CLIENT INFORMATION/ASSESSMENT SHEET

Client Name:
_____

Address:
_____

_____

Phone Number: _____ Alternate Number:_____

Male _____ Female_____ Start of Services: _____

Date of Birth: _____ SSN: _____

Guardian/Caregiver:
_____

Address:
_____

_____

Phone Number: _____ Alternate Number:_____

Emergency Contact if different:
_____

Address:
_____

_____

Phone Number: _____ Alternate Number: _____

Pay Source:
_____

Insurance Information if applicable:
_____

Physician:
_____

Address:

_____

Phone Number: _____Fax Number:_____

Diagnosis:

_____

_____

Services requested: □ CNA □ HHA □ Companion □ Homemaker

CLIENT'S MEDICAL HISTORY:

PRIMARY DIAGNOSIS: _____ ONSET: _____ EDEMA: _____

SITTING: _____ STANDING: _____ LYING DOWN:_____

CLIENT LAST HOSPITALIZATION DATE:

_____

ALLERGIES: _____ ANY VISION PROBLEMS: _____ GLASSES:_____

IS CLIENT EXPERIENCING PAIN: YES_____ NO_____ IF YES, WHERE_____

ONSET: _____ AGGRAVATED BY: _____

PAIN FREQUENCY: OCCASIONAL: _____ CONTINUOUS: _____ INTERMITTENT:____ INTRACTABLE: ____

CIRCLE PAIN LEVEL: 1 2 3 4 5 6 7 8 9 10

IS THE CLIENT ABLE TO HEAR AND UNDERSTAND: YES_____ NO_____ HEARING AID: _____

IF NO, EXPLAIN:

_____

_____

IS THE CLIENT ABLE TO SPEAK: YES_____ NO_____ ABLE TO READ AND WRITE: YES_____ NO_____

NUTRITIONAL STATUS:

DIET: REGULAR_____ MECHANICAL_____ REGULAR_____SOFT_____ LAST SEEN BY DENTIST: _____

DIET REQUIRED: YES_____ NO_____ WHO PREPARES MEALS_____

TYPE OF DIET: LOW SODIUM_____ NO ADDED SALT_____NO CONCENTRATED SUGAR_____LOW FAT_____

DIABETIC: YES_____ NO_____ FREQUENCY OF ACCU-CHECKS: _____ LAST BLOOD SUGAR LEVEL: _____

APPETITE: NORMAL_____ FAIR_____ POOR_____ OBESITY: YES_____ NO_____ (80 LBS OVER IBW) CALORIES /DAY _____

WEIGHT LOSS: YES_____ NO_____ MORE THAN 20 LBS IN 6 MONTHS: YES_____ NO_____

FALL RISK:

IS THE CLIENT ABLE TO WALK: YES_____ NO_____ ON COMPLETE BED REST: YES_____ NO_____

EXPLAIN:
_____
_____

CLEAR PATHWAYS: YES_____ NO_____ PROPER LIGHTING: YES_____ NO_____

CLIENT USE PROPER ASSISTIVE DEVICE TO AMBULATE: YES_____ NO_____

CLIENT HAS STAIRS OR STEPS IN THE HOUSE: YES_____ NO_____ CLIENT USE WHEELCHAIR: YES_____ NO_____

CRUTCHES: YES_____ NO_____ WALKER: YES_____ NO_____ CANE: YES_____ NO_____ TUB BENCH: YES_____ NO_____

CLIENT ON OXYGEN: YES_____ NO_____ IF YES, CONTINUOUS OR INTERMITTENT: _____

IS THERE NO SMOKING SIGN: YES_____ NO_____ PROPER TANK STORAGE: YES_____ NO_____

DME COMPANY FOR O2: _____ PHONE # _____

IS THE CLIENT CONFUSED OR TAKING MEDICATIONS AFFECTING BLOOD PRESSURE OR LEVEL OF CONSCIOUSNESS: YES_____ NO_____ IF YES, PLEASE EXPLAIN:
_____
_____
_____

GAIT/BALANCE PROBLEMS: YES_____ NO_____

HISTORY OF FALLS IN THE PAST 3 MONTHS: YES_____ NO_____ INJURIES: YES_____ NO_____

IF YES, PLEASE EXPLAIN:

_____
_____
_____
_____

ADDITIONAL COMMENTS:

_____

_____

_____

HIGHLY UNSTABLE: _____ MODERATE: _____
ROUTINE: _____

Client Name: _____

Client Signature: _____

Date: _____

Policy on Self-Administered and handling of Medication

Consumer Name: _____ Medicaid ID:_____

Passionate Care Services LLC. does not allow service providers (Sub-contractor) to administer any medication.

