TARGETED CASE MANAGEMENT AGENCY/REGIONAL MANAGEMENT CARE INC

INITIAL SERVICE PLAN

Initial Service Plan: X **Date:** ________

Time in: ________ AM PM Time out: ________ AM PM Units: _________

Section I:

Client's Name:___________________________________ Client's Number:___________

Diagnosis (DSM IV Number and Name):_______________________________________

Section II: Strengths and Weakness

STRENGTHS (Please include Client's strengths and Family's Strengths)
WEAKNESS (Please include Client's weakness and Family's Weakness)

SAMPLE

Client's Name:____ Client's Number:_____________

Section III: Needs

Domain's Legend:				
1 -Behavioral	2-Daily Living Skills	3-Educational	4-Substance Abuse	5- Social Relationships
6- Economical	7- Legal	8-Family	9- Mental Health	10-Physical Health
11-Employment	12-Living Environment	13- Leisure Time	14- Vocational	15-Transportation

SERVICE AREA NEEDS (Please include all needs identified, the date needs were identified and domain)

#	Need	Date identified	Domain (Number and Name)
1			
2			
3			
4			

Client's Name:___________________________________ Client's Number:________________

SAMPLE

#	Need	Date identified	Domain (Number and Name)
5			
6			
7			
8			
9			

Client's Name:____ Client's Number:______________

SAMPLE

Section IV: Long Term View

(The long term view is both the focus and foundation of the Service planning process for each client. The long term view is an optimistic, yet realistic, narrative describing what the client would like to happen, with whom and where. This section reflects the expectations and desires of the client, where the client "sees" him or herself in the future. It is written in the first person by the client with help and support from the Case Manager).

1. What I would like to happen: ____

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2. What I want to accomplish regards with specific domains included in my Service Plan: _____________

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3. What I need to accomplish this: ____

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SAMPLE

Client's Name: ____________________ Client's Number: ____________

Section V: Need-Goal-Objective-Tasks (The following goals and objectives describe the client's service needs and the activity that the Mental Health Targeted Case Manager will undertake in partnership with the client)

Domain (Number and Name): **Domain #:**

Identified Service Need: ____________________

Goal: ____________________

Objective: ____________________

SAMPLE

Resources	Tasks: Who will do what	Date Introduced	Expected Completion	Date Attained
	Client will:			
	Case Manager will:			

Check one of the following: **NEW GOAL:** **X** **ADDENDUM:** **ONGOING:**

Client's Name: ______________________________ Client's Number: ______________

Section V: Need-Goal-Objective-Tasks (The following goals and objectives describe the client's service needs and the activity that the Mental Health Targeted Case Manager will undertake in partnership with the client)

Domain (Number and Name): **Domain #:**

Identified Service Need: ____

____

Goal: ____

Objective: ____

Resources	Tasks: Who will do what	Date Introduced	Expected Completion	Date Attained
	Client will:			
	Case Manager will:			

Check one of the following: **NEW GOAL:** **X** **ADDENDUM:** **ONGOING:**

SAMPLE

Client's Name: ______________________ Client's Number: ____________

Section V: Need-Goal-Objective-Tasks (The following goals and objectives describe the client's service needs and the activity that the Mental Health Targeted Case Manager will undertake in partnership with the client)

Domain (Number and Name): **Domain #:**

Identified Service Need: ______________________

____

Goal: ______________________

Objective: ______________________

Resources	Tasks: Who will do what	Date Introduced	Expected Completion	Date Attained
	Client will:			
	Case Manager will:			

Check one of the following: **NEW GOAL: X** **ADDENDUM:** **ONGOING:**

______________________ ____________

SAMPLE

Client's Name: ______________________ Client's Number: ______________

Section V: Need-Goal-Objective-Tasks (The following goals and objectives describe the client's service needs and the activity that the Mental Health Targeted Case Manager will undertake in partnership with the client)

Domain (Number and Name): **Domain #:**

Identified Service Need: ______________________

____

Goal: ______________________

Objective: ______________________

Resources	Tasks: Who will do what	Date Introduced	Expected Completion	Date Attained
	Client will:			
	Case Manager will:			

Check one of the following: **NEW GOAL:** **X** **ADDENDUM:** **ONGOING:**

SAMPLE

Client's Name: ______________________ Client's Number: ____________

Section V: Need-Goal-Objective-Tasks (The following goals and objectives describe the client's service needs and the activity that the Mental Health Targeted Case Manager will undertake in partnership with the client)

Domain (Number and Name): **Domain #:**

Identified Service Need: ______________________

____

Goal: ______________________

Objective: ______________________

Resources	Tasks: Who will do what	Date Introduced	Expected Completion	Date Attained
	Client will:			
	Case Manager will:			

SAMPLE

Check one of the following: **NEW GOAL:** **X** **ADDENDUM:** **ONGOING:**

Client's Name: ______________________ Client's Number: ______________

Section V: Need-Goal-Objective-Tasks (The following goals and objectives describe the client's service needs and the activity that the Mental Health Targeted Case Manager will undertake in partnership with the client)

Domain (Number and Name): **Domain #:**

Identified Service Need: ______________________

____

Goal: ______________________

Objective: ______________________

Resources	Tasks: Who will do what	Date Introduced	Expected Completion	Date Attained
	Client will:			
	Case Manager will:			

Check one of the following: **NEW GOAL: X** **ADDENDUM:** **ONGOING:**

SAMPLE

Client's Name: ______________________ Client's Number: ____________

Section V: Need-Goal-Objective-Tasks (The following goals and objectives describe the client's service needs and the activity that the Mental Health Targeted Case Manager will undertake in partnership with the client)

Domain (Number and Name): **Domain #:**

Identified Service Need: ______________________

Goal: ______________________

Objective: ______________________

Resources	Tasks: Who will do what	Date Introduced	Expected Completion	Date Attained
	Client will:			
	Case Manager will:			

Check one of the following: **NEW GOAL:** **X** **ADDENDUM:** **ONGOING:**

SAMPLE

Client's Name: ______________________________ Client's Number: ______________

SECTION VI:
The Service Plan was developed on________________ and has been explained to me in terms that I can understand and reflects my criterion. This Service Plan is based in my needs. I was offered a copy of the Service Plan. Este Plan de Servicio fue desarrollado el ______________ y fue explicado a mí en términos que pude entender y refleja mi criterio. Este Plan de Servicio está basado en mis necesidades. Me ofrecieron una copia del Plan de Servicio.
____________________________ ______________________________ Client Signature Date Parent, Guardian or Surrogate Date
This Service Plan was developed in conjunction with the client, parent or legal guardian and was discussed and explained to client in terms he/she understands. This Service Plan is based on client's service needs and according with previous assessment completed in client's case.
____________________________ ____________________ Case Manager Name, Signature and Credential Date ____________________________ ____________________ Supervisor Name, Signature and Credential Date

SAMPLE

REGIONAL MANAGEMENT CARE

TARGETED CASE MANAGEMENT AGENCY

DEAR CASE MANAGEMENT RECIPIENT

Thank you for choosing our agency as your Case Management care provider. It is our privilege to be able to service you. Our mission is committed to providing quality service to all our clients.
Should you have any questions or concerns regarding our services please call us at:

954-474-7373

Our Agency i son call 24 hours a day 7 days a week. On call representative will happy to serve you to handle all problems and will contact the Case Manager Supervisor for any issues; our office is open Monday through Friday from 9:00am to 5:00pm.

