Table of Contents

FORMS AND INSTRUCTIONS

110 - INTRODUCTION

This Appendix contains forms used in care coordination.

The forms are organized alphabetically by name. The form number follows the name of the form, as indicated on the Appendix 100 Table of Contents. Instructions for each form are placed immediately after the form.

When completing forms manually, use the following guidelines:

- Use ink.
- Correct entries by placing one line through the error and initialing. Do not use "white out", felt tip markers, or other materials to obliterate the error.
- Write legibly.
- Use standard medical abbreviations and symbols.

120 - FORMS REPRODUCTION

Area Agencies on Agency (AAAs) reproduce and use DHR CCSP forms as indicated in the Care Coordination Manual. AAAs reproduce forms from the original locally. AAAs request approval from the Division of Aging Services before changing the existing forms.

Division of Medical Assistance (DMA) forms are obtained from DMA, or the pharmacist.

NOTE: Providers are responsible for reproducing the CCNF found in the Provider Manual Index.

Georgia Department of Human Resources

Name of Individual/Consumer/Patient/Applicant

Date of Birth

IF AVAILABLE:

ID Number Used by Requesting Agency

ID Number Used by Releasing Agency

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby request and authorize:

(Name of Person or Agency Requesting Information)

(Address)

to obtain from:

(Name of Person or Agency Holding the Information)

(Address)

the following type(s) of information from my records (and any specific portion thereof):

for the purpose of:

I understand that the federal Privacy Rule ("HIPAA") does not protect the privacy of information if re-disclosed, and therefore request that all information obtained from this person or agency be held strictly confidential and not be further released by the recipient. I further understand that my eligibility for benefits, treatment or payment is not conditioned upon my provision of this authorization. I intend this document to be a valid authorization conforming to all requirements of the Privacy Rule and understand that my authorization will remain in effect for: (PLEASE CHECK ONE)

☐ ninety (90) days unless I specify an earlier expiration date here: (Date)

☐ one (1) year.

☐ the period necessary to complete all transactions on matters related to services provided to me.

I understand that unless otherwise limited by state or federal regulation, and except to the extent that action has been taken based upon it, I may withdraw this authorization at any time.

(Date)

(Signature of Individual/Consumer/Patient/Applicant)

(Signature of Witness) (Title or relationship to Individual)

(Signature of Parent or other legally Authorized Representative, where applicable) (Date)

USE THIS SPACE ONLY IF AUTHORIZATION IS WITHDRAWN

(Date this authorization is revoked by Individual)

(Signature of Individual or legally authorized Representative)

Form 5459 (Rev. 4-11-03) Previous versions are obsolete and should not be used.

Instructions
Community Care Services Program

AUTHORIZATION FOR RELEASE OF INFORMATION, FORM 5459

Purpose: This form is used to obtain permission from a CCSP applicant or client to share or secure information about the client.

Who Completes/When Completed: The care coordinator completes Form 5459 for information needed but not included on the Authorization For Release of Information and Informed Consent.

Instructions:
Explain the purpose of the form to the client, complete Form 5459 and ask the client to sign or indicate a witnessed mark **(X)**

1. Enter the name of the client/patient/applicant.

2. Enter the birth date of the client/patient/applicant.

3. Enter the ID number used by the requesting agency (if available)

4. Enter the ID number used by the releasing agency (if available)

5. Enter the name of the agency requesting information.

6. Enter the address of the agency requesting information.

7. Specify the information requested.

8. Specify the purpose of information requested.

9. Specify the duration of the authorization release (not to exceed one year)

10. Enter the date the client/patient/applicant signed the release.

11. Signature of the client/patient/applicant

12. Signature of witness, if client signs by mark (**X**)

13. Signature of parent or authorized representative if client/patient/applicant is incompetent/under age 18 or has a physical disability that prevents his signing.

Distribution: At each completion, place the original in the case record and send copies to each agency/person(s) holding information about the client.

Georgia Department of Human Resources
COMMUNITY CARE SERVICES PROGRAM
AUTHORIZATION FOR RELEASE OF INFORMATION
&
INFORMED CONSENT

_____ 1. This is to certify that the Community Care Services Program is hereby authorized to release necessary information including medical data to the agencies which will provide services to me as outlined in the CCSP Comprehensive Care Plan.

_____ 2. This is to certify that I choose to participate in the Community Care Services Program.

_____ 3. This is to certify that I choose Nursing Home Placement.

_____ 4. Discharge plan discussed with client/representative.

_____ 5. This is to certify that I participated in determining which services will be provided to me through the Community Care Services Program as ordered in the Comprehensive Care Plan.

_____ 6. ALL OF THE MEDICAL, SOCIAL AND FINANCIAL INFORMATION I HAVE PROVIDED IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

7. _____
SIGNATURE OF CLIENT OR CLIENT'S REPRESENTATIVE DATE

8. _____
SIGNATURE OF CCSP CARE COORDINATOR DATE

Instructions

Community Care Services Program

AUTHORIZATION FOR RELEASE OF INFORMATION & INFORMED CONSENT

Purpose: This form allows care coordinators to release necessary information including medical data to the agencies that will provide services to the client. It also serves as the client's acknowledgment of information received regarding the CCSP, and indicates whether the client chooses CCSP or Nursing Home Placement.

