APPLICATION FOR ADMISSION

In order to facilitate review and processing, please complete all information requested.
If not applicable, please state "N/A" or "Unknown" where applicable.

If you need assistance completing this application, please call 605-444-9550 for assistance.

GENERAL INFORMATION

Applicant Name:______________________________ **Date:**__________
Last *First* *M.I.*

❑ Natural Born ❑ Adopted - If yes, what age?______ **Sex:** ❑ Male ❑ Female

Primary Diagnosis:____________________ **Secondary Diagnosis:**____________________

Date of Birth:__________ **Present Height:**__________ **Present Weight:**__________

Tribal Affiliation and Registration Number:______________________________

Address:______________________________
Street Address *City* *State* *Zip*

Current School District:____________________ **Contact:**__________ **Phone:**__________

PARENT / GUARDIAN INFORMATION

**If different from applicant's*

Father's Name:____________________ **Mother's Name:**____________________

*Address:____________________ *Address:____________________

*Home Phone:____________________ *Home Phone:____________________

*Cell Phone:____________________ *Cell Phone:____________________

*Work Phone:____________________ *Work Phone:____________________

Email Address:____________________ **Email Address:**____________________

Marital Status: ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Single

Legal Custody: ❑ Sole ❑ Joint **Name(s):**______________________________

Physical Custody: ❑ Sole ❑ Joint **Name(s):**______________________________

ADDITIONAL GUARDIAN INFORMATION:
(Attach a copy of guardianship papers to the application)

1. Does the applicant have a court appointed guardian? ❑ Yes ❑ No
2. If yes, please compete the following:
   Date of court appearance:____________________
3. Please describe the conditions of guardianship (limited, full, person, estate, etc.)
   Type of guardianship: ❑ Full ❑ Limited ❑ Person ❑ Estate ❑ Other
4. County/Tribal Court where guardian action occurred:______________________________

2501 W. 26th St., Sioux Falls, SD 57105
Phone 605.444.9500 • **Fax** 605.444.9501
www.LifeScapeSD.org

PARENT / GUARDIAN INFORMATION (con't)

Court-Appointed Legal Guardian:

Name:____

Address:____
Street Address *City* *State* *Zip*

Home Phone:____________________ Work Phone:____________________ Email:____________________

Please identify your Primary Objectives for seeking placement consideration at LifeScape:____

____

____

____

____

Please identify your concerns with your child's current setting:____

____

____

____

Is your school aware that you are currently assessing alternative placement for your child? ❑ Yes ❑ No

Do you currently have confirmed funding for your child from your school district? ❑ Yes ❑ No

What is the current staff to student ratio that your child is receiving?____

EMERGENCY CONTACT INFORMATION

Name of person completing application:____

Signature of person completing application:____

Relationship to applicant:____ Date:______________

Applicant's signature or mark:____

REFERRAL

Who referred you to LifeScape?____

Please attach a recent photo
of applicant here
(taken within the past year)

REFERRAL (con't)

Name:______________________________ Relationship to Applicant:______________________

Address:____
Street Address *City* *State* *Zip*

Home Phone:______________ Work Phone:______________ Email:______________________

GOALS:

What goals does applicant hope to attain by accessing services with LifeScape?______________________

____

What lesser restrictive options have been researched?______________________

____

SIBLING / OTHERS IN HOUSEHOLD

Siblings:

1.______________________ DOB:__________ 4.______________________ DOB:__________

2.______________________ DOB:__________ 5.______________________ DOB:__________

3.______________________ DOB:__________ 6.______________________ DOB:__________

Others in Household:

1.______________________ DOB:__________ Relationship to Applicant:______________

2.______________________ DOB:__________ Relationship to Applicant:______________

3.______________________ DOB:__________ Relationship to Applicant:______________

Do any of the above persons have a cognitive disability or mental health diagnosis? ❑ Yes ❑ No

