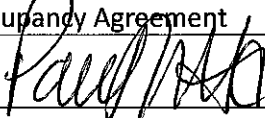


<b>Catholic Charities Disabilities Services</b>	
<b>Agency Standard and Procedure</b>	
<b>Standard Category</b>	Administration
<b>Standard Title</b>	Notification of Rights and Responsibilities for Persons Receiving OPWDD Services
<b>Regulations</b>	<ul style="list-style-type: none"> <li>• 14 NYCRR 633.4 Rights and Responsibilities of Persons Receiving Services</li> <li>• 42 CFR 483.420 (a) Protection of Client Rights</li> <li>• 14 NYCRR 633.12 Objections to Services Process</li> </ul>
<b>Original Issue Date</b>	January 10, 2011
<b>Latest Revision Date</b>	10/16/2013 12/13/2022 4/24/2023
<b>Number of Pages</b>	2
<b>Attachments</b>	Statement of Rights and Responsibilities <ul style="list-style-type: none"> <li>• Traumatic Brain Injury Program</li> <li>• Individualized Community Services</li> <li>• Residential IRAs</li> </ul> Receipt Acknowledgement <ul style="list-style-type: none"> <li>• Traumatic Brain Injury Program</li> <li>• Individualized Community Services</li> <li>• Residential IRAs</li> </ul> Occupancy Agreement
<b>Approved by:</b> Paula Jubic, Executive Director	

**Standard:**

All individuals and their respective parents(s), guardian(s), or correspondent(s) receiving services under the auspices of OPWDD will receive notification of the individual's rights and responsibilities upon admission to a residence or program and annually thereafter. That notification will also include the process available for objection to services as well as the addresses and phone numbers of parties available to receive and resolve any complaints or concerns.

**Procedure:**

Individuals supported, as well as their parents, guardians, or correspondents will receive notification regarding their legal and civil rights as citizens of the United States as well as their rights and responsibilities as recipients of program services or as participants in one of the certified programs. In all instances, the individual supported will receive assistance to ensure that opportunities are available to understand and exercise those rights.

Individuals supported, as well as their parents, guardians, or correspondents will receive a written "Statement of Rights and Responsibilities" specific to the program or service that they are participating

Standard: Notification of Rights and Responsibilities for Persons Receiving OPWDD Services, 1/10/11

in. In addition, notifications shall include the "Process for Objecting to Services" including the parties to contact to resolve any questions or concerns. Such information shall be conveyed in the individual's, and/or parents', guardians', or correspondent's primary language if necessary to facilitate comprehension. Individuals supported will be notified upon admission to certified program and/or residential setting and whenever changes occur. If the individual supported is able to provide consent, they may object to the notification to a parent or correspondent.

The Qualified Intellectual Disabilities Professional or Community Support Supervisor assume responsibility for informing the individual of their rights. It is the responsibility of the residential program or individualized community services program to ensure that the "Statement of Rights and Responsibilities" and the "Process for Objecting to Services" are reviewed with the individual supported and/or their parent, guardian, or correspondent. To the extent possible, every effort is made to ensure individuals supported understand their rights, how they can exercise those rights and the obligations and responsibilities as participants in a program and residents in a certified setting.

The receipt of the "Statement of Rights and Responsibilities" and "Process for Objecting to Services" documents shall be acknowledged by the individual supported and/or their parent, guardian, or correspondent in writing. This signed statement acknowledging understanding of these rights shall be maintained in the individual's record. A copy is also provided to the individual supported and/or their parent, guardian, or correspondent.

The rights of an individual supported will not be arbitrarily denied. Any limitations on rights must be on an individual basis, for a specific period of time, and for clinical purposes only. Such documentation will be retained in the behavior support plan of the individual supported or clinical record. Limitations on rights must involve the input and recommendation by the interdisciplinary treatment team and must be reviewed and approved by the human rights committee. If the individual supported is determined to not be capable of providing informed consent, the consent of the individual's parent, guardian, or correspondent will be sought in addition to approval by the human rights committee.

It is the responsibility of an individual supported to assist in supplying any necessary documentation involved with the admission to a service or program operated by Catholic Charities Disabilities Services, including any recertification of Medicaid waiver eligibility. Additionally, it is also the responsibility of the individual supported to assist with supplying any relevant or necessary financial paperwork or information.

On an annual basis, the Executive Director or designee shall review all relevant documents pertaining to notification of rights and will make any necessary changes or updates to those documents. The QIDP or Community Supports Supervisor will ensure the "Statement of Rights and Responsibilities" and "Process for Objecting to Services" are reviewed with, and acknowledged by the individual supported and/or their parent, guardian, or correspondent. All individuals supported will be informed in writing regarding any changes made.

