

Welcome!

On behalf of the individuals and staff of the day support program, we would like to thank you for choosing Virginia Support Group, LLC as your new day support program provider.

Our mission is to provide advocacy, assistance, and responsive Person-Centered planning to enhance the quality of life for each individual we provide support and assistance.

Our goal is for you to be pleased with the effectiveness of our services and the positive communication with Virginia Support Group’s staff. We need your continued help in improving our services so your feedback is important to us.

We welcome you to the Virginia Support Group family.

Sincerely,

**Sherry T. Ferebee**

Executive Director



**INDIVIDUAL FILE CHECKLIST**

* Application for Admission of Services
* Medical Records: Physical Examination and TB Test
* Psychological Report: Results of an exam performed within the past five (5) years to include diagnosis of functional and adaptive scores
* Level of Function Survey
* Health Status
* DS Person Centered Assessment
* DS Personal Profile
* Treatment Plan
* Support Intensity Scale (SIS) report
* Consent Forms: Release of Information and Photo Release Form
* ITS YOUR RIGHT form
* Photo Identification Card
* Birth Certificate
* Social Security Card
* Medicaid Card
* Copy of Guardianship status, if courts were involved

**Virginia Support Group, LLC**

**FORM 645C**

**APPLICATION FOR ADMISSION OF SERVICES**

***CONFIDENTIAL INFORMATION (STAFF USE ONLY)***

|  |  |
| --- | --- |
| **APPLICANT INFORMATION: PLEASE PRINT** | DATE OF ADMISSION: |
| LAST NAME: | FIRST NAME: | MIDDLE NAME: |
| SSN: | DATE OF BIRTH (MM/DD/YYYY): | AGE: |
| PLACE OF BIRTH: | PRIMARY LANGUAGE: | PREFERRED LANGUAGE: |
| ENGLISH SPEAKING: \_\_\_\_\_YES \_\_\_\_\_NO | MARITAL STATUS: \_\_\_\_\_ SINGLE \_\_\_\_\_ MARRIED \_\_\_\_\_\_ DIVORCED \_\_\_\_\_ SEPARATED |
| ETHNICITY:  | IF HISPANIC, INDICATE ORIGIN: |
| HAIR COLOR:  | EYE COLOR: | HEIGHT: | WEIGHT: | SEX: |
| **APPLICANT ADDRESS** |
| ADDRESS: |
| CITY: | STATE: | ZIPCODE: | COUNTY: |
| **SPOUSE’S ADDRESS** |
| ADDRESS: |
| CITY: | STATE: | ZIPCODE: | COUNTY: |
| FINANCIAL RESOURCES: | \_\_\_\_ SSI \_\_\_\_ SSDI \_\_\_\_ RAILROAD \_\_\_\_ BLACK LUNG COMP \_\_\_\_ OTHER \_\_\_\_\_ BANK ACCOUNTS \_\_\_\_\_ TRUSTS \_\_\_\_\_ STOCK/BOUNDS |
| **REFERRAL INFORMATION** |
| REFERRAL SOURCE & NAME: |
| ADDRESS: |
| CITY: | STATE: | ZIPCODE: | COUNTY: |
| PHONE: | REASON FOR REFERRAL: |
| **EDUCATIONAL HISTORY** |
| AGE FIRST ATTENDED SCHOOL: | YEARS COMPLETED: |
| **SCHOOLS ATTENDED:** |
| NAME OF SCHOOL(S)  | LOCATION OF SCHOOL(S) | DATES ATTENDED |
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| SPECIAL EDUCATION: \_\_\_\_\_\_ YES \_\_\_\_\_\_ NO | GRADE LEVEL: |
| **VOCATIONAL TRAINING HISTORY** |
| TRAINING PROGRAM | NAME AND LOCATION | DATES OF TRAINING |
|  |  |  |
|  |  |  |
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| **EMPLOYMENT HISTORY** |
| JOB TITLE | EMPLOYER & LOCATION | TIME OF EMPLOYMENT | REASON FOR LEAVING |
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| **INSTITUTIONALIZATION/HOSPITALIZATIONS:** |
| INSTITUTION AND LOCATION | DATE OF ADMISSION (S) & DISCHARGE(S) | REASON FOR ADMISSION |
|  |  |  |
|  |  |  |
| **PREVIOUS SERVICES RENDERED** |
| AGENCY NAME | ADDRESS | CONTACT PERSON | DATES |
|  |  |  |  |
|  |  |  |  |
| **AUTHORIZED REPRESENTATIVE:** |
| NAME (LAST, FIRST, MI): |  |
| PHONE NUMBER : | HOME: | WORK: | CELL: |
| ADDRESS: |  |
| CITY: | STATE: | ZIPCODE: |
| **FAMILY INFORMATION** |
| **FATHER’S NAME (LAST, FIRST, MI):** |  |
| ADDRESS: |  |
| CITY: | STATE: | ZIPCODE: |
| PHONE NUMBER: | HOME: | WORK: | CELL: |
| **MOTHER’S NAME (LAST, FIRST, MI):** |  |
| ADDRESS: |  |
| CITY: | STATE: | ZIPCODE: |
| PHONE NUMBER: | HOME: | WORK: | CELL: |

