Helping Hands

Homemaking Services for Chronically Ill Inc.

5 Centre Street
Hempstead, New York 11550
(516) 489-6810

130 Main Street
Northport, New York, 11768
(631) 261-0403

Date:______________

Name:____

Address:____

Telephone:__________________ Emergency Contact:_______________________

Soc. Sec. #:__________ Maiden Name:________________ Birthplace:____________

I have received the Personal Assistant guide to Consumer Directed Personal Assistance Program: Yes ( ) No ( )

Signature:________________________________ Date: _______________________

MEDICAL FORM

Name____ Date of Birth: ____________________

Address:____ Telephone: (   ) ________________
I consent to this examination and release of information:

Signature:____ Social Security #:_______________________
. . . .
Note to physician: in making your medical evaluation of the above patient, please be aware that he/she will be employed as a health care provider, which may involve homemaking and/or patient care. We are interested in this person's ability to function in this capacity.
. . . .
To be completed by physician only:
Does patient have any neurological disabilities, such as epilepsy, dizziness, paralysis, etc.?______If yes, please indicate type and degree of disability.____
Is the patient free from habituation or addiction to depressants, stimulants, narcotics, alcohol, or other drugs or substances which may alter the individual's behavior? Yes____No_____If not, please explain: _________________________________
____
………………... . . . .

PHYSICAL EXAMINATION:		NORMAL	ABNORMAL	Comment, if Abnormal:
Height:____________	EYES:			
	EARS:			
Weight:____________				
	NOSE:			
Blood Pressure:______	THROAT:			
	LUNGS:			
Pulse:______________				
	HEART:			
Respiration:_________	BACK:			

LABORATORY TESTS:

RUBELLA	Date of Titre/Titre #:	OR	Date of Vaccine:
MEASLES * *Documentation Required of Immunity if born on or after 1/1/57.	Date of Titre/Titre #: or Documented History of Childhood Disease	OR	Date of Vaccine:
TUBERCULOSIS	PPD or Mantoux Skin Test Date Read/Results:	OR	Chest X-ray: Date/Results:
DRUG SCREEN	Date	NEG	POSITIVE (see report)

FLU VACCINES Date Seasonal

I certify that the above named person is free of any infectious diseases and in my opinion:
____Has no restrictions _____ Has the following restrictions:_____________________________________

Physician's signature: ________________________________ **Physician's stamp:**
Date of examination: _________________________

Rev5/15acv

HELPING HANDS HOME CARE

Consumer Directed Personal Assistance Program – CDPAP

CONSUMER/FISCAL INTERMEDIARY AGREEMENT

This agreement is between ________________ (Consumer/Representative) and Helping Hands Home Care, Inc. (Contractor) with principal office at 5 Centre Street, Hempstead, NY 11550.

The parties to this agreement hereby agree that these are their respective responsibilities for consumer's participation in in Consumer Directed Personal Assistance Program – CDPAP.

Responsibilities of the Consumer/Representative

1. The Consumer/Representative shall be responsible for the following:
   Recruit, interview hire, train, supervise, schedule and terminate Personal Assistance as required to cover all service hours.
2. Assure that each Personal Assistant completely and safely perform the tasks that are included in the Consumers Plan of Care.
3. Provide equal employment opportunities to persons applying for work as a Personal Assistant by not subjecting them to discrimination because of race, creed, color, national origin, sex, age, disability, or marital status.
4. Inform Helping Hands Home Care of any changes in status including but not limited to, the Consumers address, telephone number. Changes in medical conditions, hospitalization, and social supports; also the Personal Assistant's name, address, telephone number, and hours worked. Inform the managed Care Plan or the Department of Social Services of any changes in status, including address and telephone number changes, change in medical condition, hospitalization and social supports.
5. Process the required paperwork for Helping Hands Home Care including time sheets, annual worker health assessment, and required employment documentation and maintain copies of the time sheets.
6. Arrange and schedule back up worker coverage for vacations, illness, etc.
7. Distribute paychecks to each Personal Assistant.
8. Attest to the accuracy of each Personal Assistant's time sheets.
9. Meet with Registered Nurses from the contractor's agency and Managed Care Plan or the Department of Social Services as required.
10. Make informed choices as to the type and quality of service including but not limited to such services as nursing care, transportation, and respite services.
11. Assume full responsibility and liability for the behavior, actions, and performance of the Personal Assistants, and waive liability actions against others for the Consumer's participation in CDPAP.
12. Acknowledge that payment for CDPAP services cannot be made to the Consumer's spouse, parent or Designated Representative but may be made to another relative if the other relative is not residing in the Consumers home; or is residing in the Consumer's home because the amount of care required by the Consumer makes the presence of such relative necessary.
13. Acknowledge that the Consumer/Contractor Agreement may be reissued based on charges in requirements or regulations.

14. Acknowledge that the services may not be automatically reinstated upon discharge of hospitalization until authorization is obtained from the Managed Care Plan or the Department of Social Services.

I the Consumer/representative,

Have read and understand my responsibilities and have chosen to participate in the Consumer Directed Personal Assistance Program, and

Understand that failure to carry out my responsibilities shall be considered in determining continued appropriateness for the program, and

Understand that fraud relating to the receipt of services shall result in the reconsideration of the Consumer's ability to participate in the Directed Personal Assistance Program, and

Agree to inform the Managed Care Plan or the Department of Social Services, as well as Helping Hands Home Care, Inc. should I decide to no longer participate in the Consumer Directed Personal Assistance program. I am aware that transferring to a traditional home care program does not guarantee immediate availability of service.

______________________	______________________	_____________
Consumer Name	Consumer Signature	Date
______________________	_____________________	_____________
Representative Name	Representative Signature	Date
______________________	______________________	_____________
Helping Hands Name	HH Signature	Date