V-CARE HOME HEALTH, INC.

# 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 ◯

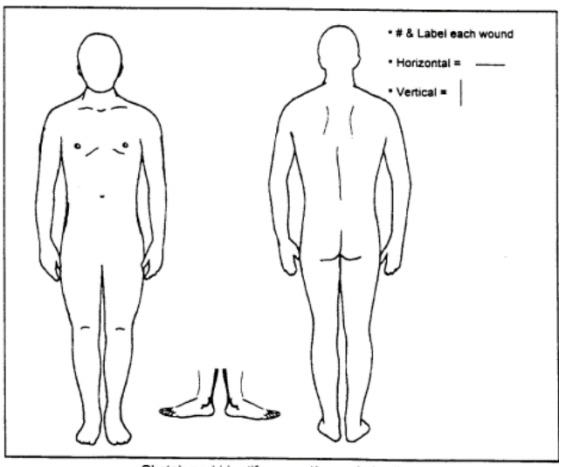
Comments: _____

**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 _____

## 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 _____

**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*<br>☐ *Within 14 days in person*<br>☐ *Every 90 days*<br>☐ *As needed* | __ *RN*<br>__ *LPN*<br>__ *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*<br>*- Unlicensed staff (Basic Services) as needed but not less than annually*<br>*-Licensed staff as needed, but not less than annually* | __ *RN*<br>__ *LPN (Basic Services)*<br>__ *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:<br>☐ Pharmacy<br>☐ Caregiver<br>☐ 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**<br>Clothing ☐ Hearing Aide ☐<br>Elastic Stockings/TEDs ☐<br>Braces/Orthotic Devices ☐ | |
| | **Bath**: Type _____<br>Shower Chair ☐ Shampoo ☐ | |
| | Assistance with **Grooming**:<br>Oral Care ☐ Hair Care ☐<br>Dentures ☐ Upper ☐ Lower ☐<br>Shaving ☐ Razor Type _____<br>Nail Care ☐ Foot Care ☐<br>Skin Care ☐ | |
| | **Toileting** Assistance<br>Incontinent Pads ☐<br>Catheter ☐ Type _____<br>Ostomy ☐ Type _____<br>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)<br>☐ See Vital Signs/Weight flowsheet<br>☐ See Blood Glucose flowsheet | |
| | Behavior/Orientation<br>☐ See also Mental Health Care Plan<br>☐ See also Behavioral Health Assessment & Interventions | ☐ See Behavioral Health flowsheet |
| | **TREATMENTS**: | |

| | | |
|---|---|---|
| | | |
| | | |
| | **HOMEMAKER INTERVENTIONS** | **Special Instructions/Frequency** |
| | Clean Kitchen<br>Remove Garbage ☐ Wash Dishes ☐<br>Monitor Foods for Freshness ☐<br>Shopping ___ | |
| | Clean Bathroom | |
| | Bedroom<br>Change Linens ☐<br>Monitor Clothing for Cleanliness ☐ | |
| | Laundry | |
| | Household<br>Vacuum ☐ Dust ☐ | |

Other Information and Instructions

| | |
|---|---|
| √ | **GOALS:**<br>☐ Promote self-care/independence<br>☐ Maintain stability ☐ Maintain dignity<br>☐ Assure safety ☐ Maintain hygiene<br>☐ Other (specify) _____ |
| √ | **Care Plan Developed** with:<br>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 |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
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| | | | |
| | | | |
| | | | |
| | | | |

## 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: _____

## 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 |

**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: _____

_____