HOME HEALTH | STAFF EDUCATION

Admission Nurse and Sign-Up Package Training

Start-of-care visit and bilingual sign-up package
Admitting RNs, therapists, and intake staff

THIS TRAINING INCLUDES

- Eligibility, homebound status, acceptance to service
- Identity, legal representative, dementia and ALF
- Client Information Handbook and required notices
- Rights, HIPAA, OASIS, AI disclosure, advance directives
- Client Service Agreement Sections 1 and 2
- Safety education and D1–D4 emergency plan
- Intake forms, documentation, final quality check
- Sample Agreement, Bill of Rights, Emergency Plan, and more
- Post-test, training record, certificate

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HOW TO USE THIS TRAINING

The admission (start-of-care) visit is the patient's first experience with the Agency and the moment the legal relationship begins. In one visit the admitting clinician must verify identity and authority, explain the Client Information Handbook, obtain informed consent on the Client Service Agreement, deliver the required notices, teach safety, classify the patient on the Emergency/Disaster Plan, and complete the clinical intake forms – accurately, without pre-selecting the patient's choices, and in a language the patient understands.

This training consolidates the Agency's **Admission Staff Training**, **Admission Professional Staff Training**, and the bilingual (English/Spanish) **Sign-Up (SU) Package** into one program. It follows the Medicare Home Health Conditions of Participation (42 CFR 484.50, 484.55, 484.60, and 484.102), Advance Directive rules (42 CFR 489.102), HIPAA, Section 1557 language access, and Florida home health agency requirements (Chapter 400 Part III, F.S., and 59A-8, F.A.C.).

OBJECTIVES

After this training, the participant will be able to:

1. Confirm eligibility, homebound status, and the Agency's ability to meet the patient's needs before admission.
2. Verify the patient's identity and the legal authority of any representative, including patients with dementia or living in an ALF.
3. Explain each section of the Client Information Handbook and deliver the required notices: rights, HIPAA, OASIS privacy, Privacy Act, AI disclosure, and advance directives.
4. Complete the Client Service Agreement (Sections 1 and 2) correctly, including one payer, services and frequency, and one patient signature.
5. Teach medication, oxygen, fall, home, and infection safety and classify the patient D1–D4 on the Emergency/Disaster Plan.
6. Complete the clinical intake forms and perform the final quality check before leaving the home.

Audience	Required content	Time
RNs and therapists who admit patients	All modules; post-test; Training Record; observed admission	2 hours
Intake, scheduling, and QA staff	Parts 1, 3, and 6; post-test; Training Record	1 hour

Completion: at orientation, before the first independent admission, and every year. Passing score: **80%**. New admitting clinicians complete at least one admission observed by the Clinical Manager or designee.

THE ADMISSION VISIT AT A GLANCE

Step	What the clinician does
1. Prepare	Review the referral, orders, and face-to-face; confirm the Agency can meet needs; bring a complete SU package; arrange an interpreter
2. Identify	Introduce yourself with your ID badge; verify the patient with two identifiers; identify any legal representative
3. Orient	Review the Client Information Handbook: services, hours, 24-hour on-call, 911
4. Rights and notices	Rights, complaints and hotlines, HIPAA, OASIS privacy, Privacy Act, AI disclosure, advance directives
5. Plan and payment	Services, discipline frequencies, supervision, payer, and charges

Step	What the clinician does
6. Safety education	Medications, oxygen, falls, home safety, infection control, D1–D4 emergency plan
7. Consent and signatures	Client Service Agreement Sections 1 and 2; representative information when applicable
8. Quality check	Review every page, leave copies and the handbook, document the visit

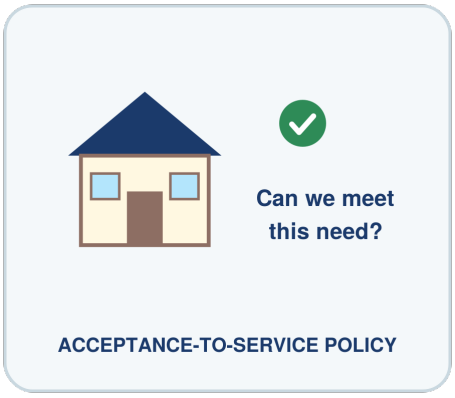
MODULE 1 – PURPOSE AND REGULATIONS



Patient rights
Inform before care begins



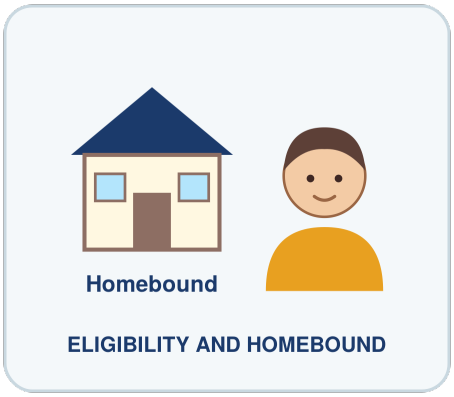
Timeframes
Initial visit and comprehensive assessment



Acceptance to service
Admit only if needs can be met

Requirement	What it means at admission
42 CFR 484.50 – Patient rights	Give written notice of rights and responsibilities, transfer/discharge policies, and the State hotline at the initial evaluation visit, **before care begins**; give verbal notice in the patient's primary language no later than the second skilled visit; inform about expected charges and payer responsibility
42 CFR 484.55 – Comprehensive assessment	Initial assessment visit within **48 hours** of referral or return home, or on the physician-ordered start-of-care date; comprehensive assessment with OASIS within **5 days** after start of care
42 CFR 484.60 – Care planning	Services follow orders and an individualized plan of care; the patient participates in developing the plan
42 CFR 484.102 and 489.102	Emergency preparedness (individual emergency plan); advance directive information and documentation
HIPAA, Section 1557, ADA	Notice of Privacy Practices; free language assistance and auxiliary aids; no discrimination
Florida (Ch. 400 Part III; 59A-8)	Service agreement, patient rights, abuse reporting, emergency management plan with priority classification

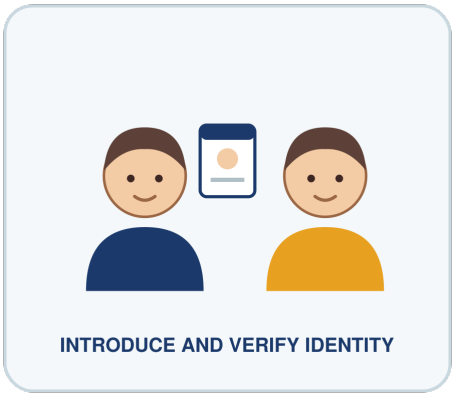
MODULE 2 – ELIGIBILITY, HOMEBOUND STATUS, AND ACCEPTANCE

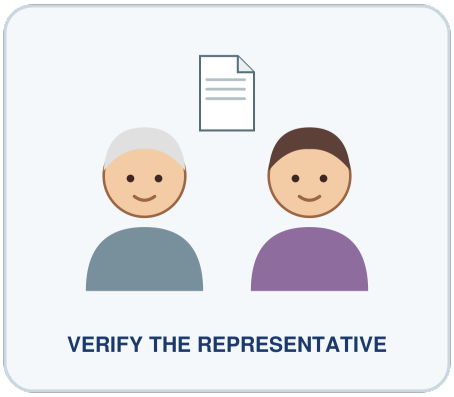


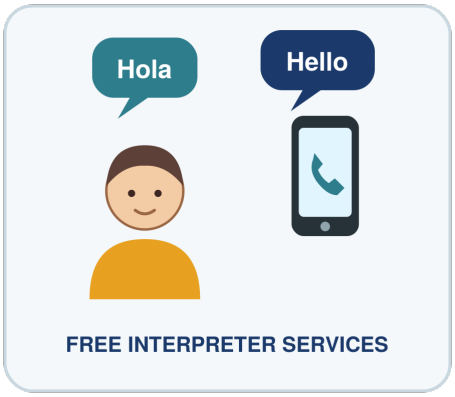
Homebound
Leaving home is a taxing effort

- **Physician-directed care:** the patient is under the care of a physician or allowed practitioner who orders and periodically reviews the plan of care, and needs intermittent skilled nursing, physical therapy, speech-language pathology, or continuing occupational therapy.
- **Face-to-face encounter:** related to the primary reason for home care, performed within **90 days before or 30 days after** the start of care and documented by the certifying practitioner.
- **Homebound – Criterion 1** (one of): needs supportive devices, special transportation, or another person's help to leave home because of illness or injury; **or** leaving home is medically contraindicated. **Criterion 2** (both): a normal inability to leave home **and** leaving requires a considerable and taxing effort. Infrequent, short absences (medical care, adult day care, religious services, a barber, a special family event) do not end homebound status.
- **Acceptance to service:** admit only when the Agency can safely meet the patient's needs in the home with available staff, services, and equipment. If not, do not start services; notify the Clinical Manager, inform the patient and physician, and help with referral.
- Medicare pays only **one home health agency** for an episode – ask whether the patient is receiving home health from another agency (CSA Section 1).

MODULE 3 – PREPARING, IDENTITY, AND THE LEGAL REPRESENTATIVE







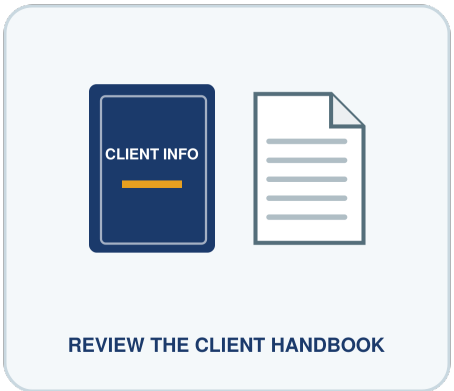
Introduce and verify
ID badge; two identifiers

Representative
Verify legal authority

Interpreter
Arrange before the visit

- **Before the visit:** review the referral, orders, diagnoses, face-to-face, payer, and caregiver information; confirm the Agency can meet the needs; bring a complete SU package in the patient's language (English/Spanish) with the cover sheet listing the assigned nurse, aide, therapist, and physician; plan for a qualified interpreter or auxiliary aids.
- **At the door:** introduce yourself by name, title, and Agency; show your photo ID badge; verify the patient with **two identifiers** (full name and date of birth) against the referral; ask whether the patient has a legal representative.
- **Legal representative:** a court-appointed guardian, health care surrogate or proxy, durable power of attorney for health care, or a person appointed on **CMS-1696 (Appointment of Representative)**. Ask for and copy the document; record name, relationship, phone, and the reason the patient cannot sign.
- **Dementia or cognitive impairment:** a diagnosis of dementia alone does not mean the patient lacks capacity. Explain in simple terms, involve the patient as much as possible, and use the representative only for what the patient cannot decide.
- **Assisted living facility (ALF):** ALF staff may not sign for a resident unless they hold legal authority. Document the facility contact, the representative's name and authority, and how they were reached.
- **If identity, authority, or consent cannot be established** – or the representative cannot be reached – stop, call the Clinical Manager, document every attempt, notify the DON, and never obtain an unauthorized signature.

