I Care
Nursing Services

ASSESSMENT & PRELIMINARY SERVICE PLAN INFORMATION

I Kindra L. Andreas, BSN, RN, RND am a qualified assessor in Washington state as defined in WAC 388-76-10150. I have a Bachelor's of Science in Nursing degree from the University of Washington. I have over a decade of experience in the healthcare field working with all ages of patients. My focus areas of nursing have been, Hospice, Home Health, ICU, Caregiver Education, and I am a DSHS approved Nurse Delegator. I am the owner of I Care Nursing Services. I Care Nurses offer Long-Term Care consulting for Adult Family Homes and Assisted Living Facilities, caregiver and staff training, family caregiver training, resident assessments and nurse delegation for both private pay and DSHS clients. I Care strongly believes that the assessment is a critical part of building a happy, healthy living environment for you or your loved one in a long-term care setting.

ASSESSMENT RULES, WHAT IS THE ASSESSMENT FOR?

If you or a loved one wishes to reside in an Adult Family Home (AFH) in Washington State, they must first have a resident Assessment and Preliminary Service plan completed by a qualified assessor. An assessment is an in-person interview in your home, current residence, or another location that is convenient to you. DSHS regulates the rules regarding AFHs and Assessments. The WAC regulations for the assessment are 388-76-10325-388-76-10345. Please look on my website to review these rules in detail. These regulations can be overwhelming and difficult to understand. I Care Nursing Services will help you navigate this first step in your transition with ease.

The assessment must be completed prior to being admitted into the AFH and reviewed by the provider of the AFH. The AFH may not admit a resident without an assessment except in cases of a genuine emergency. To establish that a true emergency exists, the home must verify that the resident's life, health or safety is at serious risk due to circumstances in the resident's current place of residence or harm to the resident has occurred. After this is verified the assessment and preliminary service plan must be completed within five working days after admitting to the AFH.

The assessment must be updated once every 12 months at a minimum. The assessment must also be updated when there is a significant change in the resident's physical or mental condition, when the resident's negotiated care plan no longer reflects the resident's current status, needs and preferences, at the resident's request or at the request of the resident's representative.

The assessment is used as a tool to get to know the resident and their care-planning needs. The provider must be knowledgeable about the resident's current needs and preferences before they can admit a resident to their home so they can ensure they can meet their needs. The AFH provider will review the assessment to determine if they have the resources, education, and ability to care for the assessed client.

CONTENTS OF THE ASSESSMENT AND WHAT TO EXPECT

The in-person portion of the assessment will take between a half an hour to 2 hrs. The nurse will perform a skin check and observe the resident during interview. The nurse will gather medical records, caregiver and family report to help determine the needs of the resident. The below topics are what the assessor is trying to evaluate.

(1) Recent medical history;
(2) Current prescribed medications, and contraindicated medications, including but not limited to, medications known to cause adverse reactions or allergies;
(3) Medical diagnosis reported by the resident, the resident representative, family member, or by a licensed medical professional;
(4) Medication management:
(a) The ability of the resident to be independent in managing medications;
(b) The amount of medication assistance needed;
(c) If medication administration is required; or
(d) If a combination of the elements in (a) through (c) above is required.
(5) Food allergies or sensitivities;
(6) Significant known behaviors or symptoms that may cause concern or require special care, including:
(a) The need for and use of medical devices;
(b) The refusal of care or treatment; and

(c) Any mood or behavior symptoms that the resident has had within the last five years.
(7) Cognitive status, including an evaluation of disorientation, memory impairment, and impaired judgment;
(8) History of depression and anxiety;
(9) History of mental illness, if applicable;
(10) Social, physical, and emotional strengths and needs;
(11) Functional abilities in relationship to activities of daily living including:
(a) Eating;
(b) Toileting;
(c) Walking;
(d) Transferring;
(e) Positioning;
(f) Personal hygiene;
(g) Dressing; and
(h) Bathing.
(12) Preferences and choices about daily life that are important to the resident, including but not limited to:
(a) The food that the resident enjoys;
(b) Meal times; and
(c) Sleeping and nap times.
(13) Activities.

After the nurse has made her best attempt to gather all necessary information an extensive document is created. It can take between 6-12 hrs to filter information and create the assessment and preliminary service plan. It can take several days at times to hear back from medical professionals and get requested medical info needed. It is best to schedule the assessment as soon as possible to avoid delay moving into the AFH as they must have this document first. Turn around time is between 7-10 days to get a copy of the completed report. I Care will make every effort to complete the assessment as fast as possible and will make exceptions for urgently needed moves.

