



OCEAN STATE CENTER FOR INDEPENDENT LIVING

1944 Warwick Ave, Warwick, RI 02889 ~ 175 Main St, Pawtucket, RI 02860

Phone: 401-738-1013 ~ VP: 244-7792 ~ Website: oscil.org

GRIEVANCE PROCEDURE FOR OSCIL CONSUMERS

Any OSCIL Consumer who has a grievance is encouraged to observe the following steps:

- 1. Discuss the grievance with the Independent Living Coordinator.**
- 2. If the grievance has not been resolved, the consumer should meet with the Program Manager.**
- 3. If the situation is not rectified, the consumer may discuss the problem with the Executive Director.**
- 4. If the consumer is still dissatisfied, the Executive Director will arrange a meeting for all parties involved and document the discussion. All parties will sign the meeting minutes document.**
- 5. If, after the meeting the consumer is dissatisfied with the outcome or decision, they may appeal to C.A.P.**

Note 1: A consumer at ANY time has the freedom to appeal directly to the C.A.P.

Note 2: Please see the Rights of a Consumer of OSCIL which explains the appeal process for C.A.P. If you have misplaced your copy, one will be furnished to you upon request.



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Confidentiality of Consumer Records

THE OCEAN STATE CENTER FOR INDEPENDENT LIVING COMPLIES WITH 34 CRF 366.42 (b) WHICH STATES:

“THE USE OF INFORMATION AND RECORDS CONCERNING INDIVIDUALS MUST BE LIMITED ONLY TO PURPOSES DIRECTLY CONNECTED WITH THE AGENCY, INCLUDING EVALUATION ACTIVITIES; AND, THAT PERSONAL INFORMATION MAY NOT BE DISCLOSED, DIRECTLY OR INDIRECTLY, WITHOUT WRITTEN CONSENT OF THE AGENCY INDIVIDUAL.”

I HAVE READ AND UNDERSTAND THAT THE INFORMATION IN MY RECORD WILL BE KEPT STRICTLY CONFIDENTIAL.

I ALSO UNDERSTAND THAT THE INFORMATION WILL NOT BE RELEASED TO OTHER AGENCIES OR PERSONS WITHOUT MY NOTIFICATION AND CONSENT.



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YOUR RIGHTS AND RESPONSIBILITIES AS A CONSUMER OF OSCIL

Any Consumer of OSCIL who feels that their rights have been violated has the right to an Appeal to the Following Decisions:

1. Your eligibility for services.
2. Provision of services.

The Following is a List of “Your Rights” as a Consumer of OSCIL:

1. Right to a fair and complete evaluation to determine eligibility.
2. Right to know why you are ineligible for services.
3. Right to an appeals process.
4. Right to confidentiality of records.
5. Right to be a partner in the planning of goals and services.
6. Right to continuous independent living coordinator involvement throughout your rehabilitation.
7. You (or Your Rep.) have the right to see your file at ANY time
8. If you do not understand something in your file, ask your independent living coordinator about it.
9. You have a right to request alternative formats of documents and communication mode.

Your Responsibilities as a Consumer are as Follows:

1. Responsibility to participate and follow through on plans you with your independent living coordinator.
2. Responsibility to keep in contact with your independent living coordinator.
3. Responsibility to be on time for appointments and cancel appointments with your independent living coordinator if unable to attend.
4. Responsibility to understand all forms before you sign them.
5. Responsibility to work with your independent living coordinator in developing a written independent living Plan.

The Above Information concerning the rights of a consumer and the responsibilities of a consumer were taken from the Rhode Island Client Assistance Program brochure and amended to reflect the policies of OSCIL.

Employment and Independent Living Services Client Assistance Program (CAP)

Disability Rights Rhode Island (DRRI) is part of the national network of Protection and Advocacy (P&A) agencies created by Congress, existing in every state and territory, to help secure and advance the rights of people with disabilities. There are 57 P&As in the United States, U.S. territories, and the District of Columbia.

DRRI's **Client Assistance Program (CAP)** provides individual legal representation and advocacy, information and referral services, outreach, and education to individuals with disabilities applying for or receiving services from state vocational rehabilitation, independent living, and services for the blind and visually impaired. We also advocate for the employment rights (Title I of the Americans with Disabilities Act) of vocational rehabilitation clients.

