START CORP.
"CREATING OPPORTUNITIES"

Patient Registration Form
Start Community Health Center

Patient Information		
Clinic Location (City):		Date:
Patient Name:		DOB:
Address:		Are you or your family member an employee of Start? ☐Yes ☐No
City:	State:	ZIP Code:
Home Phone:	Cell Phone:	Work Phone:
SSN:	Sex: ☐Male ☐Female ☐Transgender ☐Other:_____	
Sexual Orientation: ☐Straight ☐Gay or Lesbian ☐Bisexual ☐Something Else ☐Unsure ☐Choose Not To Disclose		
Ethnicity:	Language:	Race:
Email Address:		
Referring MD:	Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed	
Veteran: ☐Yes ☐No	Education: ☐None ☐HS Diploma ☐GED ☐VoTech ☐Bachelor ☐Master/Doctorate	
Highest Grade Completed:	Special Education: ☐Yes ☐No	History of Homelessness: ☐Yes ☐No
Current Housing Status: ☐Permanent ☐Homeless Shelter ☐Transitional Housing ☐Public Housing ☐Unstable/Temporary ☐Other:_____		
Transportation: ☐Personal Vehicle ☐Public Bus ☐Council on Aging ☐Medicaid Transportation ☐Family/Friends ☐ START		
Emergency Contact Information (Please list someone that we can contact in case of emergency that is not living in the home with the patient)		
Emergency Contact Name:		Relationship:
Address:		
Phone Number:	Alternative Phone:	Work Phone:
Employer and Income Information (Please list parent/guardian employer information if the patient is a minor)		
Patient Employer Name:		
Address:		
Phone Number:	Working Status: ☐Full-time ☐Part-time ☐Disabled ☐Retired	
Occupation:		Income (Gross):
Spouse Employer Name:		
Address:		
Phone Number:	Working Status: ☐Full-time ☐Part-time ☐Disabled ☐Retired	
Occupation:		Income (Gross):
Other Sources of Income (Do you receive the following and how much do you receive?)		
SSI:	SSD:	Veteran Benefits:

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Retirement:	Child Support:	Alimony:
Other:	Are you receiving food stamps? ☐Yes ☐No	If so, how much? $_____

Insurance Information
(Please give your insurance card to the receptionist for copying)

Primary Insurance Name:		
Card Holder Name:		Card Holder SSN:
Policy #:	Group #:	Card Holder DOB:
Secondary insurance Name:		
Card Holder Name:		Card Holder SSN:
Policy #:	Group #:	Card Holder DOB:

Household Information
(Please ask if additional paperwork is needed)

Name	DOB	Sex	Relationship to Patient	SSN	Race

Other Needed Information

Primary Care Doctor:	START Program:
Preferred Pharmacy & Location:	Case Worker:

Please Contact Me By:

◯ Home Phone: _____	◯ Work Phone: _____	◯ Written Communication
◯ Leave message ◯ Leave message with call back # ◯ Do not leave a message	◯ Leave a message ◯ Leave a message with a call back # ◯ Do not leave a message	◯ Mail to my Home address ◯ Mail to my Work address ◯ Mail to another address: _____ _____ _____

Start Community Health Center Consent for Treatment Form

1. I give permission for Start Corporation (including any Start Corporation programs or staff) to provide services to myself or to the person indicated below whom I have legal guardianship or power of attorney.
2. I understand that before I receive treatment or services, complete and accurate information will be provided concerning each of the following areas:
    a. The benefits of the proposed treatment
    b. Alternative treatment modes and services
    c. The manner in which treatment will be administered
    d. Expected side effects from the treatment and/or the risks of side effects from medications (when applicable).
    e. Probable consequences of not receiving treatment
3. I give permission for Start Corporation to file for insurance benefits to pay for the services I receive. I understand that:
    a. Start Corporation will send service information to my insurance company.
    b. I must pay my share of the costs, including any copayments if applicable.
    c. I must pay for the cost of these services if my insurance does not pay or I do not have insurance.
4. I understand that I have the right to refuse any procedure or treatment and that I have the right to discuss all medical treatments with my provider.
1. I understand that I have the right to opt out of data collection procedures for any Start programs. I understand that data collection activities will not have any identifying information and will protect my privacy and anonymity.