MODULE 4 – THE CLIENT INFORMATION HANDBOOK



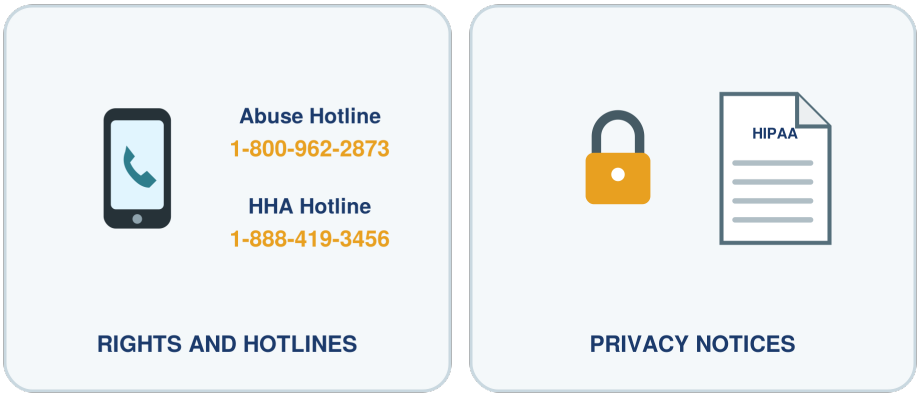
Client handbook
Explain, then leave it in the home

The handbook (English and Spanish) is the patient's written reference for everything explained at admission. Review each topic in plain language, ask the patient to teach back the key points – for example, "Who would you call at 2 a.m. if you had a problem?" – and leave the handbook in the home.

Handbook topic	Key message for the patient
Definitions, disciplines, and services	Who the nurse, therapist, MSW, and aide are and what each does
Hours, emergencies, 24-hour on-call	Office hours; answering service 24 hours, 7 days; for an emergency call 911
Ethics, non-discrimination, confidentiality	Equal care regardless of race, color, national origin, disability, age, sex, or religion
Rights, responsibilities, grievances	How to complain without fear of retaliation; State and Agency hotlines
Language assistance; sensory impairments	Free interpreters, large print, braille, TDD/relay
Face-to-face, eligibility, homebound	What Medicare requires to qualify for home health
Charges and payment	Minimum charges, copays, private pay, what Medicare covers
National Patient Safety Goals; fraud prevention	Patient identification, medication safety; how to report fraud
Notice of Medicare Non-Coverage	Right to a fast (expedited) appeal when services end
Aide duties – allowed and not allowed	What the home health aide may and may not do
Safety topics	Medication, oxygen, diabetes, pain, falls, medical devices, biohazard waste, home safety, smoke detectors, exit plan, Alzheimer's, anticoagulants and vitamin K, opioids
Infection control	Hand hygiene, universal precautions, respiratory hygiene, vaccinations (flu)

Handbook topic	Key message for the patient
Advance directives; HIPAA NPP; OASIS and Privacy Act statements; AI disclosure	Required notices – explained and left in the home
Hospitalization risk; transfer and discharge	Warning signs to call the Agency; reasons and notice for transfer or discharge
Family communication plan; special-needs emergency instructions; resource guide	Emergency contacts, special-needs shelter registration, community resources

MODULE 5 – RIGHTS, COMPLAINTS, AND REQUIRED NOTICES

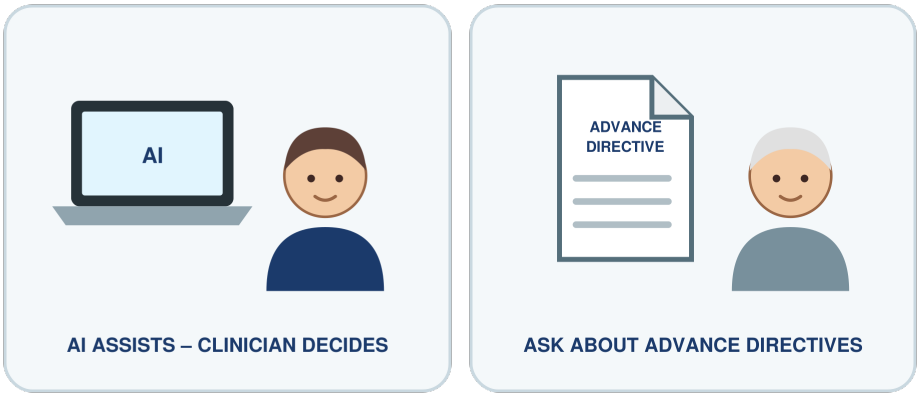


Rights and hotlines
Report without fear

Privacy notices
HIPAA, OASIS, Privacy Act

- **Bill of Rights:** explain the rights to be informed, to participate in the plan of care, to refuse care, to privacy and confidentiality, to be free from abuse, neglect, and exploitation, to voice complaints without retaliation, and to be told about charges. Review responsibilities (give accurate information, follow the plan, tell the Agency about changes). The patient signs the Bill of Rights statement acknowledging receipt.
- **Complaints:** to the Agency administrator (handbook grievance procedure); the AHCA Home Health Agency Hotline **1-888-419-3456**; abuse, neglect, or exploitation to the Florida Abuse Hotline **1-800-962-2873** (1-800-96-ABUSE).
- **HIPAA Notice of Privacy Practices (NPP):** explains how health information is used and the patient's privacy rights. The patient acknowledges receipt on the CSA.
- **OASIS privacy statement:** tells the patient that OASIS assessment data are collected and reported to CMS and how they are protected.
- **Privacy Act statement:** an information notice – **not a consent, and no signature is required**. Explain it and leave it in the home.

MODULE 6 – AI DISCLOSURE AND ADVANCE DIRECTIVES



AI disclosure
The clinician reviews and signs

Advance directives
Ask, document, respect

- **AI disclosure – talking points:** the Agency may use artificial-intelligence tools to help with documentation (for example, organizing visit notes). AI never diagnoses, prescribes, or makes care decisions; the clinician reviews, corrects, and authenticates every entry; information is protected under HIPAA and HITECH. The patient may ask questions and may decline. Do not rush this explanation – record the patient's choice on the CSA.
- **Advance directives:** ask whether the patient has an advance directive, a living will (and where it is kept), a health care surrogate or proxy (name, address, phone), or a **DNR order**. Record the answers on CSA Section 2, place a copy in the chart when available, and give the handbook's advance-directive information. Care is never conditioned on whether a patient has an advance directive.
- A Florida Do Not Resuscitate Order is honored when it is on the official Department of Health form (DH 1896) or a legible copy. Know where it is kept in the home and tell the team.

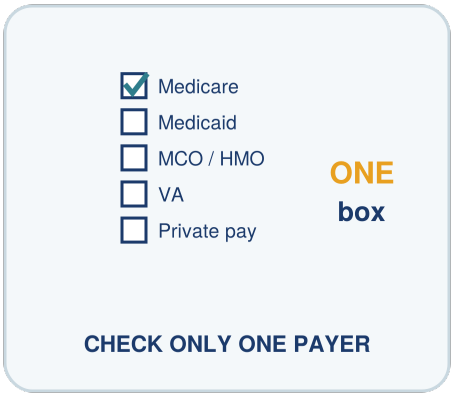
MODULE 7 – LANGUAGE ACCESS AND SENSORY IMPAIRMENTS

- Offer a **qualified interpreter free of charge** to every patient with limited English proficiency – in person, by phone, or by video. Do not use minors; avoid using family members except in an emergency or when the patient insists after being offered a free interpreter. Document the interpreter's name or ID number.
- Post or leave the language assistance notice (taglines in the top languages); the HHS Office for Civil Rights number is **1-800-368-1019** (TDD 1-800-537-7697).
- **Deaf or hard of hearing:** sign language interpreter, written materials, Florida Relay 711, or TDD; resources through the Florida Coordinating Council for the Deaf and Hard of Hearing.
- **Low vision or blind:** large-print or braille materials, read documents aloud, and confirm understanding.
- Use the Spanish SU package for Spanish-speaking patients; the English and Spanish forms are identical in content.

MODULE 8 – TRANSFER, DISCHARGE, AND NOTICE OF NON-COVERAGE

- Explain the Agency's transfer and discharge policy at admission. Reasons include: goals met; the patient's needs exceed what the Agency can provide; the physician no longer certifies; the patient moves or chooses another agency; payer stops coverage; the patient or caregiver refuses services; or the safety of staff is threatened.
- **Discharge for cause** (disruptive, abusive, or uncooperative behavior that seriously impairs care) requires the Agency to advise the patient, representative, and physician; try to resolve the problem; offer other options; and document all efforts.
- Give written notice of transfer or discharge at least **5 calendar days** before the planned date, except in situations the regulations exempt (for example, an emergency transfer or the physician ending services).
- **Notice of Medicare Non-Coverage (NOMNC, CMS-10123):** delivered at least **2 days** before covered Medicare services end. The patient may request an expedited appeal from the Quality Improvement Organization (QIO); the Agency then gives the Detailed Explanation of Non-Coverage.

MODULE 9 – CLIENT SERVICE AGREEMENT – SECTION 1



One payer box
Never blank, never two

CSA Section 1 item	How to complete it
Patient identifiers	Full legal name, date of birth, Medicare/insurance number, address, phone – exactly as on the referral
Voluntary admission	Patient agrees to admission; ask and mark whether the patient wants a copy of the plan of treatment
Consent to services	Nursing, therapy, aide, and procedures ordered by the physician (including blood draws, injections, IV therapy)
Other home health agency	Patient certifies no other home health agency is providing services – only one HHA is paid
Emergency services	Agency is not an emergency service; call 911 for emergencies
Release of information	Authorizes release to the physician, payers, and providers involved in care

CSA Section 1 item	How to complete it
Insurance – check ONLY ONE	Medicare; Medicaid (copay as stated, maximum one per day); Medicaid MCO; HMO / commercial / Medicare secondary; VA; private pay. Match the verified payer

MODULE 10 – CLIENT SERVICE AGREEMENT – SECTION 2



One signature
Complete every field first

CSA Section 2 item	How to complete it
Services and frequency	SN, HHA, PT, OT, ST, MSW, Other – frequency and duration exactly as ordered (for example, SN 1W1, 2W4)
Supervision	RN or PT supervision of the aide every ___ days per policy and regulation
Rights and abuse registry	Patient received the Bill of Rights, hotline numbers, and grievance procedure
Advance directives	Yes/No for advance directive, living will (location), proxy (name, address, phone), DNR
HIPAA / OASIS / handbook	Receipt of the NPP, OASIS privacy statement, and Client Information Handbook
Survey home visit (voluntary)	Patient agrees or declines to a home visit by State surveyors
AI consent	Patient's choice after the AI disclosure
Photo release (optional)	Mark the patient's choice; never required for care
Representative	Name, relationship, and reason the patient is unable to sign
Signatures	**One** patient (or representative) signature after all items are complete: "I participated in the development of my plan of care." Agency representative name, title, signature, and date

Never pre-select the patient's choices. A signature does not correct an incomplete form – complete every field before the patient signs.

MODULE 11 – SAFETY EDUCATION







Medications
Schedule, side effects, storage

Home safety
Exit plan, smoke detectors

Infection control
Hand hygiene every time

- **Medications:** reconcile all medications (prescription, over-the-counter, herbal); complete the Medicine Schedule; teach purpose, timing, and side effects; secure storage and disposal; extra teaching for anticoagulants (consistent vitamin K intake, bleeding signs) and opioids (constipation, drowsiness, safe storage, naloxone).
- **Oxygen:** no smoking or open flames; keep 5 feet from heat sources and 10 feet from flames; secure cylinders; post “Oxygen in Use”; know the supplier’s number.
- **Falls and home safety:** clear paths, remove loose rugs, night lights, grab bars, nonslip shoes, working smoke detectors, and an exit plan for fire.
- **Infection control:** hand hygiene, universal precautions, respiratory hygiene (cover coughs, masks when ill), safe sharps disposal in a puncture-resistant container, biohazard waste handling, and recommended vaccines (flu and others).
- Use **teach-back**: “Show me how you will take this medicine.” Document what was taught and the patient’s response.

