training, payroll and billing tasks while assisting the member or the member's guardian in the every day management of their home care services. Our goal is to empower the member and their advocates, giving them more choice and control over their home care services.

Responsibilities of the Members and Members' Guardians

1. Determining how services are to be provided
2. Help with recruiting, selecting, hiring, orientating, and training of direct care providers
3. Performing the scheduling and managing of the desired home care services
4. Disciplining direct care providers, when needed, up to and including termination.
5. Preparing an emergency back-up schedule for direct care providers
6. Reviewing and approving timesheets
7. Notifying the support coordinator of the need for changes to the ISP.
8. Notifying the Agency With Choice office of disciplinary actions and/or dismissals
9. Notifying the Agency With Choice office of reportable events/incidents
10. Completing and submitting Monthly Progress Notes

Responsibilities of Stepping Stones Care (AWC)

1. Assisting members and their guardians in the scheduling and managing of their home care services
2. Assisting members and their guardians in disciplining or terminating direct care providers
3. Ensuring that direct care providers and members/guardians meet the qualification criteria for Waiver Services.
4. Completing all payroll and accounts payable responsibilities
5. Completing all IRS paperwork
6. Collecting and maintaining all personnel and members files of record
7. Tracking utilization of the Agency With Choice portion of the ISP and providing statements to the members.
8. Billing and collecting payments for services
9. Reporting Incidents to the appropriate parties
10. Assuring compliance with all applicable state, federal, and waiver requirements.

Finding the Right Provider

Stepping Stones Care will use multiple resources to find quality care that is close, reliable, and the best fit for your loved ones.

Stepping Stones Care, an Agency With Choice, is happy to assist families and guardians in the recruitment of new direct care providers. New direct care providers may be found in the social network and professional network of the family, guardian or member. We suggest families and guardians use the following avenues in addition to Stepping Stones Care's recruitment efforts.

Neighbors
Coworkers
Friends
Social Media
Church
Local vocational schools and colleges

Even a family member can become a paid care provider. In the simplest form a potential care provider may be introduced to Stepping Stones Care and our agency will complete the necessary paperwork, background checks, and training to certify that person to become a direct care provider.

Stepping Stones Care will not pay for trainings and certifications up front, but in most cases will reimburse that provider for the cost of those certifications after providing services for 90 days. Also, the reimbursements will occur over the course of 90 days. Stepping Stones Care will not retain possession or withhold certification documents from the provider as some agencies do. The certifications belong to the provider and the provider is free to use them for other employment opportunities. The cost of the fingerprint card will not be reimbursed and other trainings will be reimbursed at the same cost in which Stepping Stones Care would normally pay for those certifications.

It is recommended that members, guardians, families and agencies work together to find the right provider.

In order for us to find the right caregiver it is recommended that guardians fill out this packet completely and with as much detail as possible. Completion of this packet does not limit the member to only Stepping Stones Care LLC. Authorization of service hours can be done once the member or guardian is confident the right care provider has been found.

All direct care providers, whether friend, family or acquaintance, must comply with state regulations and certify at the same level as regular care providers. Stepping Stones Care reserves the right to disqualify any care provider for reasons outlined in the standard operating procedure.

STEPPING
STONES
CARE

CONTACT AND OFFICE HOURS

You can call the office 24 hours a day for emergencies, but for routine matters please call during our regular hours.

Our office hours are 8:30 a.m. to 12:00 noon, and 1:00 p.m. to 5:00 p.m., Monday through Friday.

Please call us immediately if there is a service problem. Do not wait for a little problem to turn into a big one! You should expect your care provider to:

- Care for your loved one in a caring and respectful manner
- Work with your loved one's specific needs
- Be available for care during the times you have told the office
- Be on time
- Dress appropriately
- Call in advance if they are late or cannot come at the scheduled time
- Turn in their time sheets on a bi-weekly basis
- Maintain a clean, safe environment
- Assist in case of emergency

If your care provider is not delivering the service you need, a call to the office can help. The conversation will be kept in confidence, and we will work with you in developing a plan of action to improve your service.

Office Information

Office Phone	602-529-CARE	602-529-2273
Fax	480-304-3752	
On Call Staff	602-529-2273	
Kevin Kadel Cell	303-588-8279	

Date of Intake____/____/____

About the Member

Last Name______________________________ First Name ___________________________Middle initial_______

AHCCCS I.D.#____

D.O.B.____/____/_____ Age ___________________ Gender ☐ Male ☐ Female

Support Coordinator____Phone________________________________

Support Coordinator Email____

How did you hear about our services?