**Catholic Charities Disabilities Services**  
**Statement of Rights and Responsibilities**  
**Traumatic Brain Injury (TBI) Program**

Your TBI Service Coordinator is responsible for explaining to you your rights and responsibilities as a TBI Waiver Program participant, and member of CCDS. Please ask your TBI Service Coordinator if you have questions about any of these rights. These rights will be reviewed with you upon admission to the program, whenever changes occur, and on an annual basis.

**As a participant in the TBI Program, you have the right to:**

1. Be informed of your rights prior to receiving waiver services.
2. Like all citizens of the United States, you shall be given respect and dignity regardless of your race, religion, color, creed, gender, national origin, sexual orientation, marital status, or disability.
3. Be treated as an individual with consideration and respect.
4. Have access to services provided that support your health and welfare.
5. Assume reasonable risks and have the opportunity to learn from these experiences.
6. Be provided with an explanation of all services available in the Traumatic Brain Injury (TBI) waiver and other health and community resources that may benefit you.
7. Have the opportunity to develop, review, and approve all Service Plans, including any changes to the Service Plan.
8. Select individual service providers and choose to receive additional waiver services from different agencies or different providers within the same agency without jeopardizing participation in the waiver.
9. Request a change in services (add, increase, decrease, or discontinue) at any time.
10. Be informed of the name and duties of any person providing services to you under your Service Plan.
11. Have input into when and how waiver services will be provided.
12. Receive services from approved, qualified individuals.
13. Receive from the TBI Service Coordinator, in writing, a list of names, telephone numbers, and supervisors for all waiver service providers, the RRDS, and DOH.

14. Refuse care, treatment, and services after being fully informed of and understanding the consequences of such actions.
15. Have your privacy respected, including the confidentiality of your clinical record, and have the right to refuse the release of your information to anyone not authorized to have such records, except in the case of your transfer to a health care facility or as required by law or Medicaid requirements.
16. Submit complaints about any violation of rights and any concerns regarding services provided, without jeopardizing your participation in the waiver.
17. Receive support and direction from the TBI Service Coordinator to resolve your concerns and complaints about services and service providers.
18. Receive additional support and direction from the RRDS and/or DOH in the event that your TBI Service Coordinator is not successful in resolving concerns and complaints about services and service providers.
19. Have your complaints responded to and be informed of the outcome.
20. Have your service providers help protect and promote your ability to exercise your rights identified in this document.
21. Have all rights and responsibilities outlined in this document forwarded to the committee or legal guardian authorized to act on your behalf.

Waiver Participant's Responsibilities

**As a waiver participant, you are responsible for:**

1. Working with your TBI Service Coordinator to develop/revise your Service Plan to assure timely reauthorization of the Service Plan.
2. Working with waiver providers as described in your Service Plan.
3. Talking to your TBI Service Coordinator and your other waiver service providers if you want help to change your services and goals.
4. Not participating in any criminal behavior. You understand that, if you do, your service provider(s) may leave, the police may be called and your continuation in the waiver program may be jeopardized.
5. Maintaining your home in a manner which enables you to live in the community.

6. Understanding that your staff are mandated reporters of abuse, neglect, and mistreatment and are required by law to report such concerns.
7. Complying with the rules of the waiver program, and the terms and conditions of any contract you sign regarding the provision of services.
8. Understanding that it is your responsibility to assist in supplying all documentation necessary for admission to our programs and recertification of Medicaid Waiver eligibility.
9. Understanding that it is also your responsibility to supply all necessary and relevant financial documentation that may affect your Medicaid status and/or financial status within our programs, including changes in income, job status, or spend down conditions.
10. Failure to supply financial documentation in a timely manner may be considered a service recipient initiated change and could result in a reconsideration of the continuance of services with Catholic Charities Disabilities Services, at the agency's discretion.

**Catholic Charities Disabilities Services**  
**Grievance Procedure**  
**Traumatic Brain Injury Program**

It is the mission of Catholic Charities Disabilities Services to provide services with integrity, compassion, and respect. Your staff would like to take this opportunity to inform you of the methods that are available to resolve any objections to services that you may have. Each individual has the right to register and resolve grievances and recommendations as a member of CCDS and as a participant in the TBI Waiver Program. They will be protected from any form of reprisal or intimidation. Any of the following listed parties can accept grievances and recommendations.

