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Grievance Procedure

1. All persons receiving services, parents, or legal guardians will be ensured the right and means to file grievances regarding termination of services and/or plan supports, changes, reductions, or denials of services identified in the plan, individual treatment, program conditions, or violations of human rights without fear of adverse reaction from the agency. Explanation of the grievance process will be reviewed with the individual/legal guardian at the time of admission to services and annually thereafter by an authorized agency representative.
2. Grievances to discuss complaints, concerns or disagreements will be made in writing to the Program Coordinator for the service provided to the individual.
3. The Program Coordinator will make every effort to resolve the grievance at the most informal level in a prompt, non-threatening, and conversational manner.
4. The Program Coordinator will keep documentation of informal discussions and communication to resolve complaints, concerns or disagreements brought to their attention utilizing the agency Individual Grievance Form.
5. The Program Coordinator will give written documentation of findings and actions taken to address the complaint to the individual and his/her guardian or representative, if applicable.
6. If the individual, legal guardian or authorized representative remains dissatisfied with informal grievance discussion, a request for a review with the Executive Director may be made.
7. The individual will be made aware of their right to attain an advocate or legal representative through the Developmental Disabilities Planning Council.
8. A meeting with the individual and their legal guardian, authorized representative and/or advocate will be scheduled within five (5) working days following a formal grievance request.
9. Within five (5) working days following the grievance meeting, the Executive Director will make a determination, in writing, and provide the individual, guardian, and authorized representative/advocate with the determination.
10. A copy of the determination will be kept in the individual record.
11. If the grievance is not resolved, the individual will be notified of the right to request an Interdisciplinary Meeting or file a DDSD Request for Regional Office Intervention to review the decision.

I acknowledge that I have been made aware of the above procedures:

_____ _____

Guardian/Individual Signature Date

346 Clark Rd SW, Albuquerque, NM 87105
Mailing address: PO Box 9346, Albuquerque, NM 87119
(505) 873-1187 (505)717-2044 (fax)
info@mandysfarm.org www.mandysfarm.org

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Permission to Obtain/Release Information

Individual Name: _____ DOB: _____

I _____ hereby give consent (by initialing appropriate boxes) to the following parties to obtain requested records and other information regarding this participant.

Obtain **(Initial)**	Documents
	Therapist Evaluations
	Psychological/Psychiatric Reports
	Medical Records
	Previous Residential Records
	Other:
	Other:

Guardian/Individual (print): _____ Date: _____

Signed: _____

Mandy's Farm Representative: _____ Date: _____

Signed: _____

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ANE Orientation Packet Receipt

Individual Name: _____

I/we _____ have been provided information regarding the Incident Management System at Mandy's. It has been explained that all individuals working directly with _____ have been trained on identifying and reporting alleged Abuse, Neglect or Exploitation in accordance with State of New Mexico regulations. I/we are also aware of how to report alleged Abuse, Neglect or Exploitation should it be witnessed in my presence.

Guardian/Individual Signature: _____Date: _____

Mandy's Farm Representative: _____Date:_____

Location of Packet Transfer:_____Time:_____

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HIPAA ACKNOWLEDGEMENT

Individual Name: _____

Because of the Health Insurance Portability and Accountability Act (HIPAA), all employees of Mandy's are trained not to disclose any information about client care, diagnosis, or medical information unless it is absolutely necessary. Information will only be disclosed to individuals who are directly involved in the care of the client. Examples include Mandy's Special Farm staff, therapists, doctors, and emergency personnel. Any information we do give will only be pertinent to what each person actually needs to know. For example, only direct support staff and supervisors that work with the client will have access to her/his records; other staff members that do not work directly with her/him will not.

The only people who have access to unlimited information about client care, diagnosis, and medical information are the client themselves, direct support staff and supervisors who work directly with client, and the client's guardian(s). If there are any other individuals you think should have knowledge/access to the client's care records (parents who are not legal guardians, other family members, friends, etc.) please list below:

Full Name: _____ Relationship: _____
Notes (e.g., only in emergency, only therapy reports, etc.):
_____
_____

Full Name: _____ Relationship: _____
Notes:_____
_____

Guardian/Individual Name (print): _____

Signature: _____ Date: _____

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Authorization for Medication Assistance

Individual Name: _____ DOB: _____

I hereby authorize unlicensed direct support personnel to assist in the delivery of his/her medications. I am aware that the staff, though unlicensed, are required to attend and pass a two day training on assistance with medication delivery before initial assistance. Thereafter, staff are required to attend annual recertification trainings. Training includes possible adverse reactions of medications and interventions in that situation. A registered nurse is on call 24/7 to provide guidance and approval for PRN medications.

Assistance with medication delivery includes: reading a prescription label and removing a prescribed amount of medication from the container, placing the medication in the individual's hand or in another container and helping the individual to lift it to their mouth, applying topical medications, returning the medication to storage, and keeping a record of medications.

