Welcome!

Thank you for choosing Care Seniors as your home care provider. We are pleased to have you as our patient and look forward to serving your needs.

Our office hours are Monday through Friday, 9:00am to 5:00pm. The office will be closed in observance of the following holidays: New Years Day, Memorial Day, July 4th, Labor Day, Thanksgiving Day and Friday, Christmas Eve, Christmas Day, and New Years Eve.

We have a scheduler on call at 419-908-9888, that may address non-emergency medical concerns with a nurse and handle any staffing needs 24 hours a day.

We have a mission and it is to promote excellence in the provision of quality home care.

Again, we welcome you with open arms. Care Seniors!

Patient Name_____

4841 Monroe St Suite 305 *TEL: 419-490-6699 FAX: 888-261-0315*

Care Seniors, LLC

Patient Name: _____

Address: _____ **City** _____**State**: _____ **Zip**_____

Phone Number: _____ DOB: _____ Gender: _____

Emergency Contact person: _____

Phone number: _____ **Relationship:** _____

Passport Case Manager: _____ **Phone number:** _____

Type of Service: General clean up Laundry Make bed Grocery shopping Restricted Fluids
Feed/Assist Meals prepared Transportation Encouraged fluids
Assist with Dressing Clean/File Nails Mouth Care/ Shave/ Hair
Tub/Shower Walker/Cane/Crutches Moisture Skin others

Smoker : ☐YES ☐NO

Pets: ☐YES , comment: **☐NO**

Hours: _____/Week or Units: _____/Week

Please Circle Days of service Will Provide:

Monday _____hr Tuesday _____hr hrs Wednesday _____hrs Thursday _____hr Friday _____hr Saturday _____ hrs Sunday _____ hr

Backup person: _____ **Phone number:** _____

Patient Signature: _____**Date:** _____ **RN**

Signature: _____**Date:** _____

Comments_____
_____
_____

Office Copy

CARE SENIORS

PASSPORT ADMISSION AGREEMENT

NAME OF CLIENT**:** _____D.O.B _____

CONSENT FOR CARE

The services to be provided to me by the Agency staff have been explained to me. I hereby consent to the staff of said program to visit my home periodically to render PCA Services as ordered by my physician in a plan of care.

RELEASE OF INFORMATION

I authorize information in my medical record to be released to authorized representatives of Medicare, Medicaid, or another medical insurance carrier for use in determining home health care benefits payable to the Agency on my behalf. I authorize any hospital, nursing home, physician's office or other health facility where I have been a client to disclose any part or all of my medical record to the Agency. Also, I authorize the release of medical and other related information to appropriate agency staff and social/health care agencies and medical equipment/supply vendors whose services may be required in conjunction with the services provided by the Agency

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY RIGHTS

I have received the notice of privacy rights and had it reviewed with me. I have had the opportunity to ask questions, and have been given the names of contact persons for future questions.

REQUEST FOR PAYMENT

I request payment of authorized Medicaid, or other health insurance benefits and hereby assign benefits payable on my behalf directly to the Agency. I understand that should payment not be made to the Agency, I will be responsible for services rendered to me, and that this payment is contingent upon written notice from the Agency that services rendered are not authorized benefits under Medicaid or other health insurance. I understand that I am responsible for any insurance deductible, co-pay and coinsurance.

HOME CARE BILL OF RIGHTS

I acknowledge that I have been provided with a copy of the Home Care Bill of Rights. I have read the Bill of Rights or had it explained to me. I have been instructed on how to contact the agency and informed of the complaint procedure.

Signature: _____

CERTIFICATION

I certify that I have read the above agreement, received a copy thereof, agree with the above conditions, and am the client, or am duly authorized by the client as the client's general agent to execute the above and accept its terms. I understand that this agreement can be revoked at any time.

