

First
Formal
Last

Client Intake



Main Office:
744 E 13th Ave
Anchorage, AK 99501
907-644-0480 (Tel)
907-644-4655 (Fax)

Status
 ANCHORAGE VALLEY

Client Cell or Room Phone #:

ALH Name (or "Private- Last name")
Home Phone #
Address
Administrator
Administrative # Fax
E-Mail:

Current Waiver client?

Gray boxes = Office Use Only

Screening Date: By
1st outing:
Last Full Review: By
Current signed information release?
Photo on file?
OK to publish photo? (P = yes)
Last profile printed:

ALH transport notes:
Transportation contact & relationship:
Health contact & relationship:

Admin Communication Log

Private Home? Okay to be home alone?
If "yes," make note in QNotes.
one on one Other Residents and their Relationships:

Scheduling Preferences (AM, PM, days):

Date of Birth Age Gender Marital Status DSDS case #
(OA, AP, etc.)
P(ivate Pay), M(edicaid) or VA?
Medicaid # Private Pay: Service Agreement?

Legal Representative
Role/ Relationship S,POA,G?
Phone Fax
E-Mail
Mailing Address

Unless otherwise stated, clients with POAs are permitted to sign their own paperwork and make their own decisions, while clients with guardians and conservators need these representatives to make their decisions and sign for them.

Deemed unable to sign for self and make decisions?

Emergency/ Family Contact (not admin, legal rep, care coord):
Relationship Contact# E-Mail
2nd Emergency/ Family Contact
Relationship Contact # E-Mail

Care Coordinator Work# Cell#
Agency E-Mail Fax

Doctor Doctor's # Doctor's Fax #
Hospital Pref? Other Insurance?

Background (family, work, residences)
Interests

Native-Alaskan? Corporation? Religion/ spirituality?

Native-American? Tribe? Ethnicity?

Allergies

Food/Drink Restrictions Special diet? No (diabetic, renal, soft foods, choking risk) If "no," leave blank.

Diagnoses

Medications

Ambulatory? Uses Walker? Strong? Small or large?

Uses Wheelchair? Motorized? Quick Notes- amb, cell, DNR?

Transferring Notes (independent, X1 assist, X2 assist, gait belt, toilet/ vehicle assistance)

Behavioral/ Health Notes (QList)

Questions for third parties, if applicable:

Wears undergarments/ incontinent? (inc = yes)

Do Not Resuscitate/ Comfort One? DNR doc on file?

L or R side weak/ paralyzed?

Low awareness? Deemed unable to sign for self and make decisions?
Weak memory?
Become agitated?

Continent? Need prompting and direction?

Disturbed emotionally?

Catheter?

Isolation tendencies?

Colostomy? Expiration date of annual TB clearance for + PPD:

Wanders? When?

Assistance needed in any of these areas? Explain

Vision

Explain:

Hearing

Communication (language & style)

Seizures? Seizure details/ procedure:

Currently on seizure meds? (Sz = yes)

Regarding the client's past and present actions:

ER visits in the past year?

Alcohol abuse? Physically abusive?

Overall Health Stable?

Verbally abusive? Sexual offender?

Explain:

Explain:

Health & Social Concerns

Initial Evaluation

Goals: Physical

Goals: Cognitive

Goals: Social

Goals: Emotional Increased self esteem, worth, and confidence through positive attitudes, conversation and encouragement from staff and peers.

First Last DOB

Date Signed: _____ ***This signed release is valid during the duration of services rendered by Hearts & Hands. Please notify us of any changes. This release expires on the date of termination of services from Hearts & Hands.***

Legal Representative: Role:

ALH staff, admin, and/ or caregivers: Deemed unable to sign for self and make decisions?

Emergency/ Family Contact:

2nd Emergency/ Family Contact:
OK to communicate with Dept of Public Assistance about client's care and/or case management?

Unless otherwise stated, clients with POAs and conservators are permitted to sign their own paperwork and make their own decisions, while clients with guardians need these representatives to make their decisions and sign for them.

Doctor:

Hospital Preference:

Do Not Resuscitate/ Comfort One? Photograph?

Care Coordinator:

Emergency Medical Consent

I authorize Hearts and Hands staff to initiate medical help and to contact those persons listed above in case of an emergency. The representatives listed above will be updated in accordance with changes presented by any of the above representatives. If my doctor cannot be reached, permission is hereby granted for you to call a licensed physician (or authorized emergency medical response team) of your own selection and arrange transportation to the most convenient hospital. I also authorize release of any information deemed relevant during the emergency, and agree to be responsible for the medical expenses incurred.

I authorize the above legal representative, caregivers, emergency/ family contacts, care coordinator, doctor, and hospital to be contacted in the case of an emergency.

Release of Confidential Information

I hereby give permission for the administrative staff of Hearts and Hands Adult Day Services to discuss information pertaining to the background and current status of my situation with the representatives listed above, in order to best serve my needs. The representatives listed above will be updated in accordance with changes presented by any of the above representatives. This consent applies only to the matters listed above. I understand that I may revoke this consent at any time. This consent is automatically terminated when my services with Hearts and Hands is terminated.

Consent to Publication by Hearts and Hands (unless an "N" is noted in the "Photograph?" box)

I certify that I am at least 21 years of age, having the right to contract in my own name to the extent herein set forth. I hereby grant to Hearts and Hands, Inc permission to use, print, or publish for company internal communications, newsletters and/or press releases my portrait or group photographs or videos in which I may appear. I also understand that any such photos or video images will not be sold nor bartered to any other person or agency, and further, that Hearts and Hands, Inc will not make public any photo or video of me that would be deemed derogatory, insulting, or inflammatory by a reasonable public.

Except as noted above, I hereby release and discharge Hearts and Hands, Inc from any and all claims and demands arising out of or in connection with the use of any of the foregoing, including any claims for defamation, invasion of privacy or violation of any statutory right.

Client/ Legal Representative Signature: _____ Date _____

Witness to Execution of Release (Signature): _____ Date _____

Witness to Execution of Release (Printed Name): _____