If so, please describe briefly:____

INSURANCE

Subscriber's Name:____

Address:____
Street Address *City* *State* *Zip*

Name of Insurance Company (Primary Carrier):______________________________

Address:____
Street Address *City* *State* *Zip*

Type of Coverage:______________________ Policy Number:______________________

Name of Insurance Company (Secondary Carrier):______________________________

Address:____
Street Address *City* *State* *Zip*

Type of Coverage:______________________ Policy Number:______________________

Medicaid/Medicare: ❑ Yes ❑ No Name:_______________ Number:_______________

State ID Number:_______________ Date:_______________

Address:_______________
Street Address *City* *State* *Zip*

Name of Dental Insurance Company:_______________

Type of Coverage:_______________ Policy Number:_______________

ADDITIONAL FINANCIAL INFORMATION

Does the person receive SSI? ❑ Yes ❑ No If yes, amount:_______________

If denied, why?_______________

Does the person receive Child Support? ❑ Yes ❑ No If yes, amount:_______________

Does the person receive Veterans, Railroad, and/or Other benefits? ❑ Yes ❑ No If yes, amount:_______________

If person does not receive any of these benefits, has he/she applied for any? ❑ Yes ❑ No If yes, which one(s):_______________

Other Income: Wages: $_______ Interest: $_______
Stocks/Bonds: $_______ Joint Savings Account: $_______
Lease Income: $_______
Payment from US Government for land held in trust: $_______
Property Owned (home, machinery, vehicles): $_______
Other (specify):_______________ $_______

Does person have money in a checking account? ❑ Yes ❑ No If yes, amount:_______________

Bank Name:_______________ Address:_______________ Acct #:_______________

Is interest added to the account balance? ❑ Yes ❑ No Amount:_______________

Does person have money in a savings account? ❑ Yes ❑ No If yes, amount:_______________

Bank Name:_______________ Address:_______________ Acct #:_______________

Is interest paid by check? ❑ Yes ❑ No Amount:_______________

Does person have Certificates of Deposit with a bank or Savings and Loan Association? ❑ Yes ❑ No If yes, amount:_______________

Bank Name:_______________ Address:_______________ Acct #:_______________

Is interest paid by check? ❑ Yes ❑ No Amount:_______________

Does the person have an IM Account (Indian Land Lease)? ❑ Yes ❑ No If yes, amount:_______________

Does the person have a Representative Payee appointed by the Social Security Administration? ❑ Yes ❑ No

Name of Payee:_______________ Address:_______________ Phone:_______________

List all life insurance policies that may make payment to applicant:

Name of Company	Address	Policy #	Annual Premium

MEDICAL INFORMATION

Allergies: ❑ Environmental ❑ Food ❑ Medication/Other List:________________

Reactions:________________

Current Health Problems:________________

____

Primary Physician's Name:________________ **Specialty:**________

Address:________________
Street Address *City* *State* *Zip*

Phone:________________ **Fax:**________________

When was the applicant's last appointment with the physician?________________

Hospital preference:________________

BOWEL / BLADDER:

Bowel: ❑ Colostomy/Ileostomy ❑ Continent ❑ Incontinent

Bladder: ❑ Catheter (indwelling or strait) ❑ Continent ❑ Incontinent

RESPIRATORY:

❑ Tracheostomy ❑ Bi-Pap/C-Pap ❑ Vent (mode?______) ❑ Oxygen needs ❑ Suctioning more than every 4 hours

Any special medical equipment:________________

____

Immunizations up to date? ❑ Yes ❑ No If not, please explain:________________

MEDICATIONS

PRESENT MEDICATIONS:

*If the applicant is receiving any medications at the present time, please list name of drug, dosage, date started, purpose and any adverse reactions to the drug. (Please include oral and topical medications.) *Please attach sheet if they are on more medications.*

1. **Medication:**________________ **Dosage:**________ **Date Started:**________

   Purpose:________________

2. **Medication:**________________ **Dosage:**________ **Date Started:**________

   Purpose:________________

3. **Medication:**________________ **Dosage:**________ **Date Started:**________

   Purpose:________________

4. **Medication:**________________ **Dosage:**________ **Date Started:**________

   Purpose:________________

Have there been any changes in medication and/or dosages in the past 3 months? Why? ❑ Yes ❑ No________________

____

REVIEW OF CURRENT/PAST HEALTH PROBLEMS

NEUROLOGICAL:

Is there a history of seizures? ❑ Yes ❑ No If yes, age of onset:______________ Frequency:________________________

