ORIENTATION CHECKLIST FOR PERSONS RECEIVING SERVICES

Participant’s Name: __________________________________________________

Start Date: __________________________________________________________

Caregiver’s Name (if applicable): ______________________________________

I have received orientation within 24 hours of admission, or no more than 72 hours of admission which, included the following:

_____ External and internal reporting procedures

_____ The telephone number for the license holder’s common entry point

_____ The program abuse prevention plan

I received the following written information upon admission:

_____ Scope of the program’s services and care offered

_____ Description of the population served

_____ Description of the individual conditions which the center is not able to accept

_____ Grievance procedure

_____ Copy or written summary of Minnesota Statutes, section 626.557, the Vulnerable Adult Act and the license holder’s statement of compliance with that section

_____ Program’s transportation policy and arrangements

_____ Program’s policy on providing meals and snacks

_____ Program fees, billing arrangements, and plans for payment

_____ Program’s policy on smoking

_____ Types of insurance coverage carried by the program

_____ A statement of the program’s admission and employment policies and procedure

_____ Terms and conditions of the program’s DHS license, including a description of the population the program is licensed to serve

_____ Program’s policy on pets
Telephone number for the Department of Human Services, Division of Licensing, (651) 431-6500

Participant’s rights which include:
- The right to participate in developing the plan of care
- The right to refuse care or participation
- The right to physical privacy
- The right to confidentiality of records
- The right to present grievances regarding treatment or care
- The right to contest the accuracy and completeness of the data maintained in the record

_______________________  __________________
Signature of Participant or Caregiver receiving orientation             Date completed

_______________________  __________________
Signature of Person Providing Orientation                              Date completed