MODULE 12 – EMERGENCY / DISASTER PLAN – D1 TO D4

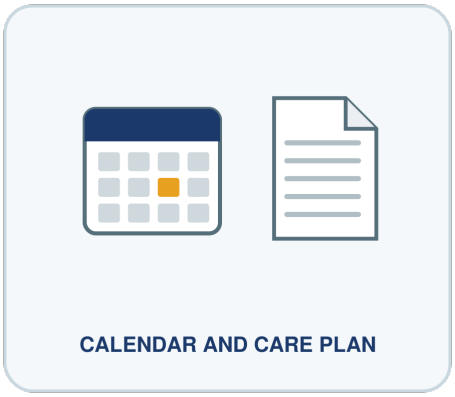


Priority level
Classify every patient at admission

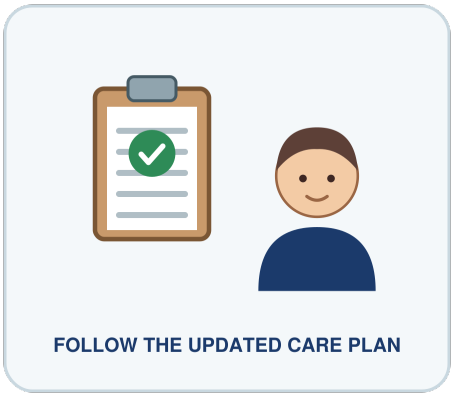
Level	Meaning	Examples
D1 – High	Cannot go without services; needs evacuation help or a special-needs shelter	Ventilator or continuous oxygen, IV therapy, insulin with no caregiver, bedbound alone
D2 – Moderate	Services may be postponed 24–48 hours; caregiver can help	Wound care with caregiver, daily medication help
D3 – Low	Services may be postponed 72 hours or more; independent	Ambulatory, stable, has caregiver and transportation
D4 – Declined	Patient declined the plan or signed a release; still give emergency information	Document the refusal and education given

- Complete the plan with the patient: emergency contacts, evacuation destination, transportation, medications and supplies for at least 7 days, equipment needs, and special-needs shelter registration with the county when appropriate.
- A blank or missing D1–D4 classification is a common error – the Agency uses it to contact and prioritize patients during a disaster.

MODULE 13 – CLINICAL INTAKE FORMS



Calendar and care plan
Visits and aide tasks



Plan of care
Follow and update

Form	Purpose and key points
Vulnerability to abuse/neglect assessment	16 Yes/No risk factors; any concern is reported to the Clinical Manager and, when abuse is suspected, to the Florida Abuse Hotline
Medicine Schedule and drug classes	Each medication, dose, times, and side-effect codes (A–T key); drug class sheet supports teaching
Medicare Secondary Payer (MSP) questionnaire	Determines whether another insurer pays first (employer plan, auto, workers' compensation)
Care plan checklist	Nursing, aide, and therapy problems and interventions selected for this patient
Home health aide care plan	Tasks and frequency for the aide; reviewed at least every 60 days and when needs change
Calendar of visits	Scheduled visits by discipline so the patient knows who is coming and when
Case management / coordination note	Communication with the physician, team, and other providers
CMS-1696; Bill of Rights statement; flu flyer; language poster	Representative appointment, rights receipt, and patient education left in the home

MODULE 14 – DOCUMENTATION AND COMMON ERRORS

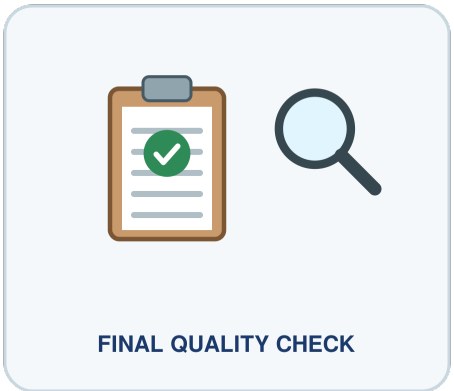


Objective documentation
Facts, not opinions

- Write legibly in ink or the EMR; no white-out; single-line corrections with initials and date; **never backdate** or pre-chart.
- Document who was present, the interpreter used, the representative and the authority document, every refusal (with the education given), and what was left in the home.

Common error	Prevention
Payer box blank or two boxes checked	Verify the payer before the visit; check exactly one
Vague comments ("pt ok", "see notes")	Write specific facts and the patient's words
D1–D4 classification missing	Complete the Emergency/Disaster Plan with the patient
Multiple or missing signatures, or signed before complete	One signature after every field is finished
AI disclosure rushed or skipped	Use the talking points; record the choice
Handbook or copies not left in the home	Final check: handbook, CSA copy, rights, calendar, Medicine Schedule
Representative without documented authority	Copy the legal document or CMS-1696; call the Clinical Manager if unclear

MODULE 15 – FINAL QUALITY CHECK BEFORE LEAVING



Final check
Every page, every field

Checklist item	Done
Patient identified with two identifiers; representative authority documented	☐
Correct language package used; interpreter documented	☐
Handbook reviewed with teach-back	☐
Bill of Rights explained and statement signed	☐
HIPAA NPP, OASIS privacy, and Privacy Act explained; NPP receipt marked	☐
AI disclosure given and choice recorded	☐
Advance directive questions answered; DNR location known	☐
CSA Section 1 complete; exactly one payer box checked	☐
CSA Section 2: services, frequencies, supervision match orders	☐
Survey visit and photo choices marked (not pre-selected)	☐
One patient/representative signature; Agency signature, title, date	☐
Emergency/Disaster Plan complete with D1–D4	☐
Vulnerability assessment, MSP, Medicine Schedule complete	☐
Care plan checklist, aide care plan, calendar complete	☐
Safety education documented with patient response	☐
Copies, handbook, and calendar left in the home	☐
Package returned to the office within the Agency timeframe	☐

MODULE 16 – PUTTING IT INTO PRACTICE

Scenario. Situation: The daughter of a patient with moderate dementia offers to sign everything "because Mom won't understand." She has no paperwork.
Best response: Dementia alone is not incapacity. Explain to the patient in simple terms and let her sign if she can. If she cannot, ask for the legal document or CMS-1696; if none, call the Clinical Manager – do not accept an unauthorized signature.

Scenario. Situation: The ALF nurse says she always signs admission papers for residents.
Best response: ALF staff cannot sign without legal authority. Identify and contact the legal representative, document attempts, and notify the DON if unreachable.

Scenario. Situation: The patient has Medicare and a Medicare supplement and asks you to check both payer boxes.
Best response: Check only one box – the primary payer verified at intake (Medicare); record secondary coverage on the MSP questionnaire.

Scenario. Situation: A Spanish-speaking patient's 14-year-old grandson offers to interpret.
Best response: Do not use a minor. Use the Spanish package and a free qualified interpreter; document the interpreter's name or ID.

Scenario. Situation: The patient asks, "Will a computer decide my treatment?"
Best response: Explain that AI only helps with documentation; the clinician and physician make all care decisions and review every entry. Record the patient's choice.

Scenario. Situation: The patient lives alone, uses continuous oxygen, and has no transportation.
Best response: Classify D1, plan evacuation and special-needs shelter registration, and confirm the oxygen supplier's emergency plan.

REFERENCES

1. 42 CFR 484.50 (patient rights), 484.55 (comprehensive assessment), 484.60 (care planning), 484.102 (emergency preparedness); CMS State Operations Manual Appendix B.
2. 42 CFR 489.102 (advance directives); 42 CFR 424.22 (certification, face-to-face); Medicare Benefit Policy Manual, Chapter 7 (homebound status).
3. HIPAA Privacy Rule (45 CFR 164.520); Section 1557 of the Affordable Care Act (45 CFR 92); CMS-1696; CMS-10123 (NOMNC).
4. Chapter 400 Part III, Florida Statutes; Rule 59A-8, F.A.C.; Florida Abuse Hotline; Agency Admission policy, Client Information Handbook, and SU Package (English/Spanish).

ADMISSION PACKAGE – CLIENT INFORMATION HANDBOOK CONTENTS (SAMPLE)

- The handbook table of contents lists every topic reviewed at admission – use it as your teaching checklist (Module 4).
- All admission forms are located between the English and Spanish handbook sections of the Sign-Up Package.

CHAP VERIFIED

CLIENT INFORMATION HANDBOOK

(TABLE OF CONTENTS)

ACHC PRODUCT CERTIFICATION

SAMPLE

SECTION	LOCATION
Welcome Letter	Inside Front Cover
Agency Regular Business Hours	Inside Front Cover
Protection from Abuse, Neglect, Exploitation & Complaints	Inside Front Cover
Our Staff Information	Inside Front Cover
Table of Contents (Index)	Page 1
Home Health Care Definitions	Page 2
Home Health Disciplines	Page 2
Tips to Reach Maximum Independence	Page 2
Hours of Operation & Emergency Services	Page 3
Information for Persons with Sensory Impairments	Page 3
Ethics Issues	Page 3
Non-Discrimination Policy	Page 3
Confidentiality	Page 3
Diminished Vision Rehabilitation / Flu Information	Page 4
Patient Rights, Complaints & Grievances	Page 4
Language Assistance Services	Page 4
Face-to-Face Requirement	Page 4
Minimum Charges for Our Services	Page 4
Home Care National Patient Safety Goals	Page 4
Fraud Prevention	Page 4
Services	Page 5
Eligibility Criteria for Admission	Page 5
Notice of Medicare Provider Non-Coverage	Page 5
The Home Health Aide	Page 5
Disposal of Biohazardous Waste	Page 5
Home Care and Alzheimer's	Page 6
Medication Safety	Page 6
Who Is Responsible for Your Medications?	Page 6
Oxygen Safety at Home	Page 6
Take Care of Yourself / Diabetes Care	Page 6
Pain Management	Page 6
Precautions to Prevent Falls	Page 7
Medical Devices & Equipment Precautions	Page 7
Help Prevent Errors in Your Care	Page 7
Basic Safety Guidelines: Home Environment	Page 7
Home Safety & Emergency Exit Plan	Page 7
Smoke Detectors	Page 8
Preventing Infections	Page 8
Infection Control Procedures	Page 8
Vaccinations & Disease Prevention	Page 8
Staff Universal / Standard Precautions	Page 8
Respiratory Hygiene Practices	Page 9
Policy on Advance Directives	Page 9
Information on Advance Directives	Pages 10–11
Notice of Privacy Practices (HIPAA)	Page 11
Hospitalization Risk Management	Page 11
Understanding Your Doctor & Caregivers	Page 11
OASIS Statement of Patient Privacy Rights / Artificial Intelligence (AI) Disclosure	Pages 12-13-14
Anti-Coagulants, Complaints / Transfer-Discharge Policy / Patient Rights & Responsibilities	Pages 15-16-17-18-19
Family Communication Log / Opioid Instructions	Page 20
Emergency Instructions for Special Needs	Inside Back Cover
Resources Guide	Inside Back Cover

(All admission forms and consents are located between the English and Spanish Patient Information Handbook sections.)

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PART 6 – SAMPLE ADMISSION DOCUMENTS

The following pages are samples from the Agency's bilingual Sign-Up (SU) Package. They are marked **SAMPLE** for training only – always use the current forms from the Agency package. Each sample lists what the admitting clinician must check before leaving the home.

