Toward Independent Living & Learning, Inc.
20 Eastbrook Road
Dedham, MA 02026
(781) 302-4600

Dear Applicant:

Thank you for your interest in becoming a Shared Living/Adult Foster Care Provider for TILL, Inc. This can be an exciting opportunity for the right person or family.

Enclosed is a packet of information about becoming a provider. The packet includes the following information:

-Fact Sheet
-Provider Responsibilities
-Application for Consulting Work
-Home Care Provider Application
-"CORI" Policy – 2 copies have been enclosed
-HIPAA Packet

PLEASE NOTE: A CORI Packet must be completed for any person living in the home over the age of 14 years. Please make additional copies of the CORI packet if needed.

Please read all information carefully. You will need to submit the application and CORI packet completely and return it to me. All information **MUST** be done in **INK**. A copy of your **current Driver's License** must be included along with the completed CORI form in order for us to obtain a report.

Once all information is submitted, you will be contacted by one of the managers in our department to complete the rest of the application process.

We are currently looking for providers in the Metro West area (Natick, Framingham), South Shore area (Quincy, Braintree, Randolph and Weymouth), Metro Boston area (Boston, Hyde Park, Roslindale and Dorchester) and Newton, Waltham and Brookline area. Please note that if you live in the Brockton area, we may not pursue your application immediately, since we currently have many approved providers in that area.

If you choose to submit a completed application, you should be aware that we will be screening and approving homes as needed in each area. Please note that TILL, Inc. receives referrals for placement from different state agencies, private families and individuals, so there may be some delay in placing someone in your home based on the location being requested for placement.

Once you have completed the application, please send it back to our office to the attention of Tammy Scott.

If you have any questions, please contact me at (781) 302-4695.

Sincerely,

Alan K. White
Director of Residential Alternatives

enclosures

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FACT SHEET
SPECIALIZED HOME CARE/SHARED LIVING/ADULT FOSTER CARE

WHAT IS SPECIALIZED HOME CARE/SHARED LIVING?

Individualized community-based living for persons with developmental disabilities. Individuals are matched with families, couples, or single persons who can provide the optimal environment for individual growth and independence.

Families, couples, or individuals are referred to as "providers" and receive a stipend and room and board payments in exchange for the responsibilities outlined below. Providers are active members of the individual's overall service team.

WHO BENEFITS FROM SHC?

Individuals of all ages and abilities can benefit from this time of living situation. Specialized Home Care was developed to meet the needs of people with disabilities, who would be better served in an alternative type of living situation. Currently, individuals living in these situations have a wide range of abilities and disabilities, such as mental retardation, autism, emotional difficulties, physical disabilities and medical needs. These individuals have previously lived at home with their family or in other residential situations. They are all individuals who would benefit from a residential option that is small and family-oriented. The length of the placement varies depending on the individual's choices and needs. The decision to pursue this type of placement is determined by individual clinical and programmatic teams.

WHAT ARE THE RESPONSIBILITIES OF THE PROVIDER?

- Provide skills training in domestic skills, socialization money management. Communication personal hygiene, community participation, etc.
- Be an active member of the service team
- Keep records in accordance with DDS requirements
- Participate in supervision and ongoing training
- Support other treatments, i.e., behavioral interventions, counseling
- Ensure preventative health and dental needs are being met
- Schedule and ensure follow through on medical and other appointments

HOW DOES IT WORK?

Individuals with disabilities are referred by the families and state agencies. The individual's residential needs are assessed by a SHC Manager and are done in conjunction with the team members, including family members. The Manager will recommend the optimal livening option for the individual, which includes an outline of provider characteristics that match the individual's needs. Funding is discussed and secured with the referral source. Providers are recruited and trained specifically to address the person's needs. Transition occurs over a two to four week period in order to assess the appropriateness of the match.

Placements are monitored closely by the SHC Manager through the provider agency and the funding source to ensure the person's needs are being met. This is done through visits to the home, day program, communication with the family and/or other team members. SHC Managers are required to visit the home at least one time per month as needed. DMR Service Coordinators are also required to visit regularly as well as develop an Individuals Support Plan (ISP) for each person.

SHC placements are considered permanent residential placements. A provider may have a maximum of 3 individuals placed in their home at any given time, although typical only one or two people are placed in a provider's home. Each provider and situation is evaluated individually based on the skills of the provider's home. Each provider and situation is evaluated individually based on the skills of the provider and the needs of the individuals living in the home.

