Vivian's House

Young Adult Family Home

24 HOUR SKILLED NURSING CARE FOR YOUNG ADULTS WITH MEDICALLY INTENSIVE OR OTHER SPECIAL HEALTH CARE NEEDS

- **Daily Respite** – daytime care up to 8 hours – days or evenings
- **Short Stay Respite** – days to weeks
- **Residential** – unlimited amount of time
- **Transitional** -- care after leaving the hospital before returning to home

We hold provider contracts with Division of Developmental Disabilities and Medicaid.

Services provided to families:

- Intake assessment for all families of young adults enrolling in program services..
- Individualized parent education and training in meeting the needs of their young adult.
- Parent/Guardian mentoring to find and maintain connections with community resources.
- Board of Review, a multidisciplinary meeting for case management of young adults with complex issues. These meetings are inclusive of parents, medical providers, adult and family services, educators, and others involved in the welfare of the young adult at risk..

If you have any questions regarding our programs please contact:

- Barb Sonnenberg, RN, BSN, Director of Nursing Services at (360) 736-9178 option 2 bsonnenberg@popeskidsplace.org
- Jaimee Dobson, RN, BSN, Assistant DNS (360) 736-9178 option 2 jdobson@popeskidsplace.org

Please review our Parent Handbook for guidance on specific policies and procedures.

****Each time your young adult comes for a respite care stay, please remember to bring any supplies your young adult will need while here, which may include:**

- Briefs and wipes
- Specialty formula or foods if needed
- Specialty skin or hair care products if needed
- Toothbrush and toothpaste
- A reasonable amount of clothing (we do laundry daily- we prefer to have initials on tags)
- Specific Medical equipment, with chargers (we supply poles)
- Medication in pharmacy labeled container with the correct instructions, or original over the counter container

Please help us remember to send all of his/her belongings home when he/she is picked up, by reviewing the items with the staff.

(You may keep this page)

Young Adult

Date _____

Young Adult's Name _____ DOB _____ Age ____

Ethnicity (please circle one)

Asian Pacific Islander African American Caucasian

Hispanic Native American Other _____

Mother/Guardian

Mother's Name _____ Social Security # _____

DOB _____ Home Phone _____

Mother's Work Phone _____ Mother's Cell Phone _____

Address _____

City _____ State _____ Zip _____

Employer _____ Phone _____

Email _____

Ethnicity (please circle one)

Asian Pacific Islander African American Caucasian

Hispanic Native American Other _____

Father/Guardian

Father's Name _____ Social Security # _____

DOB _____ Home Phone _____

Father's Work Phone _____ Father's Cell Phone _____

Address _____

City _____ State _____ Zip _____

Employer _____ Phone _____

Email _____

Ethnicity (please circle one)

Asian Pacific Islander African American Caucasian

Hispanic Native American Other _____

Emergency Contacts

#1 Emergency Contact Person _____

Address _____

Home Phone _____ Cell Phone _____

#2 Emergency Contact Person _____

Address _____

Home Phone _____ Cell Phone _____

Social / Case Worker ___ _____ Phone_____

Social / Case Worker E-mail (if you have it) _____

Family

Parents, Legal Guardians, Others living in the home

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Health Insurance

Insurance Company _____

Group / ID Number _____

Does your young adult have a funding source for respite care? _____

Physician

Physician _____ Clinic _____

Address _____ Phone _____

Date of last physical examination **(required)** _____

Diagnosis

Young Adult's Health Diagnosis _____

_____

Medication **(PLEASE LIST ON ATTACHED FORM)**

How do you give your medication to your young adult? _____

_____

Allergies

Medication allergies and reactions _____

Food allergies and reactions _____

Eating and Nutrition

Special Diet _____

Explain special feeding methods: (Does food need to be blended, pureed or cut up into small pieces, etc?)