If parent/guardian is home with recipient, service provider should remind guardian to administer medication. Only certified service providers such as: CNA, HHA, RN, and LPN; may assist with medication administration. Service providers must receive a minimum of 2 hours of training (which may be part of Home Health Training) prior to assuming their responsibility. Trainings must meet State Law Requirements concerning procedures for assisting individuals with self-administration of medication. Service providers' supervision of recipients' self-administering of medication in the home is limited to:

1. Performing appropriate hand washing before providing medication assistance.
2. Putting on gloves, making sure that recipient does not have any latex allergies.
3. Preparing necessary items of assistance such as juice, water, cups, spoons, etc.
4. Obtaining medication from storage area for recipient and verifying the following information:

- Correct Consumer
- Correct Medication
- Correct Dosage (Amount)
- Correct Time (During the day/night)
- Correct route (oral, etc.)

Service providers are expected to remind Individuals to take their medication as prescribed. They should observe recipients self-administering medication to ensure that the proper dosage has been swallowed, applied. Also service providers may assist as follow:

- Open and/or close medication container or tear open pre-packaged medications.
- Assist recipient in self-administration process by steadying the arm hand, or other parts of individual's body to allow the self-administration of medication.
- Assist the recipient with placing unused medication back into the container.

Passionate Care Services LLC. has advised Consumer/guardian or caregivers a Policy on self-administering of medication on annual basis as a reminder to follow procedures.

_____ _____

Consumer/Parent/Legal Guardian Signature **Date**

Authorization/Waiver to Transport

Authorization Is Valid:_____
Consumer Name: ___ _____

This client requires a booster seat: o Yes o No (All children under 8 years of age are required to be in a booster seat)
I authorize Passionate Care Services LLC, to transport my family member in a caregivers private vehicle. I understand my family member is expected to follow all applicable laws regarding riding in a motor vehicle and is expected to follow the directions provided by the caregiver/staff. I understand transportation is not a requirement for participation in the waiver Respite program. I have read, understand, and discussed with my family member:

(1) My family will travel in a motor vehicle driven by an adult caregiver and my family member is to wear their safety belt and not be disruptive to the driver of the vehicle.
during travel;

(2) My family is expected to listen to supervising staff/driver, respect staff and other individuals, the vehicles they ride in, and the people they travel with during the trip;

(3) Riding in a motor vehicle may result in personal injuries or death from wrecks, collisions or acts by riders, other drivers, and/or objects;

_____ I recognize participation in this activity, as with any activity involving motor vehicle transportation, my family may risk personal injury or permanent loss. I hereby attest and verify I have been advised of the potential risks, and I have full knowledge of the risks involved in this activity, and I assume any expenses incurred in the event of an accident, illness, or other incapacity, regardless of whether I have authorized such expenses.
_____ As a condition for the transportation received, I, for myself, my family, my executors and assigns, further agree to release and forever discharge Passionate Care Services LLC and their agents, officers, employees and volunteers from any claim that I might have myself or that I could bring on my family members behalf with regard to any damages, demands or actions whatsoever, including those based on negligence, in any manner arising out of this transportation.
_____ I have read this entire waiver and authorization form, I fully understand its terms and conditions, and I agree to be legally bound by its terms.

_____ _____
Client/Consumer Signature **Date**

_____ _____
Company Rep Signature **Date**

State of _____

County of _____
This instrument was acknowledged before me on _____
Date

By

_____
Name(s) of person(s)

_____
Signature of Employer

_____
Signature of Notary *(Seal)*

Health & Checkup Report

DR Name: _____ Fax #: _____

Apt Date: _____ Reason for Visit: _____

Date of next Apt: _____ Address: _____

Outcome: _____

_____

_____

Labs: _____

_____

_____

_____

DR Name: _____ Fax #: _____

Apt Date: _____ Reason for Visit: _____

Date of next Apt: _____ Address: _____

Outcome: _____

_____

_____

Labs: _____

_____

_____

_____

DR Name: _____ Fax #: _____

Apt Date: _____ Reason for Visit: _____

Date of next Apt: _____ Address: _____

Outcome: _____

_____

_____

Labs: _____

CLIENT RIGHTS, RESPONSIBILITIES, and ONGOING EDUCATION

Discussed monthly in quarter review by Agency and weekly by caregiver documented on progress notes.