Who Completes/When Completed:

- At initial assessment, the RN completes the form.
- At reassessment, the care coordinator completes items 1, 4, and 5 and other applicable items.
- At CCP Review, the care coordinator completes item 5 and other applicable items.

Instructions:

1. Client initials in the space provided allowing the care coordinator to release necessary information to the agencies which will provide his/her services.

2. Client initials if he/she chooses to participate in the CCSP.

3. Client initials if he/she chooses Nursing Home Placement.

4. Client initials confirming that discharge plan(s) have been discussed with client/representative and care coordinator.

5. Client initials that he/she has received an opportunity to provide input in determining services which will be provided by CCSP as ordered in the CCP.

6. Client initials that all medical, social and financial information provided is true and complete to the best of their knowledge.

7. Client or representative signs and dates form.

8. Care coordinator signs and dates form.

Distribution: At initial assessment and reassessment, send a copy to providers. Place the original in the case record.

CARE COORDINATION COMPLAINT LOG

Date	Provider Name	Provider contact/#	Nature of Complaint: Health, safety, welfare issues, Abuse, neglect, exploitation, Missed visits, Staff not performing duties., Insufficent staff, Lack of RN Supervision , etc	Client	Caller	Care Coordinator	CC Intervention requests Plan of Correction	CC Comments	CC Accepts Plan of Correction

Instructions
Community Care Services Program

CARE COORDINATION COMPLAINT LOG

Purpose: Care coordinators are responsible for follow up on provider complaints. The log has been developed as a quality improvement tool to assess timely follow up and resolution of complaints. It also provides an opportunity for care coordinating agencies and AAAs to analyze the number and nature of complaints to determine possible trends.

Who completes/When completed:

Care coordinators enter information into the log in Microsoft Excel. The care coordination manager reviews logs monthly to assess for trends in complaints or providers.

Instructions:

1. Date: Enter the date the complaint was received.

2. Provider Name: Enter the name of the provider the complaint is being made against.

3. Provider Contact/#: Enter the name/phone number of the person contacted regarding the complaint.

4. Nature of Complaint: State briefly the details concerning the complaint..

5. Client Name: Enter client's name.

6. Caller: Enter name of person making complaint and relationship to client.

7. Care Coord: Enter the name of the assigned Care Coordinator.

8. CC Interventions: Enter intervention(s) such as Call to Provider Agency, Letter to Provider Agency, Meeting of Concerned Parties, Removed from Rotation Log per AAA Instructions, or you may specify another intervention in the space.

9. CC Comments: Enter information about follow up activities.

10. Referral: Enter referral(s) such as AAA, ORS, APS, OMB, DAS or you may specify another intervention in the space.

11. AAA Interventions: Enter intervention(s) such as Call to Provider Agency, Letter to Provider Agency, Meeting of Concerned Parties, Letter to DAS for clarification/issues, Removed Provider from Rotation Log, Address(ed) at Network Meeting or you may specify another intervention in the space.

12. AAA Comments: Enter information received from AAA.

13. Outcome/Date: Enter resolution and date.

Note: Record detailed information about follow up and interventions in case notes.

Distribution: Send a copy of the Care Coordination Complaint Log to the AAA and your assigned care coordination specialist at DAS monthly.

Rev. 9/05

Community Care Services Program

CARE COORDINATOR′S PRIOR AUTHORIZATION REQUEST TRANSMITTAL (CCT)

The care coordinator completes this form and submits it with each prior authorization and prepayment request (DMA-80).

1. Name of client _____

2. Client Medicaid number _____

3. Date client entered service _____

4. Total cost to CCSP, in current calendar year to date _____

5. Projected cost to CCSP for balance of current calendar year _____

6. Total estimated cost to CCSP for current calendar year _____

7. Client cost share (if applicable)_____
8. Provider requesting PA ( ) PPR ( ) _____

9. Provider Number _____

10. Will client require additional PARs? Yes_____ No _____

    If "Yes", for how many months _____

11. Number of prior approvals_____ Number of prepayment reviews_____
    approved by the Division of Aging Services in current calendar year

12. Comments _____

_____
_____

Date _____ PSA _____

Care Coordinator_____ Telephone (_____)_____

rev. 12/99

Instructions

Community Care Services Program

CARE COORDINATOR′S PRIOR AUTHORIZATION REQUEST TRANSMITTAL (CCT)

Purpose: This form calculates the actual cost of services rendered for the client's care through the date of the DMA-80 request and estimates cost of care for the remainder of the calendar year.

Who Completes/When Completed: The care coordinator completes this form to accompany each DMA-80 request and copy of pended SAF to the Division of Aging Services for approval.

Instructions:

1. Enter client's name (last name, first, middle initial).

2. Enter client's Medicaid number. (Be sure Medicaid number on DMA-80 is correct.)

3. Enter month, day and year client entered service.

4. Enter cost to CCSP program for client for the current calendar year, including amount of the DMA-80 request submitted with this transmittal.