Sample	Document	Module
A–B	Client Service Agreement, Sections 1 and 2	9–10
C	Bill of Rights Statement	5
D–E	Emergency/Disaster Plan and instructions	12
F	Vulnerability to Abuse and/or Neglect Assessment	13
G	Home Health Aide Care Plan	13
H	Medicine Schedule	11, 13

SIGN-UP PACKAGE CONTENTS – WHAT IS SIGNED AND WHAT STAYS IN THE HOME

Document (English / Spanish)	Signed by patient or representative?	Copy left in the home?
Cover sheet with assigned staff; abuse and complaint numbers	No	Yes
Client Information Handbook	Receipt marked on CSA	Yes
Client Service Agreement, Sections 1 and 2	Yes – one signature	Yes (copy)
HIPAA NPP, OASIS privacy, Privacy Act, AI disclosure	NPP receipt and AI choice on CSA; Privacy Act – no signature	Yes
Bill of Rights Statement	Yes	Yes (copy)
Medicine Schedule and drug classifications	No	Yes
Medicare Secondary Payer questionnaire	Yes (as required)	No – office
Vulnerability to abuse/neglect assessment	No – clinician completes	No – office
CMS-1696 Appointment of Representative (when used)	Yes – patient and representative	Yes (copy)
Care plan checklist and Home Health Aide Care Plan	Reviewed with patient	Aide care plan – yes
Calendar of visits; flu flyer; language assistance poster	No	Yes
Emergency/Disaster Plan (D1–D4) and instructions	Yes	Yes
Case management / coordination note	No – clinician completes	No – office

SAMPLE A – CLIENT SERVICE AGREEMENT, SECTION 1

- Voluntary admission, consent to services, other-agency certification, emergency services, release of information.
- Insurance: check **only one** payer box that matches the verified payer.

CLIENT SERVICE AGREEMENT *(Spanish Translation in the back)*

Patient: _____

Medical Record: _____

Page 1/2

VOLUNTARY ADMISSION: I VOLUNTARILY CONSENT TO ADMISSION TO THE AGENCY, AND TO TREATMENT THAT MAY BE ADVISED AND OR RECOMMENDED BY MY PHYSICIAN AND TREATMENT TEAM.
I REQUEST A COPY OF THE PLAN OF TREATMENT: Y_____ N_____

CONSENT TO RECEIVE SERVICES: I HEREBY AUTHORIZE THE AGENCY, TO RENDER APPROPRIATE SERVICES AS PRESCRIBED BY MY PHYSICIAN, OR BY ANY OTHER PHYSICIAN WHO MAY BE TREATING ME, INCLUDING ALL DIAGNOSTIC AND THERAPEUTIC TREATMENT THAT MAY BE CONSIDERED ADVISABLE OR NECESSARY IN THE JUDGMENT OF THE PHYSICIAN. I HEREBY AUTHORIZE THE AGENCY, OR YOUR AGENTS TO PERFORM ANY WORK IN TAKING BLOOD SAMPLES FROM ME OR ADMINISTERING INJECTIONS OR INTRAVENOUS THERAPY FOR NORMAL MEDICAL PRACTICE. I HEREBY AUTHORIZE THIS WORK UNDER PHYSICIAN'S ORDERS, WHILE A PATIENT WITH YOUR ORGANIZATION. I CERTIFY THAT I AM NOT RECEIVING HOME HEALTH CARE SERVICES FROM ANOTHER AGENCY. I AM ALSO AWARE THAT ONLY ONE HOME HEALTH AGENCY WILL BE PAID ONCE I AM ADMITTED TO THIS AGENCY. I HEREBY ACKNOWLEDGE THAT I AM NOT UNDER ANY CIRCUMSTANCE ABLE TO OPERATE ANY MOTOR VEHICLE.

EMERGENCY MEDICAL SERVICES: I UNDERSTAND THAT DURING THE COURSE OF MY TREATMENT THE NEED FOR EMERGENCY TREATMENT AND/OR TREATMENT AND/OR TRANSFER TO A HOSPITAL MAY BECOME NECESSARY AND APPROPRIATE. I UNDERSTAND THAT THE AGENCY DOES NOT PROVIDE EMERGENCY MEDICAL CARE AND THEREFORE SHOULD THE NEED FOR SUCH TREATMENT AND/OR TRANSFER MAY BE DEEMED NECESSARY AND APPROPRIATE, THE AGENCY STAFF WILL CALL 911. I CONSENT TO SUCH EMERGENCY TREATMENT AND/OR TRANSFER TO A HOSPITAL AND HEREBY INDEMNIFY THE AGENCY FROM SUCH EMERGENCY TREATMENT AND/OR TRANSFER. I AGREE TO ASSUME SOLE RESPONSIBILITY FOR ALL CHARGES INCURRED FOR SUCH TREATMENT.

RELEASE OF INFORMATION: I AUTHORIZE ALL THE PHYSICIANS, HOSPITALS, NURSING HOMES, CLINICS, AND OTHER HEALTH CARE PROVIDERS RELEASE OF MEDICAL INFORMATION RELEVANT TO MY CARE TO THE AGENCY I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION FROM MY RECORDS TO ANY LICENSED INSTITUTIONS, STATE, FEDERAL, OR ACCREDITED INSTITUTIONS FOR THE PURPOSES OF PROVIDING CONTINUITY OF CARE, ESTABLISH CONTINUITY OF CARE, ESTABLISH CORRECT REIMBURSEMENT, ESTABLISH NEED FOR SERVICE OR AS AUTHORIZE BY LAW. I PLACE NO LIMITATIONS ON HISTORY OR ILLNESS OR DIAGNOSTIC/ THERAPEUTIC INFORMATION INCLUDING ANY TREATMENT FOR SUBSTANCE ABUSE, PSYCHIATRIC DISORDERS, OR ACQUIRED IMMUNODEFICIENCY SYNDROME. "RELEASE OF INFORMATION" WILL BE PERFORMED ACCORDING TO HIPAA REGULATIONS.

SECTION ONE
INSURANCE BENEFITS AND PAYMENT: I HEREBY AUTHORIZE MY PRIVATE INSURANCE CARRIER TO PAY INSURANCE BENEFITS TO THE AGENCY, AND AGREE TO THE RELEASE OF ALL MEDICAL INFORMATION TO MY INSURANCE CARRIER IF SHOULD BE REQUIRED BY ANY PROGRAM

☐ I HAVE BEEN ADMITTED THROUGH **MEDICARE** AND NO CHARGES WILL BE EXPECTED
I hereby request and authorize payment directly to THE AGENCY I understand that to receive Medical covered home care services, I must meet the qualifying criteria as outlined under information of Medicare coverage criteria statement contained in the home folder. if your home care services conform to this rule, your Medicare home care services should generally be covered without liability for payment.
If services should be determined as denied or non-covered by Medicare, then the patient will be notified via letter and payment will be at the discretion of the agency. I understand that I am financially responsible for charges not paid under any assignment, charges will not exceed the agency's regular Medicare charges ($100.00 per visit). I certify that the information given by me in the applying for payment under the title XVIII and/or XIX of the social security act is correct. I authorize the release of all records required to act on this request. I request that payment of authorized benefits be made on my behalf. furthermore, I hereby declare that I do not belong to any Health Maintenance Organization (HMO). If it is found otherwise, I will be responsible for the charges Incurred.

☐ I HAVE BEEN ADMITTED THROUGH **MEDICAID** AND MY RESPONSIBILITY IS $ 2.00 CO-PAY PER VISIT WITH A MAXIMUM OF ONE CO-PAYMENT PER DAY.

☐ I HAVE BEEN ADMITTED THROUGH MANAGEMENT CARE ORGANIZATION _____NOT Pt. CHARGES

☐ I HAVE BEEN ADMITTED THROUGH _____HMO, _____COMMERCIAL INSURANCE,_____MEDICARE INSURANCE AS A SECONDARY PAYER. The charges will be determined through third party contracts. ☐ I HAVE BEEN ADMITTED THROUGH VETERANS ADMINISTRATION (VA)

☐ I HAVE BEEN ADMITTED THROUGH **PRIVATE PAY** AND THE CHARGES ARE SPECIFIED IN THE PRIVATE PAY AGREEMENT ATTACHED (SECTION II).

I CERTIFY THAT THE FINANCIAL INFORMATION INDICATED ABOVE, RELATED TO THE PAYMENTS MADE BY INSURER OR THIRD PARTY PAYER, THE SCOPE AND INTENT OF COVERAGE, AND THE CHARGES FOR NON-COVERED SERVICE CHARGES, HAS BEEN EXPLAINED AND UNDERSTOOD.

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SAMPLE

SAMPLE B – CLIENT SERVICE AGREEMENT, SECTION 2

- Services and frequencies exactly as ordered; supervision interval; advance directive answers; HIPAA/OASIS/handbook receipt.
- Survey visit, AI, and photo choices are the patient's – never pre-selected. **One** signature after every field is complete.

CLIENT SERVICE AGREEMENT (Cont'd) *(Spanish Translation in the back)* Page 2/2

Patient: _____
Medical Record: _____

SECTION TWO HOME HEALTH SERVICES TO BE FURNISHED, FREQUENCY AND CHARGES:
SKILLED NURSING_____ HOME HEALTH AIDE_____
PHYSICAL THERAPY _____ MEDICAL SOCIAL WORKER _____
SPEECH THERAPY _____OCCUPATIONAL THERAPY_____
OTHER:_____
ALSO I AUTHORIZE THE AGENCY'S RN/RPT TO PERFORM VISIT OF **SUPERVISION**, EVERY _____ DAYS.

STATEMENT OF PATIENT RIGHTS, RESPONSIBILITY AND ABUSE REGISTRY: I CERTIFY THAT I HAVE READ, UNDERSTOOD AND RECEIVED A COPY OF THE STATEMENT OF PATIENT RIGHTS AND RESPONSIBILITY WHICH HAS BEEN EXPLAINED TO ME VERBALLY BY A REPRESENTATIVE OF THE AGENCY I UNDERSTAND THE POLICY AND HAVE RECEIVED A COPY WITH THE TOLL FREE ABUSE PHONE NUMBER (1-800-962-2873), AND HHA HOTLINE (1-888-419-3456).

ADVANCE DIRECTIVE AND LIVING WILLS: I HAVE RECEIVED WRITTEN INFORMATION REGARDING MY RIGHTS TO MAKE DECISIONS CONCERNING MEDICAL CARE, INCLUDING THE RIGHT TO ACCEPT OR REFUSE MEDICAL OR SURGICAL TREATMENT AND THE RIGHT TO FORMULATE ADVANCE DIRECTIVES UNDER STATE LAW.
I HAVE AN ADVANCE DIRECTIVE: ☐ YES ☐ NO.
I HAVE A LIVING WILL: ☐ YES ☐ NO. IF YES, LOCATION OF LIVING WILL:_____
I HAVE A PATIENT ADVOCATE/PROXY:☐ YES ☐ NO: MY PATIENT ADVOCATE/PROXY IS: Name: _____ADDRESS:_____PHONE:_____
I WANT TO USE THE **DNR ORDER** ☐ Y ☐ N *(If yes, complete the official Legal Form)*

HIPAA/OASIS: NOTICE OF PRIVACY PRACTICES: I HAVE RECEIVED A COPY OF THE AGENCY'S NOTICE OF PRIVACY PRACTICES, I HAVE DISCUSSED AND RECEIVED A COPY OF THE CLIENT INFORMATION/ORIENTATION HANDBOOK.

CONSENT FOR HOME VISIT: I HEREBY CONSENT TO HAVE STATE/FEDERAL/ACCREDITATION HEALTH SURVEY PERSONNEL TO CONDUCT A " HOME VISIT" TO ENSURE THAT THE FEDERAL/ACCREDITATION REQUIREMENTS ARE MET AND TO ASSIST IN EVALUATING THE EFFECTIVENESS QUALITY OF HOME HEALTH SERVICES THAT I RECEIVE FROM THE AGENCY I UNDERSTAND THAT CONSENT FOR THIS VISIT IS VOLUNTARY AND NONE OF MY RIGHTS TO CONFIDENTIALITY OR PRIVACY ARE WAIVED BY MY CONSENT. I HAVE BEEN TOLD AND UNDERSTAND THAT REFUSAL TO A HOME HEALTH VISIT WILL HAVE NO EFFECT ON THE LEVEL OR NATURE OF MEDICARE/MEDICAID BENEFITS TO WHICH I AM ENTITLED.
CONSENT FOR THE USE OF ARTIFICIAL INTELIGENCE (AI): I UNDERSTAND THE DISCLOSURE THAT HAS BEEN EXPLAINED TO ME REGARDING THE POSSIBLE USE OF **ARTIFICIAL INTELLIGENCE (AI)** TECHNOLOGY DURING THE PROVISION OF MY SERVICES AND IN THE DOCUMENTATION OF MY CARE AND TREATMENT. I **AUTHORIZE THE AGENCY TO USE AI TECHNOLOGY** THAT COMPLIES WITH APPLICABLE FEDERAL AND STATE PRIVACY LAWS, HIPAA REQUIREMENTS, AND RECOGNIZED INDUSTRY SECURITY STANDARDS.

