TRINITY HOME HEALTH SERVICES, INC.

Address: 10560 Main Street Suite 211, Fairfax VA 22030
Phone: (571) 419 8612 Fax: (866) 531 6484 E-mail: thhservices22@gmail.com

PATIENT INFORMATION		INSURANCE INFORMATION		
Patients Name:		**Admit** **Reject**		**Admitted Date:**
Address:		**Insurance:**		
City: **Zip:**		**Medicare#**		**Part A Part B**
Phone:		**Social Security:**		
DOB: **Sex: M F**		**Private Insurance:**		
Race: **Marital Status:**		**HOSPITAL INFORMATION**		
PHYSICIAN INFORMATION		**HOSPITAL ADMISSION DATE:**		
Physician Name:		**HOSPITAL DISCHARGE DATE:**		
Phone:		**SURGICAL PROCEDURES:**		
NPI:				
Address:		**DIAGNOSIS**	**ICD-10**	**SERVICES**
City: **Zip:**		**Primary:**		**SN**
CARE PERSON				**LPN/LVN**
Name:		**Secondary**		**HHA**
Relationship:				**PT**
Phone:		**3rd:**		**OT**
Address:		**4th:**		**MSW**
City: **Zip:**		**5th:**		**SLP**
REFERRAL BY		**Medications:**		
Physician Office				
Hospital				
Others		**Allergies:**		
Name:		**Diet:**		
Phone:		**Equipment Needed:**		
Taken By: **Date:**		**Assigned to:**		

CLIENT EMERGENCY AND CONTACT INFORMATION

Client Name: _____ SOC: _____

Address: _____

City_____ State_____ Zip:_____

Telephone Number: _____ Cell Phone:_____

Responsible Person's Name: _____ Relationship: _____

Home Telephone: _____ Work Phone: _____ Cell Phone: _____

Relative/Friend Not Living With You: _____ Relationship: _____

Home Telephone: _____ Work Phone: _____Cell Phone: _____

Primary Physician: _____ Telephone Number:_____

NATURAL DISASTER EMERGENCY PLAN

- Class I – Patients with life threatening conditions that require ongoing medical treatment or a medical device to sustain life.

- Class II – Patients with the greatest need for care will be seen as soon as possible. Patients requiring daily insulin injections, IV medications, sterile wound care of a wound with a large amount of drainage.

- Class III – Services could be postponed 24-48hours without adverse effects. Diabetic patients able to self-inject, sterile wound care to a wound with minimal amount or not drainage.

- Class IV – Service could be postponed 72-96 hours without adverse effects. Postoperative with no wound, routine catheter changes or discharge within 10-14 days.

TRINITY HOME HEALTH SERVICES, INC.
Address: 10560 Main Street Suite 211, Fairfax VA 22030
Phone: (571) 419 8612 Fax: (866) 531 6484 E-mail: thhservices22@gmail.com

PATIENT ACKNOWLEDGEMENT OF RECIEPT OF PATIENT INFORMATION HANDBOOK.

PATIENT NAME:_____MRN_____

I, _____ have received the following information from the

Representative of _____ prior to the beginning of care;

INFORMATION PRESENTED TO PATIENT INCLUDES:

1. Service Outline/ Care Plan
2. Patient Information Handbook
3. Emergency Contact Information
4. Non-Discrimination Polices
5. Patient Rights and Responsibilities
6. Patient Service Agreement
7. Patient Complain/ Grievance
8. Abuse, Neglect, and Exploitation
9. General Infection control
10. Activities Home Health Aide may not perform
11. Notice of Emergency preparedness.

Note: Please indicate person has approved to receive information regarding care: _____

Note: Please person has approved to receive information regarding payment for care: _____

12) Advance Directive Information Summary

Patient Name: _____ **Signature:** _____ **Date:**

Witness Name: _____ **Signature:** _____ **Date:**

TRINITY HOME HEALTH SERVICES, INC.
Address: 10560 Main Street Suite 211, Fairfax VA 22030
Phone: (571) 419 8612 Fax: (866) 531 6484 E-mail: thhservices22@gmail.com

HOME SAFETY ASSESSMENT

Patient Name: _____ **MR#:** _____

Address: _____ **Patient lives with:** _____

Evaluation Completed By: _____ **Date:** _____

Item No.	Description (ENVIRONMENT)	Yes	No	NA
1	Safe and adequate food and water supplies.			
2	Stove and means for refrigeration present.			
3	Adequate heat and ventilation.			
4	Pathways free of obstacles such as loose rugs, furniture, etc.			
5	Clean area exists in which to store medical supplies			
6	Is cautious with heating pads			
7	Has a working smoking detector			
8	Free from infestation			
9	If uses oxygen, appropriate signs posted			
	FIRE/ELECTRICAL			
1	Fire exits available; warning exits available			
2	No overuse of extension cords/adequate outlets available			
3	Turns off oven and stove burners			
4	Emergency telephone numbers posted by phone			
5	Turns pot handles to back of stove			
6	Uses space heaters cautiously			
7	Does not smoke in bed			
8	Oxygen precautions used			
	BATHROOM SAFETY			
1	No throw rugs			
2	Safety bars present in good condition			
3	Lighting is adequate			
4	The shower chair is sturdy and in good working condition			
	MEDICATION USE			
1	Keeps all medication in original bottle or med box			
2	Has a medication schedule			
3	Home Safety instructions given			

As of date of this evaluation, I attest this home is a safe environment for nursing care.

_____ Date: _____

RN Printed name and signature

PATIENT MEDICATION LIST

PATIENT NAME: _____ PATIENT ID: _____

ALLERGIES: ☐ No known allergies or _____ HEIGHT: _____ WEIGHT: _____

DOB: _____ PHYSICIAN: _____ PHONE: _____

PHARMACY: _____ PHONE: _____

Start Date	Medication Name/Dose/Route	Frequency	Administered by Agency Staff	Med Review Date/Time	Initials
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		

SIGNATURE	TITLE	INITIAL

SIGNATURE	TITLE	INITIAL

SIGNATURE	TITLE	INITIAL

REQUEST FOR SUPERVISION HOURS IN PERSONAL CARE

Participant Name: _____ Medicaid ID: _____

Primary Provider: _____ Provider Number: _____

I. PARTICIPANT COGNITIVE AND PHYSICAL NEEDS WHICH JUSTIFY NEED FOR SUPERVISION

A Cognitive Status: Describe the participant's cognitive status and the impact it has on his/her behavior. If the participant is confused at different times of the day, please explain. State whether the participant can/cannot be left alone. If the participant can be left alone without being a danger to self or others, what is the maximum amount of time that he/she can be left alone? Does the participant have appropriate judgement/decision making abilities? *(Be as detailed as possible. It is important that the RN/SF make a correct appraisal of the cognitive status of the participant. Cognitive impairment is defined as a severe deficit in mental capability that affects areas such as thought processes, prob/em-solving, judgment, memory, or comprehension and that interferes with such things as reality orientation, ability to care for self. ability to recognize danger to self or others, or impulse control.)*

B **Physical Incapacity:** Describe the degreeof physical incapacity and how it justifies a need for supervision.

I. Incontinence:

Bowel: _____ Frequency of Changes: _____

Bladder: _____ Frequency of Changes: _____

2. Can the participant change position/shift/transfer without assistance?

3. Skin Breakdown *(Note areas affected/recentlydocumented problems within the last year, including dates):*

4. Potential for skin breakdown *(Based on current condition and frequency of incontinence changing, ability to shift position, history of past skin problems. Note whether the potential breakdown is temporary or ongoing.):*

5. Falls *[Describe any falls!hat have occurred during the past 3 months, including datesand times of fa/l(s), and the scenario of thefall(s). Interactions and side effects of medications that may have contributed lo the fall(s) must be included Document what interventions, if any, have been put in place to prevent future falls:*

C The participant can call (via telephone) for assistance: 0 Yes O No

If No, explain: _____

_____

6. Unstable Medical Condition(s) *[List the participant's current medical diagnoses and needs in relation to any unstable medical condition(.s).]*

7. Seizures *(Note the frequency and severity within the past 3 months.):*

8. Mobility (Note the degree of physical mobility and describe the method of mobility (i.e., wheelchair, ambulation, with/without assistive devices.):

9. For participants age 12 and under, please describe support needs that are a barrier to participation in traditional child care arrangements.

IL CURRENT SUPPORT SYSTEM

A Primary Caregiver Information

Name: _____ Home Phone: _____

Does the primary caregiver live with the participant? D Yes D No

lfno, thecaregiver's address:

_____

_____

If yes, does the primary caregiver work out of the home? D Yes D No

If yes, employer's name: _____ Employer's Phone#: _____

Work Hours: _____

Leave Home: _____ Returns Home: _____

*Note: A schedule may be requested.

B. List the names of all adults (age 18 and older) living in the home. Provide the days and times in which they are away from the home and unable to provide supervision.

C. List the Support System / Backup System for the primary caregiver when the Personal Care Aide is absent from the home. Include the name and times the support system is available to assist. *(The provider must be able to contact the participant's support system in case of an emergency.)(Please list the names, phone number, and schedules of all active support systems for the primary caregiver when the Personal Care Aide is absent from the home.)*

D The amount of time in the Plan of Care for AOL care and Home Maintenance requirements:

E The amount of additional support time required that can not be provided by participant's support system.

# of Hours:	Between the time of:	and

F. For school age participants. Please list the times the participant is out of the home for school including time spent in travel:

School hours: .....

G. Does the participant participate in any adjunct therapies, i.e.: ABA, PT, OT, ST. Provide a schedule and frequency of the service:

Provide any additional information not addressed above to further demonstrate the need for supervision.

_____

Agency/ Screening Team

_____ _____

RN Supervisor/Service Facilitator or PAS Team Member Date

Ins/rue/ions

If a participant is requesting supervision, the provider must fill this form out completely and submit it to the DMAS ,SA contractor or MCO for authorization. The DMAS SA contractor or MCO must approve the request before DMAS will reimburse for this service.

TRINITY HOME HEALTH SERVICES, INC.
Address: 10560 Main Street Suite 211, Fairfax VA 22030
Phone: (571) 419 8612 Fax: (866) 531 6484 E-mail: *thhservices22@gmail.com*

SIGNATURE PAGE FOR DMAS PATIENT

Approval Signature

Name/Client	Date
Name/Relationship	Date

POA/LEGAL GUARDIAN/PARENT/LAWYER/SON/DAUGHTER

Home health agency Nursing or Administration representative	Date

Participant/ Caregiver Signature

The participant's signature is necessary on the original plan of care and decreases to the hours of care. It is not needed if the hours increase in a new plan of care. The provider may substitute the signature with documentation in the participant's record that shows acceptance of the plan of care.

Source: DMAS 97 A/B revised 04/19

TRINITY HOME HEALTH SERVICES, INC.
Address: 10560 Main Street Suite 211, Fairfax VA 22030
Phone: (571) 419 8612 Fax: (866) 531 6484 E-mail: thhservices22@gmail.com

ACTIVITIES THE HOME HEALTH AIDE MAY NOT PERFORM INCLUDE:

1. Administration of medication
2. Irrigation of urinary catheters, colostomies, or wounds
3. Noso-gastric tube feeding gastric irrigation.
4. Catheterization
5. Applying heat by any method.
6. Changing or sterile dressing.
7. Any other services not included in the client's care package.
8. Any services requiring the skills of licensed nurse or therapist
9. Irrigate body cavities such as giving an enema.
10. Providing care to a tracheotomy tube.
11. Please adhere/follow plan of care {97AB} do not check bladder/Bowel/ wound care/ ROM Supervision unless supervision is in client's plan of care.
12. Administer insulin.

By my signature as PCA/CAN/HHA, I acknowledge to the above restrictions set by my profession and set by DMAS & VDH.

Employee Signature: _____

Date: _____

As a recipient of Medicaid or Medicare or as Commercial Insurance member. I will accept the above restrictions will not ask the PCA/CNA/HHA to carry out these tasks. I understand these restrictions are set by DMAS &VDH. I understand that a violation of these measures must be reported to the DMAS & VDH.

