Helping Heart, LLC

Where Tender Caring Goes A Long Way

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Consumer Application Packet

Helping Heart, LLC

CONSUMER FILE CHECKLIST

	DATE	FORMS/INFORMATION
1.	_____	Consumer Information Sheet / Demographic Information
2.	_____	Health / Behavioral Assessment
3.	_____	Support Plan or Outcome Page
	_____	Service Authorization and Other Billing Documents
4.	_____	Implementation Plan
5.	_____	Consent to Release of Confidential Information Form
	_____	Emergency Notification
	_____	Authorization for Routine Medical/Dental
	_____	Authorization for Photograph
	_____	Authorization for Transportation
	_____	Religious Information
	_____	Abuse Hotline Information Receipt
	_____	Bill of Rights Receipt
	_____	HIPAA Policy Receipt
	_____	Grievance Policy Receipt
	_____	Incident Reporting Policy
6.	_____	Schedule for Individual Service
7.	_____	Annual Summary
	_____	Monthly Summary
	_____	Service Logs
8.	_____	Additional documentation to proof of Legal status:

- Guardianship/Power of Attorney ETC.

Helping Heart, LLC

Consumer Information Sheet

DEMOGRAPHIC

Date: _____ Consumer Name: _____

Primary Disability: _____ SS #: _____

Secondary: _____ Address: _____

County: _____ _____

DOB: _____ Phone (Day): _____

Gender: _____ M _____ F Phone (Evening): _____

Legal Status: _____ Guardian Name: _____

Power of Attorney :_____

Primary Language: _____ Interpreter Name: _____

Nicknames: _____ Phone: _____

INSURANCE / RESOURCES

Medicaid #: _____ Medicare #: _____

Other Insurance: _____ Policy #: _____

3rd Party Benefits: _____ SSI _____ SSA / DI Amount: _____

Income Source: _____ Amount: _____

Employer: _____ Address: _____

Supervisor: _____ Phone: _____

Available Transportation: _____ None _____ Waiver _____Bus _____Family

PEOPLE TO CONTACT

Relationship	Name	Address	Phone
Guardian:	_____	_____	_____
Mother:	_____	_____	_____
Father:	_____	_____	_____
Other:	_____	_____	_____
Friends:	_____	_____	_____
	_____	_____	_____
Physician:	_____	_____	_____

Helping Heart, LLC

Hospital:	_____	_____	_____
Dentist:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
WSC:	_____	_____	_____

Helping Heart, LLC

SPECIALIZED NEEDS AND CHARACTERISTICS

Medical: Diagnosis: _____

_____

_____

_____

Medications: _____

_____

Allergies: _____

_____

_____

Family History: _____

_____

Psychiatric: Diagnosis: _____

_____

_____

Medications: _____

_____

Family History: _____

_____

Behavioral: Issues: _____

_____

Interventions: _____

_____

Helping Heart, LLC

Consent to Release Confidential Information

_____ _____

Consumer Name SS#

The Helping Heart, LLC has my consent to release to or obtain from:

NAME: _____

PURPOSE: _____

ADDRESS: _____

_____

PHONE: _____

The following information contained in my file and/or record

_____ Daily documentation forms _____ Financial Information

_____ Implementation plans _____ Monthly summaries

_____ Annual summaries _____ Other: _____

Your signature below authorizes Helping Heart, LLC, to release or obtain only those items checked. Do not sign unless all items on form are complete.

_____ _____

Consumer Date

_____ _____

Parent/Guardian/Caregiver Date

Helping Heart, LLC

Emergency Notification

_____ _____

Consumer Name SS#

In case of sickness or death, please indicate the person(s) to be notified:

NAME: _____

RELATIONSHIP: _____

PURPOSE: _____

ADDRESS: _____

_____

PHONE: _____

In the event the above cannot be contacted, please indicate an alternate:

NAME: _____

PHONE: _____

In the event of death, please specify any preferences for funeral arrangements:

NAME: _____

ADDRESS: _____

_____

PHONE: _____

COMMENTS: _____

_____ _____

Consumer Date

_____ _____

Parent/Guardian/Caregiver Date

Helping Heart, LLC

Authorization for Routine Medical/Dental

To Whom It May Concern:

Helping Heart, LLC and its authorized representative(s) have permission to obtain routine medical and or dental care for:

_____ _____

Consumer Name SS#

The signature below approves this authorization:

_____ _____

Consumer Date

_____ _____

Parent/Guardian/Caregiver Date

Helping Heart, LLC

Authorization to Photograph

Helping Heart, LLC and its authorized representative(s) have permission to photograph:

_____ _____

Consumer Name SS#

This authorization for photography is for identification purposes only and shall not be disclosed for other purposes without further permission.