Duration:____ Date of last incidence:____________________________________

Describe (in detail) seizure activity:____

____

Does the applicant have a Vagal Nerve Stimulator? ❑ Yes ❑ No

Does the applicant have a baclofen pump? ❑ Yes ❑ No

Neurologist Name:____ Email:___________________________________

Address:____
Street Address *City* *State* *Zip*

Phone:__________________ Fax:_________________ When was last appointment with Neurologist?______________________

EYES:

Visual Impairments:_____________________________________ Eye Infections:____

Use of glasses? ❑ Yes ❑ No Purpose:__________________________ How often worn?____________________________

Opthalmologist/Optometrist Name:______________________________________ When were current glasses prescribed?_________

Address:____
Street Address *City* *State* *Zip*

EAR, NOSE, & THROAT:

Ear Infections:____

Use of hearing aid? ❑ Yes ❑ No Cochlear Implants? ❑ Yes ❑ No Most Recent Audiological Exam?___________

ENT Name:____ When was last appointment with ENT?__________________

Address:____
Street Address *City* *State* *Zip*

DENTIST:

Dentist Name:____ Date of last exam:__________________

Address:____
Street Address *City* *State* *Zip*

Phone:_____________________ Fax:____________________ Condition of Teeth?_______________________________________

OTHER SPECIALTIES: *(Cardiology, gastroenterology, endocrinology, urology, gynecology, orthopedics, etc.)*

1. Physician's Name:____ Phone Number:______________________

Address:____
Street Address *City* *State* *Zip*

Hospital Affiliation:____ Reason for Evaluation:___________________________

REVIEW OF CURRENT/PAST HEALTH PROBLEMS (con't)

2. Physician's Name:______________________________ Phone Number:______________

Address:____
Street Address *City* *State* *Zip*

Hospital Affiliation:______________________ Reason for Evaluation:______________________

3. Physician's Name:______________________________ Phone Number:______________

Address:____
Street Address *City* *State* *Zip*

Hospital Affiliation:______________________ Reason for Evaluation:______________________

PERSONAL HISTORY

Is the applicant residing at home? ❑ Yes ❑ No

Please describe applicant's living arrangements for the last five years (for example: living in an institution, foster home, family, relative, independently, etc).

____

____

Language(s) spoken at home:____

Language most frequently spoken to applicant:____________________By applicant:____________________

COMMENTS: *(Use the space below or the back of this sheet for additional information or comments concerning the applicant's personal history)*

____

____

SERVICE HISTORY

Has the applicant received services at a residential facility? ❑ Yes ❑ No

If yes, please list and indicate dates of services:______________________________

____

List Community Support Providers, vocational rehabilitation, public and/or private hospitals, clinics, mental health centers, and other facilities where person has received treatment, evaluations or training.

Current Services/Therapies:____

From:__________ To:__________ Place/Address:____________________ Reason for Leaving:__________

What therapy was used?____________________ Was it successful?____________________

What worked?____________________ What didn't?____________________

Prior Services/Therapies:____

From:__________ To:__________ Place/Address:____________________ Reason for Leaving:__________

What therapy was used?____________________ Was it successful?____________________

What worked?____________________ What didn't?____________________

ALTERNATIVE THERAPIES / INTERVENTIONS *

If the applicant is currently receiving any bio-medical procedures (i.e. secretion therapy, Kelation therapy, other hormone therapies (ACTH), immunologic therapies (IVIG), anti-yeast therapies, vitamin therapies), please identify the specifics:

____

____

____

____

LifeScape Position Statement

*In referencing the **"Clinical Practice Guideline: Report Recommendations for Autism/Pervasive Developmental Disorders,"** it is LifeScape's position that there is insufficient evidence to recommend the use of hormone therapies, immunologic therapies, anti-yeast therapies, vitamin therapies and diet therapies for the treatment of autism. Although we respect families of all their efforts in attempting to identify practices and therapies that may assist their child, LifeScape recognizes the importance of using scientific evidence as the basis for informed decisions for the treatment of autism.