Client Signature: _____

Date: _____

PROGRESS NOTES

DATE/ TIME		SIGNATURE

CLIENT NAME:

TRINITY HOME HEALTH SERVICES, INC.
Address: 10560 Main Street Suite 211, Fairfax VA 22030
Phone: (571) 419 8612 Fax: (866) 531 6484 E-mail: thhservices22@gmail.com

SERVICE AGREEMENT

Please review this agreement carefully, as it sets forth the understanding between you ("Client") and TRINITY HOME HEALTH SERVICES INC. ("Agency") regarding the services you have requested, and we will provide for you. If you have any questions, concerns, or issues about the content of this Agreement please contact us for clarification before signing it.

THIS AGREEMENT made this _____ day of_____ ("Effective Date") by and between TRINITY HOME HEALTH SERVICES INC., and

_____

Name of Client and/ or Responsible Person

_____

Street Address City State Zip Code

_____

Home Phone Cell Other

_____

Emergency Contact Name Relationship Phone No.

("Client") on the terms and conditions set out below:

1. **Term of Agreement**. The term of this agreement will start on the Effective Date and will continue an as-needed basis until the Agreement is terminated by either party, as provided hereunder.
2. **Services Requested**. We will provide the services ("Services") requested and agreed upon as set out in the Service Plan enclosed. The preferred day, time and duration of services will be mutually agreed upon by you and/or your representative and the agency.
3. **Rates, Fees & Deposits**. We will provide the services at the rates of $20 (Eighteen) per hour. A deposit of $500- or one-week fees whichever is higher, required prior to commencing services. In addition to professional fees, the Client agrees to pay costs including but not limited to materials, postage, or third-party services.
4. **Billing**. We bill on Biweekly basis. Any questions regarding your invoice should be directed to our office.

5. **Payment and Overdue Accounts.** Fees for services rendered are payable upon receipt of invoice. Payment may be made by check, money order, or cash. An account is considered overdue if not paid within 10 days of the billing date. Interest will be charged on account balances which remain unpaid for 10 days or more after the same becomes due at the rate of 3 % per month (36 % per annum), until paid. We reserve the right to discontinue providing services until the account is paid in full, including any additional charges and accrued interest. A $50.00 returned check fee will be charged. Checks are to be made payable to TRINITY HOME HEALTH SERVICES INC.
6. **Cancellations.** Cancellations may be made up to 14 days in advance of a scheduled professional service without charge. We reserve the right to charge for a scheduled professional service if notice of the cancellation is not given within 14 days.
7. **Termination**. Either "Client" or "Agency" may terminate this agreement at any time upon written notice to the other party. Client agrees to pay as part of the services any necessary time or costs of ending the services. If either party terminates this Agreement, all fees due at time of termination will be due and payable by Client immediately. Agency will refund any unearned prepaid fees within 7 days of termination.
8. **Governing Law.** The laws of the State of Virginia shall govern this agreement, and any litigation hereunder shall occur in the courts of Fairfax County, Virginia.
9. **Agency's Responsibilities**. TRINITY HOME HEALTH SERVICES INC. responsibilities are outlined on the enclosed *"Rights and Responsibilities"* form.
10. **Client's Responsibilities.** Your responsibilities are outlined on the enclosed *"Rights and Responsibilities"* form. You will be required to sign it.
11. **Transportation**. If an employee of the Agency transports a client in their own, company vehicle or the client's vehicle, the client will release the Agency and/or that employee from all liability should an injury or accident occur.
12. **Private/Direct Hiring.** You may not privately/directly hire an Agency employee for a period of 6 months following the date that employee last provided services for you. In the event you break this condition, a replacement fee of $4,000 (four thousand) is due to the Agency immediately upon your employment of that individual.
13. **Severe/Bad Weather.** In severe weather, we may determine it is not safe for our Home Care Workers to travel and provide services to your home that day and may have to cancel that day's service. When this occurs, we will notify you and reschedule. We appreciate your understanding regarding this matter.
14. **Supplies and Equipment.** You are responsible for supplying all supplies (i.e., cleaning, personal care etc.) and equipment which may be necessary in the provision of services. Extra charges will apply if the Agency provides the supplies and/or equipment.
15. **General Information.** You will be provided with a list of contact names and numbers in the event you have any questions or concerns or should an emergency arise.
16. **Modification or Waiver.** No modification or waiver of any terms of this Agreement shall be valid unless in writing and executed with the same formality as this Agreement.
17. **Severability.** If any provision or clause of this Agreement conflicts with applicable law, such conflict shall not affect other provisions of this Agreement which can be given effect without the conflicting provision. To this end the provisions of this Agreement are declared to be severable.
18. **Interpretation.** Headings in this Agreement are provided for convenience and do not constitute the terms of this Agreement. As appropriate, the singular shall include the plural and vice versa, and the masculine shall include the feminine and neuter and vice versa.

TRINITY HOME HEALTH SERVICES, INC.
Address: 10560 Main Street Suite 211, Fairfax VA 22030
Phone: (571) 419 8612 Fax: (866) 531 6484 E-mail: *thhservices22@gmail.com*

Your signature and /or your representative's signature below indicate that you and/or your representative have read, understand, and agree with the terms and conditions of this Service Agreement.

Client/Client's Representative Signature	Date
Agency Authorized Signature & Position	Date

TRINITY HOME HEALTH SERVICES, INC.
Address: 10560 Main Street Suite 211, Fairfax VA 22030
Phone: (571) 419 8612 Fax: (866) 531 6484 E-mail: *thhservices22@gmail.com*

RIGHTS & RESPONSIBILITIES

Client Name: _____

Client Address: _____

Client's Telephone Number: _____Email: _____

If applicable,

Client's Representative _____

Relationship to Client: _____

Address of Client's Representative: _____

Client Representative's Telephone Number: _____Email:_____

As a client of Trinity Home Health Services Inc., the above named client has rights and responsibilities including, but not limited to, those outlined below:

Client's Rights

The Rights and Responsibilities form shall include, but not be limited to, the client's right to:

1. Consent to or refuse service.
2. Be cared for by qualified, competent and trained personnel;
3. Receive complete information about his/her health and recommended treatments, as developed jointly with this Agency;
4. To have full access to the care record maintained by this Agency;
5. Be treated with courtesy, dignity and respect;
6. Be spoken to or communicated with in a manner or language they can understand;
7. Receive privacy and confidentiality with regard to their health, social, and financial circumstances and what takes place in their homes, in accordance with laws and Agency policies;
8. Speak freely without fear;
9. Be free from involuntary confinement, and from physical or chemical restraints;

10. Be free from any actions that would be interpreted as being abusive. e.g. intimidation, physical/sexual/verbal/mental/emotional/material or financial abuse, etc.;

11. Report all instances of potential abuse, neglect, exploitation, involving any employee of the Agency, to the Elder Abuse Hotline;

12. Be dealt with in a manner that recognizes their individuality and is sensitive to and responds to their needs and preferences, including preferences based on ethnic, spiritual, linguistic, familial and cultural factors;

13. Receive service and be dealt with without regard to race, color, age, sex, sexual orientation, creed, religion, disability and familial/cultural factors;

14. Express complaints verbally or in writing about services or care that is or is not furnished, or about the lack of respect for your person or property by anyone who is furnishing services on behalf of the Agency;

15. Be informed of procedures for initiating complaints about the delivery of service or resolving conflict, without fear of reprisal or retaliation;

16. Be informed of the cost of services and procedures for notifying them of any increase in the cost of services;

17. Be informed of the laws, regulations and policies of the Agency including:

a. Code of Ethics;

b. Unstable Health Conditions;

c. Withdrawal/Termination of Services; AND,

d. Others, as required/requested.

18. Be provided with the name, certification and staff position of all persons supplying, staffing or supervising the care and services you receive;

19. Be informed of where ownership lies for any equipment/supplies provided in the provision of services;

20. Have their property treated with respect;

21. Participate in the development of a plan for their care & receive an explanation of any services proposed, changes in service, and alternative services that may be available;

22. Receive written information on the care plan, including the names of Care Aide(s), & Supervisor assigned and the Agency's phone number;

23. Provide input on which Care Aide they want and request a change of Care Aide, if desired;

24. Be briefed on any procedure/treatment before it is carried out in order that they can give informed consent;

25. Receive regular nursing supervision of the |Care Aide, if medically-related personal care is needed;

26. Expect that the Agency will only release information about them if they have given authorization and/or if it is a requirement of law;

27. Be given written documentation on the Agency's Advance Directives Policy;

28. To die with dignity;

29. Receive notice of any changes in fees for services no later than 30 calendar days prior to the changes place;

30. Be given at least 5 (Five) days notice to the Agency's plans to terminate the care or service and/or their intention to transfer their care to another agency.

Client's Responsibilities:

The Rights and Responsibilities form shall include, but not be limited to, the client's responsibility to:

1. Provide complete information about matters relating to their health and abilities when it could influence the care they are being given.

2. Know their medical history and have details on any medications being taken.

3. Accept the consequences of their own decisions.

4. Report unexpected changes in their condition, such as having suffered a mild stroke.

5. Request information about anything that they do not understand.

6. Contact the Agency with any concerns or problems regarding services.

7. Follow service plans and/or express any concerns about the service plan.

8. Accept the consequences if the service plan is not followed.

9. Follow the terms and conditions of the service agreement.

10. Notify the Agency, in advance, of any changes to the work schedule.

11. Inform the Agency of the existence of, and any changes to, advance directives.

12. Report any potential risks that might exist to the Home Care Worker such as the possibility that a client/family member might have a contagious illness or condition.

13. Be considerate of property belonging to the Agency and/or Home Care Worker.

14. Ensure that Home Care Workers are free from any actions that could be interpreted as being abusive such as intimidation, physical/sexual/verbal/mental/emotional/material/ financial abuse; and

15. Respect the dignity and privacy of the Home Care Worker.

16. Avoid asking the Agency staff to act outside the law, in the delivery of service.

17. Notify the Agency of any changes being made to their contact information such as address or phone number.

18. Advise the Agency of any changes being made to their health care professionals. e.g., physician, physiotherapist, occupational therapist, dietician, registered nurse, etc.

19. Be responsible for payment for charges that are not covered by other parties such as Medicare & Medicaid.

20. Notify the Agency of any changes in insurance coverage for home care services.

21. Pay bills according to agreed upon rates and timeframes.

22. Assume financial responsibility for all materials, supplies and equipment required for their care, which are not covered by other parties.

23. Provide a safe environment for care and services to be delivered.

24. Exercise a reasonable level of discretion and confidentiality regarding service/treatment records that are kept in the home.

25. Give 48 (forty-eight) hours notice, when possible, if service is going to be cancelled.

26. Keep all weapons in the home away from the work area during visits made by the Home Care Workers.

27. Secure aggressive or menacing pets before the Home Care Worker enters the home.

28. Provide a smoke free environment when Home Care Worker is present.

29. Review and sign the employee time sheet, upon completion of shift; and,

30. Carry out the defined responsibilities.

Agency's Responsibilities

The Rights and Responsibilities form shall include, but not be limited to, the Agency's responsibility to:

1. Ensure that Home Care Workers meet the state's competency requirements.

2. Review Home Care Workers' competency at least annually and more often, if indicated.

3. Document face-to-face interviews with all home care workers and independent contractors.

4. Provide ongoing, competent, and appropriate supervision of Home Care Workers.

5. Carry bonding for Agency staff.

6. Carry general liability, professional liability (if appropriate) and other insurances as necessary.

7. Meet the standards of Worker's Compensation.

8. Conduct criminal background checks and child abuse clearances, if applicable, on all staff; and maintain documentation confirming these clearances have been done.

9. Advise clients whether Home Care Worker is an employee of the Agency or is an independent contractor.

10. Ensure home care service delivery standards are met.

11. Ensure federal, state, county & municipal legalities are researched and applied.

12. Adhere to labor regulations.

13. Develop contingency plans.

14. Make deductions for social security, Medicare, and other taxes.

15. Conduct needs assessments, with client's/family's input.

16. Develop service plans with client's/family's input.

17. Consult with relative professionals regarding the service plan (as required).

18. Be part of, or coordinate, a health care team to provide for the client's needs, as indicated.

19. Establish goals with client/client's representative's input and strive to meet these goals.

20. Provide clients with written documentation of:

a. The services that will be provided.

b. Names of the Home Care Workers assigned to deliver service.

c. Hours when services will be provided; and,

d. Fees for services and total costs

21. Maintain the client's/family's confidentiality, privacy, and dignity.

22. Maintain professionalism and a code of ethics.

23. Avoid inflicting its personal values and standards onto clients.

24. Be alert for and report signs of elder abuse.

25. Obtain immunizations (such as flu shots) when required unless such an act is contrary to personal beliefs and/or medical conditions.

