**Community Health Care Client Application/ADMISSIONS INTAKE/NEED FOR SERVICES AGREEMENT**

1. Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Intake Date: \_\_\_\_\_\_\_\_\_\_\_\_

2. SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ APT#\_\_\_\_COUNTY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE: \_\_\_\_\_\_\_\_\_ ZIP CODE: \_\_\_\_\_\_\_ PHONE #\_\_\_\_\_\_\_\_\_\_\_\_

5. D.O.B \_\_\_\_\_\_\_\_\_\_\_\_\_ AGE: \_\_\_\_\_\_\_\_\_ MALE \_\_\_ FEMALE \_\_\_\_

6. RACE: AFIRICAN AMERICAN \_\_\_ AMERICAN INDIAN \_\_\_ HISPANIC ORGIN\_\_\_

ASIAN AMERICAN \_\_\_ OTHER\_\_\_\_

7. MARITAL STATUS: MARRIED\_\_\_ SEPARATED\_\_\_ DIVORCED\_\_\_\_ SINGLE \_\_\_

WIDOWED \_\_\_

8. INCOME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SOURCE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. DOES CLIENT HAVE POWER OF ATTORNEY / GUARDIAN? \_\_\_\_\_YES \_\_\_\_\_ NO

10. LIVING ARRANGEMENTS: WITH SPOUSE ☐ SPOUSE & OTHERS ☐

CHILDREN ☐ OTHER RELATIVES☐ OTHERS (NOT RELATED) ☐

ALONE ☐ PERSONAL CARE PROVIDER☐ UNKNOWN☐

11. RESIDENCE TYPE: ☐HOME/APT ☐OTHER ☐ASSITED LIVING ☐OTHER

(SPECIFY) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

12. REASON FOR REFERAL \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

13. NAME OF PERSON CALLING \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

14.EMERGECNCY CONTACT /RELATIONSHIP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

15. PERSONAL PHYSICIAN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

16. PRESENTING PROBLEMS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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(1)

17. IS THERE ANY HISTORY OF MENTAL ILLNESS OR DEVELOPMENTAL

DISABILITY? ☐ YES ☐ NO

COMMENTS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

18. IS THERE ANY EVIDENCE OF MEMORY LOSS? ☐ YES ☐ NO

COMMENTS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

19. **NEED FOR SERVICES:** ACTIVITIES /INSTRUMENTAL OF DAILY LIVING

PRIMARY ADL: ☐ EATING ☐ WALKING ☐DRESSING ☐BATHING

☐ TRANSFERING ☐GROOMING ☐TOILETING

☐ MEDICATION MANAGEMENT

INSTRUMENTAL ADL: ☐ MEAL PREPARATION ☐HOUSEKEEPING ☐ERRANDS

☐ LAUNDRY

BOWEL FUNCTION \_\_\_\_\_\_\_ BLADDER \_\_\_\_\_\_ 1.CONTINENT 2.INCONTINENT

CLIENT’S SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

20. OTHER AGENCIES PROVIDING SERVICES? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

COMMENTS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

21. **STATEMENT OF RIGHTS**

COMMUNITY HEALTHCARE RECONIZES THE FOLLOWING STATEMENT OF CLIENT’S

RIGHTS:

 THE RIGHT TO BE TREATED WITH RESPECT & DIGNITY OF HIS HER

INDIVIDUALITY & PRIVACY

 TO RECEIVE CARE & SERVICES WHICH ARE ADEQUATE, APPROPRIATE WITH

RELEVANT TO FEDERAL AND STATE LAWS AND RULES & REGUALTION

 TO BE FREE OF MENTAL AND PHYSICAL ABUSE, NEGLECT & EXPLOITATION

 THE RIGHT TO ENCOURAGED & SUPPORTED IN MAINTAING ONE’S

INDEPENDENCE TO THE EXTENT THAT CONDITIONS AND CIRCUMSTANCES

PERMIT

 THE RIGHT TO SELF DETERMINATION AND BEING & BEING INFORMED ABOUT

SERVICES RENDERED & THE OPPORTUNITY TO PARTICIPATE INDEVELOPING

ONE’S PLAN OF CARE

 THE RIGHT TO BE CARED FOR IN AN ATMOSOHERE OF SINCERRE INTEREST

& CONCERN IN WHICH NEEDED SUPPORT SERVICES ARE PROVIDESD

 THE RIGHT TO HAVE PERSONAL & MEDICAL RECORDS KEPT COMFIDENTIAL &

NOT DISCLOSED WITHOUT WRITTEN CONSENT OF THE INDIVIDUAL OR

GUARDIAN

(2)

