



Everyone Deserves to Live a Life of Meaning

- We believe interdependence creates success
 - Learning to work together to accomplish a goal such as a chore, a craft project or a meal creates a sense of pride and joy
- We believe everyone's contribution is necessary
 - We can grow farther as a Team than we can grow on our own
- We believe everyone can contribute to make this world a better place
 - Giving back to our communities is vital to our sense of self worth
 - We can lend a helping hand to the elderly, the sick child and the hungry family
- We believe a meaningful day is filled with friendship and uplifting kind interactions
 - The social connections the Growers make with everyone they meet are essential to their well being
- We believe a purposeful day is filled with experiential learning activities designed to help each Grower achieve their individual goals
 - Our person centered approach ensures each Grower is treated with respect and dignity



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Program Expectations

- Day program hours are from 9 a.m. to 3 p.m., drop off can be between 8:45 and 9:15, and pick up can be between 2:45 and 3:15
- If the Grower is going to be absent, late, or needs to be picked up early please notify the Farm as soon as possible.
- If the Grower needs to go home please be able to pick them up within 1 hour of notification.
- Absences should not exceed 20% for any quarterly period. If absences do exceed the allowable limit, a team meeting will be necessary to discuss barriers related to attendance and to ensure that the Grower's current farm schedule is appropriate for their needs.
- All the required paperwork must be submitted at least 1 week prior to their start date:
 - o Grower Annual Physical Examination Form with TB Test
 - o "Getting to Know Me"
 - o Identifying a Person's Learning Style
 - o Permission for medical services
 - o Permission for outings
 - o Consent to Photograph
 - o Grower Information Sheet
- Growers will provide a new physical examination every year and provide new TB test results every 2 years.
- Growers will need a lifetime medical history summary updated annually.
- Growers will participate in an annual needs assessment survey
- Growers are expected to contribute to their community activity fees, but this is capped at a maximum of \$5 per activity (see the Community Activity Calendar). We maintain a folder for the Grower for you to keep money here for them and we will notify you when their funds are low.
- We can administer any medications prescribed by their Doctors during the program day, but we will need to have a copy of the prescriptions/orders on file.

- Each Grower will need a packed lunch every day – meals are not provided but some snacks are provided. On days when they go on community outings please pack a cold lunch.
 - Each Grower should bring rubber garden boots and a rain jacket; Farm work is done rain or shine.
 - Hope Springs Farm is closed for 6 Holidays each year:
 - o New Year's Day, January 1st *
 - o Memorial Day, Monday
 - o Independence Day, July 4th *
 - o Labor Day, Monday
 - o Thanksgiving Day, Thursday
 - o Christmas Day, December 25th *
- * When these Holidays fall on a weekend, we determine what day the Farm will be closed for the Holiday based on the day of the week it falls; if it falls on a Saturday we will close Friday, if it falls on Sunday we will close Monday.
- Snow/Weather Cancellations and Delays;
 - o Snow days (full day closings), partial snow days (early closings), and weather delays are based on notification of the Lower Dauphin School District as a guide. Monitor their website (www.LDSD.org) or the local news for their announcements for advance warning.
 - o When an official decision has been made for the Farm program, we will utilize our text/email alert system to notify all Growers with reporting instructions.
 - o Weather delays are normally 1 hour less than the Lower Dauphin School District announced delay. This is because they start classes at 8 a.m. and our Growers start at 9 a.m. So a 1 hour delay for the school has no impact on our start time, but a 2-hour delay will delay our staff reporting time and Grower start time by 1 hour; staff would report at 9 a.m. and Growers would report at 10 a.m.

**Farm of Hope Inc.
At Hope Springs Farm
201 Trail Road
Hershey PA 17033**

SUBJECT: Nondiscrimination in Services

TO: Clients/Parents

FROM: Colby Zimmerman Executive Director



Admissions, the provisions of services, and referrals of clients shall be made without regard to race (to include hair type, hair texture, or hair style), color, religious creed, disability, ancestry, national origin (including limited English proficiency), age (40 and over), or sex (to include pregnancy status, childbirth status, breastfeeding status, sex assigned at birth, gender identity or expression, affectionate or sexual orientation, and differences in sex), and retaliation.