Acknowledgements

- ➢ I acknowledge that I have read and understood the “Consent for Treatment Form” above.
- ➢ I acknowledge that I have received a copy of the PCMH Information, including the after-hours phone number.
- ➢ I acknowledge that I have received a copy of the Sliding Fee Discount Information.
- ➢ I acknowledge that I have received a copy of the “Financial Policy”.
- ➢ I acknowledge that I have received a copy of the “Patient Bill of Rights and Responsibilities”.
- ➢ I acknowledge that I have been provided with information on “Advanced Directives Information and Guide” and that Mental Health Advance Directive information is available upon request.
- ➢ I acknowledge that I have received the “Notice of Privacy Practices” from the Start Community Health Center.

Patient, Parent, or Legal Guardian Signature / Date

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name:	**Patient DOB:**

List all family members, relatives, or guardians who will have the authority to discuss your medical information:

Name	Phone Number	Relationship to Patient

By signing below, I give consent to all employees of all locations of Start Community Health Center to discuss my medical information with the individuals listed above.

Patient Signature / Date

Authorized Representative Signature / Relationship / Date

Start Community Health Center is a Patient-Centered Medical Home (PCMH)

Office Hours: Monday-Friday: 8:00 a.m. - 4:30 p.m.	**Site:** www.startcorp.org **Patient Portal:** health.healow.com/start

SERVICES PROVIDED:
Primary Care, Behavioral Health (Mental Health and Substance Use Treatment), Hepatology and PrEP, and Medicaid Enrollment. Our Civic Center Location offers Dental Services as well as Pharmacy services with delivery options available. Our Mandeville Office also offers digestive health services.

AFTER-HOURS SERVICES:
Our Houma clinic, located at 235 Civic Center Blvd, offers extended hours from 7:30 AM to 8:00 AM and from 4:30 to 5:30 PM on Mondays.
If you need to speak to your provider when the office is closed, you may contact our after-hours answering service by calling the main number to the corresponding clinic:

1. 24-hour Crisis and Mobile Crisis at 235 Civic Center Blvd. Houma, LA 70360: 985-333-1633
2. 235 Civic Center Blvd. Houma, LA 70360: 985-333-2020
3. 2300 S. Galvez Street New Orleans, LA 70125: 504-332-5713
4. 2150 General Pershing Street Mandeville, LA 70448: 985-951-4716
5. 1505 N. Florida Street Covington, LA 70433: 985-900-1626
6. 312 E Bayou Road Thibodaux, LA 70301: 985-266-0444 x2660
7. 153 N 17th Street Baton Rouge, LA 70802: 225-235-7734 x7734

CARE OUTSIDE OF OUR PRACTICE:
Please inform us if you sought services from an urgent care clinic, walk-in clinic, hospital, or other provider. We would like to maintain your most up-to-date medical information to provide you with the best care possible.

TRANSFERRING YOUR MEDICAL RECORDS TO THE PRACTICE:
Our staff will help migrate your medical records from your previous health care provider. We will identify a contact person to help coordinate the transition and follow up until your records are received.

WHO WE ARE AND WHAT WE DO:
Start Corporation is a non-profit organization that provides health services to all individuals including individuals with a mental illness,, the homeless, youth, and veterans. The organization and the clinic work together to provide holistic care to its patients by addressing their basic needs.

Our clinic consists of physicians, nurse practitioners, and licensed counselors and social workers. Our primary care providers treat illnesses that range from minor injuries to major medical conditions.

It's important to us to meet your mental health and substance abuse treatment needs. Based on your medical needs, you will be referred and scheduled with one of our behavioral health providers as needed. Our behavioral staff provides psychiatric evaluations for all psychiatric disorders, oversees medication management, and offers supportive counseling.

Our dental staff offers dental exams and extractions.

HEALTH INSURANCE ACCEPTED:
Now accepting new patients. Medicaid, Medicare, Private Insurance, and Uninsured are accepted. A Medicaid enrollment representative is available to assist with Medicaid applications.
Inquire within if you have any questions regarding your health care coverage.
Sliding scale discount is based on household and income.

WHAT TO BRING TO YOUR APPOINTMENT:
- Driver's license or picture ID
- Insurance card (if insured)
- All current medications
- Proof of income

Transportation services are available to and from the clinic. Please inquire about these services when scheduling.