5. Enter estimated cost to CCSP program for client for remainder of calendar year.

6. Enter total cost to date plus projected cost.

7. Enter amount of MAO client's cost share, even if amount is "O."

8. Indicate by (✓) if this PAR is a prior authorization or prepayment review request and indicate by name provider who is making request.

9. Enter provider ID number from DMA-80 form in Section 11.

10. Indicate (✓) □ . yes or □ . no.
    If yes, enter number of months client is anticipated to exceed monthly cost cap.

11. Enter number of PARs, excluding DMA-80 being submitted with this transmittal, approved by the Division of Aging Services in this calendar year.

12. Comments: clarify information about client not stated or explained on DMA-80.

Care coordinator: Signature of care coordinator completing transmittal.

PSA/Care coordinator (CC): Enter planning and service area code and code assigned to care coordinator completing transmittal.

Date: Enter date transmittal was completed, signed by care coordinator and mailed.

Telephone number: Enter care coordinator's area code and telephone number.

Distribution: Send original with DMA-80 and pended SAF to Division of Aging Services for approval. File copy in client's case record

Case Notes

Date Range Selected
From: 7/21/2004 **To:** 7/21/2004

Jane Doe 001-00-0001

7/21/2004 Note By: Type Contact Telephone Time in Minutes: 5
TC

Ms. Doe called to inquire about her services start date.

Instructions

Community Care Services Program

CASE NOTES

Purpose: Case notes are used to record comprehensive notations about the client's entire process from beginning to end.

Who Completes/ When Completed: The care coordinator uses CHAT to record client activities on case notes in order of occurrence.

Instructions:

Description:	Enter a brief description of the notation. For example: Home Visit (HV), Office Visit (OV), Telephone (T), Written Correspondence (W), Community Care Notification Form (CCNF), Initial Assessment (IA), Reassessment (R), or Comprehensive Care Plan Review (Review).
Date:	Enter the date in the space directly below the description, clicking in that space will automatically enter today's date.
Care coordinator:	Enter the initials of the care coordinator who is entering the notation in the space to the right of the date.
Notation:	Enter as much detail as needed about the current event/action.

Information on this form is NOT shared with other agencies and can only be obtained with a subpoena.

CCSP Care Coordination ADH checklist

Client _____ **Date** _____ **CC Coordinator**_____

Name of ADH _____ ☐ **Level 1** ☐ **Level 2**

1. <u>Physical Environment</u> (1103.1)

a. ☐Yes☐No Environment clean, odor free?
b. ☐Yes☐No Lighting is adequate for client?
c. ☐Yes☐No Temperature is comfortable for client?
d. ☐Yes☐No Environment accessible to client?
e. ☐Yes☐No System in place to monitor client's whereabouts?

f. Comments_____

2. <u>Supervision of client care</u> (1103.5)

a. ☐Yes ☐No RN supervisory visit completed <u>monthly</u>?
b. ☐Yes ☐No ☐N/A Client changes/problems documented with appropriate follow up?
c. ☐Yes ☐No ☐N/A Documentation of other services being rendered?
d. ☐Yes ☐No Documentation of client participation in therapeutic activities?
e. ☐Yes ☐No Client satisfied with services/activities provided?

f.Comments_____

3. Documentation of <u>medications</u> (1103.4)

a. ☐Yes ☐No Prescription label matches medication sheet?
b. ☐Yes ☐No Med sheets signed by RN supervising medication administration?
c. ☐Yes ☐No ☐N/A Documentation of missed medications, reason and corrective action?
d. ☐Yes ☐No Client medications under lock and key?

e.Comments_____

4. <u>Staffing</u> (1104.2)

a. ☐Yes ☐No RN or LPN on site when CC visit made?
b. ☐Yes ☐No RN available if not present during visit?
c. ____ # staff present during visit d. ____ # participants present during visit

e. Comments_____

5. <u>Other Service Providers</u> (1103.6)

a. ☐Yes ☐No Documentation of evaluation, re-evaluations and progress notes in client record?

b. Comments_____

6. <u>Client condition</u>

a. ☐Yes ☐No Client and clothing clean?
b. ☐Yes ☐No Client condition matched documentation in RN supervisory note?

c. Comments_____

Instructions
Community Care Services Program

CARE COORDINATOR CHECKLIST FOR ADH

Purpose: This form is used as a checklist to assess the facility and client care in ADH.

Who Completes/When Completed: The care coordinator completes annually at the time of CCP review or reassessment.

Instructions:

1. Physical Environment
    a. Indicate if environment is clean and well-maintained.

    b. Indicate if lighting is adequate for reading and client activities.

    c. Indicate if temperature is appropriate for client (70-75 degrees F. during winter months and 80-85 degrees F during summer months)

    d. Indicate if environment accommodates client's mobility, transfer, and handicapped access if required.

    e. Specify if a system is in place to monitor client's whereabouts when outdoors or away from site with family or friends.

    NOTE: Monitoring may include sign out book, door alarm, observation by staff, or other.

    f. Use this section to clarify any of the above.

