WesCare
Professional Services
a limited liability corporation

Name: _____

Medicaid No.: _____

Record No.: _____

DOB: _____

New Admission Packet

2704 N. Church Street · Greensboro, NC 27405 · 336.272.8335 voice · 336.272.8339 fax

WesCare Professional Services
a limited liability corporation

Name: _____

Medicaid No.: _____

Record No.: _____

DOB: _____

North Carolina Department of Health and Human Services

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Client Name _____ Date of Birth_____

Client Medical Record #_____ Client SS # *(Optional)*_____

I _____ hereby authorize
(Client or Personal Representative)

_____ to disclose specific health information
(Name of Provider/Plan)

from the records of the above named client to: _____
(Recipient Name/Address/Phone/Fax)

_____

for the specific purpose(s):_____

_____

Specific information to be disclosed: _____

_____

_____

I understand that this authorization will expire on the following date, event or condition: _____

_____

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the *Revocation Section* on the back of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information. I also 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 services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

I further understand that I may request a copy of this signed authorization.

_____	_____	_____
(Signature of Client)	*(Date)*	*(Witness-If Required)*
_____	_____	_____
(Signature of Personal Representative)	*(Date)*	*(Personal Representative Relationship/Authority)*

****

NOTE: This Authorization was revoked on _____ _____
(Date) *(Signature of Staff)*

DHHS-1000 (1/03)
Authorization to Disclose Health Information

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Professional Services
a limited liability corporation

Name: _____

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DOB: _____

REVOCATION SECTION

I do hereby request that this authorization to disclose health information of _____
(Name of Client)

signed by_____ on _____
(*Enter Name of Person Who Signed Authorization)* *(Enter Date of Signature)*

be rescinded, effective _____. I understand that any action taken on this authorization prior to the rescinded date is legal
(Date)

And binding.

_____ _____ _____ _____
(Signature of Client) *(Date)* *(Signature of Witness)* *(Date)*

_____ _____ _____
(Signature of Personal Representative) *(Date)* *(Personal Representative Relationship/Authority)*

VERBAL REVOCATION SECTION

I do hereby attest to the verbal request for revocation of this authorization by _____
(Name of Client or Personal Representative)

on _____. The client or his personal representative has been informed that any action
(Date)

taken on this authorization prior to the rescinded date is legal and binding.

_____ _____ _____ _____
(Signature of Staff) *(Date)* *(Signature of Witness)* *(Date)*

WesCare
Professional Services
a limited liability corporation

Name: _____

Medicaid No.: _____

Record No.: _____

DOB: _____

CONSENT FOR RELEASE OF CONSUMER INFORMATION

I, the above named hereby authorize _____
(Name of Center/Program to Release Information)

to release specified information to **WesCare Professional Services, LLC**
(Name of Person/Agency to Receive Information)

and in addition authorize **WesCare Professional Services, LLC**
(Name of Center/Program to Release Information)

to release specified information to _____
(Name of Person/Agency to Receive Information)

This information shall include only the nature and to the extent which is specified below:

- ☐ Reason for Referral/Admission
- ☐ Assessments/Testing – Educational/IQ, Vocational, Speech, Hearing, Vision, Psychological, Psycho-Social, etc. Affecting CURRENT level of Functioning
- ☐ CURRENT Medications, if applicable
- ☐ School Academic Achievement and Behavior Concerns
- ☐ Other Information _____

I understand the contents to be released, the need for the information, and that there are state and federal regulations protecting the confidentiality of authorized information, and that it cannot be released without my written consent unless otherwise provided for in the regulations. I hereby acknowledge that this consent is truly voluntary and is valid for a period not to exceed one year. I further acknowledge that I may revoke this consent at any time except to the extent that action based on this consent has been taken. Any revocation of consent must be in writing.

_____ _____
Client Signature Guardian/Legally Responsible Person

_____ _____
WesCare Representative Date of Consent

WesCare
Professional Services
a limited liability corporation

Name: _____
Medicaid No.: _____
Record No.: _____
DOB: _____

FACE SHEET
IDENTIFICATION PAGE

CLIENT NAME _____
First Middle Last

ADDRESS: _____

_____

COUNTY OF RESIDENCE: _____

MALE ☐ FEMALE ☐ RACE _____

HOME PHONE: _____ OTHER PHONE: _____

MARITAL STATUS: _____ DATE OF BIRTH: _____ AGE: _____

CLIENT #: _____ SOCIAL SECURITY: _____
MEDICAID: _____ MEDICARE: _____

DIAGNOSIS: AXIS I _____
AXIS II _____
AXIS III _____
AXIS IV _____
AXIS V _____
Allergies: _____

PHYSICIAN: _____ PHONE: _____
ALTERNATE PHYSICIAN _____

AMBULANCE: _____ PHONE: _____
FIRE DEPT: _____ PHONE: _____
POISON CONTROL CENTER: _____

IN CASE OF EMERGENCY, NOTIFY _____

_____

SHOULD ONLY BE NOTIFIED BY OFFICER ON DUTY:

