TLC Skilled Care, Inc

Giving the help you deserve

Historical/Demographic Information Sheet

Name: ______________________________ DOB: ____________

Social Security #: ______________ Medicare #: __________ Medicaid: ________________

County: _______ Address: ______________________________________

Phone Number Day: ________________ Evening: ____________________

Email: ________________________

Male: ________________________ Female: ______________________

Legal Status: ________________________

Participant in supported living Yes/ No: ________________ Since:____________

If adjudicated incapacitated or has a Guardian advocate: ________________________

Behavioral Status: ____________________________________________________

History of Abuse, Neglect & Exploitation:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Healthcare, wellness exams, therapeutic intervention, medical device/apparatus.

Primary Disability ______________________________________________________

Secondary Disability ____________________________________________________

____ High Blood Pressure

____ Diabetes

____ Seizure Disorder

Other Medical Concern

________________________________________________________________________

________________________________________________________________________

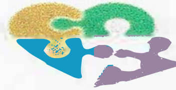
TLC Skilled Care, Inc

Giving the help you deserve

# Physical Health Tracking Logs

Consumer Name: ______________________________ Consumer ID: ___________________________

| Primary Care | Date of Visit | Date of Next Appointment |
|---|---|---|
| Name: | Date: | Date: |
| Address: | Reason: | Reason: |
| Tel:<br>Fax: | | |
| **Dentist** | **Date of Visit** | **Date of Next Appointment** |
| Name: | Date: | Date: |
| Address: | Reason: | Reason: |
| Tel:<br>Fax: | | |
| **Neurologist** | **Date of Visit** | **Date of Next Appointment** |
| Name: | Date: | Date: |
| Address: | Reason: | Reason: |
| Tel:<br>Fax: | | |
| **Specialist** | **Date of Visit** | **Date of Next Appointment** |
| Name:<br>Tel: | Date:<br>Reason: | Date:<br>Reason: |
| Name:<br>Tel: | Date:<br>Reason: | Date:<br>Reason: |
| Name:<br>Tel: | Date:<br>Reason: | Date:<br>Reason: |



TLC Skilled Care, Inc
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## Rights & Responsibilities of Persons with Developmental Disabilities

1. I have the right to be treated with dignity, privacy, and human care.
   - **I have the responsibility to treat others the way that I want to be treated."**
2. I have the right to religious freedom and practice.
   - **I have the responsibility to tell people closest to me that I want to go to church."**
3. I have the right to services that protect liberty in the last restrictive conditions necessary to achieve the treatment outcomes.
   - **I have the responsibility to discuss my dreams, preferences, want and desires with the people I trust."**
4. I have the right to social interaction and to participate in community activities.
   - **I have the responsibility to join and participate in activities that interest me."**
5. I have the right to vote.
   - **I have the responsibility to ask questions and get information about a candidate so that I can make an informed decision about voting."**
6. I have the right to a quality education and training services.
   - **I have the responsibility to actively participate in the education and training services that I have chosen."**
7. I have the right to be free from harm, including unnecessary physical, chemical, or mechanical restraint, isolation, excessive medication, abuse or neglect.
   - **I have the responsibility to care for my personal safety and not harm other; I have the responsibility to tell people closest to me when I have been exposed to harm,"**
8. I have the right to consent to or refuse treatment.
   - **I have the responsibility to ask questions and gain information to better understand what a yes or no means."**
9. I have the right not to be discriminated against due to my developmental disability.
   - **I have the responsibility to allow others equal access and to follow the rules that apply to everyone."**
10. I have the right to physical exercise and recreational opportunities.

