Joyce's Caring Touch
2266 N Prospect Ave Suite 210
Milwaukee, WI 53202
414-841-5853 (office)
414-921-5589(fax)

Date _____

AUTHORIZATION FOR RELEASE OF INFORMATION

Name _____**DOB** _____**Soc. Sec. #** _____

Address _____**Phone** _____

Information to be Released From: ☐ **Physician** ☐ **Clinic** ☐ **Hospital** ☑ **Agency**

INFORMATION TO BE RELEASED TO:

Joyce's Caring Touch Homehealth

2266 N Prospect Ave Suite 210

Milwaukee, WI 53026

414-841-5853 (office)

414-921-5589 (fax)

INFORMATION TO BE RELEASED (must check all that apply)

✓ History and Physical	• Progress Notes	• Discharge Prior Authorization
✓ Discharge Summary	✓ MD Visit Notes	• Training Records
✓ Lab reports	✓ X-ray results	• Admission Summary
✓ List of current medications	✓ List of Diagnosis	• TB Results
• Transfer PCST to agency	• Other	

INFORMATION TO BE RELEASED FOR PURPOSE OF:

☑ Initiating Care ☐ Care Coordination ☐ Employment ☐ Emergency Preparedness

TIME PERIOD TO BE INCLUDED:

From (date) _____ **To (date)** _____ **or** ☑ **most current**

Release by: ☑ **Fax** ☐ **Mail** ☐ **Pick-up**

- *I understand that this authorization for release of information is valid for one year or date of _____.*
- *If I choose to revoke this authorization I must do so in writing.*
- *A photocopy / facsimile of this authorization shall have the same force and effect as an original.*
- *By signing this release of information, I understand that authorizing the disclosure of this information is voluntary.*
- *I also understand that I am authorizing disclosure of information protected by federal law and in accordance to HIPPA.*

_____ _____ _____
Signature *Print Name* *Date*

_____
If other than signature above, list relationship

_____ April K Norwood _____ _____
Witness *Print Name* *Date*

Joyce's Caring Touch Home Health
2266 N Prospect Ave Suite 210
Milwaukee, WI 53202
414-841-5853

PRIMARY CARE PROVIDER
ORDER for PERSONAL CARE / CAREGIVING SERVICES

Date _____

Client Name _____DOB _____

Address _____Phone _____

This client/family/referral source has requested a Personal Care Worker/Caregiver to provide assistance with Activities of Daily Living incidental to medical needs in their home. If you agree, please sign and date this document authorizing Joyce's Caring Touch to evaluate this client for personal care/caregiver services.

A Plan of Care will follow after the evaluation of this client which will require your signature for our agency to comply with DHS 105 and completion of the Personal Care Screening Tool (PCST) and any other necessary insurance forms.

Client Diagnosis

1. _____ICD-10 Code _____
2. _____ICD-10 Code _____
3. _____ICD-10 Code _____
4. _____ICD-10 Code _____
5. _____ICD-10 Code _____

Primary Care Provider Name _____

PCP Address _____

Phone_____ Fax _____

Agency Signature _____ Date _____

PCP Signature X_____ Date _____

PLEASE SIGN, DATE AND FAX TO: 414-921-5589

Thank you!

CLIENT INTAKE FORM

Intake Date _____ Time 4PM ☑New Admit ☐Re-Admit

Client Name _____ ☑M ☐ F DOB_____ Age_____

Address_____ City_____ Zip_____

Home Phone _____ Cell Phone_____ Client able to Sign: ☑Y ☐N Reason_____

Race_____ Language_____ Prefers to be called _____

Emergency Contact Name_____ Phone_____ Cell _____

Emergency Contact Address_____

MEDICAL HISTORY

Allergies_____ Pet(s) in home_____ Smoker(s) in home ☐Y ☐ N

Diagnosis/Significant Medical History_____

_____

Check all that apply:

☐Acute Bronchitis	☐Chronic Pressure Ulcers	☐High Cholesterol	☐Pneumonia
☐Alzheimer's	☐Congestive Heart Failure	☐Heart Disease_____	☐Pressure Ulcer
☐ALS	☐Coronary Heart Disease	☐High Blood Pressure	☐Stroke
☐Arthritis	☐Dementia	☐Multiple Sclerosis	☐Traumatic Brain Injury
☐Asthma	☐Depression	☐Osteoporosis	_____
☐Cancer _____	☐Diabetes	☐Parkinson's	_____

Assistive Devices: ☐Brace ☐Cane ☐Crutches ☐Hospital Bed ☐Lift ☐Walker ☐Wheelchair Other_____

Ambulatory Status _____ Height _____ Weight _____ Consciousness _____

Bladder Continent: ☐Y ☐N Bowel Continent: ☐Y ☐N ☐Briefs ☐Catheter ☐Colostomy ☐Ostomy

SERVICES REQUESTED_____

_____

Days Requested: ☐SU ☐M ☐T ☐W ☐TH ☐F ☐SA ☑All Hours Requested_____

Level of Care: ☐Companion ☐Housekeeping ☐PCW ☐HHA/CNA ☐Under 3 Hours ☐Live-in (where applicable)

Other services in home_____

Primary Physician_____ Phone_____ FAX_____

Primary Physician's Address_____

REFERRAL INFORMATION:

Caller's Name_____ Relationship to Client _____Phone _____

Referral Source phone_____ Name_____ Phone_____

PAYMENT INFORMATION: ☐Private Pay ☐Trust ☐Work Comp ☐Auto Insurance ☐LTC Insurance ☑Medicaid

Medicare # _____ Social Security # _____ Medicaid # _____

Policy Info (Company Name/Case Mgr.) _____ Policy # _____

Billing Information Name_____

Billing Address_____ City_____ State_____ Zip_____

REFERRAL TAKEN BY: April K Norwood_____Title Admin_____ Date _____

START OF CARE DATE_TBD_____ **COMMENTS** _____

DEPARTMENT OF HEALTH SERVICES **STATE OF WISCONSIN**
Division of Quality Assurance
F-00784 (08/2016)

PERSONAL CARE AGENCY CLIENT RIGHTS

Clients of a state-approved personal care agency (PCA) have the right to be informed of and to exercise rights specified in state regulations. If a PCA client has been judged incompetent, the client's family or guardian may exercise those rights on the client's behalf.

Prior to or at the time of accepting a person as a client, a PCA shall provide a statement of client rights, in writing, to each client/potential client or his/her representative. The client or the client's legal representative shall verify by signature that they have received a copy of these rights. A duplicate of this signed, client rights document shall be filed with the client's care records.

The PCA must investigate complaints that the client, the client's family, or the client's guardian make regarding treatment and respect for client rights by anyone furnishing services on behalf of the PCA. The PCA must document such complaints and how they are resolved.

As a personal care agency client, you have the right:

1. To be fully informed of these rights and of all the provider's rules governing client responsibilities
2. To be fully informed of services available from the provider
3. To be informed of all changes in services and charges as they occur

Note: *For clients who are Medicaid recipients, personal care services are not subject to recipient cost sharing, per Wis. Stat. § 49.45(18)(b)11, and the provider is prohibited from charging the recipient for services in addition to or in lieu of obtaining Medicaid payment, per § 49.49(3m)*

4. To participate in the planning of services, including referral to a health care institution or other provider, and to refuse to participate in experimental research
5. To have access to information about your health condition to the extent required by law

   Note: *Wis. Stat. § 146.83 and federal HIPAA regulations (45 CFR § 164.524) generally require health care providers to make health care records available for inspection by the patient.*

6. To refuse service and to be informed of the consequences of that refusal
7. To confidential treatment of personal and medical records and to approve or refuse their release to any individual outside the provider, except in the case of transfer to another provider or health facility or as otherwise permitted by law
8. To be treated with consideration, respect, and full recognition of dignity and individuality, including privacy in treatment and in care for personal needs
9. To be taught how to perform the service required so that you can, to the extent possible, help yourself
10. To designate a person to be taught to perform the service required so that, to the extent possible, the person designated can understand and help you
11. To have your property treated with respect
12. To complain about the care that was provided or not provided and seek resolution of the complaint without fear of recrimination
13. To have your family or legal representative exercise your client rights when the legal representative is legally authorized to do so