WHAT IS ADULT FOSTER CARE?
Adult Foster Care is a program overseen by the Division of Medical Assistance-Medicaid. AFC can be used alone or in conjunction with SHC funding through DMR.

Individuals may be eligible for AFC, in addition to DMR funding; if it is determined they have significant medical needs that meet the DMA eligibility criteria. Once approved, DMA becomes the lead agency and DMR becomes the secondary agency. DMR funding is then known as "wrap" money.

AFC provides additional oversight to ensure the medical needs of a person are being met. There are nurses and social workers assigned to the person and provide ongoing case manager, in addition to the oversight provided through SHC.

AFC also provides additional funding to the provider for daily care of an individual. Some agencies will develop an interagency agreement to specify which agency is responsible for implementing each part of the Individuals Support plan.

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08/15

SHARED LIVING PARTNERSHIP

Provider Responsibilities

1. Establish a routine of cooperation between the partners in the living arrangement.

2. Create routines for managing household chores, joint meal planning, and cooking training.

3. Hold home meetings each week to discuss plans for the week regarding banking, grocery shopping, and recreational plans. At this time other issues pertaining to everyday living can be discussed and resolved.

4. Assist in setting up transportation or provide transportation for medical appointments and recreational dates as deemed necessary.

5. All household members will share sit-down meals each week day.

6. Provide financial support by paying bills on time and do banking and budgeting on a weekly basis with the individual.

7. Maintain the home in keeping with TILL's written home standards, including interior and exterior.

8. Provide written monthly progress reports and verbal reports of significant events as they occur to the Case Manager. Inform the Case Manager at least one week prior to any vacation.

9. Follow designated protocol in emergencies (call Case Manager, police and fire emergency and beeper).

10. Maintain contact with the individual'svocational program and other significant people in the community (e.g., friends and family).

11. Attend ISP meetings and follow through on any ISP goals.

12. Mow the lawn if appropriate in this setting.

13. Maintain a clean, orderly house at all times.

14. Ensure proper nutrition and well balanced meals.

15. Maintain stairs, walkways, driveways and sidewalks free and clear of snow and ice.

16. Plan with the individual for recreational and social activities to encourage active participation in the community.

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HOME CARE PROVIDER APPLICATION

Today's Date__________________

I, (We) hereby apply to Toward Independent Living and Learning (TILL), Inc., to provide Residential Home Care Services.

PROVIDER APPLICANT | **Date of Birth** | **Social Security No.**

________________________________ ____/____/______ ______________________
Name (last) (first) (middle) Month/Day/Year

________________________________ ____/____/______ ______________________
Spouse/Significant Other Name (last) (first) Month/Day/Year

Phone_________________________(home) Phone_________________________(work)

Address____

____

Marital Status Single___ Married___ (Yrs) Divorced___ (Yrs) Widowed___ (Yrs) Separated___ (Yrs)

I would prefer to provide services for males [ ] females [ ] doesn't matter [ ] ages _____ to _____.

OTHER HOUSEHOLD MEMBERS

Name	Relationship to Care Provider(s)	Age

Do any members of your household have a disability or a communicable disease? Yes _____ No

Do you have any pets? Yes _____ No _____ If yes, what kind? How many?_______________________

Names and ages of children not living in the home____

____

EMPLOYMENT HISTORY

DATES - MONTH/YEAR	EMPLOYER	POSITION	REASON FOR LEAVING

Highest degree/diploma earned to date________________ Area of concentration_____________________

List relevant professional training and dates:

____

____

____

Do you plan to continue your education? Yes _____ No _____ If so, when?_______________________

Current employment of spouse/significant other____

REFERENCES (List three references, at least one of whom is a previous employer)

Name	**Occupation**	**Phone Number**

In addition, it is a TILL policy to perform a reference check and a criminal record check for all applicants.

DESCRIPTION OF HOME

Do you own [ ] Rent [ ] your present home?