PATIENT RELEASE TO PHOTOGRAPH: I HEREBY GRANT THE AGENCY, AND THEIR REPRESENTATIVES, PERMISSION TO TAKE PHOTOGRAPHS OF ME AND TO USE THE FINISHED PHOTOGRAPHS IN ANY LEGITIMATE WAYS THEY DEEM PROPER. FURTHER I RELINQUISH AND GIVE TO THE AGENCY, ALL RIGHTS, TITLE AND INTEREST I MAY HAVE IN THE FINISHED PICTURES, NEGATIVES, REPRODUCTIONS AND COPIES OF THE ORIGINAL PRINTS AND NEGATIVES. I ALSO GRANT THE RIGHT TO GIVE TRANSFER AND EXHIBIT THE NEGATIVES, ORIGINAL PRINTS, OR COPIES AND FACSIMILES, MAIL, DELIVERY, THEREOF TO ANY RESPONSIBLE INDIVIDUAL, BUSINESS FIRM, OR PUBLICATION, OR TO ANY OTHER ASSIGNEES.

PATIENT SERVICE AGREEMENT: I HAVE RECEIVED A COPY OF THE AGENCY'S PATIENT SERVICE AGREEMENT AND HAVE ALL QUESTIONS AND CONCERNS ANSWERED TO MY SATISFACTION. ALSO I AUTHORIZE TO _____, (RELATION TO PATIENT _____) **TO SIGN ALL DOCUMENTS**, BECAUSE I'M UNABLE TO DO SO. REASON UNABLE TO SIGN: _____.

ONE PATIENT SIGNATURE: ADMISSION CONSENT/AGREEMENT FORM IS USED IN ALL PATIENT ORIENTATION BOOKLETS (this booklet), AND IS USED TO ACKNOWLEDGE RECEIPT, UNDERSTANDING AND APPROVAL OF THE CONTENTS OF THE BOOKLET AND FORMS (BILL OF RIGHTS, GRIEVANCE PROCEDURES, EMERGENCY PLAN, TRANSFER-DISCHARGE POLICY, NAMES, ADDRESSES & PHONE NUMBERS OF THE FEDERALLY-STATE FUNDED ENTITIES, NAME & CONTACT INFORMATION OF THE ADMINISTRATOR & CLINICAL MANAGER, TREATMENTS TO BE ADMINISTERED BY THE AGENCY AND INSTRUCTION RELATED TO THE CARE, VISIT SCHEDULE, INCLUDING FREQUENCY OF VISITS, NON-DISCRIMINATION SECTION 1557 INFORMATION) – ALL IN ONE BOOKLET AND WITH **ONLY ONE PATIENT SIGNATURE**. THE CONFUSION AND PATIENT'S EFFORTS OF SIGNING MULTIPLE FORMS IS ELIMINATED. I PARTICIPATED/INVOLVED IN THE DEVELOPMENT OF THE PLAN OF CARE.

⇨

_____ _____
SIGNATURE OF CLIENT OR AUTHORIZED REPRESENTATIVE DATE

_____
RELATIONSHIP OF AUTHORIZED REPRESENTATIVE

_____ _____
NAME, TITLE & SIGNATURE OF AGENCY'S REPRESENTATIVE DATE

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SAMPLE

SAMPLE C – BILL OF RIGHTS STATEMENT

- Review rights and responsibilities in the patient's language; include the hotline numbers and grievance procedure.
- The patient or legal representative signs the statement; the Spanish version (Declaración de la Ficha de Derechos) is identical.

BILL OF RIGHTS STATEMENT *(As Our Client You Have the Right to Exercise Your Rights, and/or to Designate a Representative to Exercise them for you)*

Patient Name: _____MR#:_____
Nombre del Paciente

Rights of the patient. The patient has the right to:
(1) Have his or her property and person treated with respect; Choose a health care provider, including an attending physician
(2) Be free from verbal, mental, sexual, and physical abuse, including injuries of unknown source, neglect and misappropriation of property;
(3) Make complaints to our Agency regarding treatment or care that is (or fails to be) furnished, and the lack of respect for property and/or person by anyone who is furnishing services on behalf of our Agency; Be able to identify visiting personnel members through agency-generated photo identification.
(4) Participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to (i) Completion of all assessments; (ii) The care to be furnished, based on the comprehensive assessment; (iii) Establishing and revising the plan of care; (iv) The disciplines that will furnish the care; (v) The frequency of visits; (vi) Expected outcomes of care, including patient identified goals, and anticipated risks and benefits; (vii) Any factors that could impact treatment effectiveness; and (viii) Any changes in the care to be furnished.
(5) Receive appropriate care without discrimination in accordance with physician orders. Be fully informed of one's responsibilities.
(6) Have a confidential clinical record. Access to or release of patient information and clinical records is permitted in accordance with regulations *(See OASIS privacy notice if OASIS data is applicable).* Be advised on the agency's policies/procedures regarding the disclosure of client/patient *records.*
(7) Be advised orally and in writing of (i) The extent to which payment for HHA services may be expected from Medicare, Medicaid, or any other federally funded or federal aid program known to the Agency. The charges for services that may not be covered by Medicare, Medicaid, or any other federally funded or federal aid program known to the Agency, (iii) The charges the individual may have to pay before care is initiated; and (iv) Any changes in the information provided when they occur. Our Agency will advise the patient and representative (if any), of these changes as soon as possible, in advance of the next home health visit. Be informed of client/patient rights under state law to formulate an Advanced Directive.
(8) Receive proper written notice, in advance of a specific service being furnished, if our Agency believes that the service may be non covered care; or in advance of our Agency reducing or terminating on going care. Be informed of any financial benefits when referred to an HHA.
(9) Be advised of the state toll free home health telephone hot line, its contact information, its hours of operation, and that its purpose is to receive complaints or questions about local HHAs. *(If applicable we will provide the Accreditation Body phone number also).*
10) Be advised of the names, addresses, and telephone numbers of the following Federally funded and state funded entities that serve the area where the patient resides: (i) Agency on Aging, (ii) Center for Independent Living, (iii) Protection and Advocacy Agency, (iv) Aging and Disability Resource Center; and (v) Quality Improvement Organization.
(11) Be free from any discrimination or reprisal for exercising his or her rights or for voicing grievances to our Agency or an outside entity.
(12) Be informed of the right to access auxiliary aids and language services, and how to access these services, free of charge.

Transfer and discharge: The patient and representative (if any), have a right to be informed of the HHA's policies for transfer and discharge. The HHA may only transfer or discharge the patient from our Agency if: (1) The transfer or discharge is necessary for the patient's welfare because our Agency and the physician who is responsible for the home health plan of care agree that our Agency can no longer meet the patient's needs, based on the patient's acuity. Our Agency must arrange a safe and appropriate transfer to other care entities when the needs of the patient exceed the HHA's capabilities; (2) The patient or payer will no longer pay for the services provided by our Agency; (3) The transfer or discharge is appropriate because the physician who is responsible for the home health plan of care and our Agency agree that the measurable outcomes and goals set forth in the plan of care have been achieved, and our Agency and the physician who is responsible for the home health plan of care agree that the patient no longer needs the HHA's services; (4) The patient refuses services, or elects to be transferred or discharged; (5) Our Agency determines, under a policy set by our Agency for the purpose of addressing discharge for cause that the patient's (or other persons in the patient's home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of our Agency to operate effectively is seriously impaired. Our Agency must do the following before it **discharges a patient** for cause: (i) Advise the patient, represent for the home health plan of care, and the patient's primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from our Agency (if any) that a discharge for cause is being considered; (ii) Make efforts to resolve the problem(s) presented by the patient's behavior, the behavior of other persons in the patient's home, or situation; (iii) Provide the patient and representative (if any), with contact information for other agencies or providers who may be able to provide care; and (iv) Document the problem(s) and efforts made to resolve the problem(s), and enter this documentation into its clinical records; (6) The patient dies; or (7) Our Agency ceases to operate.

Investigation of complaints. Our HHA must: (i) Investigate complaints made by a patient, the patient's representative (if any), and the patient's caregivers and family,including, but not limited to, the following topics: (A) Treatment or care that is (or fails to be) furnished, is furnished inconsistently, or is furnished inappropriately; and (B) Mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and/or misappropriation of patient property by anyone furnishing services on behalf of our Agency. (ii) Document both the existence of the complaint and the resolution of the complaint; and (iii) Take action to prevent further potential violations, including retaliation, while the complaint is being investigated. (2) Any HHA staff (whether employed directly or under arrangements) in the normal course of providing services to patients, who identifies, notices, or recognizes incidences or circumstances of mistreatment, neglect, verbal, mental, sexual, and/or physical abuse, including injuries of unknown source, or misappropriation of patient property, must report these findings immediately to our Agency and other appropriate authorities in accordance with state law.*(Contact information for our Agency administrator, including the name, business address, and business phone number will be provided in order to receive complaints)*

Accessibility. Information must be provided to patients in plain language and in a manner that is accessible and timely to: (1) Persons with disabilities, including accessible Web sites and the provision of auxiliary aids and services at no cost to the individual in accordance with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act. (2) Persons with limited English proficiency through the provision of language services at no cost to the individual, including oral interpretation and written translations.

(Service Agreement, signed by the patient, or legal representative, acknowledges that he/she received the Notice of the Bill of Rights)

Staff Name/ Title / Signature *(Nombre/Firma)*: _____ Date: _____

SAMPLE

SAMPLE D – EMERGENCY/DISASTER PLAN, PAGE 1

- Complete contacts, allergies, equipment and supplies, evacuation destination, and transportation with the patient.
- Circle the classification **D1, D2, D3, or D4** – a blank classification is a common error.

EMERGENCY/DISASTER PLAN FOR HOME HEALTHCARE PATIENTS

PLAN DE EMERGENCIA/DESASTRE PARA PACIENTES EN SU CASA

(Keep this plan where it can be easily located/*Mantenga este plan en un lugar accequible*)

Date/*Fecha*: _____ **Client:** _____ **MR #:** _____

Nombre del cliente DOB/*Fecha Nac.*:_____ Age/*Edad*: _____

Address/*Dirección*: _____

Information obtained from: Living situation/*como vive*: _____

☐ Client/Patient (*Cliente/Paciente*)

☐ Caregiver (*Persona encargada):* Name/*Nombre*: _____ Relationship/*relación*: _____ Phone: _____

Health Insurance, phone / *Seguro Médico*: _____

Service Provided (Servicios) ☐ Skilled Services ☐ Non Skilled

Client'sEmergencyClassification/*Clasificación de Emergencia del Cliente*: (circle one) D1 D2 D3 D4 (see back instructions)

Patient's Data / Datos del Paciente: ☐ Limited English proficiency (*problemas con el inglés*) . Primary language: (*lenguage primario*) _____

Allergies/Alergias: ☐ NKA ☐ Penicillin ☐ Sulfa ☐ Aspirin ☐ Iodine *(iodo)* ☐ Other: _____

☑ **Medications:** See medication scheduled/*Ver el registro de medicinas (part of the Emergency Plan)*

Supplies/DME (Suministros y *Equipos Médicos)*

☐ Stethoscope*(estetoscopo)*, Thermometer*(termómetro)*, Prove Cover, Sphygmomanometer *(esfimo)*, Gloves*(guantes)*, Alcohol Pads*(almohadillas de alcohol)*, and scale*(pesa)*.