2. Supervision
    a. Specify if supervisory visits are within the standard.

    b. Indicate whether medical, mental, emotional or behavioral changes have been identified and follow up in the clinical record.

    c. Indicate if documentation of other services client may be receiving.

    NOTE: This may include skilled nursing, therapy services such as PT, OT, ST, hospice, or other.

    d. Indicate if client participates in the therapeutic activities as identified on provider care plan.

    e. Enter client's response regarding satisfaction with services.

    f. Use this section to clarify any of the above.

3. Medications
    a. Specify client name, medication, dosage and frequency on medication package/bottle label matches client medication sheet.

    b. Note if client medication sheets are signed by RN.

    c. Indicate if medication sheets show documentation of any missed medications and action taken by staff.

    d. Indicate if client's medications are under lock and key.

    e. Use this section to clarify any of the above.

4. Staffing
    a. Specify if the RN or LPN was present during visit.

    b. Determine if RN is available off site if not present during visit.

    c. Enter number of staff present.

    d. Enter total number of participants present.

    e. Use this section to clarify any of the above.

5. Other Service Providers
    a. Determine if other provider(s) documentation is in the client record regarding evaluation, progress notes, re-evaluation, discharge plan, or other.

    b. Use this section to clarify above.

6. Client Condition
    a. Indicate if client and clothing are clean.

    b. Indicate if documentation in clinical record accurately reflects client's current status.

    c. Use this section to clarify any of above

NOTE: Discuss concerns about client care and/or physical environment with Lead Care Coordinator and/or report to DAS/CCSP Care Coordination Specialist and Provider Specialist assigned to your area. If you have answered **no** to any of the checklist question, document action taken in case notes.

Reference: CCSP General Manual
ADH Provider Manual
Distribution: File original in care coordination agency's client record and copy to binder under specific provider.

CCSP Care Coordination ALS checklist

Client _____ Date _____ Care Coordinator_____

Name of ALS _____ Type ___Family ___Group

Name of Provider Agency if Family Model_____

1. General Information

a. Provider license is posted and current for _____# clients ☐Yes ☐No
b. Total # clients living at ALS _____ c. _____#CCSP clients
d. # staff present at time of CC visit _____ e. Staff job title(s)_____
f. Is the phone number for the Ombudsman displayed? ☐Yes ☐No

g.Comments:_____

_

2. The facility provides a safe, clean homelike environment for its residents (1203.2)

a. ☐Yes ☐No Building/client room temperature comfortable? *(no lower than 70º or higher than 75º in winter; 80º or below in summer)*
b. ☐Yes ☐No Lighting in facility/client room adequate?
c. ☐Yes ☐No Client's room is neat, clean, odor-free and in good repair?
d. ☐Yes ☐No Environment accessible for client?
e. ☐Yes ☐No Furnishings are in good repair?
f. ☐Yes ☐No ☐N/A Client's assistive device(s) available and in good repair?
g. ☐Yes ☐No Facility has system to monitor client's whereabouts?

h. Comments: _____

3. Supervision of client care (1203.4 group ALS/1253.6 family model ALS) Documentation of face-to- face RN supervisory visit 2 times per month with a minimum of 14 days between visits (can alternate RN with every other LPN supervisory visit).

a. ☐Yes ☐No ☐N/A Supervisory visits completed 2 times each month with 14 days between?
b. ☐Yes ☐No ☐N/A Client changes/problems documented with appropriate follow up?
c. ☐Yes ☐No ☐N/A Documentation of any additional services being rendered?
d. ☐Yes ☐No Client satisfied with assistance provided by ALS staff?

e. Comments _____

_____

_____

4. Documentation of medications (1203.7 C Group ALS/1253.9 C Family Model ALS)

Client record shows:
a. ☐Yes ☐No Client name and medication on prescription label matches medication sheet?
b. ☐Yes ☐No Med sheets signed by RN supervising medication administration?

c. ☐Yes ☐No ☐N/A Documentation of missed medications, reason and corrective action?
d. ☐Yes ☐No Medications are under lock and key?

e. Comments_____

_____

_____

5. Client condition

a. ☐Yes ☐No Client and clothing clean?
b. ☐Yes ☐No Client condition matches documentation in progress notes?

c.Comments:_____

6. Client Incident reports

a. Any incident reports since last CC visit? (#/date of incident reports) ☐Yes ☐No ☐N/A

_____

_____

_____

b. Documentation for each incident and action taken in client record? ☐Yes ☐No

c. Has the facility documented a pattern on incident reports or elsewhere in client record? ☐Yes ☐No

d. CC identification of patterns or trends in review of all incident reports? ☐Yes ☐No

☐ Time of day ☐ Place ☐ Caregiver ☐ Cause _____

Comments: _____

e. Did client have any incidents (falls, injuries) but no incident report was completed? ☐Yes ☐No

Provider reason for incident report not being completed _____

_____

f. CC action plan to reduce/prevent client injury:

☐ See Service Evaluation ☐ See Case Notes

☐ Other_____

7. Report of findings:

Person reported to: _____Agency _____ Date _____

Comments: _____

_____

_____

Instructions

Community Care Services Program

CARE COORDINATOR CHECKLIST FOR ALS

Purpose: This form is used as a checklist to assess the facility and client care in ALS.