Program services shall be made accessible to eligible persons with disabilities through the most practical and economically feasible methods available. These methods include, but are not limited to, equipment redesign, the provision of aides, and the use of alternative service delivery locations. Structural modifications shall be considered only as a last resort among available methods.

Any individual/client/patient/student (and /or their guardian) who believes they have been discriminated against, may file a complaint of discrimination with:

Farm of Hope Inc., at Hope Springs Farm
201 Trail Road
Hershey PA 17033
717-298-1845
administrator@hopespringsfarm.org

Office for Civil Rights

U.S. Department of Health and Human
Services Centralized Case Management
Operations
200 Independence Avenue, S.W.
Room 509 HHH Bldg
Washington, D.C. 20201
Customer Response Center: (800) 368-1019
TDD: (800) 537-7697
<https://www.hhs.gov/ocr/complaints>
(Within 180 days from the date of incident)

**Commonwealth of Pennsylvania
Department of Human Services Bureau of
Equal Opportunity**
Room 225, Health & Welfare Building
P.O. Box 2675 Harrisburg, PA 17120
Inquiries: (717) 787-1127
Email: RA-PWBEOAO@pa.gov
(Within 90 days from the date of incident)

PA Human Relations Commission

333 Market Street, 8th Floor
Harrisburg, PA 17101
[https://www.phrc.pa.gov/Complaints/Pages/
How-to-File-a-Complaint.aspx](https://www.phrc.pa.gov/Complaints/Pages/How-to-File-a-Complaint.aspx)
Inquiries: (717) 787-4410
TTY users only: (717) 787-7279
(Within 180 days from the date of incident)

**Farm of Hope Inc.
At Hope Springs Farm
201 Trail Road
Hershey PA 17033**

SUBJECT: Staff and Individual (Grower) Hours of Operation

TO: Staff/Administration/Parents/ISP Team

FROM: Colby Zimmerman, Executive Director

Farm of Hope Inc., Hope Springs Farm is open Monday through Friday.

Staff members' work hours are 8:00 a.m. to 4:00 p.m.

Growers' hours are from 9:00 a.m. to 3:00 p.m., transportation providers are instructed to drop off between 8:45 a.m. and 9:15 a.m. and pick up between 2:45 p.m. and 3:15 p.m. Transportation providers are asked not to arrive prior to 2:40 p.m. as it creates issues for our Growers thinking they should go to the program building to go home.

ISP Team members and Families are asked to notify the Farm as soon as possible if a Grower will be arriving late or departing early.

**Farm of Hope Inc.
At Hope Springs Farm
201 Trail Road
Hershey PA 17033**

SUBJECT: Staff and Individual (Grower) Smoking Policy

TO: Staff/Administration

FROM: Colby Zimmerman, Executive Director

Farm of Hope Inc., Hope Springs Farm is a tobacco-free program/facility/campus.

Staff members, Growers, visitors, volunteers, or interns are not permitted to smoke or use tobacco products (including e-cigarettes, and smokeless tobacco) while participating in the Hope Springs Farm program, this includes

- Anywhere on the grounds of the property
- In any of the buildings located on the property
- In any of the program vehicles
- In any private vehicle used for an activity during the program day
- At any off-site activity during the program day

**Farm of Hope Inc.
At Hope Springs Farm
201 Trail Road
Hershey PA 17033**

SUBJECT: Grievance/Complaint Procedures

TO: Clients/Parents

FROM: Colby Zimmerman, Executive Director

Grievance Procedures, *ref; § 55 Pa. Code Chapter 51 Section 51.26, and § 55 Pa. Code Chapter 2380 Section 2380.22*

All participants (Growers), and their families have the right to file a grievance or complaint. Instructions for participants and their families regarding grievance procedures, including how to seek help in filing a grievance are provided during the intake process and made available any time upon request. Families or support team members who need assistance should consult their Supports Coordinator or the County MH/ID Office.

