Client Handbook

Wisconsin

Your rights and responsibilities as a health care consumer.

Welcome

Dear Client:

Thank you for choosing Recover Care for your home care needs – we are so honored you have chosen to partner with us. We promise you that we will do our very best to help you achieve your health care goals, by developing a Care Plan that is specifically and uniquely designed to meet your needs.

Driven by our core values, we are dedicated and committed to the highest possible quality services. The following information offers answers to commonly asked questions, as well as resources to support when you need assistance.

We value the trust you have placed in us, and we invite you to contact us whenever you have questions or concerns.

Sincerely,

Linda Engdahl
Chief Operating Officer
Recover Care

Recover Care Mission and Core Values

Our mission is to create relationships that make a meaningful difference in people's lives.

Authentic.

We mean what we say and we say what we mean. We believe in full honesty and transparency in every interaction. We give and receive feedback with grace and always assume good intent.

Invested.

We treat the company money, quality, and compliance like it is our own. The small things matter. Be cautious appropriately, and take risks appropriately. When the company does well, everyone does!

Purpose Driven.

We are here for a reason. Understand and share your personal reason and story for being here. It's not about what you do, it's about why you do it!

Relationship Focused.

We believe relationships are the most important part of our job. We do not prioritize clients, partners, or employees – we balance the relationships with all three to generate the best outcome for all!

Committed to Excellence.

We strive for 100% every time! We understand perfection is hard to achieve – learn from mistakes and those made ahead of you. Take accountability for your own actions and continue to grow and thrive!

Results Oriented.

Results matter. We cannot serve clients without business profitability, quality, and compliance. Everyone has a number that is realistic, well understood and evaluated often.

Recover Care

Recover Care

Statement of Home Care Services

Comprehensive Home Care Provider Name: Recover Care

Below is a list of all services that *may* be provided with a Comprehensive Home Care License.
Each service that is offered by this provider is indicated by a check in the box next to the service.

☒ Registered Nurse Services	☐ ~~Advanced Practice Nurse Services~~
☒ Licensed Practical Nurse Services	☐ ~~Physical Therapy Services~~
☒ Medication Management Services	☐ ~~Occupational Therapy Services~~
☒ Delegated tasks to unlicensed personnel	☐ ~~Speech Language Pathologist Services~~
☒ Hands-on assistance with transfers and mobility	☐ ~~Respiratory Therapy Services~~
☒ Providing eating assistance for clients with complicating eating problems (i.e. difficulty swallowing, recurrent lung aspirations, or requiring the use of a tube, parenteral or intravenous instruments)	☐ ~~Social Worker Services~~
☒ Assistance with dressing, self-feeding, oral hygiene, hair care, grooming, toileting, and bathing	☐ ~~Services by a Dietitian or Nutritionist~~
☒ Providing standby assistance within arm's reach for safety while performing daily activities	☐ ~~Complex or Specialty Healthcare Services~~
☒ Providing verbal or visual reminders to take regularly scheduled medication (includes bringing clients previously set-up medication, medication in original containers, or liquid or food to accompany the medication)	
☒ Providing verbal or visual reminders to the client to perform regularly scheduled treatments and exercises	
☒ Preparing modified diets ordered by licensed health professional	
☒ Laundry	
☒ Housekeeping/Other household chores	
☒ Meal preparation	
☒ Shopping	

WI Home Care Bill of Rights

(a) To be fully informed, as evidenced by home health agency documentation, of all rules and regulations governing patient responsibilities;

(b) To be fully informed, prior to or at the time of admission, of services available from the agency and of related charges, including any charges for services for which the patient or a private insurer may be responsible;

(c) To be informed of all changes in services and charges as they occur;

(d) To be fully informed of one's own health condition, unless medically contraindicated, and to be afforded the opportunity to participate in the planning of the home health services, including referral to health care institutions or other agencies, and to refuse to participate in experimental research;

(e) To refuse treatment to the extent permitted by law and to be informed of the medical consequences of such refusal;

(f) To confidential treatment of personal and medical records and to approve or refuse their release to any individual outside the agency, except in the case of transfer to another health facility, or as required by law or third–party payment contract;

(g) To be treated with consideration, respect and full recognition of dignity and individuality, including privacy in treatment and in care for personal needs;

(h) To be taught, and have the family taught, the treatment required, so that the patient can, to the extent possible, help himself or herself, and the family or other party designated by the patient can understand and help the patient.

(i) To exercise his or her rights as a patient of the home health agency;

To have the patient's family or legal representative exercise the patient's rights when the patient has been judged incompetent by a court of law.

We Listen to You

Recover Care welcomes your feedback at any time, please feel free to contact us with any question or concern. We also welcome your feedback through periodic customer satisfaction surveys. We urge you to give honest and constructive feedback, so we can be the best support you need. We value your time and appreciate any feedback that you can provide on the survey.

If You Have a Grievance

Your satisfaction is important to us; and your suggestions can help us provide the quality services described in our Mission Statement and Core Values. As our client, it is your right and obligation to tell us if you are unhappy with your care and to share your comments concerning our policies and procedures. We will make every effort to satisfy you without reprisal.

How do you file a grievance?

Call us. In most instances, it is best to start the grievance process immediately by contacting your Administrator. Although we prefer that you contact your Administrator at your local office, you may notify the Regional Director or COO through the corporate office: (office hours are 8am – 5pm Monday through Friday)

Recover Care of Wisconsin
(952) 230-6332
Director, Operations: Carly Checkalski
Chief Operations Officer: Linda Engdahl, RN

How do we respond to your grievance?

Our policy is to address your grievance immediately. Under no circumstances will our response take longer than seven days.