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| --- |
| **FAMILY INFORMATION CONTINUED:**ALL SIBLING, LIST IN ORDER OF BIRTH INCLUDING THE APPLICANT: |
| NAME: | RELATIONSHIP: | BIRTHDATE: | LIVING IN HOUSEHOLD:(YES OR NO) |
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| **OTHER PERSONS LIVING IN THE HOUSEHOLD:** |
| NAME | RELATIONSHIP: | BIRTHDATE: |
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| **INSURANCE INFORMATION:** |
| MEDICAL INSURANCE/POLICY COVERING APPLICANT (COMPANY/NUMBER): |
| MEDICAID NUMBER: | MEDICARE NUMBER: |
| GROUP NUMBER: | OTHER: |
| **APPLICANT’S PRESENT CONDITION(S):** |
| 1. PHYSICAL/MEDICAL:
 |
| 1. BEHAVIORAL/EMOTIONAL:
 |
| 1. OTHER:
 |
| DOES THE APPLICANT HAVE ALLERGIES? \_\_\_\_\_\_ YES \_\_\_\_\_\_ NO. IF YES, PLEASE LIST: |

**DOES THE APPLICANT USE THE FOLLOWING: PLEASE CHECK ALL THAT APPLY**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **EYE GLASSES** |  | **YES** |  | **NO** |  | **SOMETIMES** |
| **CONTACT LENSES** |  | **YES** |  | **NO** |  | **SOMETIMES** |
| **PROSTHESES** |  | **YES** |  | **NO** |  | **SOMETIMES** |
| **HEARING AID** |  | **YES** |  | **NO** |  | **SOMETIMES** |
| **BRACES** |  | **YES** |  | **NO** |  | **SOMETIMES** |
| **WHEELCHAIR** |  | **YES** |  | **NO** |  | **SOMETIMES** |
| **CRUTCHES** |  | **YES** |  | **NO** |  | **SOMETIMES** |
| **WALKER** |  | **YES** |  | **NO** |  | **SOMETIMES** |
| **HELMET** |  | **YES** |  | **NO** |  | **SOMETIMES** |
| **ASSISTIVE TECHNOLOGY** |  | **YES** |  | **NO** |  | **SOMETIMES** |
| **SPECIALIZED TRANSPORTATION** |  | **YES** |  | **NO** |  | **SOMETIMES** |

|  |
| --- |
| **APPLICANT’S PRESENT CONDITIONS CONTINUED:** |
| DOES THE APPLICANT HAVE A HISTORY OF DIABETES? |
| DOES THE APPLICANT HAVE A HISTORY OF SEIZURES? |
| DESCRIBE TYPES OF SEIZURES: |
| CONTRIBUTING FACTORS TO SEIZURE ACTIVITY (I.E., FLASHING LIGHTS, OVERHEATING, AGITATION, ETC.): |
| DATE OF SEIZURE ONSET: |
| NUMBER OF SEIZURES PER MONTH DURING THE LAST THREE MONTHS: |
| HOW ARE THE SEIZURES MANAGED? |
| CONDITIONS BEING TREATED: | TREATING PHYSICIAN: | PHONE NUMBER: |
| **DAILY MEDICATIONS:** |
| NAME | DOSAGE | TIME(S) GIVEN | HOW ADMINISTERED | REASON |
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| IS APPLICANT ON SPECIAL DIET (CHOPPED FOOD, LOW SODIUM, LOW CALORIE, ETC.? IF YES, PLEASE EXPLAIN: |

**REPORT OF TUBERCULOSIS SCREENING**

DATE

Name Date of Birth

**TO WHOM IT MAY CONCERN:**

**The above named individual has been evaluated by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.**

(Name of health dept/facility)

 A tuberculin skin test (PPD) is not indicated at this time due to the absence of symptoms suggestive of active tuberculosis, risk factors for developing active TB or known recent contact exposure.

