CLIENT EVALUATION/ASSESSMENT

Client Name:________________________________**DOB**:_____________________**MR#**:____________

Address: ____

City: ____ **State:** ___________ **Zip:** _________________

Phone #:_______________________________ **Alternative Phone #:**___________________________

Vitals:

Temperature: ____________________

Pulse: __________________

Respiration: __________________

Blood Pressure: ________________

Height: _____________________________

Weight: __________________lbs_

Assistive Devices Used: (circle all that apply)

Glasses	Electric Cart
Hearing Aid(s)	Walker
Dentures	Oxygen
Cane	Dressings
Wheelchair	
Other: ______________________	

Allergies: ____

Medical Condition(s): ____

____

Vaccination Status:

Pneumonia vaccination received	Yes	No	Date: _________________
Flu vaccination received	Yes	No	Date: _________________
COVID-19 vaccination received	Yes	No	Date: _________________

Communication Barriers:

Vision: Yes ____ No ____ Correction ____

Hearing: Yes ____ No ____ Correction ____

Speech: Yes ____ No ____

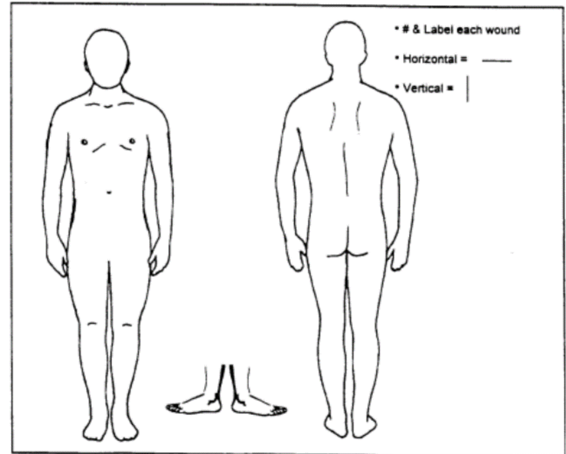
Comments: ____

ADL's

Activity	Independent	Needs Assistance	Equipment	Comment
Bathing				
Dressing				
Grooming				
Toileting				
Transferring				
Walking				
Positioning				
Eating				
Other				

Assistive Devices/Precautions ____

Skin Problems/Interventions: Use diagram to number and identify wounds



Sketch and identify wound/wounds by #.

____
____
____
____
____
____

Digestive Disorders ___ WNL

Diet _______________________ Food Allergies _______________________________________

Appetite ____________________ Weight ________________ Recent Gain/Loss ___________

Indigestion _________________ Heartburn: _____________ Nausea/Vomiting ___________

Constipation/Diarrhea _______________ Last BM __________

Nutritional Status: ___________________________ Nutritional Assessment Done ____

Other ____

Respiratory Disorders ___ WNL

Shortness of Breath _________________________ COPD ___________________________

Hx of Bronchitis, Pneumonia, Sinus Infection ____

Smoker: No ____ Yes ____ PPD _____ # Years _____ Last CXR __________________

TB Hx ____________________ Use of Inhalers/Nebulizers/Oxygen ____________________

Lung Sounds

____

Other

____

Urinary Status ___ WNL

Catheter: Indwelling ____ Suprapubic ____ Condom ____

Change Schedule/Responsible Person

____

Urinary: Frequency _______ Urgency _______ Nocturia _______ Incontinence _______

Hx UTI's or problem with kidney, bladder or prostate

____

Other Information

____

Joint/Muscle Disorders ___ WNL

Arthritis ___ Describe

____

Joint Replacements ____ Describe

____

Pain ______ Frequency/Intensity

____

Relieved by

____

Muscular Disorders

____

Endocrine ___ WNL

Diabetes _____________ Date of Onset ____________ BGM ______________________

Controlled by: Diet ____ Oral Med ____________________ Insulin __________________

Describe Assistance Needed ____

Other Endocrine ____

Cardiovascular Disease ___ WNL

Vital Signs: __________________________ Peripheral Edema _____________________

Hyper/Hypotension (describe) ____

Hx of MI/CAD/CVA ____

Neurological Disease ___ WNL

Seizure Disorder ______________________ Paralysis ____________________________

Neuropathies ____

Other ____

Mental Health Needs/Behavior Interventions

Alert __ Oriented to: Person ___ Place ___ Time ___ Date ___ SLUMS: Yes __ No ___

Anxious ____ Forgetful ____ Depressed ____ Wanders ____ Cooperative ____

Routinely sees a mental health professional ____ Condition/Illness Limits ____

Behavior Socially Acceptable: Yes ____ No ____ Describe __________________________

Responds to Redirection (describe) ____

Social Supports

Satisfied with Quality of Life: Yes ____ No ____ Family Involvement

____

Friends/Neighbors

____

Community Involvement

____

Church Membership/Involvement

____

Guardian/Conservator/Power of Attorney

____ Hobbies/Recreation

____

Barriers to Pursuing Social Activities

____

Safety Factors

History of Falls in past 6 months: Yes ____ No ____

If yes, describe number of falls, precipitating factors, injuries and falls prevention strategies:

____

____

See also Falls Risk Assessment ___

Presence of Side Rails: Yes ____ No ____ (If yes, complete Side Rails Assessment)

Home Safety Assessment

Hazard	No safety concerns	If safety concern, describe problem and action/education to correct
Flooring/Rugs		
Stairway		
Bathroom		
Kitchen		
Lighting		
Bedroom		
Phone		
Exterior		
Fire Safety		
Equipment Safety		

See also Home Safety Checklist ___

Other Health Problems

____

____

____

Other Information

____

____

__________________________________ __________________

RN Signature Date

Date Assessment Finalized/Signature

____

Statement of Home Care Services: Comprehensive Home Care Provider

Home Care Provider Name: _V Care Home Health, inc.__________________________________

Below is a list of all services that *may* be provided with a comprehensive home care license. **Each service offered by this provider is indicated by a check in the box next to the service.**

- ☐ Advanced practice nurse services
- ☐ Registered nurse services
- ☐ Licensed practical nurse services
- ☐ Physical therapy services
- ☐ Occupational therapy services
- ☐ Speech-language pathologist services
- ☐ Respiratory therapy services
- ☐ Social worker services
- ☐ Dietician or nutritionist services
- ☐ Medication management services
- ☐ Delegated tasks to unlicensed personnel
- ☐ Hands-on assistance with transfers and mobility
- ☐ Treatment and therapies
- ☐ Eating assistance for clients with complicating eating problems (i.e. difficulty swallowing, recurrent lung aspirations, or requiring the use of a tube, parenteral or intravenous instruments)
- ☐ Complex or specialty healthcare services
  Describe: ______________________________
  ____
- ☐ Assistance with dressing, self-feeding, oral hygiene, hair care, grooming, toileting, and bathing
- ☐ Standby assistance within arm's reach for safety while performing daily activities
- ☐ Verbal or visual reminders to take regularly scheduled medication (includes bringing clients previously set-up medication, medication in original containers, or liquid or food to accompany the medication)
- ☐ Verbal or visual reminders to the client to perform regularly scheduled treatments and exercises
- ☐ Preparing modified diets ordered by a licensed health professional
- ☐ Laundry
- ☐ Housekeeping/other household chores
- ☐ Meal preparation
- ☐ Shopping