☐ Internet ☐ DDD Division Referral ☐ Referral: Name___________________________

Primary Language Spoken *Check one*

☐ English ☐ Spanish ☐ Other____

The member has a diagnosis of:

____

What are the desired outcomes or supports for the member:

____
____
____

The member is receiving or has received services through:	Location
☐Early Childhood Intervention (ECI)	____________________________________
☐Preschool Program for Children with Disabilities (PPCD)	____________________________________
☐Special Education Self-Contained Classroom	____________________________________
☐Special Education Resource Program	____________________________________
☐Day Treatment Services (DTA)	____________________________________
☐Employment or Transitioning to Employment Services	____________________________________
☐Other: ____	____________________________________

Medications:

☐ Yes member is currently taking medication ☐ No medications at this time

Medication: ______________________
Dosage: ______________________
Frequency: ______________________
Reason: ______________________
Date Prescribed: ______________________

Medication: ______________________
Dosage: ______________________
Frequency:______________________
Reason: ______________________
Date Prescribed:______________________

Medication: ______________________
Dosage: ______________________
Frequency: ______________________
Reason: ______________________
Date Prescribed: ______________________

Medication: ______________________
Dosage: ______________________
Frequency:______________________
Reason: ______________________
Date Prescribed:______________________

Does the member have any chronic illnesses or medical conditions? ☐ Yes ☐ No

If yes, please explain: ____

Does the member have seizures in past or currently? ☐ Yes ☐ No
If yes, please explain preferred procedure in the case of a seizure:

____

Does the member have any allergies (e.g., food, medications, airborne)? ☐ Yes ☐ No

If yes, please explain: ____

Is the member currently ambulatory? (i.e., able to walk)

☐ Yes ☐ Yes, with assistance ☐ No

BEHAVIORS *please check all that apply:*

☐Self-injurious
☐Tantrums
☐Hitting (self or others)
☐Biting (self or others)
☐Ritualistic
☐Jeopardizes personal safety

☐Self-stimulatory
☐Run-away
☐Set Fires
☐Depressive
☐Suicidal
☐Promiscuity
☐Use of illegal drugs

☐Excessive alcohol use
☐Stealing
☐Property destruction
☐Doesn’t relate well to peers
☐Doesn’t follow rules

Explain any items checked:

____

____

____

COMMUNICATION: *Please check all that apply*

☐ Expressive

☐ Uses complete sentences

☐ Speaks in phrases only

☐ Uses augmentative communication device

☐ Speaks in single words

☐ Uses gestures and sounds

☐ Uses sign language

☐ No expressive communication

Other: ____

Articulation of Speech:

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Receptive:

☐ Understands conversations

☐ Responds to name

☐ Understands basic language

☐ Responds to simple commands

☐ No responses

☐ Understands extensive sign language

VISION:

☐No problems noted

☐Near-sighted

☐Far-sighted

☐Astigmatism

☐Glaucoma

☐Cataracts

☐Wears glasses

☐Should wear glasses but doesn't

☐Blind

Other: ____

HEARING:

☐ No problems noted

☐ Deaf

☐ Hard-of-hearing

☐ Hearing aid

☐ Should wear hearing aid but doesn't

Other: ____

Adaptive equipment not previously noted:

____
____
____

Concurrent Services with other agencies ☐ Yes ☐ No

Other Agencies Providing RSP/HAH	Provider Name	Contact Phone Number

List preferred backup plan if for any reason your provider is absent

____
____
____

PARENT/ GUARDIAN CONTACT INFORMATION:

Parent /Guardian 1: Name: ____________________
Relationship to Member:____________________
Address: ____________________
City: ____________________Zip ____________________
Home Phone: ____________________Cell Phone____________________
Email: ____________________

Parent /Guardian 2: Name: ____________________
Relationship to Member:____________________
Address: ____________________
City: ____________________Zip ____________________
Home Phone: ____________________Cell Phone____________________
Email: ____________________

Please list all other individuals that live in the home:

____
____
____

Alternative Contact in Case of Emergency (Non Parent/Non Guardian):
Name: ____________________
Address: ____________________
City: ____________________Zip ____________________
Home Phone: ____________________Cell Phone____________________
Email: ____________________

About the Home:

Is it ok provider wears shoes inside the home? ☐ Yes ☐ No

Is it ok for provider to bring food in home? ☐ Yes ☐ No

Is there a smoker in the home who regularly smokes indoors? ☐ Yes ☐ No

Are there any pets in the home? ☐ Yes ☐ No

First Pet Name ______________________________

Type ☐ Dog ☐ Cat ☐ Other________________________

☐ Inside ☐ Outside ☐ Both inside and outside

☐ Protective of home and residents ☐ Not protective of home and residents

Second Pet Name ______________________________

Type ☐ Dog ☐ Cat ☐ Other________________________

☐ Inside ☐ Outside ☐ Both inside and outside

☐ Protective of home and residents ☐ Not protective of home and residents

Third Pet Name ______________________________

Type ☐ Dog ☐ Cat ☐ Other________________________

☐ Inside ☐ Outside ☐ Both inside and outside

☐ Protective of home and residents ☐ Not protective of home and residents

About your preferred caregiver: *Check all that apply*

☐ Member will be using caregiver provided by Stepping Stones Care.