Other Agencies

A home care provider may not require a person to surrender these rights as a condition of receiving services. A guardian or conservator or, when there is not a guardian or conservator, a designated person may seek to enforce these rights. A provider must protect and promote these rights.

- Agency on Aging: 800-333-2433
- Center for Independent Living for Western Wisconsin: 877-577-8452
- Protection and Advocacy Agency: State Wide- 800-928-8778
- Wisconsin Home Health Hotline: 1-800-642-6552

Consumer Responsibilities

With your help, we can serve you better.

Just as we are accountable to you, as our client you are responsible to us to provide accurate information and to cooperate with the Care Plan created by your Registered Nurse. Without your help, we cannot serve your needs effectively.

These are your responsibilities as a home care consumer. You must…

1. Provide accurate and complete health information during your health assessment.
2. Notify us when your health changes.
3. Help your nurse develop and revise your Care Plan.
4. See your doctor regularly about your on-going health concerns
5. Report any changes in your health care insurance or private pay status immediately.
6. Notify your nurse or our office when you are hospitalized for a scheduled visit. We request a 24-hour notice, when possible.
7. Cooperate and support the treatments and services prescribed by your physician and outlined in your Care Plan. This includes a contingency plan for service interruption described in your Service Agreement.
8. Provide a safe environment for your home care services.
9. Treat our staff with consideration, courtesy, and respect.
10. Tell us when you have questions or problems regarding our services.
11. Notify us if you have a Health Care Directive or if it has been changed.
12. Pay bill by invoice date.
13. Follow the terms and conditions of your written agreement
14. Pay any fees outlined in your service agreement, by invoice due date

Health Care Directives

A Health Care Directive is a legal document in which you can state your wishes and instructions regarding the kinds of medical treatment you desire if you become terminally ill, injured, or unable to make decisions for yourself. It helps your family and caregivers to know what you want if you can't speak for yourself; and it helps to avoid family disagreements, guilty feelings, and doubts about how to treat you. A Health Care Directive is a document that includes one or more health care instructions, a Health Care Power of Attorney, or both. A Health Care Directive must be in written form and must be signed before a person is incapacitated.

Under federal and state law, Recover Care is required to explain your rights to make personal decisions regarding your medical care and to ask whether or not you have documented your wishes. We are also required to provide the following information:

Health Care Power of Attorney or Health Care Agent

You are allowed to name another person to represent you in making health care decisions if you are unable to do so yourself. That person is aware of what you want and has a copy of your Health Care Directive. This is in effect only when you are unable to make your own decisions. In most states your physician cannot be your representative.

Health Care Instructions

Health Care Instructions are a written statement of your values, preferences, guidelines or directions regarding health care. Health Care Instructions are meant to direct health care providers, family members and a health care agent to follow your wishes at a time you are not able to speak for yourself.

Nomination of a Guardian or Conservator

If you anticipate the eventual need for a court-appointed guardian or conservator, you may choose a guardian who may not normally be considered by the court. If you have executed Health Care Instructions or Health Care Power of Attorney, the proxy appointed in those documents will automatically be nominated as guardian or conservator, unless expressly stated otherwise.

Mental Health Treatment Directive

If you need psychiatric medication and/or electroconvulsive therapy, you may indicate your preference to your health care providers and/or appoint another person to make decisions for you if you become incapacitated. It is similar to Health Care Instructions, but does not require a terminal condition to be effective. Health care providers must still obtain your informed consent for treatment as long as you are able to give it. This is most often drafted and executed separately from Health Care Instructions or Health Care Power of Attorney. However, if you wish, you can give your Health Care Power of Attorney agent authority over psychiatric medications and electroconvulsive therapy by including a special provision in that document.

Our Policy on Health Care Directives

If you have a Health Care Directive, we need a copy to comply with its terms.

If there is no Health Care Directive, we will take all actions necessary to sustain life. However, not all staff who serve you are required to be CPR certified. Therefore, the first response in an emergency would be to call 911.

We will not discriminate against nor require any conditions for care based on whether or not you have executed a Health Care Directive.

If you would like more information about obtaining a Health Care Directive, we can assist you or you may call your State Health Care Hotline at 1-800-369-7994 to obtain more information about a Health Care Directive.

Recover Care Privacy Notice / HIPAA

This notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please review it carefully.

As part of providing services to you, we will collect information about your health care. We need this information to provide you with quality services and to comply with certain legal requirements. This notice applies to all of the records of your care generated by an affiliate of Recover Care.

The law requires us to:

1. Make sure that information that identifies you is kept private;
2. Give you this notice of our legal duties and privacy practices with respect to information about you; and
3. Follow the terms of the Notice that is currently in effect.

How We May Use and Disclose Information About You

Listed below is a number of reasons or ways in which information about you might be disclosed. In each category we will explain what we mean and give an example. Not every use or disclosure in a category will be listed.

The ways we might disclose information include:

For Treatment

We may disclose information about you to any personnel at Recover Care or outside of Recover Care who are involved in your care. For example, your direct care staff may need to share information about your medications with your nurse.

For Payment

We may use and disclose information about you so that services may be billed and payment may be collected from you, an insurance company, or a government health program. We may also tell your health plan about a service you may receive to obtain prior approval or to determine whether your Plan will cover the treatment.

For Health Care Operations

We may use information about you to run our agency and to make sure you receive quality services, or to decide if we should change or modify our services.

As Required by Law

We will disclose information about you when required by federal state, or local law. For example, we may reveal information about you to the proper authorities to report suspected abuse or neglect.

To Avoid a Serious Threat to Health or Safety

We may use or disclose information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Military and Veterans

If you are a member of the armed forces, we may release information about you as required by military command authorities.

