Prestige Home Care Agency LLC.

NEW PATIENT INTAKE AND PLAN OF CARE

This Form must be completed by the Agency's Patient Care Director (PCD) or Agency Owner and must be placed in the Patient's file.

1. **AGENCY INTRODUCTION:** Agency Background when it was started and the Agency owner credentials,

a. Provide Participant with a copy of the Agency State License
b. Provide Participant a copy of Agency's Legal paperwork (Incorporation)
c. Provide Participant a copy of Agency's references

2. **SERVICES PARTICIPANT NEEDS:** Discuss why the Participant called you in for:

☐ **Personal Care Services** (PCS) is a Medicaid benefit that helps clients with everyday tasks. These tasks are called activities of daily living (ADLs) and instrumental activities of daily living (IADLs).

☐ **Long term care is** ongoing assistance with some of the most basic activities of daily living such as eating, bathing, dressing, or getting in and out of bed or a chair. The need most often stems from disability, chronic illness, or cognitive impairment.

☐ **Elderly Companion Care services,** include meal preparation, light housekeeping, errands and shopping, and of course, companionship.

PLEASE SELECT THE SERVICES THE PARTICIPANT IS INTERESTED IN:

☐ Bathing (full or sponge)
☐ Companion (Support)
☐ Dressing (full or garments)
☐ Grooming (facial, Skin, hair)
☐ Medication Assistance
☐ Lawn Care (grass cutting)
☐ Transportation (to and from locations)
☐ Errand Service (grocery shopping)
☐ Grief Support
☐ Light Housekeeping (vacuuming, dusting)
☐ Ambulatory Assistance (Walking or using a Gait Belt)
☐ Cooking (Breakfast, lunch, snack or dinner)

☐ Other Needs _____

PLEASE SELECT THE HOURS THE PARTICIPANT NEEDS SERVICES:

☐ Monday Hours _____

☐Tuesday Hours _____

☐ Wednesday Hours _____

☐ Thursday Hours _____

☐ Friday Hours _____

☐ Saturday Hours _____

☐ Sunday Hours _____

How soon is Participant looking to have services start?

☐ Within 2-3 days ☐ Within 5-7 days ☐ Undecided ☐ ASAP ☐ Note: _____

Does Participant have authorization to start Agency services?

☐ Yes ☐ No, Need family member permission ☐ Waiting on Insurance

☐ Note: _____

3. **PARTICIPANT FINANCIALS:** This area needs to be discussed and completed:

Participant has the following:

☐ 3rd Party Insurance ☐ Private Pay ☐ Medicaid ☐ Other_____

☐ Insurance Company Name: _____

☐ Policy Information: _____

☐ Medicaid/Wavier: _____

☐ EVS Number: _____

☐ Private Pay: _____

☐ Amount Participant can afford: _____

4. **HOME SAFETY ASSESSMENT**

SN	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	Free from infestation			
5	Pathways free of obstacles such as loose rugs, furniture, etc.			
6	Clean area exists in which to store medical supplies			
7	Is cautious with heating pads			
8	Has a working smoke detector			
9	If uses oxygen, appropriate signs posted			
	Fire / Electrical			
1	Fire exits available; warning devices installed			
2	No overuse of extension cords / adequate electrical 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 and in good condition			
3	Lighting is adequate			
4	Shower chair is sturdy and in good working condition			
	Medication Use			
1	Keeps all medications in original bottle or med box			
2	Has a medication schedule			
3	Home Safety Instructions Given			

Recommendations: _____

_____

5. **PARTICIPANT EMERGENCY PLAN**: The Emergency evacuation plan should be based on the

Participants house and the information written down.

1. Based on your review of the Participant home is a viable Emergency Plan available?

   ☐ Yes ☐ No ☐ Need more data

2. Date the Participant Emergency Plan will be ready?

   _____

3. Do you have Participants Emergency Contact? ☐ Yes ☐ No

PATIENT CASE HISTORY

Today's Date: _____

First Name	Middle Name	Last Name
Date of Birth	Street Address/ apt #	
City	State	Zip
Home Phone	Cell Phone	Email

Marital Status:

Single	Married	Separated	Divorced	Widowed	Domestic Partner

Occupation: _____

Gender: ☐ Male ☐ Female Height: _____ Weight: _____

PATIENT HOUSEHOLD CENSUS

Do you have any children under the age of 18 living with you at home?