_____
PARENT/GUARDIAN/OTHER CONTACT RELATIONSHIP

ADDRESS _____ PHONE _____
LEGAL STATUS

_____

DATE OF ADMISSION _____ DATE FORM COMPLETED _____

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WesCare
Professional Services
a limited liability corporation

Name: _____
Medicaid No.: _____
Record No.: _____
DOB: _____

MEDICAL TREATMENT AGREEMENT

As the parent/guardian of the above-named resident of WesCare Professional Services, LLC, hereafter referred to as WesCare, I grant WesCare the right to seek and obtain medical treatment on an as needed basis from the following:

_____

_____

I understand that this permission is granted for a period of one (1) year from this date, and that I may withdraw this permission at any time I so choose by submitting a written document stating my desire to withdraw said permission to any member of the WesCare treatment team.

_____
Date

_____
Parent/Legal Guardian Signature

_____
WesCare Representative

WesCare
Professional Services
a limited liability corporation

Name: _____

Medicaid No.: _____

Record No.: _____

DOB: _____

MEDICATION AUTHORIZATION

The below mentioned medication has been prescribed for _____

_____ by his/her physician.

Medication:

_____

_____

_____

_____

You may request additional information about this medication and its side effects through the QP, RN, or Social Worker.

I, _____, give permission for certified staff of WesCare, to administer the above mentioned prescribed medication for treatment purposes. I have been notified of the possible adverse side effects that could occur.

I, _____, will self-administer medication, therefore, there are no prescriptions written and there is no medication administration record in the client file.

I hereby acknowledge that this consent will expire automatically after 365 days from the date on which it is signed.

_____ _____

Client Signature

Parent/Guardian/Legally Responsible Person

_____ _____

WesCare Representative

Date of Consent

WesCare
Professional Services
a limited liability corporation

Name: _____
Medicaid No.: _____
Record No.: _____
DOB: _____

MEDICATION IDENTIFICATION FORM

The client has been prescribed the medication listed below. This form is used for staff training purposes only.

Date	Medication	Init.

Date	Medication	Init.

The QP will update this form, as needed, if the client has a change in medication.

_____ _____
QP Signature Date

_____ _____
QP Signature Date

_____ _____
QP Signature Date

WesCare
Professional Services
a limited liability corporation

Name: _____

Medicaid No.: _____

Record No.: _____

DOB: _____

SELF-ADMINISTRATION OF MEDICATION AGREEMENT

(This form is used for adult consumers over the age of 18 that have demonstrated the ability and willingness to self-administer. It can also be used for consumers under 18 who require medications that: **1**. can be more effectively self-administered and only monitored by staff, **2.** create an uncomfortable situation for the consumer, and **3.** can more effectively be used or applied by the consumer. Some examples of these medications include topicals, enemas, and some injections.)

I, _____, (Guardian or legally responsible people) give

_____ (Consumer) permission to self-administer the following medication(s).

1) _____

2) _____

3) _____

4) _____

(Add an additional Sheet of paper in needed)

WesCare will not administer these medications (unless requested by the consumer) to the aforementioned consumer, yet will be available to assist with reading prescriptions/directions as prescribed by the physician.

I hereby acknowledge that this consent will expire automatically after 365 days from the date on which it is signed.

_____ _____

Consumer (if legally responsible person) Legally Responsible Person

_____ _____

WesCare Representative Physician/Psychiatrist Signature

_____

Date of Consent

WesCare
Professional Services
a limited liability corporation

Name: _____

Medicaid No.: _____

Record No.: _____

DOB: _____

CONSENT TO PHOTOGRAH, RECORD AND FILM

THIS FORM IS TO BE COMPLETED PRIOR TO ANY RECORDING, PHOTOGRAPHING AND/OR FILMING.

I hereby give WesCare Professional Services, LLC, hereafter referred to as WesCare, my consent to photograph, record, and/or film _____ (consumer name)

_____(Parent/Legal Guardian/Correspondent)

This material may be used for the purpose of:
_____Training and Education*
_____Public Information
_____Other _____

I understand that the materials produced are the exclusive property of WesCare and I hereby relinquish all rights, title, and interest therein and give WesCare my consent to retain, reproduce, and use the materials as authorized above in the future, except for the following exclusions or limitations: _____

_____

This consent is subject to revocation by undersigned at any time except to the extent that action has been taken in reliance thereon.