Who Completes/When Completed: The care coordinator completes at each CCP review and reassessment.

Instructions:

1. **General Information**
   a. Check appropriate box after reviewing provider license.

   b. Enter number of clients living in home.

   c. Enter how many of the clients are CCSP clients.

   d. Enter number of staff present.

   e. Enter job title of staff present. Trained direct care staff must be present.

   f. Note presence of Ombudsman poster/phone number in area accessible to residents.

   g. Use comment section to clarify any of the above.

2. **Facility**
   a. Indicate if appropriate temperature in common areas and client room.

      NOTE: PCH rules and regulations require residential areas to be no lower than 70 degrees F. or higher than 75 degrees F. in winter months during waking hours and no higher than 80 degrees F. in summer months. Mechanical heating or cooling devices are required to maintain these temperatures.

   b. Indicate if lighting is sufficient for reading and other activities (60 watt minimum).

   c. Indicate if client room is appropriately maintained and furnished.

   d. Specify if environment accommodates client's mobility, transfer and handicapped access if required.

   e. Indicate if furnishings throughout the common areas and client's room are in good repair.

f. Indicate if client's assistive device is readily available and in safe condition.

g. Indicate if appropriate system(s) in place to monitor client's whereabouts 24/7 including supervision of clients who are cognitively impaired.

NOTE: This may include a sign out book, door alarms, personal monitoring systems such as Wandergard or Watchmate used to monitor client when outside building or away from facility with family or friends. If the client has cognitive impairment, document the monitoring system in place to prevent elopement or entry into unsafe areas.

h. Use comment section to clarify any of the above.

3. Supervision

a. Specify if supervisory visits are within the standard (twice monthly with a minimum of 14 days between visits).

NOTE: The provider is not required to provide RN supervisory visits for a CCSP client enrolled in a Medicare/Medicaid hospice program. N/A may be also be appropriate for residents who are hospitalized, in a skilled facility for short term rehab or on leave from the ALS.

b. Indicate whether medical, mental, emotional or behavioral changes have been identified and follow up in the clinical record.

c. Indicate provider documentation of other services client may be receiving. This may include skilled nursing, therapy services such as PT, OT, ST, hospice or other services.

d. Enter client's response regarding satisfaction with services.

e. Use comment section to clarify any of the above.

4. Medications

a. Specify if client name, medication, dosage and frequency on medication package/bottle label matches client medication sheet.

b. Note if client medication sheets are signed by RN.

c. Indicate if medication sheets note any missed medications and action taken by staff.

d. Indicate if client's medications were under lock and key.

e. Use comment section to clarify any of the above.

5. Client Condition

a. Indicate client and clothing are clean.

b. Indicate documentation in clinical record accurately reflects client's current status.

c. Use comment section to clarify any of above.

6. Incident reports

a. Review clinical record for documentation of any incidents (falls, injuries, elopement, other).

b. Review clinical record for documentation of staff follow up for each incident.

c. Document any pattern or trend identified by staff and corrective action taken.

EXAMPLE: Incident reports indicate client has fallen three times in bathroom during night. Corrective actions might include: leave light on in bathroom at night, leave bathroom door open at night, use of alarm system at night to advise staff that client is out of bed, or every 4 hour toileting schedule at night.

d. Document patterns/trends determined by Care Coordinator after reports reviewed.

e. Indicate incident(s) not documented and provider reason for absence of documentation of incident(s) and follow up.

f. Indicate location of care coordinator documentation of plan to reduce or prevent client incidents/injury.

NOTE: Discuss concerns about client care and/or physical environment with Lead Care Coordinator and/or report to DAS/CCSP Care Coordination Specialist and Provider Specialist assigned to your area. If you have answered **no** to any of the checklist questions, document action taken in case notes.

Report Provider compliance or client Health and Safety complaints directly to Office of Regulatory Services at 404-657-5726, 404-657-5728 or 1-800-878-6442

Reference: Rules and Regulations for Personal Care Homes, Chapter 290-5-35
CCSP General Manual
ALS Provider Manual

Distribution: File original in care coordination agency's client record and copy to binder under specific provider.

Community Care Services Program

CLIENT REFERRAL FORM

1. Date of referral _____
2. Referral source_____ Telephone (____)_____
3. Is client aware of CCSP referral? Yes _____ No _____
4. Has client indicated an interest in receiving CCSP services? Yes_____ No_____
5. Is client interested in other resources if CCSP is not appropriate or available?
   Yes_____ No _____
6. Client's name_____Telephone (____)_____
   Address _____
   Street, Route, Apt. # _____ City _____ Zip _____ County _____
   Date of birth _____ Age _____Marital Status _____
   Lives alone Yes _____ No _____Monthly income _____
   Social Security # _____Medicaid # _____
   Medicare # _____
7. Contact person_____Relationship _____
   Address _____ Telephone (____)_____
8. Physician _____ Telephone (____)_____
   Address _____
9. Major health problems _____
10. What is needed from CCSP? _____
11. Is client now receiving services from other sources? Yes _____ No _____

    If Yes, what are the services? _____
    _____
    From what agencies?_____
    _____
12. Directions to client's house_____
    _____
    _____

Instructions
Community Care Services Program

CLIENT REFERRAL FORM

Purpose: To provide information to the AAA/Care Coordination Intake and Referral Unit to assure that an eligible applicant for CCSP receives CCSP and/or other appropriate services as quickly as possible. This form is a sample form for use by agencies or individuals to use when making referrals to the CCSP.