_____ _____

SIGNATURE OF CLIENT DATE SIGNED

_____ _____

AGENCY REPRESENTATIVE SIGNATURE DATE SIGNED

IF CLIENT UNABLE TO SIGN, GIVE REASON _____

CARE SENIORS

PASSPORT ADMISSION AGREEMENT

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AGENCY REPRESENTATIVE SIGNATURE DATE SIGNED

IF CLIENT UNABLE TO SIGN, GIVE REASON _____

Office Copy

CARE SENIORS, LLC • PLAN OF HOME HEALTH CARE

PERSONAL CARE	CARE TO BE PROVIDED	COMMENTS
Complete Bed Bath		☐ Every Visit ☐ OTHER:
Assist With Bed Bath-Partial/Complete		☐ Every Visit ☐ OTHER:
Shower/Peri Care		☐ Every Visit ☐ OTHER:
Shampoo/Hair Care/Comb Hair		☐ Every Visit ☐ OTHER:
Shave		☐ Every Visit ☐ OTHER:
Skin Care/Moisture		☐ Every Visit ☐ OTHER:
Oral Hygiene		☐ Every Visit ☐ OTHER:
Assist With Dressing		☐ Every Visit ☐ OTHER:

DIETARY			CARE TO BE PROVIDED	
Meal Prep: B ☐ L ☐ D ☐		Vacuum	☐ Every Visit	☐ OTHER:
		Dust	☐ Every Visit	☐ OTHER:
		Sweep	☐ Every Visit	☐ OTHER:
		Wet mop	☐ Every Visit	☐ OTHER:
		Dishes	☐ Every Visit	☐ OTHER:
Meal Serving/Set-Up ☐		Refrigerator	☐ Every Visit	☐ OTHER:
HDM ☐		Clean toilet/tub/sink	☐ Every Visit	☐ OTHER:
Assist With Feeding ☐		Laundry	☐ Every Visit	☐ OTHER:
Encourage Fluids ☐				

ACTIVITIES			
Turn and Position		☐ Every Visit	☐ Other:
Transfer to: chair		☐ Every Visit	☐ Other:
commode		☐ Every Visit	☐ Other:
wheel chair		☐ Every Visit	☐ other:
Ambulation with: cane		☐ Every Visit	☐ Other:
walker		☐ Every Visit	☐ Other:
crutches		☐ Every Visit	☐ Other:
assistance		☐ Every Visit	☐ Other:
Assist with R.O.M.		☐ Every Visit	☐ Other:

ELIMINATION	
Bedpan/urinal - Measure	☐
Commode	☐
Bathroom	☐
External Catheter Care	☐
Empty cath.drng.bag-measure	☐
Empty ostomy drng.bag-measure	☐

**Specific Instructions Given By Assessment Nurse
Do Not Cut Toenails or Fingernails. **Notify Supervisor of Need.

Foot Care**	Nail Care**	Cath Care*	Side Rails*

CARE OF PATIENT AREA	OTHER
Linen Change/Make Bed ☐ Every Visit	☐
Patient Laundry ☐ Every Visit	☐
Light Housekeeping ☐ Every Visit	☐
Kitchen Cleaning ☐ Every Visit	☐
Bathroom Cleaning/Care ☐ Every Visit	☐
Living Room Cleaning ☐ Every Visit	☐
Bedroom Cleaning ☐ Every Visit	☐
Garbage Removal ☐ Every Visit	☐
Pharmacy Errands ☐ Every Visit	☐
Errands ☐ Every Visit	☐

	Mon	Tue	Wed	Thu	Fri	Sat	Sun
PCS							
HMK							
RESPITE							

I, _____ have reviewed the Plan of Care with
CLIENT

_____, and completely understand the duties/tasks of my care that will be performed.
Assessment Nurse Name

Client Signature: _____ Date : _____

Assessment Nurse Signature : _____ Date: _____

CARE SENIORS, LLC • PLAN OF HOME HEALTH CARE

PERSONAL CARE	CARE TO BE PROVIDED	COMMENTS
Complete Bed Bath		☐ Every Visit ☐ OTHER:
Assist With Bed Bath-Partial/Complete		☐ Every Visit ☐ OTHER:
Shower/Peri Care		☐ Every Visit ☐ OTHER:
Shampoo/Hair Care/Comb Hair		☐ Every Visit ☐ OTHER:
Shave		☐ Every Visit ☐ OTHER:
Skin Care/Moisture		☐ Every Visit ☐ OTHER:
Oral Hygiene		☐ Every Visit ☐ OTHER:
Assist With Dressing		☐ Every Visit ☐ OTHER:

DIETARY			CARE TO BE PROVIDED	
Meal Prep: B ☐ L ☐ D ☐		Vacuum	☐ Every Visit	☐ OTHER:
		Dust	☐ Every Visit	☐ OTHER:
		Sweep	☐ Every Visit	☐ OTHER:
		Wet mop	☐ Every Visit	☐ OTHER:
		Dishes	☐ Every Visit	☐ OTHER:
Meal Serving/Set-Up ☐		Refrigerator	☐ Every Visit	☐ OTHER:
HDM ☐		Clean toilet/tub/sink	☐ Every Visit	☐ OTHER:
Assist With Feeding ☐		Laundry	☐ Every Visit	☐ OTHER:
Encourage Fluids ☐				

ACTIVITIES			
Turn and Position		☐ Every Visit	☐ Other:
Transfer to: chair		☐ Every Visit	☐ Other:
commode		☐ Every Visit	☐ Other:
wheel chair		☐ Every Visit	☐ other:
Ambulation with: cane		☐ Every Visit	☐ Other:
walker		☐ Every Visit	☐ Other:
crutches		☐ Every Visit	☐ Other:
assistance		☐ Every Visit	☐ Other:
Assist with R.O.M.		☐ Every Visit	☐ Other:

ELIMINATION	
Bedpan/urinal - Measure	☐
Commode	☐
Bathroom	☐
External Catheter Care	☐
Empty cath.dmg.bag-measure	☐
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Bedroom Cleaning ☐ Every Visit	☐
Garbage Removal ☐ Every Visit	☐
Pharmacy Errands ☐ Every Visit	☐
Errands ☐ Every Visit	☐

	Mon	Tue	Wed	Thu	Fri	Sat	Sun
PCS							
HMK							
RESPITE							

I, _____ have reviewed the Plan of Care with
CLIENT

_____, and completely understand the duties/tasks of my care that will be performed.
Assessment Nurse Name

Client Signature: _____ Date : _____

Assessment Nurse Signature : _____ Date: _____

Office Copy

Care Seniors, LLC

CLIENTS AUTHORIZED SIGNATURE

Care Seniors is committed to providing the best care possible to you or your loved one. In order to do so Care Seniors utilizes an app to record and verify visits. Care Seniors requires all tasks are documented and client confirms before the Aide leaves the clients house.

The client must confirm services by signing the device the aide is using to record.

The clients Power Of Attorney can also sign for the client.

This should be something simple that the client can sign on a small rectangle on a Smartphone screen.

The client's signature must be readable and consistent each visit.

If Care Seniors is not able to confirm the signature, the client will have to sign on a physical time sheet.

Client Name: _____

Client Authorized Signature:

POA Authorized Signature:

Patient / POA Signature: _____Date: _____

Witness Signature: _____Date: _____

HIPAA Notice of Privacy Practices

If you are a client of Care Seniors, this notice describes how your information may be used and disclosed and how you can get access to this information. Please review this notice carefully.

I. USES AND DISCLOSURES

The Agency will not disclose your health information without your authorization, except as described in this notice.

Plan of Care/ Treatment. The Agency will use your health information for the plan of care/ treatment; for example, information obtained by a nurse/therapist will be recorded in your record and used to determine the course of treatment. Your nurse/therapist and other health care professionals will communicate with one another personally and through the case record to coordinate care provided. You may receive more than one service (program) during your treatment period with such information shared between programs.

Payment. The Agency will use your health information for payment for services rendered. For example, the Agency may be required by your health insurer to provide information regarding your health care status so that the insurer will reimburse you or the Agency. The Agency may also need to obtain prior approval from your insurer and may need to explain to the insurer your need for home care and the services that will be provided to you.

Health Care Operations. The Agency will use your health information for health care operations. For example, Agency therapist, nurses, field staff, supervisors and support staff may use information in your case record to assess the care and outcomes of your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of services we provide. Regulatory and accrediting organizations may review your case record to ensure compliance with their requirements.

Notification. In an emergency, the Agency may use or disclose health information to notify or assist in notifying a family member, personal representative or another person responsible for your care, of your location and general condition.

Workers' Compensation. The Agency may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs established by the law.

Public Health. As required by federal and state law, the Agency may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Law Enforcement. As required by federal and state law, the Agency will notify authorities of alleged abuse/neglect; and risk or threat of harm to self or others. We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Charges against the Agency. In the event you should file suit against the Agency, the Agency may disclose information necessary to defend such action.

Duty to Warn. When a client communicates to the Agency a serious threat of physical violence against himself, herself or a reasonably identifiable victim or victims, the Agency will notify either the threatened person(s) and/or law enforcement.

The Agency may also contact you about if services cannot be provided, if there has been incidents that occurred while being provided services, or if there have been changes in the office and staff.