Grievances and complaints can be addressed to anyone on the staff. Participants or their families can submit a grievance or complaint by any means that is convenient for them. That staff member will then document the grievance/complaint on the form and pass it on to the Program Directors or the Executive Director. The Director will acknowledge the grievance/complaint in writing with 2 business days and begin conducting an investigation into the grievance or complaint. Within 5 business days of the complaint being filed a written resolution will be given to the grievant.

If the resolution of the grievance or complaint is agreed to, the grievant will be asked to provide their agreement in writing within 10 business days of the complaint being filed.

If they do not agree, the Director will have until 21 calendar days after the grievance/complaint is filed with the staff to continue to work with the grievant until an agreement can be reached. If no agreement can be reached within those 21 days a continuance will be documented and the parties will continue to work until there is an agreement. Families and support team members should seek assistance from their County MH/ID Office to mediate the unresolved grievance.

All grievances will be reviewed by the QA/IM/Risk management committee each quarter.

Instructions for filing a Grievance or Complaint

We are required to satisfactorily resolve all complaints and grievances within 21 calendar days of being filed with our staff.

If any Grower or family member is ever unhappy with the services provided, or has a complaint or question about an issue/incident at the Farm you should first attempt to speak to the Executive Director.

If the Executive Director isn't available, you should speak to any one of the Directors. And you can always speak to anyone on the staff as well.

Our first step will be to gather as much information as possible, and that might mean speaking with you to get more details.

Within 2 business days - for example; filed Friday June 1
Acknowledgement provided Tuesday June 5

We will provide you a written acknowledgement within 2 days; that will normally be done with an email. Please let us know if there is anything else you want us to include in our investigation when you get this written acknowledgement.

Within 5 business days - Response provided Friday June 8

We will immediately begin investigating your complaint and will provide you a written resolution within 5 business days.

Within 5 business days - Response provided Friday June 15

We ask that you review the resolution and provide us your agreement or disagreement within the next 5 business days.

If you agree with our resolution, we ask that you respond in writing, this can be done with a simple email.

Within 21 calendar days - Response provided Friday June 22

If you do not agree with our resolution we will continue to work on your complaint until we reach an acceptable solution. Families and support team members should seek assistance from their County MH/ID Office to mediate the unresolved grievance.

If at any time you need help or have any questions about this process, please feel free to contact the Executive Director at (717) 298-1845.

OTHER MEDICAL/ LAB/ DIAGNOSTIC TESTS:

GYN EXAM W/pap Date _____ Results: _____
(Women over age 18)

Mammogram: Date _____ Results: _____
(Every 2 year-women ages 40-49, yearly for women 50 and over)

Prostate Exam: Date _____ Results: _____
(Digital method-males 40 and over)

Hemocult Date _____ Results: _____

Urinalysis Date _____ Results: _____

CBS/ Differential Date _____ Results: _____

Hepatitis B Screening Date _____ Results: _____

PSA Date _____ Results: _____

Other (specify) _____

Part Two: GENERAL PHYSICAL EXAMINATION

Blood Pressure: ___/___ Pulse: ___/___ Respirations: ___/___ Temp: ___/___ height: ___/___ Weight: ___/___

EVALUATION OF SYSTEMS

System Name	Normal Findings	Comments/ Description
Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Ears	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Nose	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Mouth/ Throat	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Head/ Face/ Neck	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Breasts	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Lungs	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cardiovascular	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Extremities	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Abdomen	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Gastrointestinal	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Endocrine	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Musculoskeletal	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Integumentary	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Renal/ Urinary	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Reproductive	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Lymphatic	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Nervous System	<input type="checkbox"/> Yes <input type="checkbox"/> No	
VISION SCREENING	<input type="checkbox"/> Yes <input type="checkbox"/> No	Is further evaluation recommended by specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No
HEARING SCREENING	<input type="checkbox"/> Yes <input type="checkbox"/> No	Is further evaluation recommended by specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No

