Welcome to We Care For You

Thank you for choosing us. This packet helps us plan personal care for your loved one.

HOW TO RETURN THIS PACKET

- Fill it in on your computer (this PDF is fillable) or print it and write clearly.
- Fax completed pages to (224) 225-1011, or bring them to your free in-home assessment.
- Please do not email completed forms. Regular email is not secure for health information.
- Questions? Call (847) 693-8669 (Monday – Saturday, 8:00 am – 6:00 pm Central). After hours: (224) 225-1011.

WHAT'S INSIDE

- ☐ 1. Client information & contacts
- ☐ 2. Care needs & schedule
- ☐ 3. Health information for care
- ☐ 4. Payment information
- ☐ 5. Client service agreement
- ☐ 6. Client rights & responsibilities
- ☐ 7. Acknowledgment of privacy notice
- ☐ 8. Authorization to share information

PLEASE ATTACH COPIES IF YOU HAVE THEM

- ☐ Current medication list
- ☐ Insurance or Medicaid card (front & back)
- ☐ Power of attorney / guardianship papers
- ☐ Advance directive, POLST or DNR form
- ☐ Hospital discharge instructions
- ☐ Photo ID of client

OFFICE USE ONLY

Received by	Date received	Assessment date

1. Client Information & Contacts

CLIENT

Client's legal name (first, middle, last)

Preferred name

Date of birth

Phone

Alternate phone

Home address (where care will be provided)

City

State

ZIP

County

Email (optional)

Preferred language

Lives:

- [ ] Alone
- [ ] With spouse/partner
- [ ] With family
- [ ] Other

Pets in the home?

Anyone smoke in the home?

Home entry instructions / door code

Communication preferences:

- [ ] OK to leave detailed voicemail
- [ ] OK to text
- [ ] Contact my representative first

EMERGENCY CONTACTS

Emergency contact 1: name

Relationship

Phone

Emergency contact 2: name

Relationship

Phone

RESPONSIBLE PARTY / DECISION MAKER (IF NOT THE CLIENT)

Name

Relationship

Phone

Email

Mailing address

This person is the client's:

- [ ] Health care POA
- [ ] Financial POA
- [ ] Legal guardian
- [ ] Family contact only

2. Care Needs & Schedule

Tell us what kind of help would make the biggest difference. We'll finalize the plan together at your free in-home assessment.

HELP NEEDED (CHECK ALL THAT APPLY)

- ☐ Bathing / showering
- ☐ Dressing
- ☐ Grooming / hygiene
- ☐ Toileting / incontinence care
- ☐ Moving around / transfers
- ☐ Medication reminders
- ☐ Meal preparation
- ☐ Light housekeeping
- ☐ Laundry / linens
- ☐ Companionship
- ☐ Transportation / errands
- ☐ Post-surgery support
- ☐ Grocery shopping
- ☐ Respite for family caregiver
- ☐ Illness recovery support
- ☐ Other

SCHEDULE REQUESTED

Requested start date

Hours per visit

Preferred times (e.g. 8am-12pm)

Days:

☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Sun

How long do you expect to need care? (e.g. 6 weeks after surgery, ongoing)

ABOUT THE CLIENT

Daily routine, hobbies and things they enjoy

Caregiver preferences (e.g. language, gender, non-smoker)

Goals for care: what would success look like?

3. Health Information for Care

Our caregivers provide non-medical help. This information helps them understand your loved one's needs and know whom to contact.

DOCTORS AND OTHER PROVIDERS

Primary doctor

Practice / clinic

Phone

Home health agency or other provider (if any)

Phone

Preferred hospital

Pharmacy

IMPORTANT HEALTH DETAILS

Allergies (medications, foods, other)

Health conditions caregivers should know about

Mobility:

- ☐ Walks independently
- ☐ Cane
- ☐ Walker
- ☐ Wheelchair
- ☐ Needs help to transfer

Concerns:

- ☐ Fall in last 6 months
- ☐ Vision
- ☐ Hearing
- ☐ Memory / confusion
- ☐ Wanders
- ☐ Swallowing

Special diet or food restrictions

Medical equipment in the home

Advance directives on file (please attach):

- ☐ Health care POA
- ☐ Living will
- ☐ POLST / DNR
- ☐ None

Medications: our caregivers give reminders only. They do not give or administer medications. Please attach a current medication list.

4. Payment Information

How will services be paid? (check all that apply)

- ☐ Insurance plan
- ☐ Medicaid
- ☐ DRS
- ☐ Private pay

Insurance plan:

- ☐ Molina
- ☐ CountyCare
- ☐ BCBS
- ☐ Humana
- ☐ Aetna
- ☐ Paradigm
- ☐ Other

PRIVATE INSURANCE

Insurance company | Member ID | Group number

Policyholder name | Policyholder date of birth | Relationship to client

Insurance phone (on back of card)

MEDICAID

Medicaid ID number | Plan name (if in a managed care plan)

BILLING CONTACT

Name | Phone | Email

Billing address

AGREEMENT

- I authorize We Care For You Nursing Agency to bill my insurance company or Medicaid for services and to share the information needed to receive payment.
- I understand that I am responsible for any services my insurance or Medicaid does not cover, as explained before those services begin.
- I understand that private pay visits have a 4-hour minimum, and that current rates and the cancellation policy are listed on the fee schedule provided with this packet.