WHAT IS A PATIENT-CENTERED MEDICAL HOME?
"The Patient Centered Medical Home is a way of organizing primary care that emphasizes care coordination and communication to transform primary care into "what patients want it to be." Medical homes can lead to higher quality and lower costs, and can improve patients' and providers' experience of care. NCQA Patient Centered Medical Home (PCMH) Recognition is the most widely used way to transform primary care practices into medical homes." - NCQA, 2014

GOALS OF OUR MEDICAL HOME:
- You have 24-hour access to care and are able to get an appointment as soon as you need it.
- Nursing and clinical staff are skillful and ready to assist you in taking care of your health care needs.

WHAT CAN YOU EXPECT FROM A MEDICAL HOME?

Personal Physician
You will have an ongoing relationship with your personal clinician. The clinician will provide continuous care and lead the staff members to take responsibility for your continuous care.

Whole Person Orientation
We are responsible for fulfilling all of your health care needs across multiple settings such as: specialists, hospitals, and behavioral health services.

Coordinated/Integrated Care
We use technology and enhanced communications to assure that you get the recommended care when and where you need it and want it. We work in a culturally and linguistically appropriate manner so that you feel more empowered to help us care for you.

Comprehensive Patient Care
We ask you to provide us with the most up-to- date information on: your current medications, personal/family history, health status, test results, self-care information and medical records from hospitals/ERs, urgent care and other clinicians you may have seen.

Quality and Safety
We use methods that are based on scientific research (evidence-based medicine) to provide you with the most advanced treatment. Patients and families can expect our support for self-management of their health care needs. This includes

the use of educational resources, self-management tools, and medical literature regardless of your source of payment.

SLIDING FEE DISCOUNT PROGRAM

- Start Community Health Center will NOT deny health services due to an individual's inability to pay for such services. Start Community Health Center will base program eligibility on a person's ability to pay and will NOT discriminate on the basis of age, gender, race, creed, disability, or national origin.
- A sliding fee discount schedule (SFDS) has been established to minimize a barrier to care for patients and will be made available as well.
- ALL patients seeking healthcare services at Start Community Health Center are assured that they will be served regardless of their ability to pay. NO ONE is refused service because of their lack of financial means to pay.
- Requests for discounted services may be made by patients, family members, social services staff or others who are aware of existing financial hardship. (Information and forms can be obtained from the Front Desk and are available in different languages)
- All alternative payment resources must be exhausted including all third-party payment from insurance(s), Federal, and State programs.

Completion of Application

- The patient / responsible party must complete the Sliding Fee Discount Program application in its entirety.
- Signature of the Sliding Fee Discount program application authorizes Start Community Health Center to confirm the necessary income as disclosed on the application form. Providing false information on the Sliding Fee Discount Program application will result in all Sliding Fee Discount Program discounts being revoked and the full balance of the account(s) restored and payable immediately.
- If an application is unable to be processed due to the need for additional information, the applicant has 30 days from the date of notification to supply the necessary information without having the date on their application adjusted.

- **FAMILY** is defined as: a group of two people or more (one of whom is the householder) related by birth, marriage, or adoption and residing together; all such people (including related subfamily members) are considered as members of one family.

- **INCOME** is defined as: earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income (SSI), public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support assistance from outside the household, and other miscellaneous sources. Noncash benefits (such as food stamps and housing subsidies) do not count.
- Patients who refuse to provide information to Start Community Health Center regarding family income and size and declines to be assessed for eligibility for sliding fee discounts will be considered ineligible for the discount. However, these individuals may request a form at any time to apply.
- To verify income: Applicants must provide one of the following: prior year W-2, two most recent pay stubs, letter from employer, or Form 4506 (if W-2 not filed). Self-employed individuals will be required to submit details of the most recent three months of income and expenses for the business. Adequate information must be made available to determine eligibility for the program. Self-declaration of income may only be used in special circumstances. Specific examples include participants who are homeless.
- Patients who are unable to provide written verification must provide a signed statement of income, and why they are unable to provide independent verification. This statement will be presented to Start Community Health

Center's staff for review and final determination as to the sliding fee percentage.