I have received a copy of this *Statement of Home Care Services*:

ULP/Client Signature: ______________________________ Date: ______________________

1049 Payne Avenue
Saint Paul MN 55130
Phone: 651-793-7635 Fax: 651-793-7659

AUTHORIZATION TO RELEASE INFORMATION

Client: ___________________________________ DOB: _______________________

I have reviewed the Notice of Use and Disclosure Practices. I understand that the requested Protected Health Information will be used by V-Care Home Health for the purpose of home health care. I hereby authorize _______________________________ to release the following portion of my clinical record to V-Care Home Health.

____ History and Physical

____ Discharge Summary

____ Consults

____ Current Progress Notes

____ Laboratory Results (specify) ____

____ Radiology Reports (specify) ____

____ Operative Reports

____ Health Care Directives

____ Medication List

____ Physician's Orders

____ Flow Sheets

____ Other (specify) ____

- I understand that my records are protected by data privacy regulations. Alcohol and drug abuse records may be protected by Federal Law (42 CFR Part 2). These records cannot be released without my consent unless specifically directed by law.
- I understand that I have the right to refuse to sign this consent.
- I understand that I may withdraw or revoke this consent at any time if the action it authorizes has not been carried out.
- I understand that this consent expires one year from the date I signed it.
- A copy of this authorization shall be considered as effective and valid as the original.

____ ___________________________
Client/Responsible Party Signature Date

____ ___________________________
Relationship of Responsible Party Witness Signature

FALLS RISK ASSESSMENT

Client ______________________________ Date _______________

Parameter	Score	Resident Status/Condition
A. Level of Consciousness Mental Status	0	Alert (oriented X 3) or Comatose
	2	Disoriented X 3 at all times
	4	Intermittent Confusion
B. History of Falls (past 3 months)	0	No Falls in past 3 months
	2	1-2 Falls in past 3 months
	4	3 or More Falls in past 3 months
C. Ambulation/Elimination Status	0	Ambulatory/Continent
	2	Chair Bound – Requires restraints and assist with elimination
	4	Ambulatory/Incontinent
D. Vision Status	0	Adequate (with or without glasses)
	2	Poor (with or without glasses)
	4	Legally Blind
E. Gait/Balance: To assess the resident's Gait/Balance, have him/her stand on both feet without holding onto anything; walk straightforward; walk through a doorway; and make a turn.	0	Gait/Balance Normal
	1	Balance Problem while Standing
	1	Balance Problem while Walking
	1	Decreased Muscular Coordination
	1	Change in Gait Pattern when Walking through doorway
	1	Jerking or Unstable when making turns
	1	Requires use of Assistive Devices (i.e., cane, w/c, walker, furniture)
F. Systolic Blood Pressure	0	No Noted Drop between lying and standing
	2	Drop Less Than 20 mm Hg between lying and standing
	4	Drop More Than 20 mm Hg between lying and standing
G. Medications: Respond based on the following types of medications: Anesthetics, Antihistamines, Antihypertensives, Antiseizure, Benzodiazepines, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Sedatives/Hypnotics	0	None of these medications taken currently or within last 7 days
	2	Takes 1-2 of these medications currently and/or within last 7 days
	4	Takes 3-4 of these medications currently and/or within last 7 days
	1	If resident has had a change in medications and/or change in dosage in the past 5 days – score 1 additional point
H. Predisposing Diseases: Respond based on the following predisposing conditions: Hypotension, Vertigo, CVA, Parkinson's Disease, Loss of limb(s), Seizures, Arthritis, Osteoporosis, Fractures	0	None Present
	2	1-2 Present
	4	3 or More Present
Total Score of 10 or Above Represents High Risk*		**Total Score:** ___________

*See Care Plan for Interventions.

Comments: ____

RN Signature ______________________________

Questions and Answers about Health Care Directives

Minnesota Law

Minnesota law allows you to inform others of your health care wishes. You have the right to state your wishes or appoint an agent in writing so that others will know what you want if you can't tell them because of illness or injury. The information that follows tells about health care directives and how to prepare them. It does not give every detail of the law.

What is a Health Care Directive?

A health care directive is a written document that informs other of your wishes about your health care. It allows you to name a person ("agent") to decide for you if you are unable to decide. It also allows you to name an agent if you want someone else to decide for you. You must be at least 18 years old to make a health care directive.

Why Have a Health Care Directive?

A health care directive is important if your attending physician determines you can't communicate your health care choices (because of physical or mental incapacity). It is also important if you wish to have someone else make your health care decisions. In some circumstances, your directive may state that you want someone other than an attending physician to decide when you cannot make your own decisions.

Must I Have a Health Care Directive? What Happens if I Don't Have One?

You don't have to have a health care directive. But, writing one helps to make sure your wishes are followed.

You will still receive medical treatment if you don't have a written directive. Health care providers will listen to what people close to you say about your treatment preferences, but the best way to be sure your wishes are followed is to have a health care directive.

How Do I Make a Health Care Directive?

There are forms for health care directives. You don't have to use a form, but your health care directive must meet the following **requirements** to be legal:

- Be in writing and dated.
- State your name.
- Be signed by you or someone you authorize to sign for you, when you can understand and communicate your health care wishes.
- Have your signature verified by a notary public or two witnesses.
- Include the appointment of an agent to make health care decisions for you and/or instructions about the health care choices you wish to make.

Before you prepare or revise your directive, you should discuss your health care wishes with your doctor or other health care provider.

Information about how to obtain forms for preparation of your health care directive can be found in the Resource Section of this document.

I Prepared My Directive in Another State. Is It Still Good?

Health care directives prepared in other states are legal if they meet the requirements of the other state's laws or the Minnesota requirements. But requests for assisted suicide will not be followed.

What Can I Put in a Health Care Directive?

You have many choices of what to put in your health care directive. For example, you may include:

- The person you trust as your agent to make health care decisions for you. You can name alternative agents in case the first agent is unavailable, or joint agents.
- Your goals, values and preferences about health care.
- The types of medical treatment you would want (or not want).
- How you want your agent or agents to decide.
- Where you want to receive care.
- Instructions about artificial nutrition and hydration.
- Mental health treatments that use electroshock therapy or neuroleptic medications.
- Instructions if you are pregnant.
- Donation of organs, tissues and eyes.
- Funeral arrangements.
- Who you would like as your guardian or conservator if there is a court action.

