

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: _____ PH# _____
5. D.O.B. _____ AGE: _____ MALE: _____ FEMALE _____
6. RACE: AFRICAN AMERICAN ___ AMERICAN INDIAN ___ HISPANIC ORIGIN ___
ASIAN AMERICAN ___ CAUCASIAN ___ 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 ___ ASSISTED LIVING ___
(SPECIFY) _____
12. REASON FOR REFERRAL _____
13. NAME OF PERSON CALLING _____ PH# _____
14. EMERGENCY CONTACT / RELATIONSHIP _____
PHONE # _____
ADDRESS _____
15. PERSONAL PHYSICIAN _____ PH# _____
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
___ TRANSFERRING ___ GROOMING ___ TOILETING
___ MEDICATION MANAGEMENT

INSTRUMENTAL ADL: ___ MEAL PREPARATION ___ HOUSEKEEPING
___ ERRANDS ___ MEDICATION MANAGEMENT

BOWEL FUNCTION ___ BLADDER ___ 1. CONTINENT ___ 2. INCONTINENT

CLIENT'S SIGNATURE: _____

20. OTHER AGENCIES PROVIDING SERVICES? _____

COMMENTS _____

21. STATEMENT OF RIGHTS

- (1) To be informed and participate in his or her plan of care.
- (2) To be treated with respect, consideration dignity, and full recognition of his or her individuality and right to privacy.
- (3) To receive care and services that are adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations.
- (4) To voice grievances about care and not be subjected to discrimination or reprisal for doing so.
- (5) To have his or her personal and medical records kept confidential and not be disclosed except as permitted or required by applicable state or federal law.
- (6) To be free of mental and physical abuse, neglect and exploitation.
- (7) To receive a written statement of services provided by the agency and the charges the client is liable for paying.
- (8) To be informed of the process for acceptance and continuance of service and eligibility determination.
- (9) To accept or refuse services.
- (10) To be informed of agency's on call service.
- (11) To be informed of supervisory accessibility and availability.
- (12) To be advised of the agency's procedures for discharge.
- (13) To receive a reasonable response to his or her requests of the agency.
- (14) To be notified within 20 days when the agency's license has been revoked, suspended, canceled, annulled, withdrawn, recalled or amended.
- (15) To be advised of the agency's policies regarding patient responsibilities.

COMPLAINTS PLEASE CONTACT YOUR LOCAL SITE SUPERVISOR OR
Community Health Care Corporate office: 336-285-70001
P.O. Box 1633, Greensboro, NC 27402-1633

Maryland Complaints: www.dhmh.state.md.us/ohcq/faq or 1-800-494-6005
North Carolina Complaints: Division of Facility Services 1-800-624-3004 or Department of
Human Resource Care Line 1-800662-7030

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 PERSON I
DESIGNATE WHO ARE INVOLVED WITH MY MEDICAL CARE, AND/OR PAYMENT FOR
THE CARE I RECEIVE BY COMMUNITY HEALTH CARE. FURTHERMORE, MY CLIENT
INFORMATION MAY 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 THE APPLICATION AND HAVE VOLUNTEERED
REQUESTED INFORMATION.

CLIENT'S SIGNATURE/ REPRESENTATIVE: _____

DATE: _____

COMMUNITY HEALTH CARE, INC.

CERTIFIED NURSE AIDE WAIVER

I, _____ understand that I have given permission to
(print name)

Community Health Care, Inc. to employ a non-certified nurse aide to provide Personal Care Services on my behalf or to family member. I waive the requirement of a certified nurse assistant for any individual providing services. However, the personal care aide should be competent to provide nursing services as demonstrated by the competency skills assessment rendered by Community Health Care, Inc..

Client or Responsible Party Signature: _____

Date: _____