**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 <u>not</u> 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 <u>only</u> 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: _____

**APPOINTMENT OF**
***HEALTHCARE AGENT***

# ADVANCE DIRECTIVE - PART A
# APPOINTMENT OF HEALTH CARE AGENT

*(Optional Form)*

**INSTRUCTIONS**

*If you decide to appoint a healthcare agent, complete Part A (p. 1-2) and cross through any items in the form that you do not want to apply. Cross through this whole part of the form if you do not want to appoint a health care agent to make health care decisions for you.*

**PRINT YOUR NAME AND ADDRESS**

I, _____

residing at

_____

appoint the following individual as my agent to make health care decisions for me:

**PRINT THE NAME ADDRESS, AND TELEPHONE NUMBER OF YOUR HEALTHCARE AGENT (At least 18 years old)**

_____

_____

**(Full Name, Address and Telephone Number of Agent)**

**PRINT THE NAME ADDRESS, AND TELEPHONE NUMBER OF YOUR ALTERNATE HEALTHCARE AGENT (At least 18 years old)**

Optional: If this agent is unavailable or is unable or unwilling to act as my agent, then I appoint the following person to act in this capacity:

_____

_____

**(Full Name, Address and Telephone Number of Back-up Agent)**

2. My agent has full power and authority to make health care decisions for me, including the power to:

A. Request, receive, and review any information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records, and consent to disclosure of this information;
B. Employ and discharge my health care providers;
C. Authorize my admission to or discharge from (including transfer to another facility) any hospital, hospice, nursing home, adult home, or other medical care facility; and
D. Consent to the provision, withholding, or withdrawal of health care, including, in appropriate circumstances, life-sustaining procedures.

APPOINTMENT OF HEALTHCARE AGENT

# APPOINTMENT OF HEALTHCARE AGENT (continued)

**LIST RESTRICTIONS TO YOUR AGENT'S POWER (IF ANY)**

3. The authority of my agent is subject to the following provisions and limitations:_____

_____

**ADD MODIFICATIONS TO APPLY DURING PREGNANCY(OPTIONAL)**

4. If I am pregnant, my agent shall follow these specific instructions:_____

_____

**INITIAL THE OPTION THAT REFLECTS YOUR WISHES**

5. My agent's authority becomes operative *(initial only the one option that applies):*

_____When my attending physician and a second physician determine that I am incapable of making an informed decision regarding my health care, or

_____When this document is signed.

6. My agent is to make health care decisions for me based on the health care instructions I give in this document and on my wishes as otherwise known to my agent. If my wishes are unknown or unclear, my agent is to make health care decisions for me in accordance with my best interest, to be determined by my agent after considering the benefits, burdens, and risks that might result from a given treatment or course of treatment, or from the withholding or withdrawal of a treatment or course of treatment.

7. My agent shall not be liable for the costs of care based solely on this authorization.

**SIGN AND DATE THE DOCUMENT HERE**

By signing below, I indicate that I am emotionally and mentally competent to make this appointment of a health care agent and that I understand its purpose and effect.

_____Date

_____ Signature of Declarant

**WITNESSING PROCEDURE**

The declarant signed or acknowledged signing this appointment of a health care agent in my presence and, based upon my personal observation, appears to be a competent individual. *At least one of us is not knowingly entitled to any portion of the estate of the declarant or knowingly entitles to any financial benefit by reason of the death of the declarant. Neither of us is the healthcare agent, or alternate agent, for the declarant.*

**SIGNATURES AND ADDRESSES OF TWO WITNESSES (At least 18 years old)**

| | |
|---|---|
| (Witness) | (Witness) |
| | |
| | |
| | |

**SIGNATURES AND ADDRESSES OF TWO WITNESSES**

HEALTHCARE INSTRUCTIONS

# ADVANCE DIRECTIVE - PART B HEALTH CARE INSTRUCTIONS

(Optional Form)

**FOR EACH QUESTION, INITIAL THE OPTION THAT REFLECTS YOUR WISHES**

Complete this form to create written healthcare instructions (p. 3 & 4). **Initial those statements you want to be included in the document and cross through those statements that do not apply.** Cross through this whole part of the form if you do not want to give health care instructions.