NUTRITIONAL & FEEDING ASSESSMENT

What is your current diet recommendation:

- ❑ Regular
- ❑ Consistent Carbohydrate
  - ❑ Diabetic
  - ❑ Weight Loss
- ❑ Low Fat/Cholesterol
- ❑ No Added Salt
- ❑ Reduced calories for weight management
- ❑ GERD/Reflux
- ❑ Other:____

Do you have a physician ordered dysphagia diet?		
❑ Yes	❑ No	What level? ❑ Pureed ❑ Ground ❑ Chopped/Soft
Do you require thickened liquids?		
❑ Yes	❑ No	What consistency? ❑ Nectar ❑ Honey ❑ Pudding
Do you have a feeding or swallowing disorder?		
❑ Yes	❑ No	Please describe:
Do you require tube feedings?		
❑ Yes	❑ No	What type? What schedule?
Do you have any food intolerances?		
❑ Yes	❑ No	Please describe:
Do you have any food allergies?		
❑ Yes	❑ No	Please describe:

SELF HELP SKILLS

Please list any adaptive equipment used by the applicant: (i.e. bath chair)

____

____

____

SELF HELP SKILLS (con't)

COMMUNICATION:	Yes	No
Does the applicant use a communication device?	❑	❑
Speaks freely and easily	❑	❑
Communicates with gestures	❑	❑
Uses sign language	❑	❑

MOBILITY:	Yes	No
Walks freely without assistance	❑	❑
Walks with physical assistance	❑	❑
Non-ambulatory but uses adaptive equipment	❑	❑
Non-ambulatory using adaptive equipment but requires assistance with transfers	❑	❑
Non-ambulatory, requires total assistance	❑	❑

PROSTHESIS/ORTHOPEDIC DEVICES *(please list below and how worn)*

____

____

COMMENTS:

____

____

____

BEHAVIORAL

Is there a behavioral plan in place on the IEP? ❑ Yes ❑ No

❑ **Physical Aggression to self or others:** *(describe)*____

____

❑ **Fire Setting:** *(describe)*____

____

❑ **Cruelty to Animals:** *(describe)*____

____

❑ **Eloping:** *(describe)*____

____

❑ **Inappropriate Sexual Behavior:** *(describe)*____

____

❑ **Criminal Activity:** *(describe)*____

____

❑ **Other(s):**____

____

Is restraint used? If so, what type?____

Are there any other restrictive devices/procedures used? *(i.e. watchmate, care tracker, seat belt lock, straps in a stroller)*__________________

____

EMPLOYMENT HISTORY (Pathways to Life Applicants Only)

Please include work and volunteer experiences.

Employer	Dates	Type of Work/Duties	Reason for Leaving

Employer	Dates	Type of Work/Duties	Reason for Leaving

Does applicant have a valid South Dakota driver's license? ❑ Yes ❑ No

Driver's License#:____________________ **Expiration Date:**____________________

Has applicant been convicted of a crime? ❑ Yes ❑ No
If yes, please explain:____

ADDITIONAL INFORMATION REQUEST

All of the following documents must be received before a child will be considered for placement:

- ❑ Completed Referral Application
- ❑ Birth Certificate
- ❑ Social Security Card
- ❑ Immunization Records
- ❑ If applicable, copies of guardianship papers
- ❑ Most recent custody papers
- ❑ Most recent history and physical examination
- ❑ Current IEP or IFSP
- ❑ Current IEP/IFSP Addendums
- ❑ Copy of insurance card and Medicaid card (front and back)
- ❑ Summary of last vision appointment
- ❑ South Dakota SIMs Number
- ❑ Current Grade Level
- ❑ Three Year Evaluation reports, to include psychological evaluations
- ❑ Therapy notes
- ❑ Behavioral incidents or reports
- ❑ Behavior intervention plan
- ❑ Comprehensive Psychiatric evaluations
- ❑ Signed Authorization to Release Information Forms
- ❑ Summary of last dental appointment
- ❑ Summary of last hearing appointment

Thank you for your time and effort in completing this application. It will be very helpful to use in determining if LifeScape can offer appropriate services.