_____

_____

Favorite Foods _____

_____

Least Favorite Foods _____

Able to feed self? _____ right or left handed? _____

Does he/she drink from a sippy cup or regular cup or straw? _____

Does he/she use knives, forks, or other adaptive equipment? _____

How does he/she ask for food or drink? _____

Would you like her/him to have snacks? _____

What time of day? _____

Tube Feeding Schedule

G-Tube J-Tube NG-Tube (Please circle one)

Formula Type _____

Continuous Pump? Yes _____ No _____ If yes, what rate? _____

Bolus Feed? Yes _____ No _____ Amount _____ Gravity or Pump? _____

Schedule - Time on/off etc. _____

_____

Water flush after feeds? Yes _____ No _____ if yes, amount? _____

Toileting Habits

Does he/she wear briefs? _____ if yes, what size? _____

Does your daughter menstruate? Yes _____ No _____ How often? _____

What kind of supervision, assistance, or adaptive equipment does he/she need in the bathroom? _____

_____

Trouble with constipation? _____

Physical Limitations

Can he/she sit up? _____ Stand? _____ Walk? _____

What kind of assistance does he/she need to move? _____

_____

Does he/she wear orthotics/splints? If so what is his/her typical schedule? _____

_____

Communication

Does he/she speak? _____

Is his/her speech understood by those outside the family? _____

What other methods of communication does he/she use? _____

_____

_____

Typical Daily Routine

What is your young adult's typical sleep schedule? _____

Can they dress themself? If not, what sort of assistance is required? _____

_____

What kind of assistance is needed for brushing teeth? _____

_____

Does he/she bathe/shower daily? _____ Morning or evening? _____

What kind of assistance is needed for bathing? _____

Do we have permission to bathe him/her? Yes _____ No _____

Do we have permission to trim his'her nails if needed? Yes _____ No _____

Sleeping

What type of bed does he/she sleep in? _____

Are side rails or other safeguards used to prevent falling out of bed? _____

Does he/she require special positioning for sleeping? _____

_____

Does he/she take any particular item to bed? (blanket, toy, special stuffed animal, etc.) _____

_____

What is his/her normal sleeping habits? (Wake up during the night, etc? If so, interventions used so he/she will return to sleep?) _____

_____

Describe any special bedtime routines: _____

_____

_____

Activities

Favorite activities _____

_____

_____

Can he/she read? _____ If yes, what type of material do they like to read? _____

_____

Are there any activities or skills you would like us to work on with him/her? _____

_____

_____

Are there any special religious or cultural considerations we should be aware of? _____

_____

General Behavior

Reaction to strangers and animals_____

Reaction to new environment _____

Fears _____

Likes _____

_____

Dislikes _____

_____

Specific unique habits _____

_____

Other Information _____

_____

_____

The information I have given is accurate to the best of my knowledge and may be shared with all Pope's Place caregivers. I understand that all information is held in strict confidence by staff.

_____

Parent/Guardian Signature Date

_____

Registered Nurse Signature (DNS or ADNS) Date

Authorization for someone other than parents/guardians to pick up young adult from Pope's Place:

It is our policy to have young adults picked up from our programs by parents/guardians or an adult over the age of 18. Please list below persons allowed to pick up your young adult. **We must have a court order if a biological parent is not allowed to pick up your young adult.**

Young Adult's NAME: _____

Persons **ALLOWED** to pick up young adult:

1. _____

2. _____

3. _____

4. _____

Persons **NOT ALLOWED** to have contact with young adult:

1. _____

2. _____

3. _____

4. _____

Application for Sliding Fee

(this form is mandatory unless you have a state funding source)

Pope's Place offers families a discount on services if they qualify for our sliding fee scale. The discount percentage is based on the GROSS income of ALL members of the household and the number of members in the family. If you wish to apply for this discount we need income verification.

Please list <u>all</u> household members including yourself:

Name	Date of Birth	Social Security Number	Income

ALL INCOME MUST BE VERIFIED BY PROOF OF INCOME BEFORE THE SLIDING FEE DISCOUNT WILL BE EFFECTIVE.

We must have two months of pay stubs or other proof of income.

- **All proof of income must be received prior to the appointment in order to apply sliding fee scale.**
- **The above is true to the best of my knowledge.**
- **I understand that if I provide false information, I will be disqualified and all charges will be due in full immediately.**

Signature_____ Date_____

Office Use Only:

Total # of members in household:_____

Total Household Monthly Income:_____

Total Household Yearly Income:_____

Sliding Fee Category:_____

Date:_____ Initials_____

CONSENT TO MEDICAL CARE AND TREATMENT OF YOUNG ADULTS

I_____ (the parent or legal guardian) hereby give my permission that my child, _____, may be given emergency treatment to include first aid and CPR by a qualified health care staff member at Pope's Place.

I also give my permission for my young adult to be transported by ambulance or emergency center for treatment.

I further authorize and consent to medical, surgery and hospital care, treatment and procedures to be performed for my young adult by their regular physician, or when the physician cannot be reached, by a licensed physician or hospital when deemed immediately necessary or advised by the physician to safeguard my young adult's health and I cannot be contacted. I waive my right of informed consent to such treatment.

