Community Mental Health of Ottawa County
New Respite Provider/Employee Registration

Respite Provider/Employee's General Information

Name:____
First Middle Last

Residence:____
Street City State Zip

Telephone: (____)________________ Social Security #.:______________________

Date of Birth:____________________ Driver's License # .:____________________

Have you ever been convicted of a crime? Yes/No If yes, please explain:____________

____

I will be providing Respite for: (Consumers Name)________________________________

Acknowledgment

By signing below:

1. I understand this information will be used to run a criminal background check.
2. I understand this information will be used by the Fiscal Intermediary to process respite vouchers and process payments.
3. I affirm all information in this application is true and complete.

___________________________________ ____________________
Respite Provider/Employee Signature **Date**

Moral Character Statement

This provider/employee is, in my opinion, of Good Moral Character and is a person who I feel comfortable providing care for my child.

Responsible Parent – Please print your full name and sign below

____
Full Name (Print)

_____________________________ ____________________
Signature Date

Community Mental Health of Ottawa County
Respite Provider/Employee Agreement

This agreement is entered into on this _____ day of __________________, 20__, by and between _________________________Consumer/Employer, and _______________________ ______, (Provider/Employee) a provider of Respite services. The purpose of this agreement is to outline the services the Consumer/Employer is purchasing from the Provider/Employee, and how the Provider/Employee shall be compensated for providing such services.

Terms and Conditions:

1. This agreement shall be in effect until such time as it is terminated or must be modified. Either party may initiate termination or modification by providing thirty (30) days written notice to the other of the desire to terminate or modify this agreement. This agreement may be terminated with or without cause. The nature of this agreement is a personal service agreement, and as such, in the event either party substantially breaches a term or condition of this agreement, the thirty (30) day notice requirement is waived. A copy of the written notice will be sent to the Community Mental Health Respite Specialist by the consumer employer once the termination process is finalized.

2. The Provider/Employee is responsible for completing the following three (3) training modules before authorization to provider respite services:
   Recipient Rights **Basic First Aid** **Infectious Disease**

3. The Consumer/Employer shall purchase Respite services from the Provider/Employee.

4. Complaints concerning the provision of services under this agreement shall be directed to 616.494.5441. The agency shall acknowledge receipt of a complaint within five (5) business days.

5. In compensation for providing the services outlined above, the Provider/Employee shall be paid an amount agreed to by the Consumer/Employer and Provider/Employee. The payment shall be paid within twenty-one (21) business days of receipt of the respite payment request at the Provider/Employee's address.

6. If a dispute arises concerning a payment issue, the Provider/Employee should contact the Consumer/Employer to resolve the issue. If the issue cannot be resolved with the Consumer/Employer, please call the respite payment specialist at 616.393.5647.

This agreement represents the entire understanding between the parties and supersedes any and all prior agreements, whether written or oral that may exist between the parties.

______________________________	__________________
Responsible Parent/Guardian - Employer	Date
______________________________	__________________
Respite Provider/Employee	Date
______________________________	__________________
CMHOC Respite Specialist	Date

Community Mental Health of Ottawa County
Criminal Background Check

Criminal Background Check Authorization Form

Employee Name: ____

Alias or Other Names Used:____

Employee Address:____

E-mail Address_________________________

Date of Birth: ___/___/____________ Sex M or F (Circle One)

Maiden Name: ___________________ Race: __________________

Driver's License Number: ________________________ Expiration Date:_____________

I authorize the release of my criminal background information to my employer, and to Community Mental Health of Ottawa County, which acts as project administrator; and to the "Fiscal Intermediary" which serves as my employer's financial administrator.

____

Employee Signature Date

Community Mental Health of Ottawa County
Respite Program
Respite Share Information

Respite Provider/Employee Name:______________________________________

Please check all that apply:

- ☐ No, I do not wish to share my name as a registered respite provider/employee with other families enrolled in the Respite Program at Community Mental Health of Ottawa County (CMHOC).
- ☐ Yes, I do wish to share my name as a registered respite provider/employee with other families enrolled in the Respite Program at Community Mental Health.
- ☐ I would also like to have my name and phone number made available at the Community Mental Health Access Center and Customer Services Department, for referring me to families in need of a respite provider, but who are not receiving any services through CMHOC.