The signature below approves this authorization:

_____ _____

Consumer Date

_____ _____

Parent/Guardian/Caregiver Date

Helping Heart, LLC

Authorization for Transportation

Helping Heart, LLC and its authorized representative(s) have permission to transport:

_____ _____

Consumer Name SS#

This authorization of transportation is for the purposes of appointments, activities, or other required transportation needs. We will not be held responsible or liable for any mishaps which may occur during these transportation activities, but it is understood that the greatest care will be taken to insure the safety and comfort of the above mentioned consumer.

The signature below approves this authorization:

_____ _____

Consumer Date

_____ _____

Parent/Guardian/Caregiver Date

Helping Heart, LLC

Religious Information

_____ _____

Consumer Name SS#

Please indicate religious preference:

Religion	Name of Site	Member
CATHOLIC	_____	_____
JEWISH	_____	_____
PROTESTANT	_____	_____
Denomination	_____	_____
OTHER	_____	_____
Denomination	_____	_____

Please indicate activities acceptable for consumers participation:

Services at preference:	Yes	No
Services at any facility:	Yes	No
Religious classes:	Yes	No
Religious Counseling:	Yes	No

Please indicate any comments in reference to religious preference:

_____

_____

_____ _____

Consumer Date

Helping Heart, LLC

_____ _____
Parent/Guardian/Caregiver Date

Receipt of Abuse Hotline Information

_____ _____
Consumer Name SS#

Helping Heart, LLC has informed the above named consumer being service by our agency that they have the right to utilize the Abuse Hotline. The following information was provided to the consumer:

Three Ways to Make a Report

TELEPHONE: 1-800-96ABUSE / 1-800-962-2873
TDD (Telephone Device for the Deaf): 1-800-453-5145

FAX: 1-800-914-0004
You must fax a written report and include your name and contact telephone number

VOICE MAIL MESSAGE: 1-800-770-0953 (You have 5 minutes to leave the information)

When lines are busy and you are unable to wait, you may leave a voice mail report of the information. It is extremely difficult for hotline counselors to attempt callbacks so IT IS ESSENTIAL THAT YOU LISTEN CAREFULLY AND LEAVE COMPLETE INFORMATION REQUESTED OR A REPORT MAY NOT BE TAKEN.

_____ _____
Consumer Date

_____ _____
Parent/Guardian/Caregiver Date

Helping Heart, LLC

The Bill of Rights of Persons who are Developmentally Disabled

_____ _____
Consumer Name SS#

We have reviewed the "Bill of Rights of Persons Who are Developmentally Disabled" with the above mentioned consumer and/or family member/caregiver. Their signature below indicates their understanding of the Bill of Rights.

_____ _____
Consumer Date

_____ _____
Parent/Guardian/Caregiver Date

Updated Review

_____ _____
Consumer Date

_____ _____
Parent/Guardian/Caregiver Date

Updated Review

_____ _____
Consumer Date

_____ _____
Parent/Guardian/Caregiver Date

Helping Heart, LLC

HIPAA Compliance Contract

_____ _____

Consumer Name SS#

I certify that I have been informed of rules of privacy information sharing as stipulated under HIPAA and adhered to by Helping Heart, LLC. By signing this agreement I understand that no information will be disseminated without prior consent from me and/or my guardian that is not outlined in this agreement. Only designated persons and professionals will have access to my personal information.

_____ _____

Consumer Date

_____ _____

Parent/Guardian/Caregiver Date

Helping Heart, LLC

Receipt of Grievance Policy

Helping Heart, LLC will maintain the following grievance procedure:

1. We will make all attempts to resolve any conflicts between the consumer, the consumer's family/caregiver(s), legal guardian and others at our agency through discussion and meetings.

2. If the conflict continues to be an issue after discussion and/or meetings, the consumer or family/caregiver/legal guardian may request in writing or verbally a review by the agency. The requesting person may utilize the agency's Grievance Report.

3. We will review the written request for the grievance and document the grievance in a log to include:
    - Name of person requesting review
    - Relationship to the consumer
    - Date grievance was made
    - Nature of grievance
    - Date of resolution
    - Date written resolution was provided to the consumer or person requesting review, WSC, and APD.