As a client you have the right to:

*Choose your healthcare provider. *Be fully informed of your rights and receive this notice before the initiation of care.*Be treated with dignity, consideration, and respect by professional staff *Exercise your rights.(If the client has been judged incompetent, the family or legal guardian may exercise the clients rights).*Have your person and property treated with respect.*Upon request, receive a copy of your Plan of Care established and maintained by the agency.*Voice grievances regarding care or lack of respect for property without being subject to discriminate or reprisal. Supervisor can be contacted by calling _561-223-7708__. *Be informed, orally and in writing, before care is initiated of the extent to which payment for agency services may be expected from_____. or other sources.*Participate in the planning and revising of your program and updating it as your condition changes.*Be advised in advance of the staff who will provide care, the proposed frequency of visits, and/or any changes in the plan of care due to changes in your health or available resources.*Refuse all or partial services and treatments to the extent permitted by law, and be informed of possible consequences.*Be informed within a reasonable time of anticipated termination of services or transfer to another provider.*Formulate an Advance Directive and be informed of the implementation of the Advance Directive requirements.*Appropriate assessment and management of your pain.*Request information about your medical conditions, including alternative treatments and associated risks.*Talk with an agency supervisor.*Expect confidentiality of all records, communications, and personal information related to your care, in accordance with HIPAA, Federal and State Laws.*To obtain a paper copy of the "Notice of Privacy Practice".*To request restrictions your PHI(Protected Health Information).*To request confidential communications of your PHI.*To request access to your PHI.*To request an amendment to your PHI.*To request an accounting of disclosures of your PHI.*To lodge a complaint concerning your PHI.

To complain about the agency, call the Hotline number for the State Agency for Health Care Administration: Monday through Friday 8:00 a.m. to 6:00 p.m.

As a client you have the responsibility to:

*Provide the agency with a complete and accurate health history.*Remain under a doctor's care while receiving agency services.*Inform the agency of the existence of and any changes made to the Advance Directive.*Notify the agency about how satisfied you are with the service.*Accept the consequences for any refusal of treatment or choice of noncompliance.*Provide the agency with all requested insurance and financial information, including any changes in coverage.*Advise the agency of any problems or dissatisfaction with our care, without being subject to discrimination or reprisal.*Request further information concerning anything you do not understand.*Participate in the planning and revising of your home program and updating it as your condition changes.*Provide a safe home environment in which your care can be provided appropriately and adequately.*Cooperate with your doctor, agency staff, and other caregivers. * Notify the agency when unable to keep appointments. *Treat agency personnel with respect and consideration. *Sign the required consents and releases for insurance billing.

To report abuse, neglect, or exploitation call the Hotline Toll-Free number 1-800-962-2873 Monday - Friday 24 hours day

_____ _____ _____

Print Client Name: Client Signature Date

Policy on Grievance

Consumer Name: _____ Medicaid ID#_____

If an Individual/guardian or legal representative feels that the Consumer has been mistreated, neglected, has not received services as promised, or feels that services are not helpful, a grievance may be filed. That grievance procedures will be reviewed and signed by the recipient, family or guardian **within 30 days of beginning services and annually thereafter**.

- **Informal Grievance**- is made by calling the case manager assigned to the case. The case manager will work with the client to resolve the complaint within 48 hours of notification. If the Individual or guardian is still not satisfied, the case manager will notify Waiver Support Coordinator and/or Administrator.

Case Managers will keep detailed logs of informal complaints, including how each situation was resolved.

- **Formal Grievance**- Must be written and include name, address and telephone number of the person filing the grievance, as well as the Individual's name and reason for complaint in as much detail as possible. The information is to be mailed or hand-delivered to **Passionate Care Services LLC.** office.
- Within 5 business days, the case manager will respond, at the Individual's level of comprehension and will submit a copy of the grievance and response to the support coordinator. If the Individual or guardian wishes, they may request a meeting with the case manager assigned to the case or any other party involved.
- All grievances will be resolved within 30 calendar days of filing or will be forwarded to the District of Developmental Disabilities Program office for a solution.
- All grievances and correspondences are kept on file at **Passionate Care Services LLC.:** Case Managers will take actions as follow:
  1. Review these procedures on annual basis in clear, understandable language
  2. Offer assistance in utilizing a third party for solution of any issues, if needed.
  3. Complete training regarding the importance of these procedures and Individual's rights.
  4. Inform Individuals of the right to change service provider at any time for any reason without interruption of services.

  I, _____ have been instructed and informed of the above policy.

_____ _____

Individual/Parent/Guardian Signature Date

Choices and Preferences

The purpose of this questionnaire is to educate the provider of the individual's desires and needs in order to promote and prioritize the individual's choices and preferences in their plan of care. These items refer to the things that give joy, satisfaction and pleasurable feelings and that the individual enjoys.