_____ _____
Client Date

_____ _____
Legally Responsible Person Date

_____ _____
Relationship to Consumer

_____ _____
WesCare Representative Date

*Including, but not limited to, new employee training, in-service training and continuing education for staff, programs for interns and trainees in the health care field, workshop and seminars on health care. No further filming will occur at termination of services/placement.

WesCare
Professional Services
a limited liability corporation

Name: _____
Medicaid No.: _____
Record No.: _____
DOB: _____

PERSONAL FUNDS USE

Consumers of WesCare Professional Services, LLC., hereafter referred to as WesCare, will be required to use their personal funds for the following:

1. Pocket money for outings
2. Clothing, accessories and personal equipment (i.e., private radio, TV, etc.)
3. Any beauty and/or barber shop trip over $10.00
4. Money needed for school/educational outings
5. Personal video tapes, cassette tapes, or magazines for the resident's enjoyment.
6. Dry cleaning of clothing items.
7. Premiums for personal insurance policies.
8. Fees for camps, vacations, etc.

I have reviewed the above list and understand _____ (Consumer name) personal funds will be used toward this end.

_____ _____
Parent/Legal Guardian Date

WesCare
Professional Services
a limited liability corporation

Name: _____

Medicaid No.: _____

Record No.: _____

DOB: _____

INSURANCE INFORMATION

List Insurance(s) that cover this consumer:

1. _____

Address: _____

Policy Holder: _____

Insurance# _____

2. _____

Address: _____

Policy Holder: _____

Insurance# _____

3. _____

Address: _____

Policy Holder: _____

Insurance# _____

4. _____

Address: _____

Policy Holder: _____

Insurance# _____

WesCare
Professional Services
a limited liability corporation

Name: _____

Medicaid No.: _____

Record No.: _____

DOB: _____

CLIENT FEES

As a Provider of residential and periodic services, State and Federal regulations bind WesCare Professional Services, LLC., in the area of client fees.

As a consumer or Parent / Legal Guardian of a consumer who is served by WesCare Professional Services, LLC., you may expect the following in relation to client fees:

- Most of our clients are eligible for Medicaid funding services. In these cases, there shall be no fees charged for services allowed and reimbursed by Medicaid.
- In those rare cases of a private-pay consumer, the person legally responsible for the client will be billed monthly, in arrears, for services provided.
- The private-pay daily rate for services will be equal to the Medicaid daily rate for the service provided, i.e., residential or periodic.
- Those personal items and services not covered in the Medicaid daily rate include such items as toothpaste, cosmetics, hair care products, haircuts, etc. These items are generally covered by SSI. It may be necessary to bill the consumer or person legally responsible person for the consumer for these items if sufficient SSI funds are not available.

If you have any questions about these issues, please contact the supervising QP for this case.

_____ _____

WesCare Representative Parent / Legal Guardian

_____

Date

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WesCare
Professional Services
a limited liability corporation

Name: _____

Medicaid No.: _____

Record No.: _____

DOB: _____

EXPLANATION OF CLIENT RIGHTS

Basic Human Rights are assured to each client/consumer served by WesCare Professional Services, LLC. These rights include the right to dignity, privacy, humane care, and freedom from mental and physical abuse, neglect, and exploitation. Each client/consumer is assured the right to live as normally as possible while receiving care and age-appropriate treatment.

Each client/consumer has the right to:

- Have an individualized written treatment or habilitation plan setting forth program to maximize the development of her/his capabilities
- Be free from unnecessary or excessive medication. Medication shall not be sued for punishment, discipline, or staff convenience.
- Have medication administered in accordance with accepted medical standards and only upon the order of a physician as documented in the consumer's record. (WesCare Professional Services), Staff may not measure medication, but assist with self-administration of medication that has been pre-measured by the legally responsible person and left for the provider to give at a specified time. If the client/consumer refuses to take the medication, the (WesCare Professional Services), Staff or provider may not force her/him to take the medication.
- Consent to or refuse any treatment offered. Consent may be withdrawn at any time by the person who gave consent. If treatment is refused, the qualified professional shall determine whether treatment in some other modality is possible.
- Keep the same right (as age requirement permit) as any other citizen to exercise rights, unless the exercise of a civil right has been disallowed by an adjudication of incompetence, including the right to:

  - dispose of property
  - make purchases
  - register and vote
  - marry and get a divorce
  - send and receive sealed mail
  - make/receive confidential telephone calls
  - make visits and receive visitors
  - communicate with individuals of his own choice
  - keep and use personal possessions
  - keep and spend money
  - execute instruments
  - enter into contracted relationships
  - bring civil actions
  - contact and consult with legal counsel, private physicians, other professionals and consumer advocates
  - be out of doors daily and have access to physical exercise
  - participate in religious worship
  - retain a driver's license as appropriate

My signature below acknowledges that client's rights have been explained to me. I now have a working knowledge of the information above.