You may be as specific or as general as you wish. You can choose which issues or treatments to deal with in your health care directive.

Are There Any Limits to What I Can Put in My Health Care Directive?

There are some limits about what you can put in your health care directive. For instance:

- Your agent must be at least 18 years of age.
- Your agent cannot be your health care provider, unless the health care provider is a family member or you give reasons for the naming of the agent in your directive.
- You cannot request health care treatment that is outside of reasonable medical practice.
- You cannot request assisted suicide.

How Long Does a Health Care Directive Last? Can I Change It?

Your health care directive lasts until you change or cancel it. As long as the changes meet the health care directive requirements listed above, you may cancel your directive by any of the following:

- A written statement saying you want to cancel it.
- Destroying it.
- Telling at least two other people you want to cancel it.
- Writing a new health care directive.

What If My Health Care Provider Refuses to Follow My Health Care Directive?

Your health care provider generally will follow your health care directive, or any instructions from your agent, as long as the health care follows reasonable medical practice. But, you or your agent cannot request treatment that will not help you or which the provider cannot provide. If the provider cannot

follow your agent's directions about life-sustaining treatment, the provider must inform the agent. The provider must also document the notice in your medical record. The provider must allow the agency to arrange to transfer you to another provider who will follow the agent's directions.

What If I've Already Prepared a Health Care Document?   Is It Still Good?

Before August 1, 1998, Minnesota law provided for several other types of directives, including living wills, durable health care powers of attorney and mental health declarations.

The law changed so people can use one form for all their health care instructions.
Forms created before August 1, 1998, are still legal if they followed the law in effect when written. They are also legal if they meet the requirements of the new law (described above). You may want to review any existing documents to make sure they say what you want and meet all requirements.

What Should I Do With My Health Care Directive After I Have Signed It?

You should inform others of your health care directive and give people copies of it. You may wish to inform family members, your health care agent or agents, and your health care providers that you have a health care directive. You should give them a copy. It's a good idea to review and update your directive as your needs change. Keep it in a safe place where it is easily found.**What if I believe a Health Care Provider Has Not Followed Health Care Directive Requirements?**

Complaints of this type can be filed with the Office of Health Facility Complaints at 651-201-4200 (Metro Area) or Toll-free at 1-800-369-7994.

What if I Believe a Health Plan Has Not Followed Health Care Directive Requirements?

Complaints of this type can be filed with the Minnesota Health Information Clearinghouse at 651-201-5178 or Toll-free at 1-800-657-3793.

How To Obtain Additional Information

If you want more information about health care directives, please contact your health care provider, your attorney or the Minnesota Board on Aging's Senior LinkAge Line®
(1-800-333-2433). A suggested health care directive form is available on the internet at: http://www.mnaging.org/.

V-CARE HOME HEALTH INC

Title: Grievance Policy
Effective Date: April 2, 2022
Reference: MN Statute 144A.4791, Subd 11

Policy Statement: Clients of V-Care Home Health are entitled to all the rights defined in the Home Care Bill of Rights and in the Health Insurance Portability and Accountability Act, including the right to quality home care services and to protection of personal health information. Clients have the right to complain about home care services and the privacy of protected health information without retaliation. V-Care Home Health is committed to providing a quality of service that meets and exceeds clients' needs and expectations

Procedure:

1. All clients receiving home care services are informed verbally and in writing of their rights on initiation of services. Upon admission, all clients are given a copy of the Home Care Bill of Rights and the Grievance Policy.

2. The internal process for investigating and addressing a quality concern includes the following.
   - When a quality concern is initiated, the employee receiving the information documents the specific information
   - The employee taking the information attempts to resolve the problem and meet the needs of the client immediately
   - If the complaint remains unresolved, the employee will turn the documentation over to his or her immediate supervisor within 2 business days
   - The supervisor or administrator notifies the complainant of receipt of the grievance within 5 business days.
   - A resolution plan is developed, and the supervisor or administrator notifies the complainant in writing of the results and response within 14 days.
   - The supervisor or administrator shall perform employee counseling and training as appropriate.
   - The organization will set expectations, develop plans and manage processes to assess, improve and maintain the quality of organizational governance, management, quality of care and other activities

3. Clients of V-Care Home Health or their families or responsible parties may complain in writing, through E-mail, in person or by telephone to the following:
   a. Staff member providing home care
   b. Director of Nursing: Sue Xiong
   c. Administrator: Charleeya Vang
      Phone: 651-793-7635
      Fax: 651-793-7659
      Email: charleeya@vcarehome.com

4. The Administrator will maintain a written record of grievances the agency received, including the resolutions.

5. At least annually, all grievances are compiled onto a complaint log, analyzed for trends and incorporated into the Quality Improvement program.

6. Documentation of complaints will be maintained for a minimum of two (2) years after the date of entry and will be available to the commissioner for review.

7. Clients and their families or responsible parties may also complain to the Minnesota Department of Health, Office of Health Facility Complaints at:

   85 East Seventh Place, Suite 300
   P.O. Box 64970
   St, Paul, MN 55164-0970
   (651) 201-4201

8. The State Home Health Hotline is 1-800-369-7994

9. V-Care Home Health will in no way retaliate because of a complaint.

Grievance Policy Acknowledgement

I ________________________, have acknowledged and received the V-Care Home Health, Inc. Grievance Policy

I am the: (Check one box)

- ⓪ Client
- ⓪ Responsible Party
- ⓪ ULP/PCA/DSW

____ ____________________________________

Signature Date

GRIEVANCE FORM

Client Name ________________________________ Date of Receipt ______________

Identity of person filing complaint ____

Contact information/preferred method of contact ________________________________

____

Describe complaint, providing background information and identity of staff involved, as applicable

____

____

____

Signature of Person Receiving Complaint _____________________________________

The information below to be completed by the supervisor/manager conducting the investigation

Date client notified of receipt of complaint and plan for investigation ________________

Description of Investigation, including interviews and record reviews, as applicable:

____

____

____

Date Investigation Completed/Signature ______________________________________

Resolution ____

____

____

Date/method resolution communicated to client ________________________________

Other information ____

Signature/Date ____

V-CARE HOME HEALTH
AUTHORIZATION TO SHARE INFORMATION

Client ____ Date ______________________

Please indicate below those people with whom V-Care Home Health may or may not share your protected personal health information. Note that V-Care Home Health will share information as described in the Notice of Use and Disclosure Practices.