26. Ensure staff and Independent Contractors, exposed to clients, undergo screening tests to ensure they do not have an infectious disease such as Tuberculosis and/or Hepatitis.

27. Be aware of the cost portion that other parties (e.g., Medicare & Medicaid) will be responsible for, when clients receive third party financial assistance; and know what charges they will not cover.

28. When requested, ensure clients have access to all service invoices pertaining to their service, regardless of whether the bills are paid out-of-pocket or by another party.

29. Provide clients with the Department of Health's telephone number for registering complaints.

30. Ensure that staff do not assume Power of Attorney or Guardianship over any client, who is receiving services from the Agency.

31. Ensure that clients do not endorse checks over to the Agency; and,

32. Carry out its responsibilities.

This Rights and Responsibilities form has been reviewed with, and a copy given to, the named client/client's representative.

_____

Signature of Client/Client's Representative

_____

Signature of Agency's Representative & Position

_____

Date

TRINITY HOME HEALTH SERVICES, INC.
Address: 10560 Main Street Suite 211, Fairfax VA 22030
Phone: (571) 419 8612 Fax: (866) 531 6484 E-mail: thhservices22@gmail.com

CLIENT SATISFACTION QUESTIONNAIRE

Trinity Home Health Services Inc., would appreciate you taking the time to complete this *Client Satisfaction Questionnaire*, as your opinions will help us to meet your expectations concerning the quality of our service.

(Note: Provision of identification information is optional.)

Name: _____ Phone No. _____

Address: _____ Email: _____

Please tick "Yes" or "No" for the following questions. Please explain your reason(s) for "No" responses in the "Comments" section at the end of the questionnaire.

No.	Question	Yes	No
	Organization & Administration		
1.	Did you find us easy to contact?		
2.	Do you feel we responded in a timely manner?		
3.	Did we give you information on the following?		
	– Brochure/other documentation about our services		
	– *Service Agreement*		
	– Rights & Responsibilities		
	– Contact details & numbers within normal office hours		
	– Contact details & numbers outside normal office hours		
	– How to make a complaint, including who to contact		
	– Elder Abuse Hotline Number		
4.	Were you introduced to, or made aware of the Home Care Worker(s) assigned to you, prior to commencement of service?		
5.	Do you feel your needs/wants are being met & are being provided, in accordance with what was agreed upon?		

TRINITY HOME HEALTH SERVICES, INC.
Address: 10560 Main Street Suite 211, Fairfax VA 22030
Phone: (571) 419 8612 Fax: (866) 531 6484 E-mail: thhservices22@gmail.com

No.	Question	Yes	No
	Service Delivery		
6.	Was a personal *Service Plan* developed & implemented?		
7.	Were you/your representative involved in developing the Service Plan?		
8.	Do you feel you are cared for in a comfortable & non-discriminatory way?		
9.	How many Home Care Workers are usually involved in your care?		
10.	Does your Home Care Worker(s) show up for work on time?		
11.	Does your Home Care Worker(s) stay for the specified time?		
12.	Does your Home Care Worker(s) assist you with your medication? If "Yes", give specific details.		
13.	Does a supervisor occasionally make a home visit?		
14.	Are you notified in advance if your Home Care Worker is going to be changed?		
15.	Is there anything that concerns you about your Home Care Worker(s)?		
16.	Were you advised who would be supervising your Home Care Worker(s)?		
17.	Are you notified in advance if your regular services have to be rescheduled?		
18.	Were you advised who you/your representative/family may contact should you wish to speak to someone other than your Home Care Worker(s)?		
19.	Were you advised that we may employ both male & female workers?		
20.	Were you asked if you prefer a male or female worker?		
21.	Is your normal daily routine followed as much as possible within the provision of personal care such as getting up, meal times & bathing arrangements?		
22.	Do you find us to be:		
	– friendly		
	– considerate		
	– polite		
	– respectful		
	– honest		
	– believable		
	– prompt		
	– dependable		
	– efficient		

TRINITY HOME HEALTH SERVICES, INC.
Address: 10560 Main Street Suite 211, Fairfax VA 22030
Phone: (571) 419 8612 Fax: (866) 531 6484 E-mail: thhservices22@gmail.com

No.	Question	Yes	No
	– approachable		
	Financial Matters		
23.	Do Home Care Workers shop and/or handle money for you?		
24.	If Home Care Worker(s) shop and/or handle money for you, do they always return the change and receipt(s)?		
25.	If Home Care Worker(s) return change and receipts to you, do you both sign the *Financial Transactions Record?*		
26.	Do Home Care Workers have you sign their *Employee Time Sheet* after each visit?		
	Evaluation		
27.	Do you feel we have the required knowledge & skills to deliver service?		
28.	Is there anything you don't like about our service?		
29.	Have you any suggestions for ways we can improve our service?		
30.	Would you use our services in the future?		
31.	Would you recommend us to others?		
32.	How would you rate the overall quality of service you receive? Poor ___ Fair ___ Good ___ Excellent ___		
33.	How would you rate the Home Care Worker(s) treatment of you? Poor ___ Fair ___ Good ___ Excellent ___		
34.	How do you view the quality of service to its cost? Poor ___ Fair ___ Good ___ Excellent ___		

TRINITY HOME HEALTH SERVICES, INC.
Address: 10560 Main Street Suite 211, Fairfax VA 22030
Phone: (571) 419 8612 Fax: (866) 531 6484 E-mail: thhservices22@gmail.com

Comments

Client Signature_____

Date: _____

TRINITY HOME HEALTH SERVICES, INC.
Address: 10560 Main Street Suite 211, Fairfax VA 22030
Phone: (571) 419 8612 Fax: (866) 531 6484 E-mail: thhservices22@gmail.com

COMPLAINT/GRIEVANCE

Complainant's:

Please fill in all information that is applicable.

Name of Patient: _____

Address: _____

Phone Number: _____

Cell Phone: _____

Email Address:(if applicable) _____

Description of Complaint/Grievance:

_____
_____
_____
_____

Specify the location of Complaint/Grievance (if applicable):

_____
_____

Specify what you think should be done to resolve the Complaint/Grievance.

_____
_____
_____
_____

Resolution:

_____
_____
_____

Signature of Complainant: _____ Date: _____

Complain received by _____ Date: _____

TRINITY HOME HEALTH SERVICES, INC.
Address: 10560 Main Street Suite 211, Fairfax VA 22030
Phone: (571) 419 8612 Fax: (866) 531 6484 E-mail: thhservices22@gmail.com

Complaint should be directed followings address and persons:

Philbert Masele

TRINITY HOME HEALTH SERVICES INC.

10560 MAIN STREET SUITE 211

FAIRFAX, VA 22030

P: 571-419-8612 Fax:866 531 6484

Office of the State Long-Term Care Ombudsman

Virginia Association of Area Agencies on Aging (V4A)

24 E. Cary Street, Suite 100

Richmond, VA 23219

Phone: (804) 565-1600 Fax: (804) 644-5640

Toll Free: 1-800-552-3402

State Ombudsman: Joani Latimer jlatimer@thev4a.org

Assistant State Ombudsman: Gail Thompson gthompson@thev4a.org

Complaint Intake

Office of Licensure and Certification

Virginia Department of Health

9960 Maryland Drive, Suite 401

Richmond, VA 23233-1463

Phone: 1-800-955-1819

Fax: 1-804-527-4503

TRINITY HOME HEALTH SERVICES, INC.
Address: 10560 Main Street Suite 211, Fairfax VA 22030
Phone: (571) 419 8612 Fax: (866) 531 6484 E-mail: thhservices22@gmail.com

Trinity Home Health Services Inc.'s reputation and continued success depend upon the quality of the caregivers representing us to our clients. As a Heart of Hope LLC caregiver, you have been carefully selected and screened at the expense of the company. You are expected to perform your duties and responsibilities according to our company specifications and standards with the wellbeing of the client your most important priority. Therefore, by becoming a caregiver, you agree in private or secondary employment with a client of Heart of Hope Health LLC-

If a client, family member, or someone acting on behalf of the client and/or family member approach you regarding secondary or private employment, you should contact your supervisor immediately. Should your employment with the company be terminated voluntarily or involuntarily, you agree to not compete with the company with the company by accepting employment from company client for period of 180 days-

If you violate the covenant not to compete and accept employment with a company client, legal action, such as an injunction and a suit for damages, will be brought against you-

Upon my signature as witnessed by the company' s representative, I hereby understand that I have entered into a legally binding agreement between Heart of Hope Home Health Care LLC-

and myself as the caregiver- I hereby accept the conditions set forth within this agreement.

_____ _____

Caregiver Signature Date

_____ _____

Representative Date

TRINITY HOME HEALTH SERVICES, INC.
Address: 10560 Main Street Suite 211, Fairfax VA 22030
Phone: (571) 419 8612 Fax: (866) 531 6484 E-mail: *thhservices22@gmail.com*

DISCHARGE/TRANSFER: CLIENT NOTIFICATION

To:

Address _____

Street & Number City STATE Zip/Postal Code

Please be advised that effective Date: Time: ____ we will cease providing services.

to you for the reason(s) cited below: C

____Safety

____Health/Medical

____Services No Longer Required

____Admittance to Care Facility

____Left Area

____Loss Third Party Coverage

____Non-Payment of fees

____Request for Termination of Services

____Employee Safety/Health

____Non-Conformance of Service Agreement

____Deceased

____ Contract expired no renewal

____Transfer to:

Name of Facility/Agency/Other

Client Signature: _____Date: _____

Signature of Person Discharging: _____ Date: _____

DISCHARGE, TRANSFER AND REFERRAL POLICY

We may only discharge or transfer you from this agency if:

- It is necessary for your welfare, and your physician who is responsible for your home health plan of care and our agency agree that we can no longer meet your needs based on your acuity level. We must arrange a safe and appropriate transfer to another care provider when your needs exceed our agency's capabilities;
- You or your payer will no longer pay for the home health services (i.e., you are no longer homebound, you move out of our service area, you refuse to follow your physician's prescribed plan of care/treatment, etc. Note: Your physician will be notified.);
- Your physician who is responsible for your home health plan of care and our agency agree that the measurable outcomes and goals of your plan of care have been achieved and you no longer need home health services;
- You refuse services or elect to be transferred or discharged;
- Our agency closes;
- Our agency determines, based on our policy, that your behavior or the behavior of other persons in your home is disruptive, abusive or uncooperative to the extent that delivery of your care or the ability of our agency to effectively operate is seriously impaired. Prior to discharging for cause, our agency must:
    - Advise you, your representative, if any, your physician(s) issuing orders for your home health plan of care, your primary care practitioner or any other health care professional who will be responsible for providing care and services to you after discharge from our agency that a discharge for cause is being considered;
    - Make efforts to resolve the problem(s) presented by your behavior or the behavior of other persons in your home or situation;
    - Provide you and your representative, if any, with contact information for other agencies or providers who may be able to provide your care; and
    - Document in your medical record the problem(s) and efforts made to resolve the problem(s).
- Your death occurs while you are receiving home health services.

Discharge planning will begin when you are admitted to the agency based on the findings of the comprehensive assessment performed at admission. You and/or your representative will receive education and training to facilitate a timely discharge. Any revisions related to plans for your discharge will be communicated to you, your representative, your caregiver, all physicians issuing orders for our agency plan of care, your primary care practitioner and any other health care professionals who will be providing care and services to you after discharge from our agency.

You will be given advance verbal and written notice if our agency determines that services should be terminated in accordance with applicable state regulations, except in case of an emergency. All discharges or transfers will be documented in your medical record. When a discharge occurs, an assessment will be done. You will receive an updated list of your current medications along with any instructions needed for ongoing care or treatment. If we refer you to another organization, we provide you with the name, address, phone number and contact name at the referred organization.

