The Full Coverage PDN Company
Client Handbook

Welcome

Thank you for choosing The Full Coverage PDN Company for your health care needs. The purpose of this packet is to inform you of your patient rights and responsibilities, along with valuable information concerning your care needs and other health care issues.

Our mission is to build trusting relationships with patients, families, physicians, and all others devoted to patient care in the home.

Working as a team we wish to provide you with quality health care. Together we can help you reach your maximum potential.

We work hard to employ and consult with caring and qualified medical personnel. Our job is to provide you with a comprehensive and thorough evaluation of the services you will require and follow that evaluation with treatments tailored to improve your home care experience.

Mission Statement

The Mission of The Full Coverage PDN Company is to live up to its name, for its clients, families and staff, by delivering what is promised, needed and depended on - the very best possible life… at-home.

Our clients have serious medical conditions and have bravely chosen to still live at home. With this choice, they have taken on great responsibilities. They depend on us to do our part. For them, our Mission is:

- ***To never fail our clients,***
- ***To deliver the help that is promised and depended on,***
- ***And to create the best home care experience with***
- ***Respect, Care and Compassion***

Our employees have chosen the good work of helping others. They are cherished for this choice and they deserve support and assistance as well. For each employee, our Mission is:

- ***To be a helping hand, professionally and personally,***
- ***To provide opportunity to grow, learn, serve, and excel,***
- ***To recognize and value great work,***
- ***And to create a true team, that trusts, helps and cares for each other and the client.***

Our Name Is Our Aim.
Reminded, Every Time We Hear It,
Recommitted, Every Time We Say It.

We take seriously the moral character of the people we send to your home.

Moral Code:

The 21 Precepts of "*The Way To Happiness*"

1. Take Care of Yourself
2. Be Temperate
3. Don't Be Promiscuous
4. Love and Help Children
5. Honor and Help Your Parents
6. Set A Good Example
7. Seek To Live With The Truth
8. Do Not Murder
9. Don't Do Anything Illegal
10. Support A Government Designed and Run For All The People
11. Do Not Harm A Person Of Good Will
12. Safeguard And Improve Your Environment
13. Do Not Steal
14. Be Worthy of Trust
15. Fulfill Your Obligations
16. Be Industrious
17. Be Competent
18. Respect The Religious Beliefs of Others
19. Try Not To Do Things To Others That You Would Not Like Them to Do To You
20. Try To Treat Others As You Would Want Them To Treat You
21. Flourish And Prosper

What is “The Way To Happiness”? It is…

> *The first moral code based wholly on common sense, originally published in 1981, its purpose is to help arrest the current moral decline in society and restore integrity and trust to humankind. “The Way to Happiness” further holds a Guinness Record as the world’s single most translated non-religious book in the world.*
>
> *Written by L. Ron Hubbard, it fills the moral vacuum in an increasingly materialistic society, containing 21 basic principles that guide one to a better quality of life.*
>
> *This code of conduct can be followed by anyone, of any race, color or creed and works to restore the bonds that unite humankind.*
>
> *But the real power of the book is realized when it is distributed to others, hand to hand. Since the actions of those around you can affect your life, you are improving your own survival when you present copies of “The Way to Happiness” to friends, associates, employees and customers. In this way, you help others survive better and lead happier lives. They, in turn, pass copies of the book to those whose lives they influence, encouraging others to treat their fellows with kindness, compassion and respect.*
>
> *And so it goes, moving from person to person, helping others to live better lives.*
>
> From: thewaytohappiness.org/about-us/what-is-the-way-to-happiness.html

The full text of the book is available at TheWayToHappiness.Org/TheWayToHappiness.html

Copies of “The Way To Happiness” are available upon request from The Full Coverage PDN Company.

Code Of Ethics

The Full Coverage PDN Company conducts its business and operations in accordance with both the law and standards of business ethics.

The Full Coverage PDN Company requires employees to be in compliance with laws and regulations. When the application of a law or regulation is uncertain, the guidance and advice of a supervisor or the Administrator may be sought.

The Full Coverage PDN Company is dedicated to providing medically necessary home care to patients without regard to race, creed, color, national origin, gender, or disability. Admissions, transfers and discharges are made in accordance with clinical need, with applicable laws and regulations, and Company policies.

The Full Coverage PDN Company requires the loyalty of its employees in the exercise of their Company responsibilities. Except as may be approved otherwise by the Board of Directors, personal investments or other activities which may create a conflict of interest are prohibited and circumstances which may give the appearance of a conflict of interest are to be avoided.

The Full Coverage PDN Company strives to maintain accurate corporate records of its transactions.

Location and Hours

The Full Coverage PDN Company

is located at:

5208 William and Mary Drive
Raleigh, NC 27616

Private Duty Nursing is available 24 hours a day, 7 days a week.
An RN Supervisor is on-call 24/7.
A Scheduling Coordinator is on-call 24/7.

Administrative Office hours are 10am – 3pm Monday thru Friday, except major holidays.
Administrative Phone hours are 7a – 10p Monday thru Friday.
An RN Supervisor and a Scheduling Coordinator are on-call hours are 24/7.
Additional Office hours are available by appointment.

Admission Criteria

Admission to The Full Coverage PDN Company can only be made under the direction of a physician based on your health care needs.

The Full Coverage PDN Company will provide services under the direction of your physician. Our services include the following:

- ♥ Skilled Private Duty Nursing

Patient and family participation is very important when we plan and coordinate for your health care. There must be a willing and able patient or caregiver to be responsible for continual care between visits. Qualified medical personnel will visit and assess your needs; together we will discuss the services and the plan that would best benefit you.

We accept payment for services from Private Pay, VA, Insurance, Workers Compensation, or other means determined appropriate by the Administrator. Some insurers may require Pre-Certification and may limit the number and type of home visits we can provide.

Description of Service

Types of Service Available:
The Full Coverage PN Company provides Skilled Private Duty Nursing to clients that have a serious need for full coverage. Our clients and their families have taken on large responsibilities of their own and they absolutely require a Company that will fulfill its own responsibilities. Since most of our clients are ventilator dependent or have a tracheostomy, having help that "might" show up is not an option. That is why we provide dependable skilled private duty nursing- LPNs and RNs that are specially trained to care for clients who live at home even though they require substantial, complex and continuous skilled nursing.

Service Limitations:
Because we concentrate our attention on serving a few clients that have a serious need for full coverage, we do not typically accept clients that have simpler needs. These clients are typically referred to other agencies that do a good job serving a large number of clients that require less care.

Client Responsibility for Payment
The level of service we provide generally requires case by case approval from your insurance provider. We will work with your insurance provider to get the best possible coverage. Before admission we will go over what is expected from your insurance and what payment responsibility you may have.

Eligibility for Services
To enter The Full Coverage PDN Company program:

- The client must live in the area that the Company serves. Contact the Office to find out if we are serving your area, or if we can expand into your area.
- The client's home must be suitable for safe and effective in-home care, as far as environment, facilities, and equipment, etc.
- The client must have adequate family support.
- The Company must determine that it will be able to provide superior service.

Hours of Operation
The Company provides care 24 hours per day, 7 days per week. In addition to your in-home nurses, an RN Supervisor and a Schedule Coordinator are available on-call 24/7. Administrative Office hours are 10am - 3pm, Monday thru Friday, except major holidays. Administrative Phone hours are 7a – 10p Monday thru Friday. Additional Office hours are available by appointment.

