Caring Hearts & Hands, LLC

Date of Completion: _____

First Name_____ Last Name_____ Middle _____

Primary Contact #_____ Secondary_____

Address_____

City_____ State_____ Zip_____

Date of Birth_____ Age_____ Marital Status_____

Social Security #_____ Medicare #_____

Previous Occupation (s) _____ Years Retired_____

Source of Referral_____

Email: _____

Person(s) To Contact In Case Of Emergency:

Name Relationship Phone

1. _____

2. _____

3. _____

Alternate Medical Care Provider, Physician, Hospice, Etc.:

Name _____ Phone _____

Address _____

Name _____ Phone _____

Address _____

Choice Of Hospital _____

Last Doctor's Visit:

Date: _____ Where: _____

Reason: _____

Please list current and past medical problems & disabilities: _____

_____

Daily Living - Family, please give your opinion of assistance level:

Please indicate by giving one of the following numbers:

- Level 1 is independent = needs no help w/ activity
- Level 2 is supervision = able to physically do all of activity, but needs supervision for safety, confidence, or limited judgment
- Level 3 = Needs help to complete activity
- Level 4 = Unable to complete Activity

Activity	Level Number
Walking	
Transferring	
Eating	
Toileting	

Community Contact

Please list any health and/or social service agencies with whom you have had contact with in the past 12 months:

Agency Name Phone Reason for Contact Contact Person

1. _____

2. _____

3. _____

Caring Hearts & Hands, LLC

Date of Completion: _____

Applicant's Name: _____

Medical Diagnosis:

_____

_____

Allergies:

_____

_____

Dietary Restrictions:

_____

_____

Medications (Please list all medications applicant is taking):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

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Behaviors exhibited by participant and prompts used for calming/redirection:

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

Does participant become aggressive: yes no

What triggers behaviors:

_____

_____

Comments: (any information that could be helpful to staff)

_____

_____

_____

_____

_____

Date of Completion: _____

Caring Hearts & Hands, LLC

Medical Report

****PLEASE HAVE PHYSICIAN COMPLETE THIS PAGE AND RETURN TO OUR CENTER**

Participant's Name: _____Date of last visit: _____

Diagnosis: _____

Other Medical Problems: _____

_____

Dietary Restrictions: _____

_____

Allergies: _____

Current Medication & Dosage **Frequency & Route of Admission**

_____

_____

_____

Physical Activity Permitted: (Check type below)

____WALKS (on smooth pavement in groups of 3 w/ staff member or volunteer)

____EXERCISE (stretch exercises while seated in chair, arms below shoulder level)

____FIELD TRIPS (in a van, group of 10-12 clients w/ a volunteer and/or staff Member trained in CPR & first aid. Minimal walking required)

Physician's Orders	
	Patient may attend adult day services
	Patient is capable of self-administering medications independently
	Patient requires appropriate adult day center staff to administer medications needed
	Patient may take OTC medications sent to center by guardian(s) with supervision of RN, LPN, CMA, MAT, ETC.
	Comments:

Physician's Signature _____ Date _____

Physician's Name (printed): _____Phone#_____

Date of Completion: _____

Caring Hearts & Hands, LLC

Signature Page

This packet has been completed by _____ on behalf of _____ (name of client) my _____ (relation to client). I certify that all of the information contained in this packet is true and correct to the best of my knowledge. I also understand that it is my responsibility to let the staff of Caring Hearts & Hands, LLC, know if/when there are any updates to this information so that they can maintain accurate records.

_____ _____

Signature of family member Date

Emergency Procedure Authorization

I understand that in the case of an emergency, 911 will be called for emergency transport and the family will be notified simultaneously.

The only way there will not be a 911 call is if the patient has a DNR and a copy of it is in the participants file.

If the patient is on hospice, they will also be notified.

Client's Signature: _____Date:_____

Family Member's Signature: _____Date:_____

Caring Hearts & Hands, LLC

Date of Completion: _____

Photography Release Form

Client Name: _____

I understand and agree that by signing this form I am allowing Caring Hearts & Hands, LLC to take pictures of the above-mentioned party and use them for marketing purposes. By checking the appropriate categories below, you are specifying in which medias those pictures can be display/used.

	Marketing (brochures, etc)		Website		Email to CH&H families
	Facebook		Newsletters		

Please check the boxes which you consent to let WH use pictures of the above-mentioned party

Thank you so much for your cooperation!

Client's Signature: _____

Relative/Caregiver Signature: _____

Caring Hearts & Hands, LLC

Date of Completion: _____

Consumer Grievance Policy

- ✓ Should you have any questions or concerns about services provided by Caring Hearts & Hands, LLC, please discuss this with one of the Caring Hearts & Hands, LLC, Sabrina or Mendy.
    - Call us at: 580-651-HRTS (4787)
    - manager@caringhandh.com
    - sabrina@integrous.pro
    - mendy@integrous.pro
    - 1009 NE 4th Street, Guymon, OK 73942
- ✓ If your questions have not been answered using one of the two methods above, you may call Consumer Inquiry System at 1-800-435-4711.

I have read, understand, and received a copy of the Grievance Policy explained above.

_____

Signature Date

Date of Completion: _____

Caring Hearts & Hands, LLC

Client Pick Up Authorization

I, _____ authorize the people listed below to
Caregiver
pick up _____ at any time from Caring
Client's Name
Hearts & Hands, LLC.

Authorized Pick-Up Persons

NAME	RELATIONSHIP TO	PHONE NO.	DATE	STAFF

I understand that

- The "Authorized Pick-Up Person" must be listed above prior to arriving at the center and must show ID when asked.
- An "Authorized Pick-Up Person" can be added or deleted from the form by calling the center and getting approval from administrator.

_____

Signature Date

Caring Hearts & Hands, LLC

Date of Completion: _____

Caring Hearts & Hands, LLC PARTICIPANT RIGHTS

Each participant enrolled in the Caring Hearts & Hands, LLC program has the right to:

- Be informed - all participants and/or caregivers should be informed of the program's services and policies and procedures requiring participant and/or caregiver compliance
- Participate - to have participant and/or caregiver participate in care planning
- Remain free from mental and/or physical abuse
- Remain free from chemical restraints used for convenience of center staff and/or in quantities which would interfere with his/ her rehabilitation or activities of daily living
- Remain free from the use of physical restraints
- Privacy in the use of his/ her medical record (except as may be required for third party reimbursement of legal purposes)
- Privacy including, but not limited to, privacy concerning treatments and personal care needs (except as needed for assistance by nursing staff)
- Freedom from requirement to perform services for the center
- Freedom to associate and communicate privately with persons of his/ her choice and to join with her or to have their responsible party/ caregiver join with others, within or outside of the center to work for improvements in participant care
- Assistance in the reading and writing of correspondence
- Freedom to participate in center activities including meeting with and participating in social, religious or community group activities at the participant's discretion or the discretion of his/ her responsible part/caregiver
- Make independent personal decisions or if, due to cognitive impairment is unable to make independent personal decisions, to have his/her responsible party caregiver make these decisions on the participant's behalf
- Exercise civil and religious liberties and to have freedom from the imposition of religious belief, practices or attendance at religious services
- Freedom from discrimination with respect to participation in recreation, meals, leisure, other social activities because of age, race, religion, sex, or nation a li ty as defined in Title VI of the Civil Rights Act of 1964 or Section 504 of the Rehabilitation Act
- Freedom from deprivation of any constitutional, civil, and/or legal right solely by reason of admission to the center
- **CONSIDERATION, RESPECT, AND FULL RECOGNITION OF HIS/HER DIGNTIY AND INDIVID UALITY.**