**Process for Objecting to Services:**

1. The following parties may initiate an objection:  
*Referred to as the "objecting party"*
  - The adult person receiving services under the TBI Program.
  - The committee for the person or legal guardian.
  - Mental Hygiene Legal Service.
2. You should first inform your TBI Service Coordinator of your concern or grievance regarding the services you receive. Informal resolution shall first be sought between the objecting party and relevant staff of the agency, including the Director of Individualized Community Services or designee, or the Executive Director or designee if the concern or grievance is regarding the Director of Individualized Community Services. The grievance will be put in writing by the individual's TBI service coordinator and forwarded to the Director of Individualized Community Services or designee. The Informal resolution process will include your TBI service coordinator as well your legal guardian, as applicable.
3. The grievance will be investigated by the Director of Individualized Community Services or designee within 5 business days. The Director of Individualized Community Services or designee will respond to the grievance or recommendation within 10 business days with a written notification of the decision or recommendation on resolving the matter. Written confirmation of resolution or inability to reach resolution shall be sent to the objecting party by the Director of Individualized Community Services or designee.
4. If a resolution cannot be reached through an informal process within 15 days from the date the complaint was received, or if the objecting party is not satisfied with the Informal decision, the objecting party can submit an appeal to their local Regional Resource Development Specialists (RRDC). RRDC will assist in resolving the difficulties within 15 days from the date the complaint was received.
5. If the objecting party is unsatisfied with the decision by RRDC, or if a resolution is unable to be reached, the matter will be forwarded to NYS DOH Waiver management staff.
6. During the period that an objection is undergoing review, the agency will not decrease, suspend, or discontinue HCBS Waiver Service(s) at issue unless agreed to by both parties.

**Catholic Charities Disabilities Services  
RECEIPT ACKNOWLEDGEMENT  
Traumatic Brain Injury Program**

I have read the Waiver Participant's Rights and responsibilities, or it has been read to me. I understand that failure to adhere to the responsibilities outlined and/or my signed current Service Plan may result on discontinuation of waiver services(s) and termination from the waiver. I have received a copy of the following documents:

\_\_\_\_\_ Statement of rights and responsibilities

\_\_\_\_\_ Process for objecting to services

\_\_\_\_\_ Other: (please list): \_\_\_\_\_

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***Applicant/Participant***

***Signature***

***Date***

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***Legal Guardian/Committee (if applicable)***

***Signature***

***Date***

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***Authorized Representative (if applicable)***

***Signature***

***Date***

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***TBI Service Coordinator Name***

***Signature***

***Date***

cc: Participant  
Legal Guardian or Authorized Representative (if applicable)

**Catholic Charities Disabilities Services**  
**Statement of Rights and Responsibilities**  
**Individualized Community Services**

Individual Supported: \_\_\_\_\_

Your Community Support Supervisor would like to take this opportunity to explain what your rights are in Community Habilitation and Respite programs. Staff will assist you in understanding and exercising your rights on an ongoing basis. We hope that you will feel comfortable asking questions about any of these rights. These rights are reviewed with you when you begin receiving through the Individualized Community Services Department and whenever changes occur. Your parents, guardian, or advocate will also be provided a copy of these rights unless you object to such notification. To the best of our ability, your rights will be conveyed to you in your primary language if necessary so that you can comprehend your rights to the best of your ability.

**Your Rights as a member of CCDS:**

- You will not be deprived of any civil or legal right solely because of your intellectual disability.
- Like all citizens of the United States, you shall be given respect and dignity regardless of your race, religion, national origin, creed, age, gender, ethnic background, sexual orientation, handicap, or health condition such as HIV.
- As a citizen of the United States, you have the right to register and vote in elections.
- You have the right to participate in the religion of your choice, including the right to choose not to participate.
- As an individual receiving services from Catholic Charities Disabilities Services, you have right to express your concerns and grievances as well as Object to the application; adaptation, or denial of your rights. You will be provided with information on how to express grievances or concerns you may have with services. (see "Process for Objecting to Services").
- You have the right to be treated with respect, dignity, and consideration.
- You have the right to be as independent as possible and determine the direction of your life.
- You have the right to make meaningful choices, as long as they do not compromise your health and safety, as well as be an active member of your community. The choices you make will be respected and valued.
- You have the right to not be discriminated against if your status is someone who has been diagnosed as having HIV infection, AIDS, or HIV related illness.



- You have the right to have your clinical record kept confidential. Your clinical record will only be released under certain circumstances according to Mental Hygiene Law and Regulations. Instances when CCDS may release your record include, but are not limited to:
  - When it is necessary for the care and treatment of the individual.
  - When there is a court order requiring the release of information in the clinical record.
  - Upon request by Mental Hygiene Legal Service.
  - Upon request by the Commission on Quality of Care for Persons with Disabilities.
  - When a psychiatrist or psychologist has determined that an individual served by CCDS presents a serious and imminent threat, the agency may release information to a law enforcement agency as well as to the endangered person.
  - With authorized consent, to persons and entities who have a demonstrable need for such information.
  - To governmental agencies, insurance companies, and other third parties requiring the information necessary for payment of services.
  - To persons and agencies needing information to locate missing persons.
  - To governmental agencies in connection with criminal investigations.
  