Contact Us
We accept referrals from anyone authorized by the potential client to contact us. To arrange a service consultation call us at (919) 803-4000. **FullCoveragePDN.Com**

Client Rights and Responsibilities

As a home care provider, we have an obligation to protect the rights of our patients and explain these rights to you before treatment begins. Your family or your designee may exercise these rights for you in the event that you are not able to exercise them for yourself.

Clients of The Full Coverage PDN Company have the right to:

1. Be informed verbally and in writing, or by other means understood by me, of my rights to make informed decisions regarding my care.
2. Protect and promote the exercise of my rights.
3. Voice grievances regarding treatment or service, lack of respect of property or recommend changes in policy, personnel, or service without restraint, interference, coercion, discrimination, or reprisal.
4. Be informed of how to express a complaint.
5. Have grievances regarding treatment or service that is (or fails to be) furnished, or lack of respect of property investigated.
6. Confidentiality and privacy of all information contained in the client record and of Protected Health Information (PHI) and to be advised on agency's policies and procedures regarding the disclosure of client/patient records
7. Be informed of my liability for payment of services.
8. Be informed in advance, both orally and in writing, in advance of care/service being provided, of the charges, including payment for care expected from third parties and any charges for which the client will be responsible.
9. Be informed of the process of admission and continuance of services and how eligibility for services is determined.
10. Refuse care or treatment after the consequences of refusing care or treatment are fully presented.
11. Be informed of Company on-call procedures.
12. Be informed of supervisor accessibility and availability.
13. Be informed of Company policy on discharge.
14. Participate in the development and modification of the Plan of Care.

15. Have one's property and person treated with respect, consideration, and recognition of patient dignity and individuality.
16. Receive a reasonable response to requests of the Company.
17. Be notified within 10 days if the Company's license has been revoked, suspended, canceled, annulled, withdrawn, recalled or amended.
18. Be free of mental and physical abuse, neglect and exploitation.
19. Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of client ID property.
20. Be informed in advance about the care to be provided, the disciplines that will furnish care, the frequency of visits, and any modifications to the care plan..
21. Have a copy of these home care client's rights.
22. Be informed of patient rights under state law to formulate an Advanced Directive, and have advanced directives honored as permitted by law.
23. Have your property treated with respect.
24. Be involved in resolving ethical issues or conflicts about care or service.
25. Be fully informed of client responsibilities.
26. Have Company employee's refrain from smoking in my home. During the 2007 legislative session, the North Carolina General Assembly passed a law prohibiting employees of home care agencies from smoking in a client's home. This law became effective on October 1, 2007. If I observe any employee smoking in my home while providing services on behalf of The Full Coverage PDN Company I can notify the Company. Should I have any questions, I may contact your RN Case Manager, the DON or the Administrator at 919-803-4000.
27. Be able to identify visiting personnel members through an agency generated photo ID.
28. Choose a health care provider, including choosing an attending physician.
29. Receive appropriate care/service without discrimination in accordance with physician orders.
30. Be informed of any financial benefits when referred to the Company.
31. Receive information about the scope of services that the Agency will provide and specific limitations on those services.

32. Have the address and telephone numbers for information, questions, or complaints about the services provided by the Company:

The Full Coverage PDN Company
5208 William and Mary
Raleigh, NC 27616
Phone: 919-803-4000, Fax: 844-908-1432

33. To file complaints with the agency's accreditation provider: **Accreditation Commission for Health Care, (855) 937-2242, achc.org/complaint-policy-process/.**
34. Have the address and telephone numbers for The North Carolina Division of Health Service Regulation Complaint Intake Unit. The Unit is available to receive complaints regarding the care and services provided to patients by agencies. The Division is only able to investigate complaints regarding incidents that have occurred in the past year and issues that are regulated by federal regulations federal or state statutes. A complaint form (www.ncdhhs.gov/dhsr/ciu/pdf/complaint_form2.pdf) is available for written complaints but is not required to be used. Each complaint is prioritized for investigation according the seriousness of the situation. Investigations are unannounced to the agencies and complainant identifying information is not shared with the agencies. Complaints may be sent by telephone, fax or mail:
    - The Acute Care, Home Care Branch with the Licensure and Certification Section at the Division of Health Service Regulation (DHSR) is responsible for enforcing state statutes for home care agencies. Questions and requests for information are also handled by this Branch. The phone number is 919-855-4620. The address is Acute Care, Home Care and CLIA Branch, Licensure and Certification Section, Division of Health Service Regulation, 2712 Mail Service Center, Raleigh, NC 27699.
    - The Complaint Intake Unit with the DHSR receives complaints for all agencies licensed by DHSR, including home care agencies. The phone number for the Complaint Intake Unit is 1-800-624-3004 (within NC) or 919-855-4500. The fax number is 919-715-7724. The mailing address is Complaint Intake Unit, Division of Health Service Regulation, 2711 Mail Service Center, Raleigh, NC 27699.

Clients of The Full Coverage PDN Company have the responsibility to:

1. Provide an environment where Company staff may provide safe and effective care while being free from physical, verbal, sexual abuse, or harassment or discrimination. And treat agency personnel with respect and consideration.
2. Notify the Company when I feel my rights are not being respected.
3. Participate in the development and modification of the Plan of Care.
4. Express any concerns regarding the course of treatment or my ability to comply with instructions.
5. Notify the Company if we do not understand the care instructions or if they cannot be followed.
6. Be responsible for our actions if we do not follow Plan of Care.
7. Notify the Company of changes in my medications, health status, or physician.
8. Supply accurate and complete information about my medical history.
9. Cooperate with physicians and the Company in my treatment program.
10. Sign a release when refusing medication, treatments, the recommended plan of care, or home care services.
11. Inform the Company of admission to any institution that may conflict with the services the Company is providing.
12. Notify the Company when scheduled visits cannot be kept.
13. Notify the Company if I join or enroll in an HMO.
14. Provide the Company with a copy of my Advanced Directives.
15. Provide the agency with all requested insurance and financial records.
16. Sign the required consents and releases for insurance billing.

Preadmission Notifications

Before the care is started, the Company must inform a patient orally and in writing of the following:

1. The extent to which payment may be expected from third party payers.
2. The charges for services that will not be covered by third party payers.
3. Services to be billed to third party payers.
4. The method of billing and payment for services.
5. The charges that the patient may have to pay.
6. A schedule of fees and charges for services.
7. The nature and frequency of services to be delivered and the purpose of the service.
8. Any anticipated effects of treatment, as applicable.
9. The Company must inform a patient orally and in writing of any changes in these charges as soon as possible, but no later than five (5) days from the date the home health Company provider becomes aware of the change.
10. If a Company is implementing a scheduled rate increase to all clients, the Company shall provide a written notice to each affected consumer at least 30 days before implementation.
11. The requirements of notice for cancellation or reduction in services by the organization and the client; and
12. The refund policies of the organization.
13. The Company shall not assume power of attorney or guardianship over a consumer utilizing the services of the Company, require a consumer to endorse checks over to the Company or require a consumer to execute or assign a loan, advance, financial interest, mortgage, or other property in exchange for future services.

Plan of Care Supervision

All services provided to you will be directly supervised by a RN. The RN will monitor and direct your care by direct visits, team meetings, conferences with your staff, and review of documentation.