If you have an emergency please call: **911**

To report abuse, neglect, abandonment or exploitation call toll free to: **1-800-962-2873**

Or fax your report to: **1-800-914-0004**

SAMPLE

REGIONAL MANAGEMENT CARE

TARGETED CASE MANAGEMENT AGENCY

PERSONAL INFORMATION SHEET

Name:____ Date:____________________
Nombre Fecha

Address:____ Zip ____________
Dirección Código Postal

Telephone: ____________________ Sex: _____ Marital Status:_____________ Legal Status: _______________
Teléfono Sexo Estado Civil Estado legal

SS#: _________________________ Date of Birth: ___________ Age: ______ Place of birth: _________________
No. de SS Fecha de Nacimiento Edad Lugar de Nacimiento

Medicare # ________________________________ Medicaid #_____________________________
No. de Medicare No. de Medicaid

EMERGENCY CONTACT (Contacto de Emergencia):

Name (Nombre): ______________________________________ Relationship: __________________
Relación

Address:____ Phone:______________________
Dirección Teléfono

Name (Nombre): ______________________________________ Relationship: __________________
Relación

Address:____ Phone:______________________
Dirección Teléfono

LEGAL GUARDIAN _________________________________ Relationship: __________________
Tutor Relación

Address:____ Phone:______________________
Dirección Teléfono

MEDICATION'S LIST: (Lista de Medicinas): ____
____
____
____
____
____

DOCTOR'S INFORMATION (Información de los doctores):

PCP (Médico Primario) : ____
Name, address and telephone (Nombre, dirección y teléfono)

PSYCHIATRIST (Psiquiatra): ____
Name, address and telephone (Nombre, dirección y teléfono)

ALLERGIES: ____
Alergias

_______________________________ ____________________
Client's Signature (Firma del Cliente) Date (Fecha)

_______________________________ ____________________
Legal Guardian's Signature (Firma del tutor) Date (Fecha)

SAMPLE

APPENDIX J
ADULT CERTIFICATION
ADULT MENTAL HEALTH TARGETED CASE MANAGEMENT

Recipient's Name___________________________________ Medicaid ID # ____________________

Is hereby certified as meeting all of the following adult mental health targeted case management criteria.

1. Is enrolled in a Department of Children and Families adult mental health target population
2. Has a mental health disability (i.e., severe and persistent mental illness) which requires advocacy for and coordination of services to maintain or improve level of functioning;
3. Requires services to assist in attaining self sufficiency and satisfaction in the living, learning, work and social environments of choice;
4. Lacks a natural support system with the ability to access needed medical, social, educational and other services;
5. Requires ongoing assistance to access or maintain needed care consistently within the service delivery system;
6. Has a mental health disability (i.e., severe and persistent mental illness) duration that, based upon professional judgment, will last for a minimum of one year;
7. Is not receiving duplicate case management services from another provider;
8. Meets at least one of the following requirements (check all that apply):
9.
   a. Is awaiting admission to or has been discharged from a state mental health treatment facility;
   b. Has been discharged from a mental health residential treatment facility;
   c. Has had more than one admission to a crisis stabilization unit (CSU), short-term residential facility (SRT), inpatient psychiatric unit, or any combination of these facilities in the past 12 months;
   d. Is at risk of institutionalization for mental health reasons (provide explanation);
   e. Is experiencing long-term or acute episodes of mental impairment that may put him or her at risk of requiring more intensive services (provide explanation); or

10. Has relocated from a Department of Children and Families district or region where he or she was receiving mental health targeted case management services.

SAMPLE

____ ______________________
Case Manager Date

____ ______________________
Case Manager's Supervisor Date

Form must be filed in the recipient's case record.

INFORMATION TO PERSONS WITH SENSORY DISABILITIES

Our agency will take necessary steps to ensure that persons with disabilities receive effective notice or special written materials concerning services.
The identification of disabilities is part of the referral process and information regarding special services will be presented individually upon admission. These services will be provided at NO COST to the recipient.

For person with hearing impairments, the agency will perform the maximum effort to contract a qualified sing-language interpreter for person who uses sing-language of communication.

For person with visual impairments: Staff communicates the content of written materials by reading them slow and loud to visually impaired persons. Large print, taped and Braille materials are available upon request.

For person with speech impairments: Writing material, computers and communications board are available to facilitate the communication with this type of persons.

SAMPLE

NON-DISCRIMINATION (THE LAW)

In accordance with **TITLE VII of the Civil Right Act 1964** and its implementing regulations, the agency will directly or through contractual or other arrangement, admit and treat all persona without regard to race/ethnic, color, sexual orientation, religion/creed, age, sex, disabilities, cultural background or national origin in its provision of services and benefits, including assignments and/or transfers within the agency and referrals to or from our agency. Staff privileges are granted without regard race/ethnic, color, sexual orientation, and religion/creed. Age, sex disabilities or national origin.
In accordance with Section 504 of Rehabilitation Act of 1973 and its implementing regulations, the agency will not, directly or through contractual or other arrangements, discriminate on basis of age in the provision of services unless age is a factor necessary to the normal operation or achievement of any statutory objective.
The Agency considers persons with aides, persons with HIV infections, persons with AIDS-RELATED condition, or persons perceive to have AIDS, to be handicapped and include them in its non-discriminations policies as required by the implementing regulations on Section 504 if the Rehabilitation Act of 1973

CIVIL RIGHTS COMMISSION 1801 L ST NW WASHINGTON D.C.20507

REGIONAL MANAGEMENT CARE INC

CLIENT'S SERVICE AGREEMENT

CLIENT'S NAME:	
ADDRESS:	
CITY:	**ZIPCODE:**
INSURANCE INFORMATION:	**ADM. DATE:**

CONSENT FOR SERVICES

I hereby personally, request services by ***Regional Management Care Inc.*** I have had an explanation of all services to be provided, and I do hereby consent to such services by a Case Manager of ***Regional Management Care Inc***. The services should be reasonably and needed by my condition. This consent is intended as a waiver of liability for such services. I have also been explaining the care plan which will be creating to my needs and my case manager will solicit my input for participation in the care plan. I have received and understand the Privacy Act Statement.

RECIPROCAL RELEASE OF INFORMATION

I hereby authorize ***Regional Management Care Inc*** to release the complete records in your possession concerning my treatment to hospital, physician, and other medical agencies or institutions, as necessary. By this form I also authorize my psychiatric, counselor, physician, hospitals, and skill nursing facilities, mental health facilities, AHCE HIV/AIDS contract office, Health Council of South Florida, SFAN, and other medical agencies to release to ***Regional Management Care Inc*** any portion of my medical records copies, thereof which they may request.

CLIENT'S CERTIFICATION:
AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST

I certify that the information given to me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made on my behalf.