Complaints about treatment or care can be submitted in writing, by phone, or online to:

1. DHS / DQA / Bureau of Health Services
   ATTN: PCA Complaint Coordinator
   PO Box 2969
   Madison, WI 53701-2969

   Toll Free: 800-642-6552
   Phone: 608-266-8481
   http://www.dhs.wisconsin.gov/bqaconsumer/healthcarecomplaints.htm
2. The Personal Care Agency

SIGNATURE – Client or Representative	Name – Client or Representative *(Print.)*	Date Signed

CONSENT & VERIFICATION OF RECEIPT OF INFORMATION
CLIENT'S CONSENT FOR NON-MEDICAL SERVICES

Joyce's Caring Touch Home Health
2266 N Prospect
Ave Suite 210
Milwaukee, WI 53202
414-841-5853

Client Name _____ ***DOB***_____ ***ID*** _____

Consent to Services – I give my permission for authorized personnel of *Joyce's Caring Touch Home Health* to perform all necessary non-medical services. I understand that a *Joyce's Caring Touch Home Health*' Registered Nurse/Supervisor will supervise services provided. I understand that I may refuse or terminate services at any time and *Joyce's Caring Touch Home Health* may terminate services to me as explained in my Client Handbook.

Receipt of Client Information - I have read, understand and received a copy of the CLIENT HANDBOOK from *Joyce's Caring Touch Home Health* which includes the following information:

Welcome Letter (p. 4)	Client Rights (p.6-7)	Home Safety (p.10)	Non-disposable items (p. 13)
Agency Services (p.5)	Decision Making (p.7-8)	Medication Safety (p. 10)	Sharp Objects (p.13)
Changes in Payer (p.5)	Financial Information (p.8)	Equipment Safety (p.10)	Privacy Practices (p.13)
Client Satisfaction (p.5)	Client Responsibilities (p.9)	Oxygen Safety (p.10)	
Plan of Care/Services (p.5)	Right to Refuse Services (p.9)	Emergency Prepare (p.11-12)	
Medical Records (p.5)	Safety (p.9)	Infection Control (p. 12-13)	
Discharge Transfer Referrals (p.6)	Preventing Falls (p. 9-10)	Disposable Items (p.13)	

Release of Information and Medical Records - I authorize and request *Joyce's Caring Touch Home Health* to allow authorized representatives to examine my personal and medical records held by *Joyce's Caring Touch Home Health*, obtain outcomes data and to make photocopies of the records. I further consent to the release and review of my personal and medical records by, including but not limited to, regulatory and accrediting organizations, and outside consultants/vendors hired for the purpose of evaluating and improving Client care or organizational efficiency, and as required by law. I authorize *Joyce's Caring Touch Home Health* to release to or receive from hospitals, physicians, other agencies and other healthcare entities involved in my care all medical records and information pertinent to my care.

Assignment of Benefits – I hereby authorize to *Joyce's Caring Touch Home Health* all benefits from any insurance plans or any other protection maintained by the Client and/or for the Client's behalf or benefit and authorize and direct such benefits to be paid directly to *Joyce's Caring Touch Home Health* for services provided to the Client by *Joyce's Caring Touch Home Health* I certify that the Medicaid and my insurance plans or other protection is correct and complete.

Client Payment Liability- I have been informed by *Joyce's Caring Touch Home Health*, both orally and in writing, that there is a possibility of payment liability if I were to obtain cares/services from anyone other than *Joyce's Caring Touch Home Health*

I have received written information advising about the right to make decisions about my health care, the right to accept or refuse medical care and the right to write an Advance Directive and my questions have been answered. I agree to abide by all such conditions.