If yes, please provide the following information:

Name: ______________________________________

Phone #:____________________________________

City: ____

Education/Experience: (Circle all that apply)	Associates Degree Bachelor's Degree Master's Degree Licensed Childcare Provider Licensed Foster Care Provider
Location of Care: (Circle all that apply)	In Providers Home Parent/Guardian's Home Community Setting
Willing to Provide Transportation?	____________________________
Population Served: (Circle all that apply)	MI (Person with Mental Impairment) DD (Person with Developmental Disability)

By signing this form I give Community Mental Health of Ottawa County permission to share the information I have provided with any families in the Respite Program for referral purposes.

_____________________________________ ________________________

Signature Date

Community Mental Health of Ottawa County
Recipient Rights Training Test
for Respite Providers

Directions: Review the Recipient Rights Training located at www.miottawa.org/cmhrespite. Once you have reviewed the training complete the test.

______________________________ ____________________
Name – Please print clearly Date

____
Respite Employer

Circle the Correct Answer

1. All information in a recipient's mental health record is considered ______________________.

   a. privileged b. legal c. confidential

2. Staff actions that are abusive must be stopped and ____________________________.

   a. reported b. disciplined c. corrected

3. The purpose of Recipient Rights Training is to assure, protect and promote the basic ______________________ dignity to which all recipients are entitled.

   a. legal b. human c. independent

4. _________ are a way to assure all ***unusual*** events involving recipients are documented/reported when something ***unusual*** occurs during a normal day/routine or outing.

   a. Unusual incidents b. Treatment plans c. Incident Reports

5. A right is that which is defined by ____________ and there must be a legal means of protecting it.

   a. government b. law c. the dictionary

6. Swearing at, using foul language, racial or ethnic slurs or making fun of a recipient would be considered___________.

   a. neglect b. abuse c. restrictive

7. Failing to report a suspected case of abuse or neglect is also considered______________.

   a. neglect   b. abuse   c. poor judgment

8. ___________ the recipient is always the first and most important responsibility of paid staff.

   a. Helping   b. Liking   c. Protecting

9. Informed _______ is based on the competency and knowledge of the person who is agreeing to something.

   a. consent   b. treatment   c. writing

10. A recipient has the right to live in the _______________ environment necessary to achieve appropriate treatment.

   a. most restrictive   b. least restrictive   c. most expensive

11. All recipients must be notified of their ________________ ______________ upon entering the mental health system.

   a. treatment plan   b. legal rights   c. individualized services

12. Talking to others about recipients, outside of the mental health system, who do not have a legal right to know the information, is a breach of__________________________.

   a. confidentiality   b. privileged information   c. the law

13. Who is legally responsible for providing translation accommodations under the ADA and Civil Rights law? __________________

   a. consumer   b. CMH   c. volunteer agency

14. It is illegal to open a recipient's mail.

   True   False

15. The Office of Recipient Rights cannot take disciplinary action with you for violating a recipient's rights.

   True   False

16. Medications are important. A recipient may be forced to take their medications.

True False

17. Recipients you are paid to support retain their civil rights in addition to their legal rights (i.e. Michigan Mental Health Code), when they are receiving mental health services.

True False

18. HIPAA (Health Insurance Portability and Accountability Act of 1996) includes Protected Health Information (PHI) and gives recipients more control over their health information and sets boundaries on the use and release of health records.

True False

19. The law says when you see or hear about a recipient being abused or neglected, you must take action <u>immediately</u> and report all allegations to the Recipient Rights Office.

True False

20. A Recipient Rights Complaint Form must be used when there is reasonable cause to believe a recipient's rights have been violated by a paid staff.

True False

21. Unlimitable rights include the recipient's right to be free from abuse and neglect, to be treated with dignity and respect, and the right to live in a safe, sanitary and humane treatment environment.

True False

22. It is OK to share information about a recipient with family members without written consent.

True False

23. Rights can be limited/restricted, but the limitation/restriction needs to be documented in the recipients Individual Plan of Service (IPOS) and/or Behavior Treatment Plan (BTP).