Worker's Compensation

We may release information about you for workers' compensation or similar programs.

Health Oversight Activities

We may disclose information to a health oversight agency for activities authorized by law. Examples are government audits, investigations, inspections and licensure.

Recover Care Privacy Notice / HIPAA cont.

Lawsuits and Disputes
If you are involved in a lawsuit or dispute, or if there is a lawsuit or dispute concerning your services, we may disclose information about you in response to a court or administrative order. We may also disclose information about you in response to a subpoena, discover request, or other lawful process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement
In certain situations, we may release information about you to law enforcement officials. For example, we might release information about you to identify or locate a missing person; about a death we suspect may be the result of criminal conduct; or in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description and of location of the person believed to have committed the crime.

Coroners, Medical Examiners and Funeral Directors
We may release information to a coroner or medical examiner to identify a deceased person or determine a cause of death. We may release information to funeral directors as necessary to help them carry out their duties.

National Security and Intelligence, Protective Services for the President and Others
We may release information about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

Correctional Programs
If you are an inmate or in the custody of a law enforcement officer, we may release information about you to the correctional institution or law enforcement official, for example, to provide you with health, to protect your health and safety or the health and safety of others.

Health Information About a Deceased Patient
We may communicate health information about a deceased patient directly to family members or others involved in the care of the patient unless it is contrary to the wishes of the patient prior to his/her death.

YOUR RIGHTS REGARDING THE INFORMATION ABOUT YOU
You have the following rights:
To Inspect and Copy your Recover Care Service Records, this usually includes medical and billing records, but may exclude some psychotherapy notes. To inspect and copy information in your record, you must submit your request in writing to the Administrator. We may charge a fee for the costs of copying, mailing or other costs related to your request.

An authorization is required for disclosure of psychotherapy notes, use of PHI in marketing and sales of PHI. You have the right to opt out of fundraising solicitations. You have the right to restrict disclosure of PHI to your insurance company, for any out-of-pocket item or service.

Recover Care Privacy Notice / HIPAA cont.

To Amend Your Records

If the information we have about you is incorrect or incomplete, you may make a written request to the Administrator to amend the information. You must include a reason that supports your request. We may deny your request if it is not in writing or does not include a reason to support the request.

We may also deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available make the amendment;
- Is not part of the information kept in our file;
- Is not part of the information you would be permitted to inspect and copy
- We believe that information is accurate and complete.

If you disagree with the denial, you may submit a statement of disagreement requesting a review. If you request an amendment to our record, we will include your request in the record, whether the amendment is accepted or not.

To Receive An Accounting of Disclosures

We will keep a log of disclosures made on or after April 13, 2003, other than disclosures for treatment, billing or health care operation. You have the right to request the list of disclosures. You must submit a written request to the Administrator. The request may not cover more than a six-year period.

To Request Restrictions

You may request a restriction on the disclosure of information about you for treatment, payment or health care operations. Your request must be in writing and made to the Administrator. Your request must tell us 1) what information you want to limit; 2) whether you want to limit our use, our disclosure or both; and 3) to whom you want the limit to apply. For example, you could ask that we not use or disclose information to a certain person about services you've received. We do not have to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To Request Alternative Ways to Communicate

You may request that we communicate with you about your services in a certain way or at a certain location. For example you can ask that we contact you only at work, or only by mail. Your request must be in writing, must tell us how you would like us to communicate with you, and it must be and sent to the Administrator. We will accommodate all reasonable requests.

To Receive a Paper Copy or Electronic Copy of this Notice

You have the right to receive a paper copy or an electronic copy of this notice. You may request either paper or an electronic notice from the Administrator.

ADDITIONAL RIGHTS UNDER THE LAW

State privacy laws may provide additional privacy protections. Any such protections will be attached in a separate State addendum to this Notice.

The organization is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices with respect to protected health information. We are also required to notify affected individuals following a breach of unsecured protected health information.

Changes to this Notice

We may change this notice in the future.

Thank you for allowing us to be a part of your care!

www.recovercare.org

952-230-6332

Client Name: _____ Effective Date: _____

SSN: _____ DOB: _____

Phone Number: _____ Email Address: _____

The purpose of this service plan is to establish agreement between the client, or client's representative, and the home care provider regarding services to be provided.

Release of information: I authorize any hospital, TCU, physician's office or other health agency where I have been a patient to disclose any part or all of my medical records, including any Health Care Directive to **Recover Care**. In addition, I authorize the release of part or all of my medical records to health care agencies and medical equipment vendors whose services may be required in conjunction with the services provided by **Recover Care**.

Contingency Plan in the Event Scheduled Services Cannot be Provided	
☐ Reschedule	☐ Client / Responsible Party will assume all cares
☐ Emergency primary contact will be contacted: Phone Number: _____	☐ Other
Additional Instructions	

Emergency Contact: The person(s) I have designated to be contacted by **Recover Care** in case of emergency, and to receive information, if any, are:

In case of emergency, please contact:

Name:	Relationship:
Cell Phone:	Home Phone/Other:
Email Address:	
Name:	Relationship:
Cell Phone:	Home Phone/Other:
Email Address:	
Name:	Relationship:
Cell Phone:	Home Phone/Other:
Email Address:	

Person who has authority to sign on my behalf in case of Emergency (POA):

Name:	Relationship:
Cell Phone:	Home Phone/Other:

Advance Directive

I understand that emergency services will be summoned during an emergency unless there is a signed physician's order in my record that reflects my wishes according to the Adult Health Care Decisions Act.