 The individual has a history of a positive tuberculin skin test (latent TB infection). Follow-up chest x-ray is not indicated at this time due to the absence of symptoms suggestive of active tuberculosis.

 The individual either is currently receiving or has completed adequate medication for a positive tuberculin skin test (latent TB infection) and a chest x-ray is not indicated at this time. The individual has no symptoms suggestive of active tuberculosis disease.

 The individual had a chest x-ray on that showed no evidence of active tuberculosis. As a result of this chest x-ray and the absence of symptoms suggestive of active tuberculosis disease, a repeat film is not indicated at this time.

**Based on the available information, the individual can be considered free of tuberculosis in a communicable form.**

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (MD or Health Department Official)

 Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REPORT OF TUBERCULOSIS SCREENING**

DATE

Name Date of Birth

# **TO WHOM IT MAY CONCERN:**

**The above named individual has been evaluated by .**

 (Name of health dept/facility)

**Tuberculin Skin Test (PPD)**

Date given

Date read

Results : mm

 Negative

 Positive

Signature Date

(MD or Health Department Official)

Address Phone

**Chest X-ray Report – No active disease**

Date of Chest x-ray

 No evidence of active tuberculosis

**The individual listed above has no symptoms or radiographic findings compatible with active tuberculosis. The individual is free of tuberculosis in a communicable form.**

Signature Date

 (MD or Health Department Official)

Address Phone

**Chest X-ray Report – Abnormal Report**

Date of Chest x-ray

 Chest x-ray abnormal, active tuberculosis to be ruled out

**Active tuberculosis cannot be ruled out in the individual listed above. The individual should be referred to a physician or health department for further evaluation.**

Signature Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (MD or Health Department Official)

Address Phone

#  Virginia Support Group, LLC

Day Support Program

 **Annual Physical Exam Report**

**Physician Name:**  **Date of Exam:**

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Date of Birth | Age | Gender[ ] Female [ ] Male |

|  |
| --- |
| Vital Signs: HR\_\_\_\_ RR\_\_\_\_ BP\_\_\_\_ Temp.\_\_\_\_ Growth: Weight \_\_\_\_\_ lbs. \_\_\_\_\_ %  Height: \_\_\_\_\_inches \_\_\_\_ %  |

 **Review and Description of Systems** (Please note pertinent findings)

|  |
| --- |
| General [ ] fatigue [ ] fever [ ] weight loss [ ] diaphoresis |
| Skin [ ] persistent rash/spots [ ] acne [ ] tattoos |
| HEENT [ ] headache [ ] TMJ pain [ ] visual/hearing problems [ ] rhinitis [ ] sore throat [ ] frequent nosebleeds |
| Neck [ ] masses |
| Chest [ ] chronic cough [ ] wheezing [ ] DOE [ ] chest pain [ ] breast lumps/discharge |
| CVS [ ] murmurs [ ] HTN [ ] palpitations |
| GI [ ] abdominal pain [ ] vomiting [ ] diarrhea/constipation [ ] jaundice [ ] food intolerance |
| GYN [ ] cycle length [ ] flow [ ] dysmenorrhea [ ] vaginal discharge [ ] dyspareunia |
| GU [ ] dysuria [ ] discharge [ ] scrotal masses [ ] urinary frequency [ ] incontinence [ ] enuresis |
| CNS [ ] fainting [ ] LOC [ ] weakness [ ] tremor [ ] seizures |
| Muscles-skeletal [ ] scoliosis [ ] joint aches/swelling [ ] recent trauma [ ] limp [ ] sport injury |
| Nutrition [ ] usual eating habits [ ] currently dieting binges [ ] diet pills [ ] body image |
| Psychiatric [ ] depression [ ] suicide contemplated/attempted [ ] hallucinations [ ] previous psychological |

**Screening Tests Risk-Based Lab Tests**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Yes | No | Results |  | Yes | No | Results |
| Hearing |  |  |  | Venereal Warts  |  |  |  |
| Vision |  |  |  | Cultures for STDs  |  |  |  |
| Lead Poisoning |  |  |  | Blood test for STDs |  |  |  |
| Hemoglobin/ Hematocrit |  |  |  | Hepatitis screen  |  |  |  |
| Urine Analysis  |  |  |  | Tuberculosis |  |  |  |
| Other: |  | Other: |  |

|  |
| --- |
| **Overall Health/General Physical Condition:** |
| **Recommendations (Further treatment, referrals. Lab work, med change, other exams needed)** |
| **Specific Instructions (Dietary guidelines/mobility/activity restrictions; medication instructions.)** |