Number of Rooms Total ________ Bedrooms

Type of Heating Central [ ] Type (oil, gas, etc.)
Installed electric [ ] Other ____

Water Supply Public [ ] Private [ ]
Both hot and cold [ ] **NH only - Submit copy of water analysis**

Sewer System Public [ ] Private [ ]

Are you willing to relocate? Yes _____ No _____ If so, list preferred communities__________________

____

QUESTIONNAIRE

1. Have you ever applied to operate a Specialized Home Care home or foster home for any public or private agency before? Yes ____ No ____ If yes, list each individual's age, dates of placement and agency:

____

____

____

____

2. Have you worked with individuals with developmental or physical disabilities before? Yes ____ No

____

3. How did you learn of, or who referred you to, this program?

____

4. Which of the following would you say is the most accurate description of individuals with developmental disabilities? **Circle your answer.**

   a. Sick or unwell individuals
   b. Somehow less than human
   c. Dangerous to society
   d. Individuals to be pitied
   e. The responsibility of charitable groups
   f. Holy or innocent individuals
   g. None of the above

5. At what age does human development stop, that is, when is a person too old to grow further? Please comment for people with and without developmental disabilities.

____

____

____

6. Can you think of some of the basic rights which our society has denied people with developmental disabilities in the past?

____

____

7. The term "sexual needs" refers to many other things in addition to sexual intercourse. Can you think of one or two examples?

____

____

8. Is a person who is developmentally disabled considered legally to be incompetent? Yes ______ No
Explain briefly.

____

9. Have you ever thought about examining someone's behavior and making a plan to change it?

Yes _____ No _____ ____

10. Please indicate on the following list which of the behaviors you could tolerate or work to change with the person sharing your home. The list is meant to be as comprehensive as possible. You should not expect to have a person with all of the behavioral issues identified below!

Behaviors	Could Cope	Could Not Cope	Could Cope with Assistance	Behaviors	Could Cope	Could Not Cope	Could Cope with Assistance
has social needs (e.g., have friends in)				drinks alcoholic beverages			
wants family to visit				is untidy			
is defiant				has poor hygiene			
is stubborn				sleeps all day			
bullies others				is forgetful			
talks back				has excessive fears			
lets self be pushed around				wets bed			
is withdrawn				wakes during night			
is destructive				feels despondent			
is self-abusive				masturbates			
is overly dependent				smokes			
talks incessantly				lies, blames others			
sucks thumb				has seizures			
has speech problems				is manipulative			
bites nails or chews clothes				Won’t eat or vomits after eating			
has unattractive appearance							

11. From this list of different qualities and characteristics, which five most describe you? **Please circle five.**

fatherly	motherly	like to instruct	enthusiastic
relaxed	neat	casual	calm
clean	orderly	idealistic	cheerful
athletic	musical	artistic	good manager
self reliant	trusting	able to keep a secret	skeptical
supportive of others	dependent	tolerant	well known in the community
submissive	modest	liberal	creative
strong	able to ask for help	authoritarian	daring
careful	listener	enjoy pleasing others	competitive
assertive	shy	express feelings easily	inquisitive
outspoken	honest	tactful	achieving
active	independent		

Are there other words you would use to describe yourself?____

12. Is it important to have feminine qualities if you are female or masculine qualities if you are male?

Yes ___ No ____ ____

13. In a marriage or relationship, who should decide the following?

a. number of children
b. to buy a house
c. budgeting of income
d. what job would you take
e. what job the other should take

14. In what ways are you **like** the parent of your own sex?____

____

____

In what ways are you **different?**____

____

____

15. Are you a spiritual person? Yes ___ No ____ ____

16. Do you attend a religious service or participate in church activities? Yes ___ No
Regularly? Yes ___ No ____ ____

17. Do you feel that you have control over your own life or that the direction of your life has been set by forces beyond your control?

____

18. How important is keeping a tidy house?____

19. If a member of your household appears moody, how do you generally respond?

____

20. Is your way of life gratifying to you at the present?

____

21. What satisfaction do you most expect to gain in caring for a person with developmental disabilities?

____

22. Where were you brought up?____

23. Where were your parents brought up?____

24. What were the occupations of your parents?
    Father: ____
    Mother: ____

25. In how many places have you lived? Specify according to:
Childhood __________________________ Adulthood
Where are the last two places you lived?

____

____

26. How long have you lived in your present home?____

27. Do you want to share your home for long or short periods of time?_______________________

____

28. Have you ever worked with a social worker or a Case Manager? Yes _____ No
Under what circumstances?____

29. What is your understanding of a social worker's or Case Manager's job with individuals with developmental disabilities?

____

30. Care Providers are considered an integral part of the agency, that is, part of the service team. With this in mind, what functions do you think are most important for the Care Provider to perform?