V-Care Home Health may share my protected personal health information with the following (initial all that pertain):

My family

___ Parents ___ Spouse ___ Siblings ___ Children

___ Stepchildren ___ Grandparents

___ Aunts/Uncles

___ Other family members (list) ____

___ Others: List others with whom we may share your personal health information

____

___ I do not want my protected personal health information shared with anyone.

___ I do not want my protected personal health information shared with the following specific people:

____

Comments/additional information ____

____

____ ___________________________
Client/Responsible Party Signature Date

____ ___________________________
Relationship of Responsible Party Witness Signature

NOTICE OF USE AND DISCLOSURE PRACTICES (HIPAA)

This notice describes how clinical information may be used and disclosed, and how you can get access to this information. Please review this notice carefully.

V-Care Home Health will make every effort to protect the privacy of your personal health information. Personal Health Information (such as diagnosis, home care services, clinical data, or medications) will be disclosed:

1) To other health care providers currently providing service to you (e.g. case manager, physician, pharmacist)
2) To health care providers who may provide service to you through a referral at your request or at your responsible party's request (e.g. medical transportation service, equipment supplier)
3) To other providers when so requested by you or your responsible party.
4) To your insurance or other funding source as required for reimbursement.
5) To governmental agencies overseeing home health care.

Only the minimum amount of protected health information necessary to accomplish the purpose of the disclosure or request will be provided. For instance, we will provide only information about functional limitations to the transportation provider. Except as required by law, V-Care Home Health will not release your health records without a signed/dated consent from you.

As a recipient of home care services, you have the right under law to have personal, financial, and medical information kept private, and to be advised of our policies and procedures regarding disclosure of such information. You also have the right to be allowed access to records and written information. We will comply with your written request for copies of records or a summary of the information in the records unless such information is detrimental to your physical or mental health or would cause you to harm yourself or another. In such a situation, the information can be given to another provider or to your responsible party.

You have the right to ask us to change personal health information in the clinical record. Please make any such request in writing. We will not amend records in the following situations.

V-Care Home Health:

1) Does not have the records you want amended,
2) Did not create the records you want amended,
3) Has determined that the records are accurate and complete or
4) The records have been compiled in anticipation of a civil, criminal or administrative act or proceeding.

V-Care Home Health is required by law to maintain the privacy of its clients' protected health information. If you would like further information about our privacy policies, please contact Charleeya Vang, Administrator at 651-793-7635. You may also contact Charleeya by email (charleeya@vcarehome.com), phone or in writing with any concerns or complaints you have about the privacy of your protected health information. Your signature below indicates that you have received a copy of and understand this notice.

______________________________________ __________________________

Client/Responsible Party Signature Date

HOME SAFETY CHECKLIST

Client ____ MR # ____________________

HAZARD	OK	NO	SUGGESTION/ACTION
Interior			
Small rugs are tacked down or slip resistant			
Flooring, such as tile, rugs, boards, is in good repair			
Cords are not stretched along pathways or under rugs			
Door sills are low			
Pathways are free of clutter			
Stairway			
The handrails are secure and extend from top to bottom			
Steps and flooring are in good condition			
Steps have non-skid surface			
Steps are evenly spaced to allow sure footing			
There are no items cluttering the steps			
Bathroom			
Bathtubs and showers have non-skid mats or surfaces			
Grab bars are present and accessible			
A shower chair is used			
The toilet's height is appropriate and easy to get on and off			
Kitchen			
Regularly used dishes and food are placed within easy reach			
If needed, the step stool is sturdy with a handrail.			
Lighting			
Exits, halls, stairways and pathways are well lit			
Lights can be turned on before going through a dark area			
Night lights are used in hallways, bedroom and bath			
A working flashlight is available in case of power outage			
There is a light or light switch within reach of the bed			
Bedroom			
Bed is proper height			
Furniture is arranged to prevent tripping			
Phone			
There is a working phone by the bed			
Emergency numbers are posted and can be seen			
Exterior			
Outside porch light is working			
Outside stairs are in good repair and have a handrail			
Outside steps have non-slip surface			
Sidewalks and steps are free of debris and snow			
Sidewalks and steps are in good condition			

Other			
Smoke and carbon monoxide detectors are present and checked twice yearly			
Canes, walkers and wheelchairs are clean and in good repair			
Water temperature is at 120 degrees or less			
Windows and doors are in good repair, easy to use and airtight			

RN Signature ____ Date ______________________

SERVICE AGREEMENT

Client ____ Date ___________________________

Service	Frequency	Staff Title	Supervision Schedule	Fees	Financial Responsibility

Contingency Plan

If services cannot be provided, V-Care Home Health will: ___________________________________

If services cannot be provided, Client/Client Representative will: ______________________________

Emergency Plan

In case of emergency or change in condition, V-Care Home Health should contact: ________________

____________ Relationship: _____________ Phone Number(s): __________________________

Address: ____

If a medical emergency arises during a home visit, staff will call 911, the physician and V-Care Home Health office unless otherwise instructed. If a medical emergency arises when staff are not present, the client or responsible party should call the physician or 911.

Important Contact Information

V-Care Home Health ____

Office of the Ombudsman for Long-Term Care: 1-800-657-3591

Health Care Directives: __ Information Provided __ Client has Advance Directives __ Copy on File __ Living Will __ Mental Health Declaration __ Guardian/Conservator __ Durable Power of Attorney

Assignment of Benefit: I request payment of health insurance benefits for all services furnished me by V-Care Home Health, Inc. I assign to V-Care Home Health benefits payable to me for home care services rendered.

I have received a copy of: ___ Notice of Personal Health Information Privacy ___ Complaint Process ___ Recipient Rights ___ Home Care Bill of Rights

I have had the opportunity to participate in the development of the Service Agreement and Care Plan. I have read this agreement, understand it and agree to abide by its terms.

Date: ___________ Client/Responsible Party Signature: ___________________________________

Date: ___________ V-Care Home Health Representative: __________________________________

If Client is not able to sign, provide reason:____

Print Name and Relationship of Responsible Party:____

SERVICE PLAN: PART 1

Licensee: V-Care Home Health, Inc.

Address: 1049 Payne Ave N; St Paul, MN 55130

Office Phone #: _651-793-7635__ **Fax:** __651-793-7659_ **After Hours Call:** _651-343-4454__

Client Name: ______________________ **DOB**: ___________ **Telephone #:** _______________

RATE SHEET AGREEMENT

Service ________________ **Rate** _________________

_________________ _________________

AGENCY POLICIES

Rate Changes: All rates are subject to change with 30 days notice.

Cancellation: Except in an emergency (as defined by the agency) four (4) hours notice is required to cancel scheduled service.