4. We will notify the Support Coordinator of the consumer for review of the grievance.

5. Written resolution will be documented and placed in the consumer's file.

6. If after 30 days, resolution is not achieved, we will provide the consumer or the requesting party any and all appropriate contact persons at the APD Program Office for further review of the grievance.

I certify with my signature I have read and understand the above procedure. I understand that the policy allows me as the consumer to file a grievance against Helping Heart, LLC and that a response must be made to me. I also understand if I am not satisfied with the resolution, that I have further options to pursue my grievance.

_____ _____

Consumer Date

_____ _____

Parent/Guardian/Caregiver Date

HELPING HEART, LLC

_____ _____

Staff Date

Incident Reporting Policy & Procedure

I understand that Helping Heart, LLC is bound by the State laws of Florida and by the policies and procedures of the Agency for Persons with Developmental Disabilities in accordance with the Agency For Health Care Administration as written in the Florida Medicaid Developmental Disabilities Waiver Services Coverage and Limitations Handbook (May 2010) to keep incident reports.

I or my legal guardian has read or it has been explained to me or my legal guardian the following:

a. **Critical Incidents**

(1) Critical incidents must be reported to the appropriate APD Area Office by telephone or in person within one hour of becoming aware of the incident. If this occurs after normal business hours or on a weekend or holiday the person reporting the incident shall call the APD after-hours designee. If the incident occurs between the hours of 8:00pm and 8:00am, an oral report may be submitted no later than between 8:00am and 9:00am of the following day. It shall be within the provider's discretion and judgment to determine the appropriateness of waiting until the following morning.

(2) The oral report must be followed by an APD Incident Reporting Form (Appendix 1), submitted to the APD Area Office at the earliest opportunity but no later than the next business day. Whenever possible, the form should be completed electronically and submitted as an e-mail attachment to the Area Office. If handwritten, it must be legible. The first page of the form must be completed in its entirety by the person who initiated the original verbal report.

(3) The APD Area Office Administrator or designee will immediately inform APD's Deputy Director for Operations or designee at the Central Office in Tallahassee of the critical incident.

(4) The reporter must also provide immediate notification to the consumer's support coordinator and to a child's or incompetent adult's parent or guardian. If the child is in the custody of the Department of Children and Family Services, the child's family services counselor (or DCF after-hours on-call staff) must be immediately notified.

(5) Follow-up measures taken by the provider (or APD staff as appropriate) to protect consumers, gain control or manage the situation must be noted on the second page of the Incident Reporting Form which may be completed at a later date. The measures must specify what actions will be taken to mitigate a recurrence of a similar incident.

(6) **Critical Incidents include**:

(a) **Consumer Death** – The death of a person who is receiving services from an APD operated, licensed or contracted provider, Medicaid waiver provider, or ICF/DD that occurs due to or allegedly due to an accident, act of abuse, neglect, or other unexpected incident.

(b) **Sexual Misconduct** - Any sexual activity, as described in s. 393.135, F.S., between a provider and a consumer, regardless of the consent of the consumer, or incidents of nonconsensual sexual activity between consumers. A provider is any paid staff member, volunteer, or intern; any person under contract with APD; or any person providing care or support to a consumer on behalf of APD.

(c) **Missing Child or Adult Who Has Been Adjudicated Incompetent** - The unauthorized absence or unknown whereabouts of a minor or an adult who has been adjudicated incompetent who is receiving services from an APD operated, licensed or contracted provider, Medicaid waiver provider, or ICF/DD (see additional procedures below).

(d) **Media** - An unusual occurrence or circumstance that may initiate unfavorable media attention.

b. **Reportable Incidents**.

(1) Other reportable incidents that are not critical incidents must be reported within one business day to the appropriate APD Area Office through the completion of an APD Incident Reporting Form (Appendix 1).

(2) The form may be faxed, electronically mailed, or personally delivered to the Area Office. If handwritten, it must be legible. The first page of the form must be completed in its entirety by the person who is initiating the report.

(3) Follow-up measures taken by the provider (or APD staff as appropriate) to protect consumers, gain control or manage the situation must be noted on the second page of the Incident Reporting Form which may be completed at a later date. The measures must specify what actions will be taken to mitigate a recurrence of the same type of incident.

(4) The reporter must also provide notification to the consumer's support coordinator, and to a child or incompetent adult's parent or guardian. If the child is in the custody of the Department of Children and Family Services, the child's family services counselor must be notified.

(5) These incidents will be managed at the area level, and only aggregate data on such incidents will be reported to APD's Deputy Director for Operations.

