Class Home Health, Inc.
8660 W Flagler St. Suite 121
Miami, Fl 33144
Ph: 305-227-1998
Fax: 305-227-1726
E-mail: 1classhomehealth@bellsouth.net

ACKNOWLEDGMENT FORM

I ____ the undersigned employee, Independent Contractor or agent of 1st Class Home Health, Inc. hereby acknowledge and certify that the assessments, notes, and information that I have provided for the period of ____________________________ for the patients listed below:

Patient Name	Patient Name
Patient Name	Patient Name
Patient Name	Patient Name
Patient Name	Patient Name
Patient Name	Patient Name

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I attest to 1st Class Home Health, Inc. that the service provided, are the result of direct patient care and observation and they are correct to the best of my knowledge. I certify that the patients that are under my care are all homebound as outlined in CMS guidelines and that all patients are authentic. I understand that this information will be used by the company to bill third parties, including the state and federal government. I further agree that I have been informed to report any discrepancy in treatment or patient status that I observe, including any change in patients condition including homebound status.

I agree to attend training sessions specifically designed to cover company's policies and procedures in detail and have been given the opportunity to ask any questions relating the company's policies including its compliance plan.

I will cooperate fully with the Compliance Committee and Compliance Officer to the extent necessary or helpful to assure that 1st Class Home Health, Inc. is fully compliant with all State and Federal regulations.

A copy of this form will be given. Please retain for your records.

Employee/Independent Contractor: ____________________________________

Position: ____________________________________

Date: ____________________________________

Witness: ____________________________________

CARI HOME CARE, INC.

AFFIDAVIT OF SERVICE AUTHORIZATION/APPROVAL

(see attached the Plan of Care Signed)

Patient Name: ____ Date: _________________________

Address: ____ MR #: _________________________

____ Dx: _________________________

Phone: ____ _______________________________

Attending Physician: ____

Address: ____

____

Phone: ____

Type of Visit: SN HHA Therapy MSW (circle) Other: _______________________________________

AFFIDAVIT

I Affirm that the above mentioned Patient, was under my Care in the Period of: _________________________ to __________________________, He/She was referred to CARI HOME CARE, INC. for Home Care Services, that was Medically Necessary at that time, due to:

____

____

____

Homebound reason: ____

I, ____, hereby swear or affirm that these statements are true and correct.

____ ____________________________

Signature of Physician Date / Fecha

____

Witness/Testigo

____

Agency Representative Name/Signature

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Universal Home Healthcare, Inc.
8603 South Dixie Hwy. Suite 310. Miami. Fl 33143
Tel: (305) 665-8101 Fax: (305) 665-8208

CAREGIVER AFFIDAVIT

Patient Name: ____ Date: ________________________

Attending Physician: ____ Medicare #: ____________________

Type of Visit: Injectable medication administration; Type of Medication: ________________________________

Name of Caregiver(s): ____

Relationship to Patient: ____

Reason caregiver unable to administer injectable medication:

___ Caregiver refused to be instructed, explain:

____

____

___ Busy work schedule, explain:

____

____

___ Functional limitations, explain:

____

____

___ Other

____

____

Affidavit

I, ____________________________________, hereby swear or affirm that these statements are true and correct.

____ ________________________

Signature of Caregiver Date

____

Witness

____

Universal Representative Title

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CARI HOME CARE, INC.

PATIENT AFFIDAVIT FOR SERVICES

Patient Name *(Nombre)*: ______________________ Date/*Fecha*: ______________

Address: ______________________ MR #: ______________

Dirección: ______________________ Dx: ______________

Phone/Teléfono: ______________________ ______________

If ALF, Nursing Home, Facility name: ______________________

(Nombre/teléfono del ALF) Phone: ______________________

SOC Date: ______________________

Staff Assigned: ______________________

(Empleados) ______________________

____

Type of Service: SN HHA Therapy MSW (circle) Other: ______________________

Servicios

AFFIDAVIT

I Affirm that I receive Services from CARI HOME CARE, INC. From: ______________ to ______________. In my place of residency I'm able to receive the following services:

Yo afirmo que recibo servicios de CARI HOME CARE, INC. Desde: ____________ to ____________. donde yo vivo.