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____ **Date:** _____

Vivian's House – Young Adult Home

PERMISSION TO PHOTOGRAPH

I give permission for my young adult (please print name) _____ to be included in photographs, video, or slides to be used for educational purposes or to help promote our program, and which may appear in media such as newspapers, photo albums, television, internet, or classes for other parents and caregivers. _____ yes _____ no

If my young adult no longer participates in the programs at Pope's Place his/her photograph may still be used in the future _____ yes _____ no
(I will contact Pope's Place if I change my mind in the future.}

Parent/Guardian Name (please print) _____

Parent/Guardian Signature _____**Date**_____

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PATIENT BILL OF RIGHTS

I have been provided with a copy of the Patient Bill of Rights by Pope's Place. I have reviewed the document and been given the opportunity to have my questions answered by a staff member.

Parent/Guardian Signature _____**Date**_____

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NOTICE OF PRIVACY PRACTICES

I have been provided with a copy of the Pope's Place Notice of Privacy Practices. I have reviewed the document and been given the opportunity to have my questions answered by a staff member.

Parent/Guardian Signature _____**Date**_____

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PARENT HANDBOOK

I have been provided with a copy of the Pope'sPlace Parent Handbook. I have reviewed the document and been given the opportunity to have my questions answered by a staff member.

Parent/Guardian Signature _____**Date**_____
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Vivian's House – Young Adult Home

BED SIDE RAIL SAFETY

Young Adult's Name _____

Choose an option (check mark):

_____I request that Vivian's House use bed side rails to protect my young adult from falls and injury while sleeping. I understand that side rails will only be used as a safety measure and not for staff convenience or as a restraint. I am aware that all types of side rails are known to present a potential risk of harm in the form of entrapment, injury, and death.

OR

_____I do not authorize the use of bed side rails for my young adult as they are not necessary for my his/her safety during sleep.

Parent/Guardian Signature _____**Date**_____

List of Current Medication

YOUNG ADULT:_____ DOB:_____

Allergies:_____

Date	Name of Medication & Strength	Dosage	Route	Times	Stop Date

Parent Signature_____ Date:_____

Nurse Signature _____ Date:_____

Patient Bill of Rights

Introduction

Effective health care requires collaboration between patients and health care providers. Open and honest communication, respect for personal and professional values, and sensitivity to differences are integral to optimal patient care. As the setting for the provision of health services, health care centers must provide a foundation for understanding and respecting the rights and responsibilities of patients, their families, physicians, and other caregivers. Health care centers must ensure a health care ethic that respects the role of patients in decision making about treatment choices and other aspects of their care. Health care centers must be sensitive to cultural, racial, linguistic, religious, age, gender, and other differences as well as the needs of persons with disabilities. Pope's Place is presenting this Patient Bill of Rights in an attempt to ensure that patients and their families understand their rights and responsibilities.

Bill of Rights

These rights can be exercised on the patient's behalf by a designated parent/guardian who has legal responsibility to make decisions regarding medical care on behalf of the patient:

1. The patient has the right to considerate and respectful care.

2. The patient has the right to and is encouraged to obtain from health care providers and other direct caregivers relevant, current, and understandable information concerning diagnosis, treatment, and prognosis.

   Except in emergencies when the patient lacks decision-making capacity and the need for treatment is urgent, the patient is entitled to the opportunity to discuss and request information related to the specific procedures and/or treatments, the risks involved, the possible length of recuperation, and the medically reasonable alternatives and their accompanying risks and benefits.

   Patients have the right to know the identity of physicians, nurses, and others involved in their care, as well as when those involved are students, residents, or other trainees. The patient also has the right to know the immediate and long-term financial implications of treatment choices, insofar as they are known.

3. The patient has the right to make decisions about the plan of care prior to and during the course of treatment and to refuse a recommended treatment or plan of care to the extent permitted by law and Popes Place policy and to be informed of the medical consequences of this action. In case of such refusal, the patient is entitled to other appropriate care and services that Pope's Place provides or transfer to another facility. Pope's Place should notify patients of any policy that might affect patient choice within our facility.

4. The patient has the right to have an advance directive (such as a living will, health care proxy, or durable power of attorney for health care) concerning treatment or designating a surrogate decision maker with the expectation that Pope's Place will honor the intent of that

directive to the extent permitted by law and facility policy.