☐ Walker *(andador)* ☐ Oxygen supplies *(oxígeno)*

☐ Cane *(bastón)* ☐ Hoyer lift *(grúa)*

☐ W/C *(silla de rueda)* ☐ IV supplies *(sueros)*

☐ Commode *(cómoda)* ☐ Injection Supplies *(inyecciones)*

☐ Hospital Bed *(cama de hospital)* ☐ Foley Supplies *(cateter)*

☐ Diabetic Supplies *(suministros DM)* ☐ Ostomy Supplies *(ostomia)*

☐ Wound care Supplies *(heridas)* ☐ INR supplies *(coagulación test)*

☐ Other*(otro)*: _____

Mental Status/Depresion Hx _____

☐ Oriented *(orientado)* ☐ Disoriented *(desorientado)*

☐ Dementia *(demencia)* ☐ Forgetful*(olvidadizo)*

☐ Anxiety *(ansiedad)*

☐ Alert *(alerta)*

☐ Alzheimer

☐ Memory Impairm.

Special Needs/Functional Limitations *(Necesidades especiales, limitaciones)*

☐ Vision Impairments *(problemas de visión)* ☐ Service animal*(ayuda canina)*

☐ Fall precautions *(caidas)* ☐ Obesity *(obesidad)*

☐ Diabetic precautions *(Diabetis prec.)*

☐ Bedbound *(confinado a la cama)* ☐ W/C bound *(silla de rueda)* ☐ Severe pain *(dolor severo)*

☐ Anticoagulant/Bleeding prec. *(sangramiento)* ☐ Speech *(habla)*

☐ Wound/Pressure ulcer prec. *(heridas ulceras)* ☐ Hearing *(oido)*

☐ Infection control precautions *(Prevención de Infecciones)* ☐ Ambulation *(ambulación)*

☐ Amputation *(Amputación)* ☐ Incontinence *(Incontinencia)* ☐ Endurance *(resistencia)*

☐ Oxygen therapy, precautions *(Precaución con el oxigeno)* ☐ Dyspnea *(falta de aire)*

☐ Seizures precautions *(convulsiones)* ☐ Weakness *(débil)*

☐ Aspiration precautions *(aspiración)*

☐ Other *(otros)*: _____

Home Medical Equipment*(Compañía de equipos)*: _____ *Phone:* _____ ☐ None ☐ Unknown

(nombre y teléfono) **Pharmacy/** *Farmacia*	**Doctor** *(nombre y teléfono)*
Name: _____	Name: _____
Phone: _____	Phone: _____

IN CASE OF EMERGENCY CALL 911 *(EN CASO DE EMERGENCY MEDICA LLAMAR AL 911)*

In Case of Nursing or related problem, please call our Agency (phone in the cover of you handbook)

Problemas con el Servicio llame a nuestra Agencia (el número en la cubierta de su manual)

In Case of Emergency Notify to/*En caso de Emergencia notificar a:* *(nombre, relación y teléfono)*

☐ Name: _____ Relationship: _____ Phone: _____

☐ Name: _____ Relationship: _____ Phone: _____

Your nurse/*enfermera(o)* (name/*nombre*) : _____ Phone/*Teléfono*: _____

In the event of Emergency (Or Natural Disaster) I will/*En caso de emergencia (o desastre natural) Yo:*

☐ Stay at home (*Me quedaré en casa*. Who will help with meds/*Quien le ayudará con medicinas*): _____

☐ Stay with family (Voy con familiares): Name/Address: _____

☐ Go to Shelter (Voy al Refugio) address: _____

☐ Go to hospital, if medically necessary (Name): _____ *(No necesaria)*

TRANSPORTATION: ☐ Not needed, N/A ☐ Client will be driven by family *(La familia lo llevará)* ☐ Client will be picked up by special needs transportation service *(servicio de transporte para necesidades especiales)*

☐ Client will take public transportation *(transportación pública)* ☐ Other*(Otro)*: _____

☐ I do not want assistance for transportation or shelter placement at this time. If I desire assistance in the future, I understand it is may responsibility to contact the Office of Emergency Management of my respective County. *No deseo asistencia para transportacion o traslado a refugio en este momento. Si deseara asistencia en el futuro, entiendo que es mi responsabilidad contactar a la Oficina de Manejos de Emergencias de mi respectivo Condado.*

_____ _____

Staff Name/ Title / Signature *Nombre/Firma del Empleado* Date / *Fecha*

PLEASE CONTACT OUR AGENCY FOR ALTERNATE SERVICE OPTIONS IN CASE OF DISASTER

POR FAVOR CONTACTAR NUESTRA AGENCIA PARA OPCIONES EN SERVICIOS ALTERNOS O EN CASO DE DESASTRE

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SAMPLE

SAMPLE E – EMERGENCY/DISASTER PLAN, PAGE 2 (INSTRUCTIONS)

- Leave this page in the home: what to do in an emergency, how the Agency will contact the patient, and the meaning of D1–D4.

GENERAL INSTRUCTIONS TO CLIENT ON USE OF THIS FORM:

This information is provided to you as a quick reference source in case any emergency occurs. Keep this document where it can easily be found. Inform other persons close to you (relative, neighbor, etc.) of its location.

1. Our Agency has a nurse on call 24 hours a day. You can reach the nurse through our phone number (on the cover of the book), After office hours and on weekends an answering service will reach the nurse and he/she will return your call and come to see the client if necessary, or simply answer any questions you may have.
2. In case of a serious medical emergency, the client should be taken to the hospital. Our Agency does not operate as an emergency service, therefore valuable time may be lost by contacting the Agency for a serious emergency such as diabetic coma, severe chest pain, unconsciousness, etc.
3. Ambulance service number is 911.

CLASSIFICATION

(Please circle the correct classification for client)

D1- Category 1 (High Risk)

Patients who cannot safely forgo care: Special needs clients of anyone who needs (Cpap mask, nebulizer, oxygen, etc.), anyone with mild to moderate cognitive impairment, highly unstable patients with high probability of inpatient admission if home care is not provided; IV therapy, highly skilled wound care, with no family/caregiver, life sustaining medication or equipment.

D2-Category 2 (Moderate Risk)

Client whose condition recently worsened: moderate level of skilled care. That should be provided that day, but could postpone visit until emergency situation improves. Client with untrained families/caregivers who could provide basic care in an emergency.

D3-Category 3 (Low Risk)

Client who can safely forgo care or a scheduled visit including Home Health Aide visits, Clients receiving routine supervisory visit, evaluation visits. Client with 1 or 2 visits/ week, or Clients who have a competent family/caregiver.

D4-Category 4

Patient who refused information, or signed the registration release form releasing the Agency from evacuation responsibilities.

INFORMACIÓN GENERAL PARA EL PACIENTE SOBRE ESTE FORMULARIO. Esta información es en caso de una Emergencia. Deben de dejar este formulario en un lugar rápido de encontrar,(Dígale a su familia, Vecinos, etc) donde se encuenta este formulario.

1. *Nuestra Agencia tiene un Representante en servicios las 24 hora al día. Usted se puede comunicar con la agencia llamando a nuestro número de teléfono (en la cubierta del libro), después de hora o fin de semana, la agencia llamará a la persona que se encuentre "ON CALL" (de guardia), Esta persona le devolverá la llamada.*
2. *En caso de una EMERGENCIA, el paciente debe ser llevado(a) al hospital más cercano. Nuestra Agencia No opera como un servicio de Emergencia.*
3. *Para llamar a a una AMBULANCIA, deben marcar el 911.*

CLASIFICACION

(favor de circular la clasificación del paciente)

D1 (category 1) (Alto Riesgo)

Pacientes que no pueden renunciar a la atención de forma segura: clientes con necesidades especiales de cualquier persona que lo necesite (máscara Cpap, nebulizador, oxígeno, etc.), cualquier persona con deterioro cognitivo leve a moderado, pacientes altamente inestables con alta probabilidad de ingreso hospitalario si la atención domiciliaria es no provisto; Terapia IV, cuidado de heridas altamente calificado, sin familia / cuidador, medicamento o equipo para mantener la vida.

D2 (category 2) (Riesgo Moderado)

Pacientes cuyas condiciones empeoraron recientemente, moderado nivel de cuidado, que debe darse según calendario, pero puede posponerse hasta que la situación de emergencia mejore. Pacientes con familiares/encargados no entrenados, pero que pueden dar cuidados básicos en emergencias.

D3 (categoria 3) (Poco Riesgo)

Pacientes que de una forma segura se puede dejar de visitar, incluyendo la assistente de enfermera, clientes reciviendo rutinarias visitas de supervisión, evaluación. Clientes con 1 a 2 visitas por semana, o clientes que tienen familiares/encargados entrenados y competentes.

D4 (Categoria 4)

Rehusó dar información, o liberó a la Agencia de Responsabilidades de Evacuación.

SAMPLE

SAMPLE F – VULNERABILITY TO ABUSE AND/OR NEGLECT ASSESSMENT

- Answer all 16 risk factors Yes or No; any concern goes to the Clinical Manager.
- Suspected abuse, neglect, or exploitation is reported to the Florida Abuse Hotline, 1-800-962-2873.

ASSESSMENT FOR CLIENT VULNERABILITY TO ABUSE AND/OR NEGLECT
EVALUACIÓN DE PACIENTES VULNERABLES A ABUSOS Y/O NEGLIGENCIAS

Client Name: *Nombre del Paciente*	**M.R. #:** *No. de expediente*
Date Client Assessed: *Fecha en que el cliente fue evaluado*	

VULNERABILITY RISK FACTORS / FACTORES VULNERABLES

VULNERABILITY RISK FACTOR *Factor Vulnerable*	Vulnerability RISK? *¿Es vulnerable?* YES	NO	EXIST RISK FACTOR? *¿Existen factores?* YES	NO
Demonstrates orientation to time, place, and person *Demuestra orientación en tiempo, espacio y persona*				
Demonstrates ability to follow directions consistently *Demuestra habilidad para seguir indicaciones*				
Demonstrates assertiveness *Demuestra ser asertivo*				
Demonstrates ability to give accurate information consistently *Demuestra habilidad para dar información correcta*				
Demonstrates interest in environment activities *Demuestra interés en las actividades en su alrededor*				
Demonstrates ability to walk without assistive devices *Demuestra habilidad para caminar sin ningún equipo*				
Demonstrates full range of motion *Demuestra movimientos completos*				
Demonstrates adequate endurance *Demuestra resistencia adecuada*				
Demonstrates pain-free condition/illness *Demuestra condición o enfermedad sin dolor*				
Demonstrates freedom from communicable disease *Libre de enfermedades contagiosas*				
Demonstrates adequate auditory perception *Demuestra buena audición*				
Demonstrates adequate speech *Demuestra habla adecuada*				
Demonstrates adequate touch sensation *Demuestra adecuada sensación al tacto*				
Demonstrates cooperative behavior *Demuestra comportamiento cooperativo*				
Demonstrates ability to adhere to safety precautions consistently *Sigue instrucciones de precauciones adecuadamente*				
Demonstrates ability to report abuse and/or neglect *Tiene habilidad para comunicar abuso o negligencia*				
Other / Otros: _____				