- You and other qualified persons (including your parent, legal guardian, adult child, or spouse), have the right to submit a written request for clinical records and certain investigatory records. These will be made available in accordance with Mental Hygiene Law and Regulations. If a treating practitioner determines that the review of the record may cause substantial and identifiable harm to you or others, the request to review the clinical record may be denied. In the event a qualified person is denied access to records, they will be informed of their right to obtain a review free of charge by the clinical records access committee designated by the Commissioner of OPWDD.
  
- You have the right to be free from all kinds of abuse, including psychological abuse, physical abuse, and corporal punishment.
  
- You have the right to be protected from commercial or other exploitation.
  
- You have the right to receive appropriate health care, including the opportunity to participate in choosing your physician or dentist to the fullest extent that you are capable. You also have the right to a second medical opinion.
  
- You have the right to make an informed decision regarding cardiopulmonary resuscitation, in accordance with public health law and other applicable provisions.
  
- You have the right to have a Health Care Proxy.
  
- You have the right to have access to clinically sound instructions on the subject of sexuality and family planning services, including access to medication or devices to regulate conception, when clinically indicated. This right includes:
  - Freedom to express your sexuality as limited by your consensual ability to do so, as long as such expression does not infringe on the rights of others.
  - To make decisions regarding pregnancy and conception pursuant to the mandates of applicable state and federal laws.

- You have the right to receive assistance and guidance from staff who are trained to provide services adequately, skillfully, safely, and compassionately with full respect for your dignity and individuality.
- You have the right to not be discriminated against if you don't speak English. All necessary steps will be taken to provide information in appropriate languages. Other people such as a significant other or adult family member may serve as an interpreter for you if you and your parents, guardian, or advocate agree to it.
- To receive services, assistance, and guidance from staff who are trained to deliver services adequately, skillfully, safely, and compassionately with full respect for your dignity and individuality.
- To receive information on services provided by the Individualized Community Services Department.
- If you receive Community Habilitation, you have the right to select the areas you would like support in and if we do not capture them as intended in your Staff Action Plan, you have the right to object to the plan or request that it be modified provided that the activities are considered to be allowable Community Habilitation activities.
- To review and sign off on the documentation regarding the service that was delivered by your Individualized Community Services staff.
- To request a new Individualized Community Services staff and the right to be involved in such changes. Timely notice shall be provided before transfer or discharge except in an emergency. All efforts will first be made to resolve the matter before transfer or discharge occurs.

### **Statement of Responsibilities:**

It is also important for you to understand the responsibilities that you have when you participate in the Individualized Community Services Programs. Exercising your rights entails inherent risks. To the extent reasonable, such risks shall be described to you and/or your parents, guardians, or advocates if applicable. However, you assume responsibility for the risks that you decide to take when you participate in normal activities, to the extent that you are able to participate.

#### **As a recipient of Individualized Community Services:**

- You have the responsibility to provide Catholic Charities Disabilities Services with accurate, current, and relevant information while receiving services.
- If you are receiving Community Habilitation, you have the responsibility to participate in the development of your Staff Action Plan and express yourself if you have any questions or disagreements with the plan.
- You have the responsibility to communicate any changes to your health or medication regime so that we may be as informed as possible to assist you with your health and safety and avoid situations and activities that may pose too much of a risk or are inappropriate.
- It is your responsibility to recognize that providing you with competent, trained, and well-matched staff that meet your needs depends on the availability of staff. We cannot always guarantee that the service will be delivered 100% of the time based on staff availability. It is our responsibility to do our best in attaining staff.

- You, or your parent/guardian have the responsibility to sign the timesheets and service notes of staff who have worked with you as verification of service hours that were provided to you. Your signature also acknowledges that you are in agreement with your service notes and the times that service was provided.
- You have the responsibility to be respectful toward Catholic Charities Disabilities Services staff and property.
- You have the responsibility to keep scheduled appointments with your Individualized Community Services staff, or cancel any appointments with appropriate advanced notice. Frequent cancellations are an indication that the services are not working and will need to be reviewed if this occurs-repeatedly.
- You have the responsibility to refrain from illegal activities and unsafe behaviors in the presence of your Individualized Community Services staff. This includes avoiding gatherings where your safety or the safety of the staff may be at risk or compromised.
- You have the responsibility to tell the Individualized Community Services Department if/when you are changing locations or addresses and provide us with up-to-date contact information in a timely manner.
- You have the responsibility to understand that all staff who work with you are mandated reporters of abuse, neglect, and mistreatment and are required by law to report such concerns.
- It is your responsibility to assist in supplying all documentation necessary for admission to our programs and recertification of Medicaid Waiver eligibility.
- It is also your responsibility to supply all necessary and relevant financial documentation that may affect your Medicaid status and/or financial status within our programs, including changes in income, job status, or spend down conditions.
- Failure to supply financial documentation in a timely manner may be considered a service recipient initiated change and could result in a reconsideration of the continuance of services with Catholic Charities Disabilities Services, at the agency's discretion.

