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 REFERAL ____
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 of federal law.
(6) To be free or 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 infored 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 Compaints: 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.

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 ______________________________

NOTICE OF NO SMOKING IN CLIENTS' HOMES

I am hereby notified of the No Smoking Policy signed and dated by all Nurse Aides who provide services in my place of resident. According to the Division of Health Service Regulations, a bill was issued in effect October 1, 2007 which prohibits the smoking by employees in homes of their clients.

Client/Representative Signature: ____

Date: ____________________________