



COMMUNITY INTEGRATION

ISP To-Go Packet

**COMMUNITY SERVICES
INDIVIDUAL SERVICE PLAN WORKSHEET**

Some things that have happened in the past year that have made me happy:

Things from the past year I'm not happy about:

Some things I feel I have achieved:

I am currently receiving these services:

The changes to these services I'd like to make are:

People who I would like Toolworks to talk to about these things are:

I'd like to work on the following goals:

Financial Goals:

Community Goals

Personal/Social

Annual ISP

INDIVIDUAL SUPPORT PLAN GOAL SHEET & ANNUAL REVIEW

Client: _____

Attending the meeting:

Date: _____

GGRC: _____

Client: _____

Caregiver: _____

Toolworks staff: _____

Significant changes for client over the past year:

Comments on changes:

Previous Goals - Review:**Goal 1:**

.

Goal 2:**Goal 3:**

Client

Toolworks Staff

Will previous goals be carried over?

 all none some

Goal #1

What is my goal?

Where am I with my goal now?

What I hope to do in 1 month:

What I hope to do in 6 months:

By this time next year:

Who can help me, and how?

How will I know I have reached my goal?

Goal #2

What is my goal?

Where am I with my goal now?

What I hope to do in 1 month:

What I hope to do in 6 months:

By this time next year:

Who can help me, and how?

How will I know I have reached my goal?

Goal #3

What is my goal?

Where am I with my goal now?

What I hope to do in 1 month:

What I hope to do in 6 months:

By this time next year:

Who can help me, and how?

How will I know I have reached my goal?

AUTHORIZATION FOR RELEASE OF INFORMATION

Period of Authorization:

from _____ to _____

To: _____	Re: _____
Individual	Client or Applicant
_____	_____
Agency	Address
_____	_____
Address	City State Zip
_____	_____
City State Zip	

Information to be released:

_____ Medical	_____ Vocational	_____ Follow-up information
_____ Psychological	_____ Photo	after transfer or termination
_____ Educational	_____ Job Placement Follow-up	of services provided by
_____ Other _____		Toolworks.

Purpose:

Form of release:

_____ Letter/Report _____ Verbal _____ Video _____ Fax _____ Photo

I, _____, hereby authorize release of information between
 (client/applicant)
 Toolworks, Inc. and _____. I understand that information shared
 (agency or individual)
 between agencies or individuals will be handled in the strictest of confidentiality.

 Signature of Client/Applicant
 (Parent/Guardian ID under 18 years of age)

 Date

 Signature of Staff Member

 Date

HUMAN RIGHTS & GRIEVANCE PROCEDURE

Toolworks affirmatively supports all Federal and State civil rights laws and will not knowingly do business with any agency or entity which discriminates on the basis of ethnic group identification, national origin, race, color, creed, religion, sex, age, sexual orientation, physical or mental ability, medical conditions, marital status or ancestry.

It is the policy of Toolworks to assure and protect the human rights of clients whom it serves. This specifically includes a prohibition on physical and psychological abuse in any form.

Any Toolworks staff member or volunteer shall be subject to immediate dismissal for violating this policy.

In addition to the above rights, clients have the following rights (see Section 4502, Welfare and Institutions Code):

1. A right to treatment and habilitation services
2. A right to dignity and humane care
3. A right to participate in an appropriate program of publicly supported education, regardless of degree of handicap
4. A right to prompt medical care and treatment
5. A right to religious freedom and practice
6. A right to social interaction and participation in community activities
7. A right to physical exercise and recreational opportunities
8. A right to be free from harm, including unnecessary physical restraint or isolation, excessive medication, abuse or neglect
9. A right to be free from hazardous procedures

Should you believe that you have a grievance, you may present it to your direct supervisor for redress. If the problem is not resolved, you may request to meet with the department Director within 5 working days. The Director of Human Resources will also be informed and will be available for this meeting. You will receive a response from this meeting within 5 working days. If you wish to pursue the grievance further, a meeting will be arranged with the Executive Director, at which time you may bring an advocate. The Executive Director will respond to the grievance within 10 working days.

Should exception be taken to a decision resulting from the grievance procedure, a written appeal may be submitted within 10 working days of the decision. This grievance will be reviewed by the Board of Directors who will render a written decision within 10 working days of receipt of the appeal.

Signature of Client

Date

CONSUMER SATISFACTION SURVEY

Name

Date

It is very important to Toolworks that we know how you feel about the support services you receive from Toolworks. Please feel free to answer all the questions honestly and give us any feedback you want. Circle the word or phrase that best comes close to your answer.