**Catholic Charities Disabilities Services**  
**RECEIPT ACKNOWLEDGEMENT**  
**Individualized Community Services Programs**

I/We, the undersigned, have received copies of the forms checked below:

- \_\_\_\_\_ Statement of rights and responsibilities
- \_\_\_\_\_ Process for objecting to services
- \_\_\_\_\_ Other: (please list):

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Individual: \_\_\_\_\_ Date: \_\_\_\_\_

Patent/Guardian  
Or Advocate: \_\_\_\_\_ Date: \_\_\_\_\_  
(if applicable)

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Staff Name/Title: \_\_\_\_\_

cc:     **Individual**  
          **Parent/Guardian/advocate**  
          **(if applicable)**  
          **The individual's Individualized Community Services Record**

**Catholic Charities Disabilities Services**  
**Statement of Rights and Responsibilities**  
**For Individualized Residential Alternatives (IRAs)**

Individual Receiving Services: \_\_\_\_\_

Our staff would like to take this opportunity to explain what your rights and responsibilities are as an individual residing in one of our residences. Staff will assist you in understanding and exercising your rights on an ongoing basis. Please feel comfortable asking your staff questions about any of these rights. These rights will be reviewed with you upon admission to the residence and whenever changes occur. Your parents, guardian, or advocate will also be provided a copy of these rights. Upon request, your rights will be conveyed to you in your primary language if necessary so that you can comprehend your rights to the best of your ability.

**Statement of Rights as a Member of CCDS:**

- You will not be deprived of any civil or legal right solely because of your intellectual disability.
- Like all citizens of the United States, you shall be given respect and dignity regardless of your race, religion, national origin, creed, age, gender, ethnic background, sexual orientation, handicap, or health condition such as HIV.
- As a citizen of the United States, you have the right to register and vote in elections.
- You have the right to participate in the religion of your choice, including the right to choose not to participate.
- As an individual receiving services from Catholic Charities Disabilities Services, you have right to express your concerns and grievances as well as object to the application, adaptation, or denial of your rights. You will be provided with information on how to express grievances or concerns you may have with services. (see "Process for Objecting to services")
- Your rights will never be arbitrarily denied. Any limitation on your rights will be on an individual basis, for a specific period of time, and for clinical purposes only. None of these rights shall be limited for disciplinary purposes, retribution, or for the convenience of staff. Any restrictions must be reviewed and approved by the Human Rights Committee.
- You have the right to be treated with respect, dignity, and consideration.
- You have the right to be as independent as possible and determine the direction of your life.
- You have the right to make meaningful choices, as long as they do not compromise your health and safety, as well as be an active member of your community. The choices you make will be respected and valued.
- You have the right to not be discriminated against if your status is someone who has been diagnosed as having HIV infection, AIDS, or HIV related illness.

- You have the right to have your clinical record kept confidential. Your clinical record will only be released under certain circumstances according to Mental Hygiene Law and Regulations. Instances when CCDS may release your record include, but are not limited to:
  - when it is necessary for the care and treatment of the individual.
  - when there is a court order requiring the release of the clinical record.
  - upon request by Mental Hygiene Legal Service.
  - upon request by the Commission on Quality of Care for Persons with Disabilities.
  - when a psychiatrist or psychologist has determined that an individual served by CCDS presents a serious and imminent threat, the agency may release information to a law enforcement agency as well as to the endangered person.
  - with authorized consent, to persons and entities who have a demonstrable need for such information.
  - to governmental agencies, insurance companies, and other third parties requiring the information necessary for payment of services.
  - to persons and agencies needing information to locate missing persons.
  - to governmental agencies in connection with criminal investigations.
  
- You and other qualified persons (including your parent, legal guardian, adult child, or spouse), have the right to submit a written request for clinical records and certain investigatory records. These will be made available in accordance with Mental Hygiene Law and Regulations. If a treating practitioner determines that the review of the record may cause substantial and identifiable harm to you or others, the request to review the clinical record may be denied. In the event a qualified person is denied access to records, they will be informed of their right to obtain a review free of charge by the clinical records access committee designated by the Commissioner of OPWDD.
  
- You have the right to not be discriminated against if you don't speak English. All necessary steps will be taken to provide information in appropriate languages. Other people such as a significant other or adult family member may serve as an interpreter for you if you and your parents, guardian, or advocate agree to it.

### **Your Rights as a Resident:**

- You, and/or your parent, guardian, or advocate have the right to be informed of your medical condition, developmental and behavioral status, the risks of treatment, and the right to refuse treatment.
  