- Those with incomes at or below 100% of poverty will receive a full 100% discount for primary and behavioral services and a flat nominal fee of $50 for dental services. Those with incomes above 100% of poverty, at or below 200% of poverty, will be charged according to the attached sliding fee schedule for all services.
- In certain situations, patients may not be able to pay the discounted fee. Waiving of charges may only be used in special circumstances and must be approved by Start Community Health Center's director or their designee.
- Start Community Health Center will service patients with third party insurance that does or does not cover or only partially covers fees for certain health center services. These patients may apply for the sliding scale discount program. If eligible, the charge for each sliding fee discount schedule pay class is the maximum amount an eligible patient in that pay class is required to pay for certain services, regardless of insurance status.

- The Sliding Fee Discount Program determination will be provided to the applicant(s) in writing, and will include the percentage of Sliding Fee Discount Program write off, or, if applicable, the reason for denial. If the application is approved for less than a 100% discount or denied, the patient and/or responsible party must establish payment arrangements with Start Community Health Center. Sliding Fee Discount Program applications cover outstanding patient balances for six months prior to application date and any balances incurred within 12 months after the approved date, unless their financial situation changes significantly. The applicant has the option to reapply after the 12 months have expired or anytime there has been a significant change in family income. When the applicant reapplies, the look back period will be the lesser months or the expiration of their last Sliding Fee Discount Program application.
- If a patient verbally expresses an unwillingness to pay or vacates the premises without paying for services, the patient will be contacted in writing regarding their payment obligations. If the patient is not on the sliding fee schedule, a copy of the sliding fee discount program application will be sent with the notice. If the patient does not make an effort to pay or fails to respond within 60 days, this constitutes refusal to pay. At this point in time, Start Community Health Center can explore options not limited, but including offering the patient a payment plan or waiving of charges.
- Information relating to the Sliding Fee Discount Program will be notified by phone and letter.
- Applicants that have been approved for the Sliding Fee Discount Program will be notified at the time of service.

FINANCIAL POLICY

Thank you for choosing Start Community Health Center. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy which we require that you read, agree to and sign prior to any treatment. All patients must complete our Patient Registration Form before seeing the doctor.

Assignment of Benefits

I request that payment of authorized Medicare and/ or insurance benefits be made on my behalf to Start Corporation for any services rendered to me. I authorize any holder of my medical information to release information needed to determine these benefits to CMS (Centers for Medicare and Medicaid Services), its agents, or any insurance carrier I have. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Financial Agreement

I agree that I am responsible for payment of services provided at Start Community Health Center. It is the policy of Start Community Health Center to provide essential services regardless of the patient's ability to pay. If uninsured, discounts

are offered based on family size and annual income. The discount will apply to all services received at this clinic, but not those services or equipment that are purchased from outside, including laboratory testing, medications, X-rays, and other such services. The sliding scale discount will be determined upon initial clinic visit then every 12 months or if your financial situation changes.

If insured, I understand that claims will be filed with my insurance company, and that I am responsible for any co-payments, co-insurance, and/or deductibles as designated by my health plan. I understand that the authorized co-payment of my health plan is to be paid on the date of service. I understand that it is my responsibility to inform Start Corporation of any changes in my personal information or insurance information, and that it is my responsibility to obtain appropriate referrals if required by my insurance company.

Start Community Health Center shall make a reasonable effort to collect all charges for health care services rendered, regardless of whether discounted or standard charges apply. A reasonable effort may include, but not limited to, issuance of a bill to the patient or responsible party and follow up with subsequent billing, letters and telephone calls.

NOTICE OF PRIVACY PRACTICES

HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT)

This notice describes how your private information concerning you may be used, disclosed and how you can have access to this information.

Start Corporation may use & disclose information without your authorization:

- To health care providers who are involved in your health care.
- To get payment or to pay for the health care services you receive.
- To review the quality of services provided such as during program audits.
- To remind you of appointments or to send you important information regarding services.
- For Public Health notices and updates.
- As Required by Law and for Law Enforcement.
- For Abuse Reports & Investigations
- For Government Programs.
- To Avoid Harm.
- For Research.
- To Family, Friends, and Others that you identified as involved in your services on your patient intake forms. You may remove persons at any time.

Uses and Disclosures

Start Corporation is permitted by law to disclose the minimum necessary personal health information of each patient to carry out treatment, payment, and healthcare operations of the facility.

Required Authorizations

The facility will not disclose any patient's personal health information for any purpose aside from payment, treatment, data-related purposes, and healthcare operations, without the patient's authorization to disclose such. Upon request for such authorization, the patient shall have the right to refuse and/or revoke any disclosure of the patient's personal health information.