____

____

31. Describe your experience in working with a team. What were the positive and negative aspects?

____

____

32. Give a description of why you want to be a Care Provider.______________________________

____

____

BACKGROUND FAMILY RELATIONSHIPS

1. List all the members of the family in which you grew up. Include your parents, step or foster parents, full, half, foster and step brothers and sisters. List all others who lived with you.
   Was the family closeknit? Yes _____ No

NAME	RELATIONSHIP	OCCUPATION	AGE	DATE OF DEATH; AGE AT DEATH
1.				
2.				
3.				
4.				
5.				
6.				

2. Who was the closest to you while you were growing up?______________________________

3. Who is close enough to you now to advise you on personal, financial, or other important matters? (You may include relatives, friends, co-workers, clergy, etc.)

NAME	RELATIONSHIP
1.	
2.	
3.	

Have you discussed, with your closest advisors, your wish to share your home with a person with developmental disabilities? Yes _____ No

If yes, what was their reaction? (disapproval, approval, indecision, etc.)______________________________

NAME	RELATIONSHIP	REACTION
1.		
2.		
3.		

5. If your advisors disapprove of your decision, will you respond to their feelings; and if so, how?

____

____

____

HOME SUPPORTS

Do you have family and/or friends who will help you in providing care for a person with developmental disabilities living in your home, everyday and in the event of an emergency? Yes _____ No _____

If yes, please list name, relationship and telephone number.

NAME	RELATIONSHIP	TEL. NO.

Please fill out the following page with explicit directions to your home.

Applicant's Name

Address____

Please give detailed directions for reaching your home by car.

Toward Independent Living & Learning, Inc.
20 Eastbrook Road
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(781) 302-4600

PLEASE READ AND MAINTAIN FOR YOUR OWN RECORDS

"CORI" POLICY

TILL, Inc., has been approved by the Criminal History Systems Board and the Security and Privacy Council of the Commonwealth of Massachusetts for access to Criminal Offender Record Information ("CORI") pursuant to M.G.L. C.6 172 (c). "CORI" checks will be done on all employees, volunteers, consultants or providers, or if a current employee, volunteer, consultant or provider's position changes in a way which necessitates a "CORI" check according to state or federal regulations.

This process will be used to verify information which individuals provide on their applications. Our current policy of terminating employees, volunteers, consultants and providers who knowingly provide false information on applications and on their New Employee, Volunteer, Consultant, or Provider Authorization Form will continue.

The existence of "CORI" information in and of itself will not necessarily affect an individual's eligibility for work, volunteer services or consultant work. Decisions regarding the relevance of record information will be made on an individual basis.

Any information received as a result of a "CORI" check is confidential information. The only individual at TILL who are authorized to receive "CORI" information is the Vice President of Human Resources. All information received will be kept in a locked file separate from the individual's file.

Individuals will be required to sign a form authorizing TILL, Inc., to conduct a "CORI" check. Such authorization will be a condition of employment, consultant, provider or volunteer services.

Where Criminal Offender Record Information (CORI) checks are part of a general background check for employment, consultant, provider and volunteer services or licensing purposes, the following practices and procedures will generally be followed.

I. CORI checks will only be conducted as authorized by CHSB. All applicants will be notified that a CORI check will be conducted. If requested, the Employee, Consultant, Provider or Volunteer will be provided with a copy of the CORI policy.

II. An informed review of a criminal record requires adequate training. Accordingly, all personnel authorized to review CORI in the decision making process will be thoroughly familiar with the educational materials made available by CHSB.

III. Unless otherwise provided by law, a criminal record will not automatically disqualify an employee, provider, consultant or volunteer. Rather, determinations of suitability based on CORI checks will be made consistent with this policy and any applicable law or regulations.

IV. If a criminal record is received from CHSB, the authorized individuals will closely compare the record provided by CHSB with the information on the CORI request form and any other identifying information provided by the employee, consultant, provider or volunteer, to ensure the record relates to the employee, consultant, provider or volunteer.

V. If TILL, Inc. Is inclined to make an adverse decision based on the results of the CORI check, the employee, consultant, provider or volunteer will be notified immediately. The employee, consultant, provider or volunteer shall be provided with a copy of the criminal record and the organization's CORI policy, advised of the part(s) of the record that make the individual unsuitable for the position or license, and given an opportunity to dispute the accuracy and relevance of the CORI record.