SAMPLE

ASSIGNMENT OF BENEFITS AND GUARANTEE OF PAYMENT

1. To Insurance and Third party Payers: I, the undersigned, hereby assign, transfer, and convey payment and authorize said payment to be made directly to ***Regional Management Care Inc,*** the insurance benefits herein specified and otherwise payable to me, but not to exceed the balance due, I, the undersigned, understand that I am financially responsible to ***Regional Management Care Inc*** for the changes not covered by this authorization. I, the undersigned, further authorize the release of any information required for payment and services rendered.
2. I. the undersigned, acknowledge financial responsibility for the above consented services. I understand the Regional Management Care Inc philosophy of client care services regardless of my ability to pay.

Signed: ______________________________________ Witnessed: ______________________________ Date: _____________
(Patient or Legal Guardian)

REGIONAL MANAGEMENT CARE INC

CLIENT'S SERVICE AGREEMENT

CLIENT'S NAME:	
ADDRESS:	
CITY:	**ZIPCODE:**
INSURANCE INFORMATION:	**ADM. DATE:**

CONSENT FOR SERVICES

I hereby personally, request services by ***Regional Management Care Inc.*** I have had an explanation of all services to be provided, and I do hereby consent to such services by a Case Manager of ***Regional Management Care Inc***. The services should be reasonably and needed by my condition. This consent is intended as a waiver of liability for such services. I have also been explaining the care plan which will be creating to my needs and my case manager will solicit my input for participation in the care plan. I have received and understand the Privacy Act Statement.

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2. I. the undersigned, acknowledge financial responsibility for the above consented services. I understand the Regional Management Care Inc philosophy of client care services regardless of my ability to pay.

Signed: ______________________________________ Witnessed: ______________________________ Date: _____________

(Patient or Legal Guardian)

MEDICATION SCHEDULE* Patient's Name: ________________________________ MR Number____________________

Pharmacy Name:______________________________ Phcy Phone:____________________ Date: ___________________________

Address: ______________________________ Primary MD Name: ____________________________ MD ph:____________________

DO NOT USE ABBREVIATION: U, IU, QD, Q.D., qd, q.d., QOD, Q.O.D., qod, q.o.d., >, <, @, cc, µg, MS, MSO_4, $MgSO_4$, trailing zero: X.0 mg, .X mg

N C O	**Date** **Ordered** *Fecha*	**Medications** **Dose, Route, Frequency** *Medicinas, Dosis, Ruta, Frecuencia*	**Breakfast** *Desayuno*	**Lunch** *Almuerzo*	**Dinner** *Comida*	**Bedtime** *Acostarse*	**Clasification** *Clasificación*	**Side Effects** *Efectos Secundarios*	MD Ordering Full Name *Doctor que ordena*	Level of Understanding Good Fair Poor	**D/C Date** *Alta*

SAMPLE

Key To Side Effects/*Guía de Efectos Secundarios*

A-Nausea/Vomiting *Vómito*
B- Constipation *Estreñimiento*
C- Diarrhea *Diarrhea*
D- Hypertension *Presión Alta*
E- Hypotension *Presión Baja*

F- Skin Rash/Urticaria *Erupción de la piel*
G- Headaches *Dolor de Cabeza*
H- Dizziness *Mareos*
I- Hypoglycemia *Hypoglicemia*
J- Hyperglycemia *Hiperglicemia*

K- Edema *Edema*
L- Diaphoresis *Sudoración*
M-Hemorrhage *Hemorrageas*
N- Hematuria *Hematuria*
O- Dry Mouth Thirst/*Sed* *Boca Seca*

P- Bradycardia *Bradicardia*
Q- Tachycardia *Taquicardia*
R- Tremors *Temblores*
S- Tinitus *Zumbidos en oidos*
T- Fluid/Electrolyte Imbalance *Desbalance líquido*

U- Anorexia
V- Malaise *Malestar*
W- Dyspnea *Falta de Aire*
X- Confusion
Y- Flushing/Blurred Vision *Enrojecimiento/Visión borrosa*