**CONSUMER RESPONSIBILITYS:**

- Provide the agency with a complete and accurate health history.
- Remain under a doctor's care while receiving agency services.
- Inform the agency of the existence of and any changes made to the Advance Directive.
- Notify the agency about how satisfied you are with the service.
- Provide the agency with all requested insurance and financial information, including any changes in coverage
- Advise the agency of any problems or dissatisfaction with our care, without being subject to discrimination or reprisal
- Request further information concerning anything you do not understand
- Participate in the planning and revising of your home program and updating it as your condition changes
- Provide a safe home environment in which your care can be provided appropriately and adequately.
- Cooperate with your doctor, agency staff, and other care givers.
- Notify the agency when unable to keep appointments
- Treat agency personnel with respect and consideration

________________________ ________________________

**CONSUMER SIGNATURE** **DATE**

TLC Skilled Care, Inc
Giving the help you deserve

# Consent Form

**I ____________________________ give consent to TLC SKILLED CARE, Inc. to provide services to me and to help me reach my goal and live independently as possible**

______________________________ ______________________________

**Consumer Signature** **Date**

______________________________

**Expiration Date**

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## CURRENT MEDICATIONS

Recipients Name: ______________________________________________

| | *MEDICATION* | *TIMES PER DAY* | *WHAT ITS FOR* | *SIDE EFFECTS* |
|---|---|---|---|---|
| *1.* | | | | |
| *2.* | | | | |
| *3.* | | | | |
| *4.* | | | | |
| *5.* | | | | |
| *6.* | | | | |
| *7.* | | | | |
| *8.* | | | | |
| *9.* | | | | |

______________________________ ______________________

**Recipient/ Guardian Signature** **Date**

______________________________ ______________________

**Relationship to Recipient**

______________________________

**Expiration Date**

# TLC Skilled Care, Inc.

The help you deserve.

## Grievance Procedures

I hereby acknowledgment that I have been provided with information for the followings:

A. Grievance Procedures

In the event of a conflict with the consumer and the service provider, the followings procedures shall take place:

1. The consumer, Parent/guardian, and/ or consumer advocate will notify the supervisor of the conflict
2. A meeting will arranged for all parties to listen to the concerns and/or complaints
3. Notes of the meeting will be taking and a plan of action will be putting into place.
4. A follow-up meeting will be schedule with the consumer, parent/guardian, and/or consumer advocate. A resolution will be put into place and implemented within (7) seven days
5. If no resolution is reached, the service provider will contact the support coordinator, they will become involved, and further assist until a resolution is agreed upon.

B. 24 hours agency access number/emergency contact:
Patricia 561.674.3777 or Dawn 678.577.0742

C. The abuse, neglect or exploitation hotline at: 1-(800) 962-2873 1-(800)-96-ABUSE
TTY users may call 1-(800) 453-5145

D. Sexual abuse may be reported at 1-(800) 962-2873

E. Complaint Hotline at : 1-(800) 419-3456

F. Fraud report to: 1-(800) 966-7226 or report to APD Southeast region (WPB) at: (561) 837-5564 or for Broward (954) 467-4218.

______________________________ Consumer/ Guardian Signature

______________________ Date

# ABUSE, NEGLECT AND EXPLOITATION INFORMATION

SHORT FORM

**TO REPORT ABUSE CALL 1-800-96ABUSE / 1-800-962-2873**

TDD 1-800-453-5145 (FOR HEARING IMPAIRED)

IF ANY OF THE ITEMS LISTED BELOW HAS HAPPENED TO YOU, YOUR FAMILY, OR SOMEONE YOU KNOW, CALL THE NUMBER ABOVE

1. **Physical Abuse**: Any physical contact with an individual by staff that intentionally causes the physical pain or suffering. (Examples: pain induced restraint techniques, striking, corporal punishment, and use of weapon).

2. **Verbal Abuse:** Any verbally abusive statement by staff directed toward an individual. (Examples: use of obscene names, threats of physical violence, repeated or excessive screaming or yelling, use of derogatory statements).

3. **Sexual Abuse:** Any verbal sexual solicitation, sexual coercion, forced sexual activity or sexual intercourse, between staff and individual.

4. **Neglect:** Failure to meet the individual's basic needs for food, hydration, shelter, clothing, and supervision.

5. **Material:** Misuse of, or theft of the individual's personal property, taking advantage of, or exploitation of, an individual's finances and property.