Current Declaration

☐ **Living Will / Health Care Directive** ☐ **DNR** ☐ **DNI** ☐ **NONE**

Service Cancellations: I understand **Recover Care** requires any request for schedule change or cancellation, twenty-four hours in advance, or I will be billed for my scheduled service time.

Personal Belongings/Property: I understand **Recover Care** is not responsible for my valuables or personal belongings, and is not responsible for items that are lost or damaged while **Recover Care** is providing care in my home.

Safe Environment: I understand I am required to ensure a safe and clean environment for **Recover Care** staff. I understand I am responsible to provide supplies necessary for adherence to infection control (i.e. trash bags, alcohol based sanitizer and / or antibacterial soap and paper towels). If unable to fulfill responsibility to provide supplies, **Recover Care** can supply necessities and bill primary payer.

Photograph Consent: I authorize **Recover Care** to use and publish my likeness or photo to conduct business activities in print and/or electronically. I understand that I can revoke this authorization at any time.

☐ Accept ☐ Decline Initials: _____

Use of Employee's Car: In rare cases, I understand my serviecs may require a **Recover Care** employee to transport me in his / her car. In In the event there is an accident I agree to hold Recover Care harmless. If I require transportation in an employee's car, I understand I will be billed $1.15 / mile.

☐ Accept ☐ Decline Initials: _____

Termination of Services: I understand **Recover Care** may terminate this service plan if:

- I do not provide a safe and clean environment for **Recover Care** employees.
- I do not meet payment obligations as stated in this service plan.
- **Recover Care** cannot sufficiently or safely meet my needs.
- Other reasons as identified in the Home Care Bill of Rights.

If **Recover Care** terminates this service plan, and I continue to need home care services, **Recover Care** shall provide me or my representative with a written notice of termination including effective date of termination, reason for termination, and a list of known licensed home care providers in my geographic area. If necessary, **Recover Care** will coordinate transfer of care to another home care provider, health care provider, or caregiver, as required by the Home Care Bill of Rights.

Billing & Payment: I understand all **Recover Care** services will be billed directly to the primary payer outlined in this service plan, and understand **Recover Care** does not accept any third-party payers. **Recover Care** bills for services after they are provided. I understand I will receive an invoice monthly, following the services provided. Payment will be expected within 14 days of the invoice date.

Purchases on My Behalf: I understand **Recover Care** employees may purchase household good (groceries, cleaning supplies, medication, etc.) on my behalf. The employee will provide me with receipts for all transactions and purchases paid with my funds.

Service Guarantee: The Recover Care Commitment. Recover Care will issue a credit for any inadequate service that is reported to a **Recover Care** employee, with report of service dates and times in which inadequate service was performed.

Permission to Communicate: I understand **Recover Care** will communicate about my health care needs, via email or voicemail. I understand these methods are not a secure form of communication. I give consent for **Recover Care** to communicate about my health care needs via email or voicemail messages.

☐ Accept ☐ Decline Initials: _____

Electronic Signatures: I understand that **Recover Care** staff use an electronic record system to document services rendered and that, from time to time, I may be asked to electronically sign documents in that system (e.g., to confirm the documented services were rendered). I consent to the use of my electronic signature in **Recover Care**'s system.

☐ Accept ☐ Decline Initials: _____

Permission to Enter Apartment: Recover Care is committed to respecting our clients' privacy. In an effort to ensure that our clients' privacy is protected, our employees will always knock on your apartment door prior to entering your apartment. However, if you do not answer your door when we come to check on you or when we have an appointment to provide services, we are requesting your written permission to enter your apartment with a key provided to us by the management of this site. If we do not have your written permission on file, we will only enter your apartment when you are able to open the door for us.

I give Recover Care staff permission to enter my apartment using a key in the event of an emergency or at times a staff member is scheduled to provide services.

☐ Accept ☐ Decline Initials: _____

Services Provided	Provided by	Description of Services	Frequency	Charge
☐ Initial Comprehensive Assessment	Registered Nurse	An individualized initial comprehensive assessment must be conducted, in person, by a registered nurse.	1 time at initiation of service	$125/visit
☐ Nursing Supervision	Registered Nurse	**A Nurse will perform monitoring visits:** ▪ For ongoing monitoring and reassessment via face-to-face visit or telecommunication	At least every 90 days after initial	$_____/visit
☐ Nurse Visit	RN/LPN	**An RN/LPN will see client:** ▪ Coordination of Care ▪ Visits as needed ▪ Upon change of condition, requiring reassessment		$25/15 – minutes
☐ Medication Setup	RN/LPN	A nurse will setup medications for clients requiring medication management services		$60/visit
☐ Medication Change	RN/LPN	If a medication(s) update is required before the regularly scheduled medication setup, a nurse will update medication.		$30/visit
☐ Scheduled HHA Visit	HHA	**A home health aide will assist with one or more of the following:** ▪ Assistance with dressing, grooming ▪ Toileting and incontinence care ▪ Assistance with transfers and exercise		$12/15-minutes
☐ Medication Assistance	HHA	A home health aide will assist client with taking medications by verbal cues		$12/15-minutes
☐ Bathing Assistance	HHA	A home health aide may assist clients with bathing or showering		$24/30-minutes
☐ Escort-in-House or Meal Delivery	HHA	A home health aide will provide an escort to meals, activities, or other within the building		$12/round-trip
☐ Escort-in-Community	HHA	A home health aide will accompany a client outside of the building for MD visits, shopping, etc.		$50/hour
☐ Laundry	HHA	A Recover Care employee will assist client with laundry		$12/load
☐ Foot Care	RN	Client will be assisted with foot care		$30/visit
☐ Homemaker Services	HHA	A Recover Care employee will assist with light housekeeping		$30/hour
☐ INR Draw	RN	A Recover Care employee will complete INR Draw		$30/visit
☐ Unscheduled Service	HHA	When a HHA responds to a client need that is not scheduled, regardless of the service type.	As Needed	$15/15-minutes
☐ Pet Care	Any Role	Assistance with pets		$15/15-minutes
☐ Mileage	Any Role	If client requires transportation he or she will be billed an additional charge per mile traveled.		$1.15/mile
☐ Other:				

Based on the RN comprehensive assessment, I understand that my estimated monthly cost is _____ per month.