Medicaid/Managed Care Organization (MCO) Clients: All the information I provided when applying for Medicaid payment is correct. I request that payment of authorized Payer benefits be made on my behalf to the Agency for any services furnished to me by the Agency. I authorize any holder of medical information about me to release to Medicaid Services/MCO and its agents any information needed to determine these benefits or the benefits payable for related services.

- I realize Agency staff may not be present in my house at all times and I, my caregiver, or legal guardian will assume responsibility for my care when Agency staff is not present.
- I understand the Agency does not routinely perform drug testing on its employees.
- I understand the Agency will notify me in writing and orally no later than 30 days from the date they become aware of charges not covered by Medicaid or other sources.

Notice of Privacy Practices – Information from my records will be released only upon my written authorization as provided in the "RELEASE OF AUTHORIZATION" form, which I may stop at any time. I understand that my records will be kept locked at all times at *Joyce's Caring Touch Home Health* except when used by authorized agency personnel. I understand I have the right to have access to my records according to *Joyce's Caring Touch Home Health'* policy.

_____ _____
Client's Signature Date Signature of representative if Client unable to sign Date

_____ _____
Witness Signature Date State reason Client is unable to sign Date

SERVICE AGREEMENT/ASSIGNMENT OF BENEFITS

Joyce's Caring Touch Home Health
2266 N Prospect Ave Suite 210
Milwaukee, WI 53202
414-841-5853

Date _____ ☑ **Start of Care** ☐ **Update**

Client Name _____ **DOB**_____ **ID** _____

I understand that the service(s) checked below will be billed to:

Medicaid/Family Care #_____

☐MCO Name _____Bill to _____

Private Insurance Bill to_____

Policy/Group #_____Phone #_____

I authorize *Joyce's Caring Touch Home Health* to provide the services listed below:

SERVICE DESCRIPTION	PAYOR	SOURCE reimburses for Services	PAYMENT SOURCE will not cover	CHARGES for SERVICES	CLIENT WILL HAVE TO PAY
☑ PCW/Caregiver Services				$0.00	$0.00
☑ RN Visit				$0.00	$0.00
☐ Other Services				$0.00	$0.00
☐ Other Services					

Client Signature verifies agreement with the following statements:

- ☑ I have been explained both orally and in writing services and payment responsibilities BEFORE services are provided.
- ☑ I have participated in the development of and agree with the established care plan as explained to me.
- ☑ I understand my Rights and Responsibilities as explained to me and have a copy of them in the Client Handbook.
- ☑ I have received a copy of the Wisconsin Complaint Form and the purpose/use has been explained to me.
- ☑ It has been explained to me and I understand that I may be discharged for any of the reasons listed in the Client Rights located in the Client Handbook.
- ☑ I understand the contents and purpose of the Joyce's Caring Touch Home Health in-home folder/binder. I agree to maintain it in my home and protect its confidentiality.
- ☑ I authorize Joyce's Caring Touch Home Health to bill the above-named payment sources on my behalf for payment toward the total charges of services rendered to me. I AGREE TO A DIRECT ASSIGNMENT OF BENEFITS AS MY RIGHT UNDER THE TERMS OF MY POLICY. If my Policy prohibits direct payment to a provider, I also instruct and direct them to make out the check to me and mail it as follows: Joyce's Caring Touch Home Health 6019 W. Lincoln Creek Drive Milwaukee, WI 53218
- ☑ I authorize Joyce's Caring Touch Home Health to deposit checks received on my accounts when made out to me.
- ☑ I agree to pay, in a current manner, any balance left by my insurance company as described under "Client Liability."
- ☑ If paying privately, I understand that I will receive monthly invoices and payment must be received within 14 days of receipt of the invoice to assure continuation of service.
- ☑ I understand all legal holidays will be charged at one and one-half (1.5) times the base rate.
- ☑ I authorize Joyce's Caring Touch Home Health to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
- ☑ A photocopy of this Agreement/Assignment shall be considered as effective and valid as the original.

Client Signature *Date* *Client's Representative if Client unable to sign* *Date*

Witness Signature *Date* *State Reason Client is unable to sign* *Date*