Vocational Rehabilitation Services: If you want to obtain services, or have concerns about your existing services at the Office of Rehabilitation Services (ORS), Services for the Blind and Visually Impaired (SBVI), or Tribal Vocational Rehabilitation (Tribal VR), CAP can provide information about vocational rehabilitation (VR) services, and help if you:

- Have trouble applying for VR services
- Have been denied VR services
- Disagree with your Order of Selection category
- Are placed on a wait list for services
- Have concerns about your rehabilitation counselor
- Are not satisfied with the VR services you are receiving
- Do not agree with a decision to close your case
- Need post-employment services
- Are a student aged 14 to 21 and have questions about Pre-employment transition services, or "PRE-ETS"
- Have other problems with VR services

Employment Discrimination: If you believe you have been discriminated against by your employer, CAP can:

- Provide information about your rights under Title I of the Americans with Disabilities Act
- Give you information about how to request a reasonable accommodation
- Provide information about how and where you can file a complaint

Independent Living Services: If you need help with information about independent living services at the Ocean State Center for Independent Living (OSCIL), CAP can help. Independent Living services include:

- Training on independent living skills
- Peer counseling
- Services that help you move from an institution to a home in the community
- Services to help you stay in your home rather than move to an institution
- Information about Assistive Technology (AT) and AT Services that can help you to live independently

You should contact DRRRI if:

- You want more information about ORS services
- You have applied for ORS services and were denied
- You are dissatisfied with the ORS services you are receiving
- You have questions about ORS policies, procedures, or programs.
- You need information about employment rights under Title I of the ADA
- You need information to request a reasonable accommodation at work
- You were denied services from Ocean State Center for Independent Living (OSCIL)
- You are dissatisfied with the services you are receiving from OSCIL
- You want to remain in your own home and need IL services
- You want help to move from an institution to the community
- You would like information about Assistive Technology or AT services
- Need other help or information about ORS, SBVI, Tribal VR, or OSCIL



Rhode Island Special Needs Emergency Registry

For Rhode Islanders with disabilities, chronic conditions, and special healthcare needs

The Rhode Island Department of Health (RIDOH) and the Rhode Island Emergency Management Agency (RIEMA) maintain a registry for Rhode Island residents with disabilities, chronic conditions, and/or special healthcare needs who live at home or in group homes. Residents of assisted living residences and nursing homes already have staff to assist first responders. By participating in the Registry, you permit RIDOH and RIEMA to share your information with local and state emergency responders, such as your town/city police and/or fire department. The information that you provide may help responders meet your needs during an emergency, though assistance cannot be guaranteed.

Instructions: To be included in the Registry, please fill out this form, sign it, and send it to:

RIDOH - RISNER, 3 Capitol Hill, Providence, RI 02908 OR register online at www.health.ri.gov/emregistry

If you have questions, please call (401) 222-5960 or RI Relay 711 (TTY). If you cannot fill out this form on your own, please have a family member, caregiver, or other representative complete the form and submit it on your behalf.

GENERAL INFORMATION Fields marked with an asterisk (*) are mandatory. Please print clearly.

Name*: _____
First Name Middle Name Last Name

Gender*: M F Date of birth*: _____
(MM/DD/YYYY)

PHYSICAL STREET ADDRESS

Street address*: _____ Apartment unit/floor: _____
City/town*: _____ ZIP code: _____

MAILING ADDRESS AS RECOGNIZED BY THE US POSTAL SERVICE (if different from physical street address)

Street address: _____ Apartment/unit: _____
City/town: _____ State: _____ ZIP code: _____

CONTACT INFORMATION (* A phone number is required)

Home phone: () - _____ Text only number: () - _____
Cell phone: () - _____ Videophone number: () - _____
Email: _____ TTY: () - _____

EMERGENCY CONTACT

Name: _____ Relationship: _____
Phone: () - _____ Email: _____

LIVING SITUATION

I live in Rhode Island (check all that apply to you):
 Seasonally from: _____(month) to: _____(month)
 Year-round
 Split my time between multiple Rhode Island addresses