Complaints and Grievances Procedure

We want you to be satisfied with the services provided by anyone working on behalf of The Full Coverage PDN Company. You may report a complaint or grievance at any time without reprisal or disruption of services. A complaint or grievance may concern services, care, lack of respect, mishandling of property or any issue that concerns you.

Complaints and Grievances Procedure:

1. Report the complaint or grievance to any staff member.
2. The staff members must report the issue to the Supervising RN.
3. The Company must investigate the issue and report back to you within 72 hours.
4. The Company must notify you when appropriate action has been taken or when the problem has been resolved.
5. The Company must complete the investigation and handling within 30 calendar days unless there is reasonable cause for delay.
6. If you are not satisfied with the handling, you may appeal to the Governing Body by submitting a written complaint to: The Full Coverage PDN Company Governing Body, 8396 Six Forks Road, Suite 102, Raleigh, NC 27616.

We hope that you will contact us with any concerns you have. You also may contact the NC Division of Health Service Regulation or the Accreditation Commission for Health Care, Inc. at any time without reprisal or disruption in services.

NC Division of Health Service Regulation Complaint Intake Unit, 2711 Mail Service Center Raleigh, NC 27699-2711 Complaint Hotline: 800-624-3004 (within N.C.) or 919-855-4500. Fax 919-715-7724	Accreditation Commission for Health Care, Inc. 139 Weston Oaks Court, Raleigh, NC 27513 customerservice@achc.org Phone: (919) 785-1214 Fax: (919) 785-3011	**Full Coverage PDN** **5208 William and Mary Dr** **Raleigh, NC 27616** **919-803-4000** **Fax: 844-908-1432** **Admin@FCPDN.com**

HIPAA Notice of Privacy Practices

In compliance with HIPAA
(The Health Insurance Portability and Accountability Act of 1996)

If you are a client of The Full Coverage PDN Company, this notice describes how your medical information may be used and disclosed and how you can get access to this information. Please review this notice carefully.

I. USES AND DISCLOSURES

The Company will not disclose your health information without your authorization, except as described in this notice.

Plan of Care/Treatment. The Company will use your health information for the plan of care; for example, information obtained by a nurse will be recorded in your record and used to determine the course of treatment. Your nurse and other health care professionals will communicate with one another personally and through the case record to coordinate care provided.

Payment. The Company will use your health information for payment for services rendered. For example, the Company may be required by your health insurer to provide information regarding your health care status so that the insurer will reimburse you or the Company. The Company may also need to obtain prior approval from your insurer and may need to explain to the insurer your need for home care and the services that will be provided to you.

Health Care Operations. The Company will use your health information for health care operations. For example, Company nurses, field staff, supervisors and support staff may use information in your case record to assess the care and outcomes of your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of services we provide. Regulatory and accrediting organizations may review your case record to ensure compliance with their requirements.

Notification. In an emergency, the Company may use or disclose health information to notify or assist in notifying a family member, personal representative or another person responsible for your care, of your location and general condition.

Workers´ Compensation. The Company may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers´ compensation or other similar programs established by the law.

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Public Health. As required by federal and state law, the Company may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Law Enforcement. As required by federal and state law, the Company will notify authorities of alleged abuse/neglect; and risk or threat of harm to self or others. We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Charges against the Company. In the event you should file suit against the Company, the Company may disclose health information necessary to defend such action.

Duty to Warn. When a client communicates to the Company a serious threat of physical violence against himself, herself or a reasonably identifiable victim or victims, the Company will notify either the threatened person(s) and/or law enforcement.

The Company may also contact you about appointment reminders, treatment alternatives or for public relations activities.

In any other situation, the Company will request your written authorization before using or disclosing any identifiable health information about you. If you choose to sign such authorization to disclose information, you can revoke that authorization to stop any future uses and disclosures.

II. INDIVIDUAL RIGHTS

You have the following rights with respect to your protected health information:

1. You may request in writing that the Company not use or disclose your information for treatment, payment or administration purposes or to persons involved in your care except when specifically authorized by you, when required by law, or in emergency situations. The Company will consider your request; however, the Company is not legally required to accept it. You have the right to request that your health information be communicated to you in a confidential manner such as sending mail to an address other than your home. Patients may request a copy of their electronic medical record in an electronic form. The Company will charge you a reasonable amount, as allowed by statute for providing a copy of the electronic medical record.
2. Within the limits of the statutes and regulations, you have the right to inspect and copy your protected health information. If you request copies, the Company will charge you a reasonable amount, as allowed by statute.

HIPAA Notice of Privacy Practices

3. If you believe that information in your record is incorrect or if important information is missing, you have the right to submit a request to the Company to amend your protected health information by correcting the existing information or adding the missing information.
4. You have the right to receive an accounting of disclosures of your protected health information made by the Company for certain reasons, including reason related to public purposes authorized by law and certain research. The request for an accounting must be made in writing to Privacy Officer. The request should specify the time period for the accounting. Accounting request may not be made for periods of time in excess of six (6) years. The Company would provide the first accounting you request during any 12-month period without charge. Subsequent accounting request may be subject to a reasonable cost based fee.
5. If this notice was sent to you electronically, you may obtain a paper copy of the notice upon request to the Company.
6. When patients pay by cash they can instruct this Company not to share information about their treatment with their health plan/ insurance provider.
7. This Company will not disclose genetic information.
8. This Company will not use patient information for the purpose of fundraising or marketing. This Company will not sale patient health information.

III. COMPANY´S DUTIES

1. The Company is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices with respect to protected health information.
2. The Company is required to abide by the terms of this Notice of its duties and privacy practices. The Company is required to abide by the terms of this Notice as may be amended from time to time.
3. The Company reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all protected health information that it maintains. Prior to making any significant changes in our policies, Company will change its Notice and provide you with a copy. You can also request a copy of our Notice at any time. For more information about our privacy practices, please contact the office 919-263-4009.

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4. It is the duty of this Company to notify the patient of a breach of their protected health information. This Company will notify the patient within 15 business days of discovery of any breach in the patients protected health information. Notification will occur regardless of whether the breach was accidental or if a business associate was the cause. A "breach" of PHI is any unauthorized access, use or disclosure of unsecured PHI, unless a risk assessment is performed that indicates there is a low probability that the PHI has been compromised. The risk assessment must be performed after both improper uses and disclosures, and include the nature and extent of the PHI involved, a list of unauthorized persons who used or received the PHI, if the PHI was in fact acquired or viewed, and the degree of mitigation. This Company and if any business associate was involved must consider all the following factors in assessing the probability of a breach:
   - the nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification;
   - the unauthorized person who used the protected health information or to whom the disclosure was made;
   - whether the protected health information was actually acquired or viewed; and
   - the extent to which the risk to the protected health information has been mitigated.

   "Unsecured" protected health information means protected health information that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology.

5. If the breach is determined to have no or low probability of risk to the patient then the patient will not be notified. Any other risk factor requires the Company to notify the patient in writing within 15 business days of the conclusion of the determination.

IV. COMPLAINTS

If you are concerned that the Company has violated your privacy rights, or you disagree with a decision the Company made about access to your records, you may contact the office at 919-803-4000. You may also send a written complaint to the Federal Department of Health and Human Services. The Full Coverage PDN Company office staff can provide you with the appropriate address upon request. Under no circumstances will you be retaliated against for filing a complaint.

