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 _____
_____
_____

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

- 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: 336-285-7001
P.O Box 6028 1633 Greensboro N.C 27402-1633

Maryland Complaints: 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.

CLIENT'S SIGNATURE: _____ DATE: _____

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

CLIENT'S SIGNATURE /REPRESENTATIVE _____ DATE _____

COMMUNITY HEALTH CARE, INC.

ELECTRONIC VISIT VERIFICATION (EVV) SYSTEM ACKNOWLEDGEMENT

As a recipient of Medicaid Funding for Personal Care Services in the State of North Carolina, I am being informed about the Electronic Visit Verification (EVV) System that was implemented January 1, 2021. This system is used by Community Health Care, Inc. to verify that services are delivered at my resident by my caregiver using a telephone and computer-based solution for clocking in and out for the time of service provision on each specified date. Therefore, Medicaid will be billed for services rendered according the recorded information gathered for each home visit.

Client Signature _____