GOSHEN HEALTHCARE INC.

HOME MAKER SERVICES

ADMISSION PACKET LIST OF CONTENTS

⇒ On the **left side** of folder (to LEAVE with FOLDER as **Client's File at Home**):

1. Welcome Letter
2. Emergency Plan
3. Clients' Bill of Rights and Responsibilities
4. Statement of Clients' Privacy Rights
5. Home service client agreement with explanation of Client Fees for Service (copy)
6. Basic Home Safety Instruction
7. List of Services with fees for services
8. Brochure/flyer

⇒ On the **Right side** of folder are as follows (to be **returned to the agency**):

1. Referral form
2. Intake Assessment
3. Home Service Plan (original)
4. Daily Service report
5. Home Service Supervisory note
6. Monthly Calendar of Hour of Service
7. Home Safety Checklist

GOSHEN HEALTHCARE INC.

REFERRAL INTAKE FORM

( ) New Intake

( ) Re-Admission

Payor Information: ______________________

Date of Referral: ______________________

Referred By: ______________________

Telephone No. ______________________

Clients' Name: ______________________

Address: ______________________

City/State/Zip: ______________________

Telephone No: ______________ Sex: ( ) M ( ) F

Birth Date: ______________ Race: ______________

Contact Person: ______________________

Relationship: ______________________

Telephone No: ______________________

Referral Source

( ) Hospital ( ) Rehab ( ) Self ( ) DHS

( ) Nursing Home ( ) MD Clinic ( ) DOA

Physician's Name: ______________________

Address: ______________________

City/State/Zip: ______________________

Telephone No.: ______________________

Fax No: ______________________

Medical History ______________________

____

____

Reason for referral /Special Instructions:

____

____

____

____

____

Service Requested: ☐Homemaker ☐Companion

Days per week ______________________ **Hours per day** __________

Total monthly hours ______________________

Intake Completed by: ______________________

GOSHEN HEALTHCARE INC.

HOME SERVICE INTAKE FORM

Intake Date ____________________ DOB: __________________________

Name: __________________________________ Phone: ______________________

Address: ____

____

Payer: ____________________________________ Referral from: ____________________

MEDICAL PROVIDER INFORMATION

Primary Physician: __________________ Phone: ____________ Fax: ________________

Address:____

Pharmacy: ____

Phone: _______________________________ Fax: __________________________

ADVANCE DIRECTIVE □ **Living Will** □ **POA** □ **DNR** □**None**

Is Client on medications? ___________

Is Client receiving home health services? ________. if yes, name of home health agency:

____ Phone_____________________

Diet: ____

Allergies: ____

____

Services Requested [R] **Services needed [N]**

	Bathing		Incontinence
	Grooming		Eating
	Dressing		Managing Money
	Transferring		Telephoning
	Routine Health		Preparing Meals
	Special Health		Laundry
	Being Alone		Housework
	Outside Home		Other

GOSHEN HEALTHCARE INC.

Client uses the following: ☐ **Wheelchair** ☐ **Walker** ☐ **Cane** ☐ **Oxygen**

Client has pets: ☐ **YES** ☐ **NO. If yes, please identify pets and how many:**

____

SUMMARY OF INTAKE

____
____
____
____
____
____
____
____
____
____
____
____
____
____

Approximate date for start of service: ______________________________

Completed by:

Signature: ______________________ Name: ______________________

Title: ______________________ Date: ______________________

Reviewed by:

Signature: ______________________ Print Name: ______________________

Title: ______________________ Date: ______________________

GOSHEN HEALTHCARE INC.

HOME SERVICE PLAN.

Patient Name____________________ **Phone Number**________________

Diagnosis____________________ **Lives Alone?** ☐ **Yes** ☐**No**

Address________________________________

Caregiver's Name____________________ **Date Assigned**____________

Date Service Started________________**Client's Physician:** ________________

Hours per day __________ **Days per week:** __________ **Hours per month** __________

Clients should be encouraged to assist with as much of their daily care as possible. Should client at any time refuse their bath, other personal care should be offered. If however, client still refuses all personal care, please document on your daily note the reason the client has given for their refusal.