HIPAA Notice of Privacy Practices

V. CONTACT INFORMATION

The Company is required by law to protect the privacy of your information, provide this Notice about our information practices, and follow the information practices that are described in this Notice.

If you have any questions or complaints, please contact the Administrator.

You may contact the Administrator at:

The Full Coverage PDN Company
5208 William and Mary Drive
Raleigh, NC 27616
919-803-4000 Fax: 844-908-1432 Admin@FCPDN.com

Complaints may also be directed to State Licensing Authority at:

Accreditation Commission for Health Care, Inc.
139 Weston Oaks Court, Raleigh, NC 27513
customerservice@achc.org
Phone: (919) 785-1214
Fax: (919) 785-3011
Or:
NC Division of Health Service Regulation
Complaint Intake Unit
2711 Mail Service Center
Raleigh, NC 27699-2711
Complaint Hotline: 1-800-624-3004 (within N.C.) or 919-855-4500
Fax 919-715-7724
Care Line Number: 1-800-662-7030

Medicaid Fraud Reporting

If you have reason to believe that, someone is defrauding the Medicaid program please report to the appropriate agency listed below.

Medicaid	**Office of Inspector General Hotline**
By Telephone: 1-800-HHS-TIPS (1-800-447-8477) **TTY Toll-Free:** 1-877-486-2048	**By Us Mail:** Office of the Inspector General HHS TIPS Hotline P.O. Box 23489 Washington, DC 20026 **By Fax:** 1-800-223-2164 **By email:** HHSTips@oig.hhs.gov

Abuse, Neglect, Exploitation Policy

Company employees and independent contractors shall report all actual or suspected cases of abuse, neglect or exploitation of a patient/child to a Company supervisor and the appropriate state agency. If Company personnel detect any signs of family violence, the information required by law is given to the victim and suspected family violence is reported to the employee's supervisor.

Abuse means: the negligent or willful inflection of injury, unreasonable confinement, intimidation, or cruel punishment with resulting physical or emotional harm or pain to an elderly or disabled person by the person's caretaker, family member or other individual who has an ongoing relationship with the person; or sexual abuse of an elderly or disabled person, including any involuntary or nonconsensual sexual conduct that would constitute an offense, (indecent exposure, assault offenses), committed by the person's caretaker, family member, or other individual who has an ongoing relationship with the person.

Neglect means: the failure to provide for one's self the goods or services, including medical services which are necessary to avoid physical or emotional harm or pain or the failure of a caretaker to provide such goods or services.

Exploitation means: the illegal or improper act or process of a caretaker, family member, or other individual who has an ongoing relationship with an elderly or disabled person using the resources of such person for monetary or personal benefit, profit, or gain without the informed consent of such person.

Contact numbers for adult and child protective services in each North Carolina County are listed on the following pages.

County	Child Protective Services	Adult Protective Services
ALAMANCE	(336) 229-2942	(336) 229-2921
ALEXANDER	(828) 632-1080	(828) 632-1080
ALLEGHANY	(336) 372-1445	(336) 372-1445
ANSON	(704) 694-9351	(704) 694-9351
ASHE	(336) 982-7800	(336) 846-5719
AVERY	(828) 733-8257	(828) 733-8252
BEAUFORT	(252) 940-6026	(252) 940-6042
BERTIE	(252) 794-5320	(252) 794-5320
BLADEN	(910) 862-6876	(910) 862-6893
BRUNSWICK	(910) 253-2080	(910) 253-2106
BUNCOMBE	(828) 250-5500	(828) 250-6545
BURKE	(828) 764-9627	(828) 764-9659
CABARRUS	(704) 920-2277	(704) 920-1891
CALDWELL	(828) 426-8257	(828) 426-8343
CAMDEN	(252) 331-4787	(252) 331-4787
CARTERET	(252) 728-3181	(252) 728-3181
CASWELL	(336) 694-2032	(336) 694-2008
CATAWBA	(828) 695-4536	(828) 695-5607
CHATHAM	(919) 642-6937	(919) 642-6933
CHEROKEE	(828) 837-7455	(828) 837-7455
CHOWAN	(252) 482-1448	(252) 482-1448
CLAY	(828) 389-6301	(828) 389-6301
CLEVELAND	(704) 487-0661	(704) 487-0661
COLUMBUS	(910) 641-3211	(910) 641-3114
CRAVEN	(252) 636-4900	(252) 636-4900
CUMBERLAND	(910) 677-2045	(910) 677-2840
CURRITUCK	(252) 232-3083	(252) 232-3083
DARE	(252) 475-5500	(252) 475-5500
DAVIDSON	(336) 242-2506	(336) 242-2592
DAVIE	(336) 753-6250	(336) 753-6250
DUPLIN	(910) 296-2200	(910) 296-2200
DURHAM	(919) 560-8316	(919) 560-8600
EDGECOMBE	(252) 641-7698	(252) 641-7988
FORSYTH	(336) 703-3800	(336) 703-3800
FRANKLIN	(919) 496-8169	(919) 496-8102
GASTON	(704) 862-7610	(704) 862-7636
GATES	(252) 357-0075	(252) 357-0075

County	Child Protective Services	Adult Protective Services
GRAHAM	(828) 479-7911	(828) 479-7911
GRANVILLE	(919) 693-1511	(919) 693-1511
GREENE	(252) 747-5932	(252) 747-5932
GUILFORD	(336) 641-7618	(336) 641-3380
HALIFAX	(252) 536-6541	(252) 536-6538
HARNETT	(910) 893-7500	(910) 814-6638
HAYWOOD	(828) 452-6620	(828) 452-6620
HENDERSON	(828) 694-6353	(828) 694-6306
HERTFORD	(252) 358-7830	(252) 358-7830
HOKE	(910) 878-1929	(910) 878-1935
HYDE	(252) 926-4199	(252) 926-4199
IREDELL	(704) 878-5020	(704) 878-5089
JACKSON	(828) 587-2079	(828) 587-2053
JOHNSTON	(919) 989-5373	(919) 989-5342
JONES	(252) 448-2581	(252) 448-2581
LEE	(919) 718-4690	(919) 718-4690
LENOIR	(252) 559-6213	(252) 559-6235
LINCOLN	(704) 736-8775	(704) 732-1969
MACON	(828) 349-2131	(828) 349-2139
MADISON	(828) 649-2711	(828) 649-2711
MARTIN	(252) 789-4468	(252) 789-4471
MCDOWELL	(828) 659-0679	(828) 652-3355
MECKLENBURG	(704) 336-2273	(704) 336-3000
MITCHELL	(828) 688-2175	(828) 688-2175
MONTGOMERY	(910) 576-6531	(910) 576-6531
MOORE	(910) 947-2436	(910) 947-2436
NASH	(252) 459-1253	(252) 459-1434
NEW HANOVER	(910) 798-3475	(910) 798-3719
NORTHAMPTON	(252) 534-1246	(252) 534-1246
ONSLOW	(910) 219-1894	(910) 219-1894
ORANGE	(919) 245-2260	(919) 245-2881
PAMLICO	(252) 745-4086	(252) 745-4086
PASQUOTANK	(252) 338-2126	(252) 338-2126
PENDER	(910) 259-1367	(910)-259-1366
PERQUIMANS	(252) 426-1806	(252) 426-1806
PERSON	(336) 503-1152	(336) 503-1178
PITT	(252) 902-1282	(252) 902-1086