If you transfer from this agency to another home health agency, skilled nursing facility, inpatient rehabilitation facility or long-term-care hospital, we will assist you and your caregivers in selecting the facility that best meets your needs by using and sharing information that includes, but is not limited to, data on quality measures and resource use measures that is relevant and applicable to your care goals and treatment preferences.

Following your discharge or transfer, we will send a discharge or transfer summary within the timeframes specified by federal regulations to your primary care practitioner, other health care professional and/or facility that will be providing care and services to you after discharge or transfer from our agency. The summary will include all necessary medical information pertaining to your illness and current course of treatment, post-discharge care goals and treatment preferences. We will comply with requests for additional clinical information as may be necessary for your treatment by the receiving facility or health care practitioner.

If you elected to transfer from another agency and were under an established plan of care, Medicare requires us to coordinate the transfer. The initial home health agency will no longer receive Medicare payment on your behalf and will no longer provide you with Medicare covered services after the date of your elected transfer to our agency.

You or your authorized representative will receive and be asked to sign and date a **Notice of Medicare Non-Coverage (NOMNC)** (included in the back of this booklet) at least two days before your covered Medicare services will end. If you or your authorized representative are not available, we will make contact by phone, and then mail the notice. If you do not agree that your covered services should end, you must contact the Quality Improvement Organization (QIO) at the phone number listed on the form no later than noon of the day before your services are to end and ask for an immediate appeal.

TRINITY HOME HEALTH SERVICES, INC.
Address: 10560 Main Street Suite 211, Fairfax VA 22030
Phone: (571) 419 8612 Fax: (866) 531 6484 E-mail: thhservices22@gmail.com

RESPITE CARE AGREEMENT

We want to inform you that every year the respite care hours authorized are 480.

I_____ understand that Respite care service are for the relief of the unpaid primary caregiver. Respite services have nothing to do with the client services, but the primary caregiver. They are meant to be used in an emergence when the primary caregiver (PCG) is unable attend to the client Per DMAS regulations. In case I need to use the hours, I will call the office in advance so that they can record the usage of hours and the reason.

We will not schedule ahead of time Respite Hours their measure

In instance you authorize usage of respite hour, we argue you to document on bottom of the timesheet, that you authorize the respite hours be used.

Client: _____ Signature: _____ Date: _____

Administrator: _____Signature: _____ Date: _____

TRINITY HOME HEALTH SERVICES, INC.

Address: 10560 Main Street Suite 211, Fairfax VA 22030
Phone: (571) 419 8612 Fax: (866) 531 6484 E-mail: thhservices22@gmail.com

MEDICATIONS AND ALLERGIES

Name: _____ Date: _____ DOB: _____

For us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is essential information. Please fill out every item. It is important for your doctor to know that you have carefully reviewed every area of this form. This information will be entered into the computer, and you are welcome to have a copy of the report if you wish.

CURRENT MEDICATIONS: Are you taking any medications right now? Yes [ ] No [ ]

(This includes prescription, over the counter, or herbal medications). If yes, please list below.

Medication Name	Dosage	Frequency (how many times a day)

MEDICATION ALLERGIES: ARE YOU ALLERGIC TO ANY MEDICATIONS? Yes [ ] No [ ]

Are you allergic to: [ ] Latex [ ] Contrast Dye [ ] Adhesive tape

Medication's Name(s)	Reactions

Patient Signature: _____ Nurse Signature: _____

TRINITY HOME HEALTH SERVICES, INC.

Address: 10560 Main Street Suite 211, Fairfax VA 22030
Phone: (571) 419 8612 Fax: (866) 531 6484 E-mail: thhservices22@gmail.com

HOME HEALTH STAFF SUPERVISORY VISIT

CLIENT INFORMATION	
Patient Name	ID No:
Name or Staff Member Being Supervised	Staff Person in home During Visit YES NO

11. STAFF INFORMATION

STAFF MEMBERS					
ITEM	EXCEEDS REQUIREMENTS	MELTS REQUIREMENI'S	DOES NOT MEET REQUIREMENTS	NOT OBSERVED	COMMENTS
Reports for work assignments as scheduled					
Identifies self by name and title to the patient					
Honors patient rights					
Demonstrate courteous and positive behavior toward the patient and Others					
Demonstrate cooperative behavior with the patient and others					
Maintains an open communication process with the patient. representative (if a. caregivers. and family					
Demonstrate competency with assisted Tasks					
Follows patient's plan of care					
Complies with infection prevention and control policies & procedures					
Reports changes in the patient's condition					
Informs nurse supervisor of client needs as appropriate. in timely manner					
Documents accurately the care being avoided					
Adheres to Trinity Home Health Services Inc., policies and procedures					
Utilizes proper body mechanics					
Utilizes good grooming habits					

17. Be informed of the laws, regulations and policies of the Agency including:
    a. *Code of Ethics;*
    b. *Unstable Health Conditions;*
    c. *Withdrawal/Termination of Services*; AND,
    d. Others, as required/requested.
18. Be provided with the name, certification and staff position of all persons supplying, staffing or supervising the care and services you receive;
19. Be informed of where ownership lies for any equipment/supplies provided in the provision of services;
20. Have their property treated with respect;
21. Participate in the development of a plan for their care & receive an explanation of any services proposed, changes in service, and alternative services that may be available;
22. Receive written information on the care plan, including the names of Care Aide(s), & Supervisor assigned and the Agency's phone number;
23. Provide input on which Care Aide they want and request a change of Care Aide, if desired;
24. Be briefed on any procedure/treatment before it is carried out in order that they can give informed consent;
25. Receive regular nursing supervision of the |Care Aide, if medically-related personal care is needed;
26. Expect that the Agency will only release information about them if they have given authorization and/or if it is a requirement of law;
27. Be given written documentation on the Agency's Advance Directives Policy;
28. To die with dignity;
29. Receive notice of any changes in fees for services no later than 30 calendar days prior to the changes place;
30. Be given at least 5 (Five) days notice to the Agency's plans to terminate the care or service and/or their intention to transfer their care to another agency.

Client's Responsibilities:

The *Rights and Responsibilities* form shall include, but not be limited to, the client's responsibility to:

1. Provide complete information about matters relating to their health and abilities when it could influence the care they are being given.
2. Know their medical history and have details on any medications being taken.
3. Accept the consequences of their own decisions.
4. Report unexpected changes in their condition, such as having suffered a mild stroke.
5. Request information about anything that they do not understand.
6. Contact the Agency with any concerns or problems regarding services.
7. Follow service plans and/or express any concerns about the *service plan*.
8. Accept the consequences if the service *plan* is not followed.
9. Follow the terms and conditions of the *service agreement*.
10. Notify the Agency, in advance, of any changes to the work schedule.
11. Inform the Agency of the existence of, and any changes to, advance directives.
12. Report any potential risks that might exist to the Home Care Worker such as the possibility that a client/family member might have a contagious illness or condition.
13. Be considerate of property belonging to the Agency and/or Home Care Worker.
14. Ensure that Home Care Workers are free from any actions that could be interpreted as being abusive such as intimidation, physical/sexual/verbal/mental/emotional/material/ financial abuse; and
15. Respect the dignity and privacy of the Home Care Worker.
16. Avoid asking the Agency staff to act outside the law, in the delivery of service.

17. Notify the Agency of any changes being made to their contact information such as address or phone number.
18. Advise the Agency of any changes being made to their health care professionals. e.g., physician, physiotherapist, occupational therapist, dietician, registered nurse, etc.
19. Be responsible for payment for charges that are not covered by other parties such as Medicare & Medicaid.
20. Notify the Agency of any changes in insurance coverage for home care services.
21. Pay bills according to agreed upon rates and timeframes.
22. Assume financial responsibility for all materials, supplies and equipment required for their care, which are not covered by other parties.
23. Provide a safe environment for care and services to be delivered.
24. Exercise a reasonable level of discretion and confidentiality regarding service/treatment records that are kept in the home.
25. Give 48 (forty-eight) hours notice, when possible, if service is going to be cancelled.
26. Keep all weapons in the home away from the work area during visits made by the Home Care Workers.
27. Secure aggressive or menacing pets before the Home Care Worker enters the home.
28. Provide a smoke free environment when Home Care Worker is present.
29. Review and sign the *employee time sheet*, upon completion of shift; and,
30. Carry out the defined responsibilities.

Agency's Responsibilities

The *Rights and Responsibilities* form shall include, but not be limited to, the Agency's responsibility to:

1. Ensure that Home Care Workers meet the state's competency requirements.
2. Review Home Care Workers' competency at least annually and more often, if indicated.
3. Document face-to-face interviews with all home care workers and independent contractors.
4. Provide ongoing, competent, and appropriate supervision of Home Care Workers.
5. Carry bonding for Agency staff.
6. Carry general liability, professional liability (if appropriate) and other insurances as necessary.
7. Meet the standards of *Worker's Compensation*.
8. Conduct criminal background checks and child abuse clearances, if applicable, on all staff; and maintain documentation confirming these clearances have been done.
9. Advise clients whether Home Care Worker is an employee of the Agency or is an independent contractor.
10. Ensure home care service delivery standards are met.
11. Ensure federal, state, county & municipal legalities are researched and applied.
12. Adhere to labor regulations.
13. Develop contingency plans.
14. Make deductions for social security, Medicare, and other taxes.
15. Conduct needs assessments, with client's/family's input.
16. Develop service plans with client's/family's input.
17. Consult with relative professionals regarding the service plan (as required).
18. Be part of, or coordinate, a health care team to provide for the client's needs, as indicated.
19. Establish goals with client/client's representative's input and strive to meet these goals.
20. Provide clients with written documentation of:
    a. The services that will be provided.
    b. Names of the Home Care Workers assigned to deliver service.
    c. Hours when services will be provided; and,
    d. Fees for services and total costs
21. Maintain the client's/family's confidentiality, privacy, and dignity.
22. Maintain professionalism and a code of ethics.
23. Avoid inflicting its personal values and standards onto clients.

24. Be alert for and report signs of elder abuse.
25. Obtain immunizations (such as flu shots) when required unless such an act is contrary to personal beliefs and/or medical conditions.
26. Ensure staff and Independent Contractors, exposed to clients, undergo screening tests to ensure they do not have an infectious disease such as Tuberculosis and/or Hepatitis.
27. Be aware of the cost portion that other parties (e.g., Medicare & Medicaid) will be responsible for, when clients receive third party financial assistance; and know what charges they will not cover.
28. When requested, ensure clients have access to all service invoices pertaining to their service, regardless of whether the bills are paid out-of-pocket or by another party.
29. Provide clients with the Department of Health's telephone number for registering complaints.
30. Ensure that staff do not assume Power of Attorney or Guardianship over any client, who is receiving services from the Agency.
31. Ensure that clients do not endorse checks over to the Agency; and,
32. Carry out its responsibilities.

This *Rights and Responsibilities* form has been reviewed with, and a copy given to, the named client/client's representative.

_____
Signature of Client/Client's Representative

_____
Signature of Agency's Representative & Position

_____
Date

COMMONWEALTH OF VIRGINIA
UNIFORM AUTHORIZATION TO USE AND EXCHANGE INFORMATION

I understand that different agencies provide different services and benefits. Each agency must have specific information to provide services and benefits. By signing this form, I allow agencies to use and exchange certain information about me, including information in an electronic database, so it will be easier for them to work together efficiently to provide or coordinate these services or benefits.