- Your rights will not be arbitrarily denied. Any limitation on your rights will be on an individual basis, for a specific period of time, and for clinical purposes only. None of these rights shall be limited for disciplinary purposes, retribution, or for the convenience of staff. Any restrictions must be reviewed and approved by the Human Rights Committee.
  
- You have the right and opportunity to participate in social, religious, and community events of your choosing.
  
- It is your right to have a plan that is individualized and which helps you to achieve the lifestyle you would like to develop. Your plan should also assist you in creating and maintaining meaningful relationships, participate in community activities, and enables you to live as independently as possible. You will always be afforded the opportunity to participate in developing and modifying your plan. You will also have the opportunity to object to any aspect of your plan and have the opportunity to appeal any decision about the plan that you may disagree with.

- Each resident of a CCDS residence has the RIGHT:
  - To a safe and sanitary environment.
  - To be free from abuse, including physical, sexual, and psychological abuse.
  - To be free from neglect and mistreatment.
  - To be free from corporal punishment.
  - To be free from unnecessary uses of mechanical restraining devices.
  - To be free from unnecessary use of excessive medication and to receive support in reducing your dependency on medication.
  - To be protected from commercial or other exploitation.
  - To receive assistance and guidance from staff who are trained to provide services adequately, skillfully, safely, and compassionately with full respect for your dignity and individuality.
  - To receive appropriate health care including the opportunity to participate in choosing your physician or dentist to the fullest extent that you are capable. You also have the right to a second medical opinion.
  - To have access to clinically sound instructions on the subject of sexuality and family planning services, including access to medication or devices to regulate conception, when clinically indicated. This right includes:
    - freedom to express your sexuality as limited by your consensual ability to do so, as long as such expression does not infringe on the rights of others.
    - To make decisions regarding pregnancy and conception pursuant to the mandates of applicable state and federal laws.
  - To receive information on the supplies and services provided by the residence, or when additional charges are made. You will be notified upon admission to the residential program and will receive timely notification whenever changes may occur.
  - To use your personal money and property, including the right to receive regular notice of your financial status and receive assistance in the use of your resources. You have the right to manage your finances to the extent that you are capable.
  - To a balanced and nutritious diet which is not altered or denied for behavior management purposes. This right ensures that each individual supported receives three meals per day and are served at times the individual supported prefers. Altering the composition and timing of regularly served meals for disciplinary or punishment purposes, for the convenience of staff, or for behavior management purposes is prohibited.
  - To have your own clothes and be involved in the selection of your clothes, which fit properly and which are appropriate for your age, season, and activity.
  - To have your own grooming and hygiene supplies.
  - To have a reasonable degree of privacy when sleeping, bathing, or using the bathroom.
  - The right to receive visitors at reasonable times and to have privacy when visiting with them, as long as those visits do not infringe on the rights of others. This also includes the right to communicate freely to anyone within or outside the residence.
  - You have the right to send and receive unopened mail.
  - You have the right to access telephones with privacy for incoming and outgoing calls except for factors identified in your plan.
  - You have the right to access personally owned computers, tablets, etc. with privacy to communicate with others except for factors identified in your plan(s).
  - To share a room in the residence as husband and wife.
  - To a reasonable amount of safe, accessible storage space for clothing and other personal belongings used on a day-to-day basis.
  - To have the opportunity to request an alternative residential setting, whether in a new residence or change of room, and to be involved in the decisions regarding such changes.
  - To make an informed decision regarding cardiopulmonary resuscitation in accordance with Public Health law and other applicable provisions.

- To have a Health Care Proxy.
- To be provided transportation to desired activities, visits with family members, medical appointments, and other programming with appropriate advanced notice.

### **Statement of Responsibilities For Residents:**

It is also important for you to understand the responsibilities you have as a resident. Exercising your rights entails inherent risks. To the extent reasonable, such risks shall be described to you and/or your parents, guardians, or advocates. However, you assume responsibility for the risks that you decide to take when you participate in normal activities, to the extent that you are able to participate.

#### **As an individual living in a CCDS Residence:**

- You have the responsibility to respect the rights, privacy, and property of others.
- You have the responsibility to keep appointments to the best of your ability.
- You have the responsibility to inform staff in a timely manner when you are leaving the residence, including the destination and expected return time, including notifying staff if your plans have changed.
- You have the responsibility to notify staff of any guests that are visiting the residence.
- You have the responsibility to keep your personal belongings in a safe and secure manner.
- You have the responsibility to assist with house maintenance to the best of your ability.
- You have the responsibility to maintain good personal hygiene.
- You have the responsibility to use the telephone and personal electronic equipment such as audio devices, computers, tablets, etc. in a manner that does not infringe on the rights of others.
- You have the responsibility to smoke in designated areas outside of the residence and agency vehicles.
- You have the responsibility to seek prior approval before obtaining a pet.
- If you are over 21 years old and wish to consume alcoholic beverages, you have the responsibility to obtain written approval from a physician if on medications or when medically necessary, and also to demonstrate the ability to use good judgment when drinking alcohol.
- You have the responsibility to understand and accept that there could be times when it may be requested to participate in a room or roommate change.
- If you plan on moving from the residence, it is your responsibility to give advanced notice.
- You have the responsibility to refrain from illegal activities and other unsafe behavior at the residence.
- You have the responsibility to provide Catholic Charities Disabilities Services with accurate and relevant information while receiving services.