(6) **Reportable incidents include**:

(a) **Altercations** - A physical confrontation occurring between a consumer and a member of the community, a consumer and provider, or two or more consumers at the time services are being rendered and that results in law enforcement contact. If the altercation results in the consumer's injury requiring medical attention in an urgent care, emergency room or physician office setting, it is to be reported as a Consumer Injury. If the altercation results in consumer arrest, it is to be reported as a Consumer Arrest.

(b) **Consumer Injury** - An injury sustained or allegedly sustained due to an accident, act of abuse, neglect or other incident occurring while receiving services from an APD operated, licensed or contracted provider, Medicaid

waiver provider, or ICF/DD that requires medical attention in an urgent care center, emergency room or physician office setting.–

(c) **Consumer Arrest** – An incident resulting in the arrest of a consumer who is receiving services from an APD operated licensed or contracted provider, Medicaid waiver provider, or ICF/DD.

(d) **Missing Competent Adult** - The unauthorized absence or unknown whereabouts beyond eight hours (or less time if the person is known to lack capacity to make safe decisions) of a legally competent adult who is receiving services from an APD operated, licensed or contracted provider, Medicaid waiver provider, or ICF/DD. Local providers should refer to their Area Office procedures to determine if they are required to report missing persons sooner than the time frame stated above.

(e) **Suicide Attempt** - An act which clearly reflects the physical attempt by a consumer to cause his or her own death while receiving services from an APD operated, licensed or contracted provider, Medicaid waiver provider, or ICF/DD

(f) **Other** - Any event not listed above that jeopardizes a consumer's health, safety or welfare. Examples may include but are not restricted to severe weather condition damage (e.g. tornadoes or hurricanes), criminal activity by providers or employees, fires or other hazardous events or conditions, etc. If the event may generate unfavorable media attention, it is to be reported as a critical incident (see 'Media' above).

Procedures for Missing Children or Incompetent Adults.

Upon discovering that a minor or adult who has been adjudicated incompetent is missing, staff of an APD operated, licensed or contracted provider, Medicaid waiver provider, or ICF/DD who is responsible for the consumer's care, shall:

a. Immediately call local law enforcement and ask the officer to:
   (1) Take a report of the missing child or incompetent adult.
   (2) Assign a case number and provide the number to the person reporting the child or incompetent adult as missing.
   (3) Provide a copy of the law enforcement missing person report, when it is available.
   (4) If the responding law enforcement officer refuses to take a missing person report, for any reason, the person making the report will document the name of the officer's and the responding local law enforcement agency and request to speak to the appropriate Watch Commander.

b. The person will then immediately notify the APD's Area Office Administrator (or after-hours designee) and provide all the information listed above, including the case number. If the law enforcement officer refused to take the missing person report, the staff person shall inform the Area Office Administrator or designee and the Administrator will contact the law enforcement agency to request assistance in filing the report.

The consumer/legal guardian understands that the above policies and procedures have been adapted from APD Operating Procedure 10-002 and that Helping Heart, LLC will follow the same policies and procedures.

_____ _____

Consumer Date

_____ _____

Parent/Guardian/Caregiver Date

Helping Heart, LLC

Schedule for Individual Services

Consumer: _____ SS#:_____

Service	MON.	TUE.	WED.	THURS.	FRI.	SAT.	SUN.	Total HRS.
Companion								
In-Home Day								
In-Home QH								
PCA								
Respite Day								
Respite QH								
SLC								

Helping Heart, LLC schedule the above day(s) and hour(s) per individual's request and according to approval of service.

NOTE: The above request(s) may vary due to individual request or other personal appointments. If the day(s) and or hour(s) need to be changed, please give 24 hours notice to the provider.

By signing this, I agree that I have read and understand this scheduling of services.

_____ _____

Signature of Consumer/Legal Guardian Date

_____ _____

Helping Heart, LLC

Signature of Provider Date

INDIVIDUAL'S NAME: _____ **DATE:** _____

Please note: All question must be adapted to the individual's understanding. Please ask all questions and indicate "Y" for "yes", "N" for "no" or "N.A." for not applicable. CHANGES ARE HIGHLIGHTED IN YELLOW.