County	Child Protective Services	Adult Protective Services
POLK	(828) 894-2100	(828) 894-2100
RANDOLPH	(336) 683-8030	(336) 683-8028
RICHMOND	(910) 997-8496	(910) 997-8414
ROBESON	(910) 671-3716	(910) 671-3168
ROCKINGHAM	(336) 342-1394	(336) 342-1394
ROWAN	(704) 216-8479	(704) 216-8357
RUTHERFORD	(828) 287-6174	(828) 287-6282
SAMPSON	(910) 592-4200	(910) 592-4200
SCOTLAND	(910) 277-2525	(910) 277-2525
STANLY	(704) 986-2009	(704) 986-2007
STOKES	(336) 593-2861	(336) 593-2861
SURRY	(336) 401-8800	(336) 401-8800
SWAIN	(828) 488-6921	(828) 488-6921
TRANSYLVANIA	(828) 884-3174	(828) 884-3174
TYRRELL	(252) 796-3421	(252) 796-3421
UNION	(704) 296-4440	(704) 296-4349
VANCE	(252) 436-0407	(252) 492-5001
WAKE	(919) 212-8447	(919) 250-3835
WARREN	(252) 257-5007	(252) 257-5024
WASHINGTON	(252) 793-4041	(252) 793-4041
WATAUGA	(828) 265-8100	(828) 265-8100
WAYNE	(919) 731-1103	(919) 731-1077
WILKES	(336) 651-7487	(336) 651-7553
WILSON	(252) 206-4130	(252) 206-4000
YADKIN	(336) 679-4210	(336) 679-3385
YANCEY	(828) 682-2470	(828) 682-2470

Drug Testing Policy

The Full Coverage PDN Company is a drug free workplace. The use of drugs or alcohol in the workplace or being under the influence while on duty is prohibited. Drug screening or testing may be requested as a condition of employment, conducted on a random basis, or in the event an associate is involved in a major accident during working hours. Alcohol use or chemical substance abuse during working hours and eight (8) hours prior to reporting for duty is prohibited and is considered grounds for immediate termination of employment. Any staff member suspected of impairment or substance abuse is to be relieved of duty immediately. The associate is to undergo drug screening within 2 hours adhering to the appropriate lab protocol. Refusal to consent to drug testing is considered grounds for termination of employment.

Medical Care Decisions and Advance Directives: What You Should Know

Who decides about my medical care or treatment?
If you are 18 or older and are able to make and communicate health care decisions, you have the right to make decisions about your medical and mental health treatment. You should talk to your physician or other health care or mental health provider about any treatment or procedure so that you understand what will be done and why. You have the right to say yes or no to treatments recommended by your physician or mental health provider. If you want to control decisions about your medical and mental health care even if you become unable to make decisions or to express them yourself, you should be sure to tell your physician or mental health provider and your family and friends what you want, but you also should have an advance directive.

What is an advance directive?
An advance directive is a set of directions you give about the medical and mental health care you want if you ever lose the ability to make decisions for yourself. North Carolina has three ways for you to make a formal advance directive. These include: living wills; health care powers of attorney; and advance instructions for mental health treatment.

Do I have to have an advance directive and what happens if I don't?
Making an advance directive is your choice. If you become unable to make your own decisions, and you have no advance directive, your physician or mental health care provider will consult with someone close to you about your care. Discussing your wishes for medical and mental health treatment with your family and friends now is strongly encouraged, as this will help ensure that you get the level of treatment you want when you can no longer tell your physician or other health care or mental health providers what you want.

What is a living will?
In North Carolina, a living will is a legal document that tells others that you want to die a natural death if you:

- become incurably sick with an irreversible condition that will result in your death within a short period of time;
- are unconscious and your physician determines that it is highly unlikely you will regain consciousness; or
- have advanced dementia or a similar condition which results in a substantial cognitive loss and it is highly unlikely the condition can be reversed.

Medical Care Decisions and Advance Directives: What You Should Know

In a living will, you can direct your physician not to use certain life-prolonging treatments such as a breathing machine ("respirator" or "ventilator"), or to stop giving you food and water through a tube ("artificial nutrition or hydration" through feeding tubes and IVs).

A living will goes into effect only when your physician and one other physician determine that you meet one of the conditions specified in the living will. Discussing your wishes with family, friends, and your physician now is strongly encouraged so that they can help make sure that you get the level of care you want at the end of your life.

What is a health care power of attorney?
A health care power of attorney is a legal document in which you can name a person(s) as your health care agent(s) to make medical and mental health decisions for you if you become unable to decide for yourself. You can say what medical or mental health treatments you would want and not want. You should choose an adult you trust to be your health care agent. Discuss your wishes with that person(s) before you put them in writing. Again, it is always helpful to discuss your wishes with your family, friends, and your physician or eligible psychologist. A health care power of attorney will go into effect when a physician states in writing that you are not able to make or to communicate your health care choices. If, due to moral or religious beliefs, you do not want a physician to make this determination, the law provides a process for a non-physician to do it.

What is an advance instruction for mental health treatment?
An advance instruction for mental health treatment is a legal document that tells physicians and mental health providers what mental health treatments you would want and what treatments you would not want, if you later become unable to decide for yourself. You also can name a person to make your mental health decisions at that time. Your advance instruction for mental health treatment can be a separate document or combined with a health care power of attorney or a general power of attorney. An advance instruction for mental health may be followed by a physician or mental health provider when your physician or an eligible psychologist determines in writing that you are no longer able to make or communicate mental health care decisions.

Medical Care Decisions and Advance Directives: What You Should Know

Other Questions

How do I make an advance directive?

You must follow several rules when you make a formal living will, health care power of attorney or an advance instruction for mental health treatment. These rules are to protect you and ensure that your wishes are clear to the physician or mental health provider who may be asked to carry them out. A living will, a health care power of attorney and an advance instruction for mental health treatment must be: (1) written; (2) signed by you while you are still able to make and communicate health care decisions; (3) witnessed by two qualified adults; and (4) notarized.

Who is a qualified witness?

A qualified witness is a competent adult who sees you sign, is not a relative, and will not inherit anything from you upon your death. The witness cannot be your physician, a licensed employee of your physician or mental health providers, or any paid employee of a health care facility where you live or that is treating you.

Are there forms I can use to make an advance directive?

Yes. Forms for living wills, health care powers of attorney, and advance instructions for mental health treatment may be obtained from the North Carolina Secretary of State website, at: www.secretary.state.nc.us/ ahcdr. These forms meet all the rules for a formal advance directive. For more information, visit the website, or call 919-807-2167, or write to:

Advance Health Care Directive Registry
Department of the Secretary of State
PO Box 29622
Raleigh, NC 27626-0622

What happens if I change my mind?

- You can cancel your living will anytime by communicating your intent to cancel it in any way. You should inform your physician and those closest to you about your decision. It is also a good idea to destroy copies of it.
- You can cancel or change your health care power of attorney while you are able to make and communicate your decisions. You can do this by executing another one and telling your physician and each health care agent you named of your intent to cancel the previous one and make a new one, or by communicating your intent to cancel it to the named health care agents and the attending physician or eligible psychologist.

Medical Care Decisions and Advance Directives: What You Should Know

- You can cancel your advance instruction for mental health treatment while you are able to make and communicate your decisions by telling your physician or mental health provider that you want to cancel it.

