6808 N Dysart Rd Suite 152
Glendale, AZ 85307
Office: 623 547-4839 and Fax: 623 547-4567
www.divinecare.org

# Member Consent Packet

**Date** _____

**Consumer Name** _____

**Date of Birth** _____/_____/_____ **Gender: Male** _____ **Female:** _____

**Address** _____

**City, State, Zip-code** _____

**Phone Number (_____)** _____

**Guardianship Status (please provide copies of supporting court documents)**

_____

_____

**Parent/Guardian** _____

**Mailing Address** _____

**City, State, Zip-code** _____

**Home Phone (_____)** _____ **Cell or Work Phone (_____)** _____

**Email Address** _____@_____

**Name and Address of School (if applicable)**

_____

| | |
|---|---|
| **Support Coordinator:** | |
| **Office:** | |
| **Address:** | |
| **Phone:** | |
| **Fax:** | |
| **Email:** | |

# Emergency Contact Information

**In case of an emergency and you are unable to be reached, who we should contact:**

**Name: _____ Relation _____**

**Address _____ Phone (  ) _____**

**Name: _____ Relation _____**

**Address _____ Phone (  ) _____**

---

**Member's Doctor's Name _____**

**Doctor's Phone _____**

**Hospital Preference _____**

**Hospital Address _____**

**Hospital Phone _____**

**Name of Health Plan/Medical Insurance _____**

**Group Number/ Policy Number _____**

**Primary Name on Insurance _____**

---

**Please list the name and relationship of any persons NOT authorized to pick up or interact with the consumer:**

| **Name** | **Relation** |
|---|---|
| _____ | _____ |
| _____ | _____ |

# Divine Care

6808 N Dysart Rd Suite 152
Glendale, AZ 85307
Office: 623 547-4839 and Fax: 623 547-4567
www.divinecare.org

Divine Care's goal is to offer excellent care to our members as well as to provide transparent services. Divine Care has a standing Open Door Policy, which means a parent or guardian at any time may visit our program and have full access to their member(s). All visitors are required to check-in at our administrative front desk and sign into the visitor's log. After the check-in process is completed parent/guardians will be escorted to visit their member(s). All visits in the community space will need to be limited to a few minutes, due to the need of protecting the privacy and rights of all our members, but if more visitation time is required member and visitor will be escorted to conference room or private space to continue visitation.

**Please initial that you have read and understand this letter regarding Divine Care's Open Door Policy.**

_____ _____

**Member's Signature (if applicable)** **Date**

_____ _____

**Responsible Person's Signature** **Date**

# Divine Care

6808 N Dysart Rd Suite 152
Glendale, AZ 85307
Office: 623 547-4839 and Fax: 623 547-4567
www.divinecare.org

**Dear Parents:**

**Divine Care is not responsible for personal items brought to the program or the replacement of those items. For example: toys, electronics, money, jewelry, or anything else of a personal nature. If your child/adult brings personal items from home and it is broken, lost or stolen, Divine Care will not reimburse you for the replacement.**

**Thank you,**
**Divine Care Staff**

**Please initial that you have read and understand this letter regarding the issue that Divine Care will not be held responsible for any personal items your child/adult brings to the program.**

_____ _____

**Member's Signature (if applicable)** **Date**

_____ _____

**Responsible Person's Signature** **Date**

# General Agreements and Consents

**I _____, certify that I am the**
(Full name of the legally responsible person)

**_____ of _____, who**
Relationship to the individual full name of the individual

**is supported by Divine Care LLC.**

**I consent to the following for members named above and supported by Divine Care for a period of time not to exceed 12 months from the date of the signature below.**

**(Check all that apply):**

- ☐ **Routine medical treatment.**
- ☐ **Emergency medical treatment.**
- ☐ **I request to receive a copy of Outcomes / Progress notes quarterly.**
- ☐ **Divine Care DOES NOT Administration over the counter medications without physician's orders.**
- ☐ **Participation in routine recreational/leisure activities.**
- ☐ **Participation in planned and un-planned field trips.**
- ☐ **Release of medical records.**
- ☐ **Release of educational records.**
- ☐ **Release of psychological records**.

_____ _____
**Member's signature (if applicable)** **Date**

_____ _____
**Responsible person's signature** **Date**

**Comments or exclusions to the consents:**

_____
_____
_____
_____

# Divine Care

## Member Picture Consent

**Date: _____**

**RE: _____ (print son/daughter's name)**

**I _____ (parent/guardian).**

**Please only check 1 box.**

☐ **agree to allow the staff of Divine Care, LLC to use my son, daughter's picture(s) or reproduction in their advertising brochures, pamphlets, newspaper print ads, job fair flyers, display boards, or other print media.**

**OR**

☐ **agree to allow the staff of Divine Care, LLC to use my son/daughter's picture(s) or reproduction on the Divine Care, LLC annually produced calendars only.**

**OR**

☐ **do not wish to have my son/daughter's picture(s) or reproduction used by Divine Care, LLC for any advertising brochures, pamphlets, newspaper print ads, job fair flyers, display boards, other print media nor the annual calendar.**

**This agreement will be valid for the duration that I am receiving service(s) by Divine Care, LLC, although I understand that the right to discontinue it at any time. Should my services discontinue, or should I choose retract this agreement, I understand that anything already in print will continue to be used.**

**If I decide to withdrawal my consent, I must give written notice to:**

6808 N Dysart Rd Ste 152
Glendale, AZ 85307

_____ _____

**Signature** **Date**

**elation to the member**

**Individual Information:**

Individual's Name: _____ M or F: _____ Date of Birth: _____

Name the individual prefers to be called: _____ Grade: _____

**Primary Guardian's Information:**

Primary Guardian's Name: _____ Cell Phone #: _____

Physical Address: _____

Mailing Address: _____

E-mail Address: _____ Home #: _____

Employer: _____ Employer Phone #:_____

**Secondary Guardian's Information:**

Secondary Guardian's Name: _____ Cell Phone #: _____

Mailing Address: _____

E-mail Address: _____ Home #: _____

Employer: _____ Employer Phone #:_____

List persons who can either pick up and/or assume responsibility for your individual in the event of an emergency if parents cannot be reached. At least one non-guardian contact person must be listed with their phone number:

Non-Guardian Contact Name: _____ Cell Phone #: _____

Does your individual have any health concerns (medications, chronic conditions, behavioral or cognitive disabilities) that we should know about in order to facilitate safe and successful participation? Yes or No

If yes, please describe: _____

Known allergies and reactions: _____

Medications and frequency of use: _____

Physician: _____ Phone #:_____

Dentist: _____ Phone #: _____

Please give any additional information concerning your child, which may be helpful: _____

**AUTHORIZATION FOR EMERGENCY MEDICAL CARE:**

I hereby give permission to the Divine Care staff to secure emergency medical and/or surgical treatment for my individual while in their care. All expenses of such care will be accepted by the parent(s)/legal guardian, including fees for an ambulance, if deemed necessary by staff. I realize attempts to reach me prior to any decisions will be made unless a life-threatening situation is at hand or circumstances do not allow.

Signed: _____ Date: _____

Parent or Legal Guardian