

**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.dhmd.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.

PERSONNEL POLICIES AND PROCEDURES

DATE: January 10, 2025

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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 permissible. 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.

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: _____