True False

24. Anyone may file a Recipient Rights Complaint on behalf of a recipient, at any time.
.

True False

25. A recipient tells you that he has been hurt by a staff person. The recipient is angry and wants something done.

a. You do nothing. You do not believe what this person just told you.
b. You help the person fill out a Recipient Rights Complaint Form and help them mail the form to the Recipient Rights Office.
c. You do "b" with the addition of telling your supervisor, calling the Recipient Rights Office and writing an Incident Report.

Community Mental Health of Ottawa County
Basic First Aid Test

Directions: Review the Basic First Aid Training located at www.miottawa.org/cmhrespite. Once you have reviewed the training complete the test.

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1. It is very important to know where to find the first aid supplies and emergency numbers when you are the responsible adult caring for someone.

   True False

2. If someone is choking but can cough and make noises, stand by and let them cough.

   True False

3. Firm, ________ pressure with clean or sterile bandages is one of the first steps in caring for a bleeding wound.

   a. soft
   b. gentle
   c. direct
   d. indirect

4. First aid for a burn includes cooling the area with large amounts of________.

   a. butter
   b. vaseline
   c. ice
   d. cool water

5. If someone has a nosebleed, you should have the person lean back and look to the ceiling.

   True False

6. Use a cool water spray for someone who is experiencing a heat related-injury

   True False

7. When someone is experiencing a cold-related injury the first thing you should do is lie down next to them and use your own body heat to warm them.

   True False

8. If someone ingests or comes in contact with something potentially poisonous, the first call you should make is to ________and follow their instructions.

    a. CMH
    b. Poison Control
    c. their family doctor
    d. Dr. Oz

9. If you suspect a head injury and a person is unconscious, do not move the person.

    True False

10. If someone is having a seizure, you should put something in their mouth and try to stop them from chocking on or biting their tongue.

    True False

11. If someone is experiencing shock, keep them still and cover them with a blanket until emergency medical personnel arrive.

    True False

12. If a tooth is loose, have the person bite down on a piece of gauze and call a dentist.

    True False

13. If someone is experiencing pain in one eye they should keep both eyes closed to decrease irritation and/or further injury.

    True False

14. When an object punctures or penetrates a part of someone's body________.

    a. pull it out
    b. push it in further
    c. leave it there
    d. dump peroxide on it.

15. When someone is bit by a tick it is best to leave it attached until it lets go on its own.

    True False

16. If a part of someone's body is amputated, call 911.

    True False

17. If someone has a potentially broken bone or has a sprain, reduce the movement of the injured area and suggest they see a medical professional.

    True False

18. If someone is electrocuted, the first thing you should do is________.

    a. grab them and pull them out of the area.
    b. shut off the power and call 911.
    c. throw a rope to them and try to pull them out.
    d. shout at them to stop, drop, and roll.

19. If you are transporting someone you are caring for, it would be a good idea to have a first aid kit in your backseat or trunk.

    True False

20. If there is an insect stinger embedded in someone's skin, scrape it out and wash the area with soap and water.

    True False

NAME (PRINTED): ______________________________________ DATE: ______________

SIGNATURE: ____

Community Mental Health of Ottawa County
Infectious Disease Test

Directions: Review the Infectious Disease Training located at www.miottawa.org/cmhrespite. Once you have reviewed the training complete the test.

1. Pathogens are germs that most commonly enter through your skin or mucous membranes.

   True False

2. There is a vaccine available for Hepatitis B.

   True False

3. You do not need to report blood borne pathogen exposures.

   True False

4. Hepatitis C is the most chronic blood borne pathogen in the United States.

   True False

5. Know where the gloves and disinfecting supplies are located in the home you work in.

   True False

6. Blood, semen, and vaginal secretions are all potentially infectious body fluids.

   True False

7. You can contract HIV/AIDS by kissing.

   True False

8. MRSA is a staph infection that is resistant to some antibiotics.

   True False

9. Universal Precautions means that even when a situation is perceived as “low risk” we still need to act is if blood and other body fluids are potentially harmful.

   True False

10. If you are transporting someone you are caring for it would be a good idea to have a first aid kit in your backseat or trunk.

    True False

Name (Printed): ___________________________________

Signature: ______________________________________ Date: _____________