I, _____, am signing this form for
(FULL PRINTED NAME OF AUTHORIZING PERSON OR PERSONS)

_____
(FULL PRINTED NAME OF INDIVIDUAL)

_____
(INDIVIDUAL'S ADDRESS) *(INDIVIDUAL'S BIRTH DATE)* *(INDIVIDUAL'S SSN – OPTIONAL)*

My relationship to the individual is: ☐ Self ☐ Parent ☐ Power of Attorney ☐ Guardian
☐ Other Legally Authorized Representative

I want the following confidential information about the individual to be exchanged:

Yes	*No*		*Yes*	*No*		*Yes*	*No*	
☐	☐	Assessment Information	☐	☐	Medical Diagnosis	☐	☐	Educational Records
☐	☐	Financial Information	☐	☐	Mental Health Diagnosis	☐	☐	Psychiatric Records
☐	☐	Benefits/Services Needed, Planned, and/or Received	☐	☐	Medical Records	☐	☐	Criminal Justice Records
			☐	☐	Psychological Records	☐	☐	Employment Records
☐	☐	Substance Abuse Records				☐	☐	All of the Above

Other Information (write in): _____

I want _____

_____
(NAME AND ADDRESS OF REFERRING AGENCY AND STAFF CONTACT PERSON)

and the following entities to be able to use and exchange this information among themselves:

Yes	No		Identify By Name	
☐	☐	No Wrong Door Tools/SeniorNavigator	_____	Area Agencies on Aging
☐	☐	Dept. of Medical Assistance Services	_____	Centers for Independent Living
☐	☐	DMHMRSAS	_____	Community Services Boards
☐	☐	DRS Local/Regional	_____	Dept. of Social Services
☐	☐	Dept. Blind and Visually Impaired	_____	Home Health Agencies
☐	☐	Dept. Deaf and Hard of Hearing	_____	Hospices
			_____	Hospitals
Other: _____			_____	Local Health Departments
			_____	Nursing Facilities
			_____	Physicians

I want this information to be exchanged ONLY for the following purpose(s):
☐ Service Coordination and Treatment Planning ☐ Eligibility Determination
☐ Other: _____

I want this information to be shared by the following means: *(check all that apply)*
☐ Written Information ☐ In Meetings or By Phone ☐ Computerized Data ☐ Fax

I want to share additional information received after this authorization is signed: ☐ Yes ☐ No

This authorization is effective: _____
(DATE)

This authorization is good until: ☐ My service case is closed. ☐ Other: _____
For No Wrong Door this authorization is valid for one year from date of signature, unless the individual or his authorized representative specify an expiration date, event or condition that will occur prior to one year from the date of signature.

I can withdraw this authorization at any time by telling the referring agency. The listed agencies must stop sharing information after they know my authorization has been withdrawn. I have the right to know what information about me has been shared, and why, when, and with whom it was shared. If I ask, each agency will show me this information. I want all agencies to accept a copy of this form as valid authorization to share information. **If I do not sign this form, information will not be shared and I will have to contact each agency individually to give information about me that is needed.** However, I understand that treatment and services cannot be conditioned upon whether I sign this authorization. There is a potential for information disclosed pursuant to this authorization to be re-disclosed by the recipient and not be subject to the HIPAA Privacy Rule.

Signature(s): _____ Date: _____
(AUTHORIZING PERSON OR PERSONS)

Person Explaining Form: _____
(Name) *(Address)* *(Phone Number)*

Witness *(If Required)*: _____
(Signature) *(Address)* *(Phone Number)*

Approved by the Attorney General's Office 3/10/08

INDIVIDUAL PATIENT EMERGENCY PREPAREDNESS PLAN

IDENTIFING INFORMATION

Patient Name: _____ SOC Date: _____
Phone Number: _____ Physician: _____
Address: _____
City: _____ State: _____ Zip: _____

Relevant Healthcare Information

Primary Dx: _____ Secondary Dx: _____
Daily or more frequently Agency Services: No_____ Yes _____
If Yes, describe: _____

Oxygen dependent: Flow Rate _____Hours of Use: _____Delivery Device: _____
Life-Sustaining Infusion: No _____ Yes _____
If Yes, describe: _____

Other IV Therapy: No_____ Yes _____
If Yes, describe: _____

Patient/Caregiver Independent: No_____ Yes _____
Ventilator Dependent: No _____ Yes _____
Dialysis: No _____ Yes _____
If Yes, describe: _____

Tube Feeding: No _____ Yes _____
If Yes, describe: _____
Patient/caregiver Independent with Self-Administered Medications: No_____ Yes _____
Functional Disabilities (check all that apply): _____ Walker/cane _____Wheelchair ____Bedbound
____Hearing Impairment _____Visual Impairment _____Mental/Cognitive Impairment

EMERGENCY PLAN

Emergency Contact Name: _____ Phone Number: _____
If necessary, patient will evacuate to: Relative/Friend: _____
(Name/Phone Number): _____
Hotel (Name/Phone Number): _____
Shelter (Location): _____
Is Patient registered for special needs shelter? No _____ Yes _____
Other (Describe): _____

Priority/Acuity Level: _____

Clinician/Date: _____

*Copy to patient and Original on medical record.

HOME HEALTH AIDE/HOMEMAKER ASSIGNMENT/CARE PLAN

CLIENT ID | CLIENT NAME | STAFF ASSIGNED | DATE

ADDRESS | FREQUENCY/TIME

CITY | ZIP | PHONE# | RN REQUESTING | DAYS OF WEEK SA SU M T W TH F

FAMILY MEMBERS IN HOME

PETS

DIAGNOSIS

DISABILITIES
- ☐ Blind ☐ R ☐ L
- ☐ Glasses ☐ R ☐ L
- ☐ Deafness ☐ R ☐ L
- ☐ Hearing aid ☐ R ☐ L
- ☐ Other aids: _____
- ☐ Dentures: upper ____ lower ____
- ☐ Alert ☐ Confused
- ☐ Unconscious
- ☐ CPR ☐ No CPR

PERSONAL CARE Indicate frequency: _____
- ____ ☐ Bed bath
  - ☐ Total
  - ☐ Assist
- ____ ☐ Shower (assist)
- ____ ☐ Tub (assist)
- ____ ☐ Hair care
- ____ ☐ Dress (assist)
- ____ ☐ Foot care
- ____ ☐ Non sterile dressing
- ____ ☐ ROM exercises
- ____ ☐ Ambulate/transfer (assist)
- ____ ☐ Shampoo
- ____ ☐ Peri care
- ____ ☐ Skin care
- ____ ☐ Shave
- ____ ☐ Oral hygiene

SPECIAL INSTRUCTIONS

Dressing change: _____

Other: _____

CHANGES AND DATES

VITAL SIGNS/REPORTABLE SIGNS/SYMPTOMS

Report if: above below
- ____ BP ____ ____
- ____ T ____ ____
- ____ P ____ ____
- ____ R ____ ____
- ____ Int ____ ____

Frequency: _____ ☐ Each visit

Reportable signs and symptoms: _____

Baseline weight: _____
Date: _____
Weigh: ☐ every visit or ____

Notify RN of:
Weight gain of ___ pounds
Weight loss of ___ pounds

ELIMINATION Indicate frequency: _____
- ____ ☐ Intake/output
- ____ ☐ Empty bag (type: _____)
- ____ ☐ Catheter care
- ____ ☐ Bed pan
- ____ ☐ Bathroom
- ____ ☐ Check bowel movement (BM)
- ____ ☐ Assist with ostomy: _____
- ____ ☐ Commode
- ____ ☐ Bathroom with assist

* Notify RN if no BM in _____ days

ACTIVITY Indicate frequency: _____
- ____ ☐ Total bed rest
- ____ ☐ Turn or reposition every 2 hours/prn
- ____ ☐ Up in chair
- ____ ☐ Ambulate ☐ with assist ☐ without assist
- ____ ☐ Walker ____ ☐ Crutches
- ____ ☐ Cane ____ ☐ Wheelchair

Bed rails up _____

ROM: _____

HOMEMAKER
- ____ ☐ Clean client immediate area
- ____ ☐ Wash dishes
- ____ ☐ Dust
- ____ ☐ Vacuuming/mop floors
- ____ ☐ Grocery shopping/errands
- ____ ☐ Clean bedroom/bath/kitchen
- ____ ☐ Shopping/errands
- ____ ☐ Personal laundry
- ____ ☐ Garbage disposal
- ____ ☐ Change bed linens
- ____ ☐ Prepare and serve meal
- ____ ☐ Light housekeeping
- ____ ☐ Medication reminder

DIETARY
- ☐ Regular
- ☐ Bland
- ☐ Low Salt
- ☐ Low Cholesterol
- ☐ Diabetic _____ calories
- ☐ Encourage fluids
- ☐ Feed client
- ☐ Nothing by mouth
- ☐ Fluids restricted _____ ml/day
- ☐ Fluids forced _____ glasses/day
- ☐ Medication assist

SAFETY MEASURES

DIRECTIONS TO HOME

☐ **Client safety: high risk for falls**

DATE REVIEWED/INITIALS

_____ _____ _____

_____ _____ _____

SIGNATURE: _____ **TITLE:** _____ **DATE/TIME:** _____

AGENCY OR CONSUMER DIRECTION PROVIDER PLAN OF CARE

☐ Agency-Directed Services ☐ Consumer-Directed Services Current DMAS-99 Date: _____

Participant: _____ Medicaid ID#: _____

Provider: _____ Provider ID#: _____

Categories/Tasks	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
1. ADL's							
Bathing							
Dressing							
Toileting							
Transfer							
Assist Eating							
Assist Ambulate							
Turn/Change Position							
Grooming							
Total ADL Time:							
2. Special Maintenance							
Vital Signs							
Supervise Meds							
*Range of Motion							
*Wound Care							
*Bowel/Bladder Program							
***MD order required**							
Total Maint. Time:							
3. Supervision Time							
4. IADLS							
Meal Preparation							
Clean Kitchen							
Make/Change Beds							
Clean Areas Used by Participant							
Shop/List Supplies							
Laundry							
(CD only) Money Management							
Medical Appointments							
Work/School/Social							
Total IADLS Time:							
TOTAL DAILY TIME:							

This Section Must Be Completed in its Entirety for Agency & Consumer-Directed Services

Composite ADL Score = (The sum of the ADL ratings that describe this participant)

BATHING SCORE		TRANSFERRING SCORE	
Bathes without help or with MH only	0	Transfers without help or with MH only	0
Bathes with HH or with HH & MH	1	Transfers w/ HH or w/HH & MH	1
Is bathed	2	Is transferred or does not transfer	2
DRESSING SCORE		**EATING SCORE**	
Dress without help or with MH only	0	Eats without help or with MH only	0
Dresses with HH or with HH & MH	1	Eats with HH or HH & MH	1
Is dressed or does not dress	2	Is fed: spoon/tube/etc.	2
AMBULATION SCORE		**CONTINENCY SCORE**	
Walks/Wheels without help w/MH only	0	Continent/incontinent < wkly self care of internal	
Walks/Wheels w/ HH or HH & MH	1	/external devices	0
Totally dependent for mobility	2	Incontinent weekly or > Not self care	2

LEVEL OF CARE (LOC)	☐ **A** (Score 0 - 6)	☐ **B** (Score 7 - 12)	☐ **C** (Score 9 + wounds, tube feedings, etc.)
	Maximum Hours of 25/Week	Maximum Hours 30/Week	Maximum Hours 35/Week

Participant _____ Medicaid ID#: _____

Provider: Provider ID#:

Initial Plan of Care hours must be pre-authorized & should not exceed the maximum for the specified LOC category. Documentation must support the amount of hours provided to the participant.

Reason Plan of Care Submitted: ☐ New Admission ☐ ↑ In Hours ☐ ↓ In Hours ☐ Transfer

Reason for change/additional instructions for the aide: _____

_____

Required Backup Plan (Person's name, relation and phone #) for Services: _____

Plan of Care Effective Date: _____ Total Weekly Hours: _____

Participant / Primary Caregiver Signature: _____ Date: _____

RN, LPN or SF Signature _____ Date: _____

Instructions for the DMAS-97A/B

Provider Notification to Participant

This Plan of Care has been revised based on your current needs and available support. If you agree with the changes, no action is required on your part. If you do not agree with the changes, please contact the RN Supervisor who has signed the plan of care to discuss the reason that you disagree with the change.

If the provider agency is unwilling or unable to change the information, and you still disagree, you have the right to an appeal by notifying, in writing, The Client Appeals Division, The Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, Virginia 23219. The request for an appeal must be filed within thirty (30) days of the time you receive this notification. If you file a request for an appeal before the effective date of this action, _____ (enter effective date), services may continue unchanged during the appeal process.

Category/Tasks

Place a check mark for each task and put the total time for each category, for each day. Writing the amount of time for each task to the nearest 15 minutes is not necessary, but it greatly assists in the review of authorization requests.

Level of Care Determination for Maximum Weekly Hours

Enter a score for each activity of daily living (ADL) based on the participant's current functioning. Sum each ADL rating & enter the composite score under the appropriate category: A, B, or C. The amount of time allocated under **TOTAL DAILY TIME** to complete all tasks **MUST NOT EXCEED** the maximum weekly hours for the specified LOC of A, B, or C. Service Authorization (SA) must be obtained prior to initiating a change outside the authorized LOC category.

