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. <u>STATEMENT OF RIGHTS</u>

(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: _____

XXIX. CLIENT APPROVED WORK SCHEDULE POLICY

All clients will have approved work schedules for their nurse aides for the number of weekly hours approved by Maryland Department of Health and Mental Hygiene (DHMH) and North Carolina Department of Medicaid. The standard work week is Sunday through Saturday. Appropriate Client Schedules will be reviewed and approved by Supervisor and Director. At no time should a nurse aide clock in and clock out over 12 hours consecutive for a given shift. Example: If you clock in at 8:00 a.m. until 9:00 p.m., a total of 13 hours or more are not permissable. You would only be paid for 12 hours and not the one (1) additional hour.

It is highly mandatory that all employees and clients follow the approved Client Schedule. DHMH and North Carolina Department of Medicaid along with Community Health Care DO NOT PAY for unapproved client hours. Employees must never work over approved weekly hours for their clients because those hours are unauthorized by DHMH, North Carolina Medicaid and Community Health Care. Employees must only report hours worked according to Client Approved Work Schedules for the week.

All clients and employees are informed that no pay will be given to employees when clients are in hospitals, nursing facilities, mental institutions that are not the clients' private homes. COMAR 10.09.84.14A requires that clients reside at home to receive personal assistance services. Violators will have consequences. ONLY FOLLOW CLIENTS APPROVED WORK SCHEDULES IN THEIR PRIVATE HOMES.

Post the Client Approved Work Schedule on the client's refrigerator if they allow you or where it can be seen in the client's home at all times.

Client Signature: _____

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: _____