Z. Other______________________ *Otros*

Allergies: ______________________ *Alergías*

Firma Enfermera/Fecha
Nurse Signature/Date:______________________

Reconciliation
Update on: ______________ By: ______________
Actualizado en *Por*

Reconciliation
Update on: ______________ By: ______________

Reconciliation
Update on: ______________ By: ______________

** Part of Emergency/Disaster Plan* *Rev. Date: 09/7/2011*

DRUG CLASSIFICATIONS

NOTE: CLASSIFICATIONS ARE NOT INCLUSIVE OF ALL SIDE EFFECTS

#	CLASS	SIDE EFFECTS
1	ANALGESICS / NARCOTIC	SEDATION / CONSTIPATION
2	ANALGESICS / NON-NARCOTIC	WELL TOLERATED
3	ANALGESICS / NSAIDS / ANTINFLAMMATORY	GI DISTRESS / DROWSINESS
4	ANTIBIOTICS	GI DISTRESS / ANAPHYLAXIS
5	ANTICOAGULANTS / ANTIPLATELETS	DIARRHEA / RASH / FEVER / BLEEDING
6	ANTICONVULSANTS	GI DISTRESS / ATAXIA / CONFUSION
7	ANTIDEMENTIA / CEREBRAL METABOLIC / ENHANCERS	GI DISTRESS / DIZZY / HA / INSOMNIA
8	ANTIDOTE	GI DISTRESS / TACHYCARDIA / HTN
9	ANTIFUNGAL	GI DISTRESS / HA / CHILLS
10	ANTIHYPERLIPIDEMICS	GI DISTRESS / DIZZY / MUSCLE PAIN
11	ANTIMPOTENCE	HA / DIZZY / FLUSHING
12	ANTIMIGRAINE	DIZZY / TINGLING / SEDATION
13	ANTIPARASITIC	DIZZY / LOCAL IRRITATION
14	ANTITUBERCULAR	GI DISTRESS / RASH
15	ANTIVIRAL / ANTIRETROVIRAL	GI DISTRESS / HA / FUNGAL INFECTION
16	BLOOD / BLOOD DERIVATIVES	ANAPHYLAXIS / RASH / FEVER
17	BPH	DIZZY / HA
18	CANCER / CHEMOTHERAPEUTIC / ANTINEOPLASTICS	GI DISTRESS / BLOOD DYSCRASIA / ALOPECIA
19	CARDIAC / ANGINA / CAD / ASCVD	DIZZY / LOW BP / EDEMA / ΛK+
20	CARDIAC / CHF / CARDIOMYOPATHY	DIZZY / LOW BP / EDEMA / ΛK+
21	CARDIAC / DYSRHYTHMIA	LOW BP / LOW PULSE / EDEMA / ΛK+
22	CARDIAC / HTN / ASHD	DIZZY / LOW PULSE / EDEMA / ΛK+
23	CNS STIMULANT	INSOMNIA / NERVOUSNESS
24	CORTICOSTEROID ANTINFLMMATORY	GI DISTRESS / EDEMA / ΛBS / EUPHORIA
25	DERMATOLOGIALS MISC	RASH / LOCAL IRRITATION / BURNING
26	DIABETES	LOW BS / ANAPHYLAXIS / HEPATOTOXICITY
27	DIETARY SUPPLEMENTS	GI DISTRESS / RASH
28	DIGESTANTS / GI ENZYMES	GI DISTRESS
29	DIURETICS	ELECTROLYTE DISTURBANCES / LOW BP
30	ELECTROLYTES	GI DISTRESS
31	GI / ANTIACIDS	CONSTIPATION / DIARRHEA / FLATULENCE
32	GI / ANTIDIARRHEAL / ANTISPASMODIC	CONSTIPATION / DRY MOUTH / URINARY RETENTION
33	GI / GASTRITIS / ULCER / REFLUX	GI DISTRESS / CONFUSION / HA
34	GI / LAXATIVES	GI DISTRESS / DEPENDENCE DIARRHEA
35	GI / NAUSEA / VOMITING	SEDATION / DRY MOUTH / BLURRED VISION
36	GLAUCOMA	HA / NAUSEA
37	GOUT / URICOSURIC	GI DISTRESS
38	HEMATINIC	GI DISTRESS / BLACK STOOLS
39	HEMATOPOIETIC	BONE PAIN / HTN
40	HEMOSTATIC	GI DISTRESS
41	HERBAL	GI DISTRESS / RASH
42	HORMONES	HOT FLASHES / BOATING / DEPRESSION
43	IMMUNOLOGIC / IMMUNOSUPRESSANTS	HA / TREMORS / CANDIDA INFECTION
44	IV FLUSH	BURNING
45	MUSCLE RELAXERS	DROWSINESS / DRY MOUTH
46	OPTHALMIC LUBRICANTS	REDNESS / IRRITATION
47	OSTEOPOROSIS	GI DISTRESS / LOCAL IRRITATION
48	OXYGEN	NASAL IRRITATION
49	PARKINSONS	LOW BP / DYSKINESIA / HALLUCINATIONS
50	PLASMA VOLUME EXPANDERS	EDEMA / ANAPHYLAXIS
51	PSYCHIATRIC / ANTIANXIETY / ANTIDEPRESSANTS	DIZZY / DROWSINESS / DRY MOUTH
52	PSYCHIATRIC / ANTIPSYCHOTICS / ANTIMANICS	EPS / DROWSINESS / DRY MOUTH
53	RESPIRATORY / ANTIHISTAMINES / DECONGESTANTS / ANTIALLERGY	DIZZY / DROWSINESS / DRY MOUTH
54	RESPIRATORY / ANTITUSSIVES / EXPECTORANTS	SEDATION
55	RESPIRATORY / BRONCHODILATORS	TACHYCARDIA / TREMORS / NERVOUSNESS / HA
56	SALICYLATES	GI DISTRESS / TINNITUS
57	SEDATIVES / HYPNOTICS	SEDATION / CONFUSION
58	THYROID	TACHYCARDIA / TREMORS / INSOMNIA
59	URINARY ANTISPAMODICS	LOW BP / URINARY RETENTION / DIZZY
60	VERTIGO / SYNCOPE	DRY MOUTH / DROWSINESS
61	VITAMINS / MINERALS	GI DISTRESS / ANAPHYLAXIS
62	OTHER	

SAMPLE

EMERGENCY/DISASTER PLAN FOR HOME HEALTH CARE PATIENTS

(Keep this plan where it can be easily located)

PLAN DE EMERGENCIA/DESASTRE PARA PACIENTES EN SU CASA

(Mantenga este plan en un lugar accesible)

Date/*Fecha*: ___________ **Client:** ____________________________________ **MR:**_____________

Information obtained by: ☐ **Client/Patient** *(Cliente/Paciente)* ☐ **Caregiver** *(Familiar/persona Encargada)*

If caregiver, relationship to patient/*Relación*: ____

The Emergency Medical Service dispatcher will need to know (caregiver):

El operador del Servicio de Emergencia Médica necesita conocer (Responsable)

Name/*Nombre*: ____ Phone: _________________________

Address/*Dirección*:____

CLIENT's EMERGENCY CLASSIFICATION (circle one): **D1 D2 D3 D4** ***(see back for instructions)***

CLASIFICACION DE EMERGENCIA DEL CLIENTE

Patient's Data/*Datos del Paciente*:

Allergies: ☐ NKA ☐ Penicillin ☐ Sulfa ☐ Aspirin ☐ Pollen ☐ Iodine **Special needs:**________________________

Alergias: ☐ Other: ______________________ *Necesidades especiales:*________________________________

Medications ☐ See medication scheduled *(part of Emergency plan)* *(Ver el registro de medicinas, parte del Plan de Emergencia)*

Comments ____

Comentarios ____

Supplies/DME: ☐ Walker ☐ W/C ☐ Cane ☐ Commode ☐ Hoyerlift ☐ O_2 concentrator ☐ Gloves ☐ Alcohol Pads

Equipos médicos: ☐ Hospital Bed ☐ Sharp Container ☐ 4x4 Gauze ☐ Other: ___________________________

Pharmacy/Phone/Farmacia/teléfono: ____

Address/*Dirección:*____

Doctor: ____ **phone**: __________________________

(IN CASE OF MEDICAL EMERGENCY DIAL 911) *EN CASO DE EMERGENCIA MEDICA LLAMAR AL **911**.*

IN CASE OF NURSING OR RELATED PROBLEM CALL THE AGENCY AT PHONE IN THE COVER

(EN CASO DE PROBLEMA CON EL SERVICIO O SI QUIERE COMUNICARSE LLAME A LA AGENCIA AL TELEFONO EN EL COVER)

To contact your nurse directly you may call her/him at:___________________________________

(Puede llamar a su enfermera/ro al teléfono) (24 hrs a day, 7 days a week, 24 hrs/día, 7 días/semana)

Name/*Nombre*: ___________________________________ ___________________________

IN CASE OF EMERGENCY NOTIFY TO: *EN CASO DE EMERGENCIA NOTIFICAR A:*

Name/Nombre: ____ Phone: ______________________

Address/Dirección:____

Service Provided: ☐ Skilled Services ☐ Non-Skilled Services (Personal Care only)

SAMPLE

IN THE EVENT OF A HURRICANE (OTHER NATURAL DISASTER) I WILL:

EN CASO DE UN HURACAN (U OTRO DESASTRE NATURAL) YO:

☐ **Stay at home**/*Me quedaré en casa.*Who will help with meds/*Quién le ayudará con medicinas*____________________

☐ **Stay with family** *(voy con familiares)* – Name/address/telephone:_______________________________________

☐ **Go to shelter** *(voy a Refugio)*____

Shelter address/*Dirección*

☐ **Go to a hospital, if medically necessary**____

Voy a un hospital, si es medicamente necesario **Hospital Name**/*Nombre*

Type of Transportation/*Tipo de tranporte:* ____

PLEASE CONTACT OUR AGENCY FOR ALTERNATE SERVICE OPTIONS IN CASE OF DISASTER.

POR FAVOR CONTACTAR NUESTRA AGENCIA PARA OPCIONES EN SERVICIOS ALTERNOS O EN CASO DE DESASTRE.