SCOPE OF SERVICE								
Personal care/Task	**Frequency**							**Client Limitations**
	Su	**M**	**T**	**W**	**Th**	**F**	**Sa**	
Assist with Bathing								Bed bound
Assist with Grooming								Bedrest with BRP
Assist with Dressing								Paralysis LUE RUE LLE RLE
Assist with Transferring								Amputation
Incontinence Care								Fracture
Assist with eating								Cast
Running Errands								Traction
Telephoning								Prosthesis
Preparing Meals								Disoriented/Confused
Laundry								Speech difficulty/Loss
Housework								**Others**
Assist with grocery shopping								
Companionship								
Medication Reminding								

Activities: ____________________________
Diet: ____________________________
Any other Information: ____________________________

* *Clients limitations are for the workers information only and not task to be performed*

Assistive Devices: ☐Wheelchair ☐Walker ☐Cane ☐Other____________________

Evaluation of Service Plan

Date	By	Changes
__________	________________	☐Yes ☐ No

Agency Staff Signature____________________ Client Signature________________

☐ *Service plan was reviewed with in-home service worker*

GOSHEN HEALTHCARE INC.

HOMEMAKER DAILY SERVICE REPORT

TO BE COMPLETED EVERYDAY SERVICES WAS PROVIDED TO CLIENTS

Homemaker Name____________________________**Client Name** ___________________________

Date___________________ **Time IN**__________ **Time OUT**___________**Total Hours**________

Services Provided (Check All that Apply)

	Assist with Bathing		Assist with Transferring		Assist with ambulation		Assist with Eating
	Assist with Grooming		Housework		Telephoning		Medication Reminding
	Assist with Dressing		Laundry		Housework		Escort Client for Health checkups
	Meal Preparation		Incontinence Care		Being alone/Companionship		Running Errands
	Telephoning		Other (Specify)				

Please provide observations on client's condition____

____

Changes in Client's condition (current or anticipated)

____

____

Changes to Home Service Plan of care recommended

____

____

____

____

Homemaker Signature____________________________________**Date** __________________

Client Signature ____**Date** __________________

GOSHEN HEALTHCARE INC.

Homemaker Supervisory Visit Report

Client ________________ Check one : [ ] Orientation [ ] Quarterly [ ] Annual Competency

Supervisor Name:_________________________

Homemaker/PCA Name:________________________ Client Name:______________________________

Date:__________________ Time in:______________ Time out:___________ Total Hours:_________

Services Provided & Supervised (Check All)

	Care Provided	CODE E, G, F, NA			Comments
	Assist with Eating				
	Assist with Bathing				
	Assist with Grooming				
	Meal Preparation				
	Money Management				
	Housework				
	Laundry				
	Bowel/Bladder				
	Outside Home				
	Telephoning				
	Assist with Dressing/Undressing				
	Supervision				
	Other* (Specify Below)				
	Routine Health				
	Special Health				
	Follows Service Plan				
	Documentation Complete				
	Attitude toward client				
	Interaction with client/family/DRS worker				

Goals: [ ] Met [ ] Not Met Homemaker Present [ ] Yes [ ] No

Other:____

Change in Homemaker/PCA frequency:

____

Supervisor Signature:_______________________ Date: ___________________________

E = Excellent- little or no supervision; **F**= Fair – needs more teaching and supervision; **G** = Good – needs some supervision; **NA** = not applicable

GOSHEN HEALTHCARE, INC.

HOME SAFETY CHECKLIST

Client Name: ______________________ Date: ______________

Client Address:
______________________________________A

SAFETY CRITERIA	YES	NO
ENTRANCE TO HOME		
• Are there outside lights covering the sidewalks and/or other entrance ways?		
• Are the steps & sidewalks in good repair and free from debris/material?		
• Are the railings on the steps secured?		
• Is there a functional peephole in the front door?		
• Does the door have a deadbolt lock that does not require a key to open it from the inside (unless client has a tendency to wander)?		
GENERAL		
• Is there an emergency plan in place?		
• Are working smoke detectors installed?		
• Is there a "ready-to-use" fire extinguisher(s) on the premises?		
• Are inside halls and stairways free of clutter/debris?		
• Are throw rugs removed?		
• Are there sturdy handrails or banisters by all steps and stairs?		
• Are electrical cords unfrayed and placed to avoid tripping?		
• Are electric outlets/switches overloaded (e.g. warm to the touch)?		
• Are rugs secured around the edges?		
• Are hazardous products labeled and kept in a secure place?		
• Is there a need for a stool to reach high shelves/cupboards?		
• Is smoking paraphernalia handled safely (e.g. cigarettes put out)?		
• Does anybody smoke in homes where oxygen is in use?		
• Are all animals, on site, controlled?		
• Is the home free from bugs, mice and/or animal waste?		
• Are materials stored safely and at a proper height?		
• Does the client wear an emergency response necklace/bracelet?		
MEDICAL EQUIPMENT/SUPPLIES		
• Are used needles placed in a sharp container?		
• Is oxygen tubing kept off the walking path?		
• Is medical equipment properly stored?		
LIVING AREAS		
• Are doorways wide enough to carry loads through and get a wheelchair/walker through?		
• Are light switches accessible so they can be turned on/off without walking across a dark room?		
• Are sofas & chairs high and firm enough for easy sitting and rising?		
• Is there a telephone in the room that is easily accessible from the bed?		