Individual: _____ **Date:** _____

Completed by: _____

Food Preference:

	Never	Sometimes	Always
Preferred fruits:	□	□	□
a.	□	□	□
b.	□	□	□
c.	□	□	□
Preferred beverages:	□	□	□
a.	□	□	□
b.	□	□	□
Preferred dessert:	□	□	□
Ice Cream (what kind)	□	□	□
a.	□	□	□
b.	□	□	□
Cookies/cakes	□	□	□
a.	□	□	□
Favorite food:	□	□	□
a.	□	□	□
b.	□	□	□
c.	□	□	□
d.	□	□	□
e.	□	□	□
f.	□	□	□
Food allergies:			
a.			
b.			

Entertainment:

	Never	Sometimes	Always
Favorite TV shows and movies:	□	□	□
a.	□	□	□
b.	□	□	□
c.	□	□	□
Music (favorite artists):	□	□	□
a.	□	□	□
b.	□	□	□
Favorite events to attend:	□	□	□
a.	□	□	□
b.	□	□	□
Riding bike/Skating	□	□	□
Table games	□	□	□
Video games	□	□	□
Other forms of entertainment:	□	□	□
a.	□	□	□

Arts/Crafts/Hobbies:

Playing instrument	□	□	□
Singing	□	□	□
Dancing	□	□	□
Drawing	□	□	□
Building models	□	□	□
Others:	□	□	□
a.	□	□	□
b.	□	□	□
c.	□	□	□
d.			
e.			
f.			
g.			

Community Interaction:

	Never	Sometimes	Always
Car rides	□	□	□
Visiting relative/friends	□	□	□
Going to the store (browse or shop)	□	□	□
Going to restaurants	□	□	□

Going for a walk (exercise or pleasure)	□	□	□
Going to the mall	□	□	□
Outings (zoo, fairs, etc)	□	□	□
Other:	□	□	□
a.	□	□	□
b.	□	□	□

Social Interactions:

Being hugged	□	□	□
Being touched	□	□	□
Group activities	□	□	□
Talking and socializing with others	□	□	□
Spending time alone	□	□	□

Activities of daily living:

Setting table/cleaning up after dinner	□	□	□
Making bed	□	□	□
Sweeping/dusting	□	□	□
Working outdoors	□	□	□
Cooking/meal preparation	□	□	□
Meal planning	□	□	□
Shopping/running errands	□	□	□
Exemption from chores	□	□	□
Other:	□	□	□
a.	□	□	□
b.	□	□	□
c.	□	□	□

Personal Appearance:

	Never	Sometimes	Always
Choses outfits/clothing style	□	□	□
Likes to get haircuts/hair styled	□	□	□
Photogenic	□	□	□
Sensory Stimulation:			
Sensitive to smell	□	□	□
Sensitive to colors	□	□	□
Sensitive to noise	□	□	□
Sensitive to light	□	□	□
Rocking	□	□	□
Ticking	□	□	□

Other Activities:			
Likes to read or being read to	□	□	□
Having free time	□	□	□
Having own money	□	□	□
Other:	□	□	□
a.	□	□	□
b.	□	□	□
c.	□	□	□

PLEASE INITIAL EACH MONTH CHOICES AND PREFERENCES WAS DISCUSSED THIS FISCAL YEAR

_____JULY
_____AUGUST
_____SEPTEMBER
_____OCTOBER
_____NOVEMBER
_____DECEMBER
_____JANUARY
_____FEBRUARY
_____MARCH
_____APRIL
_____MAY
_____JUNE

CLIENT DISASTER PLAN

CLIENT: _____ RECIPIENT ID: _____

ADDRESS: _____ PHONE:_____

CITY: _____ ZIP: _____

My Disaster Plan is to

_____

_____

My Alternate Plan is to:

_____

_____

Transportation Provided By:

_____

Living Arrangement:

_____

Address of Contact Person:

_____

Name of Person Responsible for: _____

- Insure person has all recommended disaster preparedness supplies
- Insuring person has recommended first-aid items in stock
- Insuring person has evacuation supplies prepared.
- Insuring person is trained to use disaster-preparedness and first aid supplies.
- Insuring that transportation is arranged in the event of an evacuation.
- Serving as a companion to person while in special needs circumstances.
- Verifying person's health and safety within 2 hours after emergency mgmt.
- Assisting the person to assess damage to home and whether it is safe to return home.
- Notifying APD of any client injury or illness or significant damage to client property as result of disaster.
- Training person in all aspects of this plan.

This disaster plan is current as of:
It has been reviewed with the client and all parties assigned responsibility in the plan.

➢ **Register with Special Needs Shelter if Oxygen Dependent or Has Medical Needs and Must Be Evacuated.**

Client Name: _____

Client Signature: _____

Date_____