

Welcome to Von & Bick Healthcare Associates

This packet gets your services started. Type directly into the fields, or print and write. Items marked **State form** are official Georgia DBHDD forms that we give you exactly as issued; they are not part of this fillable file.

SERVICES STARTING

- ☐ CLS - Community Living Supports
 ☐ Adult Skilled Nursing
 ☐ CAI - Community Access (Individual)
 ☐ SMS

☐ Other

Other service / SMS service name

Requested start date

ADMISSION CHECKLIST (OFFICE USE)

Form	Done	Date	Staff initials
1. Face sheet & emergency contacts	☐		
2. Consent for services & freedom of choice	☐		
3. Rights & responsibilities (annual review log)	☐		
4. Confidentiality preferences & privacy notice receipt	☐		
5. Grievance & abuse/neglect reporting acknowledgment	☐		
6. Advance directive acknowledgment	☐		
7. Medication & health information	☐		
8. Nursing intake assessment (nursing clients)	☐		
9. Service plan (tied to ISP)	☐		
10. Transportation, visitation & personal funds	☐		
11. Emergency & missing-person plan	☐		
12. Discharge planning & admission sign-off	☐		
State form: DBHDD Notice of Privacy Practices	☐		
State form: DBHDD Authorization for Release of Information (23-110)	☐		
State form: Georgia Advance Directive (if client wants one)	☐		
Copy of ISP, guardianship papers, physician orders	☐		

1. FACE SHEET

Full legal name	Preferred name	Date of birth

Medicaid ID	Primary phone	Preferred language

Home address (street, city, state, ZIP)

Waiver: ☐ NOW ☐ COMP ☐ Lives with family ☐ Own home ☐ Host home

Legal guardian / representative (if any)	Relationship	Phone

☐ Guardianship papers on file ☐ Healthcare agent named ☐ No guardian

Emergency contact 1	Relationship	Phone

Emergency contact 2	Relationship	Phone

Support coordinator	Agency	Phone

Primary physician	Pharmacy	Phone

Diagnoses

Allergies (food, medication, other) - write NKA if none

Precautions (seizures, choking risk, fall risk, elopement, other)

Communication: ☐ Hearing loss / deaf ☐ Vision ☐ Interpreter ☐ Device or signs ☐ Limited English

Date DBHDD Office of Deaf Services notified (404-232-1624), if deaf / hard of hearing	Mobility / equipment

2. CONSENT FOR SERVICES & FREEDOM OF CHOICE

I am asking Von & Bick Healthcare Associates for the services marked on page 1. I have had the chance to ask questions and I understand what the services are, who will provide them, and how to reach the agency. I understand I may accept or refuse any service and may change my mind at any time. I was told that services are provided under my Individual Service Plan (ISP), that I may choose my provider, and that I may choose a home- and community-based setting instead of an institution.

I understand an assessment may be needed to learn about my needs and preferences.

Assessment: ☐ I agree to the assessment ☐ I do not agree

Freedom of choice: ☐ I was offered a choice of provider ☐ I was offered a choice of setting

ISP INFORMATION

ISP effective date	ISP annual review due	Region / Field Office

Authorized service	Units / frequency	Start date	End date

No service is billed unless it is on the ISP approved by DBHDD. A copy of the ISP is kept in the record.

SIGNATURES

Individual signature (typed or signed)	Date
Guardian / representative signature	Date
Agency representative (name and title)	Date

3. RIGHTS & RESPONSIBILITIES

You have the right to: be treated with dignity and respect; be free from abuse, neglect, exploitation and coercion; receive services in the least restrictive setting; take part in your plan and know about changes before they happen; accept or refuse services; keep your personal belongings, money and privacy; have your records kept confidential; see visitors you choose and use the phone and mail privately; practice your religion; vote; make complaints without fear of punishment.

Your responsibilities: give accurate information; tell us about changes in your health or situation; take part in planning; treat staff with respect; tell us if you need to cancel; help keep a safe home for staff.

These rights follow Georgia Rules Chapter 290-4-9 (Client Rights). A full written summary is provided to you.

Format I understand: ☐ Written ☐ Read aloud ☐ Easy-read pictures ☐ Interpreter

Initials

I received a written copy of my rights and responsibilities and they were explained to me in a way I understand.

Individual / guardian signature

Date

Staff explaining (name and title)

Date

ANNUAL REVIEW LOG (RIGHTS AND RESPONSIBILITIES)

Date reviewed	Rights	Respons.	Individual / guardian initials	Staff initials
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		

4. CONFIDENTIALITY PREFERENCES & PRIVACY NOTICE RECEIPT

You decide who we may talk to about your services, health and billing. You can change this at any time in writing.

Name	Relationship	Phone	All	Sched.	Health	Billing
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐

Do NOT share information with:

Best way to contact me: ☐ Phone ☐ Text ☐ Email ☐ Mail ☐ Through guardian

Contact details

NOTICE OF PRIVACY PRACTICES

I received a copy of the DBHDD Notice of Privacy Practices. I can ask for a paper copy at any time. For any release of records not covered above, a separate DBHDD Authorization for Release of Information (Policy 23-110) is completed.