GOSHEN HEALTHCARE, INC.

SAFETY CRITERIA	YES	NO
• Is list of emergency telephone numbers by the telephone?		
• Do telephone cords/electronic wires run across walking areas?		
• Are there castors or wheels on furniture?		
• Does sitting furniture have armrests which are strong enough for getting in and out?		
BATHROOM		
• Are there glass doors on the bathtub/shower?		
• Is there a non-skid surface/mat in the bathtub/shower?		
• Are there grab-bars on the bathtub/shower and adjacent to the toilet?		
• Is there a raised toilet seat (if client has trouble getting on/off toilet)?		
• Is the water temperature below scalding (e.g. below 120°?		
• Is there a shower bench/bath seat with a hand-held shower wand available?		
• Does the bathroom have a night light?		
BEDROOM		
• Are there any scatter rugs?		
• Is the bed lower than "back-of-the-knee" height?		
• Is there a chair with armrests & firm seat (to reduce falls while dressing)?		
• Does furniture have castors or roll?		
• Is there a telephone in the room that is easily accessible from the bed?		
• Is list of emergency telephone numbers by the telephone?		
• Is there a flashlight, light switch or lamp beside the bed?		
• Is there a night light?		
KITCHEN		
• Is the floor waxed or otherwise slippery?		
• Are there any flammable items near the heat source?		
• Do the "ON" buttons work on all appliances?		
• Are items used the most stored between eye and knee level?		
• Is there an uncluttered work space near the cooking area (to avoid having to carry items)?		
LIGHTING		
• Is there adequate lighting in all stairways and hallways?		
• Is there a light switch at both the top and bottom of stairs?		
• Is there a light switch by the doorway of each room?		

Completed by: ______________________________ Date: ____________________

GOSHEN HEALTHCARE INC.

In-Home Services

Charges for Services

Companion Care Fees	**Personal Care Fees**
$18.00 per hour*	$18.00 per hour*
Live - in worker $200.00 per day*	Live - in worker $250.00 per day*

Time and a half pay may apply when care is provided for more than one person. Rates may be negotiated on a case by case basis.

- Personal Care fees include all service provided under 'Companion Care' plus any assistance in: bathing, incontinence care/toileting, feeding, limited transferring, and ambulation assistance

- Mileage charge: .70₵ (seventy cents) per mile will be added for all transportation services if our caregiver is required to use their own vehicle.

- Holiday Rates: All rates will double for services that are needed on any major holidays.

State of Illinois
Department of Human Services

Homemaker/Home Health Monthly Service Report

Agency: GOSHEN HEALTHCARE INC

Worker's Name: ______

Customer's Name: ______

Services Provided: (Check all that apply)

Case Number: ______

	Eating		**Money Management**		**Outside Home**		**Teaching Skills**
	Bathing		**Housework**		**Telephoning**		**Other***
	Grooming		**Laundry**		**Dressing & Undressing**		**Routine Health**
	Meal Preparation		**Bowel/Bladder**		**Supervision**		**Special Health**

* Please Specify: ______

Changes in Customer's Condition (Current or Anticipated)

Changes to HSP Service Plan Recommended

Services Interrupted ☐ Yes ☐ No

Reason for Interruption: ______

Record of Contacts in Hours

Month/Year: ______

1.	2.	3.	4.	5.	6.	7.
8.	9.	10.	11.	12.	13.	14.
15.	16.	17.	18.	19.	20.	21.
22.	23.	24.	25.	26.	27.	28.
29.	30.	31.				

Vendor Signature: ______ Date: ______