6. **Chemical Abuse:** Unauthorized administration of any medication.

| | |
|---|---|
| Individual | Date |
| Parent on behalf of Individual | Date |
| Guardian (if applicable) | Date |

TLC Skilled Care, Inc
Giving the help you deserve

## Emergency Telephone Numbers

**Directions: In case of Medical Emergency. Please call 911**

Non-Medical Emergency, please follow Directory:

| | |
|---|---|
| Tlc Skilled Care, Inc. | 561-406-5046 Office Number |
| Tlc Skilled Care, Inc. 24/7 (Patricia) | 561-674-3777 President |
| Dawn Fatig | 678-577-0742 Administrator |
| American Red Cross | 1-800-833-0599 Main Number |
| American Red Cross | 561-833-7701 Main Number |
| Palm Beach County Sheriff | 561-688-3000 Main Number |
| Crime Stoppers | 561-684-6333 Main Number |
| Hurricane Preparedness | 561-712-6400 Main Number |
| Poison Control Hotline | 800-222-1222 Main Number |
| Florida Power Light (24 Hour Emergency) | 800-468-8243 Hotline |
| Federal Emergency Management | 800-621-3362 Main Line FEMA |

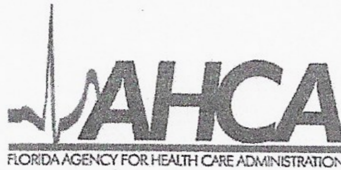
**To Report any type of Abuse, neglect or exploitation, please call!**

**1 (800) 96 ABUSE or 1 (800) 962-2873**

Emergency Numbers has been reviewed with Individual/Legal guardian and all parties assigned responsible in the plan and I have also received a copy of the emergency telephone numbers provided by TLC SKILLED CARE, Inc.

- I am also aware that TLC SKILLED CARE Inc. has a 24/7 availability, backup phone number listed above.

| Individual/Legal Guardian Signature: |
|---|
| Date: |
| Case Management Signature: |
| Update: |
| Copy: Consumer, central record, APD, and all parties' assigned responsibility. |




# Authorization for the Use and Disclosure of Protected Health Information

Please note that Medicaid regulations restrict the use and disclosure of information concerning Medicaid applicants and recipients to purposes directly connected with the administration of the Medicaid State Plan (see 42 United States Code 1396(a)(7)).

**Please provide the following information about the person whose Medicaid records are to be disclosed.**

| Name | | Social Security Number | |
|---|---|---|---|

Disclosure of your Social Security Number is not mandatory for purposes of completing this form. However, the Agency for Health Care Administration may request your Social Security Number pursuant to Section 119.071, Florida Statutes. Should you choose to provide your Social Security Number as requested, the Agency shall use your information for purposes of finding the requested information.

| Phone | | Date of Birth | | | |
|---|---|---|---|---|---|
| Medicaid ID Number or Gold Card Number | | | | | |
| Street Address | | | | | |
| City | | State | | Zip Code | |

I authorize the Agency for Health Care Administration to share the health information listed below with the following person(s), group or entity:

Describe the *specific* information that you are giving the Agency permission to disclose (for example, "A report showing the health care services Medicaid has paid for from May 2008 to October 2008.")

The information described above is to be disclosed for the following purpose (For example, "Treatment of my health condition" or "For legal representation in my medical malpractice lawsuit.")

| Please enter the date you want this authorization to expire (authorization will expire in one year if no date is provided): | Expiration Date | |
|---|---|---|

I understand that the information described above may be redisclosed by the person or group that I am giving the Agency permission to disclose and therefore my information may no longer be protected by Federal privacy regulations.
I understand that I may inspect or request copies of any information disclosed by this authorization if the Agency initiated this request for disclosure.
I understand that I may revoke this authorization by notifying the Agency in writing with the understanding that previously disclosed information would not be subject to my revocation request.
I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for health care services or eligibility for benefits.