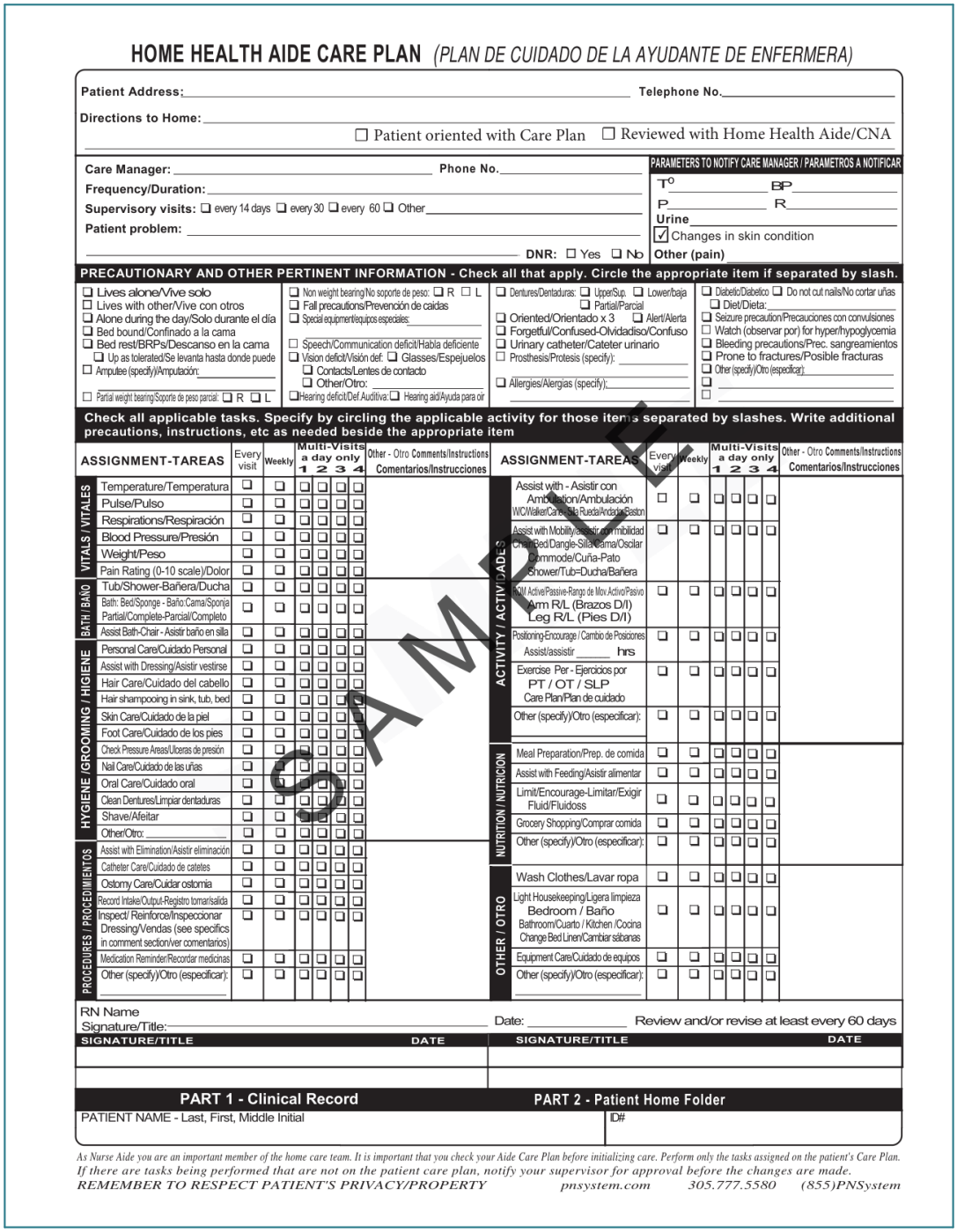
Signature of Individual Completing the Form *Firma del individual completando la forma*	**Date** *Fecha*

This form is confidential and is part of the patient's medical record. · Este formulario es confidencial y forma parte del expediente médico del paciente. *www.pnsystem.com*

SAMPLE

SAMPLE G – HOME HEALTH AIDE CARE PLAN

- Mark each aide task with its frequency and the precautions; the aide performs only what is written.
- Reviewed at least every 60 days and whenever the patient's needs change.



HOME HEALTH AIDE CARE PLAN *(PLAN DE CUIDADO DE LA AYUDANTE DE ENFERMERA)*

Patient Address: _____ Telephone No. _____

Directions to Home: _____

☐ Patient oriented with Care Plan ☐ Reviewed with Home Health Aide/CNA

Care Manager: _____ Phone No. _____

Frequency/Duration: _____

Supervisory visits: ☐ every 14 days ☐ every 30 ☐ every 60 ☐ Other _____

Patient problem: _____

DNR: ☐ Yes ☐ No

PARAMETERS TO NOTIFY CARE MANAGER / PARAMETROS A NOTIFICAR

T° _____ BP _____

P _____ R _____

Urine _____

☑ Changes in skin condition

Other (pain) _____

PRECAUTIONARY AND OTHER PERTINENT INFORMATION - Check all that apply. Circle the appropriate item if separated by slash.

☐ Lives alone/Vive solo
☐ Lives with other/Vive con otros
☐ Alone during the day/Solo durante el día
☐ Bed bound/Confinado a la cama
☐ Bed rest/BRPs/Descanso en la cama
☐ Up as tolerated/Se levanta hasta donde puede
☐ Amputee (specify)/Amputación: _____
☐ Partial weight bearing/Soporte de peso parcial: ☐ R ☐ L

☐ Non weight bearing/No soporte de peso: ☐ R ☐ L
☐ Fall precautions/Prevención de caidas
☐ Special equipment/equipos especiales: _____
☐ Speech/Communication deficit/Habla deficiente
☐ Vision deficit/Visión def: ☐ Glasses/Espejuelos
☐ Contacts/Lentes de contacto
☐ Other/Otro: _____
☐ Hearing deficit/Def. Auditiva: ☐ Hearing aid/Ayuda para oir

☐ Dentures/Dentaduras: ☐ Upper/Sup. ☐ Lower/baja ☐ Partial/Parcial
☐ Oriented/Orientado x 3 ☐ Alert/Alerta
☐ Forgetful/Confused-Olvidadiso/Confuso
☐ Urinary catheter/Cateter urinario
☐ Prosthesis/Protesis (specify): _____
☐ Allergies/Alergias (specify): _____

☐ Diabetic/Diabetico ☐ Do not cut nails/No cortar uñas
☐ Diet/Dieta: _____
☐ Seizure precaution/Precauciones con convulsiones
☐ Watch (observar por) for hyper/hypoglycemia
☐ Bleeding precautions/Prec. sangreamientos
☐ Prone to fractures/Posible fracturas
☐ Other (specify)/Otro (especificar): _____

Check all applicable tasks. Specify by circling the applicable activity for those items separated by slashes. Write additional precautions, instructions, etc as needed beside the appropriate item

	ASSIGNMENT-TAREAS	Every visit	Weekly	Multi-Visits a day only 1 2 3 4	Other - Otro Comments/Instructions Comentarios/Instrucciones
VITALS / VITALES	Temperature/Temperatura	☐	☐	☐ ☐ ☐ ☐	
	Pulse/Pulso	☐	☐	☐ ☐ ☐ ☐	
	Respirations/Respiración	☐	☐	☐ ☐ ☐ ☐	
	Blood Pressure/Presión	☐	☐	☐ ☐ ☐ ☐	
	Weight/Peso	☐	☐	☐ ☐ ☐ ☐	
	Pain Rating (0-10 scale)/Dolor	☐	☐	☐ ☐ ☐ ☐	
BATH / BAÑO	Tub/Shower-Bañera/Ducha	☐	☐	☐ ☐ ☐ ☐	
	Bath: Bed/Sponge - Baño: Cama/Sponja Partial/Complete-Parcial/Completo	☐	☐	☐ ☐ ☐ ☐	
	Assist Bath-Chair - Asistir baño en silla	☐	☐	☐ ☐ ☐ ☐	
HYGIENE /GROOMING / HIGIENE	Personal Care/Cuidado Personal	☐	☐	☐ ☐ ☐ ☐	
	Assist with Dressing/Asistir vestirse	☐	☐	☐ ☐ ☐ ☐	
	Hair Care/Cuidado del cabello	☐	☐	☐ ☐ ☐ ☐	
	Hair shampooing in sink, tub, bed	☐	☐	☐ ☐ ☐ ☐	
	Skin Care/Cuidado de la piel	☐	☐	☐ ☐ ☐ ☐	
	Foot Care/Cuidado de los pies	☐	☐	☐ ☐ ☐ ☐	
	Check Pressure Areas/Ulceras de presión	☐	☐	☐ ☐ ☐ ☐	
	Nail Care/Cuidado de las uñas	☐	☐	☐ ☐ ☐ ☐	
	Oral Care/Cuidado oral	☐	☐	☐ ☐ ☐ ☐	
	Clean Dentures/Limpiar dentaduras	☐	☐	☐ ☐ ☐ ☐	
	Shave/Afeitar	☐	☐	☐ ☐ ☐ ☐	
	Other/Otro: _____	☐	☐	☐ ☐ ☐ ☐	
PROCEDURES / PROCEDIMIENTOS	Assist with Elimination/Asistir eliminación	☐	☐	☐ ☐ ☐ ☐	
	Catheter Care/Cuidado de catetes	☐	☐	☐ ☐ ☐ ☐	
	Ostomy Care/Cuidar ostomia	☐	☐	☐ ☐ ☐ ☐	
	Record Intake/Output-Registro tomar/salida	☐	☐	☐ ☐ ☐ ☐	
	Inspect/ Reinforce/Inspeccionar Dressing/Vendas (see specifics in comment section/Ver comentarios)	☐	☐	☐ ☐ ☐ ☐	
	Medication Reminder/Recordar medicinas	☐	☐	☐ ☐ ☐ ☐	
	Other (specify)/Otro (especificar): _____	☐	☐	☐ ☐ ☐ ☐	

	ASSIGNMENT-TAREAS	Every visit	Weekly	Multi-Visits a day only 1 2 3 4	Other - Otro Comments/Instructions Comentarios/Instrucciones
ACTIVITY / ACTIVIDADES	Assist with - Asistir con Ambulation/Ambulación W/C/Walker/Cane/Silla Rueda/Andador/Baston	☐	☐	☐ ☐ ☐ ☐	
	Assist with Mobility/Asistir con movilidad Chair/Bed/Dangle-Silla/Cama/Oscilar Commode/Cuña-Pato Shower/Tub=Ducha/Bañera	☐	☐	☐ ☐ ☐ ☐	
	ROM Active/Passive-Rango de Mov Activo/Pasivo Arm R/L (Brazos D/I) Leg R/L (Pies D/I)	☐	☐	☐ ☐ ☐ ☐	
	Positioning-Encourage / Cambio de Posiciones Assist/assistir _____ hrs	☐	☐	☐ ☐ ☐ ☐	
	Exercise Per - Ejercicios por PT / OT / SLP Care Plan/Plan de cuidado	☐	☐	☐ ☐ ☐ ☐	
	Other (specify)/Otro (especificar): _____	☐	☐	☐ ☐ ☐ ☐	
NUTRITION / NUTRICION	Meal Preparation/Prep. de comida	☐	☐	☐ ☐ ☐ ☐	
	Assist with Feeding/Asistir alimentar	☐	☐	☐ ☐ ☐ ☐	
	Limit/Encourage-Limitar/Exigir Fluid/Fluidoss	☐	☐	☐ ☐ ☐ ☐	
	Grocery Shopping/Comprar comida	☐	☐	☐ ☐ ☐ ☐	
	Other (specify)/Otro (especificar):	☐	☐	☐ ☐ ☐ ☐	
OTHER / OTRO	Wash Clothes/Lavar ropa	☐	☐	☐ ☐ ☐ ☐	
	Light Housekeeping/Ligera limpieza Bedroom / Baño Bathroom/Cuarto / Kitchen /Cocina Change Bed Linen/Cambiar sábanas	☐	☐	☐ ☐ ☐ ☐	
	Equipment Care/Cuidado de equipos	☐	☐	☐ ☐ ☐ ☐	
	Other (specify)/Otro (especificar): _____	☐	☐	☐ ☐ ☐ ☐	

RN Name Signature/Title: _____ Date: _____ Review and/or revise at least every 60 days

SIGNATURE/TITLE	DATE	SIGNATURE/TITLE	DATE

PART 1 - Clinical Record **PART 2 - Patient Home Folder**

PATIENT NAME - Last, First, Middle Initial ID#

As Nurse Aide you are an important member of the home care team. It is important that you check your Aide Care Plan before initializing care. Perform only the tasks assigned on the patient's Care Plan. If there are tasks being performed that are not on the patient care plan, notify your supervisor for approval before the changes are made.
REMEMBER TO RESPECT PATIENT'S PRIVACY/PROPERTY pnsystem.com 305.777.5580 (855)PNSystem

SAMPLE

SAMPLE H – MEDICINE SCHEDULE

- List every medication with dose and times; use the side-effect key (A–T) and the drug classification sheet to teach.