I understand **Recover Care** requires a service deposit of 50% of my estimated monthly cost, totaling: _____. This will be reimbursed, or applied to outstanding balance, upon termination of services.

I will pay this via:

☐ **Check – Check # _____** ☐ **ACH** ☐ **Credit Card**

Primary Payer	
Name:	Relationship:
Phone:	Mailing Address:
Email Address:	

Secondary Payer	
Name:	Relationship:
Phone:	Mailing Address:
Email Address:	

Consent for care:
I authorize **Recover Care** staff to render home care services in my home as documented on my Service Plan. Services to be rendered by **Recover Care** have been fully explained to me. I understand that my Service Plan may change and that all changes will be discussed with me in advance. Instructions for my care have been explained to me and, as indicated in the Service Plan, will become my responsibility in the absence of home care staff.

☐ Accept ☐ Decline Initials: _____

Client rights and responsibilities:
I have read, received a copy, and acknowledge understanding of my rights under the State and Federal provisions in the Home Care Bill of Rights. I have received a copy of **Recover Care's** Client Handbook containing the Home Care Bill of Rights, contact information for the Office of Ombudsman and Compliant Process, information on Healthcare Directives, a copy of the HIPAA Privacy Notice and Statement of Home Care Services.

☐ Accept ☐ Decline Initials: _____

Certification:
I acknowledge I have had the opportunity to participate in the development of this service plan and agree with the conditions stated herein and certify that I am the client or the client's legal representative and am capable of executing the aforementioned conditions and accepting the terms. Further, I understand that this agreement can be revoked at any time by either party.

_____ _____
Print Client Name **Recover Care** Witness

_____ _____
Signature of Client or Legal Representative Date

Contact a Recover Care Representative 24 hours / day, 7 days / week at:
Recover Care Phone Number: (952) 230-6332
Recover Care Website: www.recovercare.org

Recover Care

Client Face Sheet

Client Name:	**DOB**:	**SS#**:
Admission Date:	**Phone Number**:	**Address**:

Advance Directives: ☐Full Code ☐DNR ☐N/A

Primary Diagnosis:	**Known Allergies**:	**Preferred Hospital**:
Physician Name:	**Physician Phone**:	**Physician Fax**:

Pharmacy Name:	**Pharmacy Phone**:	**POA Name**:	**POA Phone**:

Marital Status: ☐ Single ☐ Married ☐ Separated/Divorced ☐ Widowed - How long?

Lives: ☐ Alone ☐ With:	Primary Language:	Other Language:	Religion:

In Case of an Emergency Contact:

Primary Contact	☐*Check if same as POA*	**Secondary Contact**	
Relationship to Client		Relationship to Client	
Home Phone #		Home #	
Work Phone #		Work Phone #	
Cell #		Cell #	
E-mail:		E-mail:	
Address		Address	
City/State/Zip		City/State/Zip	

Other Information:

Recover Care

Authorization Request for Information

Release of information: I, hereby, authorize any hospital, TCU, physician's office or other health agency where I have been a patient to disclose any part or all of my medical records, including any Health Care Directive to **Recover Care**. In addition, I authorize the release of part or all of my medical records to health care agencies and medical equipment vendors whose services may be required in conjunction with the services provided by **Recover Care**.

_____ _____

Signature of Patient/Legally Authorized Representative Date

Please send requested information to Recover Care at:

- ☐ Fax #: _____
- ☐ Email: _____

Regarding the following client:

Name: _____ Date of Birth: _____

Requested Records:

☐ Discharge Summary	☐ Laboratory Report
☐ Emergency Room Report	☐ Pathology Report
☐ History & Physical	☐ Other: _____

Purpose of Release:

☐ Continuing / Transfer of Care	☐ Insurance	☐ Other: _____

_____ _____

Signature of Recover Care Staff Date

CLIENT NAME: _____ **ASSESSMENT DATE:** _____

SOC Human Systems Review

Vitals			
Temperature:	**Pulse:**	**Respiration:**	**Blood Pressure:**
Height:	**Weight:**	**Recent Gain/Loss? Yes ☐ No ☐ _____Lbs**	

Assistive Devices Used (Select all that apply)

☐ Glasses ☐ Hearing Aid(s) ☐ Dentures ☐ Oxygen ☐ Dressings
☐ Walker ☐ Wheelchair ☐ Electric Cart ☐ Cane ☐ Other: _____

Health History

Primary Diagnosis:

Secondary Diagnoses:

Recent Health Changes:

Allergies: (Medications/Foods/Environmental)

History of Falls:_____ 12months _____ 6 months _____ 3 months

Number of ER Visits in the past 12 months:	**Recent Hospitalizations:**

Vaccination Status:

Pneumonia vaccination received Yes ☐ No ☐ Date:_____
Flu vaccination received Yes ☐ No ☐ Date:_____

TB Status (if known): _____Any recent exposure to Communicable disease? Yes ☐ No ☐

History of: MRSA ☐ Yes ☐ No **VRE**: ☐ Yes ☐ No **C-Diff**: ☐ Yes ☐ No **Hepatitis**: ☐ Yes ☐ No