1. I feel like the support I get from Toolworks is:

Enough

Needs to be a little more

Needs to be much more

Comments:

2. The people from Toolworks who support me are:

Great

Okay

Not who I want to work with

Comments:

3. Overall, I think the services I receive from Toolworks are:

Excellent

Good

Average

Poor

Comments:

4. I understand how to make suggestions or complaints to Toolworks.

Yes

No

Comments:

5. If I could change my services, or something about Toolworks, I would:

All answers are private and confidential. You do not have to write your name on this document, but you can if you choose.

Name

Date

MEDICAL AUTHORIZATION (CLIENTS)

If you become injured or sick here at Toolworks, we can take you to an emergency care facility.

The facility will be chosen depending upon the seriousness of the illness or injury. After this is determined, the next criterion will be based upon your insurance provider and/or regular medical service provider.

If you wish, you may list a provider below that is your first choice in non-emergency cases. Please include a doctor's name, hospital name and address:

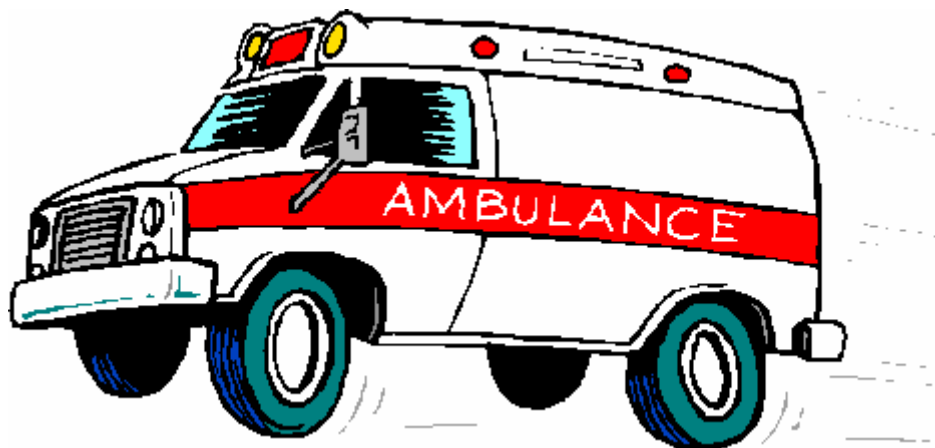
By signing below, you give Toolworks permission to treat you in an emergency.

(Signature)

(Date)

(Signature; Parent or Guardian)

(Date)



PROGRAM PARTICIPANT INFORMATION SUMMARY

DATE OF ADMISSION _____ DATE CLOSED _____

- Community Support
 Community Integration
 Employment Services
 Supportive Housing
 Independent Living
 Supported Living

IDENTIFICATION

First Name _____ Last Name _____ Social Security # _____

DEMOGRAPHICS

_____ M F T
 Date of Birth Gender Eyes Height Weight

PRIMARY LANGUAGE

- English
 ASL
 Mandarin
 Cantonese
 Spanish
 Other: _____

ETHNICITY

- Asian African-American
 Southeast Asian Latino
 Filipino, Pacific Islander White
 Indigenous American Other: _____

Allergies: hay fever

PHOTO



INSURANCE

Kaiser Permanence

Provider _____

Policy Number _____

MEDICAL SUMMARY

Last Physical _____ Last TB Test _____
 Medication (with dosage): _____

MEDICAL CONTACTS

NAME _____

Specialty/Role _____

Phone _____

NAME _____

Specialty/Role _____

Phone _____

DISABILITY

- Deaf
 Hard of Hearing.....
 Developmental Disorder.....
 Learning Disorder
 Physical.....
 Visual Impairment
 Autism
 Cerebral Palsy
 Psychiatric.....
 Seizure Disorder
 Substance Abuse.....
 Other

RESIDENCE

Street _____

City, Zip _____

Phone _____

Resident Caregiver or guardian Name _____

EMERGENCY CONTACT 1

NAME _____

Relationship _____

Phone _____

EMERGENCY CONTACT 2

NAME _____

Relationship _____

Phone _____

EMERGENCY CONTACT 3

NAME _____

Relationship _____

Phone _____

EMPLOYER

NAME _____

Supervisor _____

Phone _____

REFERRING AGENCY CONTACTS

NAME _____

Title _____

Agency _____

Phone _____

Date: _____

To whom it may concern,

It is mandatory for all Toolworks Community Integration clients to have an **annual TB Test** and provide a copy of the results for documentation.

If you have been tested within the year, please provide a copy of the TB Test results to your day program coordinator. The results will be kept in your client file, and may be copied and forwarded to specific volunteer sites that also request annual TB tests as a condition of volunteering.

If you have NOT been tested within the year, please get tested and submit the results. You can be tested by your own doctor, or refer to the attached sheet for a list of Free OR Low Cost Clinics.

Thank you in advance for your prompt attention to this matter.

Toolworks
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San Francisco, CA 94108