☐ Yes ☐ No

If yes, please list ALL individuals, including children, residing in the same residence as the consumer, where they live and/or receive services:

S.N.	Name of the resident	Date of Birth	Relationship
1.			
2.			
3.			
4.			
5.			
6.			

NOTE: Please be aware that according to CHC Waiver requirements, if a Direct Care Worker (DCW) offers services in a setting with children present, Prestige Home Care Agency LLC requires they must obtain a fingerprint-based FBI background check report, a PA Police Clearance Report, and a Child Abuse Clearance Report.

MEDICAL HISTORY

What kinds of treatment have you tried?

_____

Have they helped alleviate the condition/problem?

_____

Are you currently receiving treatment for your problem? If so, describe:

_____

_____

Illnesses:

_____

Surgeries:

_____

Significant trauma (car accidents, falls, etc): _____

Do you or have you ever had any infectious diseases? Please describe: _____

_____

Medications (prescriptions, over the counter drugs, vitamins & herbs taken in last 3 months):

Medication: _____ Reason for taking it: _____

Medication: _____ Reason for taking it: _____

Medication: _____ Reason for taking it: _____

Medication: _____ Reason for taking it: _____

Medication: _____ Reason for taking it: _____

Medication: _____ Reason for taking it: _____

Date of last Medical Exam: _____Allergies: _____

PERSONAL MEDICAL HISTORY

SIGNIFICANT ILLNESSES:

☐ Cancer ☐Tuberculosis ☐ Stroke
☐ Hepatitis ☐ Herpes ☐ Mental Illness
☐ HIV (AIDS) ☐ Diabetes ☐ Other: _____
☐ Allergies ☐ Thyroid Disease
☐ Asthma ☐ Venereal Disease
☐ Seizures ☐ Addictive Disorders ☐ Heart Disease ☐ High Blood Pressure
☐ Weight Problems ☐ Rheumatic Fever

Please check if you have experienced any of the following in the last three months:

GENERAL:

☐ Poor Appetite ☐ Localized Weakness ☐ Peculiar Taste ☐ Sweat Easily
☐ Fever(s) ☐ Insomnia ☐ Peculiar Smells ☐ Fatigue
☐ Change in Appetite ☐ Strong Thirst ☐ Bleeding ☐ Night Sweats
☐ Tremors ☐ Poor Balance ☐ Weight Gain ☐ Depression
☐ Cravings ☐ Chills ☐ Joint Pain ☐ Emotional Changes
☐ Headaches ☐Sudden Energy Drop ☐Hearing Loss ☐ Bruising

SKIN & HAIR:

☐ Rashes ☐ Hair Loss ☐ Change in Hair Texture
☐ Eczema ☐ Hives ☐ Ulcers
☐ Recent Moles ☐ Change in Skin Texture ☐ Acne
☐ Itching ☐ Dandruff ☐ Psoriasis

HEAD, EYES, EARS, NOSE AND TEETH:

☐ Dizziness ☐ Ringing in Ears
☐ Sore Throat ☐ Gum Problems
☐ Eye Strain ☐ Sores on Tongue
☐ Grinding Teeth ☐ Floaters
☐ Cataracts ☐ Concussions
☐ Blurred Vision ☐ Jaw Click ☐ Eye Pain ☐ Earaches

☐ Sinus Problems
☐ Night Blindness
☐ Mouth Ulcers
☐ Spots in Front of Eyes
☐ Poor Hearing
☐ Migraines
☐ Glasses

☐ Poor Vision
☐ Headaches
☐ Facial Pain
☐ Toothache
☐ Nose Bleed
☐ Color Blindness
☐ Glaucoma

RESPIRATORY:

☐ Cough ☐ Cough Blood
☐ Bronchitis ☐ Asthma
☐ Easily Winded ☐ Phlegm

☐ Short of Breath
☐ Pain Breathing ☐ Wheeze

CARDIOVASCULAR:

☐ Blood Clots ☐ Fainting
☐ Dizziness ☐ Chest Pain

☐ Low Blood Pressure
☐ Shortness of Breath

☐ Hands Swell ☐ Swelling of Feet ☐ Irregular Heartbeat ☐ Cold Sweats ☐ Palpitations ☐ Difficulty Breathing
☐ High Blood Pressure ☐ Cold Hands/Feet ☐ Phlebitis

GASTROINTESTINAL:

☐ Nausea ☐ Constipation ☐ Bad Breath
☐ Belching ☐ Hemorrhoids ☐ Intestinal Gas
☐ Diarrhea ☐ Parasites ☐ Vomiting
☐ Indigestion ☐ Blood in Stools ☐ Black Stools ☐ Bloating ☐ Abdominal Pain
☐ Gastric Ulcers

GENITO-URINARY:

☐ Painful Urination ☐ Frequent Night Urination ☐ Blood in Urine
☐ Frequent Urination ☐ Discolored Urination ☐ Impotence
☐ Unable to Hold Urine ☐ Scanty Urination ☐ Kidney Stones
☐ Urgent Urination ☐ Genital Sores

GYNECOLOGY & PREGNANCY:

☐ Irregular Periods ☐ Difficult Births _____ ☐ # of Births _____
☐ Clots ☐ Fertility Problems _____ ☐ # of Miscarriages _____
☐ Painful Periods ☐ Age of First Menses _____ ☐ # of Pregnancies _____
☐ Light Flow ☐ Date of Last Menses _____ ☐ # of Premature Births ____
☐ Heavy Flow ☐ PMS ☐ # of Abortions _____
☐ Vaginal Discharge ☐ Vaginal Sores ☐ Date of Last Exam: _____
☐ Duration of Flow ☐ Currently Pregnant Due____

NEURO-PSYCHOLOGICAL:

☐ Seizures ☐ Lack of Coordination ☐ Dizziness
☐ Depression ☐ Migraines ☐ Stress
☐ Poor Memory ☐ Concussion ☐ Irritable
☐ Disoriented ☐ Mood Swings ☐ Headaches
☐ Areas of Numbness ☐ Anxiety
☐ Loss of Balance ☐ Easily Angered

Have you ever received psychiatric treatment? ☐ Yes ☐ No
Have you ever considered or attempted suicide? ☐ Yes ☐ No

Do you have nervous habits? _____
Do you have any other problems you would like us to be aware of?
_____

ALLERGIES:

Do you have itchy ear canals? ☐ Sometimes ☐ Often ☐ Never
Do you have itchy eyes? ☐ Sometimes ☐ Often ☐ Never

Do you have itchy palate or back of the throat? ☐ Sometimes ☐ Often ☐ Never
Do you seem to be tired, weak or get fatigued more ☐ Sometimes ☐ Often ☐ Never
Do you have problems with muscle or joint aches, ☐ Sometimes ☐ Often ☐ Never
Have you ever been treated or tested for ☐ Sometimes ☐ Often ☐ Never

MUSCULAR SKELETAL:

☐ Neck Pain	☐ Shoulder Pain	☐ Injuries
☐ Scoliosis	☐ Arthritis	☐ Muscle Spasms
☐ Hip Pain	☐ Weak Joints	☐ Muscle Cramping
☐ Recent Sprains	☐ Joint Pain	☐ Muscle Soreness
☐ Hand/Wrist Pain	☐ Knee Pain	☐ Foot/Ankle Pain
☐ Back Pain	☐ Muscle Weakness	

LIFESTYLE:

Do you regularly smoke? ☐ Cigarettes ☐ Cigar ☐ Pipe
If yes, for how many years? _____ How many per day? ____

Do you regularly drink alcoholic beverages?

Liquor: ☐ 1 oz. per day ☐ 2 oz. per day ☐ over 2 oz. per day
Beer: ☐ 12 oz. or 1 per day ☐ 24 oz. or 2 per day ☐ 48 oz. or over 4 per day
Wine: ☐ less than 6 oz. per day ☐ 6 oz. per day ☐ over 12 oz. per day

Do you regularly drink coffee? ☐ Yes ☐ No
How many per day: Regular _____ Decaffeinated _____

MALE UROLOGY IS FOR ACUPUNCTURE <u>PATIENTS ONLY:</u>

Have you been treated for genital problems? ☐ Yes ☐ No
Do you have genital herpes? ☐ Yes ☐ No
Do you have discharge from the penis? ☐ Yes ☐ No
Do you have a hernia (rupture)? ☐ Yes ☐ No
Are you experiencing a prostate problem? ☐ Yes ☐ No
Do you have any difficulties of a sexual nature? ☐ Sometimes ☐ Often ☐ Never
If yes, check the following that apply:

☐ Premature ejaculation ☐Painful intercourse ☐Loss of erection ☐ Other: _____
☐Failure to reach orgasm ☐Lack of desire ☐Sexual anxiety