Vision Screening, Hearing Screening must be checked 'Yes'. If checked 'No', please explain below or attach copy of visit with hearing or vision specialist. "Deferred due to special needs/disability" is not an acceptable explanation:

Additional Comments:

Lifetime medical history summary reviewed? Yes No *If No, list the reason why it was not reviewed.*
Please attach the Lifetime Medical History Summary

Medication added, changed, or deleted (*from this appointment*):

Special medication considerations or side effects:

Recommendations for health maintenance: (*i.e.: lab work at reg. intervals, exercise, hygiene, weight control, etc.*)

Recommended diet and special instructions:

Information pertinent to diagnosis and treatment in case of emergency:

Free of Communicable Diseases? Yes No
If no, list specific precautions to prevent the spread of disease to others

Limitations or restrictions for activities (*including work day, lifting, standing, and bending*) No Yes (*specify*):

Change in health status from previous year? No Yes *If Yes specify:*

Specialty consults recommended? No Yes *If Yes specify:*

Based on their diagnosis of Intellectual Disabilities, I certify this individual is eligible for ICF/ID level of care. Yes No

Name of Physician (<i>please print</i>)		Physician's Signature	Date
		Credentials (please Circle): RN LPN MD PA-C CNP	
Phone		Fax	
Address			

State regulations require this form be completed in its entirety by RN, LPN, MD, PA-C or CNP

Physical and TB tests CANNOT be read by any Medical Assistant (CMA or MA)

**Farm of Hope Inc., 201 Trail Road, Hershey, PA 17033
717-298-1845 (phone), 717-312-8903 (fax)**



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TESTING FOR TUBERCULOSIS BY THE INTRACUTANEOUS MANTOUX METHOD

Patient Name:		Patient date of birth:	
Date Test applied:		Date Test Read:	
Interpretation of Tuberculosis Test Results	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	Date Interpretation Made:	
For POSITIVE Results	Date of Chest X-Ray:	Chest X-Ray Report Attached <input type="checkbox"/> YES <input type="checkbox"/> NO	
Name of Person Certifying the Results:		Signature:	Credentials (please Circle): RN LPN MD PA-C CNP

Tuberculin skin testing may be completed and certified in writing by a registered nurse or a licensed practical nurse as well as a licensed physician, registered physician's assistant or certified nurse practitioner.

TB tests CANNOT be read by any Medical Assistant (CMA or MA)



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“GETTING TO KNOW ME”

My name is _____

I like to be called _____

Age _____

I live at _____

I need help doing some of these things _____

My favorite things are: _____

I don't like: _____

My vision is _____ My hearing is _____

I communicate by _____

When I walk, I _____

In order to help me, I use _____

When I eat, I may need help with _____

Some of my favorite foods are _____

Foods that I dislike are _____



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IDENTIFYING A PERSON'S LEARNING STYLE

Grower's Name:

Date:

I learn best when:

Comments

<p>Sound</p> <ul style="list-style-type: none"> <input type="checkbox"/> Quiet place <input type="checkbox"/> Somewhat noisy place <input type="checkbox"/> It helps when you talk as I am learning the skill <input type="checkbox"/> Please be quiet when I am learning the skill 	
<p>Light</p> <ul style="list-style-type: none"> <input type="checkbox"/> Bright <input type="checkbox"/> Dark 	
<p>Crowds</p> <ul style="list-style-type: none"> <input type="checkbox"/> Many others around <input type="checkbox"/> One or two others around <input type="checkbox"/> When I am alone with the "instructor" <input type="checkbox"/> Alone 	
<p>Location</p> <ul style="list-style-type: none"> <input type="checkbox"/> I prefer to practice the skill at home before I try it for real <input type="checkbox"/> I prefer to try it out for the first time wherever I really need to do the skill <input type="checkbox"/> I like to do a "dry run" practice when there are a few others in the real environment 	
<p>Help</p> <ul style="list-style-type: none"> <input type="checkbox"/> Help me to figure out how to ask others for help, if I need it <input type="checkbox"/> Point out environmental cues that may help me learn <input type="checkbox"/> I don't want anyone else to know you are helping me when we are in public <input type="checkbox"/> I would prefer if I could learn from watching others rather than having staff with me 	



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PERMISSION FOR MEDICAL SERVICES

I hereby give permission for Farm of Hope Inc./Hope Springs Farm to secure all routine medical services or emergency first aid.