PREPARING FOR THE ASSESSMENT

The assessment is a private pay responsibility and currently there are no insurance companies that cover the cost of the assessment other than Medicaid “not Medicare”. Payment for the assessment must be made when making the appointment via Debit, Credit, or electronic check. You can make this payment via telephone or invoice online. Due to the assessment being as comprehensive as it is the time required to complete it requires a longer time slot and cancellations must be made 48 hrs in advance to receive a refund for payment. I Care will make exceptions for extenuating circumstances to bring payment at time of assessment and for cancellations.

Below is a list of documents to bring with you to the assessment to make the interview process as smooth as possible. If the assessment is completed in a facility this information is usually in the chart and easily accessible. If you notify the discharge planner or Social Worker that you will be having an assessment, they can make a packet for you with these documents.

- **A list of current medical problems, diagnosis, surgeries, and hospitalizations**
- **A current list of all prescribed and over the counter medications with dose and times taken**
- **Copy of insurance cards**
- **Copy of POLST forms**
- **Copy of any legal documents (DPOA, Guardianship Paperwork etc)**
- **A list with current phone numbers and addresses of any medical providers involved in care**

Please fill out the below forms prior to the assessment if possible. If you do not have access to a computer, the nurse will have copies with her at time of assessment.

- **Intake Card**
- **Consent for Assessment**
- **Release of information**
- **Photo Release Form**
- **EFT form if needed**

If you have any questions please call I Care Nursing at 206-291-0937 or send an email to info@icarenurses.com.

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ASSESSMENT & PRELIMINARY SERVICE PLAN CONSENT FORM

To fill these documents out electronically click on this link or copy & paste it into your web browser https://pdf.ac/62Sge2

Patient Name (print name)	*Date of Birth*	*Phone #*
Address		*Email Address*

* ***Complete the following only if the person authorizing the use or disclosure is not the patient:***

Name	*Relationship to Patient*	
Representative's Address	*Phone #*	*Email Address*

CHECK BOXES OF ALL SOURCES OF INFORMATION YOU AGREE TO ALLOW I CARE NURSES TO USE TO COMPLETE THE ASSESSMENT

	Personal Interview
	Skin Check
	Physical Assessment
	Caregiver Report
	Family Report
	Friends Report
	Medical Records
	Anyone the nurse cannot communicate with about your needs _____
	Anything the nurse cannot review _____

By signing below

- You/representative agree that you have been given a copy of the Assessment and Preliminary Service Plan information sheet.
- You understand what you have read in the Assessment and Preliminary Service Plan information sheet.
- You agree to allow I Care Nursing to perform your assessment
- You agree to answer all questions honestly and truly to the best of your ability
- You understand that I Care cannot be held liable for any misinformation in the assessment report
- You understand the assessment must be done initially prior to moving into an AFH, If there is a significant change in your care, and at least every 12months.
- You understand any necessary changes to the assessment must be done within 14 days or there may be a fee for the corrections/changes.
- You agree to have electronic communication via email
- You agree to receive a copy of the assessment via email

Signature of Patient or Legal Representative: _____ *Date:* _____

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PHOTO AUTHORIZATION FORM

Patient Name (print name)	*Date of Birth*	*Phone #*
Address		*Email Address*

Complete the following only if the person authorizing the use or disclosure is not the patient:

Name	*Relationship to Patient*	
Representative's Address	*Phone #*	*Email Address*

By signing this form, I authorize the following:

The following protected health information may be disclosed: (*Check all that apply)*

☐ Photographs taken during a health care encounter
☐ Accounts, summaries, narratives describing a health care encounter
☐ Photographs taken to help improve teaching
☐ Photographs taken to help promote wellness and healing
☐ Photographs taken to document concerns of abuse or neglect
☐ Photographs taken to document skin concern
☐ Photographs taken to be sent electronically via email
☐ Photographs taken to identify me on my face sheet and/or medication record
☐ Other (*describe)* _____

Description of Protected Health Information Disclosed in Photos or Images:

I understand that the following identifiable information may be included in the photos, narratives, and/or images: my facial and/or other body images and verbal descriptions about my medical condition including my prognosis as well as other related descriptions and information about the care or my treatment. I understand that my first name may be used. I further understand that no other identifiable information will be made available such as my address, medical record or other identifying numbers, etc. I consent for medical imaging to be made of me (or for person whom I am legal representative). I understand that the information may be in my medical record.

By signing this Authorization, I am giving permission for the use or disclosure of the information described above for the purpose(s) described. I hereby release I Care Nursing and its agents and employees from any and all liability that may arise from the release of information as I have directed.