**If I am incapable of making an informed decision regarding my health care, I direct my health care providers to follow my instructions as stated below.**

**TERMINAL CONDITION**

1. If I am close to death due to injury, disease or illness, and my doctors believe there is no reasonable hope of recovery, even with life sustaining procedures, I direct that my life (initial one):

____ Not be extended by any medical treatment except comfort care and medication to alleviate pain, even if the pain medication would shorten my remaining life.

____ Not be extended by any life sustaining procedures (such as tube feeding, ventilators and CPR).

____ Not be extended by life sustaining procedures, except that if I can not take food or liquids by mouth, I wish to be tube fed.

____ Be extended by all available medical means in accordance with accepted healthcare standards.

**PERSISTENT VEGETATIVE STATE**

If I am permanently unconscious and my doctors believe that there is no reasonable hope of recovery, I direct that my life (initial one):

____ Not be extended by any medical treatment except comfort care and medication to alleviate pain, even if the pain medication would shorten my remaining life.

____ Not be extended by any life sustaining procedures (such as tube feeding, ventilators and CPR).

____ Not be extended by life sustaining procedures, except that if I can not take food or liquids by mouth, I wish to be tube fed.

____ Be extended by all available medical means in accordance with accepted healthcare standards.

**END-STAGE CONDITION**

If I have become so sick or seriously injured from a progressive condition that I am unable to make medical decisions and I am completely dependent on others with no reasonable hope of recovery, I direct that my life (initial one):

____ Not be extended by any medical treatment except comfort care and medication to alleviate pain, even if the pain medication would shorten my remaining life.

____ Not be extended by any life sustaining procedures (such as tube feeding, ventilators and CPR).

____ Not be extended by life sustaining procedures, except that if I can not take food or liquids by mouth, I wish to be tube fed.

____ Be extended by all available medical means in accordance with accepted healthcare standards.

HEALTHCARE INSTRUCTIONS

# HEALTHCARE INSTRUCTIONS (continued)

**ADD MODIFICATIONS TO APPLY DURING PREGNANCY (OPTIONAL)**

4. If I am pregnant, my decision concerning life-sustaining procedures shall be modified as follows: _____

_____

**ADD FURTHER PERSONAL INSTRUCTIONS (IF ANY)**

5. I further direct (in the following space, indicate any other instructions regarding receipt or nonreceipt of any health care):

**ORGAN DONATION (OPTIONAL)**

6. I provide the following instructions regarding donation of my organs and tissues for transplant, medical study or education. If I choose to be a donor, I want artificial heart/lung support devices continued only until such time as organ suitability is confirmed and organ recovery has taken place (initial one):

_____ I want to donate all my organs and tissues.
_____ I do not wish to donate any of my organs and tissues.
_____ I wish to donate only these organs and tissues:

_____

_____

**SIGN AND DATE THE DOCUMENT HERE**

By signing below, I indicate that I am emotionally and mentally competent to write these healthcare instructions and that I understand the purpose and effect of this document.

_____(Date)

_____(Signature of Declarant)

**WITNESSING PROCEDURE**

The declarant signed or acknowledged signing this appointment of a health care agent in my presence and, based upon my personal observation, appears to be a competent individual. *At least one of us is not knowingly entitled to any portion of the estate of the declarant or knowingly entitles to any financial benefit by reason of the death of the declarant. Neither of us is the healthcare agent, or alternate agent, for the declarant.*

**SIGNATURES AND ADDRESSES OF TWO WITNESSES**
**( At least 18 years old)**

| | |
|---|---|
| (Witness) | (Witness) |
| | |
| | |

*(Signatures and Addresses of Two Witnesses)*

Community Health Care, Inc.

communityhealthcareinc.com

## DECLINATION OF ADVANCE DIRECTIVES

I, _____, received the Advance Directive Form to complete from Community Health Care. I am declining to accept and decline the form.

Client Signature: _____

Date: _____

P. O. Box 1633
Greensboro, NC 27402-1633
(336) 285-7001 Voice