History of : Cancer

Other medical services involved (home care, social work, medical supplies etc.):

Family/Social Supports:

SOC Human Systems Review

Human Systems Review

Sensory and Communication

Problem *(Select all that apply)*	**Assessment**
☐ **Vision** ☐ Glaucoma ☐ Cataracts ☐ Surgery ☐ Macular Degeneration ☐ Legally Blind ☐ Other: _____	☐ Right Eye ☐ Left Eye Wear Glasses ☐ For reading ☐ all the time ☐
☐ **Hearing**	Hearing Aids Yes ☐ No ☐ Refuses ☐
☐ **Smell**	
☐ **Communication**	Aphasia Yes ☐ No ☐ Primary Language English ☐ Other: _____
☐ **Other: Taste/ Temperature Sensation**	

Mobility

Problem *(Select all that apply)*	**Assessment**
☐ Tremor ☐ Ataxia ☐ Contractures ☐ Amputation ☐ Fracture ☐ Other: _____	Gait/ Balance Normal ☐ Balance problem with ambulation ☐ Decreased muscular coordination ☐ Unstable Gait Pattern ☐ Immobile (bed or WC bound) ☐ Use of Devise: ☐ Cane ☐ Walker ☐ Wheelchair ☐ Sit to Stand ☐ Hoyer Lift High Fall Risk ☐ Yes ☐ No

Skin Integrity

Problem *(Select all that apply)*	**Assessment**
☐ Rash ☐ Wounds ☐ Skin Tears ☐ Itching ☐ Cellulitis ☐ Easily bruises ☐ Other:_____	Location: _____

Endocrine

Problem *(Select all that apply)*	**Assessment**
☐ Thyroid Disorder: ☐ Hypo ☐ Hyper ☐ Diabetes Last A1C:_____ ☐ Liver Disease ☐ Other: _____	Insulin ☐ Yes ☐ No Oral ☐ Yes ☐ No Diet Controlled ☐ Yes ☐ No Blood Glucose Monitoring: ☐ Independent ☐ Assistance Frequency: _____ Normal Range: _____ Parameters: _____

SOC Human Systems Review

Neurological

Problem *(Select all that apply)*	**Assessment**
☐ Stroke/ TIA's ☐ Paralysis ☐ Multiple Sclerosis ☐ Parkinson's ☐ Neuropathy: ☐Diabetic ☐Vascular ☐ Seizures ☐ Headaches ☐ Other: _____	Weakness; Right Side ☐ Left Side ☐ Upper Extremities ☐ Lower Extremities ☐ Paralysis: Right Side ☐ Left Side ☐ Upper Extremities ☐ Lower Extremities ☐ Weight bearing status: Full ☐ R ☐ L ☐ Weak ☐ R ☐ L ☐ Upper Extremity Strength: Full ☐ R ☐ L ☐ Weak ☐ R L ☐

Gastrointestinal

Problem *(Select all that apply)*	**Assessment**
☐ Heartburn ☐ Gastric Reflux ☐ Nausea/Vomiting ☐ Constipation ☐ Diarrhea ☐ Bowel Incontinence ☐ Ulcer ☐ G Tube ☐ J Tube ☐ Other: _____	

Nutritional Status

Problem *(Select all that apply)*	**Assessment**
☐ Difficulty Chewing ☐ Pain in mouth/teeth/gums ☐ Denture Fit Periodontal disease Issues with tongue ☐ Other: _____	
Appetite: Fluid Intake: Nutritional Supplement: Yes ☐ No☐ Intake of Caffeine: ☐ Intake of Alcohol: ☐	Good ☐ Fair ☐ Poor ☐ NPO ☐ Good ☐ Fair ☐ Poor ☐ NPO ☐ _____cups per day _____drinks per day/ week/ month
Sleep Pattern:	_____Hours per night Awake at _____am Bedtime at _____pm

Cardiovascular/Circulatory

Problem *(Select all that apply)*	**Assessment**
☐ Blood Pressure ☐ High ☐ Low ☐ Atrial Fibrillation ☐ Chest Pain ☐ Heart Attack ☐ Pacemaker ☐ Edema: ☐ Heart Disease ☐ CHF ☐ Other: _____	

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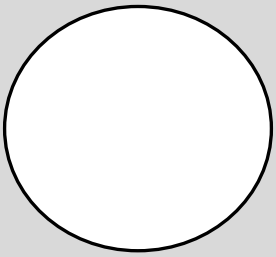
Genitourinary	
Problem *(Select all that apply)*	**Assessment**
☐Urinary Incontinence ☐ Partial ☐ Total ☐ HX UTI's ☐ Catheter: ☐ Yes ☐ No ☐ Other _____	Voiding Pattern: Who is responsible for managing catheter and supplies: _____ _____(Add to ITP)
Respiratory	
Problem *(Select all that apply)*	**Assessment**
☐ Shortness of Breath ☐ Chronic Lung Disease ☐ CPAP/ BiPAP ☐ Cough ☐ Pneumonia ☐ Emphysema ☐ Smoker/History of Smoking ☐ Asthma ☐ Other: _____	Lung Sounds: _____ Oxygen Use: ☐ Yes ☐ No: Reason for use: _____ _____Liters per minute _____Hour use per day Oxygen supply Company: _____ CPAP/ BiPAP Supply Company: _____ Who is responsible for monitoring use and ordering supplies: _____ _____(Add to ITP)
Musculoskeletal	
Problem *(Select all that apply)*	**Assessment**
☐ Neuropathy ☐ Fractures ☐ Arthritis ☐ Osteoporosis ☐ Back Problems ☐ Joint Replacement ☐ Other: _____	
☐ Pain	Location: Cause: Intensity: Scale of 1 to 10 (worst): _____ Relieved by:
Psychological/Cognitive (Select all that apply)	
Problem *(Select all that apply)*	**Assessment**
☐ Alert ☐ Oriented to: Person Place ☐ Time ☐ Forgetful ☐ Confused ☐ Anxiety ☐ Sad/Depressed (Depression screen) ☐ Paranoid ☐ Cognitive Impairment (SLUMS) ☐ Mental Illness ☐ Behavior Issues ☐ Wandering ☐ Agitation ☐ Other: _____	Level Of Cooperation: ☐ Cooperative ☐ Unpredictable Not Cooperative Diagnosis:

Evaluation / Baseline Assessment completed by:

_____ _____

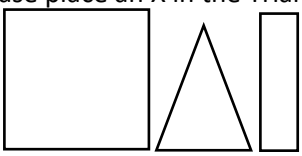
Signature of RN Date

SLUMS Cognitive Assessment

#	Question	Client Answer	Correct Answer	Points	Points Possible
1	What day of the week is it?		Today's day		1
2	What is the year?		Today's year		1
3	What state are we in?		Minnesota		1
4	Please remember these five objects. I will as you what they are later: Apple/ Pen / Tie / House / Car				
5	You have $100 to spend and you go to the store and buy a dozen apples for $3 and a tricycle for $20.				
	How much did you spend?		23		1
	How much do you have left?		77		2
6	Please name as many animals as you can in one minute.				0-4 = **0** 5-9 = **1** 10-14 = **2** 15+ = **3**
7	What are the five objects I asked you to remember?		Apple Pen Tie House Car		5
8		I am going to give you a series of numbers and I would like you to give them to me backwards. For example, if I say 42, you would say 24.			
	87		78		0
	648		846		1
	8537		7358		1
9	This is a clock face. Please put in the hour markers and the time at ten minutes to eleven o'clock				
	Hour markers okay	☐ Yes ☐ No			2
	Time correct	☐ Yes ☐ No	10:50		2

CLIENT NAME: _____

SOC Human Systems Review

10	Please place an X in the Triangle 				1
11	Which of the above figures is largest?		Square		1
12	I am going to tell you a story. Please listen carefully because afterwards I am going to ask you some questions about it. *"Jill was a very successful stockbroker. She made a lot of money on the stock market. She then met Jack, a devastatingly handsome man. She married him and had three children. They lived in Chicago. She then stopped work and stayed at home to bring up her children. When they were teenagers, she went back to work. She and Jack lived happily ever after."*				
	What was the female's name?		Jill		2
	When did she go back to work?		When the kids were teenagers		2
	What work did she do?		Stockbroker		2
	What state did she live in?		Illinois		2

Score = 0 **/30**

High School Education	Scoring	Less than High School Education
27-30	Normal	25-30
21-26	Mild Neurocognitive Disorder	20-24
1-20	Dementia	1-19

Evaluation / Baseline Assessment completed by:

_____ _____

Signature of RN Date

DEPARTMENT OF HEALTH SERVICES
DIVISION OF PUBLIC HEALTH
F-44763 (Rev 08/2015)

STATE OF WISCONSIN
Ch. 154 Wis. Stats
PO Box 2659
Madison, WI 53701-2659
(608) 266-1568

EMERGENCY CARE
DO NOT RESUSCITATE ORDER (DNR)

(See Page 2 for Background Information and Instructions on how to complete this form)

Only the Do Not Resuscitate (DNR) bracelet identifies to the Emergency Medical Service Responders that you are DNR. This form cannot be used to communicate your wishes to Responders. This form is a legal document and is used to request a DNR bracelet by the attending physician on the patient's behalf. This form also provides specific care instructions for health care providers responding to emergency calls. If this form is appropriately completed, emergency personnel should limit care as outlined.

The patient and the legal guardian or health care agent of an incapacitated patient have the right to revoke these restrictions on care at any time.

Emergency provider as appropriate will provide:	Emergency provider will NOT:
• Clear airway • Administer oxygen • Position for comfort • Splint • Control bleeding • Provide pain medication • Provide emotional support • Contact hospice or home health agency if either has been involved in patient's care, or patients attending physician	• Perform chest compressions • Insert advanced airways • Administer cardiac resuscitation drugs • Provide ventilator assistance • Defibrillate

☐ Male ☐ Female

Print Patient Name _____ Date of Birth _____

Patient's Address Street City State Zip Code

I / patient, legal guardian or health care agent understand this document identifies the level of care to be rendered to the patient by an emergency medical technician, first responder, or emergency health care facility personnel in situations where death may be imminent. I / patient, legal guardian or health care provider make this request knowingly and am aware of the alternatives as explained to by the attending physician. I / patient, legal guardian or health care agent expressly release all persons who will in the future provide medical care of any and all liability whatsoever for acting in accordance with this request. I / patient, legal guardian or health care agent is aware that this order can be revoked at any time by removing or defacing the identification bracelet or by requesting resuscitation.

SIGNATURE - Patient or Legal Guardian or Health Care Agent of an incapacitated patient (Circle title of who is signing this request) _____ Date Signed _____

Print Attending Physician's Name _____ Telephone Number _____

SIGNATURE - Attending Physician's _____ Date Signed _____

THE ABOVE SIGNATURES AND DATES ARE REQUIRED FOR THIS ORDER TO BE VALID AND ITS INTENT CARRIED OUT.