SN HHA Therapy MSW (circle) Other: ______________________

I refuse the services offered in my place of residence, due to:*(Rechazo los servicios ofrecidos a mi en mi lugar de residencia por:)*

____

____

____

I exercise my right/choice to use the Services from CARI HOME CARE, INC. *Yo he ejercido mi derecho de Utilizr los servicios de CARI HOME CARE, INC.*

I, ______________________, hereby swear or affirm that these statements are true and correct. *Afirmo que lo dicho anteriormente es verdad y correcto.*

______________________ ______________

Patient/Client Signature / Firma Date / Fecha

____

Witness/Testigo

____

Agency Representative Name/Signature

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305.818.5940

KEYS HEALTH CARE, INC.

CAREGIVER AFFIDAVIT/*Declaración Jurada*

Willing to assist Patient in Disease Management/*de Asistencia al Paciente*

Patient Name: ______________________ **Med. Record:** __________ **Date:** __________
Nombre del Paciente *Fecha*

Attending Physician: ______________________ **Medicare or HIC #:** ______________________
Nombre del Doctor *Número de Medicare o Reclamo de salud*

Type of Service: ☐ **Injectable medication administration** **Type of Medication:** ______________________
Administracion de medicamento injectable *Tipo de medicamento*

Tipo de servicio **Administration time:** ☐ **AM** ________ ☐ **Noon** ________ ☐ **PM** ________ ☐ **Other:** __________

☐ **Reinforced technique***(Repaso de Tecnica)* ☐ **Encouraged Aseptic/Universal precautions/Infection Control/Handwashing**

☐ **Instructed to call Physician/Agency/911 if any problem arises** *(llamar por ayuda)* ☐ **Instructed to use Biohazard container**

☐ **Other Instructions:** ______________________ ☐ **All information was explained to me in my primary language**

☐ **Wound Care***(cuidado de heridas)* ☐ **Ulcers/***Ulceras* **Wound Care Order:** ______________________

Wound Care time: ☐ **AM** ________ ☐ **Noon** ________ ☐ **PM** ________ ☐ **Other:** __________

☐ **Reinforced technique** ☐ **Encouraged Aseptic/Universal precautions/Infection Control/Handwashing**

☐ **Instructed to call Physician/Agency/911 if any problem arises** ☐ **Instructed to use Biohazard container**

☐ **Other Instructions:** ______________________ ☐ *Toda la información se me explicó en mi idioma*

Other Service: ☐ ______________________ **Procedure:** ______________________
Otros Servicios

Procedure time: ☐ **AM** ________ ☐ **Noon** ________ ☐ **PM** ________ ☐ **Other:** __________

☐ **Reinforced technique** ☐ **Encouraged Aseptic/Universal precautions/Infection Control/Handwashing**

☐ **Instructed to call Physician/Agency/911 if any problem arises** ☐ **Instructed to use Biohazard container**

☐ **Other Instructions:** ______________________

Name of Caregiver(s): ______________________

☐ **Qualified/willing to perform the procedure** ☐ **Need further training** ☐ **Accept full responsibilities**
Estoy calificado para realizar el procedimiento *Necesito mas entrenamiento* *Acepto las responsabilidades*

Comment/*Comentario*: ______________________

Relationship to Patient: ______________________
Relación con el paciente

☐ **Other Caregiver concerns, explain** *(Otras preocupaciones del cuidador, explicar)*: ______________________

☐ **Any Functional limitations, explain** *(Cualquier limitacion funcional, explicar)*: ______________________

☐ **Other/Safety precautions, explain** *(Otras/Precauciones de seguridad, explicar)*: ______________________

AFFIDAVIT/*Declaración Jurada*

I, ______________________, **hereby swear or affirm that these statements are true and correct.**
Yo *Juro que todo lo escrito en la forma es verdad.*

Signature of Caregiver: ______________________ **Date:** __________
Firma del Cuidador *Fecha*

☐ **All information was explained to me in my primary language** ☐ *Toda la información se me explicó en mi idioma*

Witness/Agency Signature: ______________________ **Date:** __________
Testigo/Firma del Representante de la Agencia *Fecha*

Agency Representative Name/Title: ______________________
Representante de la Agencia

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305.818.5940

HMHC INC
Health Med Home Care, Inc.