1. Do you have any health concerns? ___ Yes (but needs are being met) ___ Yes (but needs are **not** being met) ___ Maybe, I am not sure ___ No

2. Do you have any of the following? ___ Yes ___ No ___ N.A. Check all that apply. (NEW)

___ Guardian over health ___ Health Care Proxy ___ Advanced Medical Directives

___ Living Will ___ Power of Attorney over health

___ Health Care Surrogacy ___ Supports do not know if any apply ___ Other

3. Do you need additional assistance in any of the following areas to meet your health care needs? Check all that apply. (NEW)

___ Understanding/accessing transportation ___ Understanding/accessing benefits (SSA/SSI)

___ Obtaining Medical or Specialist Appts. ___ Understanding/accessing preventive health needs

___ Understanding/accessing health insurance ___ Understanding/accessing medications

___ Understanding diagnosis ___ Understanding/modifying plans of care

___ Understanding/accessing therapies

4. Please select the following health and safety risk factors addressed in the annual Support Plan. Check all not addressed in the document. (NEW)

___ Number of reportable critical incidents, if applicable ___ Type of reportable critical incidents

___ Person has completed an annual physical ___ Person reports feeling safe at home

___ Person reports freedom from abuse, neglect, and/or exploitation

___ Person reports feeling treated with dignity and respect

5. Which physicians and specialists have you had appointments with in the past twelve (12) months? Check all that apply. (UPDATED)

Neurology		Psychiatry	
Primary Care		Gastroenterology	
Cardiology		Endocrinology	
Pediatrician		Hematology	
Rheumatology		Allergy	
Podiatry		Dermatology	
Gynecology		Urology	
Orthopedics		Neurosurgery	
Ear/Nose/Throat		Oncology	
Optometry/Ophthalmology			
Other:			

6. Have Reactive Strategies under 65G-8 been used due to behavioral concerns in the past twelve (12) months? (NEW) ___ Yes ___ No
If "Yes" when: _____Why: _____
Report Completed ___ Yes ___ No

7. Has the Abuse Hotline been contacted by you or others to report abuse, neglect, or exploitation in the past twelve (12) months? (NEW) ___ Yes ___ No
If "Yes" when: _____Why: _____
IR Completed ___ Yes ___ No

8. Have you been Baker Acted in the past twelve (12) months? **(NEW) ___ Yes ___ No**
If "Yes" when: _____Why: _____
IR Completed ___ Yes ___ No

9. Have you been to an Urgent Care Center in the past twelve (12) months? **(NEW) ___ Yes ___ No**
If "Yes" when: _____Why: _____
IR Completed ___ Yes ___ No

10. Have you been to an Emergency Room in the past twelve (12) months? **___ Yes ___ No**
If "Yes" when: _____Why: _____
IR Completed ___ Yes ___ No

11. Have you been admitted to the hospital in the past twelve (12) months? **___ Yes ___ No**
If "Yes" when: _____Why: _____
IR Completed ___ Yes ___ No

12. Have you had any instances of medication errors in the past twelve (12) months? **___ Yes ___ No**
If "Yes" when: _____Why: _____
IR Completed ___ Yes ___ No

13. Have you been a patient in a same day surgery center in the past twelve (12) months? **(NEW)**
___ Yes ___ No
If "Yes" when: _____Why: _____

14. Are you and your supports aware of your family medical history as it relates to ensuring preventive care for yourself? **(NEW)** **___ Yes** **___ No**

15. Have you received any of the following preventive health in the past twelve (12) months?
___ Yes ___ No. Check all that apply.
___ Annual Physical Exam
___ Annual Physical Exam including gait assessment and fall risk assessment **(NEW)**
___ Flu Vaccine **(NEW)**
___ Pneumonia Vaccine **(NEW)**
___ Zoster (Shingles) Vaccine **(NEW)**
___ Tetanus-Diphtheria Booster **(NEW)**
___ Colorecteral Cancer Screening **(NEW)**
___ PSA **(Male only)**
___ Female Pre-Natal Care if applicable **(NEW)**
___ Female preventative health care: mammogram
___ Female preventative health care: Pap smear or other exams such as ultrasound
___ Bone Density Scan **(NEW)**
___ Education on self-breast exams **(NEW)**
___ Vision Exam o Glaucoma
___ Cataracts
___ Hearing Exam (ear wax and hearing screening)
___ Dental Exam
___ Dermatology Exam including skin cancer check **(NEW)**
___ Areas specific to pertinent family history **(NEW)**

16. Have you had any of the following over the last twelve (12) months? (NEW) **___ Yes** **___ No**
___ Unplanned weight gain of 10 or more lbs.
___ Unplanned weight loss of 10 or more lbs.
___ Two (2) or more falls
___ Problems with skin breakdown

17. What Prescription medications do you currently take? Check all that currently apply. **(UPDATED).**
INDICATE USING THE LETTER "Y" (YES).