In any other situation, the Agency will request your written authorization before using or disclosing any identifiable health information about you. If you choose to sign such authorization to disclose information, you can revoke that authorization to stop any future uses and disclosures.

II. INDIVIDUAL RIGHTS

You have the following rights with respect to your protected health information:

1. You may request in writing that the Agency not use or disclose your information for treatment, payment or administration purposes or to persons involved in your care except when specifically authorized by you, when required by law, or in emergency situations. The Agency will consider your request; however, the Agency is not legally required to accept it. You have the right to request that your health information be communicated to you in a confidential manner such as sending mail to an address other than your home.

2. If you believe that information in your record is incorrect or if important information is missing, you have the right to submit a request to the Agency to amend your protected health information by correcting the existing information or adding the missing information.

3. If this notice was sent to you electronically, you may obtain a paper copy of the notice upon request to the Agency.

HIP AA Notice of Privacy Practices

III. AGENCY'S DUTIES

1. The Agency is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices with respect to protected health information.

2. The Agency is required to abide by the terms of this Notice of its duties and privacy practices. The Agency is required to abide by the terms of this Notice as may be amended from time to time.

3. The Agency reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all protected health information that it maintains. Prior to making any significant changes in our policies, Agency will change its Notice and provide you with a copy. You can also request a copy of our Notice at any time. For more information about our privacy practices, please contact the office at: (419) 490-6699.

IV. COMPLAINTS

If you are concerned that the Agency has violated your privacy rights, or you disagree with a decision the Agency made about access to your records, you may contact the office by phone at: (419) 490-6699.
You may also send a written complaint to the Federal Department of Health and Human Services. The Care Seniors office staff can provide you with the appropriate address upon request. Under no circumstances will you be retaliated against for filing a complaint.

V. CONTACT INFORMATION

The Agency is required by law to protect the privacy of your information, provide this Notice about our information practices, and follow the information practices that are described in this Notice.
If you have any questions or complaints, please contact Robbie Dickerson RN, or Ali Osman Administrator, at (419) 490-6699.

Complaints may also be directed to the Ohio Department of Health at 614-564-2422 or 1-800-342-0553 without fear of retaliation.

Restoring healthy lives one block at a time!

HHA - ACTIVITY REPORT Timesheets

Employee Name: _____ Employee No: _____

Client Name: _____ Client No: _____

Date	Day	Time – In AM	Time – Out AM	Time – In PM	Time – Out PM	Hours	HHA Full Signature	Consumer authorize Signature	Hours
	Monday								
	Tuesday								
	Wednesday								
	Thursday								
	Friday								
	Saturday								
	Sunday								

Services:	M	Tu	W	Th	F	Sa	Su
BATH CIRLCE ONE							
Tub/Shower							
Bed – Partial							
Bed – Complete							
Assist Bath-Chair							
Shampoo Hair							
Comb Hair							
Mouth Care							
Shave ☐ Elect ☐ St							
Assist with Dressing							
Clean/File Nails							
Soak Feet							
ELIMINATION							
Perinea Care							
External Cath Care							
Measure Cath Care							
Bedpan/Urinal-							
Commode							
Empty Drainage Bag							
CIRCLE ONE							
Dry, Red, Bruised, Itch							
SWELLING IN							
Hand/Legs (R/L)							

Services:	M	Tu	W	Th	F	Sa	Su	Changes in Cond /Comments
SKIN CARE								
Moisture Skin								
ACTIVITY								
Ambulate/Mobility								
Walker/Cane/Crutches								
Chair/Bed/Commode								
Transfer-Chair/WC								
Turn/Position Pt.								
Other/ROM								
MEALS								
Prepare								
Feed								
Setup								
Encourage/Offer Fluids								
Homemaker								
Change Bed Linen								
Make Bed								
Light Housekeeping								
Bathroom care								
Living Room Cleaning								
Kitchen care/Cleaning								
Laundry/Ironing								
Removing trash								
Errands/Shopping								
Pharmacy Errands								
							Total Hours	

NOTE: **Your signature indicates your approval of the hours that have been documented. LATE TIME SHEETS WILL RESULT IN DELAY OF PAY.**

Careseniorsllc.com 4841 Monroe St 2nd floor Suite 305 Toledo, Ohio 43623 Tel: 419-490-6699 Fax: 888261-3415

Client Copy