Privacy Compliance

In accordance with the privacy regulations promulgated under the Health Insurance Portability and Accountability Act, 45

CFR Parts 160 and 164 ("The Privacy Regulations"), the facility has adopted privacy policies regarding usage of patients' personal health information. The facility is in compliance with the Privacy Regulations and all other laws and regulations regarding patients' right to privacy.

Additional Information

For additional information regarding the facility's privacy policy or for a copy of this notice, please contact our office. The facility reserves the right to change this notice and to make the revised and changed notice effective for medical information that the facility already has about you, as well as any information the facility receives in the future. The notice will contain the effective date.

Other Uses and Disclosures Require Your Written Authorization

Written authorizations are typically in effect for one year or for a specified amount of time. You may cancel authorizations at any time; however, we cannot retrieve information that has already been sent as authorized.

PATIENT BILL OF RIGHTS

You have the right to:

- Be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
- Freedom from abuse, neglect, financial or other exploitation, humiliation, or retaliation.
- Know what patient support services are available, including whether an interpreter is available if he or she does not speak English and the right to request translation services.
- Impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap or source of payment.
- See and get copies of your records. In most cases, you have the right to look at or get copies of your records. You must make the request in writing. You may be charged a copying fee. The records will be provided within 5-7 business days.
- Request to correct, amend, or update your records. Requests must be written.
- Formulate an Advance Directive and to know the organization will honor that directive to the extent permitted by law.
- Request limits on uses or disclosures of protected health information. Requests must be in writing. Start Community Health Center will attempt to honor requests to the extent possible within the scope of the law and clinical judgment.
- Choose how we communicate with you such as by telephone, email, or via mail.
- File a complaint.
- Get a paper copy of this notice.
- Receive notice of changes to Start Community Health Center Privacy Practices.
- Competent and professional treatment that is respectful and focused on your preferences.
- Clear communication of rights, rules, and regulations at start of services and annually thereafter.
- Involvement of family and significant others as you request.
- Prompt information regarding conditions, treatment alternatives, and the right to refuse treatment to the extent permitted by law including consequences of refusing treatment.
- Encouragement to exercise your rights as an individual, and as a citizen, including the right to vote.
- Participation in developing treatment plan goals, objectives, and plans.
- Involvement in your community including social, religious, and other activities
- Confidentiality within the program except when disclosure is authorized by you or required by law.

- ➢ Manage your finances as you see fit while maintaining financial obligations.
- ➢ Make suggestions or complaints in person or in writing to the Program Director and/or the Executive Director.
- ➢ Access to an impartial advocate whenever your rights or desires appear to be in conflict or jeopardy.
- ➢ Access to your own records and information about disclosures of your records.

Individual Responsibilities For Persons In All Programs

- ➢ Be fully involved in services and motivated to accomplish treatment plan goals and objectives.
- ➢ Do not use or sell illegal drugs, illegally obtained drugs or other substances that can interfere with your recovery or the recovery of those around you.
- ➢ Maintain active contact with family and other important persons (contact information up to date).
- ➢ Respect the property of others by not touching, taking, or borrowing items without permission.
- ➢ Prevent damage or loss of items for self, others, or the agency (replacement may be required).
- ➢ Observe "quiet time" as defined by local jurisdiction or landlord/lease requirements.
- ➢ Respect the privacy of others at all times, including knocking on doors and receiving permission before entering.
- ➢ When applicable, attend work or school programs regularly, participating to your fullest potential.
- ➢ Participate fully in services and notify staff at any time if you feel services are not meeting your needs.
- ➢ Work towards personal recovery, independence, and quality of life.
- ➢ Do not smoke inside the residence (unless allowed by lease agreement) or in Start Corporation's vehicles.
- ➢ When required, allow Start Corporation to be your designated payee for Social Security and other benefits.
- ➢ Maintain good personal hygiene at all times.

ADVANCE DIRECTIVE INFORMATION AND GUIDE

The Louisiana Declaration is your state's living will. It lets you state your wishes about medical care in the event that you become terminally and irreversibly ill and can no longer make your own medical decisions.
In addition, this Declaration lets you designate another person, called an agent, to make healthcare decisions for you in the event you become terminally and irreversibly ill and can no longer make your own medical decisions.
Your Louisiana Declaration goes into effect when your doctor determines that you are terminally and irreversibly ill and can no longer make your own medical decisions.
This form also includes an optional section that allows you to make decisions about organ donation.
This form does not expressly address mental illness. Information about Mental Health Advance Directives is available upon request.
Note: This document will be legally binding only if the person completing it is a competent adult (at least eighteen years old).