Ability (Aripiprazole)		Lopressor (Metoprolol)	
Adderall		Mellaril (Thioridazine)	
Anafranil (Clomipramine)		Metformin (Glucophage)	
Ativan (Lorazepam)		Mysoline(Primidone)	
Baciafen (Liorasal)		Neurantin (Gabapentin)	
Buspar (Buspirone)		Norvasc (Amlodipine)	
Catapres (Clonidine)		Paxil (Paroxetine)	
Celexa (Citalopram)		Phenobarbital	
Cogentin (Benztrapine)		Pravachol (Pravastatin)	
Concerta (Methylphenidate)		Prevacid (Lansoprazole)	

Depakote (Divalproex)		Prinivil (Lisinopril)	
Desyrel (Trazadone)		Prozac (Fluoxetine)	
Detrol (Tolterodine)		Risperdal (Risperidone)	
Dilantin (Phenytoin)		Ritalin (Methylphenidate)	
Effexor (Venlafaxine)		Seroquel (Quetiapine)	
Geodon (Ziprasisone)		Symmetrel (Amantadine)	
Haldon (Haloperidol)		Synthroid (Levothyroxin)	
Inderal (Propanolol)		Tegretol (Carbamezaphine)	
Keppra (Levetiracetam)		Thorazine (Chlorpromazine)	
Klonopin (Clonazepam)		Topamaz (Topiramate)	
Lamictal (Lamotragine)		Vasotec (Enalapril)	
Lasix (Flurosemide)		Wellbutrin (Bupropion)	
Lexapro (Excitalopram)		Xanax (Alprazolam)	
Lipitor (Atorvastin)		Zoloft (Sertraine)	
Lithium (Eskalith)		Zyprexa (Olanzapnine)	
Others			

18. Do you currently take any PRN (pro-re-nata/as needed) medications (e.g. pain relievers)? (NEW)
___ Yes ___ No
__ Acetylsalicylic Acid __ Tylenol __ Advil __ Nuprin __ Diastat __ Metamucil
__Docusate __ Other: _____

19. Do you currently take any other medications (e.g. Over the Counter, Herbal Supplements, Vitamins, and Dietary Supplements)? **___ Yes ___ No**

List these	_____ _____ _____

20. Are you aware of the risks of any of the following habits? (Indicate "Y" for Yes or "N" for No)
___ Sexual Activity
___ Smoke Tobacco or tobacco products
___ Alcohol Beverages including wine, liquor, or beer

21. Do you want more education about any of the following? Mark if answer is yes.
___ Medications and Side Effects
___ Safe Sex
___ Alcohol Programs if you feel you have a problem
___ Smoking Cessation Programs
___ Preventive Health

22. Does the individual appear to have or report a need for any of the following therapies that are not currently being rendered? Check all that apply.
___ Occupational Therapy ___ Speech Therapy ___ Physical Therapy
___ Massage Therapy ___ Nutritional Support ___ Respiratory Therapy
___ Adaptive Equipment Evaluation ___ Oral Motor Evaluation

___Swallow Study ___ Nursing Evaluation ___ Behavior Assessment
___ Environmental Accessibility Assessment
___ Specialized Mental Health Assessment

23. Is adaptive equipment in good working condition? ___ Yes ___ No ___ N.A.

24. Do you need any additional special supports or equipment to assist in mobility, drinking liquids or eating food? Check all that apply. ___ Yes ___ No ___ N.A.

___ Wheelchair ___ Lap tray ___ Utensils ___ Positioning equipment
___ Shower chair ___ TTD ___ Communication device
___ Helmet ___ Splints/Brace ___ Hearing Aid
___ Dentures ___ Glasses

25. Have you registered with a special need shelter or have an emergency evacuation plan in place?
(NEW) ___ Yes ___ No ___ N.A.

26. Do you currently have Medicare (in addition to Medicaid)? **___ Yes Medicare#: _____**
___ No

27. Do you currently have Private Insurance? **___ Yes Carrier: _____ ___ No**

28. Did you Private Pay for any of your health care services in the past twelve (12) months?
___ Yes ___ No

29. Did the reviewer contact? ___ Yes ___ No
___ Delmarva RN reviewer
___ Region/Area Medical Case Manager
___ Region/Area APD Staff
IF NOT (WHY): _____

_____

_____

_____ _____

Individual/Legal Guardian/Parent Signature Date

_____ _____

Helping Heart, LCC Staff or Provider Signature