_________________________________ _______________

Employee Signature / *Firma del Empleado* **Date**/*Fecha*

GENERAL INSTRUCTIONS TO CLIENT ON USE OF THIS FORM:

This information is provided to you as a quick reference source in case any emergency occurs. Keep this document where it can easily be found. Inform other persons close to you (relative, neighbor, etc.) of its location.

1. **Our Agency has a nurse on call 24 hours a day. You can reach the nurse through our phone number (in the cover of the book), After office hours and on weekends an answering service will reach the nurse and he/she will return your call and come to see the client if necessary, or simply answer any questions you may have.**
2. **In case of a serious medical emergency, the client should be taken to the hospital. Our Agency does not operate as an emergency service, therefore valuable time may be lost by contacting the Agency for a serious emergency such as diabetic coma, severe chest pain, unconsciousness, etc.**
3. **Ambulance service number is 911.**

CLASSIFICATION

(Please circle the correct classification for client)

Dl- Category 1

Clients who cannot safely forgo care: highly unstable clients with high probability of inpatient admissions if home care is not provided: IV therapy, highly skilled wound care, with no family/caregiver, life sustaining medication or equipment.

D2-Category 2

Client whose condition recently worsened: moderate level of skilled care. That should be provided that day, but could postpone visit until emergency situation improves. Client with untrained families/caregivers who could provide basic care in an emergency.

D3-Category 3

Client who can safely forgo care or a scheduled visit including Home Health Aide visits, Clients receiving routine supervisory visit, evaluation visits. Client with 1 or 2 visits/ week, or Clients who have a competent family/caregiver.

D4-Category 4

Patient who refused information, or signed the registration release form releasing the Agency from evacuation responsibilities.

INFORMACIÓN GENERAL PARA EL PACIENTE SOBRE ESTE FORMULARIO. Esta información es en ***caso de una Emergencia****. Deben de dejar este formulario en un lugar rápido de encontrar,(Dígale a su familia, Vecinos, etc) donde se encuenta este formulario.*

1. *Nuestra Agencia tiene un Representante en servicios las 24 hora al día. Usted se puede comunicar con la agencia llamando a nuestro número de teléfono (en la cubierta del libro), después de hora o fin de semana, la agencia llamará a la persona que se encuentre "ON CALL" (de guardia), Esta persona le devolverá la llamada.*
2. *En caso de una EMERGENCIA, el paciente debe ser llevado(a) al hospital más cercano. Nuestra Agencia No opera como un servicio de Emergencia.*
3. *Para llamar a a una AMBULANCIA, deben marcar el 911.*

CLASIFICACION

(favor de circular la clasificación del paciente)

D1 (category 1)

Paciente que no se puede dejar sin servicio, muy inestable, con gran probabilidad de Ingreso si el cuidado en la casa no es proveido: terapia IV, cuidado de ulceras, sin familiar/encargado, medicación o equipos de por vida.

D2 (category 2)

Pacientes cuyas condiciones empeoraron recientemente, moderado nivel de cuidado, que debe darse según calendario, pero puede posponerse hasta que la situación de emergencia mejore. Pacientes con familiares/encargados no entrenados, pero que pueden dar cuidados básicos en emergencias.

D3 (categoria 3)

Pacientes que de una forma segura se puede dejar de visitar, incluyendo la assistente de enfermera, clientes reciviendo rutinarias visitas de supervisión, evaluación. Clientes con 1 a 2 visitas por semana, o clientes que tienen familiares/encargados entrenados y competentes.

D4 (Categoria 4)

Rehusó dar información, o liberó a la Agencia de Responsabilidades de Evacuación.

SAMPLE

REGIONAL MANAGEMENT CARE INC

CLIENT'S BILL OF RIGHTS

AS OUR CLIENT YOU HAVE THE RIGHT TO: Considerate and respectful care.*to expect reasonable continuity care.* to request from your physician complete current information concerning your diagnosis, prognosis and treatment in terms you can reasonably understand.*to expect that all communication and records pertaining to your care be treated as confidential. *To every consideration of your privacy concerning your own medical program, case discussion, consultations and treatments are confidential and should be conducted discretely.*Those not directly involved in your care must have your permission to be present.*To know the name of the responsible person coordinating and supervising your Case Management Case and the manner in which that person may be contacted during regular working hours.*To know the name and professional relationship of those individuals involved in your care.*To refuse any segment of treatment to the extent permitted by the law without relinquishing other segments of the treatment plan. You have the right to be informed of the medical consequences of your action.*to the extend that is reasonably possible to be involved in the planning and implementation of the Case Management Plan of Care and its expected outcome.* to be informed of the policy and procedure for registering formal complaint about the services being provided. You have the right to be informed that the Case Management Services will not be disrupted as a result of filing a complaint.*to expect that within its capacity the agency must make a reasonable response to your request for services.*To receive and examine an explanation of our bill regardless of source of payment.*To know what agency rules and expectations apply to your conduct as a client.*To be informed of the Plan of Care *To have a copy of the Plan of Care if requested.*Be informed of the right to formulate and Advance Directive and/or Do not resuscitate (DNR) order.*To have the pain evaluated and intensity controlled.*Be free of physical and mental abuse/neglect and/or exploitation. Be informed of the availability to report **Abuse, Neglect or exploitation: 1-800-962-2873.***To have your property treated with respect.*To voice grievance regarding services furnished, or regarding lack of respect for property by anyone who is furnishing services on behalf of the Agency, and must not be subjected to discrimination or reprisal for doing so.

YOUR RIGHTS AS A CLIENT TO PRIVACY OF YOUR HEALTH AND MENTAL INFORMATION

RIGHT TO REQUEST RESTRICTIONS You have the right to request restrictions on our use and disclosures of your health and mental information, however we may refuse to accept the restriction.***RIGHT TO REQUEST CONDIFENTIAL COMMUNICATIONS** You have the right to request that we communicate with your confidentially, for example to speak with you only in private; to send mail to an address you designate; or to telephone you at a number you designate. We will make every attempt to honor your request**.*RIGHT TO REQUEST ACCESS TO YIOUR HEALTH INFORMATION** you have the right to request access to your health information in order to inspect or copy it. Your request must be in writing. We may deny your request and, if so, you may request a review if the denial. However, we will make every attempt to honor your request**.*RIGHT TO REQUEST AN AMENDAMENT OF YOUR HEALTH INFORMATION** you have the right to request an amendment to your health information. Your request must be in writing and must provide a reason for the amendment. We may deny your request and, if so, you may submit a statement of disagreement. However, we will make every attempt to honor your request.***RIGHT TO REQUEST AN ACCOUNTING OF DISCLOSURES OF YOUR HEALTH NFORMATION** you have the right to request an accounting of our disclosures of your health information for purpose other than treatment , payment m, and case management operations. We will make every attempt to honor your request. We are not required to provide an accounting for disclosures for more than 6 years prior to the date or your request.***RIGHT TO OBTAIN A PAPER COPY OF THE PRIVACY NOTICE** If you received the Privacy Notice electronically, you have the right receive a paper copy. To exercise any of these rights please write of telephone to our Agency.