I live in (select one type of housing):
 Single family house
 Apartment _____floor
 Condo/duplex/townhouse
 Mobile home
 Other: _____

I live (check all that apply to you):
 Alone
 With family/friends
 With caregiver
 In a group home operated by _____
 In an independent senior living facility
 With other people who are disabled
 Other: _____

LANGUAGE

I prefer to communicate in (select one):
 English
 American Sign Language
 Spanish
 Portuguese
 French
 Other: _____

ETHNICITY

Do you consider yourself Hispanic or Latino? Yes No

RACE Select one:

White
 African American/Black
 Asian
 Native Hawaiian/Pacific Islander
 American Indian/Alaskan Native
 Other: _____

LIFE SUPPORT SYSTEMS Check all that apply to you:

- Oxygen tanks
 - I have spare tanks
- Oxygen concentrator
 - I have battery or generator back up for this
- Respirator/ventilator
 - I have battery or generator back up for this
- Tracheostomy
- IV line
- Urinary catheters
- Colostomy/ileostomy
- Feeding tube
- Suction
 - I have battery or generator back up for this
- Dialysis at a clinic
- Dialysis at home
 - I have battery or generator back up for this
- Pacemaker
- Defibrillator
- Other electrical needs: _____
- None of the above

SENSORY Check all that apply to you:

- Hard of hearing
- Use of hearing aid(s)
- Deaf
- Use of cochlear implant(s)
- Visually impaired
- Legally blind
- None of the above

COGNITIVE/PSYCHIATRIC/ NEUROLOGICAL/ MUSCULAR Check all that apply to you:

- Seizure disorder
- Speech impaired
- Non-verbal
- Cognitively/developmentally delayed
- Autism spectrum disorder
- Alzheimer's/dementia
- Parkinson's
- Cerebral palsy
- Multiple sclerosis
- Depression
- Anxiety
- Bipolar disorder
- Schizophrenia
- Post-traumatic stress disorder (PTSD)
- Obsessive compulsive disorder (OCD)
- Other: _____
- None of the above

MOBILITY Check all that apply to you:

- Use a wheelchair/mobility vehicle
 - Wheelchair/mobility vehicle is power dependent
 - I have battery or generator back up for this
- Use a walker/cane
- Use crutches
- Use prosthesis (specify prosthesis): _____
- Confined to a bed
 - Bed is power dependent
 - I have battery or generator back up for this
- Other: _____
- None of the above

TRANSPORTATION Check all that apply to you:

When I leave my home, I most frequently use a(n):

- Personal vehicle
- Taxi/car service
- Public bus
- RIDE
- Wheelchair van/bus
- Ambulance
- Bicycle
- Other: _____

If I needed to evacuate, I would be accompanied by:

- No one
- Caregiver
- Family/friend
- Other: _____

ASSISTANCE REQUIRED Check all that apply to you:

On a normal day, I require assistance with:

- Feeding myself
- Taking medication(s)
- Communicating to others
 - Assistive technology - I use: _____
- Transportation
- Using the toilet
- Dressing/undressing
- Bathing/grooming
- Transferring from/to:

<input type="checkbox"/> Bed	<input type="checkbox"/> Wheelchair
<input type="checkbox"/> Toilet	<input type="checkbox"/> Shower/tub

Other assistance:

- I use a service animal
- I require supervision
- I receive medical treatment(s) from a nurse/doctor at home.
- I receive medical treatment(s) at a healthcare facility at least once a week.
- Other: _____
- None of the above

OTHER DISABILITIES/CONDITIONS

- Diabetes
 - I use insulin
- I weigh between 300 and 549 lbs
- I weigh between 550 and 799 lbs
- I weigh 800 lbs or greater

Please list other disabilities or relevant conditions:

NOTE: By signing this form, I agree to permit my information to be shared with local and state emergency responders. I understand that this is a voluntary program and while RIDOH/RIEMA will share this information in order to better assist me during an emergency, they cannot guarantee assistance in all cases.

Signature: _____

Print name: _____

Date: _____

If you are completing this form on someone's behalf, please indicate your name and relationship to that individual: _____