Who Completes/When Completed: An individual or agency outside CCSP, such as the client/client representative or a provider when referring an individual to the CCSP.

Instructions:

1. Enter the date the form is completed and mailed or faxed by an outside person to the AAA/care coordination unit.

2. Enter the name of the agency and person making the referral. That agency contact person's telephone number is listed in case further information is needed.

3. Check (✓) the appropriate space if individual is not aware of being referred.

4. Check (✓) the appropriate space to indicate whether or not individual is interested in receiving CCSP services.

5. Check (✓) the appropriate space if individual is/is not interested in being referred to other services if CCSP is not appropriate or available.

6. Enter individual information, providing data which assists the AAA/care coordination staff in their efforts to contact and get the individual into service.

7. Identify the contact person for the individual being referred. The AAA/care coordination staff may need the name, address, telephone number, and relationship in order to get or verify information or to set up an appointment for a visit.

8. Enter the name, address, telephone number, including area code, of the individual's physician.

9. Document the individual's major health problems.

10. Record what the individual says is wanted or needed from CCSP or other appropriate services.

11. To prevent duplication of effort and to make sure the appropriate individuals get into CCSP, or receive other appropriate services, identify current services and who is providing services.

12. The care coordination unit will need accurate directions to the individual's home in order to complete the assessment.

Distribution: The Client Referral Form is sent to the AAA/care coordination Intake and Referral Unit.

Community Care Services Program

CLIENT REFERRAL FORM - HOME DELIVERED MEALS

Date _____

SSN:_____

Client Name_____
Client Address_____
_____
_____

Meal Delivery Instructions

Number per day M__T__W__T__F__S__S__
Days per week M T W T F S S
(Please circle specific days for meals)

Type of Meal: __Regular ___Modified ___ Special ___Alternative(explain)

__ADA (how many calories)_____

Nutrition Education and Counseling Needs:
_____
_____
_____
_____
_____

Special Instructions/Notations:
_____
_____
_____
_____
_____

Comments:
_____
_____
_____

Care Coordinator: _____

Telephone: (_____)_____

Instructions
Community Care Service Program

CLIENT REFERRAL FORM- HOME DELIVERED MEALS

Purpose: The Client Referral Form is used to initiate Home Delivered Meals (HDMs) from the home delivered meals provider on behalf of the CCSP client. The form contains information needed by the HDMs provider regarding the client's condition, dietary needs and specific instructions.

Who Completes/When Completed: The care coordinator completes this form when:

- ordering HDM service and
- reporting changes.

Instructions:

Enter the clients name, social security number and the date of the referral.

Indicate the number of meals ordered per day.

Circle the specific days of the week that the meals are to be delivered.

Indicate the type of meal required by the client. Therapeutic meals must have physician's orders on the LOC page.

Indicate any nutrition education and counseling needs of the client.

Indicate any special instructions/notations such as limitations which might impact the delivery of the meal. For example the client has arthritis and is slow to answer the door, or client is very hard of hearing- KNOCK LOUDLY.

Indicate any other additional comments that may be helpful to the provider, such as instructions to the home etc.

Enter name and phone number of the care coordinator.

Distribution: The care coordinator completes this form and sends it to the home delivered meals provider. A copy of the form is kept in the client's case record.

Program: _____

CCSP Client Registration Report for AIMS

☐ New Assessment ☐ Reassessment

Basic Information:

1.SSN 1-00-0001

2a.Last Name: Doe 2b.Suffix: _____ 2c. First Name: Jane 2d.Middle Name: _____

3a. Residential Address: _____ 3b. Additional Address Information: _____

3c. City: _____ 3d. State: GA 3e. Zipcode: _____

4. Mailing Address: ☐ Uncheck if Mailing Address is Different

4a.Mailing Address: _____ 4b. Additional Address Information: _____

4c.City: _____ 4d. State: GA 4e. Zipcode: _____

5.Medicaid #: _____ 6.Medicare #: _____ 7.County: _____

8.Gender: ☐ Male ☐ Female 9.Phone #: _____ 10.DOB: _____

11.Marital Status
- ☐ Divorced
- ☐ Married
- ☐ Never Married
- ☐ Other: _____
- ☐ Separated
- ☑ Unknown
- ☐ Widow/Widower

12.Race/Ethnicity
- ☐ Asian/Pacific Islander
- ☐ Black (not Hispanic)
- ☐ Hispanic
- ☐ Other: _____
- ☐ Native American
- ☑ Unknown
- ☐ White (not Hispanic)