I understand that Farm of Hope Inc./Hope Springs Farm will make every reasonable effort to contact my designated emergency contacts whenever a condition arises that requires other than routine medical services. However, in the event that an emergency exists and my designated emergency contacts cannot be reached within a reasonable time, I give permission to Farm of Hope Inc./Hope Springs Farm to secure any and all medical services to meet the medical emergency.

Individual's Printed Name: _____

Individual's Signature: _____

Date: _____

Signature of Family Member or Guardian: _____



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PERMISSION FOR OUTINGS

The staff of Farm of Hope Inc./Hope Springs Farm will take me on pre-scheduled day outings during program hours of 9:00 a.m. to 3:00 p.m.

I agree to allow Farm of Hope Inc./Hope Springs Farm to take me on pre-scheduled day outings during program hours of 9:00 a.m. to 3:00 p.m.

I do not agree to allow Farm of Hope Inc./Hope Springs Farm to take me on pre-scheduled day outings during program hours of 9:00 a.m. to 3:00 p.m.

Individual's Printed Name: _____

Individual's Signature: _____

Date: _____

Signature of Family Member or Guardian: _____

Relationship to Individual: _____



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CONSENT TO PHOTOGRAPH

Farm of Hope Inc./Hope Springs Farm will use my photograph for educational and marketing purposes. These images may appear in our printed brochure, publications, website or our social media page(s).

Farm of Hope Inc./Hope Springs Farm has complete ownership of these pictures and may use them for any purpose consistent with the mission of Farm of Hope Inc./Hope Springs Farm. These uses may include: illustrations, publications, advertisements, and promotional or educational materials. I acknowledge that I will not receive any compensation.

I agree to allow Farm of Hope Inc./Hope Springs Farm to take and use my photo as described above.

I do not agree to allow Farm of Hope Inc./Hope Springs Farm to take and use my photo as described above.

Individual's Printed Name: _____

Individual's Signature: _____

Date: _____

Signature of Family Member or Guardian: _____

Relationship to Individual: _____



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GROWER INFORMATION SHEET

Name			
Sex		Admission Date	
Birthdate		SS#	
Race		Height	
Weight		Hair Color	
Eye Color		Identifying Marks	
Language		Religious Preference	

PRIMARY CARE PHYSICIAN

Name	Name of Clinic
Address / City / State / Zip	
Phone	Fax

NOTIFY IN CASE OF EMERGENCY

Contact	Name and Address	Phone Number/Email	Relationship to Grower
1st			
2nd			
3rd			
4th			

DECISION MAKER FOR EMERGENCY MEDICAL TREATMENT

Name and Address	Phone Number/Email	Relationship to Grower



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CONSENT TO RELEASE INFORMATION

I hereby give permission for Farm of Hope Inc./Hope Springs Farm to receive all relevant medical and personal information, from any service provider listed in the Individual Support Plan, Family member or Guardian, including my Physicians.

I also hereby give permission for Farm of Hope Inc./Hope Springs Farm to provide all relevant medical and personal information including attendance and billing data, to any service provider listed in the Individual Support Plan, Family member or Guardian, including my Physicians.

Individual's Printed Name: _____

Individual's Signature: _____

Date: _____

Signature of Family Member or Guardian: _____

Relationship to Individual: _____



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GROWER INTAKE CONTACT INFORMATION FORM

Grower Name: _____

Supports Coordinator Name: _____

Phone Number: _____

Email: _____

County: _____

Contact #1:

Name: _____

Address: _____

Phone Number: _____

Email: _____

Relationship to Grower: _____

Contact #2:

Name: _____

Address: _____

Phone Number: _____

Email: _____

Relationship to Grower: _____

Contact #3:

Name: _____

Address: _____

Phone Number: _____

Email: _____

Relationship to Grower: _____

