

First Name_____ Last Name____ Middle ____ Primary Contact # Secondary_____ 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 Alternate Medical Care Provider, Physician, Hospice, Etc.: Name ______ Phone _____ Name ______ Phone _____ Address _____ Choice Of Hospital

Date of Completion:	



Last Doctor's Visit:

Date:	Where:		
Reason:			
Please list curren	t and past medica	Il problems & disabilities	::
Daily Living - Fa	amily, please giv	ve your opinion of ass	sistance level:
Please indicate b	y giving one of the	e following numbers:	
Level 2 is s supervisionLevel 3 = N	upervision = able	•	• •
	Activity	Leve	el Number
Tra	ansferring		
	Eating		
Т	Toileting		
Community Co	ntact		
•	alth and/or social ne past 12 months	service agencies with w	hom you have had
Agency Nan	ne Phone	Reason for Contact	Contact Person
1			



Applicant's Name:	
Medical Diagnosis:	
Allergies:	
Dietary Restrictions:	
Medications (Please list all medications applicar	nt is taking):
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	



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

1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
Does participant become aggressive:			
What triggers behaviors:			
Comments: (any information that could	be helpful	to staff)	



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 Permi	tted: (Check type below)
WALKS (on smooth pavement in groups of	f 3 w/ staff member or volunteer)
EXERCISE (stretch exercises while seated in	n chair, arms below shoulder level)
FIELD TRIPS (in a van, group of 10-12 clien	ts w/ a volunteer and/or staff
Member trained in CPR & first a	id. Minimal walking required)
Physicia	n's Orders
Patient may attend adult day services	
Patient is capable of self-administering m	edications independently
Patient requires appropriate adult day ce	nter staff to administer medications needed
-	center by guardian(s) with supervision of RN,
LPN, CMA, MAT, ETC.	
Comments:	
Physician's Signature	Date
Physician's Name (printed):	Phone#

Date



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





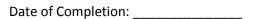
Emergency Procedure Authorization

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:





Photography Release Form

Client Name:			
I understand and agree that Hands, LLC to take pictures marketing purposes. By cl specifying in which medias th	s of the above-mentione hecking the appropriate	ed pa categ	rty and use them for gories below, you are
Marketing (brochures, etc)	Website		Email to CH&H families
Facebook	Newsletters		
Please check the boxes which you co			,
Client's Signature:			
Relative/Caregiver Signature	:		



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.
 - o Call us at: 580-651-HRTS (4787)
 - o manager@caringhandh.com
 - o sabrina@integrous.pro
 - o mendy@integrous.pro
 - o 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.

explained above.	,		
Signature		Date	

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



Client Pick Up Authorization

I, _____ authorize the people listed below to

	Authorized Pic	k-Up Persons		
NAME	RELATIONSHIP TO	PHONE NO.	DATE	STAFF
understand that The "Authorized Picand must show ID v	ck-Up Person" must be lis when asked.	ted above prior to a	rriving at the c	center
	k-Up Person" can be adde ng approval from admini		ne form by call	ing
 Signature		Date		



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 DIGHTIY AND INDIVIDUALITY.