**Physician’s Name (Please print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician's Signature Date**



**Photo Release Form**

**AUTHORIZATION TO USE PHOTOGRAPHS AND/OR AUDIO-VISUAL**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, (Individual/Authorized Representative) agree to allow Virginia Support Group, LLC to use, reproduce, and/or publish photographs that may pertain to me—including my image, likeness without compensation. I understand that this material may be used in various publications, recruitment materials, and broadcast public service advertising (PSAs) or for other related endeavors. This material may also appear on the Virginia Support Group, LLC Internet Web Page. This authorization is continuous and may only be withdrawn by my specific rescission of this authorization.

Description of Material (Photos):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Individual/Authorized Representative Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Individual/Authorized Representative Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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



**RULES OF CONDUCT**

1. Individuals will be courteous and considerate of the rights of others at all times.
2. Individuals will participate and show an interest in their training programs.
3. No physical violence or threatening behavior will be tolerated.
4. No profanity or verbal abuse is permitted.
5. No weapons are allowed on the premises.
6. Alcohol or illegal substances in the possession of consumers, during service delivery, is prohibited and can result in suspension or termination from the Program.
7. Smoking during service delivery is limited to designated smoking areas and only if you have the legal right.
8. Sexual harassment is prohibited by this Program and can result in termination of services.
9. Sleeping is not allowed during service delivery.
10. Theft is not tolerated.
11. Consumers or authorized representatives will be held financially responsible for property damage caused by consumers. Continued incidents of destruction can result in suspension or termination of services.
12. Consumers are encouraged to comply with all passenger safety rules while traveling in agency or staff vehicles.
13. Consumer’s recurrent refusal to cooperate with training and/or assistance provided by program staff as agreed to in the Individual Service Plan can result in termination of Program services.
14. Individuals will adhere to safety standards and will participate in emergency training. When issues of safety are involved, the advice of the trainer/provider will be followed.
15. Lying or falsification of records will not be tolerated.

These rules are designated to maintain a safe and orderly environment for the consumers and staff, and will be fairly applied to all consumers of this Program. You are encouraged to help, modify, and enforce these rules. Anyone who violates these rules may be asked to leave the Program. A lesser action may be imposed if it is deemed appropriate by the administration of Virginia Support Group, LLC. These rules of conduct may change at any time that the need arises.

I have read or have had the Rules of Conduct explained to me, I agree to comply with these rules as long as I am a recipient of services from Virginia Support Group, LLC and I am aware of the consequences if I violate them.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Consumer/Legal Authorized Representative Signature Date

**IT IS YOUR RIGHT**

* TO BE TREATED WITH DIGNITY AND RESPECT
* TO BE TOLD ABOUT YOUR TREATMENT
* TO HAVE A SAY IN YOUR TREATMENT
* TO SPEAK TO OTHERS IN PRIVATE
* TO HAVE YOUR COMPLAINTS RESOLVED
* TO SAY WHAT YOU PREFER
* TO ASK QUESTIONS AND BE TOLD ABOUT YOUR RIGHTS
* TO GET HELP WITH YOUR RIGHTS

 **YOUR HUMAN RIGHTS ADVOCATE:** MR. REGINALD DAYE

 **ADDRESS:** EASTERN STATE HOSPITAL

 4601 IRONBOUND ROAD

 WILLIAMSBURG, VA 23187

 **PHONE:** 757-253-7061

 **EMAIL:** reginald.daye@dbhds.virginia.gov

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

 *Client/Authorized Representative*

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

 *Program Director*

**V**irginia **S**upport **G**roup**,** LLC

Form 80.B (4)

# **RELEASE OF INFORMATION**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize Virginia Support Group, LLC to release information pertaining to the services received at Virginia Support Group, LLC to:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

for the purpose of (indicate the specific reason): For program staff, physicians, social services, CSBs and all other essential contacts\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that authorization shall remain valid from the date of my signature below and for nine (9) months thereafter ending on: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

I have been informed that I may revoke this authorization by written or oral communication to the Virginia Support Group, LLC. I certify that this form has been fully explained to me and that I understand its contents.

Signature of Client Date of Authorization

Signature of Legal Authorized Representative Date

Form 80.B (4)

 Created 05/2011

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