SAMPLE

____________________________	____________________________	______________
PATIENT'S SIGNATURE	DATE	MR#

REGIONAL MANAGEMENT CARE INC

GRIEVANCE PROCEDURES

1. Any person, who believes he or she has been subjected to discrimination, or otherwise denied equitable and fair treatment, may file a grievance under this procedures, The Agency will not retaliate against anyone solely for filing a grievance or cooperation in the investigation of a grievance.
2. Grievances must be submitted to the Agency within thirty (30) days of the date the filing the grievance becomes aware of the action.
3. A complaint should be in writing/phone, containing name and address of the person filing it. The complaint must state the problem or action alleged to have occurred and the remedy of relief sought by the grievant.
4. The Supervisor of Case Manager or Administrator shall conduct an investigation of the complaint to determinate its validity. This investigation may be informal, but it has to be thorough, affording all interested persons the ability to submit evidence relevant to the complaint.
5. The Supervisor of Case Management will maintain the files and records of the Agency relating to such grievance.
6. The Supervisor of Case Management will issue a written decision on the grievance no later than thirty days (30) after its filing.
7. The grievant may appeal the decision of the Supervisor of case Manager by filling an appeal in writing to the Administrator of the Agency within fifteen (15) days of receiving the Supervisor of Client Services decision.
8. The Administrator shall issue a written decision in response to the appeal no later than thirty (30) days after filing.
9. The availability and use of the grievance procedure does not preclude a person pursuing other remedies accorded by local, State and Federal Laws and regulations.

PROCEDIMIENTO DE QUERELLAS O QUEJAS

1. Cualquier persona que crea que el o ella ha sido víctima de discriminación o en cualquier otra forma le ha sido negado un tratamiento o servicio justo y equitativo puede plantear una querella bajo este procedimiento. La agencia no tomara represalia alguna en contra de nadie solamente por haber presentado o por cooperar en la investigación de una querella.
2. Las querellas deben someterse a la Agencia dentro de un término de treinta (30) días de la fecha que la persona que está presentando la querella conoce de la acción que motiva la misma.
3. La queja debe someterse por escrito/teléfono, conteniendo el nombre y la dirección de la persona que la presenta. La queja debe explicar el problema o acción que alegadamente ocurrió y la solución o remedio que busca el querellante.
4. El Supervisor debe llevar a cabo una investigación de la queja para determinar su validez, Esta investigación puede ser informal, pero debe ser completa, dando la oportunidad a todas las personas interesadas a someter evidencia relevante a dicha queja.
5. El Supervisor de la mantendrá los archivos y expedientes de la agencia relacionados con la querella.
6. El Supervisor de la Agencia proveerá por escrito su decisión respecto a la querella, en un término de treinta (30) días después de haber sido planteada o sometida.
7. El querellante puede apelar la decisión tomada por el/la Supervisora de la Agencia, dirigiéndose por escrito al Administrador de la Agencia en un plazo de quince (15) días después de haber recibido la decisión del Supervisor de la Agencia.
8. El Administrador de la Agencia proveerá su decisión por escrito, en respuesta a la apelación, en un término de treinta (30) días después de haber sido sometida la misma.
9. El uso de las leyes u regulaciones Estatales y Federales están a la disposición del querellante, en el caso que desee recurrir a ellas.

SAMPLE

PATIENT’S SIGNATURE:	DATE:
EMPLOYEE’S SIGNATURE:	DATE:

REGIONAL MANAGEMENT CARE INC

ASSESSMENT FOR CLIENT VULNERABILITY TO ABUSE AND/OR NEGLECT

Client's Name: ___________________________________ Case Record # _____________

Date Client Assessed for Vulnerability: ____

Client Vulnerability risk exists? □YES □ NO

VULNERABILITY RISK FACTOR	YES	NO
Demonstrates orientation to time, place and person		
Demonstrates ability to follow directions consistently		
Demonstrates assertiveness		
Demonstrates ability to give accurate information consistently		
Demonstrates interest in environment and activities		
Demonstrates ability to walk without assistive devices		
Demonstrates full range of motion		
Demonstrate adequate endurance		
Demonstrate freedom from communicable disease		
Demonstrate adequate auditory perception		
Demonstrate adequate visual perception		
Demonstrate adequate speech		
Demonstrate adequate touch sensation		
Demonstrate adequate communication		
Demonstrate cooperative behavior		
Demonstrate ability to adhere to safety precautions consistently		
Demonstrate ability to report abuse and/or neglect		
Others:		

SAMPLE

____ ____________________

SIGNATURE OF INDIVIDUAL COMPLETING FORM DATE

MONTHLY CALENDAR

Year: ____________

JANUARY □	FEBRUARY □	MARCH □	APRIL □	MAY □	JUNE□
JULY□	AUGUST □	SEPTEMBER □	OCTOBER □	NOVEMBER □	DECEMBER □

Patient's Name: ____ Client Record #: ______________________________

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

SAMPLE

TARGETED CASE MANAGEMENT AGENCY/REGIONAL MANAGEMENT CARE INC

CLIENT NUMBER: _________ TIME IN: _____AM PM TIME OUT: ______ AM PM UNITS: _______

CASE MANAGEMENT ASSESSMENT

The primary goal of mental health targeted case management is to optimize the functioning of recipients who have complex needs by coordinating the provision of quality treatment and support services in the most efficient and effective manner.

Client's Full Name:		Date:
Social Security No.:	DOB:	Age:
Place of Birth:	Primary Language:	
Residential Status:	Referral Date (referral form must be previously completed):	
Marital Status (If married, divorced, widow, separated, how time ago):		

I. SOURCES OF INFORMATION

Client's Report		Client's legal guardian (attach copy of court disposition)	
Client's family and friends		Agency who referred the client	
School		Other previous treating providers	

Other source (specify):

II. PRESENTING PROBLEMS (Diagnosis, Current symptoms, Treatment Compliance, Decompensation, client's own appraisal of his/her situation)

DIAGNOSIS (Specify DSM IV Number and Name):

CURRENT SYMPTOMS (Select all that apply)

Depression		Nervousness		Restlessness she couldn't sit still	
Anxiety		Lack of motivation		Lost or gained weight without trying	
Sadness/blue		Spells of terror or panic		Fear to go out of your home alone	
Fearfulness		Tension		Fear in open spaces or on the streets	
Worthlessness		Confusions		Being suddenly scared for no reason	
Loneliness		Hopelessness		Hallucinations (verbal or auditory)	
Lack of energy		Helplessness		Disorientation:(Time/ Place/ Person)	

Other Symptoms:

Client's own appraisal of his/her situation:

What were the major problems that have distressed client during the last seven days? :

SAMPLE

Family's assessment/Legal representative's assessment of client's situation (if applicable):

Is client being attended by a psychiatrist at moment? (If yes, include doctor's name and how long time client is being receiving psychiatrist care with this doctor. If not, explain reasons):

III. PSYCHIATRIC HISTORY

(Onset of mental illness (include approximate date) and significant events that have triggered , previous hospitalizations, Baker Act, history of psychiatrist care and treatment. If client has been hospitalized in the last 12 months, please document the dates, hospitals, and circumstances)**:**

Suicidal Ideation/Suicidal attempts:

Homicidal Ideation/Homicidal attempts:

If client refers suicidal/homicidal ideations, planning or attempt at interview time or during the last six months, please contact Supervisor and Crisis Team if required

IV. MEDICAL HISTORY

(Include all physical illness client's suffers, injuries, surgeries and hospitalizations)

Is client being attended by a Primary Physician at moment? (If yes, include doctor's name and how long time client is being receiving medical care with this doctor. If not, explain reasons)**:**

Allergies or intolerance:

SAMPLE

Current Medications (Please include medication's name, dosage and side effects. Please include any OTC medicine being taking by client at moment):

V. RESOURCES AVAILABLE TO THE CLIENT

(Please include information about all resources available in client's case- Psychiatrist, Therapist, Primary Care Physician, Specialists, Home Health Services, Legal guardian, Care Worker, DCF Case Worker, Probation officers, Housing program representative/manager, others. Please, include Effectiveness rating of current services).