☐ Member will be coming to Stepping Stones Care with an outside caregiver

Language Preferred

☐ English ☐ Spanish ☐ Other(s)________________________________

Transportation

Request driver for transportation: ☐Yes ☐No

Transportation Destinations

☐School ☐Therapies ☐ Activities ☐ Leisure and Recreation

☐ Other____

Member prefers to work with the following:

Preferred Caregiver Gender: ☐Male ☐Female ☐No preference

Preferred Ratio

☐ Prefer 1-1 ratio with caregiver and minimal interactions with other members

☐ Ok with approved interactions and small ratios

☐ Prefer and encourage more interactions and socialization

Request Service location

☐ Prefer services in both home and community

☐ Prefer services in home only ☐ Prefer services in community only

Times requested for caregiver

	Morning		Afternoon		Evening	
	From	*Until*	*From*	*Until*	*From*	*Until*
MONDAY						
TUESDAY						
WEDNESDAY						
THURSDAY						
FRIDAY						
SATURDAY						
SUNDAY						

Start date for services

☐ Prefer services start ASAP ☐ Prefer services start on date______/_______/_______

☐ Start date not known yet

Additional comments:
____
____
____

The attached questionnaire is a chance for you to tell us more about your loved one. It helps us to learn more about your needs, and possible concerns. It helps us to know more about your loved one's health and behavior, and current treatments. The person who takes care of the loved one most of the time should fill out the questionnaire. Please answer each question to the best of your ability.

Member Profile

Likes: *(Check all that apply)*

☐ Arts	☐ Movies	☐ Games	☐ Exploration
☐ Sports	☐ Outdoors	☐ Puzzles	☐ Food
☐ Animation	☐ Animals	☐ Pool	☐ Science fiction
☐ Shopping	☐ Library	☐ Craft	☐ Downtime
☐ Music	Other likes ______________________		

Strengths:____

____

____

Needs:____

____

____

Dislikes:____

____

____

Personal goals:

____

____

____

Please describe a typical day in your household:

____

____

____

____

______________________________	__________	______/______/______
Parent/Guardian (Print & Sign)	Initials	Date
______________________________	__________	______/______/______
Presented by (Print & Sign)	Initials	Date

Stepping Stones Care L.L.C.
Waiver for In-Home Services

Stepping Stones Care LLC does not allow providers to bring clients into their homes unless the home is certified and inspected by the State of Arizona. If the provider does decide to certify their home we require one year's employment to have certification. If you have documents or certification showing proof of home certification we will honor that one-year probation period with monitoring.

I ____ have read the paragraph above and comply with these terms.

Guardian's Printed Name____Date______/_______/________

Guardian's Signature____Date______/_______/________

Stepping Stones Care L.L.C.
Transportation Waiver

Please complete the following form if you wish to receive transportation from your provider.

I, ____, give permission to
Guardian printed name

____from Stepping Stones Care L.L.C. or other
Providers printed name

Designated staff, to transport ____in an
DDD Member

authorized personal vehicle, company vehicle and or public transportation as Stepping Stones Care

sees necessary and appropriate.

Guardian's Printed Name____Date_______/_______/_______

Guardian's Signature____Date______/_______/_______

Stepping Stones Care L.L.C.
Photo Consent

If you, as the parent or guardian, wish to rescind this agreement, you may do so at any time in writing.

Check one of the following choices:

☐ We GRANT permission for a photo/image that includes this member without any other bottom of form personal identifiers to be published on the company public Internet site.

☐ We GRANT permission for this member's photo/image **and** name to be published on the bottom of form company public Internet site.

☐ We DO NOT GRANT permission for photo/image that includes this member to be published on the company public Internet site.

Statement of Understanding/Responsibility

I understand the above written information and agree to adhere to all policies, procedures, and instructions as they are written above and have been explained to me. I acknowledge that I will contact Administration if I have any questions.

____ ________/______/_______
Parent/Guardian (Print & Sign) Date

____ ________/______/_______
Presented by (Print & Sign) Date

Authorization of Medical Treatment

By signing this agreement, the parent/ guardian affirms that he/ she is the person authorized to enter into this agreement, and authorizes the Stepping Stones Care provider on duty to seek and obtain emergency medical treatment at a licensed medical care facility for the member listed above if circumstances appear to warrant such treatment. The parent/guardian agrees to reimburse the person or persons who obtain such emergency medical treatment for any expense reasonably incurred. The parent/ guardian agree to indemnify the person or persons who obtain such emergency medical treatment from any and all claims for payment by medical service providers arising from the authorization of reasonable medical expenses.

____
Member's Name

____
Printed First & Last Name of Parent Guardian

____ _______/________/_________
Signature of Parent or Guardian Date