_____ _____.

Client Date

_____ _____.

Parent/Guardian Date

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WesCare
Professional Services
a limited liability corporation

Name: _____

Medicaid No.: _____

Record No.: _____

DOB: _____

CONSENT FOR SERVICE

I, _____ give my consent to

WesCare Professional Services to provide direct consumer services for

_____

Guardian:_____

WesCare Rep.:_____

Title:_____

Date:_____

WesCare
Professional Services
a limited liability corporation

Name: _____

Medicaid No.: _____

Record No.: _____

DOB: _____

CONSENT FOR TRANSPORTATION

I, _____ give my consent to

WesCare Professional Services to provide and/or arrange general transportation services for

_____

Signed Parent/Guardian:_____

WesCare Rep.:_____

Title:_____

Date:_____

WesCare
Professional Services
a limited liability corporation

Name: _____
Medicaid No.: _____
Record No.: _____
DOB: _____

MEDICAL/SURGICAL AGREEMENT

As the parent/legal guardian of the above-named resident of WesCare Professional Services, LLC hereafter referred to as WesCare, I hereby grant limited power of attorney to act on behalf of the consumer in case of a medical emergency or condition requiring immediate medical/surgical intervention when attempts to contact the parent/legal guardian have been unsuccessful for the purpose of gaining signed consent for treatment.

Parent/Legal Guardian Signature: _____

Date: _____

NORTH CAROLINA

County of _____

I, _____ , Notary Public, do certify that _____personally came before me this day and acknowledged that _____ is a consumer of W.P.S., and that the facility personnel has the authority to act on behalf of _____ _____ , and willingness agrees to the foregoing stipulation of this agreement.

Witness my hand and notaries seal this _____ day of _____ , 200 .

_____
Notary Public

My Commission expires: _____

WesCare
Professional Services
a limited liability corporation

Name: _____
Medicaid No.: _____
Record No.: _____
DOB: _____

Screening/Referral Form

Date: _____ Referring Agency: _____

DSM IV Diagnosis:

_____
_____
_____
_____

Current Status/Issues:

_____
_____
_____
_____

Medication:

_____
_____
_____
_____

Educational Status/Needs:

_____
_____
_____
_____

Family History:

_____
_____
_____
_____

Vocational Status/Needs:

_____
_____
_____
_____

Physical Concerns or Problems:

_____
_____
_____
_____

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WesCare
Professional Services
a limited liability corporation

Name: _____

Medicaid No.: _____

Record No.: _____

DOB: _____

Screening/Referral Form **(con't)**

Previous Placement History:

_____
_____
_____
_____

Recommendations:

_____
_____
_____
_____

Signature: _____ **Title:**_____

Phone: _____

Date: _____

WesCare
Professional Services
a limited liability corporation

Name: _____
Medicaid No.: _____
Record No.: _____
DOB: _____

VISITATION REPORT

Resident's Name: _____

Persons who have permission to visit the consumer, _____at their residence.

_____

_____

_____

_____

Persons who have permission to visit the consumer, by a pre-arranged meeting or can remove the consumer from the premises for day visits. These are not to be overnight visits.

_____

_____

_____

_____

Comments:

_____

_____

I understand that WesCare Professional Services, LLC., its personnel, and attending physician will NOT be held responsible for any accidents or for any deterioration while the consumer is not at their residence in any of the above-referenced person's care. I further understand that I can rescind this permit at any time by notifying the supervising QP, the Clinical Director, or the Operations Director in writing.

_____ _____

WesCare Representative Parent / Legal Guardian

_____

Date

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WesCare
Professional Services
a limited liability corporation

Name: _____

Medicaid No.: _____

Record No.: _____

DOB: _____

RESTRICTIVE INTERVENTION CONSENT

Date: _____

Our company's policy requires all staff to complete a restrictive interventions course, as there are times when the behavior of our consumers calls for physical/restrictive intervention by staff. Therefore, WesCare Professional Services, LLC. requires consent to use restrictive interventions, if needed, if continuous behaviors exist, namely:

- Consumer is causing or attempting to cause injury to another consumer, staff, or other individual
- Consumer is causing or attempting to cause injury to himself or herself
- Consumer is causing or attempting to cause excessive property damage

WesCare will not use time outs, isolation, or seclusion. Nor does WesCare use mechanical devices or medication regimen protocols as a means to control the behaviors of a consumer. WesCare will only use prescribed medications from a licensed physician, and only for its intended purpose.