Medicine Schedule / Horario de Medicamentos

Patient's Name / *Nombre del Paciente:* _____ **MR #:** _____

Pharmacy Name / *Nombre de la Farmacia:* _____ **Pharmacy Phone / *Teléfono de Farmacia:*** _____

Address / *Dirección:* _____ **MD Name / *Nombre del Médico:*** _____

Allergies / *Alergias:* _____ **MD Phone / *Teléfono del Médico:*** _____

DO NOT USE THESE ABBREVIATIONS / *NO USAR ESTAS ABREVIATURAS:* U, IU, QD, Q.D., qd, q.d., QOD, Q.O.D., qod, q.o.d., >, <, @, cc, µg, MS, MSO4, MgSO4, and trailing zeros (e.g. 1.0 mg)

	Date Ordered *Fecha de Orden*	N/C/O	D/C Date *Fecha de Alta*	Medications / Dose, Route, Frequency *Medicamentos / Dosis, Vía, Frecuencia*	Breakfast *Desayuno*	Lunch *Almuerzo*	Dinner *Cena*	Bedtime *Acostarse*	Classification *Clasificación*	Side Effects *Efectos Secundarios*	Level of Understanding: Good, Fair, Poor	Administered by: Patient / Nurse Caregiver / Physician
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												

SAMPLE

Key to Side Effects / *Guía de Efectos Secundarios*

A- Nausea/Vomiting *(Náusea/Vómito)*
- Constipation *(Estreñimiento)*

C- Diarrhea *(Diarrea)*
D- Hypertension *(Presión Alta)*
E- Hypotension *(Presión Baja)*
F- Skin Rash/Hives *(Erupción/Urticaria)*
- Headaches *(Dolor de Cabeza)*

H- Dizziness *(Mareos)*
I- Hypoglycemia *(Hipoglucemia)*
- Hyperglycemia *(Hiperglucemia)*
- Edema *(Edema)*

L- Diaphoresis *(Sudoración)*
M- Hemorrhage *(Hemorragia)*
N- Hematuria *(Hematuria)*
O- Dry Mouth/Thirst *(Boca Seca/Sed)*
P- Bradycardia *(Bradicardia)*
Q- Tachycardia *(Taquicardia)*
R- Tremors *(Temblores)*
S- Tinnitus *(Zumbido en Oídos)*
T- Fluid/Electrolyte Imbalance *(Desbalance de Líquidos/Electrolitos)*
U- Anorexia *(Anorexia)*
- Malaise *(Malestar)*
- Dyspnea *(Falta de Aire)*
- Confusion *(Confusión)*
- Flushing/Blurred Vision *(Enrojecimiento/Visión Borrosa)*

Z- Other *(Otros)* _____ _____

Medication Status / *Estado de la Medicación:*
[ ] Medication Regimen Completed/Reviewed/Reconciled *Régimen de medicamentos completado/revisado/reconciliado*
[ ] No Change *Sin cambios*
[ ] Order Obtained *Orden obtenida*

[ ] No medication interaction identified by the nurse within the patient's medication schedule.
No se identificó interacción de medicamentos por la enfermera dentro del horario de medicamentos del paciente.

Check if any of the following were identified / *Marque si se identificó alguno de los siguientes:*
[ ] Potential Adverse Effects/Drug Reaction *(Posibles efectos adversos/reacción a medicamentos)* [ ] Ineffective Drug Therapy *(Terapia de medicamentos inefectiva)* [ ] Significant Side Effects *(Efectos secundarios significativos)*
[ ] Significant Drug Interactions *(Interacciones significativas de medicamentos)* [ ] Duplicate Drug Therapy *(Terapia de medicamentos duplicada)* [ ] Non-Compliance with Drug Therapy *(Incumplimiento con la terapia de medicamentos)*
Care Coordination / *Coordinación de Cuidado:* [ ] Physician *(Médico)* [ ] SN [ ] PT [ ] OT [ ] ST [ ] MSW [ ] Aide *(Asistente)* [ ] Other/*Otro:* _____

Reconciliation Update on / *Actualización de Reconciliación en:* _____ **By / *Por:*** _____
Reconciliation Update on / *Actualización de Reconciliación en:* _____ ___ **By / *Por:*** _____ ___
Nurse Name / *Nombre de la Enfermera(o):* _____ **Nurse Signature / *Firma de la Enfermera(o):*** _____
[X] Completed/reviewed copy provided to patient **Date / *Fecha:***

** Part of Emergency/Disaster Plan*

POST-TEST – ADMISSION NURSE AND SIGN-UP PACKAGE

Admitting clinicians and intake staff – 20 questions

Name: _____ **Discipline:** _____ **Date:** _____

Circle the best answer or write the letter in the answer grid at the end. Passing score: 80%.

1. **The face-to-face encounter must occur:**
   A. Only after discharge
   B. Within 1 year before start of care
   C. Within 90 days before or 30 days after the start of care
   D. Within 7 days after discharge

2. **The initial assessment visit must be done within:**
   A. 14 days
   B. 30 days
   C. 60 days
   D. 48 hours of referral or return home, or on the ordered start-of-care date

3. **If the Agency cannot meet the patient's needs in the home, the clinician should:**
   A. Not start services and notify the Clinical Manager
   B. Admit and hope for the best
   C. Ask the family to provide skilled care
   D. Start services without orders

4. **Patient identity is verified with:**
   A. Two identifiers, such as full name and date of birth
   B. The house number only
   C. The caregiver's word
   D. The patient's photo on a wall

5. **A diagnosis of dementia:**
   A. Does not by itself mean the patient lacks capacity
   B. Means services cannot start
   C. Always means the family signs
   D. Means no consent is needed

6. **ALF staff may sign admission forms for a resident:**
   A. Only if they hold legal authority
   B. If the resident is asleep
   C. Always
   D. If the nurse asks them to

7. **If the legal representative cannot be reached, the clinician should:**
   A. Sign for the patient
   B. Have a neighbor sign
   C. Skip the consent
   D. Document attempts, notify the DON, and not obtain an unauthorized signature

8. **The Privacy Act statement:**
   A. Is optional to explain
   B. Must be signed twice
   C. Is a notice only – no signature is required
   D. Is a consent to treatment

9. **The Florida Abuse Hotline number is:**
   A. 1-800-222-1222 B. 911 only C. 1-800-962-2873 D. 1-888-419-3456

10. **On CSA Section 1, the insurance section requires:**
    A. Leaving it blank
    B. The patient to write in any insurer
    C. Checking every box that applies
    D. Checking only one payer box

11. **The patient signature on the CSA should be obtained:**
    A. On every page before completing it
    B. Before explaining the form
    C. Once, after every field is completed
    D. Only by the aide

12. **When explaining the AI disclosure, the clinician says AI:**
    A. Assists with documentation; the clinician reviews and authenticates every entry
    B. Replaces the nurse
    C. Prescribes medications
    D. Diagnoses the patient

13. **Advance directive information is documented by asking about:**
    - A. Favorite foods
    - B. Advance directive, living will location, proxy, and DNR
    - C. The patient's income
    - D. Religion only

14. **For a patient with limited English proficiency, the Agency provides:**
    - A. An interpreter at the patient's cost
    - B. A minor family member as interpreter
    - C. English forms only
    - D. A free qualified interpreter

15. **A patient on continuous oxygen who lives alone without transportation is usually classified:**
    - A. No classification needed
    - B. D1 – high priority
    - C. D4 – declined
    - D. D3 – low priority

16. **D4 on the Emergency/Disaster Plan means:**
    - A. The patient declined the plan or signed a release
    - B. Moderate priority
    - C. Ventilator dependent
    - D. Highest priority

17. **The home health aide care plan is reviewed at least every:**
    - A. Five years
    - B. Year
    - C. Never
    - D. 60 days and when needs change

18. **The Notice of Medicare Non-Coverage is delivered:**
    - A. At least 2 days before covered services end
    - B. Only on request
    - C. At admission only
    - D. After discharge

19. **Which is a correct documentation practice?**
    - A. Pre-charting the next visit
    - B. Using white-out
    - C. Backdating a note
    - D. Single-line correction with initials and date

20. **Before leaving the home, the clinician must:**
    - A. Skip the Medicine Schedule
    - B. Perform the final quality check and leave the handbook and copies
    - C. Take the handbook back to the office
    - D. Leave the CSA unsigned

ANSWER GRID

1. _____	**2.** _____	**3.** _____	**4.** _____	**5.** _____
6. _____	**7.** _____	**8.** _____	**9.** _____	**10.** _____
11. _____	**12.** _____	**13.** _____	**14.** _____	**15.** _____
16. _____	**17.** _____	**18.** _____	**19.** _____	**20.** _____

Score: _____ **Graded by:** _____ **Date:** _____

INFORMATION, TRAINING RECORDS

Admission Nurse and Sign-Up Package Training

Staff: _____ **Date:** _____

Instructions given by: _____

Items	Y	N	Comments
Regulations, eligibility, face-to-face, homebound, acceptance to service	☐	☐	
Preparing for the visit; identity; legal representative; dementia and ALF	☐	☐	
Client Information Handbook orientation and teach-back	☐	☐	
Rights, complaints, hotlines, HIPAA, OASIS privacy, Privacy Act	☐	☐	
AI disclosure and advance directives	☐	☐	
Language access and sensory impairments	☐	☐	
Transfer, discharge, and Notice of Medicare Non-Coverage	☐	☐	
Client Service Agreement Sections 1 and 2	☐	☐	
Safety education and Emergency/Disaster Plan (D1–D4)	☐	☐	
Clinical intake forms, documentation, and final quality check	☐	☐	

Observed admission – patient initials/MR#: _____ **Date:** _____

Other:

_____

_____

Employee signature: _____ **Date:** _____

Instructor signature: _____ **Date:** _____

Questions, answers, and discussions were completed at the end of the training between the instructor and all participants.

IN-SERVICE ATTENDANCE RECORD

Admission Nurse and Sign-Up Package

Date: _____ **Time:** _____ **Location / method:** _____

Instructor (name/title): _____ **Hours:** _____

#	Name (print)	Discipline	Signature	Score
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				

Instructor (Name/Title): _____ **Signature** _____ **Date** _____

CERTIFICATE OF COMPLETION

This certifies that

_____

has successfully completed

Admission Nurse and Sign-Up Package

In-Service Education Program

_____ Contact hours

_____ Date completed

_____ Instructor (name/title)

_____ Director of Nursing / Administrator signature