Agency Name	Services provided	Contact Person (Include name, address and phone/fax)	Effectiveness rating of current services (Specify if Non Effective, Somewhat Effective or Highly Effective).

SAMPLE

COMMENTS (Include any comment about areas from I to V):

Strengths and Needs of the client and Support System

Please select N for needs identified, S for Client's strengths and N/A if applicable.

VI. Psychological and Social Area

1. Substance Abuse History (List types of substances, duration of use and any treatment received) N ☐ S ☐ N/A ☐

2. Physical or Emotional Abuse/Domestic Violence (perpetrator's data, times, dates, and whether reported) N ☐ S ☐ N/A ☐

3. General Level of Performance before the Onset of the Illness:	N ☐	S ☐	N/A ☐

4. Intellectual Functioning (memory, concentration , ability to perform and understand tasks)	N ☐	S ☐	N/A ☐

MMSE Score: Date:

5. Relationship with Others (ability to trust in others, ability to socialize, cooperativeness with others)	N ☐	S ☐	N/A ☐

6. Social Support Network (support from friends, acquaintances, peers, neighbors, coworkers or others)	N ☐	S ☐	N/A ☐

7. Family Support (communication with family, type of support received, effectiveness)	N ☐	S ☐	N/A ☐

8. Leisure activities/Interests/Skills and talents (specify kind and how it contribute to client's recovery)	N ☐	S ☐	N/A ☐

9. Employment concern. Desire to work.	N ☐	S ☐	N/A ☐

SAMPLE

10. Level of Education. Vocational Trainings. School concern. Desire to learn.	N ☐	S ☐	N/A ☐

11. Beliefs and Cultural Traditions (beliefs and spiritual practices, and how it assist client in dealing with stressors)	N ☐	S ☐	N/A ☐

12. Stability/Maturity. Behavior during interview (Term of relationships, frequency of moving/changes)	N ☐	S ☐	N/A ☐

13. Level of Functioning. Ability to perform ADL's and IADL's (include level of assistance required, if any)	N ☐	S ☐	N/A ☐
Level of functioning (Write The GAF score at the time of assessment):			

14. Awareness and insight. Compliance with appointments and treatments	N ☐	S ☐	N/A ☐

15. Financial resources (Specify amount of income and source. Specify economical condition as referred by client)	N ☐	S ☐	N/A ☐
(Please include also information about food, clothing, housing):			

16. Transportation Means (Means of transportation, ability to use private/public transportation)	N ☐	S ☐	N/A ☐

COMMENTS (Include any comment about Psychological and Social Area):

SAMPLE

VII. Legal Area

1. Legal History (delinquency, antisocial behavior. Specify charges, dates, convictions and incarcerations): N ☐ S ☐ N/A ☐

2. Legal status (Client's current legal status, if legal documentation is updated) N ☐ S ☐ N/A ☐

3. Legal guardian or proxy (Client has a legal guardian or needs one. Communication with guardian). N ☐ S ☐ N/A ☐

Please, attach a copy of the court disposition in case client has a legal guardian.

COMMENTS (Include any comment about Legal Area):

VIII. Physical Area

1. Physical Health (Specify if client's health interfere with day-to-day functioning, if is required medical care continuity) N ☐ S ☐ N/A ☐

(Please, include medical services required by client as per his/her report: Dentist, specialist, therapy, diagnostic test or others):

2. Personal hygiene/Dressing N ☐ S ☐ N/A ☐

3. Nutrition (Client's appetite, meals per day, if special diet is required. Be specific) N ☐ S ☐ N/A ☐

4. Age-Appearance (Specify if level of functioning and appearance is in accordance with chronological age) N ☐ S ☐ N/A ☐

COMMENTS (Include any comment about Physical Area):

SAMPLE

IX. HOME VISIT (The case manager must conduct a home visit prior to completion of the assessment, if the case manager is unable to complete a home visit, a face-to-face interview must be conducted in another setting).

Was a home visit conducted prior to the completion of Assessment: Yes: No:

Was the home visit conducted in the setting in which the client resides: Yes: No:

If home visit cannot be performed, please explain reasons (explanation must be signed by TCM and Supervisor)

TCM's Signature: ______________________________ Supervisor's Signature: ____________________________

Address:	**Date of Home Visit:**

Description of the house (House's location, neighborhood (rural/urban, crime level). Physical condition of the house, number of bedrooms, living and sleeping arrangements, low income housing program if applies.)

Description of appliances, roof, floor, sanitary condition, accessibility (Please describe potential safety or accessibility problems)

Indirect signs of abuse, violence and/ or drug use

Amount of rent and monthly utilities (specify, who is responsible for monthly payments)

X. Recommended Service Coordination

Each Mental Health Targeted Case Management's client must receive a thorough assessment, which will serve as the basis for the development of his/her Service Plan.

	Behavioral		Mental Health/Substance Abuse Services
	ADL/IADL Training		Medical and dental services
	Education		Assistance with employment opportunities
	Recreational activities		Living Environment/Housing
	Economical/Financial Assistance		Environmental support (peers groups)
	Legal Assistance		Family/Caregiver support and education
	Vocational or job training		Transportation
	Others:		

Other/Comments regarding recommended services :

SAMPLE

XI. SIGNATURES

I certify that I have provided the service(s) documented above in accordance with all applicable regulations.

______________________	______________________	______________
Case Manager's Name	Case Manager's Signature and credentials	Date
______________________	______________________	______________
Supervisor's Name	Supervisor's Signature and credentials	Date

SAMPLE

REGIONAL MANAGEMENT CARE INC
3810 INVERRARY BLVD
SUITE #404-A
LAUDERHILL FL 33319
PH: 954-474-7373
FAX: 954-449-0522

SPECIAL AUTHORIZATION FOR RELEASE INFORMATION

I, ____, date of birth ___________________________

Social Security Number _______/___________/______________, hereby authorize Regional Management Care Inc, to collect any relevant information pertaining to my treatment, including psychiatric profiles, drug and alcohol abuse, HIV/AIDS test results, and other information for my records, For the purpose of continuity of services, Regional Management Care Inc, is authorized to release the information to other facilities (including but not limited to physicians, clinics and hospitals) should such it be required by a persona or facility.