CONSENT/DECLINE TO SPECIAL TREATMENTS

I HEREBY AUTHORIZE HEALTH MED HOME CARE, INC., TO RENDER APPROPRIATE SERVICES AS PRESCRIBED BY MY PHYSICIAN, OR BY ANY OTHER PHYSICIAN WHO MAY BE TREATING ME, INCLUDING ALL DIAGNOSTIC AND THERAPEUTIC TREATMENT THAT MAY BE CONSIDERED ADVISABLE OR NECESSARY IN THE JUDGMENT OF THE PHYSICIAN.
I HEREBY AUTHORIZE/DECLINE, AS BELLOW, HEALTH MED HOME CARE, INC., OR THEIR AGENTS TO PERFORM ANY WORK IN TAKING BLOOD SAMPLES FROM ME OR ADMINISTERING INJECTIONS OR INTRAVENOUS THERAPY FOR NORMAL MEDICAL PRACTICE. I HEREBY AUTHORIZE THIS WORK UNDER PHYSICIAN'S ORDERS, WHILE A PATIENT WITH YOUR ORGANIZATION.

Service authorization or decline:

- ☐ I authorized IV therapy
- ☐ I authorized Flu vaccine
- ☐ I authorized blood work
- ☐ I authorize vaccine of ______________
- ☐ Other, explain: ________________________________

- ☐ I decline IV therapy
- ☐ I decline flu vaccine
- ☐ I decline blood work
- ☐ I decline vaccine of ________________
- ☐ I decline other ____________________

AUTORIZACIÓN/RECHAZO PARA RECIBIR TRATAMIENTOS ESPECIALES

YO AUTORIZO A HEALTH MED HOME CARE, INC., A QUE PROVEA LOS SERVICIOS APROPIADOS TAL COMO HAN SIDO PRESCRITOS POR MI MEDICO, O POR CUALQUIER OTRO MEDICO QUE PUEDA ESTAR TRATÁNDOME, INCLUYENDO TODOS LOS TRATAMIENTOS MÉDICOS Y DIAGNÓSTICOS QUE PUEDAN SER CONSIDERADOS RECOMENDABLES O NECESARIOS A JUICIO DEL MEDICO.
TAMBIÉN AUTORIZO/RECHAZO (según abajo) A HEALTH MED HOME CARE, INC. Y/O A SU PERSONAL A REALIZAR CUALQUIER TAREA REQUERIDA PARA MI TRATAMIENTO COMO: OBTENER MUESTRAS DE SANGRE, ADMINISTRACIÓN DE INYECCIONES O TERAPIA INTRAVENOSA PARA LA PRACTICA MEDICA. AUTORIZO ESTO BAJO LAS ORDENES DE UN MEDICO MIENTRAS SEA PACIENTE DE ESTA ORGANIZACIÓN.

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305.816.5940

Autorización de servicios o Rechazos de los mismos:

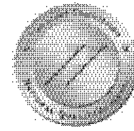
- ☐ Yo autorizo terapia de sueros
- ☐ Yo autorizo la vacuna contra el gripe
- ☐ Yo autorizo extracción de sangre
- ☐ Yo autorizo la vacuna de ______________
- ☐ Otros, explicar: ________________________________

- ☐ Yo rechazo terapia de sueros
- ☐ Yo rechazo la vacuna contra la gripe
- ☐ Yo rechazo extraerme sangre
- ☐ Yo rechazo la vacuna de ____________
- ☐ Yo rechazo otro: ____________________

________________________________ ________________
Client/Patient Signature - *Firma del Paciente* Date - *Fecha*

________________________________ ________________
Witness/Employee - *Testigo/Empleado* Date - *Fecha*

Harmony Home Health, Inc.



Patient acknowledge Form

I ____ hereby acknowledge that I am not under any circumstances:

- ☐ able to operate any type of motor vehicle
- ☐ living my home alone
- ☐ driving
- ☐ receiving home health care service at home from another agency
- ☐ attend day care services
- ☐ attend Partial Hospitalization Program (PHP)
- ☐ frequently living the home for non-medical purposes
- ☐ Other: ____

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Compromiso de los Pacientes

Yo __________________________________ por medio de la presente le aseguro a la administracion de esta Agencia que bajo ninguna circunstancia estoy capacitado(a)

- ☐ operar cualquier tipo de vehículo de motor
- ☐ salir solo de mi casa
- ☐ manejar
- ☐ recibir cuidados de salud a domicilio por otra agencia
- ☐ recibir cuidados de día en un “Day Care” de adultos
- ☐ atender el programa de Hospitalización Parcial (PHP)
- ☐ frecuentemente salir de mi casa por motivos no médicos
- ☐ Otro: ____

_________________________ Date/Fecha

_______________________________ Signature/Firma del Paciente

Copy Patient / Original Medical Record