VI. Employees, consultants, providers or volunteers challenging the accuracy of the policy shall be provided a copy of CHSB's Information Concerning the Process in Correcting a Criminal Record. If the CORI record provided does not exactly match the identification information provided by the employee, consultant, provider or volunteer, TILL, Inc. will make a determination based on a comparison of the CORI record and documents provided by the employee, consultant, provider or volunteer. TILL, Inc. may contact CHSB and request a detailed search consistent with CHSB policy.

VII. If TILL, Inc. reasonably believes the record belongs to the employee, consultant, provider or volunteer and is accurate, based on the information as provided in section IV on this policy, then the determination of suitability for the position or license will be made. Unless otherwise provided by law, factors considered in determining suitability may include, but not limited to the following:

a) Relevance of the crime to the position sought;
b) The nature of the work to be performed;
c) Time since the conviction;
d) Age of the candidate at the time of the offense;
e) Seriousness and specific circumstances of the offense;
f) The number of offenses;
g) Whether the applicant has pending charges;
h) Any relevant evidence of rehabilitation or lack thereof;
i) Any other relevant information, including information submitted by the candidate or requested by the hiring authority

VIII. TILL, Inc. will notify the employee, consultant, provider or volunteer of the decision and the basis of the decision in a timely manner.

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20 Eastbrook Road
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XTILLC
EOHHS

CORI REQUEST FORM

	Initials of person leaving this form for Human Resources

Toward Independent Living and Learning, Inc., has been certified by the Criminal History Systems Board for access to conviction and pending criminal case data. As an employee, volunteer, consultant or provider for the position of _________________________, I understand that a criminal record check will be conducted for conviction and pending criminal case information only and that it will not necessarily disqualify me. The information provided above is correct to the best of my knowledge.

☒ ____
Employee/Consultant/Volunteer/Provider Signature

EMPLOYEE/CONSULTANT/VOLUNTEER/PROVIDER INFORMATION

______________________ ______________________ ______________________
LAST NAME **FIRST NAME** **MIDDLE NAME**

________________________________ ________________
MAIDEN NAME OR ALIAS (IF APPLICABLE) **PLACE OF BIRTH**

DATE OF BIRTH: ____/____/____
Month Day Year

____
SOCIAL SECURITY NUMBER

____
MOTHER'S MAIDEN NAME
(Last Name) (First Name)

FORMER ADDRESSES:____

____

SEX:_____ **HEIGHT:**__**ft.** __**in.** **WEIGHT:**______ **EYE COLOR**:_________

STATE DRIVER'S LICENSE NUMBER:____

*****THE ABOVE INFORMATION WAS VERIFIED BY REVIEWING THE FOLLOWING FORM OF GOVERNMENT ISSUED PHOTOGRAPHIC INDENTIFICATION:**

____

Requested by:____ ________________
Signature of CORI Authorized Employee Date Submitted
Vice President of Human Resources

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f) The number of offenses;
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CORI REQUEST FORM

	Initials of person leaving this form for Human Resources

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☒ ____
Employee/Consultant/Volunteer/Provider Signature

EMPLOYEE/CONSULTANT/VOLUNTEER/PROVIDER INFORMATION

______________________	______________________	______________________
LAST NAME	**FIRST NAME**	**MIDDLE NAME**

______________________________ ________________
MAIDEN NAME OR ALIAS (IF APPLICABLE) **PLACE OF BIRTH**

DATE OF BIRTH: ____/____/____
Month Day Year

______________________ ______________________
SOCIAL SECURITY NUMBER **MOTHER'S MAIDEN NAME**
(Last Name) (First Name)

FORMER ADDRESSES:____

____

SEX:_____ HEIGHT:__ft. __in. WEIGHT:_____ EYE COLOR:_________

STATE DRIVER'S LICENSE NUMBER:______________________________

*****THE ABOVE INFORMATION WAS VERIFIED BY REVIEWING THE FOLLOWING FORM OF GOVERNMENT ISSUED PHOTOGRAPHIC INDENTIFICATION:**

____

Requested by:______________________________________ ________________
Signature of CORI Authorized Employee Date Submitted
Vice President of Human Resources

March 31, 2003

Business Associate Contract Provisions
to comply with the HIPAA Privacy Rule

I: Definitions:

Terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms in the Privacy Rule.