ALL THE FOLLOWING QUESTIONS ARE FOR ALL PATIENTS

Do you use illicit drugs socially? ☐Yes ☐No

List drugs and frequency:

_____

_____

List all exercise, physical activities and frequency (Hobbies, sports, etc.):

_____

_____

Nutrition

List all the foods which disagree with you:

_____

_____

_____

List your favorite, craved or particularly enjoyed foods and beverages:

_____

_____

_____

_____ _____

Patient's/Representative's Signature Date

_____ _____

Agency Representative's Signature Date

PATIENT CONSENT FOR USE AND
DISCLOSURE OF PROTECTED HEALTH INFORMATION✶

With this consent, this Agency may use and disclose Protected Health Information (PHI) about me to carry out service, payment, and healthcare operations (SPO). Please refer to the Agency's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. The Agency reserve the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer at the Agency.

With my consent, the Agency may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the Agency in carrying out SPO, such as appointment reminder, and any call pertaining to my Home Care.
With my consent, the Agency may mail to my home or other designated location any items that assist the Agency in carrying out SPO, such as appointment reminder cards, as long as they are marked "Personal and Confidential".

I have the right to request that the Agency restrict how it uses or discloses my PHI to carry out SPO. However, the Agency is/are not required to agree to my requested restrictions, but if it does, it is bound by this Agreement.

By signing this form, I am consenting to the Agency use and disclosure of my PHI to carry out SPO. When my information is used or disclosed pursuant to this Authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the applicable privacy laws. I have the right to revoke this Authorization in writing except to the extent that the Agency have acted in reliance upon this authorization. My written revocation must be submitted to the Agency's Privacy Officer.

_____ _____
Date Signature of Patient or Legal Guardian

_____
Relationship to Patient

_____
Patient's Name

_____
Print Name of Patient or Legal Guardian

PRESTIGE
HOME CARE AGENCY

CLIENT CARE PLAN

Client's Name: _____

☐ Hospice Case ☐ Resuscitate ☐Do Not Resuscitate

Diagnosis: _____

Admission Date: _____ Review Dates: _____

Goals:

Personal Care

(Frequency)

☐ Bed Bath _____
☐ Partial Bath _____
☐ Shower _____
☐ Tub Bath _____
☐ Oral Hygiene/Denture Care _____
☐ Shampoo _____
☐ Comb/Brush Hair _____
☐ Shave _____
☐ Clean/File Nails _____
☐ Foot Soak _____
☐ Skin Care (Lotion, Massage, Pressure Areas) _____

Toileting:

☐ Use Bathroom
☐ Use Bedpan
☐ Urinal
☐ Diapers/Depends
☐ Other, Specify: _____

Homemaking

Prepare Meals:

☐ Breakfast
☐ Lunch
☐ Dinner
☐ Snack _____
☐ Dishes

Dietary Restrictions: _____

Housekeeping:

☐ Kitchen
☐ Bathroom
☐ Bedroom
☐ Other: _____

☐Grocery Shopping
☐Errands
☐ May ☐ May Not leave patient to do errands ☐ Other, Specify: _____

Treatments

(Always record in chart)

☐ Temperature:
☐ Oral ☐ Rectal
☐ Auxiliary ☐ Pulse:
☐ Radial ☐ Apical
☐ Blood Pressure:
☐ Right Arm ☐ Left Arm
☐ Both Arms
☐ Test Urine for S & A
☐ Monitor Blood Glucose
☐ Weigh Patient
☐ Apply Elastic Bandage
☐ AES Stockings
☐ Apply Heat _____
☐ Apply Cold _____
☐ Bowel & Bladder Program

Record:

☐ Intake of foods/fluids
☐ Output: ☐ Emesis
☐ Bowel Movements
☐ Urine ☐ Catheter Bag
☐ Ostomy Bag
☐ Other Treatments, Specify

Activities

Out of Bed:

☐ Up as tolerated
☐ Transfer Board
☐ Hoyer Lift

Ambulation:

☐ With Assist
☐ Cane ☐ Walker
☐ Crutches ☐ Wheelchair

Bedrest:

☐ Complete
☐ Turn and reposition
☐ To bathroom only
☐ Use commode chair
☐ Bed/fracture pan

Exercises:

☐ Range of motion as taught by RN/PT ☐ Other, Specify: _____

AGENCY USE ONLY

Other Directions/Comments:

[please refer to Individualized Service Plan]

_____
Admission Supervisor Name

_____
Admission Supervisor Signature