Provider Notification to Participant

Any time the RN Supervisor or Services Facilitator (SF) changes the plan of care that results in a change in the total number of weekly hours, the RN or SF must complete the entire front section of this form. If the change the agency is making does not require SA approval, the RN Supervisor or SF is required to enter the effective date on the Provider Agency Participant Notification Section which gives the participant their right to appeal. The participant should get a copy of both the front and back of the form.

SA Contractor Notification to Participant

If the changes to the Plan of Care require SA approval, the entire front portion of this form and the DMAS-98 must be completed and forwarded to the SA contractor for approval. If supervision is requested, attach the Request for Supervision form (DMAS-100). Once received by the SA contractor, the SA analyst will review the care plan and indicate whether the request is pended, approved, or denied. The participant will receive by mail the decision letter from the SA Contractor.

Participant / Caregiver Signature

The participant's signature is necessary on the original plan of care and decreases to the hours of care. It is not needed if the hours increase in a new plan of care. The provider may substitute the signature with documentation in the participant's record that shows acceptance of the plan of care.

AGENCY OR CONSUMER DIRECTION PROVIDER PLAN OF CARE

☐ Agency-Directed Services ☐ Consumer-Directed Services Current DMAS-99 Date: _____

Participant: _____ Medicaid ID#: _____

Provider: _____ Provider ID#: _____

Categories/Tasks	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
1. **ADL's**							
Bathing							
Dressing							
Toileting							
Transfer							
Assist Eating							
Assist Ambulate							
Turn/Change Position							
Grooming							
Total ADL Time:							
2. **Special Maintenance**							
Vital Signs							
Supervise Meds							
*Range of Motion							
*Wound Care							
*Bowel/Bladder Program							
***MD order required**							
Total Maint. Time:							
3. **Supervision Time**							
4. **IADLS**							
Meal Preparation							
Clean Kitchen							
Make/Change Beds							
Clean Areas Used by Participant							
Shop/List Supplies							
Laundry							
(CD only) Money Management							
Medical Appointments							
Work/School/Social							
Total IADLS Time:							
TOTAL DAILY TIME:							

This Section Must Be Completed in its Entirety for Agency & Consumer-Directed Services

Composite ADL Score = (The sum of the ADL ratings that describe this participant)

BATHING SCORE		TRANSFERRING SCORE	
Bathes without help or with MH only	0	Transfers without help or with MH only	0
Bathes with HH or with HH & MH	1	Transfers w/ HH or w/HH & MH	1
Is bathed	2	Is transferred or does not transfer	2
DRESSING SCORE		**EATING SCORE**	
Dress without help or with MH only	0	Eats without help or with MH only	0
Dresses with HH or with HH & MH	1	Eats with HH or HH & MH	1
Is dressed or does not dress	2	Is fed: spoon/tube/etc.	2
AMBULATION SCORE		**CONTINENCY SCORE**	
Walks/Wheels without help w/MH only	0	Continent/incontinent < wkly self care of internal /external devices	0
Walks/Wheels w/ HH or HH & MH	1	Incontinent weekly or > Not self care	2
Totally dependent for mobility	2		

LEVEL OF CARE (LOC)	☐ **A** (Score 0 - 6)	☐ **B** (Score 7 - 12)	☐ **C** (Score 9 + wounds, tube feedings, etc.)
	Maximum Hours of 25/Week	Maximum Hours 30/Week	Maximum Hours 35/Week

Participant _____ Medicaid ID#: _____

Provider: Provider ID#:

Initial Plan of Care hours must be pre-authorized & should not exceed the maximum for the specified LOC category. Documentation must support the amount of hours provided to the participant.

Reason Plan of Care Submitted: ☐ New Admission ☐ ↑ In Hours ☐ ↓ In Hours ☐ Transfer

Reason for change/additional instructions for the aide: _____

_____

Required Backup Plan (Person's name, relation and phone #) for Services: _____

Plan of Care Effective Date: _____ Total Weekly Hours: _____

Participant / Primary Caregiver Signature: _____ Date: _____

RN, LPN or SF Signature _____ Date: _____

Instructions for the DMAS-97A/B

Provider Notification to Participant

This Plan of Care has been revised based on your current needs and available support. If you agree with the changes, no action is required on your part. If you do not agree with the changes, please contact the RN Supervisor who has signed the plan of care to discuss the reason that you disagree with the change.

If the provider agency is unwilling or unable to change the information, and you still disagree, you have the right to an appeal by notifying, in writing, The Client Appeals Division, The Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, Virginia 23219. The request for an appeal must be filed within thirty (30) days of the time you receive this notification. If you file a request for an appeal before the effective date of this action, _____ (enter effective date), services may continue unchanged during the appeal process.

Category/Tasks

Place a check mark for each task and put the total time for each category, for each day. Writing the amount of time for each task to the nearest 15 minutes is not necessary, but it greatly assists in the review of authorization requests.

Level of Care Determination for Maximum Weekly Hours

Enter a score for each activity of daily living (ADL) based on the participant's current functioning. Sum each ADL rating & enter the composite score under the appropriate category: A, B, or C. The amount of time allocated under **TOTAL DAILY TIME** to complete all tasks **MUST NOT EXCEED** the maximum weekly hours for the specified LOC of A, B, or C. Service Authorization (SA) must be obtained prior to initiating a change outside the authorized LOC category.

Provider Notification to Participant

Any time the RN Supervisor or Services Facilitator (SF) changes the plan of care that results in a change in the total number of weekly hours, the RN or SF must complete the entire front section of this form. If the change the agency is making does not require SA approval, the RN Supervisor or SF is required to enter the effective date on the Provider Agency Participant Notification Section which gives the participant their right to appeal. The participant should get a copy of both the front and back of the form.

SA Contractor Notification to Participant

If the changes to the Plan of Care require SA approval, the entire front portion of this form and the DMAS-98 must be completed and forwarded to the SA contractor for approval. If supervision is requested, attach the Request for Supervision form (DMAS-100). Once received by the SA contractor, the SA analyst will review the care plan and indicate whether the request is pended, approved, or denied. The participant will receive by mail the decision letter from the SA Contractor.

Participant / Caregiver Signature

The participant's signature is necessary on the original plan of care and decreases to the hours of care. It is not needed if the hours increase in a new plan of care. The provider may substitute the signature with documentation in the participant's record that shows acceptance of the plan of care.

AGENCY OR CONSUMER DIRECTION PROVIDER PLAN OF CARE

☐ Agency-Directed Services ☐ Consumer-Directed Services Current DMAS-99 Date: _____

Participant: _____ Medicaid ID#: _____

Provider: _____ Provider ID#: _____

Categories/Tasks	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
1. ADL's							
Bathing							
Dressing							
Toileting							
Transfer							
Assist Eating							
Assist Ambulate							
Turn/Change Position							
Grooming							
Total ADL Time:							
2. Special Maintenance							
Vital Signs							
Supervise Meds							
*Range of Motion							
*Wound Care							
*Bowel/Bladder Program							
***MD order required**							
Total Maint. Time:							
3. Supervision Time							
4. IADLS							
Meal Preparation							
Clean Kitchen							
Make/Change Beds							
Clean Areas Used by Participant							
Shop/List Supplies							
Laundry							
(CD only) Money Management							
Medical Appointments							
Work/School/Social							
Total IADLS Time:							
TOTAL DAILY TIME:							

This Section Must Be Completed in its Entirety for Agency & Consumer-Directed Services

Composite ADL Score = (The sum of the ADL ratings that describe this participant)

BATHING SCORE		TRANSFERRING SCORE	
Bathes without help or with MH only	0	Transfers without help or with MH only	0
Bathes with HH or with HH & MH	1	Transfers w/ HH or w/HH & MH	1
Is bathed	2	Is transferred or does not transfer	2
DRESSING SCORE		**EATING SCORE**	
Dress without help or with MH only	0	Eats without help or with MH only	0
Dresses with HH or with HH & MH	1	Eats with HH or HH & MH	1
Is dressed or does not dress	2	Is fed: spoon/tube/etc.	2
AMBULATION SCORE		**CONTINENCY SCORE**	
Walks/Wheels without help w/MH only	0	Continent/incontinent < wkly self care of internal	
Walks/Wheels w/ HH or HH & MH	1	/external devices	0
Totally dependent for mobility	2	Incontinent weekly or > Not self care	2

LEVEL OF CARE (LOC)	☐ **A** (Score 0 - 6)	☐ **B** (Score 7 - 12)	☐ **C** (Score 9 + wounds, tube feedings, etc.)
	Maximum Hours of 25/Week	Maximum Hours 30/Week	Maximum Hours 35/Week

Participant _____ Medicaid ID#: _____

Provider: Provider ID#:

Initial Plan of Care hours must be pre-authorized & should not exceed the maximum for the specified LOC category. Documentation must support the amount of hours provided to the participant.

Reason Plan of Care Submitted: ☐ New Admission ☐ ↑ In Hours ☐ ↓ In Hours ☐ Transfer

Reason for change/additional instructions for the aide: _____

_____

Required Backup Plan (Person's name, relation and phone #) for Services: _____

Plan of Care Effective Date: _____ Total Weekly Hours: _____

Participant / Primary Caregiver Signature: _____ Date: _____

RN, LPN or SF Signature _____ Date: _____

Instructions for the DMAS-97A/B

Provider Notification to Participant

This Plan of Care has been revised based on your current needs and available support. If you agree with the changes, no action is required on your part. If you do not agree with the changes, please contact the RN Supervisor who has signed the plan of care to discuss the reason that you disagree with the change.

If the provider agency is unwilling or unable to change the information, and you still disagree, you have the right to an appeal by notifying, in writing, The Client Appeals Division, The Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, Virginia 23219. The request for an appeal must be filed within thirty (30) days of the time you receive this notification. If you file a request for an appeal before the effective date of this action, _____ (enter effective date), services may continue unchanged during the appeal process.

Category/Tasks

Place a check mark for each task and put the total time for each category, for each day. Writing the amount of time for each task to the nearest 15 minutes is not necessary, but it greatly assists in the review of authorization requests.

Level of Care Determination for Maximum Weekly Hours

Enter a score for each activity of daily living (ADL) based on the participant's current functioning. Sum each ADL rating & enter the composite score under the appropriate category: A, B, or C. The amount of time allocated under **TOTAL DAILY TIME** to complete all tasks **MUST NOT EXCEED** the maximum weekly hours for the specified LOC of A, B, or C. Service Authorization (SA) must be obtained prior to initiating a change outside the authorized LOC category.

Provider Notification to Participant

Any time the RN Supervisor or Services Facilitator (SF) changes the plan of care that results in a change in the total number of weekly hours, the RN or SF must complete the entire front section of this form. If the change the agency is making does not require SA approval, the RN Supervisor or SF is required to enter the effective date on the Provider Agency Participant Notification Section which gives the participant their right to appeal. The participant should get a copy of both the front and back of the form.

SA Contractor Notification to Participant

If the changes to the Plan of Care require SA approval, the entire front portion of this form and the DMAS-98 must be completed and forwarded to the SA contractor for approval. If supervision is requested, attach the Request for Supervision form (DMAS-100). Once received by the SA contractor, the SA analyst will review the care plan and indicate whether the request is pended, approved, or denied. The participant will receive by mail the decision letter from the SA Contractor.

Participant / Caregiver Signature

The participant's signature is necessary on the original plan of care and decreases to the hours of care. It is not needed if the hours increase in a new plan of care. The provider may substitute the signature with documentation in the participant's record that shows acceptance of the plan of care.