Initials | Date

Signature of client or legal representative | Date | Printed name

If signed by a representative: relationship to client | Authority (POA, guardian, etc.)

5. Client Service Agreement

This agreement explains how We Care For You Nursing Agency ("the agency") will provide services and what you can expect.

OUR SERVICES

- The agency provides non-medical home services, such as personal care, companion care, medication reminders, meals, light housekeeping and transportation.
- Caregivers do not perform skilled nursing tasks, give injections, change sterile dressings, or give or administer medications. They may remind the client to take medications.
- Services follow a written care plan created after the free in-home assessment. We review the plan with you and update it when needs change.
- The agency will tell you before any change to your schedule, caregiver or rates whenever possible.

SCHEDULING AND EMERGENCIES

- To change or cancel a visit, call the office at (847) 693-8669 as soon as possible. Our cancellation policy is on the fee schedule.
- In an emergency, caregivers will call 911 first and then notify the agency and your emergency contact.
- Caregivers may not accept money, gifts, loans or valuables, use your credit cards, or sign documents for you.
- Please report any concern about a caregiver to the office right away so we can address it.

ENDING SERVICES

- You may stop or change services at any time by calling the office. The agency may end services with notice if it can no longer meet the client's needs, and will help with referrals when possible.

CONSENT

I have read this agreement, had a chance to ask questions, and consent to receive non-medical home services from We Care For You Nursing Agency.

Signature of client or legal representative

Date

Printed name

If signed by a representative: relationship to client

Authority (POA, guardian, etc.)

Agency representative signature

Date

Printed name

6. Client Rights & Responsibilities

AS OUR CLIENT, YOU HAVE THE RIGHT TO

- Be treated with dignity, courtesy and respect, and have your property respected.
- Be free from abuse, neglect, exploitation and discrimination.
- Take part in planning your care and be told in advance about the services you will receive and their cost.
- Refuse any service and to change or end services at any time.
- Privacy and confidentiality of your personal and health information, as described in our Notice of Privacy Practices.
- Voice concerns or complaints without fear of retaliation, and to have them addressed promptly.
- Receive information in a way you can understand.

YOU ARE RESPONSIBLE FOR

- Giving us accurate, complete information about your needs and telling us when they change.
- Providing a safe environment for caregivers, including securing pets and weapons during visits.
- Letting us know about schedule changes as soon as possible.
- Paying for services as agreed.

HOW TO SHARE A CONCERN

- Call the office at (847) 693-8669 (Monday – Saturday, 8:00 am – 6:00 pm Central) or (224) 225-1011 after hours. We will look into it and respond promptly.
- To report suspected abuse, neglect or exploitation of an adult 60 or older or an adult with a disability, call the Illinois Adult Protective Services Hotline at 1-866-800-1409 (24 hours a day; TTY users dial 711).
- In an emergency, call 911.

I have received and reviewed a copy of these Client Rights & Responsibilities.

Signature of client or legal representative

Date

Printed name

If signed by a representative: relationship to client

Authority (POA, guardian, etc.)

7. Acknowledgment of Receipt of Notice of Privacy Practices

Our Notice of Privacy Practices explains how we may use and share your health information and describes your rights. You can read it at wecareforyouagency.com/notice-of-privacy-practices or ask us for a paper copy at any time.

By signing below, I acknowledge that I have received a copy of the We Care For You Nursing Agency Notice of Privacy Practices.

Client name

Date of birth

Signature of client or legal representative

Date

Printed name

If signed by a representative: relationship to client

Authority (POA, guardian, etc.)

OFFICE USE ONLY: COMPLETE IF ACKNOWLEDGMENT WAS NOT OBTAINED

Reason:

- ☐ Client declined to sign
- ☐ Unable to obtain signature
- ☐ Emergency situation
- ☐ Other

Describe the good-faith effort made to obtain acknowledgment

Staff name

Date

Initials

8. Authorization to Share Health Information

Use this form if you want us to share information about your care with family members or others who are not already involved in your care or payment.

Client name

Date of birth

I authorize We Care For You Nursing Agency to share the information checked below with these people or organizations:

Person or organization 1

Relationship

Phone

Person or organization 2

Relationship

Phone

Person or organization 3

Relationship

Phone

Information that may be shared:

- ☐ Visit schedule and updates
- ☐ Care plan
- ☐ Changes in condition observed by caregivers
- ☐ Billing and payment information
- ☐ Other (describe below)

Other information / limits on what may be shared

Purpose (e.g. keep my family informed about my care)

This authorization ends on (date or event)

PLEASE READ

- You may revoke this authorization at any time by giving us written notice. Revoking it will not affect information already shared.
- Your care, payment, enrollment or eligibility for benefits will not depend on whether you sign this form.
- Information shared under this authorization may be re-disclosed by the person who receives it and may no longer be protected by federal privacy law.
- You have the right to a copy of this signed form.

Signature of client or legal representative

Date

Printed name

If signed by a representative: relationship to client

Authority (POA, guardian, etc.)