I, _____, hereby give consent for WesCare Professional Services, LLC. to use restrictive interventions, as needed, if the aforementioned conditions exist. I further understand that this consent is valid for six months from the date that it is signed. This consent may be revoked with written notice at any time prior to the six month expiration date.

_____ _____

Signature of Parent/Guardian Date

_____ _____

Signature of WesCare Representative Date

For office use only

NCI INSTRUCTOR'S TEMP APPROVAL DATE (good for 30 days)**:** _____

NCI INSTRUCTOR'S SIGNATURE:_____

---------- **CLIENT RIGHTS COMMITTEE USE BELOW** ----------

CRC REVIEW DATE:_____ ☐ **APPROVED** ☐ **DENIED**

REASON FOR DENIAL:_____

CRC APPROVAL DATE: _____ **CRC EXPIRATION DATE:** _____

NCI INSTRUCTOR SIGNATURE: _____

CRC CHAIR SIGNATURE: _____

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WesCare
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Name: _____

Medicaid No.: _____

Record No.: _____

DOB: _____

STANDING ORDERS

The following orders are good for 1 year from the date signed. Strike through any orders you do not want applied to this consumer. Age and weight have been taken into consideration, and dosages may be administered according to age/weight if different than directions listed below.

PAIN: Tylenol (Acetaminophen) 650mg – Q 4 hrs prn for minor pain/headache x 48 hrs (may give tablet, liquid=20 cc or suppository form as patient's condition indicates). Notify M.D. of continued minor pain or headache.

COUGH: Robitussin D.M. (Guaifenesin w/Dextromorphan) 10ml – po Q 4 hrs prn for cough x 48 hrs. Notify M.D. of continued cough. (DO NOT TAKE WITH TYLENOL COLD.)

SORE THROAT: Chloraseptic spray/lozenges – 5 sprays or dissolve 1 lozenge Q 2 hrs prn for sore throat x 48 hrs. Notify M.D. of continued sore throat.

RUNNY NOSE: Tylenol Cold Tabs every 6 hrs, not to exceed 8 tabs in 24 hrs. Do not take any Tylenol or any ANSAIDS while on this.

INDIGESTION: Mylanta (antacid) susp. – 30ml po Q 4 hrs prn indigestion/stomach upset x 48 hrs. Notify M.D. of continued symptoms.

CONSTIPATION: MOM – 30ml po Q day x 1 prn for constipation. If no results within 24 hrs, may give Dulcolax (bisacodyl) supp. PR x 1 prn for constipation. If no bowel movement in 24 hrs. check for impaction. If impacted, remove impaction. If not impacted, give Fleets Enema PR x 1. If not effective, notify M.D.

DIARRHEA: If 3 loose stools in 24 hrs, hold all laxatives and stool softeners. Kaopectate 30 cc po after 1st loose stool, then every 2 hrs prn – no more than 6 doses in 24 hrs.

NAUSEA: Dramamine (dimenhydrinate) 50mg po Q 4 hrs prn for nausea x 48 hrs. Or Phenergan 25mg supp. Q 4 hrs prn for nausea x 48 hrs. If not effective, notify M.D.

MINOR SCRATCHES: Cleanse area with peroxide and apply Neosporin (triple antibiotic ointment), and then apply non-adhering dressing Q day until healed.

RASH: Benadryl (diphenhydramine) 25mg bid prn for rash x 24 hrs. Do not overlap with other antihistamine medications. If not resolved in 24 hrs, call M.D.

Allergies: _____ Weight: _____

Signature of Physician: _____ Date: _____

Other Orders / Modifications: _____

_____

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WesCare
Professional Services
a limited liability corporation

Name: _____
Medicaid No.: _____
Record No.: _____
DOB: _____

PROVIDER SELECTION FORM

I, _____, have been provided a list of service providers. My signature below confirms that I have selected my service provided freely, without influence, pressure or coercion, direct or indirect, from my Case Manager or any member of my family or treatment team.

I have selected **WesCare Professional Services, LLC.** to be my *(mark all that apply)*

_____ Residential/Supported Living
_____ Community Support (child, adolescent, team)
_____ Supported Employment
_____ Targeted Case Management
service provider.

_____	_____	_____
Consumer	Legal Guardian	Date

_____	_____
WesCare Representative	Date