**You have the right to revoke this authorization at any time by writing to the Agency's Privacy Officer or completing the revocation section on the second page of this form and sending it to the address listed for the Agency's Privacy Officer.**

| Signature | | Date | |
|---|---|---|---|

If the information you are requesting to be disclosed is not about you or your minor child, please complete the section below. If you are a legal representative of the person whose information is to be disclosed, you must provide documentation proving your legal authority to request this information. (For example, an authorization, power of attorney, guardianship papers, health care surrogate form, Order Appointing Personal Representative, Letters of Administration).

| Legal Representative (Signature) | | | |
|---|---|---|---|
| Legal Representative (Print Name) | | | |
| Relationship of Legal Representative | | Date | |

Rev. 12/12

**Instructions for Completing the Authorization for the Use and Disclosure of Protected Health Information Form**

1. Complete the first page of this form and return it to: HIPAA Privacy Officer, Agency for Health Care Administration, 2727 Mahan Dr., Mail Stop #4, Tallahassee, FL 32308, Phone: 850-412-3960.

2. If the signer is a legal representative, guardian, health care surrogate or has power of attorney, documentation of the representative's legal authority to act on behalf of the individual whose information is to be disclosed must be attached with the authorization form. If an agency has custody of a child and a representative signs the release, include a copy of the custody order.

3. Special types of health information have specific laws and rules that must be followed before that information may be disclosed:

HIV/AIDS and Sexually Transmitted Diseases (STD): All information about HIV/AIDS and sexually transmitted diseases is protected under Federal and State laws and cannot be disclosed without your written authorization unless otherwise provided in the regulations. To release HIV/AIDS or STD information, this authorization must include a statement of the specific HIV/AIDS or STD information you are giving the Agency permission to disclose. Redisclosure of HIV/AIDS information is not allowed except in compliance with law or with your written permission.

Alcohol or Drug Treatment: Alcohol and/or drug treatment records are protected under Federal and State laws and regulations and cannot be disclosed without your written authorization, unless otherwise provided for in Federal and State laws or regulations. To release alcohol and/or drug treatment information, this authorization must include a statement of the specific information that you are giving the Agency permission to disclose (for example, "For the purposes of my assessment, treatment plan, attendance, or discharge plan.") Redisclosure of your alcohol and/or drug treatment records is not allowed except in compliance with law or with your written permission (see 45 CFR Part 2).

Mental Health Treatment: Mental health treatment records are protected under Federal and State laws and regulations and cannot be disclosed without your written authorization unless otherwise allowed in Federal or State laws or regulations. To release mental health treatment information, this authorization must include a statement of the specific information that you are giving the Agency permission to disclose (for example, "For the purposes of my assessment, treatment plan, attendance, or discharge plan.") Disclosure of your psychotherapist's notes needs separate written permission. Redisclosure of your mental health treatment records is not allowed except in compliance with law or with your written permission.

| **Revocation of Authorization** | | | | | |
|---|---|---|---|---|---|
| To revoke your authorization, please complete the following section and send the form to the Privacy Officer at the address given above. Use of this form to revoke your authorization is optional but your authorization revocation request must be in writing. | | | | | |
| Name | | Date of Birth | | | |
| Phone | | Social Security Number | | | |
| Medicaid ID Number or Gold Card Number | | | | | |
| Street Address | | | | | |
| City | | State | | Zip Code | |
| I hereby revoke my authorization for the Agency for Health Care Administration to disclose my protected health information to the following person(s), group or entity: | | | | | |
| Signature | | | | Date | |
| If the information you are requesting to be disclosed is not about you or your minor child, please complete the section below. If you are a legal representative of the person whose information you are requesting, you must provide documentation proving your legal authority to request this information. (For example, an authorization, power of attorney, guardianship papers, health care surrogate form, Order Appointing Personal Representative, Letters of Administration). | | | | | |
| Legal Representative (Signature) | | | | | |
| Legal Representative (Print Name) | | | | | |
| Relationship of Legal Representative | | | | Date | |

Date________________________________

The records OF ____________________________________________________(CLIENT NAME), shall be current to the greatest extent possible and updated at least 30 days following receipt of new information. If any of the required information is not available, the licensee shall include written documentation in the record that a diligent effort was made to obtain the missing information.