Assistance with medication delivery does NOT include: calculating medication dosages, putting medications in an individual's mouth, preparing or administering injections, applying rectal, urethral, or vaginal preparations, administering medications by way of a tube inserted in a body cavity, administering parenteral preparations, conducting irrigations or using debriding agents for treating skin conditions, administering medications through intermittent positive pressure breathing machines or nebulizers, or performing any medication task which requires judgment or discretion.

_____ _____

Signature of Physician Date

_____ _____

Signature of Guardian Date

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Interdisciplinary Team Visit & Transportation Release

Individual Name: _____

I have been notified that Mandy's Farm collaborates with any and all client therapists, case managers, and service coordinators employed by an agency selected via the Secondary Freedom of Choice. I understand that these individuals will be allowed on-site during program hours to conduct therapy sessions or on-site wellness visits.

Through the below indication, I (please circle) permit or not permit therapists, case managers, or service coordinators who participate in the Interdisciplinary Team to spend time with _____ (individual) without direct supervision from Mandy's farm employees.

Additionally, I permit/ do not permit (circle one) members of the Interdisciplinary Team to accompany _____ (individual) without direct supervision from Mandy's farm employees, into the community (community walks, community events, etc.).

I acknowledge that I have been made aware of the above procedures:

_____ _____

Guardian/Individual Signature Date

346 Clark Rd SW, Albuquerque, NM 87105
Mailing address: PO Box 9346, Albuquerque, NM 87119
(505) 873-1187 (505) 503-6832 (fax)
info@mandysfarm.org www.mandysfarm.org

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Photo Release

Please read entire document before completing:

I _____ (individual) hereby authorize Mandy's Farm to use, reuse, publish, and republish in whole or in part, individually or in connection with other material in any and all media now and hereafter known, and for any purpose whatsoever, specifically including newsletters, brochures, website, fundraising materials, and/or other promotional materials, without restriction as to alteration, in connection with any use Mandy's Farm chooses. I will allow the following for use in the aforementioned items, unless otherwise specified:

_ Photographs
_ Quotes or positive blurbs
_ My first name
_ My first initial (if first name is not allowed)
_ Notes (if any of the forgoing is not allowed, please specify):

_____

_____

I release and discharge Mandy's Farm from any and all claims and demands that may arise out of or in connection with the use of the photographs, including without limitation any and all claims for libel or violation of any right of publicity or privacy. This authorization and release shall also inure to the benefit of the heirs, legal representatives, licensees, and assigns of Mandy's Farm, as well as the person(s) for whom he/she took the photographs.

I understand that Mandy's Farm respects my privacy and follows the Health Insurance Portability and Accountability Act. Mandy's Farm will only publish a minimal amount of positive information about progress in newsletters and on its website. Parents/guardians/Employees/Individuals have the right to review and approve any written information Mandy's Farm wishes to publish. I have read this document and fully understand and approve of its contents.

Guardian/Individual Signature: _____ Date: _____

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Request For Additional Information

Individual Name: _____

In order to better serve our clients, Mandy's requests the following information. Please provide any details you feel may be applicable and/or helpful in creating a person-centered program.

Cultural preferences/beliefs: _____

_____

_____

_____

☐ No preference ☐ Don't know ☐ Prefer not to disclose

Religious/spiritual affiliation: _____

_____

_____

_____

☐ No preference ☐ Don't know ☐ Prefer not to disclose

Sexual orientation: _____

_____

☐ Prefer not to disclose ☐ Don't know

Any additional information: _____

_____

Individual Signature: _____ Date: _____

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Horsemanship Medical Release

This form must be completed by a licensed medical professional, preferably the participant's Primary Care Physician.

Individual's Name: _____

Height: _____ Weight: _____ Birthdate: _____

Diagnosis(es): _____

Allergies: _____

Shunt present? Y ____ N ___ Wheelchair Use? Y ____ N ___

Seizure Disorder? Y ____ N ___ Atlanto-Axial Instability? Y ____ N ___

Other Medical Concerns/ Special Precautions to consider: _____

_____

_____

Given the above diagnosis(es) and medical information this person is not medically precluded from participation in a horsemanship program. In my opinion the above-named participant can participate in horsemanship activities, including riding, for a duration of 45-60 minutes under appropriate supervision.

Physician Name/Title (print): _____Signature: _____

Address: _____ Phone: _____ Date: _____

The undersigned participant, or participant's parent/guardian, does/do hereby release, acquit, discharge, and hold harmless Mandy's Special Farm, its officers, trustees, agents, employees, representatives, staff, volunteers, successors and assigns on account of any personal injuries, physical or mental condition, known or unknown, to the person of said rider, or resulting from horsemanship activities, including riding.

I acknowledge that participation in horsemanship activities, including riding, has inherent risks. With this in mind, I acknowledge that the benefits to participation in the Mandy's Farm Horsemanship program outweigh the risks, and therefore release and hold harmless Mandy's Special Farm in the event of any injury as a result of the horsemanship programs/ activities.

_____ _____ _____

Guardian/Individual Name (Printed) Guardian/Individual Signature Date

Mandy's Farm
346 Clark Rd SW
Albuquerque, NM 87105
505.873.1187
(fax) 505.503.6832