- You have the responsibility to participate in the development of your Staff Action Plan and express yourself if you have any questions or disagreements with the plan.
- You have the responsibility to understand that your staff are considered mandated reporters of abuse, neglect, and mistreatment and are required by law to report such concerns.
- It is your responsibility to assist in supplying all documentation necessary for admission to our programs and recertification of Medicaid Waiver eligibility.
- It is also your responsibility to supply all necessary and relevant financial documentation that may affect your Medicaid status and/or financial status within our programs, including changes in income, job status, or spend down conditions.
- Failure to supply financial documentation in a timely manner may be considered a service recipient initiated change and could result in a reconsideration of the continuance of services with Catholic Charities Disabilities Services, at the agency's discretion.

Individual Receiving Services: \_\_\_\_\_

Catholic Charities Disabilities Services

Receipt Acknowledgement

I/We the undersigned acknowledge that I/we have received copies of:

- Emergency Medical Consent
- Consent to Obtain/Release Information
- CFDS Notice of Privacy
- CFDS Consent to Treat
- Transitions in Residential Services
- Incident Management
- Home and Community Based Settings
- Notification of Rights and Responsibilities for Persons Receiving OPWDD Services
  - Process of Objection to Services
  - Grievance Procedure

Individual: \_\_\_\_\_

Parent/Guardian/Advocate: \_\_\_\_\_

Staff Providing Forms: \_\_\_\_\_

Print Staff Name and Title: \_\_\_\_\_

**COMMUNITY RESIDENTIAL PROGRAM PARTICIPANT OCCUPANCY AGREEMENT  
FOR VOLUNTARY PROVIDER OPERATED RESIDENCES**

*PURPOSE OF THIS AGREEMENT: As of March 2023, providers of Home and Community-Based (HCBS) residential settings are required by federal regulation to have legally enforceable occupancy agreements with people receiving these services. This agreement complies with those federal regulations. It identifies the rights that you, the Resident, already have under New York State Office for People With Developmental Disabilities ("OPWDD") regulations while living in a state-operated residence. You have these rights and process as soon as you begin or began living in a residence. By signing this Agreement, you are not giving up or losing any legal rights that you have as a Resident including under applicable local, state, or federal laws and regulations, or court order. This agreement also does not give (Agency Name) any additional powers or rights that it does not already have.*

This Agreement between me \_\_\_\_\_ (Resident) and (Name of Agency Providing Residential Service), outlines each of our responsibilities while I am living at the following address:

\_\_\_\_\_ (Residence).

Date I will/did move into Residence ("Move-in Date"): \_\_\_\_\_

**Contact Information for Resident:**

Name:

Name of representative, if any, and relationship to Resident:

Residence (if different from above):

Telephone Number:

Email Address:

**Agency Contact Information (Executive Director or Director Designee):**

Name:

Title:

Address:

Telephone Number:

Email Address:

**Rent or Room and Board Calculation:**

- My rent is based on my income and is calculated every month. My first month's rent may be an estimate. I understand that whenever my income changes, my rent may change.
- Rent is calculated as follows:

My Total Income from all Sources (this amount must be verified)

Less (-) My Personal Allowance

Equals (=) My Total Rent Owed (Up to Provider maximum allowable as set by OPWDD)

**Below**, I have initialed those sections that apply to me. My representative or guardian can also initial this for me. I have provided the information to calculate my rent.

\_\_\_\_\_ **Section A: If my income has been verified by my Move-in Date**

I agree that my rent will be \$ \_\_\_\_\_ per month. My rent can be paid by me and/or someone authorized by me and will be made payable to (Agency Name). I understand that my rent must be paid 10 days after I receive a bill. I also understand that if I move into a residence after the first day of the month, my rent for that first month will be calculated from the date I move in until the last day of the month.

-or-

\_\_\_\_\_ **Section B: If my Income has NOT been verified by my Move-in Date**

If my income has not been verified by my move-in date, I understand that my rent will be estimated based on the financial information that I give to (Agency Name). Once (Agency Name) has verified my income, I will be given written notice of the correct amount of rent I owe. I understand that this amount may be higher or lower than the amount of rent I paid when I first moved in. I also understand that I may owe more money if my actual rent is higher than the rent I initially paid. If my actual rent is lower than the amount I initially paid, I understand that I may receive a credit toward future rent. If I owe more money, I agree to pay the amount owed.