Please return completed packet and additional documentation to:

LifeScape
Attn: Admissions
2501 W. 26th Street
Sioux Falls, SD 57105
Fax: 605-444-9501
Email: Admissions@LifeScapeSD.org

Parent/Guardian Signature:________________________________ **Date:**______________

Office Use Only
Application has been:
❑ Accepted ❑ Denied ❑ Pending (due to):____________________ Date:______________

Authorization to Release Information

<table>
<tr><td colspan="4">Name:</td><td colspan="2">DOB:</td></tr>
<tr><td rowspan="4">Release from:
Which facility is releasing information?</td><td colspan="3">Name:</td><td colspan="2">Attn:</td></tr>
<tr><td colspan="5">Address:</td></tr>
<tr><td colspan="3">City:</td><td>State:</td><td>Zip:</td></tr>
<tr><td colspan="3">Phone:</td><td colspan="2">Fax:</td></tr>
<tr><td rowspan="4">Release to:
Where is information being sent?</td><td colspan="3">Name:</td><td colspan="2">Attn:</td></tr>
<tr><td colspan="5">Address:</td></tr>
<tr><td colspan="3">City:</td><td>State:</td><td>Zip:</td></tr>
<tr><td colspan="3">Phone:</td><td colspan="2">Fax:</td></tr>
<tr><td colspan="6">_______ **Initial here if you would like results and other records interchanged between the above 2 parties.**</td></tr>
<tr><td>Information to be Released/Disclosed</td><td colspan="2">☐ Physician Summaries/Progress Notes
☐ History & Physical/Discharge Summary
☐ Nursing Health History
☐ Medications
☐ 3 Year Comprehensive Evaluation
☐ Individual Education Program (IEP)
☐ Psychological/Behavioral Evaluation
☐ ICAP
☐ Autism Evaluation</td><td colspan="3">☐ Immunizations
☐ Therapy Progress Notes (PT, OT, ST)
☐ Therapy Evaluations (PT, OT, ST)
☐ Comprehensive Functional Assessment (CFA)
☐ Individual Service Plan (ISP)
☐ Behavioral Intervention Plan (BIP)
☐ Verbal Information Only
☐ Other: ____________________________
__________________________________</td></tr>
<tr><td colspan="6">Dates of Service From:_____________ To:____________ (If not specified, most recent items will be sent)</td></tr>
<tr><td>Purpose of Disclosure</td><td>☐ Diagnosis and Treatment</td><td>☐ Legal Purposes</td><td colspan="2">☐ Application/Referral for Placement or Services</td><td>☐ Other</td></tr>
<tr><td>Expiration Date</td><td colspan="5">This authorization will expire one year from the date of signature or ________________</td></tr>
<tr><td>Revocation</td><td colspan="5">I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on this authorization.</td></tr>
<tr><td>Authorization</td><td colspan="5">1. I authorize the above facility to disclose information as noted above. 2. I understand that sensitive information may be released such as mental health, alcohol and drug usage, and HIV. 3. I understand that once the information is disclosed, it may be subject to re-disclosure by the recipient and may no longer be protected. 4. I understand that this authorization is voluntary and I may refuse to sign. 5. I also understand that unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits. 6. I understand that the exchange of information may include electronic transmissions. 7. I authorize you to release information created 12 months after this authorization is signed, as well as previous information.</td></tr>
</table>

Patient/Person/Student or Legal Guardian (sign) | Date | Print Name (include legal guardian name if signing for patient/person/student)

*Please supply copy of legal guardianship papers.

Relationship to Patient/Person/Student

Acknowledgment
of Receipt of Privacy Practices

I have received a copy of the Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling (605) 444-9619, or on LifeScape's website at *www.lifescapesd.org,* or by requesting one at the LifeScape offices.

____________________________ ____________________
(Person Supported or Patient) (Date)

____________________________ ____________________
(Signature*) (Print or Type Name)

*As the representative of the above individual, I acknowledge receipt of the Notice on his or her behalf.

____________________________ ____________________
(Signature) (Relationship)

____
(Date)

LifeScape & Rehabilitation Medical Supply

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 and retain a copy for your records.

Effective Date: October 15, 2013

Under applicable law, LifeScape and Rehabilitation Medical Supply (referred to as "we," "our,") is required to protect the privacy of your individual health information (information we refer to in this notice as "Protected Health Information" or "PHI"). PHI includes all information that relates to: the past, present, or future physical or mental health of an individual; the provision of health care to an individual; and the past, present, or future payment for the provision of health care to an individual. PHI also includes genetic information including information relating to genetic testing and manifested diseases/disorders of family members such as your parents, grandparents, siblings and children as well as relatives by affinity such as your spouse, stepchildren and other relatives even if you do not share common genes. We are required to provide you with this notice regarding our policies and procedures regarding your Protected Health Information, and to abide by the terms of this notice, as it may be updated from time to time.

