24/7 On Call: □ Yes □ No

Languages staff speak: _____

Agency County Coverage:

□ Adams	□ Clinton	□ Lackawanna	□ Pike
□ Allegheny	□ Columbia	□ Lancaster	□ Potter
□ Armstrong	□ Crawford	□ Lawrence	□ Schuylkill
□ Beaver	□ Cumberland	□ Lebanon	□ Snyder
□ Bedford	□ Dauphin	□ Lehigh	□ Somerset
□ Berks	□ Delaware	□ Luzerne	□ Sullivan
□ Blair	□ Elk	□ Lycoming	□ Susquehanna
□ Bradford	□ Erie	□ McKean	□ Tioga
□ Bucks	□ Fayette	□ Mercer	□ Union
□ Butler	□ Forest	□ Mifflin	□ Venango
□ Cambria	□ Franklin	□ Monroe	□ Warren
□ Cameron	□ Fulton	□ Montgomery	□ Washington
□ Carbon	□ Greene	□ Montour	□ Wayne
□ Centre	□ Huntingdon	□ Northampton	□ Westmoreland
□ Chester	□ Indiana	□ Northumberland	□ Wyoming
□ Clarion	□ Jefferson	□ Perry	□ York
□ Clearfield	□ Juniata	□ Philadelphia	

Business References

#1 Company: _____

Phone: _____ Fax: _____

Contact Name: _____ Relationship: _____

Address: _____

#2 Company: _____

Phone: _____ Fax: _____

Contact Name: _____ Relationship: _____

Address: _____

#3 Company: _____

Phone: _____ Fax: _____

Contact Name: _____ Relationship: _____

Address: _____

Home Care Grant

Confidential Information

Have you, an agent, or a managing employee ever:

- □ Been terminated, excluded, precluded, suspended, debarred from or had their participation in any federal or state health care program, limited in any way, including voluntary withdrawal from a program for an agreed to definite or indefinite period of time?

- □ Been the subject of a disciplinary proceeding by any licensing or certifying agency, had his/her license limited in anyway, or surrendered a license in anticipation of or after the commencement of a formal disciplinary proceeding before a licensing or certifying authority(e.g., license revocations, suspensions, or other loss of license or any limitation on the right to apply for or renew license or surrender of a license related to a formal disciplinary proceeding)?

- □ Been convicted of a criminal offense related to Medicare or Medicaid; practice of the provider's profession; unlawful manufacture, distribution, prescription or dispensing of a controlled substance; or interference with or obstruction of any investigation?

- □ In connection with the delivery of a health care item or service, been convicted of a criminal offense relating to neglect or abuse of patients or fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct?

If you answered "yes" to any of the above, please attach documentation/explanation.

By signing below, you certify that the information provided by your organization is accurate and complete. You attest that your organization in good standing with the PA Department of Health and any other applicable regulatory bodies of oversight.

_____ _____

Signature of Authorized Designee Title

_____ _____

Print Name Date

HIPAA Release Authorization

I,_____, hereby authorize my physicians, nurses, home care agency, and all other health care providers and their staff (collectively, "health care providers") involved in my health care treatment, to release information regarding my location, medical condition, diagnosis and prognosis, as well as any other information about me, to include individually identifiable health information, and to freely converse and communicate, both orally and in writing, with the persons named below.

This document does not grant health care decision-making authority and does not in any way affect, inhibit, or otherwise limit the authorization granted in any existing health care power of attorney that I may have executed.

This document, executed by me pursuant to the Health Insurance Portability and Accountability Act of 1996, is effective immediately and is not to be affected by any subsequent incapacity.

I hereby release the disclosers of the above information from any liability for its release to the persons below. This authorization shall be in force and effect only for a period of one year from the date signed, below. The persons to whom my health care providers may disclose the above information, including individually identifiable health information, are:

The PA Foundation for Home Care and Hospice
and any of its employees or representatives
600 N. 12th Street, Suite 200, Lemoyne, PA 17043
Phone: 717-975-9448

AND

Name: _____ Phone:_____

Address: _____

AND

Name: _____ Phone:_____

Address: _____

_____ _____

Client/Representative Signature **Date**

_____ _____

Witness Signature **Witness Printed Name**

Home Care Grant

Client Information and Home Care Plan

Client Demographics

Name_____ Phone_____ DOB_____

Address_____

Emergency Contact_____ Relationship_____

Email_____ Phone_____

PCP Name_____ Phone_____

Planned Frequency of Home Health Care Services

(subject to change by customer request)

Care to be delivered in increments of_____ hours per_____ *(i.e. 2 hrs/week)*

Type of Care Requested

Personal Care

- ☐ Toileting
- ☐ Incontinence Care
- ☐ Bathing
- ☐ Grooming
- ☐ Lifting/Transfer Assistance
- ☐ Ambulation Assistance
- ☐ Medication Reminders

Other _____

Homemaker

- ☐ Meal Preparation
- ☐ Housekeeping
- ☐ Laundry
- ☐ Transportation

Skilled Care

- ☐ Skilled Assessment/Observation
- ☐ Medication Adherence/Management
- ☐ Disease Management
- ☐ Patient Education

Reason for Home Health Care Need

Check all that apply:

- ☐ Decline in Health Status
- ☐ Hospitalization within 30 days
- ☐ Discharge from LTCF within 30 days
- ☐ Other: _____
- ☐ Supplementing private pay services
- ☐ Waiting for funding approval through:_____

Other Current In-Home Services

Check all that apply:

- ☐ Meals on Wheels
- ☐ Other funded skilled Home Health Care
- ☐ Other funded non-medical Home Care
- ☐ Personal Emergency Response System
- ☐ Telehealth
- ☐ Other:

Client, representative and agency must notify The Foundation immediately if another funding source for home care services becomes available while active with The Foundation's Home Care Grant.