Who should I talk to about an advance directive?
You should talk to those closest to you about an advance directive and your feelings about the health care you would like to receive. Your physician or health care provider can answer medical questions. A lawyer can answer questions about the law. A trusted advisor or clergy member might be able to help with more personal questions.

Where should I keep my advance directive?
Keep a copy in a safe place where your family members can get it. Give copies to your family, your physician or mental health providers, your health care agent(s), and any family members or close friends who might be asked about your care should you become unable to make decisions. Always remember to take a copy of your Advance Directive with you for hospital admissions, emergency room visits, clinic visits for cardiac procedures, etc. so it can be put into your chart. Also, consider registering your advance directives with the North Carolina Advance Health Care Directive Registry: www.secretary.state.nc.us/ahcdr.

What if I have an advance directive from another state?
A living will or health care power of attorney created outside North Carolina is valid in North Carolina if it appears to have been executed in accordance with the applicable requirements of the place where it was created or of this State.

Where can I get more information?
Contact your health care provider or attorney, or visit the North Carolina Depart- ment of the Secretary of State Advance Health Care Directive Registry website at: www.secretary.state.nc.us/ahcdr.

Are there other forms available that will help ensure my health care decisions are known and followed?
Other forms that you may want to be aware of include: Authorization to Consent to Health Care for a Minor, Organ Donor Card, Portable Do Not Resuscitate (DNR) Orders, and Medical Orders for Scope of Treatment (MOST).

Infection Control

The following instructions will help control the spread of infection and protect others form illness and/or injury.

Hand washing:

Hand washing is the single most effective technique in the prevention of the spread of disease and infection. Hands should be washed thoroughly with soap and water before and after eating or food preparation, after using the bathroom, before and after performing medical procedures and immediately following contact with blood or other potentially infections materials.

Disposal of Medical Waste:

Used, disposable supplies such as diapers, incontinence pad, non-blood saturated dressings, IV tubing and gloves should be placed in a heavy-duty plastic bag and securely fastened at the top to close. If a heavy-duty bag is not available, the items should be double-bagged and disposed of with the client's regular garbage.

Items heavily contaminated with blood or body fluids contaminated with blood should be placed in a leak-proof heavy duty bag or tied securely at the neck and double-bagged. All bags should be appropriately labeled as biohazardous or color-coded and securely colored prior to removal from the home. The nurse will transport to the office or arrange for pick-up by a biohazardous waste disposal company.

Liquids such as betadine and irrigating solutions may be flushed down the toilet.

Sharp items including hypodermic needles and syringes, scalpel blades, razor blades, disposable razors, lancets, scissors, knives, staples, IV stylets and rigid introducers are placed directly in a hard plastic or metal container with a screw-on or tightly secured lid. The lid should be reinforced with heavy-duty tape prior to discarding in regular trash. Sharps are not to be placed in any container planned for recycling or to be returned to a store. Glass or clear plastic containers are not to be use.

Used needles and syringes should not be recapped, bent or removed from disposable syringes or manipulated by hand.

Sanitation in the Home:

Linens soiled with infectious wastes should be placed directly into the washer and prewashed with cool water and 1 cup bleach.

Dishes should be washed in a dishwasher or soaked and cleaned in hot, soapy water.

Family Disaster Plan

Families should be prepared for all hazards that affect their area and themselves. NOAA's National Weather Service, the Federal Emergency Management Agency, and the American Red Cross urge each family to develop a family disaster plan. Where will your family be when disaster strikes? They could be anywhere-at work, at school, or in the car. How will you find each other? Will you know if your children are safe? Disasters may force you to evacuate your neighborhood or confine you to your home. What would you do if basic services-water, gas, electricity or telephones- were cut off?

Follow these Basic Steps to Develop a Family Disaster Plan

I. Gather information about hazards. Contact your local National Weather Service office, emergency management office or civil defense office, and your local American Red Cross chapter. Find out what type of disasters could occur and how you should respond. Learn your community's warning signals and evacuation plans.

II. Meet with your family to create a plan. Discuss the information you have gathered. Pick two places to meet: (1) a spot right outside your home for an emergency, such as fire, and (2) a place away from your neighborhood in case you can not return home. Choose an out-of-state friend as your "family check-in contact" for everyone to call if the family gets separated. Discuss what you would do if advised to evacuate.

III. Implement your plan. (1) Post emergency telephone numbers by phones; (2) Install safety features in your house, such as smoke detectors and fire extinguishers; (3) Inspect your home for potential hazards, such as items that can move, fall, break, or catch on fire, and correct them; (4) Have your family learn basic safety measures, such as CPR and first aid, how to use a fire extinguisher, and how and when to turn off the water, gas, and electricity in your home; (5) Teach children how and when to call 9-1-1 or your local Emergency Medical Services number; (6) keep enough supplies in you home to meet your needs for at least three days. Assemble a disaster supplies kit with items you may need in case of an evacuation. Store these supplies in sturdy easy-to-carry containers, such as backpacks or duffle bags. Keep important family documents in a waterproof container. Keep a smaller disaster supplies kit in the trunk of your car. A Disaster Supplies Kit should include:
    - A three day supply of water (one gallon per person per day) and food that will not spoil
    - One change of clothing and footwear per person
    - One blanket or sleeping bag per person
    - A first-aid kit, including prescription medicines

Family Disaster Plan

- Emergency tools, including a battery-powered NOAA Weather radio and a portable radio, flashlight, and plenty of extra batteries
- An extra set of car keys and cash
- Special items for infant, elderly, or disabled family member.
- Pet care items, if applicable

Practice and maintain your plan. Ask questions to make sure your family remembers meeting places, telephone numbers, and safety rules.

IV. Conduct drills. Test your smoke detectors monthly and change the batteries at least once a year. Test and recharge your fire extinguishers(s) according to manufacturer's instructions. Replace stored water and food every six months.

Emergency Telephone Numbers

In case of a medical emergency, you should contact emergency medical services by telephone at:

911

POISON CONTROL

1-800-222-1222

Home Safety Guidelines

General Information:

- Install proper locks and keep doors locked. Ask visitors to identify themselves before opening the door. Open the door only if you know the person, or if you are expecting that person
- Be cautious with sharp objects
- Mark glass doors and windows with decals

Medication Safety:

- Keep all medications in original containers and label clearly.
- Write medication schedule and take only as prescribed.
- Be aware of side effects of medications

Poison Prevention:

- Label all poisons.
- Keep all substances in their original containers.
- Do not mix cleaning products, such as chlorine and ammonia.
- Have syrup or IPECAC on hand.
- Store cleaning agents away from foods and medications.

Fall Prevention:

- Remove all scatter rugs forever.
- Tack down the edges of all carpets.
- Never leave articles of clothing on the floor.
- Keep boxes out of hallways or stairwells.
- Keep electric cords, telephone cords, newspaper, magazines and other clutter away from walking areas.
- Use handrails that are sturdy and strong.
- Avoid use of extension cords.
- Lift feet when walking
- Wear proper fitting shoes with non-ski soles.
- Do activities and exercises to improve balance and strengthen legs.
- Do not attempt to climb or use ladders.
- Be careful if using tranquilizers.
- Have sufficient lighting throughout house.

Home Safety Guidelines

Bathroom:

- Install grab bars or handrails by toilet and tub.
- Place skid-proof floor covers and tub/shower mats in bathroom.
- Install a stable tub/shower seat.