13.Living Arrangement
- ☐ Alone
- ☐ Group Setting with Non-Relatives
- ☐ Transient/Homeless
- ☐ With Child
- ☐ With Domestic Partner
- ☐ With Others Not Spouse/Child
- ☐ With Spouse Only
- ☐ With Spouse and Others
- ☐ Unknown

14.Language Spoken:
- ☐ African Generic
- ☐ Chinese
- ☐ English
- ☐ Farsi
- ☐ French
- ☐ German
- ☐ Hindi
- ☐ Italian
- ☐ Japanese
- ☐ Laotian
- ☐ Other: _____
- ☐ Norwegian
- ☐ Russian
- ☐ Spanish
- ☐ Vietnamese

15.Education Level:
- ☐ 1 - Completed 8th grade or less
- ☐ 2 - Completed 9th-11th grade
- ☐ 3 - Completed 12th grade
- ☐ 4 - 1 - 3 years college
- ☐ 5 - 4 years college
- ☐ 6 - over 4 years college
- ☐ Unknown

16.Number in household: 0 17.Gross Annual Income $: _____ 18. Economic Need Category _____

19. ☐ Veteran

20. ☐ Disability

21.Referred by:
- ☐ Area Agency on Aging
- ☐ DFCS
- ☐ Family Member
- ☐ Friend
- ☐ Home Health Agency
- ☐ Hospital/Health Care Facility
- ☐ Other Client
- ☐ Other Health Professional
- ☐ Other Service Professional
- ☐ Primary Caregiver
- ☐ Primary Care Physician
- ☐ Self
- ☐ Social Security Office

22.Referral Date: _____

23.How did you hear about us?:
- ☐ Brochure
- ☐ Educational Session
- ☐ Health Fair
- ☐ Internet
- ☐ Medicare Publication
- ☐ Newspaper/Magazine
- ☐ Other
- ☐ Radio/T.V.
- ☐ Social Security

24. Care Coordinator _____

Version 3.04 = Minimum Required Data Entr

Additional Information:

1. Data Entry Initials: _____
2. Date: _____
3. Provider: _____
4. Provider Site: _____

Program: _____

CCSP Client Registration Report for AIMS

☐ New Assessment ☐ Reassessment

Client Assessment Information:

1. Assessment Date: 1/23/2004

2. Program:
- ☐ AoA Demo Grant
- ☑ CCSP
- ☐ Caregiver
- ☐ HCBS

3. Type of Assessment:
- ☐ 6 Month Followup Assessment
- ☐ Initial Assessment
- ☐ Reassessment
- ☐ Other
- ☐ Prior to discharge
- ☐ Return from Hosital

4. Assessed By: _____

5. Diagnosis:

Congestive Heart Failure 428

Dementia other than Alzheimer's disease 294.8

Arthritis 716.9

Thyroid disease (hyper or hypo) 246.9

6.Number of Prescribed Medications _____

7. Over the Counter Medications _____

Nutritional Status

8. NSI Checklist Score (0-21): _____

9. ☐ Nutrition Level 1 Screening Done:

10.Medical Foods:
- ☐ Do Not Know
- ☐ Not Needed
- ☐ Theraputic Diet
- ☐ Modified Diet
- ☐ Supplement

DON-R/Functional Assessment

NAPIS Report

11.Total A: _____ 12.Total B: _____ 13.Total C: _____ 14.Total D: _____ 15.Total No. ADLs: _____ 16.Total No. IADLs: _____

Scores

17. MMSE: _____

18. LOC Date: _____

19.Eligibility Type:
- ☐ MAO
- ☐ PMAO
- ☐ Other
- ☐ SSI

20. Advanced Assessment:
- ☐ Caregiver Assessment
- ☐ Depression Assessment

Version 3.04 = Minimum Required Data Entr

Jane Doe

Additional Information:

1. Data Entry Initials: _____
2. Date: _____
3. Provider: _____
4. Provider Site: _____

Instructions
Community Care Services Program

CLIENT REGISTRATION REPORT FOR AIMS

Purpose: The Client Registration Report for AIMS provides the mandatory information for entering client data in AIMS.

Who Completes/When Completed: The care coordinator/CHAT completes the fields listed below for client registration in AIMS. Only highlighted fields are needed for AIMS registration. The care coordinator registers the client after brokering services. Care coordinators register clients in AIMS within 3 business days of brokering services to CCSP.

Instructions:

Complete only the numbered items below to enter AIMS data.

1. SSN: CHAT automatically enters the data in this field based on data entered in other fields.

2. Name: CHAT automatically enters the data in this field.

3. Residential address: CHAT automatically enters the data in this field.

4. Mailing address: The care coordinator writes the mailing address. If the address is the same as the residential address, write the word "same as residential" on the line.

5. Medicaid #: CHAT automatically enters the data in this field.

7. County: CHAT automatically enters the data in this field.

8. Gender: CHAT automatically enters the data in this field.

9. Phone: CHAT automatically enters the data in this field.

10. DOB: CHAT automatically enters the data in this field.

11. Marital Status: CHAT automatically enters this data into field.

12. Race/Ethnicity: CHAT automatically enters the data in this field.

13. Care Coordinator: CHAT automatically enters the data in this field.

14. Assessment/LOC date: The care coordinator writes the initial LOC date in this field. The care coordinator updates the LOC date at every reassessment.