BACKGROUND INFORMATION AND INSTRUCTIONS FOR COMPLETING DO NOT RESUSCITATE (DNR) ORDER

I BACKGROUND INFORMATION

Cardiopulmonary resuscitation (CPR) is a procedure used after cardiac arrest in which cardiac massage, drugs, and artificial ventilation are used to restore breathing and circulation. It is standard medical practice to perform CPR on all persons found to be in cardiac or respiratory arrest in the absence of directives from an attending physician to withhold such action. However, patients may legally and ethically decline these treatments. The DNR order is used to implement the decision that CPR is not to be performed. This decision to limit CPR rests with the attending physician and his/her qualified patient, legal guardian, or health care agent as described in Chapter 154, Subchapter III of the Wisconsin Statutes. A qualified patient means a person who is at least 18 years old and to whom any of the following conditions applies:

1. The person has a terminal medical condition.
2. The person has a medical condition that if the person were to suffer cardiac or pulmonary failure, resuscitation would be unsuccessful in restoring cardiac or respiratory function or the person would experience repeated cardiac or pulmonary failure within a short period before death occurs.
3. The person has a medical condition that if the person were to suffer cardiac or pulmonary failure, resuscitation of that person would cause significant physical pain or harm that would outweigh the possibility that resuscitation would successfully restore cardiac or respiratory function for an indefinite period.

The bracelet is intended to communicate the existence of a "Do Not Resuscitate" order to the emergency medical personnel who may be summoned in the event of an emergency. In addition, it provides guidelines for comfort and supportive care short of CPR that may be administered by emergency personnel.

II GUIDELINES FOR COMPLETING FORM, ORDERING PLASTIC BRACELET, METAL BRACELET

After discussing treatment options the patient or the legal guardian or health care agent of the incapacitated patient, complete the DNR order, F-44763. The types of care to be rendered and withheld should be carefully explained to the patient, legal guardian or health care agent, and family members by the attending physician or the attending physician's designee before the form is signed. After the form is completed and signed, the attending physician or designee shall either affix the "Do Not Resuscitate" plastic bracelet to the patient's wrist or order a metal bracelet from StickyJ Medical ID Jewelry. This decision must be documented in the patient's medical record. It is recommended that this documentation include:

1. The rationale for the decision including, **qualifying medical condition**
2. The presence or absence of decision making capacity on the part of the patient

Two dated signatures are required for this document to be valid and its intent carried out.

1. Patient, legal guardian, or health care agent's signature and date signed
2. Attending Physician's signature and date signed by physician

The metal bracelet includes an emblem that displays an internationally recognized symbol "Staff of Aesculapius" along with the words "Wisconsin Do-Not-Resuscitate-EMS, and the qualified patient's first and last name on the back. Wisconsin DNR residents may provide StickyJ Medical ID Jewelry with other important health information to be engraved on the back of the bracelet at the time of ordering.

To order a metal bracelet include the following:

1. **A copy of the Wisconsin DNR form: signed by the attending physician and the patient, legal guardian or health care agent. The patient should receive a copy of the DNR Order Form. An original signed form or a legible photocopy or electronic facsimile is presumed to be valid.**
2. **Copy of the completed StickyJ Medical ID Jewelry order form https://www.stickyj.com/media/pdf/StickyJ_Wisconsin_DNR_Order_Form.pdf**
3. **Payment made out to StickyJ Medical ID Jewelry.**
4. **Mail to: StickyJ Medical ID Jewelry,** 1698 34th Street North, St. Petersburg Florida 33713.

III REVOKING AN EXISTING DNR ORDER

The patient, legal guardian or health care agent can revoke the DNR order by any of the following methods:

1. The patient, legal guardian or health care agent expresses to emergency personnel the desire that the patient be resuscitated.
2. The patient, legal guardian or health care agent defaces, or otherwise destroys the DNR bracelet.
3. The patient, legal guardian, or health care agent removes the DNR bracelet or another person, at the request of the patient, legal guardian, or health care agent removes the DNR bracelet.

The DNR order (and copies) should be torn up and the patient's attending physician should be notified of the revocation. Only the patient, legal guardian or health care agent may revoke an order issued under Chapter 154 Wisconsin Status. The DNR order is NOT revoked when an ambulance is called. Ambulance personnel will honor the DNR and will provide comfort care only.

Recover Care

5900 Green Oak Drive, #200
Minnetonka, MN 55343

Recurring Payment Authorization Form

Please complete the below form if you have chosen to have your monthly Recover Care payment deducted from your credit card, or directly from your bank account.

I authorize Recover Care to charge the credit/debit card or bank account below for the client, _____ on the 4th business day of each month for services from the prior month, and an initial service deposit of _____.

I understand if I choose to pay via credit card, a 3% service fee will be charged for each credit card transaction.

Please complete the information below with your method of payment:

Credit Card Information

◯ Visa ◯ MasterCard ◯ Discover ◯ American Express

Cardholder Name: _____ Account Number: _____

Exp. Date: _____ CVV code: _____

Cardholder Address: _____

Cardholder City/St/Zip: _____ Cardholder Phone: _____

Bank Information

◯ Checking ◯ Savings

Account Name _____ Billing Address _____

Bank Name _____ City _____

Account Number _____ State _____

Routing Number _____ Zip _____

My signature below authorizes Recover Care to regularly debit my credit card or bank account listed above each month, for the invoice amount. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Recover Care, of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. I understand and agree, as this is an electronic transaction, adequate funds must be available for withdrawal from my account by the payment due date. In the case of an ACH or Credit Card transaction being rejected for Non Sufficient Funds (NSF), I understand I may be charged applicable fees.

PRINTED NAME _____ **SIGNATURE** _____ **DATE** _____

I understand, if the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I understand that if I fail to make my monthly payments, my account will be due in full. I acknowledge that the origination of transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card, or bank account and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form.