Uses and Disclosures of Protected Health Information

We are permitted to make certain types of uses and disclosures under applicable law for treatment, payment, and healthcare operations purposes without obtaining your authorization.

For treatment purposes, we may use and disclose your PHI for the purpose of providing, coordinating, or managing the delivery of healthcare services to you by one or more healthcare providers, including doctors, nurses, technicians, medical students or other hospital personnel who are involved in taking care of you. For example, your primary care physician may consult with us regarding your condition or treatment. We do not limit the use or disclosure of your PHI for purposes of your care or treatment. Otherwise, we limit use and disclosure of PHI to that which is reasonably necessary for a permitted purpose.

For payment purposes, we may use and disclose your PHI to obtain payment or reimbursement for providing healthcare services, such as when we request payment from your insurer, health plan, or a government benefit program.

For healthcare operations purposes, we may use and disclose your PHI internally in a number of ways, including for quality assessment and improvement, for planning and development, management, and administration. Your information could be used, for example, to assist in the evaluation of the quality of services that you were provided. Healthcare operations also includes conducting training programs in which students, trainees or practitioners in areas of health care learn under supervision to practice or improve their skills.

- In addition, we may contact you to provide appointment reminders, care coordination, plan benefits, refill reminders, or advise you concerning the availability of generic equivalents, information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- Where applicable, we may disclose your health information to your health plan sponsor. This applies to a group health plan, a health insurance issuer, or a Health Maintenance Organization (HMO) with respect to a group health plan.
- We will not sell your PHI or use or disclose your PHI for marketing purposes unless you authorize such use or disclosure.
- Generally, we may not disclose psychotherapy notes without your prior authorization.

We may not use and disclose your PHI for purposes not expressly permitted in this Notice, without your authorization. We may use and disclose your PHI for treatment, payment and health care operations purposes either within LifeScape and Rehabilitation Medical Supply or with health care providers, health plans, and those that process health care claims, benefits and related information. We are also permitted to share your PHI, without your authorization, in the following instances.

We may also use or disclosure your PHI as permitted or required by law, including, for example:

- To public health authorities for the purposes of preventing or controlling disease or other public health purposes;
- To appropriate government authorities to report about victims of suspected abuse, neglect, or domestic violence;
- To the Food and Drug Administration to report quality, safety, or effectiveness of the FDA-regulated products or activities;
- In certain limited circumstances to an employer such as if we are asked to evaluate or treat a work-related illness or injury;
- To qualified health authorities for purposes of conducting health oversight activities;
- In response to subpoenas, discovery requests, or other lawful legal processes in the course of a judicial or administrative proceeding;
- To law enforcement authorities as required or permitted by law such as, for example, to report a death, to report a crime on our premises, or if it appears necessary to alert law enforcement to respond to an emergency;
- To persons involved with respect to matters pertaining to a decedent, or relating to cadaveric organ, eye or tissue donation;
- In certain instances, for research purposes;
- We may disclose your PHI if we believe, in good faith, that it is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public;
- We may disclose your PHI for certain specialized government functions such as, for example, to Armed Forces Authorities with reference to military personnel or for national security purposes.

(over)

Unless you object, we may also disclose to a member of your family or other relative, to a close personal friend, or to any other person identified by you, PHI that is directly relevant to that person's involvement with your care or payment related to your care. In addition, unless you object, orally or in writing, to a LifeScape or Rehabilitation Medical Supply employee or our Privacy Officer, we may use or disclose the PHI to notify, identify, or locate a member of your family, your personal representative, another person responsible for your care, or certain disaster relief agencies of your location, general condition, or death.

We may share with the LifeScape Foundation information such as demographic information (name, address, phone number) and the dates you received services in order to contact you for fundraising efforts. If we contact you for fundraising efforts, you can tell us not to contact you again. All fundraising communications will direct you how to opt-out from future communications. You have the right to revoke your opt-out election if you change your mind and wish to start receiving fundraising information.

If you are incapacitated, there is an emergency, or you otherwise do not have the opportunity to object to this use or disclosure, we will do what in our judgment is in your best interest regarding such disclosure and will disclose only the information that is directly relevant to the person's involvement with your healthcare. We will also use our judgment and experience regarding your best interest in allowing people to pick up filled prescriptions, medical supplies, test results, or other similar actions involving disclosure of PHI.