Holidays: The following holidays are billed and employees paid at time and one-half:

Assessment and Supervisory Visits: The charge for the supervisory visit may be waived when daily services are scheduled.

Live In/Sleepover

1. If a live-in or sleepover home health aide is required to be up more than twice/night or is unable to sleep for at least eight (8) hours per night due to the client's care needs, hourly charges will apply.
2. The live-in and sleepover rates will be adjusted for couples.

Billing and Payment

1. A _______ retainer is required for all home health services.
2. Invoices are sent ____________ and payment is due upon receipt.
3. Late payments (over 21 days from date of invoice) are subject to a late payment charge of 1.5% per month pro-rated of the amount past-due. Charges will be compounded monthly until the past due amount has been paid.
4. Should an account balance be assigned to a collection agency or an attorney for legal action, the client will is responsible for all collection charges and legal fees.
5. Services may be cancelled for non-payment.

Liquidation Damages: .

SERVICE PLAN: PART 2

Client ____ Date _____________________________

Service Description	Frequency/Schedule	Staff Title/Method	Fees/Financial Responsibility
________ *services/care plan as attached*			
Client Review/Reassessment *(in person and/or by phone)*	__ *On admission in person* __ *Within 14 days in person* __ *Every 90 days* __ *As needed*	__ *RN* __ *LPN* __ *Other ____________*	
Monitoring/Supervision of Staff *(in person)*	*-Unlicensed staff providing delegated services within 30 days of hire and as needed, but not less than annually* *- Unlicensed staff (Basic Services) as needed but not less than annually* *-Licensed staff as needed, but not less than annually*	__ *RN* __ *LPN (Basic Services)* __ *Other____________*	

Contingency Plan

If services cannot be provided, V-Care Home Health will: _____________________________________.

If services cannot be provided, Client/Client Representative will: _______________________________.

Emergency Plan

In case of emergency or change in condition, V-Care Home Health should contact: _________________

___________ Relationship: ________________ Phone Number(s): ___________________________

Email: ____________________________________ Address: _________________________________

I understand that emergency services (911) will be summoned during an emergency unless there is a written physician's/prescriber's order directing V-Care Home Health to refrain from doing so. Other instructions/action in case a medical emergency arises during a home visit:

____

Important Contact Information

V-Care Home Health _651-793-7635____

Office of the Ombudsman for Long-Term Care: 1-800-657-3591

Health Care Directives: __ Information Provided __ Client has Advance Directives __ Copy on File
__ Living Will __ Mental Health Declaration __ Guardian/Conservator __ Durable Power of Attorney
Code Status: __ Full Resuscitation __ DNR/DNI

Assignment of Benefit: I request payment of health insurance benefits for all services furnished me by V-Care Home Health, Inc. I assign to V-Care Home Health benefits payable to me for home care services rendered.
I have received a copy of: ___Home Care Bill of Rights ___Notice of Personal Health Information Privacy ___Complaint Process ___Statement of Scope of Home Care Services ___ I understand that a Dementia Notice is available

SERVICE PLAN: PART 2

I have had the opportunity to participate in the development of the Service Plan. I have read this agreement, understand it and agree to abide by its terms.

Date: _____________ Client/Responsible Party Signature: ____

Date: _____________ V- Care Home Health Representative: ______________________________________

If Client is not able to sign, provide reason: ____

Print Name and Relationship of Responsible Party: ____

SERVICE PLAN: PART 3 - TREATMENT PLAN

Client ____ Record ID ____________

Treatment	Frequency	Responsible Person	Supervision

When to notify RN: ____

____

Other Instructions/Comment: ____

____

Goal(s) ____

Plan prepared with ___ client ___ caregiver/family

____ ________________________

RN Signature Date

____ ________________________

Client/Responsible Party Signature Date

SERVICE PLAN: PART 4 - MEDICATION MANAGEMENT PLAN

Client ____ Record ID ___________

Medication Activity ✓ all that apply	**Frequency**	**Responsible Person**	**Supervision**
___ Reminders			
___ Refill			
___			
___			
___			
___			
___			
___			
Coordination: ___ Pharmacy ___ Caregiver ___ Family Member			
___ Other (specify)			

When to notify RN: ____

Other Instructions/Comment: ____

Goals for Medication Management Plan: ___ Medication Adherence
___ Early Identification of Side Effects/Adverse Reactions ___ Optimal Therapeutic Effect

Plan prepared with ___ client ___ caregiver/family

____ _______________________
RN Signature Date

____ _______________________
Client/Responsible Party Signature Date

SERVICE PLAN: PART 5 – CARE PLAN
PCA/DSW/ULP CARE PLAN

Client ____ Medical Record # _____________________

ASSESSMENT

Medical Diagnosis ____

Special Diet/Instructions ____ Allergies ___________________ Special Equipment/Instructions ____

Vulnerability Risks addressed by interventions: ___ Self-Abuse ___ Behavior ___ Susceptibility Factors

Resuscitation Status _____________ Other Instructions regarding Advance Directives ___________________

√	HOME HEALTH AIDE INTERVENTIONS	Special Instructions/Frequency
	Assistance with **Dressing** Clothing ___ Hearing Aide ___ Elastic Stockings/TEDs ___ Braces/Orthotic Devices ___	
	Bath: Type _____________________________ Shower Chair ___ Shampoo ___	
	Assistance with **Grooming**: Oral Care ___ Hair Care ___ Dentures ___ Upper ___ Lower ___ Shaving ___ Razor Type ________________ Nail Care ___ Foot Care ___ Skin Care ___	
	Toileting Assistance Incontinent Pads ___ Catheter ___ Type _____________________ Ostomy ___ Type _____________________ Other _________________________________	
	Assistance with Meals (specify)	
	Exercise Program (specify)	
	Assistance with Mobility (specify)	
	Assistance with Transfer	
	Assistance with Positioning	
	Medication Assistance	___ See Medication Management Plan
	Vital Signs, Weight & Blood Glucose (specify) ___ See Vital Signs/Weight flowsheet ___ See Blood Glucose flowsheet	
	Behavior/Orientation ___ See also Mental Health Care Plan ___ See also Behavioral Health Assessment & Interventions	___ See Behavioral Health flowsheet
	TREATMENTS:	

	HOMEMAKER INTERVENTIONS	**Special Instructions/Frequency**
	Clean Kitchen Remove Garbage___ Wash Dishes___ Monitor Foods for Freshness___ Shopping___	
	Clean Bathroom	
	Bedroom Change Linens___ Monitor Clothing for Cleanliness___	
	Laundry	
	Household Vacuum___ Dust___	

Other Information and Instructions ____

____

____

√	**GOALS:** ___ Promote self-care/independence ___ Maintain stability ___ Maintain dignity ___ Assure safety ___ Maintain hygiene ___ Other (specify) ____
√	**Care Plan Developed** with: Client _______ Family/Responsible Party (specify) _________________________

RN Signature ____ Date ____________________

Care Plan Review Care Plan Updates developed with: Client _______ Family/Responsible Party (specify) _____________________________________	
Date of Review/Update	**Signature(s)**

PCA'S ORIENTED TO CARE PLAN
AND SIGNATURE SHEET

Client ___________________________________ MR #___________

By my signature below, I indicate that I have been oriented to the Care Plan for this client by the QP.