☐ I received the notice ☐ Offered; signature refused (staff note below)

Staff note if refused

Individual / guardian signature

Date

Staff (name and title)

Date

5. GRIEVANCE PROCESS & REPORTING

You may complain at any time, and no one may punish you for doing so. You can tell any staff member, the Director of Nursing, or the agency office at **470-256-3897**. The Director will meet with you and anyone involved within 24 hours and report back with a resolution within 5 days.

If you are not satisfied, or you prefer not to go through the agency, you may contact the **DBHDD Office of Constituent Services** at **404-657-5964** or **888-785-6954**, or visit dbhdd.georgia.gov/office-constituent-services. You may do this at any point.

Initials

I was told how to make a complaint and who to call, including DBHDD, and my questions were answered.

Abuse, neglect and exploitation. Staff must report any suspected abuse, neglect or exploitation immediately to the Director and as required by law (including DBHDD incident reporting, Adult Protective Services and law enforcement as applicable). Staff cannot be punished for reporting.

Initials

I received information about reporting abuse, neglect and exploitation and my responsibilities were explained to me.

Individual / guardian / staff signature

Date

Witness

Date

6. ADVANCE DIRECTIVE ACKNOWLEDGMENT

Initials

I was given written information about my right to accept or refuse medical treatment and to make advance directives.

Initials

I understand I do not need an advance directive to receive services.

Initials

I understand the agency will follow any advance directive I give it, as the law allows, once a copy is on file.

Choose one: ☐ I have an advance directive and will give a copy ☐ I do not have one and do not want to talk about it now
☐ I do not have one but want more information

Individual / guardian signature

Date

Administrator signature

Date

7. MEDICATION & HEALTH INFORMATION

Allergies / adverse reactions

Pharmacy / phone

Medication	Dose	Route	Time / frequency	Prescriber	Purpose

Medications are: ☐ Nurse administered ☐ Self-administered with supervision ☐ Family / other

☐ Physician orders (dated within the past year) on file ☐ MAR started

Any psychotropic medication needs a signed informed consent completed by the prescriber (capacity check, risks and benefits explained). That consent is a clinician-completed form and is filed separately.

Psychotropic medication consent: ☐ Not applicable ☐ On file ☐ Requested

Reviewed by (licensed nurse, name and title)

Date

8. NURSING INTAKE ASSESSMENT (NURSING CLIENTS)

Health conditions: ☐ Diabetes ☐ Seizures ☐ High blood pressure ☐ Heart ☐ Breathing / asthma
☐ Feeding tube ☐ Bowel / bladder ☐ Skin concerns ☐ Swallowing / choking risk ☐ Falls ☐ Mental health
☐ Other

Daily living	Independent	Needs help	Dependent
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐

Rows: bathing, dressing, toileting, eating, walking / transfers, medication.

Diet (regular / special / texture / fluid limits)

Equipment

Nursing observations, risks and needed healthcare plans

☐ Healthcare plan needed ☐ Referred to physician ☐ No concerns

Assessing nurse (name, license, title)

Date

9. SERVICE PLAN (SUPPORTS THE ISP)

Services / hours (per ISP authorization)

Start date

First review

ISP goal	Objective	Staff support / frequency	Target date

How specific tasks will be done (personal care, meals, community activities, nursing tasks)

Behaviors that may affect services and supports. If a behavior support or crisis/safety plan exists, attach it.

Special treatments

Special equipment

☐ Positive behavior support plan attached ☐ Crisis / safety plan attached

Supervisor (name and title)

Date

Individual / guardian signature

Date

10. TRANSPORTATION, VISITORS & PERSONAL FUNDS

Transportation is provided only as the ISP authorizes and according to agency policy. Please choose:

☐ I want transportation to ISP activities ☐ I do not want transportation

Staff may use their own vehicle: ☐ Yes ☐ No

Staff may help with my money: ☐ Yes ☐ No

Maximum per visit (\$)

Notes

Initials

I understand my choices about transportation and money and can change them at any time by telling the agency.

Agency/legal review needed on: liability wording for personal-vehicle use and the rules for handling client funds.

Visitors. I was told I may have visitors I choose and can withdraw consent at any time. Any restriction must be ordered in writing by my physician, reviewed at least yearly, and explained to me.

Visitors I choose (names)

☐ No restrictions ☐ Restriction ordered by physician (attach order)

Individual / guardian signature

Date

11. EMERGENCY & MISSING-PERSON PLAN

Needs in an emergency: ☐ Cannot evacuate alone ☐ Needs electricity for equipment ☐ Needs medication on hand

☐ Wanders / elopement risk ☐ Cannot call 911 alone

Where I shelter in place / who comes for me

Physical description (height, hair, marks)

Recent photo on file?

Places I may go if missing

If a person is missing, staff call 911 and notify the Director immediately; Georgia requires law enforcement to be notified within 30 minutes of discovering a missing individual in residences.

12. DISCHARGE PLANNING & ADMISSION SIGN-OFF

Discharge planning begins at admission. Moving to another provider or leaving services needs prior approval from the DBHDD Regional Field Office, and a discharge summary goes in the record within 30 days.

Goals and what needs to happen before services lessen or end

Strengths, preferences and abilities to carry forward

Planned next supports or referrals

ADMISSION SIGN-OFF

☐ All forms complete ☐ Copies given to individual / guardian ☐ ISP in record

Admitting nurse / supervisor

Date

Administrator

Date