Health care centers must advise patients of their rights under state law and organizational policy to make informed medical choices, ask if the patient has an advance directive, and include that information in patient records. The patient has the right to timely information about any Pope's Place policy that may limit its ability to implement fully a legally valid advance directive.

5. The patient has the right to every consideration of privacy. Case discussion, consultation, examination, and treatment should be conducted so as to protect each patient's privacy.

6. The patient has the right to expect that all communications and records pertaining to his/her care will be treated as confidential by Pope's Place, except in cases such as suspected abuse and public health hazards when reporting is permitted or required by law. The patient has the right to expect that Pope's Place will emphasize the confidentiality of this information when it releases it to any other parties entitled to review information in these records.

7. The patient has the right to review the records pertaining to his/her medical care and to have the information explained or interpreted as necessary, except when restricted by law.

8. The patient has the right to expect that, within its capacity and policies, Pope's Place will make reasonable response to the request of a patient for appropriate and medically indicated care and services. Pope's Place must provide evaluation, service, and/or referral as indicated by the urgency of the case. When medically appropriate and legally permissible, or when a patient has so requested, a patient may be transferred to another facility. The facility to which the patient is to be transferred must first have accepted the patient for transfer. The patient must also have the benefit of complete information and explanation concerning the need for, risks, benefits, and alternatives to such a transfer.

9. The patient has the right to ask and be informed of the existence of business relationships among Pope's Place, educational institutions, other health care providers, or payers that may influence the patient's treatment and care.

10. The patient has the right to consent to or decline to participate in proposed research studies or human experimentation affecting care and treatment or requiring direct patient involvement, and to have those studies fully explained prior to consent. A patient who declines to participate in research or experimentation is entitled to the most effective care that Pope's Place can otherwise provide.

11. The patient has the right to expect reasonable continuity of care when appropriate and to be informed by health care providers and other caregivers of available and realistic patient care options when care at Pope's Place is no longer appropriate.

12. The patient has the right to be informed of Pope's Place policies and practices that relate to patient care, treatment, and responsibilities. The patient has the right to be informed of available resources for resolving disputes, grievances, and conflicts, such as ethics committees, patient representatives, or other mechanisms available in the organization. The patient has the right to be informed of the charges for services and available payment methods.

The collaborative nature of health care requires that patients, or their families/guardians, participate in their care. The effectiveness of care and patient satisfaction with the course of treatment depends in part, on the patient fulfilling certain responsibilities. Patients are responsible for providing information about past illnesses, hospitalizations, medications, and other matters related to health status. To participate effectively in decision making, patients must be encouraged to take responsibility for requesting additional information or clarification about their health status or treatment when they do not fully understand information and instructions. Patients are also responsible for ensuring that Pope's Place has a copy of their written advance directive if they have one. Patients are responsible for informing their health care providers and other caregivers if they anticipate problems in following prescribed treatment.

Patients should also be aware of the Pope's Place obligation to be reasonably efficient and equitable in providing care to other patients and the community. Pope's Place's rules and regulations are designed to help the organization meet this obligation. Patients and their families are responsible for making reasonable accommodations to the needs of the organization, other patients, medical staff, and other employees. Patients are responsible for providing necessary information for insurance claims and for working with Pope's Place to make payment arrangements, when necessary.

A person's health depends on much more than health care services. Patients are responsible for recognizing the impact of their life-style on their personal health.

Conclusion

Health care facilities have many functions to perform, including the enhancement of health status, health promotion, and the prevention and treatment of injury and disease; the immediate and ongoing care and rehabilitation of patients; the education of health professionals, patients, and the community; and research. All these activities must be conducted with an overriding concern for the values and dignity of patients.

Direct concerns to Washington State Hotline # **1-800-633-6828,** hours of operation: Monday through Friday 8:00 AM to 4:00 PM

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Pope's Place respects your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.
The law protects the privacy of the health information we create and obtain in providing our care and services to you. Your protected health information includes your symptoms, test results, diagnoses, treatments, health information from other providers, and billing and payment information relating to these services.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations. State law requires us to get your authorization to disclose this information for payment purposes.

For Treatment: Information obtained by a nurse, provider, or other member of our health care team will be recorded in your medical record and used to help decide what care may be right for you. We may also provide information to others in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work or referrals. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have. We will request your permission before sharing health information with your family or friends unless you are unable to give permission to such disclosures due to your health condition.

For Payment: We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses, procedures performed, or recommended care.