Examples of specific definitions:

a. Business Associate. "Business Associate" shall mean ________________________
Business Associate Name

b. Covered Entity. "Covered Entity" shall mean TILL, Inc.

c. Individual. "Individual" shall have the same meaning as the term "individual" in 45 CFR § 164.501 and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).

d. Privacy Rule. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E.

e. Protected Health Information. "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR § 164.501, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

f. Required By Law. "Required By Law" shall have the same meaning as the term "required by law" in 45 CFR § 164.501.

g. Secretary. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his designee.

II: Obligations and Activities of Business Associate:

a. Business Associate agrees to not use or disclose Protected Health Information other than as permitted or required by the Agreement or as Required By Law.

b. Business Associate agrees to use appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this Agreement.

c. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement. Business Associate agrees to report to Covered Entity any use or disclosure of the Protected Health Information not provided for by this Agreement of which it becomes aware.

d. Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by Business Associate on behalf of Covered Entity agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information.

e. Business Associate agrees to provide access, at the request of Covered Entity, and in the time and manner agreed upon, to Protected Health Information in a Designated Record Set, to Covered Entity or, as directed by Covered Entity, to an Individual in order to meet the requirements under 45 CFR § 164.524.

f. Business Associate agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 CFR § 164.526 at the request of Covered Entity or an Individual, and in the time and manner agreed upon.

g. Business Associate agrees to make internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity available to the Covered Entity, or to the Secretary, in a time and manner agreed upon or designated by the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.

h. Business Associate agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR § 164.528.

i. Business Associate agrees to provide to Covered Entity or an Individual, in time and manner agreed upon, information collected in accordance with Section [Insert Section Number in Contract Where Provision (i) Appears] of this Agreement, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR § 164.528.

III: Permitted Uses and Disclosures by Business Associate:

Except as otherwise limited in this Agreement, Business Associate may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, Covered Entity provided that such use or disclosure would not violate the Privacy Rule if done by Covered Entity or the minimum necessary policies and procedures of the Covered Entity.

IV: Specific Use and Disclosure Provisions:

Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

a. Except as otherwise limited in this Agreement, Business Associate may disclose Protected Health Information for the proper management and administration of the Business Associate,

provided that disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

b. Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information to provide Data Aggregation services to Covered Entity as permitted by 42 CFR § 164.504(e)(2)(i)(B).

c. Business Associate may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with § 164.502(j)(1).

V: Obligations of Covered Entity:

Provisions for Covered Entity to Inform Business Associate of Privacy Practices and Restrictions

a. Covered Entity shall notify Business Associate of any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45 CFR § 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of Protected Health Information.

b. Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information, to the extent that such changes may affect Business Associate's use or disclosure of Protected Health Information.

c. Covered Entity shall notify Business Associate of any restriction to the use or disclosure of Protected Health Information that Covered Entity has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of Protected Health Information.

VI: Permissible Requests by Covered Entity:

Covered Entity shall not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by Covered Entity.

Term and Termination

a. Term. The Term of this Agreement shall be effective as of April 14, 2003, and shall terminate when all of the Protected Health Information provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this Section.

b. Termination for Cause. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall either:

Provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Agreement.

Immediately terminate this Agreement if Business Associate has breached a material term of this Agreement and cure is not possible;

or

If neither termination nor cure are feasible, Covered Entity shall report the violation to the Secretary.

VII: Effect of Termination:

Except as provided in paragraph (2) of this section, upon termination of this Agreement, for any reason, Business Associate shall return or destroy all Protected Health Information received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.

In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon that return or destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

VIII: Miscellaneous

a. Regulatory References. A reference in this Agreement to a section in the Privacy Rule means the section as in effect or as amended.

b. Amendment. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy Rule and the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191.

c. Survival. The respective rights and obligations of Business Associate under Section VII of this Agreement shall survive the termination of this Agreement.

d. Interpretation. Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy Rule.

______________________	Kevin M Stock
For the Business Associate	For TILL, Inc
______________________	April 7, 2003
Date	Date

Toward Independent Living & Learning, Inc.
20 Eastbrook Road
Dedham, MA 02026
(781) 302-4600

SPECIALIZED HOME CARE

COMMUNICABLE DISEASE STATEMENT

*FILL OUT TOP PORTION OF THIS FORM AND THEN HAND TO A PHYSICIAN TO COMPLETE.