- I have the right to receive a copy of this Authorization.
- I will not receive any compensation for my images
- I understand that I have the right to revoke this Authorization at any time, if I do so in writing, and address it to I Care Nursing. The revocation will not apply to any information already released as a result of this Authorization.
- I understand that I may refuse to sign this Authorization, and that I Care Nursing cannot deny or refuse to provide services if I refuse to sign.
- I understand that information disclosed pursuant to this Authorization may no longer be protected by the federal health information privacy law and could be re-disclosed by the person or agency that receives it.

*_____ *(Please place Initials)* I agree that this Authorization will remain in effect until I revoke it in writing.

Signature of Patient or Legal Representative: _____ *Date:* _____

RESIDENT INTAKE CARD

BACKGROUND INFO

RESIDENT NAME	NICK NAME	DATE

AGE	DATE OF BIRTH	GENDER	SSN	LANGUAGE	ETHNICITY

ASSESSMENT LOCATION	PREVIOUS LIVING SITUATION	MARITAL STATUS	MAIDEN NAME

MEDICAL CONTACTS

PRIMARY CARE PHYSICIAN	ADDRESS	PHONE	FAX

SPECIALIST	ADDRESS	PHONE	FAX

SPECIALIST	ADDRESS	PHONE	FAX

PHARMACY NAME	PHONE	FAX

DENTIST NAME	PHONE	FAX

PREFERRED HOSPITAL	PHONE

EMERGENCY CONTACT INFO

ADVANCE DIRECTIVE	YES ☐	NO ☐	(SUPPLY COPY TO ADULT FAMILY HOME) WHERE IS THE ORIGINAL KEPT ?

FUNERAL ARRANGEMENTS	YES ☐	NO ☐	WITH WHOM	PHONE NUMBER

SUBSTITUTE DECISION MAKER	YES ☐	NO ☐	WHO	PHONE NUMBER

CHILDREN'S NAMES	CHILDREN'S PHONE	EMAIL	WHERE HE/SHE LIVES

CHILDREN'S NAMES	CHILDREN'S PHONE	EMAIL	WHERE HE/SHE LIVES

CHILDREN'S NAMES	CHILDREN'S PHONE	EMAIL	WHERE HE/SHE LIVES

SPOUSE'S/LONG TERM PARTNER'S NAME	SPOUSES PHONE	EMAIL	WHERE HE/SHE LIVES

INSURANCE INFO & FUNDING

HEALTH INSURANCE COMPANY	POLICY NUMBER	PHONE NUMBER

MEDICAID #	MEDICARE #	HOSPICE ☐ YES ☐ NO WHAT HOSPICE?	VETERAN ☐ YES ☐ NO WHAT BRANCH?

MEDICAL INFO

CURRENT HEIGHT	CURRENT WEIGHT	PULSE	BLOOD PRESSURE	RESPIRATIONS	TEMPERATURE	PAIN

ALLERGIES:

CUSTOMER PAYMENT AGREEMENT

I Care
Nursing Services
10420 19th Ave S.
Seattle, WA 98168
(206) 291-0937

CLIENT NAME (PLEASE PRINT)			**DATE OF BIRTH**
HOME ADDRESS (NOT P.O. BOX): **STREET**			
CITY	STATE	ZIP	COUNTY
MAILING ADDRESS (IF DIFFERENT THAN HOME ADDRESS): **STREET**			
CITY	STATE	ZIP	COUNTY
PHONE NUMBER (HOME/CELL):		**PHONE NUMBER (WORK):**	

E-CHECK AUTHORIZATION ☐ CHECKING ☐ SAVINGS

I have selected the E-Check payment option and I hereby authorize I Care Nursing Services to initiate funds transfer from the bank or depository institution account indicated below. I authorize my financial institution to honor this/these transfer(s).

Financial Institution or Bank Name:			
Account Holders Name (print):			
CITY		STATE	ZIP
ACCOUNT NUMBER		ROUTING NUMBER	

CREDIT/DEBIT AUTHORIZATION

NAME AS IT APPEARS ON CARD			
CREDIT CARD #	___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___		
EXPIRATION DATE	___ ___ / ___ ___	**CODE ON THE BACK OF THE CARD**	___ ___ ___ ___
BILLING ADDRESS			
PHONE # ASSOCIATED WITH THE ACCOUNT	(___ ___ ___) - ___ ___ ___ - ___ ___ ___ ___		

ADDITIONAL TERMS AND CONDITIONS:

Amount Authorized

$

Funds are to be withdrawn on

DATE	

This is a one-time only transaction

Initial In Box	

Future Invoices may be charged to this card

Initial In Box	

PLEASE ENCLOSE VOIDED CHECK (FOR CHECKING ACCOUNT) OR DEPOSIT SLIP (FOR SAVINGS ACCOUNT) FROM THE ACCOUNT TO BE DEDUCTED.

Account Holders Signature: _____ Date (MM/DD/YYYY): _____/_____/_____