Community-Based Care Member Assessment

☐ Agency-Directed Services ☐ Consumer-Directed Services *Assessment Date:* _____

☐ Initial Visit ☐ Routine Visit ☐ Six-Month Re-assessment

Member's Name: _____ Date of Birth: _____

Medicaid ID #: _____ Start of Care: _____

Member's Current Address: _____ Agency Name: _____

Member's Phone: ( ) _____ Provider ID #: _____

FUNCTIONAL STATUS

ADLs	Needs No Help	MH Only	Human Help		MH & Human Help		Always Performed By Others	Is Not Performed At All
			Supervise	Phys. Asst.	Supervise	Phys. Asst.		
Bathing								
Dressing								
Toileting								
Transferring								
Eating/Feeding								

CONTINENCE	Continent	Incontinent < Weekly	Incontinent Self Care	Incontinent Weekly or >	External Device Not Self Care	Indwelling Cath Not Self Care	Ostomy Not Self Care
Bowel							
Bladder							

MOBILITY

Needs No Help	MH Only	Human Help		MH & Human Help		Confined Moves About	Confined Does Not Move About
		Supervise	Phys. Asst.	Supervise	Phys. Asst.		

ORIENTATION

Oriented	Disoriented-Some Spheres/Sometimes	Disoriented-Some Spheres/All Times	Disoriented-All Spheres/Sometimes	Disoriented-All Spheres/All Times	Semi-Comatose/ Comatose

Spheres Affected: Source of Info:

BEHAVIOR

Appropriate	Wandering/Passive < Than Weekly	Wandering/Passive Weekly or >	Abusive/Aggressive/ Disruptive< Weekly	Abusive/Aggressive/ Disruptive > Weekly	Semi-Comatose/ Comatose

Describe Inappropriate Behavior:

Source of Info:

JOINT MOTION
___ Within normal limits or instability corrected 0
___ Limited motion 1
___ Instability uncorrected or immobile 2

MED. ADMINISTRATION
___ Without assistance 0
___ Administered/monitored by lay person 1
___ Administered/monitored by professional nursing staff 2

MEDICAL/NURSING INFORMATION

Diagnoses: _____
Medications: _____
Current Health Status/Condition: _____
_____
Current Medical Nursing Needs: _____
_____
Therapies/Special Medical Procedures: _____
_____
Hospitalizations: Date(s):_____ Reason(s):_____
_____
Critical Incidents: ☐ Yes ☐ No
Description/Action: If yes, what was the nature of the critical incident and what steps were taken as a result?
_____
_____

SUPPORT SYSTEM

Waiver services the member is receiving, and the provider agency, at the time of the visit (check all that apply):
☐ Agency Personal Care: _____ ☐ CD Personal Care _____
☐ Agency Respite _____ ☐ CD Respite _____
☐ ADHC _____ (*if applicable*) Hours: _____
☐ PDN _____ (*if applicable*) Hours: _____
Hours the aide/attendant provides care to the member: Total Weekly Hours: _____ Days per Week: _____
Specific Hours the aide/attendant is in the member's home: _____
Does the aide/attendant live with the member: ☐ Yes ☐ No; Relationship to member: _____
Other Medicaid/non-Medicaid funded services received: (example: services through the Veterans Administration) _____
_____
Who is the primary care giver(s): _____
Is the primary caregiver (PCG) paid or unpaid? ☐ Paid ☐ Unpaid
Type of care the PCG provides to the member: _____
_____
How often does the PCG see the member? ☐ Daily ☐ Weekly ☐ Monthly ☐ Other _____
Who other than the member is authorized to sign the aide/attendant records? _____

Is the member in need of supervision or PERS at all times to be maintained safely? : ☐ Yes ☐ No
Is the member receiving supervision? ☐ Yes ☐ No If yes, has he/she been informed of PERS (if applicable)? ☐ Yes ☐ No
Is the member receiving PERS? ☐ Yes ☐ No If applicable, is he/she receiving a Medication Monitor? ☐ Yes ☐ No

If the member has PERS and/or Medication Monitoring, answer the following questions:

Is the member 14 years of age or older? ☐ Yes ☐ No
Is PERS adequate to meet the member's needs? ☐ Yes ☐ No
Is there a time when the telephone service is disconnected? ☐ Yes ☐ No
Is the member pleased with the service from the PERS provider? ☐ Yes ☐ No

CONSUMER-DIRECTED SERVICES:

Person directing/managing the care: _____ Relationship to member: _____
Person providing the care: _____ Relationship to member: _____

SERVICE FACILITATOR (SF) / RN/ LPN SUPERVISION

Dates of RN/LPN supervisory / SF visits for the last 6 months: _____
Did the member/caregiver agree to frequency of visits, and is it documented in the member's file?
☐ Yes ☐ No Frequency of supervisory visits (pick one choice) ☐ 30 days ☐ 60 days ☐ 90 days
Supervisory Visit for Personal Care: ☐ Yes ☐ No Supervisory Visit for Respite Care: ☐ Yes ☐ No **(check all that apply)**
Does the aide document accurately the care provided? (Agency-Directed only) ☐ Yes ☐ No
Does the Service Plan reflect the needs of the member? ☐ Yes ☐ No
If No to either, please describe follow-up: _____
_____

CONSISTENCY AND CONTINUITY

Number of days of no service in the last 6 months: (Do not include hospitalizations) _____
Number of aides/attendants assigned to the case in the last 6 months: Regular Aides/Attendants: _____
Sub-Aides/Attendants: _____
Has the member or caregiver had any problems with the care provided in the last six months? ☐ Yes ☐ No If yes, please describe problem(s) and the follow-up taken: _____
_____
Is the member satisfied with the service he/she is receiving by the provider agency? ☐ Yes ☐ No If no, please describe and the follow-up taken: _____
_____

Date of most recent DMAS-225: Patient Pay Amount (if applicable):

Aide/Attendant Present During Visit? ☐ Yes ☐ No Name of Aide/Attendant: _____

SF / NURSING NOTES: *(if additional space is needed, use the back or add attachment)*

Member/Caregiver Signature _____ **DATE:** _____

RN /LPN/ SF SIGNATURE: _____ **DATE:** _____

Community-Based Care Member Assessment

☐ Agency-Directed Services ☐ Consumer-Directed Services *Assessment Date:* _____

☐ Initial Visit ☐ Routine Visit ☐ Six-Month Re-assessment

Member's Name: _____ Date of Birth: _____

Medicaid ID #: _____ Start of Care: _____

Member's Current Address: _____ Agency Name: _____

Member's Phone: ( ) _____ Provider ID #: _____

FUNCTIONAL STATUS

ADLs	Needs No Help	MH Only	Human Help		MH & Human Help		Always Performed By Others	Is Not Performed At All
			Supervise	Phys. Asst.	Supervise	Phys. Asst.		
Bathing								
Dressing								
Toileting								
Transferring								
Eating/Feeding								

CONTINENCE	Continent	Incontinent < Weekly	Incontinent Self Care	Incontinent Weekly or >	External Device Not Self Care	Indwelling Cath Not Self Care	Ostomy Not Self Care
Bowel							
Bladder							

MOBILITY

Needs No Help	MH Only	Human Help		MH & Human Help		Confined Moves About	Confined Does Not Move About
		Supervise	Phys. Asst.	Supervise	Phys. Asst.		

ORIENTATION

Oriented	Disoriented-Some Spheres/Sometimes	Disoriented-Some Spheres/All Times	Disoriented-All Spheres/Sometimes	Disoriented-All Spheres/All Times	Semi-Comatose/ Comatose

Spheres Affected: Source of Info:

BEHAVIOR

Appropriate	Wandering/Passive < Than Weekly	Wandering/Passive Weekly or >	Abusive/Aggressive/ Disruptive< Weekly	Abusive/Aggressive/ Disruptive > Weekly	Semi-Comatose/ Comatose

Describe Inappropriate Behavior:

Source of Info:

JOINT MOTION
___ Within normal limits or instability corrected 0
___ Limited motion 1
___ Instability uncorrected or immobile 2

MED. ADMINISTRATION
___ Without assistance 0
___ Administered/monitored by lay person 1
___ Administered/monitored by professional nursing staff 2

MEDICAL/NURSING INFORMATION

Diagnoses: _____

Medications: _____

Current Health Status/Condition: _____

Current Medical Nursing Needs: _____

Therapies/Special Medical Procedures: _____

Hospitalizations: Date(s):_____ Reason(s):_____

Critical Incidents: ☐ Yes ☐ No

Description/Action: If yes, what was the nature of the critical incident and what steps were taken as a result?

SUPPORT SYSTEM

Waiver services the member is receiving, and the provider agency, at the time of the visit (check all that apply):
☐ Agency Personal Care: _____ ☐ CD Personal Care _____
☐ Agency Respite _____ ☐ CD Respite _____
☐ ADHC _____ (*if applicable*) Hours: _____
☐ PDN _____ (*if applicable*) Hours: _____
Hours the aide/attendant provides care to the member: Total Weekly Hours: _____ Days per Week: _____
Specific Hours the aide/attendant is in the member's home: _____
Does the aide/attendant live with the member: ☐ Yes ☐ No; Relationship to member: _____
Other Medicaid/non-Medicaid funded services received: (example: services through the Veterans Administration) _____
_____
Who is the primary care giver(s): _____
Is the primary caregiver (PCG) paid or unpaid? ☐ Paid ☐ Unpaid
Type of care the PCG provides to the member: _____
_____
How often does the PCG see the member? ☐ Daily ☐ Weekly ☐ Monthly ☐ Other _____
Who other than the member is authorized to sign the aide/attendant records? _____

Is the member in need of supervision or PERS at all times to be maintained safely? : ☐ Yes ☐ No
Is the member receiving supervision? ☐ Yes ☐ No If yes, has he/she been informed of PERS (if applicable)? ☐ Yes ☐ No
Is the member receiving PERS? ☐ Yes ☐ No If applicable, is he/she receiving a Medication Monitor? ☐ Yes ☐ No

If the member has PERS and/or Medication Monitoring, answer the following questions:

Is the member 14 years of age or older? ☐ Yes ☐ No
Is PERS adequate to meet the member's needs? ☐ Yes ☐ No
Is there a time when the telephone service is disconnected? ☐ Yes ☐ No
Is the member pleased with the service from the PERS provider? ☐ Yes ☐ No

CONSUMER-DIRECTED SERVICES:

Person directing/managing the care: _____ Relationship to member: _____
Person providing the care: _____ Relationship to member: _____

SERVICE FACILITATOR (SF) / RN/ LPN SUPERVISION

Dates of RN/LPN supervisory / SF visits for the last 6 months: _____
Did the member/caregiver agree to frequency of visits, and is it documented in the member's file?
☐ Yes ☐ No Frequency of supervisory visits (pick one choice) ☐ 30 days ☐ 60 days ☐ 90 days
Supervisory Visit for Personal Care: ☐ Yes ☐ No Supervisory Visit for Respite Care: ☐ Yes ☐ No **(check all that apply)**
Does the aide document accurately the care provided? (Agency-Directed only) ☐ Yes ☐ No
Does the Service Plan reflect the needs of the member? ☐ Yes ☐ No
If No to either, please describe follow-up: _____
_____

CONSISTENCY AND CONTINUITY

Number of days of no service in the last 6 months: (Do not include hospitalizations) _____
Number of aides/attendants assigned to the case in the last 6 months: Regular Aides/Attendants: _____
Sub-Aides/Attendants: _____
Has the member or caregiver had any problems with the care provided in the last six months? ☐ Yes ☐ No If yes, please describe problem(s) and the follow-up taken: _____
_____
Is the member satisfied with the service he/she is receiving by the provider agency? ☐ Yes ☐ No If no, please describe and the follow-up taken: _____
_____

Date of most recent DMAS-225: Patient Pay Amount (if applicable):

Aide/Attendant Present During Visit? ☐ Yes ☐ No Name of Aide/Attendant: _____

SF / NURSING NOTES: *(if additional space is needed, use the back or add attachment)*

Member/Caregiver Signature _____ **DATE:** _____

RN /LPN/ SF SIGNATURE: _____ **DATE:** _____

Community-Based Care Member Assessment

☐ Agency-Directed Services ☐ Consumer-Directed Services *Assessment Date:* _____

☐ Initial Visit ☐ Routine Visit ☐ Six-Month Re-assessment

Member's Name: _____ Date of Birth: _____

Medicaid ID #: _____ Start of Care: _____

Member's Current Address: _____ Agency Name: _____

Member's Phone: ( ) _____ Provider ID #: _____

FUNCTIONAL STATUS

ADLs	Needs No Help	MH Only	Human Help		MH & Human Help		Always Performed By Others	Is Not Performed At All
			Supervise	Phys. Asst.	Supervise	Phys. Asst.		
Bathing								
Dressing								
Toileting								
Transferring								
Eating/Feeding								

CONTINENCE	Continent	Incontinent < Weekly	Incontinent Self Care	Incontinent Weekly or >	External Device Not Self Care	Indwelling Cath Not Self Care	Ostomy Not Self Care
Bowel							
Bladder							

MOBILITY

Needs No Help	MH Only	Human Help		MH & Human Help		Confined Moves About	Confined Does Not Move About
		Supervise	Phys. Asst.	Supervise	Phys. Asst.		