THIS NOTE AUTHORIZES TLC SKILLED CARE, INC. the right to request AND/OR RELEASE ANY AND ALL MEDICAL RECORDS, LABS AND X-RAYS, LIST OF MEDICATIONS INCLUDING ALL DIAGNOSIS, CPT 10 CODES ON BEHALF OF OUR CLIENT AND OR LEGAL GUARDIAN AT ANYTIME FOR ANY REASON PERTAINING THE CLIENT.

THIS ALSO RELEASES INSURANCE COMPANIES OR GOVERNMENT AGENCIES TO RELEASE ANY AND ALL INFORMATION PERTAINING TO THE CLIENT AS IT RELEATES TO THE SERVICES PROVIDED BY OUR COMPANY FOR ALL TIME.

PATIENT NAME____________________________________________________________________

DATE OF BIRTH____________________________________________________________________

LEGAL GUARDIAN NAME_____________________________________________________________

Signature of AUTHORIZED________________________________ for ____________________________

PRINTED PATIENT NAME

TLC Skilled Care, Inc

Giving the help you deserve

Tel: 561.406.5046

# PERMISSION TO PHOTOGRAPH

I HEREBY DO OR DO NOT (CIRCLE ONE) GIVE PERMISSION FOR MYSELF MY CHILD/ ADULT

:_______________________________________________

TO HAVE MINE HIS/HER PHOTGRAPH TAKEN BY TLC SKILLED CARE FOR SOCAIL MEDIA, ADVERTISMENT, AND OR TRAINING PURPOSES. TLC SKILLED CARE WILL NOT TAKE PHOTOS OR VIDEOS WITHOUT PERMISSION OF THE CLIENT, PARENT OR LEGAL GARDIAN.

PRINT NAME:_______________________________________________

PARENT/ GARDIAN SIGNATURE:_______________________________________________

DATE:_______________________________________

Corporate Office: 15655 75th way N Palm Beach Gardens, Fl.33418 tel: 561.674.3777 fax: 561.7458459 email : tlcskilledcare@gmail.com

## INFORMATION AND ASSIGNMENT OF BENEFITS:

I HEREBY AUTHORIZE TLC SKILLED CARE, INC TO APPLY FOR BENEFITS ON MY BEHALF FOR COVERED SERVICES RENDERED BY. I REQUEST THAT PAYMENT FROM MY INSURANCE COMPANY BE MADE DIRECTLY TO TLC SKILLED CARE, INC. (OR TO THE PARTY WHO ACCEPTS ASSIGNMENT). I AUTHORIZE THE RELEASE OF MY PROTECTED HEALTH INFORMATION SUCH AS MY MEDICAL HISTORY AND DIAGNOSIS, TREATMENT PLAN AND PERSONALLY IDENTIFIABLE INFORMATION NOT LIMITED TO MY NAME AND DATE OF BIRTH AS WELL AS MY MEDICAL HISTORY AND DIAGNOSIS, TREATMENT PLAN AND PERSONALLY IDENTIFICABLE INFORMATION NOT LIMITED TO MY NAME AND DATE OF BIRTH AS WELL AS ANY OTHER INFORMATION THAT MY INSURANCE COMPANY REQUIRES IN ORDER TO PROCESS AND PAY MY CLAIM.

I CERTIFY THAT THE INFORMATION I HAVE REPORTED WITH REGARD TO MY INSURANCE COVERAGE IS CORRECT AND I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES.

I PERMIT A COPY OF THIS AUTORIZATION TO BE USED IN PLACE OF THE ORIGINAL. EITHER I OR MY INSURANCE COMPANY MAY REVOKE THIS AUTHORIZATION AT ANYTIME IN WRITING.

DATE________________________ SIGNATURE________________________________

(PATIENT OR LEGAL GAURDIAN)