Kitchen:

- Store commonly used items within easy reach.
- Use a cart to move heavy or awkward objects.
- Avoid the use of floor wax. Use the non-skid type and never walk on wet floors.

Stairs:

- Install handrails and always use them.
- Place a strip of bright tape on the top and bottom step on each staircase.
- Place non-skid threads on steps.

Bedroom:

- Use nightlight in hall between bedroom and bathroom.
- Take your time, get up from bed or chair slowly to avoid dizziness.
- Sit on the edge of the bed or in a chair when putting on socks, shoes, or slacks.
- Ensure that side rails are in upright position on hospital beds.

Living Room:

- Avoid sharp-cornered furniture.
- Utilize proper transfer techniques (ex. Chair to bed or toilet).
- Utilize proper ambulation techniques; use walker, cane or crutch as prescribed.
- Utilize wheelchair safety:
    - Install ramps; 12 foot ramp for 1 foot rise.
    - Rearrange furniture placement and always lock wheels.

Home Safety Guidelines

Fire Safety:

- Make an escape plan; then practice it.
- Keep at least one fire extinguisher; check the charge often.
- Be aware that nylon catches fire.
- Do not every smoke in bed!
- Be very careful with space heaters; do not tip them!
- Make sure your electrical wiring is not frayed and is free of shorts.
- Keep electrical appliances away from water and unplug after use.
- Have smoke detectors properly located; check battery monthly.
- Store flammables properly.
- Turn off oven and stove; clearly mark controls on stove.
- Be cautious around any open flame heater or fireplace.
- Do not use lighted matches or lighters around any suspected natural gas leaks.

Burn Prevention:

- Always check hot water for temperature; label hot and cold faucets.
- Keep pot handles turned to the back of the stove.
- Keep flammable towels away from the stove.
- Open lids away from you to avoid steam burns.
- Use heating pads with caution:
    - Use only on low (unless Doctor/Nurse states otherwise)
    - Check area frequently for redness
    - Do not apply directly to skin.

Medical Equipment Safety:

- The company that supplies your medical equipment should instruct you in the safe use of each item.
- If you have question or need assistance with any item, please ask your nurse!
- If a piece of equipment breaks or seems not to work correctly, notify the company that brought the item to you immediately!
- Do not use an item unless you are sure it is working properly.
- Never smoke when Oxygen is in use.

Cold Weather Precautions:

- Avoid icy sidewalks and porch steps.
- Always cover head, hands and feet if you are going out.
- Use warm blankets, clothes and socks.

Tornados: Plan and Get Ready

Anything. Anytime. Anywhere.

Forget The Wizard of Oz notion that "twisters" only happen in Kansas! Tornadoes have been reported in every state. In addition, while they general occur during spring and summer, they can happen anytime during the year.

With winds, swirling at 200 miles per hour or more, a tornado can destroy just about anything in its path. Generally, weather signs and warnings will alert you to take precautions.

Be prepared by having various family members do each of the items on the checklist below. Then get together to discuss and finalize your Home Tornado Plan.

Pick a safety spot in your home where family members could gather during a tornado. (If you have a basement, it will most likely be your best safety spot.) Make sure there are no windows or glass doors in the area. Keep this place uncluttered. If you live in a mobile home, choose another safety spot in a sturdy, nearby building.

Location of Safety Spot: _____

Put together a Tornado Safety Kit in a clearly labeled, easy-to-grab box.

Location of Safety Kit: _____

Write instructions on how and when to turn off your utilities-- electricity, gas, and water.

Written Instructions (date): _____

Make sure all family members know the name of the county or parish where you live or are traveling since tornado WATCHES AND WARNINGS are issued by county.

Name of County Where You Live: _____

Name of County Where You Are Traveling:_____

Emergency Information Sheet

NAME _____**GENDER** _____

ADDRESS _____

_____

DATE OF BIRTH _____ **BIRTHPLACE** _____

PHONE _____ **RELIGION** _____

HAIR COLOR _____ **EYE COLOR** _____

ANY DISTINGUISHING FEATURES

_____

_____

_____

DOCTOR'S NAME AND PHONE _____

DOCTOR'S NAME AND PHONE _____

SPECIAL MEDICAL CONDITIONS/ALLERGIES

_____

_____

_____

IN CASE OF EMERGENCY PLEASE CONTACT:

NAME AND CONTACT INFORMATION_____

_____

NAME AND CONTACT INFORMATION_____

_____

NAME AND CONTACT INFORMATION_____

The Full Coverage PDN Company may be able to provide addition medical information.

HOME ENVIRONMENT SAFETY EVALUATION

Check Yes, No or N/A (Not Applicable) for each of the following items. For all "No" responses identify, in the space provided, item number, action plan to correct the problem and document the date the patient was instructed.

		YES	NO	N/A
1.	There is a working telephone and emergency numbers are accessible.			
2.	Electrical cords and outlets appear to be in good repair in the patient area (i.e., cords not frayed, outlets not overloaded, etc.).			
3.	There are functional smoke alarm(s).			
4.	Fire extinguisher is available and accessible.			
5.	Access to outside exits is free of obstruction.			
6.	Alternate exits are accessible in case of fire.			
7.	Walking pathways are level, uncluttered and have non-skid surfaces.			
8.	Stairs are in good repair, well lit, uncluttered and have non-skid surfaces. Handrails are present and secure.			
9.	Lighting is adequate for safe ambulation and ADL.			
10.	Temperature and ventilation are adequate.			
11.	Medicines and poisonous/toxic substances are clearly labeled and placed where patient can reach, if needed, yet not within reach of children.			
12.	Bathroom is safe for the provision of care (i.e., raised toilet seat, tub seat, grab bar, non-skid surface in tub, etc.).			
13.	Kitchen is safe for the provision of care (i.e., working appliances, hygienic area for food prep, etc.).			
14.	Environment is safe for effective oxygen use.			
15.	Overall environment is adequately sanitary for the provision of care.			
16.	Other			

FOR ALL ITEMS CHECKED "NO" ABOVE, SPECIFY ACTION PLAN AND DOCUMENT DATE PATIENT WAS INSTRUCTED

ITEM NO.	DATE INSTRUCTED	TEACHING MATERIALS PROVIDED	TEACHING MATERIALS REVIEWED	ACTION PLAN

CHECK ANY OF THE FOLLOWING THAT NEED TO BE OBTAINED

❑ Raised toilet seat	❑ Plug covers	❑ Wheelchair	❑ Other _____
❑ Tub seat	❑ Cabinet latches	❑ Lifeline or other PERS	❑ Other _____
❑ Grab bar	❑ Window locks	❑ Car seat	❑ Other _____
❑ Non-skid surface (bath)	❑ Ipecac syrup	❑ Seat/bed cushion	❑ Other _____
❑ Infant tub	❑ Smoke alarm	❑ First aid kit	❑ Other _____

Emergency preparedness plan discussed with/provided to patient? ❑ Yes ❑ No, explain: _____

SIGNATURE OF PERSON COMPLETING EVALUATION _____ DATE ___/___/___

CARE MANAGER SIGNATURE/TITLE _____ DATE ___/___/___

PART 1 – Clinical Record **PART 2 – Patient**

PATIENT NAME - Last, First, Middle Initial	ID#

Contents of this Section

The Full Coverage PDN Company

I have received and understand the Client Handbook information listed above.

