.

Service Plan

Georgia Department of Human Resources; Department of community health for home care units, requires that a written plan of care shall be established in collaboration with the client, responsible party and the clients physician.

Client Name: _____

Address: _____

Home Telephone: _____ **Other Phone:** _____

Birth Date: _____ **Age:** _____ **Weight:** _____

Personal Care _____ **Companion Care** _____ **Skilled Nursing** _____

Frequency: _____ **Duration:** _____

S M T W TH F S **Time:** _____----_____

Functional Limitations:

_____

_____

_____

Diagnoses: _____

_____

_____

_____

Medications: _____

_____

Treatment: _____

_____

Equipment Used:

_____

_____

List of Diet and Nutrition:

_____

Clinical/progress notes:

_____

_____

1. Is client? MF [ ] MC [ ]
2. Is the patient depending on someone to his/her with activities of daily living? [ ] Yes [ ] No
3. Is the client bed bound? [ ] Yes [ ] No
4. Is the client wheelchair bound? [ ] Yes [ ] No
5. Is the patient unable to see? [ ] Yes [ ] No
6. Is the patient unable to hear? [ ] Yes [ ] No

Goals and objectives of the Service: (Provide in full detail the reason for the request of this service and what the desired outcome)

_____
_____
_____

Discharge Plan:

_____
_____
_____
_____

Types of Services required (list specific tasks)

ADLs	Status	Tasks
Bathing	□ Independent □ Needs Assistance	
Transfers & Ambulation	□ Independent □ Needs Assistance	
Dressing & Grooming	□ Independent □ Needs Assistance	
Incontinence Care	□ Independent □ Needs Assistance	
Eating Assistance	□ Independent □ Needs Assistance	

IADLs	Status	Tasks
Meals	□ Independent □ Needs Assistance	
Light Housekeeping	□ Independent □ Needs Assistance	
Laundry	□ Independent □ Needs Assistance	
Transportation	□ Independent □ Needs Assistance	
Household Management	□ Independent □ Needs Assistance	
Companionship	□ Independent □ Needs Assistance	
Medication Reminder	□ Independent □ Needs Assistance	

APPENDIX U

CLIENT EMERGENCY INFORMATION FORM

Client's Name: _____

Medicaid Number: _____

Home Address: _____

_____

Home Telephone: _____

Emergency transportation for treatment: ----------911----------

Advance Directive Information:

Medical Information	
Physician's Name:	
Physician's Telephone:	
Physician's Address:	
Client's Hospital Preference:	
Known Medication Allergies/Pertinent Medical Information:	

Client Representative or Family Members/Emergency Contacts:

1. Name: _____ Telephone: ( ) _____-_____ Date: _____
   Relationship: _____ Review Date: _____
2. Name: _____ Telephone: ( ) _____-_____ Date: _____
   Relationship: _____ Review Date: _____

I _____ (Client/Client rep) understand that I have the right to make choices by accepting or refusing services and I have the right to participate in the service planning process.

Client Signature _____ Favored RN _____
Review Date: _____
Client Signature _____ Favored RN _____
Review Date: _____
Client Signature _____ Favored RN _____

"This plan is subject to revision by the registered Nurse with coordination of the client and client's care coordinator at least once a year. All revisions made to the original care plan must be signed and dated by both the RN and the Client.''

REQUEST FOR SERVICE

I, _____ (client's name) request that Favored Healthcare Services provide the described service

Date: _____ Client: _____

Phone: (_____)_____DOB: _____ Medicaid # _____

Address: _____
City/State/Zip: _____

I, _____ (client) do waive all liability from **FAVORED HEALTHCARE SERVICES**, as well as my appointed Home Care Worker(s) who provide services for me if I should ask them to transport me in my vehicle or their vehicle as part of the service I need.

I understand that I have the primary responsibility for my vehicle insurance and maintenance. I agree to hold **FAVORED HEALTHCARE SERVICES** harmless in the event that there is an accident in which there is damage to my vehicle or injury to me or its occupants.

I agree to inform my insurance company of my intention to allow my Home Care Worker(s) to drive my vehicle. *I understand that I have to provide **FAVORED HEALTHCARE SERVICES** a copy of my vehicle certification of insurance before the Home Care Worker(s) will be able to transport me.*

I also agree to hold **FAVORED HEALTHCARE SERVICES** and the Home Care Worker(s) harmless in the event that while I am being transported in the Home Care Worker's vehicle an accident occurs and I am hurt. I also understand that if I refuse to sign this agreement my Home Care Worker(s) will not be able to transport me in his/her vehicle.

X _____ X _____

Client/Responsible Party Signature Date

HPPA PRIVACY

Acknowledgement of Receipt of Private Notice

By signing this acknowledgement of the Receipt of Notice of Privacy Practices (the "Notice"), I acknowledge and agree that I have received a copy of the Notice of Privacy Practices for review and to keep for my records on the date identified below.