ORIENTATION

Oriented	Disoriented-Some Spheres/Sometimes	Disoriented-Some Spheres/All Times	Disoriented-All Spheres/Sometimes	Disoriented-All Spheres/All Times	Semi-Comatose/ Comatose

Spheres Affected: Source of Info:

BEHAVIOR

Appropriate	Wandering/Passive < Than Weekly	Wandering/Passive Weekly or >	Abusive/Aggressive/ Disruptive< Weekly	Abusive/Aggressive/ Disruptive > Weekly	Semi-Comatose/ Comatose

Describe Inappropriate Behavior: Source of Info:

JOINT MOTION
___ Within normal limits or instability corrected 0
___ Limited motion 1
___ Instability uncorrected or immobile 2

MED. ADMINISTRATION
___ Without assistance 0
___ Administered/monitored by lay person 1
___ Administered/monitored by professional nursing staff 2

MEDICAL/NURSING INFORMATION

Diagnoses: _____
Medications: _____
Current Health Status/Condition: _____
_____
Current Medical Nursing Needs: _____
_____
Therapies/Special Medical Procedures: _____
_____
Hospitalizations: Date(s):_____Reason(s):_____
_____
Critical Incidents: ☐ Yes ☐ No
Description/Action: If yes, what was the nature of the critical incident and what steps were taken as a result?
_____
_____

SUPPORT SYSTEM

Waiver services the member is receiving, and the provider agency, at the time of the visit (check all that apply):
☐ Agency Personal Care: _____ ☐ CD Personal Care _____
☐ Agency Respite _____ ☐ CD Respite _____
☐ ADHC _____ (*if applicable*) Hours: _____
☐ PDN _____ (*if applicable*) Hours: _____
Hours the aide/attendant provides care to the member: Total Weekly Hours: _____ Days per Week: _____
Specific Hours the aide/attendant is in the member's home: _____
Does the aide/attendant live with the member: ☐ Yes ☐ No; Relationship to member: _____
Other Medicaid/non-Medicaid funded services received: (example: services through the Veterans Administration) _____
_____
Who is the primary care giver(s): _____
Is the primary caregiver (PCG) paid or unpaid? ☐ Paid ☐ Unpaid
Type of care the PCG provides to the member: _____
_____
How often does the PCG see the member? ☐ Daily ☐ Weekly ☐ Monthly ☐ Other _____
Who other than the member is authorized to sign the aide/attendant records? _____

Is the member in need of supervision or PERS at all times to be maintained safely? : ☐ Yes ☐ No
Is the member receiving supervision? ☐ Yes ☐ No If yes, has he/she been informed of PERS (if applicable)? ☐ Yes ☐ No
Is the member receiving PERS? ☐ Yes ☐ No If applicable, is he/she receiving a Medication Monitor? ☐ Yes ☐ No

If the member has PERS and/or Medication Monitoring, answer the following questions:

Is the member 14 years of age or older? ☐ Yes ☐ No
Is PERS adequate to meet the member's needs? ☐ Yes ☐ No
Is there a time when the telephone service is disconnected? ☐ Yes ☐ No
Is the member pleased with the service from the PERS provider? ☐ Yes ☐ No

CONSUMER-DIRECTED SERVICES:

Person directing/managing the care: _____ Relationship to member: _____
Person providing the care: _____ Relationship to member: _____

SERVICE FACILITATOR (SF) / RN/ LPN SUPERVISION

Dates of RN/LPN supervisory / SF visits for the last 6 months: _____
Did the member/caregiver agree to frequency of visits, and is it documented in the member's file?
☐ Yes ☐ No Frequency of supervisory visits (pick one choice) ☐ 30 days ☐ 60 days ☐ 90 days
Supervisory Visit for Personal Care: ☐ Yes ☐ No Supervisory Visit for Respite Care: ☐ Yes ☐ No **(check all that apply)**
Does the aide document accurately the care provided? (Agency-Directed only) ☐ Yes ☐ No
Does the Service Plan reflect the needs of the member? ☐ Yes ☐ No
If No to either, please describe follow-up: _____
_____

CONSISTENCY AND CONTINUITY

Number of days of no service in the last 6 months: (Do not include hospitalizations) _____
Number of aides/attendants assigned to the case in the last 6 months: Regular Aides/Attendants: _____
Sub-Aides/Attendants: _____
Has the member or caregiver had any problems with the care provided in the last six months? ☐ Yes ☐ No If yes, please describe problem(s) and the follow-up taken: _____
_____
Is the member satisfied with the service he/she is receiving by the provider agency? ☐ Yes ☐ No If no, please describe and the follow-up taken: _____
_____

Date of most recent DMAS-225: Patient Pay Amount (if applicable):

Aide/Attendant Present During Visit? ☐ Yes ☐ No Name of Aide/Attendant: _____

SF / NURSING NOTES: *(if additional space is needed, use the back or add attachment)*

_____

_____

_____

Member/Caregiver Signature _____ **DATE:** _____

RN /LPN/ SF SIGNATURE: _____ **DATE:** _____

CONFIDENTIAL

Home and Community Based Services Request Form

Plus
Commonwealth Coordinated Care Plus
Your Health. Your Care.

All FIELDS REQUIRED

Health Plan Fax #:			**Health Plan Phone #:**	
1. ☐ **New Request**			☐ **Change Request**	
2. Date of Request (mm/dd/yyyy) / /	**3. Member Phone Number:**			
4. Member Medicaid ID (12 digits):	**5. Member Last Name:**	**6. Member First Name:**	**7.** ☐ **Date of Birth (mm/dd/yyyy)** / /	**8. Gender** ☐ Male ☐ Female

9. Service Provider Information	**10. Primary Diagnosis Code/Description:**	
a. Service Provider Name:	**a.**	
b. NPI/API Provider ID Number:	**b.**	
c. Provider Street Address and City	**c.**	
d. 9 digit zip code: (required)	**d.**	
11. Additional Information (if any)	**12. Service Authorization Type:**	
	☐ **0900-CCC Plus Waiver (members not receiving PDN)** ☐ **0960-CCC Plus Waiver (members receiving PDN)** ☐ **0090- EPSDT Private Duty Nursing**	☐ **0091- EPSDT Personal/ Attendant Care** ☐ **0092 EPSDT Assistive Technology** ☐ **0098- EPSDT Private Duty Nursing in School- MCO**

13. Justification/Need for Service Requested:

CONFIDENTIAL

Home and Community Based Services Request Form

Plus
Commonwealth Coordinated Care Plus
Your Health. Your Care.

14. Additional Comments (See instructions pertaining to each procedure code):

Member Last Name:		**Member First Name:**				**Member Medicaid ID Number:**		
15. Procedure Code (National Code):	**16. Narrative Description:**	**17. Modifiers (If Applicable)**	**18. Units/Hours Requested**	**19. Frequency**	**20. Actual Cost per Unit (if applicable)**	**21. Total Dollar Requested (if applicable)**	**22. Dates of Service**	
							From (mm/dd/yyyy)	**Thru (mm/dd/yyyy)**
							/ /	/ /
							/ /	/ /
							/ /	/ /
							/ /	/ /
							/ /	/ /
23. Provider Contact Person:		**24. Provider Contact Phone Number:**				**25. Provider Contact Fax Number:**		

CONFIDENTIAL

Home and Community Based Services Request Form

Plus
Commonwealth Coordinated Care Plus
Your Health. Your Care.

All FIELDS REQUIRED

Health Plan Fax #:			**Health Plan Phone #:**	
1. ☐ **New Request**			☐ **Change Request**	
2. Date of Request (mm/dd/yyyy) / /	**3. Member Phone Number:**			
4. Member Medicaid ID (12 digits):	**5. Member Last Name:**	**6. Member First Name:**	**7.** ☐ **Date of Birth (mm/dd/yyyy)** / /	**8. Gender** ☐ Male ☐ Female

9. Service Provider Information	**10. Primary Diagnosis Code/Description:**	
a. Service Provider Name:	**a.**	
b. NPI/API Provider ID Number:	**b.**	
c. Provider Street Address and City	**c.**	
d. 9 digit zip code: (required)	**d.**	
11. Additional Information (if any)	**12. Service Authorization Type:**	
	☐ **0900-CCC Plus Waiver (members not receiving PDN)** ☐ **0960-CCC Plus Waiver (members receiving PDN)** ☐ **0090- EPSDT Private Duty Nursing**	☐ **0091- EPSDT Personal/ Attendant Care** ☐ **0092 EPSDT Assistive Technology** ☐ **0098- EPSDT Private Duty Nursing in School- MCO**

13. Justification/Need for Service Requested:

CONFIDENTIAL

Home and Community Based Services Request Form

Plus
Commonwealth Coordinated Care Plus
Your Health. Your Care.

14. Additional Comments (See instructions pertaining to each procedure code):

Member Last Name:		**Member First Name:**				**Member Medicaid ID Number:**		
15. Procedure Code (National Code):	**16. Narrative Description:**	**17. Modifiers (If Applicable)**	**18. Units/Hours Requested**	**19. Frequency**	**20. Actual Cost per Unit (if applicable)**	**21. Total Dollar Requested (if applicable)**	**22. Dates of Service**	
							From (mm/dd/yyyy)	**Thru (mm/dd/yyyy)**
							/ /	/ /
							/ /	/ /
							/ /	/ /
							/ /	/ /
							/ /	/ /
23. Provider Contact Person:		**24. Provider Contact Phone Number:**				**25. Provider Contact Fax Number:**		

CONFIDENTIAL

Home and Community Based Services Request Form

Plus
Commonwealth Coordinated Care Plus
Your Health. Your Care.

All FIELDS REQUIRED

Health Plan Fax #:			**Health Plan Phone #:**	
1. ☐ **New Request**			☐ **Change Request**	
2. Date of Request (mm/dd/yyyy) / /	**3. Member Phone Number:**			
4. Member Medicaid ID (12 digits):	**5. Member Last Name:**	**6. Member First Name:**	**7.** ☐ **Date of Birth (mm/dd/yyyy)** / /	**8. Gender** ☐ Male ☐ Female

9. Service Provider Information	**10. Primary Diagnosis Code/Description:**	
a. Service Provider Name:	**a.**	
b. NPI/API Provider ID Number:	**b.**	
c. Provider Street Address and City	**c.**	
d. 9 digit zip code: (required)	**d.**	
11. Additional Information (if any)	**12. Service Authorization Type:**	
	☐ **0900-CCC Plus Waiver (members not receiving PDN)** ☐ **0960-CCC Plus Waiver (members receiving PDN)** ☐ **0090- EPSDT Private Duty Nursing**	☐ **0091- EPSDT Personal/ Attendant Care** ☐ **0092 EPSDT Assistive Technology** ☐ **0098- EPSDT Private Duty Nursing in School- MCO**
13. Justification/Need for Service Requested:		

CONFIDENTIAL

Home and Community Based Services Request Form

Plus
Commonwealth Coordinated Care Plus
Your Health. Your Care.

14. Additional Comments (See instructions pertaining to each procedure code):

Member Last Name:		**Member First Name:**				**Member Medicaid ID Number:**		
15. Procedure Code (National Code):	**16. Narrative Description:**	**17. Modifiers (If Applicable)**	**18. Units/Hours Requested**	**19. Frequency**	**20. Actual Cost per Unit (if applicable)**	**21. Total Dollar Requested (if applicable)**	**22. Dates of Service**	
							From (mm/dd/yyyy)	**Thru (mm/dd/yyyy)**
							/ /	/ /
							/ /	/ /
							/ /	/ /
							/ /	/ /
							/ /	/ /
23. Provider Contact Person:		**24. Provider Contact Phone Number:**				**25. Provider Contact Fax Number:**		