For Health Care Operations: We may use your medical records to assess quality and improve services. We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
We may contact you to remind you about appointments and give you information about treatment alternatives or other health-related benefits and services.
We may use and disclose your information to conduct or arrange for services, including: medical quality review by your health plan; accounting, legal, risk management, and insurance services; audit functions, including fraud and abuse detection and compliance programs.

For Fund-Raising: We may contact you to ask for your help with fund-raising campaigns. Please notify us if you do not wish to be contacted during fund-raising campaigns. If you advise us in writing that you do not wish to receive such communications, we will not use or disclose your information for these purposes.

SPECIAL SITUATIONS

We may use or disclose health information about you for the following purposes, subject to all applicable legal requirements and limitations:

Family and Friends: Unless you object, we may disclose health information about you to your family members or friends who are involved in your medical care. We may also give information to someone who helps pay for your care. We may tell your family or friends your condition and that you are in a hospital. You have the right to object to this use or disclosure of your information. If you object, we will not use or disclose it.

To Avert a Serious Threat to Health or Safety: We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Public Health Risks: We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

Health Oversight Activities: We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Required By Law: We will disclose health information about you when required to do so by federal, state, or local law.

Military and National Security: If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you.

Specialized Government Functions: We may share information for national security purposes.

Research: We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address, or other information that reveals who you are, or will be involved in your care at the office.

Organ and Tissue Donation: If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

Coroners and Funeral Directors: We will release information consistent with applicable law to allow them to carry out their duties.

Workers' Compensation: We will release information about you if you make a workers' compensation claim.

Law Enforcement: We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

Information Not Personally Identifiable: We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

OTHER USES AND DISCLOSURES OF HEALTH INFORAMTION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written authorization.

We also will not use or disclose your health information for the following purposes without your specific, written authorization:

- For our marketing purposes. This does not include face-to-face communication about products or services that may be of benefit to you.
- For the purpose of selling your health information. We will not be selling your health information.
- Psychotherapy Notes. If we record or maintain psychotherapy notes, we must obtain your authorization for most uses and disclosures of psychotherapy notes.

If you give us authorization to use or disclose health information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose information about you for the reasons covered by your written authorization, but we cannot take back any uses or disclosures already made with your permission.

In some instances, we may need specific, written authorization from you in order to disclose certain types of specially-protected information such as psychotherapy notes, HIV, substance abuse, mental health, and genetic testing information for purposes such as treatment, payment and healthcare operations.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

The health and billing records we create and store are the property of the practice/health care facility. The protected health information in it, however, generally belongs to you.

Right to Inspect and Copy. You have the right to inspect and copy your health information, such as medical and billing records, that we keep and use to make decisions about your care. You must submit a written request in order to inspect and/or copy your records. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. If you request to view a copy of your health information, we will not charge you for inspecting your health information. We may deny your request to inspect and/or copy your record or parts of your record in certain limited circumstances. If you are denied, you may ask that our denial be reviewed. If the law gives you a right to have

our denial reviewed, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to Amend. You may request in writing to amend your records. We may deny your request if your request is not in writing or does not include a reason to support the request. In addition, we may deny or partially deny your request if you ask us to amend information that we did not create or if the information is accurate and complete.
If we deny or partially deny your request, you have the right to submit a rebuttal and request the rebuttal be made a part of your medical record.

Right to Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment, health care operation, when specifically authorized by you and a limited number of special circumstances involving national security, correctional institutions and law enforcement.
To obtain this list, you must submit your request in writing stating a time period no longer than six years and indicate in what form you want the list. The first list you request within a 12-month period will be free. For additional lists, we will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to a written request for a restriction on use or disclosure of health information. The only time we are required to agree to your written request is when you pay for treatment "out of pocket" and you request the information not be communicated to your health plan for payment.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised notice effective for protected health information we already have about you as well as any information we received in the future. We will post the current notice at our location(s) with its effective date at the bottom.

BREACH OF HEALTH INFORMATION

We will inform you if there is a breach of your unsecured health information.

FOR HELP OR COMPLAINTS

If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may contact the management team under direction of the Executive Director at 360 736-9178.

If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also deliver a written complaint to the management team under direction

of the Executive Director at our office. You may also file a complaint with the U.S. Secretary of Health and Human Services.

We respect your right to file a complaint with us or with the U.S. Secretary of Health and Human Services. You will not be penalized for filing a complaint.

Web Site: We have a web site that provides information about us. www.popeskidsplace.org

Notice Effective Date: September 19, 2013