I agree that rent will be paid to (Agency Name) by me and/or someone authorized on my behalf in the estimated amount of \$ \_\_\_\_\_ per month. Payment will be made payable to (Agency Name). I understand that my rent is due 10 days after I receive a bill. I also understand that if I move into a residence after the first day of the month, my rent for that first month will be calculated from the date I move in until the last day of the month.

**My Rights as a Resident:**

I understand that I have rights under federal, state, and local laws and regulations. Any modifications to my rights must be in my Life Plan and will only be in place as long as needed for health and safety reasons.

My rights for my Residence under the HCBS and New York State regulations can be found at 42 C.F.R. § 441.301(c)(4) and 14 NYCRR § 636-2.4. Copies will be given to me or my representative if we ask for them. The full text of these regulations can also be found at:

[https://www.ecfr.gov/cgi-bin/text-idx?node=pt42.4.441&rgn=div5#se42.4.441\\_1301](https://www.ecfr.gov/cgi-bin/text-idx?node=pt42.4.441&rgn=div5#se42.4.441_1301)

and

[https://govt.westlaw.com/nycrr/Document/lef895d65b44911e98c4eb5f7c15361ca?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=\(sc.Default\)](https://govt.westlaw.com/nycrr/Document/lef895d65b44911e98c4eb5f7c15361ca?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default))

If I or my representative have any questions about this Agreement, free legal advice may be available from the Mental Hygiene Legal Service (MHLS) (<http://www.courts.state.ny.us/ad3/mhls/index.html> (518) 451-8710); or Disability Rights New York (DRNY) (<http://www.drny.org> (518) 432-7861 or (800) 993-8982).

**(Agency Name) Responsibilities:**

1. (Agency Name) will follow all applicable laws and regulations for the operation of the Residence and providing services, including all requirements under the Home and Community-Based Services regulations.
2. The Residence will meet all applicable state and local codes including health, safety, and building codes and OPWDD requirements.
3. When I move in, (Agency Name) will give me or my representative a copy of the Residence's written policies, responsibilities, and procedures. They will also be given to me or my representative if we ask for them.
4. If my income changes, I or my representative will receive notice of the change. My team will work with me so that I pay the correct amount.

**If I, or someone on my behalf (legal guardian or representative), end this Agreement:**

If I end this Agreement, I understand that I will have to move, and I will work with my Care Manager to plan the move. My Care Manager will help me explain my plans to the appropriate staff at my Residence. Until I move out, (Agency Name) will continue to maintain my services at my Residence.

**If I am asked to move:**

If (Agency Name) is no longer able to provide services to me at my Residence, including when the health, welfare, or safety of me or others in jeopardy, I may be asked to move out and find another place to live. If (Agency Name) does ask me to move, I am protected by the procedures in 14 NYCRR § 633.12 ("633.12"). If I do not want to move, I, or my representative, may object to the move under 633.12.

While my objection is being reviewed, I may only be moved or discharged with the Commissioner's approval. Every reasonable effort will be made to maintain my services at my Residence during this review. I may also request assistance from my Care Manager who will work with me and (Agency Name) to develop a safe discharge plan.

I understand that I may be temporarily moved to another residence or bedroom for health, welfare, and safety reasons ("emergency moves"). These moves may happen over my objection, but I will be given the opportunity to object to my new residence if I remain there more than 60 days.

**How long does this Agreement last?**

This Agreement remains in effect as long as I live at this Residence. If I move to another residence operated (Agency Name), this Agreement will continue until there is a new agreement. I understand

that I will need to sign a new agreement if I move to a new residence, and I agree to sign that agreement as soon as possible after I move.

I understand that I do not need to sign a new agreement every time there is a change in my income, even if it means my rent changes. (Agency Name) must give me written notice of the new amount of rent that I owe and how it was calculated.

I have received a copy of this Agreement and I understand it. Upon request, my representative or guardian may also receive a copy of this Agreement. By signing this Agreement, I am not giving up any legal right guaranteed to me in this Residence, including under applicable local, state, or federal laws and regulations, or court order.

\_\_\_\_\_  
Signature of Resident (or Parent or Guardian if resident is under 18)

\_\_\_\_\_  
Date

**or**

\_\_\_\_\_  
Signature of Resident's Guardian or Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Agency Executive Director or Designee

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Title

CC:  
Care Manager

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**FOR AGENCY STAFF USE ONLY**

Dates of Attempts to sign (up to 3) \_\_\_\_\_

Agency Staff Name and Signature \_\_\_\_\_