 THE RIGHT TO VOICE GRIEVIENCES ABOUT THEIR CARE & NOT BE SUBJECT

TO DESCRIMINATION OR REPRISAL FOR DOING SO

 THE RIGHT TO BE INFORMED OG THEIR LIABBILITY FOR PAYMENT SERVICES

THE RIGHT TO BE INFORMED OF THE PROCESS OF ACCEPTANCE &

CONTINUANCE OF SERVICES & ELIGIBILITY DETERMINATION

 THE RIGHT TO ACEPT OR REFUSE SERVICES

 THE RIGHT TO BE INFORMED OF THE AGENCY’S ON CALL SERVICE

 THE RIGHT TO BE INFORMED OF SUPERVISORY ACCESSIBILITY &

AVAILABILITY

 THE RIGHT TO BE ADVISED OF THE AGENCY’S PROCEDURE FOR DIDCHARGE

COMPLAINTS PLEASE CONTACT YOUR LOCAL SITE SUPERVISOR OR

Community Health Care Corporate office: 336-617-0426

P.O Box 6028 1633 Greensboro N.C 27402

Maryland Complaints: [www.dhmh.state.md.us/ohcq/faq](http://www.dhmh.state.md.us/ohcq/faq) or 1-800-492-6005

North Carolina Complaints: Division of Facility Services 1-800-624-3004 or Department of Human Resource Care Line 1-800-662-7030

I HAVE READ, UNDERSTOOD AND HAVE A COPY FOR MY RECORDS OF THE AGENCY’S CLIENT RIGHTS & RESPONSIBILITIES.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CLIENT’S SIGNATURE DATE

22. I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HEREBY GIVE COMMUNITY HEALTH CARE

AUTHORIZATION CONSENT TO RELEASE INFORMATION WITHIN MY CLIENT

RECORD TO THE FOLLOWING:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHYSICIAN (S) MEDICAL PROVIDER (S)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

THIRD PARTY PAYER OTHER

THE RELEASE INFORMATION WITHIN MY CLIENT RECORD TO THE ABOVE NAMED PARTIES MAY BE USED TO PROVIDE ME, THE CLIENT, WITH PROPER HEALTH CARE TREATMENT; FOR REFERENCE TO OTHER HEALTH CARE PROVIDERS; TO OBTAIN PAYMENT FOR SERVICES; COLLECTION DEPARTMENTS; HEALTH PLANS AND THEIR AGENTS WHICH PROVIDE MY COVERAGE AND AGENTS OR STAFF WHO REVIEW THE CARE I RECEIVE TO PROVE THAT IT AND THE COST ASSOCIATED ARE APPROPRIATE FOR MY MEDICAL CONDITIONS AND /OR INJURIES.

THIS AUTHORIZATION CONSENT ALSO MAY BE USED TO SHARE CLIENT RECORD INFORMATION WITH A FAMILY MEMBER, RELATIVE, FRIEND, OR OTHER PERSONS I DESIGNATE WHO ARE INVOLVED WITH MY MEDICAL CARE, AND/OR PAYMENT FOR THE CARE I RECEIVE BY COMMUNITY HEALTH CARE. FURTHERMORE, MY CLIENT INFORMATIONCAN BE SHARED FOR STAFFING THE SERVICES REQUIRED IN THE AGENCY’S ASSIGNMENT PROCESS OR TO OTHER PUBLIC OR PRIVATE AGENCIES FOR DISASTER RELIEF AND/OR EMERGENCY CIRCUMSTANCES.

(3)

CLIENT’S SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

I HAVE READ THE TERMS OF APPICATION AND HAVE VOLUNTEERED REQUESTED INFORMATION

**CLIENT’S SIGNATURE /REPRESENTATIVE** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_

(4)