I understand that Favored Healthcare Services may use and disclose necessary health information (for example, my name, address, social security number, physical/mental condition information and/or type of products/ services provided) to another party to permit Favored Healthcare Services to perform its administrative duties, provide me with home health services and products, process my home health benefit claims and communicate with me regarding home health services provided by Favored Healthcare Services (for example, mailings of billing invoice, quality assurance interviews, or information about services/products by Favored Healthcare Services).
I can be assured that Favored Healthcare Services does not sell my personal health information of any kind to a third party for such party's own use. I authorize Favored Healthcare Services to submit my home health benefit claims to my plan sponsor or health plan to receive reimbursement directly for the home health services/products that I have received from Favored Healthcare Services.

_____ _____

Client's Name (printed) or Client's Legal Representative Date

_____ _____

Client's Signature Date

Refusal Acknowledgement
For Office Use Only

This section is to be completed by the Personnel of Favored Healthcare Services only if unable to obtain the client's or client's legal representatives signature on the Acknowledgement or receipt of the Notice of Privacy Practices for the following reasons:

_____ (Please initial here) Client or Client's Representative refused to sign
_____ (Please initial here) other: (Please specify, e.g. emergency care)

_____

_____

_____ _____ _____

Provider/Associate Name (printed) Provider/Associate Signature Date

Service Plan Review Form

DATE	Update	RN Signature

Client Name: _____ RN: _____

Physician Order

Only the attending physian may prescribe therapeutic or preventive medications. Only licensed nursing staff may admminister medication, and only on the direct order from the physician. The following is required for physcian's verbal order

1. The physician authorization for the administration of any medication.

2. Use of the Physician Verbal Order Form with follow-up within thirty (30) days to confirm the authorization.

3. The name, dosage, route, and frequency of any medication administered by the nursing staff. The person administering the medication must sign and date all notions.

The Original order is sent/faxed to the physian for signature, and a copy is retained in the clients medical record and/or file. Favored may utilize faxed physician orders, Plan of care or verbal order as original. A manual or electronic log is maintained to ensure timely reciept of signed orders. If ordersare not returned, the company may call the physican, re-fax order or hand carry a copy of the order to the physician's office.

Faxed orders will have a cover sheet identifying company name and nummber, who is to be recipient of faz, date sent, a statement the informs recipient that if fax is recieved in error to notify the company immediately and a confidentiality clause.

Electronic physican's signature is acceptable if Favored maintains client records by computer rather than hard copy. Authentication by the physican, should be available if requested.

The entry must be dated and indicated as an electronic signature and must be authenticated by the individual who reviewed and approved the entry. Authentication may be by signature, written initials, or computer secure entry by a unique identifier.

If utilizing digital signatures, confidentiality/seurity measures must be taken as well as the signature must not be in an encrypted format.

Favored personnel will verify upon return of order that the order is complete, accurate, signed with date of order, and final. If changes are made to original order, appropriate personnel involved in the care of the client are notified. When receved by Favored, the signed order replaces the copy in the client's medical record.

Supplemental verbal orders may be obtained before care is provided and are written within 24 hours of receving the orders. The verbal orders may be signed by an RN, LPN with co-signature by the RN.

Assistance with Self- Administered Medications

An aide may assist the client with physican-prescribed medications that are to be self-administered. Assistance is limited to the following :

1. Remind the client to take medication
2. Reading to the member/client the correct dosage and frequency indicated on the container label

Caregiver will report to RN and document on the Task Sheet, any changes in clients condition, including those that may be related to medications. Any and all reports made to the RN regarding clients medication, including the numbber or frequency in use must immediately be reported to clients physican. The RN must also report these concerns to the care cordinator within 24 hours. Within three (3) business days of verballt notifying the care Cordinator, the RN must also send a Completed Communicaton Care Notification Form (''CCNF'') to the Care Cordinator.

Approved by :

_____ _____

Administrator Date

Physician Telephone/Verbal Order

Initial Order _____ Follow-up Order: _____
Physician's Name: _____
Address: _____
Tele. #: _____ Fax #: _____
Client's Name: _____
Address: _____
Tele. #: _____
UPIN No.: _____ NPI: _____ SOC: _____
DOB: _____ SS#: _____
Medicaid: _____ Medicare: _____
Passport: _____
MRDD: _____
Private: _____
Clinical Rationale: _____Skilled nursing assessment to assess cardiopulmonary status, vital signs, home safety measures and home health needs, which may include blood sugar monitoring (aacu-check), and dressing change, prn

ADMITTING DIAGNOSIS:
PRIMARY:
_____
SECONDARY:
_____
SPECIFIC ORDERS:
_____
_____
_____
_____

New medications Start and Date_____ Old medications start and date _____
_____
_____
_____

Change in MEDICATIONS and date
_____

Physician signature: _____
Nurse's signature: _____ Date: _____
Date: from: _____ to: _____

Verbal order "read back" confirmation made by:

_____

(Indicate name of person providing confirmation, date and time)