INITIALS	SIGNATURE	PRINT NAME	DATE

Vulnerability Assessment / Abuse Prevention Plan

Client Name: ____ DOB: _____________________

MR#: _____________________

VULNERABILITIES	YES/NO (CIRCCLE)		DESCRIBE	APPROACH/INTERVENTION	GOALS / OUTCOME /PLAN
Is not oriented to person, place, and time ☐ Some of the time ☐ Most of the time	YES	NO		☐ Staff to provide cues and reminders regarding orientation ☐ Staff to monitor and provide for safety ☐ Other:	☐ Client will remain safe in familiar surroundings. ☐ Client will achieve the highest level of orientation as possible ☐ Other:
Environment is not always safe/clean	YES	NO		☐ Staff to provide daily and weekly housekeeping and keep area free of clutter and safety hazards ☐ Other:	☐ Client's living space will remain clean and well organized ☐ Other:
Visual difficulties	YES	NO		☐ Staff to ensure eyeglasses are clean and available for client to wear ☐ Staff to assist with daily activities involving vision ☐ Other:	☐ Client will experience improved vision by wearing clean, well-fitting glasses/ contacts ☐ Client will remain safe despite vision deficits ☐ Other:
Hearing difficulties	YES	NO		☐ Staff to speak slowly and clearly to client at all times ☐ Staff to ensure hearing devices are available and in working order for use ☐ Other:	☐ Client will experience improved hearing by using hearing devices ☐ Client will understand communication from others ☐ Other:
Speech/language barriers	YES	NO		☐ Staff to listen carefully, ask client to repeat as needed ☐ Staff to allow client time to respond ☐ Staff to use non-verbal communication methods as appropriate ☐ Staff to use communication board as appropriate ☐ Staff to anticipate client needs ☐ Other:	☐ Client will be able to make needs known through verbal and non-verbal communication methods Other:

VULNERABILITIES	YES/NO (CIRCCLE)		DESCRIBE	APPROACH/INTERVENTION	GOALS / OUTCOME /PLAN
Does not understand and/or follow instructions ☐ Some of the time ☐ Most of the time	YES	NO		☐ Staff to use clear instructions & repeat as needed ☐ Staff to demonstrate instructions as needed ☐ Use cues and reminders for daily activities ☐ Other:	☐ Client will be able to follow simple instructions verbally, or non-verbally throughout day and will remain safe ☐ Other:
Is not able to ambulate safely with/without device (not able to remove self from bad situation)	YES	NO		☐ Staff to encourage client to use ambulation device at all times while ambulating ☐ Staff to keep area free of hazards ☐ Other:	☐ Client will experience safety while ambulating ☐ Client will remain free of falls ☐ Other:
Chronic conditions / pain / illness / disability	YES	NO		☐ Client will have regular follow-up with physicians regarding chronic conditions ☐ Client will take prescribed medications as directed ☐ Staff to notify nurse promptly for any changes in condition ☐ Other:	☐ Client will experience comfort, free of pain ☐ Client will find stabilization of chronic conditions, if possible ☐ Other:
Not able to call for help ☐ Cannot use telephone ☐ Cannot use emergency notification system	YES	NO		☐ Staff to anticipate client needs and provide appropriate support ☐ Call light within reach ☐ Safety Checks ☐ Client alarm mechanism ☐ Other:	☐ Client will receive assistance when needed ☐ Other:
Unable to manage finances	YES	NO		☐ Responsible party manages finances ☐ Power of Attorney manages finances ☐ Other:	☐ Client's financial well-being will be stable ☐ Client's bills will be paid in a timely manner ☐ Client will have the necessary supplies and items needed for their care ☐ Other:
Does not have social support system in place	YES	NO		☐ Staff will encourage client to meet new people and engage in social activities offered in the community ☐ Other:	☐ Client will verbalize a sense of belonging in the setting ☐ Client will appear to be comfortable in the setting, participating with others despite level of communication ☐ Other:

VULNERABILITIES	YES/NO (CIRCCLE)		DESCRIBE	APPROACH/INTERVENTION	GOALS / OUTCOME /PLAN
Wandering / elopement risk	YES	NO		☐ Staff to monitor whereabouts of client while up and about ☐ Staff to monitor for statements of wanting to leave or "go home" ☐ Secure environment ☐ Provide supervised opportunities to be outdoors, when appropriate ☐ Other:	☐ Client will remain safe while residing at the community and planned outings ☐ Other:
Are there concerns with safe smoking? ☐ Client does not smoke	YES	NO		☐ Staff to supervise client while smoking ☐ Smoking apron to be used ☐ Staff to encourage smoking cessation if client is willing ☐ Staff will hold smoking supplies and provide to client as needed ☐ Other:	☐ Client will remain safe while smoking ☐ Other:
Falls and/or frequent bruising	YES	NO		☐ Staff to report any falls to nurse promptly ☐ Staff to report bruising to nurse promptly ☐ Client takes and anticoagulant ☐ Use care with transfers and personal cares to prevent bruising ☐ Other:	☐ Client will remain free of falls and injury ☐ Other
Alcohol, chemical and/or other medication abuse	YES	NO		☐ Client may not use alcohol/ chemicals while client is at [name of company] ☐ Staff to report any use of alcohol or chemicals by client to nurse promptly ☐ Use of alcohol requires a physician order ☐ Other:	☐ Client will remain free of illegal drugs ☐ Staff to monitor for risky behaviors with prescription medications ☐ Other:

VULNERABILITIES	YES/NO (CIRCCLE)		DESCRIBE	APPROACH/INTERVENTION	GOALS / OUTCOME /PLAN
Has Side Rails / Bed Mobility Devices	YES	NO		☐ Side Rail/ bed positioning device assessment is in place ☐ Side rail/ bed positioning agreement is in place ☐ Safety checks of side rail/ bed positioning device every shift when in use ☐ Staff to report any concerns with side rails/ bed positioning device to nurse promptly ☐ Other:	☐ Client will experience improved ability in bed mobility and positioning ☐ Client will remain free from injury ☐ Side rails/ bed positioning device will remain in proper working order ☐ Other:
Unable to report abuse/neglect/concerns	YES	NO		☐ Staff to monitor for signs or symptoms of abuse or neglect and report to nurse promptly ☐ Other:	☐ Client will remain free of abuse & neglect while residing at [name of company] ☐ Other:
Is client susceptible to abuse from another individual, including other vulnerable adults?	YES	NO		☐ Staff to monitor for signs or symptoms of abuse or neglect from others and report to nurse promptly ☐ Other:	☐ Client will remain free of abuse & neglect while residing at [name of company] ☐ Other:
Is the client at risk of abusing another individual, including other vulnerable adults?	YES	NO		☐ Staff to monitor client behavior and intervene with any actions of abuse toward others ☐ Other:	☐ Client will not be abusive toward other vulnerable adults ☐ Peers will remain safe ☐ Other:
Is the client at risk of self-abuse?	YES	NO		☐ Staff to monitor client for concerns of self-abuse and report promptly to the nurse ☐ Other:	☐ Client will remain free of self-abuse ☐ Other:
Identify other areas specific to individual:	YES	NO			

This information is based on:

☐ Interview with Client
☐ Information received from: ____
☐ Observation and Assessment of Client

Check all appropriate statements:

☐ Client does not appear to have any areas of vulnerability requiring interventions at this time
☐ Client has some identified areas of potential vulnerability, but there are no signs of abuse or neglect

- Interventions to address areas are described above and available to staff (location): ______________________________

☐ There are signs of maltreatment, which have been or are being reported
☐ Client does not appear to pose a threat to other vulnerable adults
☐ Client may pose a risk to other vulnerable adults as identified

- Interventions to address areas are described above and available to staff (location): ______________________________

____ ______________________

Signature and Title of Home Care Staff Completing Assessment and Plan Date

VULNERABILITY ASSESSMENT

Client: ____ MR # ________________

Other vulnerable individuals in home: None ___ Yes ___ If yes, # ________________________

Do Vulnerabilities exist in each area	**Yes**	**No**	***Individual Abuse Prevention Plan**
Mark "Yes" if there is a problem in the area and mark "No" if there is not			Complete for all areas marked, "Yes"
Oriented to person, place & time			
Environment safe/clean			
Visual difficulties			
Hearing difficulties			
Speech/language barriers			
Understands/follows instructions			
Able to ambulate safely with/without device			
Risk for elopement			
Chronic condition(s)/pain/ illness/disability			
Ability to use telephone			
Ability to manage finances			
Social support system			
Ability to self administer medications			
Possesses functional limitations			If yes, specify:
Presence of risk factors in environment or with other residents			
Susceptible to abuse by others in home or community environment			
Ability to report abuse/neglect concerns			
Client at risk for abusing other vulnerable individuals			

*A plan to minimize the risk of abuse/neglect may also be established in the Care Plan for each vulnerable area identified in this assessment.

Comments: ____

RN Signature ____ Date:__________________

Minnesota Home Care Bill of Rights for Clients of Licensed Only Home Care Providers

Statement of Rights

A client who receives home care services in the community has these rights:

1. Receive written information, in plain language, about rights before receiving services, including what to do if rights are violated.
2. Receive care and services according to a suitable and up-to-date plan, and subject to accepted health care, medical or nursing standards and person-centered care, to take an active part in developing, modifying, and evaluating the plan and services.
3. Be told before receiving services the type and disciplines of staff who will be providing the services, the frequency of visits proposed to be furnished, other choices that are available for addressing home care needs, and the potential consequences of refusing these services.
4. Be told in advance of any recommended changes by the provider in the service plan and to take an active part in any decisions about changes to the service plan.
5. Refuse services or treatment.
6. Know, before receiving services or during the initial visit, any limits to the services available from a home care provider.
7. Be told before services are initiated what the provider charges for the services; to what extent payment may be expected from health insurance, public programs, or other sources if known; and what charges the client may be responsible for paying.
8. Know that there may be other services available in the community, including other home care services and providers, and to know where to find information about these services.
9. Choose freely among available providers and to change providers after services have begun, within the limits of health insurance, long-term care insurance, medical assistance, other health programs or public programs.
10. Have personal, financial, and medical information kept private, and to be advised of the provider's policies and procedures regarding disclosure of such information.
11. Access the client's own records and written information from those records in accordance with Minnesota Health Records Act, Minnesota Statute, Sections 144.291 to 144.298.
12. Be served by people who are properly trained and competent to perform their duties.
13. Be treated with courtesy and respect, and to have the client's property treated with respect.
14. Be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act.
15. Reasonable, advance notice of changes in services or charges.
16. Know the provider's reason for termination of services.

17. At least ten calendar days' advance notice of the termination of a service by a home care provider. This clause does not apply in cases where:

   - The client engages in conduct that significantly alters the terms of the service plan with the home care provider;
   - The client, person who lives with the client, or others create an abusive or unsafe work environment for the person providing home care services; or
   - An emergency or a significant change in the client's condition has resulted in service needs that exceed the current service plan and that cannot be safely met by the home care provider.

18. A coordinated transfer when there will be a change in the provider of services.
19. Complain to staff and others of the client's choice about services that are provided, or fail to be provided, and the lack of courtesy or respect to the client or the client's property, and the right to recommend changes in policies and services, free from retaliation, including the threat of termination of services.
20. Know how to contact an individual associated with the home care provider who is responsible for handling problems and to have the home care provider investigate and attempt to resolve the grievance or complaint.
21. Know the name and address of the state or county agency to contact for additional information or assistance.
22. Assert these rights personally or have them asserted by the client's representative or by anyone on behalf of the client, without retaliation.
23. Place an electronic monitoring device in the client's or resident's space in compliance with state requirements.

You may choose to discuss any concerns with your provider. As a reminder, providers are required to work to assure your rights and other requirements are followed. When providers violate the rights in this section, they are subject to the fines and license actions.

Providers must do all of the following:

- Encourage and assist in the fullest possible exercise of these rights.
- Provide the names and telephone numbers of individuals and organizations that provide advocacy and legal services for clients and residents seeking to assert their rights.
- Make every effort to assist clients or residents in obtaining information regarding whether Medicare, medical assistance, other health programs, or public programs will pay for services.
- Make reasonable accommodations for people who have communication disabilities, or those who speak a language other than English.
- Provide all information and notices in plain language and in terms the client or resident can understand.

No provider may require or request a client or resident to waive any of the rights listed in this section at any time or for any reasons, including as a condition of initiating services or entering a home care provider contract.

Interpretation and Enforcement of Rights

These rights are established for the benefit of clients who receive home care services. All home care providers must comply with these rights. The commissioner shall enforce this. A home care provider may not request or require a client to surrender any of these rights as a condition of receiving services. This statement of rights does not replace or diminish other rights and liberties that may exist relative to clients receiving home care services, persons providing home care services, or licensed home care providers.