This authorization is given freely and voluntarily, and hereby releases Regional Management Care Inc form all legal liability that may arise from the release of the client information requested.

I understand that this consent may be revoked by me at any time, but no retroactive to the release of information made in good faith; this consent will expire one year from the date of signature indicated below.

____ _______________
SIGNATURE OF CLIENT **DATE**

____ _______________
SIGNTURE OF NEXT OF KIN/REPRESENTATIVE **DATE**

____ _______________
WITNESS **DATE**

SAMPLE

REGIONAL MANAGEMENT CARE INC

SIGNATURE AUTHORIZATION ON BEHALF OF PATIENT

PATIENT'S NAME: ________________________________ CASE RECORD# ____________

THIS PATIENT IS UNABLE TO SIGN DOCMENTS BECAUSE:

____

NAME OF PERSON/'S AUTHORIZED TO SIGN:

____

RELATIONSHIP: □RELATIVE □ CAREGIVER □ OTHER

EXPLAIN: ____

SIGNATURE: ______________________ ______________DATE: ______________

AUTORIZACIÓN PARA AFIRMAR POR EL PACIENTE

NOMBRE DEL PACIENTE: ________________________________ CASO # ____________

EL PACIENTE ESTA INCAPACITADO PARA FIRMAR DOCUMENTOS POR LA SIGUIENTE RAZON:

____

NOMBRE DE LA O LAS PERSONAS AUTORIZADAS A FIRMAR SON:

____

PARENTESCO: □FAMILIAR □ PERSONA QUE LO CUIDA □ OTHER

EXPLIQUE: ____

SIGNATURE: ________________________________ DATE: ______________

SAMPLE

WITNESS/TESTIGO: ________________________________ DATE: ______________

TARGETED CASE MANAGEMENT AGENCY

CASE MANAGER PROGRESS NOTES

Date: __________

Employee Name:

Case Manager Name:
Case Manager Employee Number:

Client's Information:

Client's Name:		**Client's #:**
Time In:	**Time out:**	**Units:**
Diagnosis (DSM-Name & Number):		

Reason for Follow: Up or Face to Face Contact:

Reason for Follow Up:	
Regular Follow Up: □ YES □ NO	
Face to Face Follow Up: □ YES □ NO	**If YES please Write Location:**

SAMPLE

NOTES: ____

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REMARKS: ____

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Next Visit Set for: ____

Goal for Next Follow up or Next Visit: ____

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SAMPLE

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Case Manager Signature

SUPERVISOR REVIEW: □YES □NO
REVIEW DATE:
SUPERVISOR NAME:
SUPERVISOR SIGNATURE:

REGIONAL MANAGEMENT CARE

TARGETED CASE MANAGEMENT AGENCY

COORDINATION OF CARE

Name:____ Date: ____________________
Nombre Fecha

Telephone: ________________ SS#: ____________________ Date of Birth: ________________
Teléfono No. de Seguro Social Fecha. de Nacimiento

Information to be (La información será:) ☐ released (entregada a:) ☐ requested to (solicitada a):

PROVIDER'S INFORMATION (Información del Proveedor):

PROVIDER (Especialidad)	NAME (Nombre)	ADDRESS (Dirección)	PHONE-FAX (Teléfono-Fax)

Information Format : ☐ Verbal ☐ Written record(s) ☐ Facsimile ☐ Other: ____________

(Formato de la información): ☐ Verbal ☐ Escrito ☐ Facsímil ☐ Otro: ____________

Please send the information requested to:

Regional Management Care Inc
by Fax: 954-449-0522
by Mail: 38110 Inverrary Blvd Suite#404-A
Lauderhill, Fl 33319.

Dear Provider: We wish to inform you that the person previously mentioned is receiving Targeted Case Management Services in our agency. The regulations of Medicaid, as well as the norms of quality assurance of RMC, consider that the care coordination is crucial. Therefore the client and/or guardian has authorized our mutual exchange of information at the end of this letter. In order to coordinate the care of the client in an efficient manner, we would appreciate that you contact our office at 954-474-7373 with any pertinent information, preoccupation or questions on this matter.

Authorization or Rejection emitted by the Client and/or Guardian:

____I authorize in that the provider previously mentioned and RMC Agency interchange health information to provide better coordination of care and services for me.

____ I reject the exchange of information between RMC and my other providers.

Estimado Proveedor: Deseamos informarle que la persona anteriormente mencionada está recibiendo servicios de Manejo de Caso en nuestra agencia. Las regulaciones de Medicaid así como las normas de garantía de calidad de **Regional Management Care Inc** consideran que la coordinación de cuidado es crucial. Por consiguiente el cliente/padre/guardián ha autorizado nuestro mutuo intercambio de información de salud al final de esta carta. Para coordinar eficientemente el cuidado de la persona servida, apreciaríamos que contacte nuestra oficina al 954-474-7373 con cualquier información pertinente, preocupación o pregunta al respecto.

Autorización o Rechazo emitida por la Persona Servida/Padre/Guardián

____Yo autorizo en mi nombre/o a nombre del niño, que el doctor anteriormente mencionado y **Regional Management Care Inc** intercambien información de salud para proveer una mejor coordinación de cuidado.

____ Yo rechazo el intercambio de información entre RMC y mis proveedores de servicios de salud.

SAMPLE

REGIONAL MANAGEMENT CARE

TARGETED CASE MANAGEMENT AGENCY

______________________________	___________________________	_________________
Client/Padres/Guardián's Name	Signature	Fecha

TCM's Name and Signature: ____ Date: _____________

SAMPLE

REGIONAL MANAGEMENT CARE INC

HOME ENVIRONMENT SAFETY EVALUATION

Please, check off client's home evaluation. Items that are satisfactory check "YES", no satisfactory check "NO" and no apply "N/A". Document the action plan with date to correct any problem.

ITEMS TO CHECK	YES	NO	N/A
Fire extinguish is available and accessible			
There are functional smoke alarm (s)			
Telephone and emergency # are accessible			
Access to outside exits is free of obstruction			
Alternate exits are accessible in case of fire			
Walking pathways are level, uncluttered and non-skid surfaces			
Stairs are in good repair, well it, uncluttered, have non-skid surfaces. Handrails are present /secure.			
Lighting is adequate for safe ambulation and ADL			
Temperature and ventilation are adequate			
Electrical cords and outlets appear in good repair in client's area, cord not frayed, outlet not overload.			
Bathroom is safe for the provision of care raised toilet seat, tub seat, grab bar, non-skid surface.			
Environment is safe for effective oxygen use			
Kitchen is safe provision of care (i.e., working appliances, hygienic area for food prep, etc)			
Check Flashlights every 2 weeks, notify client to have replacement batteries (if necessary)			
Medicines clearly labeled and placed in safe storage			
Overall environment is adequately sanitary for the provision of care			
Relevant medical appliances in safety place and accessible (walker, w/c, pumps, monitors)			
Other:			
Other:			

SAMPLE

DATE	CORRECTION PLAN

Case Manager Signature: _______________________________________ Date: ____________________