Patient Signature: _____Date:_____
Printed Name: _____

Legal Guardian: _____Date:_____
Printed Name: _____
Relationship to Patient: _____

Company Staff: _____Date:_____
Printed Name and Title: _____

The Full Coverage PDN Company

CONSENT FOR SERVICE AND CARE

I _____ (client name) hereby consent to admission to and care by The Full Coverage PDN Company. I acknowledge and consent to the following:

- I understand my care is based on a treatment plan and/or ordered by my physician per agency policy. I have participated in the development of, and am in agreement with, the treatment plan outlined. My treatment plan may change as my care needs change and I will be informed.
- I understand that this is the initial plan and I will be notified by the agency each time there are changes made in my plan of care.
- I understand that the agency will provide supervision for all services rendered to me.
- I understand that I have the right to refuse care or treatment at any time.

Disciplines Proposed to Provide Care and Frequency
Skilled Nursing _____

Release of Information: I hereby authorize your agency to release to or receive from hospitals, physicians or other agencies involved in my care all medical records and information pertinent to my care. I herby give permission for the review of my medical record by the agency's accrediting and/or other regulatory bodies.

Authorization for Payment: I certify that the information given by me in applying for payment under Title XVIII 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 from Insurance, Workers Compensation, VA, Medicaid, or other responsible payer sources be made in my behalf to the above named Home Care Agency. I understand that I am responsible for all amounts not paid by my insurance. If I am a private pay patient, I agree to pay for all services rendered by the agency.

Patient Signature: _____Date:_____
Printed Name: _____

Legal Guardian: _____Date:_____
Printed Name: _____
Relationship to Patient: _____

Company Staff: _____Date:_____
Printed Name and Title: _____

The Full Coverage PDN Company

ADVANCE DIRECTIVES DECLARATION

I understand that the Advance Directive Act of 1999 requires that I be made aware of my right to make healthcare decisions for myself. I understand that I may express wishes in a document called an Advanced Directive so that my wishes may be know when I am unable to speak for myself.

I have made a Directive to Physician (Living Will): Yes No
If Yes, location of the COPIES:_____

I have made a Medical Power of Attorney: Yes No
To: _____Phone: _____

I have made an Out of Hospital DNR: Yes No
If Yes, location of the COPIES:_____

I have made a Declaration of Mental Health: Yes No
If Yes, location of the COPIES:_____

Patient Signature: _____Date:_____
Printed Name: _____

Legal Guardian: _____Date:_____
Printed Name: _____
Relationship to Patient: _____

Company Staff: _____Date:_____
Printed Name and Title: _____

The Full Coverage PDN Company
EMERGENCY PREPAREDNESS, RISK ASSESSMENT AND DISASTER PLAN

CLIENT NAME:_____

ADDRESS: _____

PHYSICIAN: _____PHONE:_____

NEAREST HOSPITAL: _____

EMERGENCY CONTACT PERSON: _____PHONE:_____

PATIENT DISASTER CODE

(Check the one that applies)

☐ I Services required today as scheduled. For example:

- New insulin dependent diabetic, unable to inject self
- IV medications
- Sterile wound care with moderate to large amount of drainage
- Patient's actively dying and family unable to cope
- Client has tracheostomy and requires suctioning
- Client uses ventilator

☐ II Services could be postponed 24-48 hours without adverse effect to the patient. For example:

- New insulin dependent diabetic, but able to inject self
- Cardiovascular and/or respiratory assessment
- Sterile wound care with minimal amount to no drainage
- Terminal patient with predictable deterioration, family coping adequately

☐ III Services could be postponed 72-96 hours without diverse effect to the patient. For example:

- Post-operative with no open wound
- Anticipated discharge within next 10-14 days
- Routine catheter changes
- Observation/Assessments on frail, elderly, case management patients

The Full Coverage PDN Company

EMERGENCY PREPAREDNESS, RISK ASSESSMENT AND DISASTER PLAN

RISK LEVEL

- ☐ High Risk: Needs high level assistance to evaluate or stay in home, dependent on homecare. Oxygen dependent, ventilator dependent, or requires suctioning with no capable caregiver.
- ☐ Moderate Risk: Needs high level assistance to evaluate or stay in home, dependent on homecare. Oxygen dependent, ventilator dependent, or requires suctioning with capable caregivers insufficient to provide 24 hour care.
- ☐ Low Risk: Needs high level assistance to evaluate or stay in home. Dependent on homecare. Oxygen dependent, ventilator dependent, or requires suctioning with capable caregivers sufficient to provide 24 hour care.

ELETRICAL POWER RISK LEVEL

If electricity were lost, would there be any risk to life? N = No risk Y = Yes Risk to Life

SIGNATURE/TITLE:_____ DATE: _____

The Full Coverage PDN Company
AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION TO SPECIFIC INDIVIDUALS

I hereby authorize The Full Coverage PDN Company to provide my health care information to the following person(s):

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

(Void out any lines not completed above.)

Patient Signature: _____Date:_____
Printed Name: _____

Legal Guardian: _____Date:_____
Printed Name: _____
Relationship to Patient: _____

Company Staff: _____Date:_____
Printed Name and Title: _____

The Full Coverage PDN Company

AUTHORIZATION TO RELEASE INFORMATION

Patient Name:_____ Date of Birth:_____

I hereby authorize The Full Coverage PDN Company to release to, or receive from, hospitals, physicians or others involved in my care all medical records and information pertinent to my care and payment for my care. I hereby give permission for the review of my medical record by the Company's accrediting and/or other regulatory bodies.

_____ _____
Patient Signature Date

_____ _____
Legal Guardian Signature Date

_____ _____
Legal Guardian Printed Name Relationship to Patient

_____ _____
The Full Coverage PDN Company Staff Witness Date

_____
Printed Name

The Full Coverage PDN Company

PAYMENT FOR SERVICES

Medicaid Patients:

Medicaid covers 100% of home health services including nursing, therapy, and home health aide assistance. You should not be responsible for any part of the bill for services. In the event that we suspect any services or goods will not be covered by Medicaid, we will notify you prior to delivery of said goods and services.

Insurance Patients:

We will bill your insurance company for all services that we provide. We will bill secondary insurance policies as well. Please provide all insurance information to the nurse during the admission process. The Full Coverage PDN Company will attempt to collect charges not covered by your insurance.

Fee Schedule:

_____

_____

_____ _____

Patient Signature Date

_____ _____

Legal Guardian Signature Date

_____ _____

Legal Guardian Printed Name Relationship to Patient

_____ _____

The Full Coverage PDN Company Staff Witness Date

_____

Printed Name

The Full Coverage PDN Company

RECEIPT OF ADMISSION DOCUMENTS

I have received copies of the following Admission documents:

- Client Handbook Receipt
- Consent for Service and Care
- Advance Directives Declaration
- Emergency Preparedness, Risk Assessment and Disaster Plan
- Authorization to Release Healthcare Information to Specific Individuals
- Authorization to Release Information
- Payment for Services
- Receipt of Admission Documents
- Home Environment Safety Evaluation

Patient Signature: _____Date:_____
Printed Name: _____

Legal Guardian: _____Date:_____
Printed Name: _____
Relationship to Patient: _____

Company Staff: _____Date:_____
Printed Name and Title: _____