Resources

You may contact your licensed provider as indicated below:

Licensee Name: V Care Home Health, Inc.

Phone: (651) 793-7635

Email: info@vcarehome.com

Address: 1049 Payne Ave
St Paul, MN 55130

Name and title of person to whom problems or complaints may be directed:
Sue K Xiong
Operations Manager / HR

Report suspected abuse, neglect, or financial exploitation of a vulnerable adult:

MINNESOTA ADULT ABUSE REPORTING CENTER (MAARC) Phone: 1-844-880-1574 For more information:
Vulnerable adult protection and elder abuse (https://mn.gov/dhs/adult-protection/)

For all other complaints that are not suspected abuse, neglect, or financial exploitation of a vulnerable adult, please contact the Office of Health Facility Complaints at the Minnesota Department of Health:

MINNESOTA DEPARTMENT OF HEALTH
OFFICE OF HEALTH FACILITY COMPLAINTS PO Box 64970
St. Paul, Minnesota 55164-0970
Phone: 651-201-4201 or 1-800-369-7994 Fax: 651-281-9796
health.ohfc-complaints@state.mn.us
Office of Health Facility Complaints
(https://www.health.state.mn.us/facilities/regulation/ohfc/index.html)

If you have a complaint about the provider or the person providing your home care services, you may call, write, or visit the office of Health Facility Complaints, Minnesota Department of Health. You may also contact the Office of Ombudsman for Long Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities.

MINNESOTA DEPARTMENT OF HEALTH
OFFICE OF HEALTH FACILITY COMPLAINTS PO Box 64970
St. Paul, Minnesota 55164-0970

Phone: 651-201-4201 or 1-800-369-7994 Fax: 651-281-9796
health.ohfc-complaints@state.mn.us
Office of Health Facility Complaints
(https://www.health.state.mn.us/facilities/regulation/ohfc/index.html)

To request advocacy services, please contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities:

OFFICE OF OMBUDSMAN FOR LONG-TERM CARE
PO Box 64971
St. Paul, MN 55164-0971
1-800-657-3591 or 651-431-2555 MBA.OOLTC@state.mn.us
Ombudsman for Long-Term Care (http://www.mnaging.org/Advocate/OLTC.aspx)

OFFICE OF OMBUDSMAN FOR MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES 121 7th Place East
Metro Square Building
St. Paul, MN 55101-2117
1-800-657-3506 or 651-757-1800 Ombudsman.mhdd@state.mn.us
Office of Ombudsman for Mental Health and Developmental Disabilities (https://mn.gov/omhdd/)

MID-MINNESOTA LEGAL AID/MINNESOTA DISABILITY LAW CENTER
(Protection and Advocacy Systems)
430 First Avenue North, Suite 300
Minneapolis, MN 55401-1780
1-800-292-4150 mndlc@mylegalaid.org
Legal Aid (http://mylegalaid.org/)

MINNESOTA DEPARTMENT OF HUMAN SERVICES
(Medicaid Fraud and Abuse-payment issues)
Surveillance and Integrity Review Services
PO Box 64982
St Paul, MN 55164-0982
1-800-657-3750 or 651-431-2650 DHS.SIRS@state.mn.us

SENIOR LINKAGE LINE
(Aging and Disability Resource Center/Agency on Aging)
Minnesota Board on Aging
PO Box 64976 St. Paul, MN 55155
1-800-333-2433
senior.linkage@state.mn.us
Senior LinkAge Line (www.SeniorLinkageLine.com)

For general inquiries, please contact:

Minnesota Department of Health
Health Regulation Division
85 E. 7th Place

PO Box 64970
St. Paul, MN 55164-0970 651-201-4101
health.fpc-web@health.state.mn.us
Minnesota Department of Health (www.health.state.mn.us)

To be used by licensed only home care providers per Minnesota Statute, Section 144Aa.44 Subdivision 1. These rights pertain to clients receiving home care services from licensed only home care providers.

The home care provider shall provide the client or the client's representative a written notice of the rights before the date that services are first provided to that client. The provider shall make all reasonable efforts to provide notice of the rights to the client or the client's representative in a language the client or client's representative can understand.

Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900
651-201-4101
health.fpc-licensing@state.mn.us

Revised November 10, 2021

Acknowledgment of Receiving Bill of Rights

I ________________________, have acknowledged and received the V-Care Home Health, Inc. new and revised Bill of Rights. (Bill of Rights Revised on November 10, 2021)

Language of Bill of Rights that I have received:

- ⓪ English
- ⓪ Hmong
- ⓪ Karen

____ ______________________________
Client Signature / Responsible Party Signature Date

1049 Payne Avenue
Saint Paul MN 55130
Phone: 651-793-7635 Fax: 651-793-7659

EMERGENCY INFORMATION

Client Information

Name ____
First Middle Last DOB

MR# ________ Address ______________________________________

Diagnosis ____________________________ Allergies ___________________________

DNR/DNI Status ____________ Health Care Directives ___________________________

Other Health Information ____

Attach Medication List

Emergency Contacts

1st Contact ______________________________ Relationship _______________________

Address ____

Phone: H) ______________________________ W) _________________________________

Cell) _____________________________ P) __________________________________

2nd Contact ______________________________ Relationship _______________________

Address ____

Phone: H) ______________________________ W) _________________________________

Cell) _____________________________ P) __________________________________

Primary Physician ________________________ Phone _____________________________

Address/Specialty ____

Other Physician __________________________ Phone _______________________________

Address/Specialty ____

Hospital Preference ____

Other Health Care Providers/Phone ____

____

EMERGENCY PREPAREDNESS

Priority Code: _____

Level 1: High Priority: Clients in this priority level need uninterrupted services. The client must have care. In case of a disaster or emergency, every possible effort must be made to see this client. The client's condition is highly unstable and deterioration or inpatient admission is highly probable if the client is not seen. Included in this level are clients with life sustaining equipment or medication and unstable clients with no caregiver or informal support to provide care
Level 2: Moderate Priority: Services for clients at this priority level may be postponed with telephone contact. A caregiver can provide basic care until the emergency situation improves. The client's condition is somewhat unstable and requires care that should be provided that day but could be postponed without harm to the client.
Level 3: Low Priority: The client may be stable and has access to informal resources for assistance. The client can safely miss scheduled service with basic care provided safely by family, other informal support or by the client personally.
Level 4: Lowest Priority: Home care services may be postponed 72 hours or more with little or no adverse effects. A willing and able caregiver is available or the client is independent in most ADL's.

Evacuation Plan/Location: ____

____

Other Information: ____

____