15. The care coordinator writes the primary diagnoses as indicated on the LOC page.

16. The care coordinator writes the secondary diagnoses as indicated on the LOC page.

17. The care coordinator writes the tertiary diagnoses as indicated on the LOC page.

18. NSI checklist score (pre-services): The care coordinator writes the NSI score from the screening completed at initial assessment.

    NOTE: If the care coordinator completes the NSI for an active client, enter the reassessment score as the initial score.

19. Eligibility type: CHAT automatically enters the data in this field.

20. The care coordinator writes the number obtained from DON-R completed at assessment.

21. The care coordinator writes the number obtained from DON-R completed at assessment.

22. Begin date: The care coordinator completes this field. Enter date from CCNF that client received first CCSP waivered service reimbursed by Medicaid.

23. Initial Services Begin Date: Same as #80.

24. End Date: The care coordinator completes this field. The last date on which the service was provided.

25. Eligibility Disposition Code: The care coordinator completes this field. The reason the case was closed.

26. Data entry initials and date: The person entering the data into AIMS initials and dates the form and returns it to the care coordinator.

Distribution: The form is returned to the care coordinator to be filed in the client's record when data entry is completed.

Community Care Services Program

CLIENT RIGHTS AND RESPONSIBILITIES

As a client, you have the following *rights*:

To be treated with respect and maintain one's dignity and individuality.

To be free of any discrimination because of race, creed, color, religion, national origin, or handicap.

To voice grievances and complaints regarding treatment or care that is furnished or fails to be furnished, without fear of retaliation, discrimination, coercion, or reprisal.

To a choice of approved service provider(s).

To accept or refuse services.

To be informed of your service plan and the right to participate in the planning.

To be advised in advance of the provider(s) that will furnish care and the frequency of visits ordered.

To be promptly and fully informed of any changes in the services plan.

To be informed of any charges and/or cost of services rendered.

To confidential treatment of all information, including information in your record.

To receive services in accordance with the current care plan.

To expect to be notified by the provider agency(s) of any temporary changes in the service plan.

To have your property and residence treated with respect.

As a client, you have the following *responsibilities:*

To notify service provider(s) of temporary changes in your care needs.

To treat provider staff in a courteous and respectful manner, including not discriminating because of race, creed, color, religion, national origin, or handicap.

To be as accurate as possible when providing information on your health history and personal care needs.

To actively participant in decisions regarding your health care.

To follow your physician's advice and instructions.

To notify your physician, service provider(s), or care giver if you notice a change in your condition.

To cooperate with and respect the rights of the care givers providing services.

To maintain a safe home environment.

To inform provider(s) of safety hazard(s) in the home.

I acknowledge that I have reviewed this information and I understand my rights and responsibilities as a client.

Client/Client Representative Signature	Date

Rev. 10/03

Instructions
Community Care Services Program

CLIENT RIGHTS AND RESPONSIBILITIES

Purpose: This form is used to inform clients of their rights and responsibilities as participants in the CCSP.

Who Completes/When Completed: During the initial assessment, the care coordinators gives this form to new participants in the CCSP.

1. Client reads or has someone read the contents of this form.
2. A signature or witnessed mark (X) indicates that client and/or representatives understands the rights and responsibilities of CCSP participation.

Distribution: The original is given to the client at initial assessment and a copy is filed in the client's case record.

Community Care Services Program

CLIENT TRANSFER FORM

1. Client name _____
   (Last, First, M.I.)
2. Social Security number _____
3. Medicaid number _____
4. Client transfer from:
   PSA _____

   County _____

   Care coordinator / Contact person _____

   Telephone (___) _____

   Last service day _____

   Client's previous address _____

   City _____ State _____ Zip _____
5. Client transfer to:

   PSA _____

   County _____

   Care coordinator/Contact person _____

   Telephone _____

   Client's new address _____

   City _____ State Zip _____ _____

   Telephone (_____) _____

Rev. 12/98

Instructions
Community Care Services Program

CLIENT TRANSFER OUT OF PSA

Purpose: The client transfer form is used to transfer case records from one PSA to another.

Who Completes/When Completed: The care coordinator completes the client transfer form. It accompanies the original case record to the receiving PSA.

Instructions:

1. Enter client's name (last name, first, and middle initial).

2. Enter client's social security number.

3. Enter client's Medicaid number.

4. Enter PSA and county client is transferring from.

   - Enter the name, area code, and telephone number of the care coordinator/contact person transferring the case record.

   - Enter client's last date of service.

   - Enter client's prior address.

5. Enter PSA and county client is transferring to.

   - Enter the name, area code, and telephone number of the care coordinator/contact person receiving the case record. If the new care coordinator's name is not known default to care coordinator unassigned.

   - Enter client's new address.

Distribution: The original Client Transfer Out of PSA accompanies the original client case record to the receiving PSA. A copy is filed in the duplicate case record maintained at the transferring PSA.

NOTE: This form or a copy of this form is used by the care coordinator or data entry to update AIMS.