How do I make my Louisiana Declaration legal?
The law requires that you sign your Declaration in the presence of two competent adult witnesses, who must also sign the document to show that they personally know you and believe you to be of sound mind. These witnesses cannot be:

- related to you by blood or marriage; or
- entitled to any portion of your estate.

Note: You do not need to notarize your Louisiana Declaration.

Whom should I designate as my agent?
Your agent is the person you appoint to make decisions about your medical care if you become unable to make those decisions yourself. Your agent may be a family member or a close friend whom you trust to make serious decisions. The person you name as your agent should clearly understand your wishes and be willing to accept the responsibility of

making medical decisions for you.
You can appoint a second person as your alternate agent. The alternative will step in if the first person you name as an agent is unable, unwilling, or unavailable to act for you.

Can I add personal instructions to my Declaration?

One of the strongest reasons for naming an agent is to have someone who can respond flexibly as your medical situation changes and deal with situations that you did not foresee. If you add instructions to this document, it may help your agents carry out your wishes and act with care that you do not unintentionally restrict your agent's power to act in your best interest. In any event, be sure to talk with your agent about your future medical care and describe what you consider to be an acceptable "quality of life."

What if I change my mind?

You may revoke your Louisiana Declaration at any time, regardless of your mental condition, by:

- Canceling, defacing, obliterating, burning, tearing, or otherwise destroying the document, or directing another to do so in your presence;
- Signing and dating a written revocation; or
- Orally expressing your intent to revoke your Declaration.

Your revocation becomes effective once you notify your doctor.

I have filled out my Advanced Directive, now what?

1. Your Louisiana Declaration is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.
2. Give photocopies of the signed original to your agent and alternate agent, doctor(s), family, close friends, clergy and anyone else who might become involved in your healthcare. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.
3. Be sure to talk to your agent(s), doctor(s), clergy, family and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.
4. Louisiana maintains a Living Will Declaration Registry. By filing your advance directive with the registry, your health care provider and loved ones may be able to find a copy of your directive in the event you are unable to provide one. You can read more about the registry, including instructions on how to file your advance directive, at http://www.sos.la.gov/OurOffice/EndOfLifeRegistries/Pages/default.aspx.
5. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.
6. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.
7. Remember, you can always revoke your Louisiana document.
8. Be aware that your Louisiana document will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives called "prehospital medical care directives" or "do not resuscitate orders" are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency personnel not to attempt CPR if your heart or breathing should stop.

We suggest you speak to your physician if you are interested in obtaining this form.

SUGGESTIONS, GRIEVANCES, AND COMPLAINTS

- You have a right to express your concerns, suggestions, or complaints. Please follow these steps to do so:
  - Provide a verbal or written report to the staff or supervisor as soon as possible. You may ask for assistance in doing this.
  - Provide full and accurate details, including witnesses, as best you can.
  - If you are not satisfied with the response, please report your concern to the program supervisor or manager.
  - If you are not satisfied with the response, please notify the Administrative Office at 985 879-3966. The Administrative management team will review the complaint and as necessary, involve members of the board to determine a resolution.
  - If you are still not satisfied with the response, you may request an outside advocate through an impartial resource.
- All complaints and grievances by individuals served by Start Corporation shall be treated with respect, confidentiality, and promptness. All efforts shall be made to arrive at a fair and just resolution, with no retaliation toward the person making the complaint.
- All complaints and grievances will receive prompt response and investigation as warranted. The staff member primarily involved in the response shall notify the complainant at least weekly of progress. The formal response will be provided in writing to the complainant within 3 working days following the decision.
- You and others have a right to live free of abuse, neglect, and exploitation. Mistreatment of children, the elderly, and adults with disabilities should be reported promptly. Please use the following agencies and phone numbers for reporting:
  - CHILDREN: Dept. Child and Family Services (DCFS)1- 855-4LA-KIDS
  - ADULTS/ ELDERLY: Adult/Elderly Protective Services – 1-800 898-4910 (or) 1-800 259-4990
- To file a complaint, please contact your local program office or the main office by mail, phone, or fax.