We will not use your genetic information for insurance underwriting purposes such as in connection with enrollment, eligibility and coverage determinations; certification of premium and contribution amounts; application of pre-existing condition exclusions or other activities related to placement of health insurance. Your health plan may not provide genetic information to your employer if it is a health plan sponsor in regard to coverage or premium decisions. Your health plan may utilize genetic information for determination of medical appropriateness, for example, approving a mammogram for a woman under the age of 40 based on family history.

Other uses and disclosures will be made only with your written authorization, and you may revoke your authorization by notifying us by contacting our Privacy Officer as described below. We may not sell your protected health information.

Your Privacy Rights

You may ask us to restrict uses and disclosures of your PHI to carry out treatment, payment, or healthcare operation or to restrict uses and disclosures to family members, relatives, friends, or other persons identified by you who are involved in your care or payment for your care. However, we are not required to agree to your request in most instances. We must honor your request to restrict our disclosures of PHI to a health plan for payment or health care operations purposes where the disclosure pertains solely to a health care item or service for which you paid out-of-pocket. In such cases, if you paid for the medical expense from a health savings account (HSA) or Flexible Spending Account (FSA), you can instruct us not to disclose this to another health plan but you may not restrict the disclosures necessary to process payment. If you wish to make such a request you must advise our Privacy Officer, identified below, in writing.

You have the following rights with respect to your PHI: (i) to inspect and copy this information, including an electronic health record; (ii) to amend or correct incorrect information; (iii) to receive an accounting of the disclosures of this information by us, including disclosures made using an electronic health record; and (iv) to receive a paper copy of this notice upon request.

If we maintain an electronic version of your medical records in an electronic designated record set, we must provide you that information in an electronic form and format requested by you if it is readily producible. If it is not readily producible, we will provide you the information in a mutually agreeable machine readable format or, if we cannot agree on a format, a paper copy will be provided. We will send the records to clearly identified designated recipient upon your written request. We may charge a reasonable cost -based fee for providing access to your records.

In addition, you may request to receive communications of PHI by alternative means or at alternative locations. We will accommodate the request, if reasonable.

You have the right to be notified if there has been a breach of confidentiality with respect to your unsecured Protected Health Information. If you wish to exercise any of the above rights, you must notify our Privacy Officer, identified below, in writing.

We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI we maintain, including PHI that is created or received prior to issuing the revised notice. We will promptly revise and distribute a new Privacy Notice wherever there is a material change to the uses or disclosures, your rights, our legal duties, or other privacy practices stated in this Notice. If we revise this Notice, we will mail you a notice of our new policy to your last known residential address or, if applicable, to an alternative address that you have provided to us. We are required to abide by the terms of the Privacy Notice that is then currently in effect. If we revise the Privacy Notice the revision date will be the effective date of the Notice.

If you believe your privacy rights have been violated you have the right to file a complaint with us by contacting the Privacy Officer identified below and/or to the Department of Health and Human Services by contacting its website (http://www.hhs.gov/ocr/privacyhowtofile.com) or calling them toll-free at 1-800-368-1019. We will not retaliate against you in any way for the filing of a complaint.

For further information concerning our privacy policy, your privacy rights, or the complaint procedure, please contact our Privacy Officer: Gayle Finn, phone (605)444-9619, fax (605)444-9501, email gayle.finn@LifeScapeSD.org, or sending a letter to the Privacy Officer's attention to LifeScape, 2501 West 26th Street, Sioux Falls SD 57105.

Rehabilitation
Medical Supply

1020 West 18th Street, Sioux Falls, SD 57104 • (605) 444-9700
7110 Jordan Drive, Rapid City, SD 57702 • (605) 791-7400
www.cchs.org

The LifeScape Way

Mission: We empower children and adults with disabilities to lead fulfilling lives.

Vision: All people are valued and respected.

Integrity

Excellence

Fiscal Responsibility

Collaborative Relationships

Compassion

Residential

Outreach

Specialty Hospital

Volunteers

Foundation

Outpatient

Rehabilitation Medical Supply

Administration

Support Services

Community Life

Supported Employment

Specialty School

People Supported & Families

Lives Fulfilled!