Provider/Adult Member of Household____

Date of Birth

Address____

****
THIS SECTION TO BE COMPLETED BY PHYSICIAN.

I hereby certify that, based on clinical observation and/or laboratory test(s), the above-named individual is free of serious communicable disease.

This certification is based on the results of the following examinations and/or laboratory tests:

Routine physical exam ____

Other clinical observation (please specify) ___________________________

____

Laboratory test(s) ____

The above-named individual has tested positive for the following communicable disease(s):

Recommendations for treatment and/or prevention:

____
Physician's Signature Date

____
Physician's Address

Toward Independent Living & Learning, Inc.
20 Eastbrook Road
Dedham, MA 02026
(781) 302-4600

SPECIALIZED HOME CARE

51-A STATEMENT
CHILD ABUSE STATEMENT

FOR APPLICANTS AND ALL ADULT MEMBERS OF HOUSEHOLD TO COMPLETE

READ & INITIAL ONLY THE APPROPRIATE STATEMENT

__________ Initial	As an adult member of a household applying to become a Specialized Home Care Provider family, I hereby confirm that I **have no knowledge** of any reports, substantiated or unsubstantiated, filed against me naming me as a perpetrator of child abuse or neglect under Massachusetts General Laws (MGL) Chapter 119 Section 51A-C.
__________ Initial	I hereby confirm that I **have knowledge** of a report (or reports) filed against me naming me as a perpetrator of child abuse or neglect under MGL C.119 S.51A-C. However, I wish to discuss the matter in greater detail and proceed with the application/homestudy process to become a Specialized Home Care Provider family. I realize that this issue will be weighed heavily in considering my application, and may prevent me (us) from becoming a Specialized Home Care Provider. **Initialing this statement will require a written explanation on a separate sheet of paper.*

____

Signature Date

____

Name (print or type)

Toward Independent Living & Learning, Inc.
20 Eastbrook Road
Dedham, MA 02026
(781) 302-4600

SPECIALIZED HOME CARE

19-C STATEMENT
DISABLED PERSON'S PROTECTION COMMISSION STATEMENT

FOR APPLICANTS AND ALL ADULT MEMBERS OF HOUSEHOLD TO COMPLETE

READ & INITIAL <u>ONLY</u> THE APPROPRIATE STATEMENT

________ Initial	As an adult member of a household applying to become a Specialized Home Care Provider family, I hereby confirm that I **<u>have no knowledge</u>** of any reports, substantiated or unsubstantiated, filed against me to the Disabled Person=s Protection Commission naming me as a perpetrator of abuse or neglect of an adult with a disability under Massachusetts General Laws (MGL) Chapter 19C
________ Initial	I hereby confirm that I **<u>have knowledge</u>** of a report (or reports) filed against me to the Disabled Person=s Protection Commission naming me as a perpetrator of abuse or neglect under MGL Chapter 19C. However, I wish to discuss the matter in greater detail and proceed with the application/homestudy process to become a Specialized Home Care Provider family. I realize that this issue will be weighed heavily in considering my application, and may prevent me (us) from becoming a Specialized Home Care Provider. **Initialing this statement will require a written explanation on a separate sheet of paper.*

____

Signature Date

____

Name (print or type)

Toward Independent Living & Learning, Inc.
20 Eastbrook Road
Dedham, MA 02026
(781) 302-4600

SPECIALIZED HOME CARE

CRIMINAL RECORD STATEMENT

*** * * * * FOR ALL APPLICANTS TO COMPLETE * * * * ***

As an adult member of a household applying to become a Specialized Home Care Provider family, I hereby confirm that I have no criminal convictions in the past, nor do I have any knowledge of outstanding criminal charges filed against me either in the Commonwealth of Massachusetts or anywhere else. I understand that failure to provide information regarding convictions or outstanding charges is grounds for immediate dismissal of the application to become a Specialized Home Care Provider or dismissal from the program, should the program become aware of any such information after approving the application for services.

Signature   Date

Name (print or type)

As an adult member of household providing Specialized Home Care services, I herby confirm that I have no criminal convictions in the past, nor do I have any knowledge of outstanding criminal charges filed against me either in the Commonwealth of Massachusetts or anywhere else. I understand that failure to provide information regarding convictions or outstanding charges is ground for my/our/the family being terminated from the Specialized Home Care program.

Signature   Date

Name (print or type)