



Ease My Way Community Care Agency LLC.

4506 SE Belmont St. Suite 103. Portland, OR 97215

Office Phone: (503) 756 - 6123 Email: Info@ewccare.com

Website: www.ewccare.com

CLIENT RIGHTS and DISCLOSURE STATEMENT REVIEW SIGNATURE PAGE

Client Full Name:

Client's Address:

Date

My signature below confirms that I have received and reviewed the Ease My Way Community Care Agency's Disclosure Statement and Clients' Rights statement.

Client's Signature

Date Signed

Client's Representative Name (If client is unable to Sign)

Signature

Date

EWCC Administrator or Designee Name

Signature

Date



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CONSENT TO RELEASE INFORMATION

Name of Client:

Client Date of Birth:

Client Address:

This signed form authorizes the following persons/agency/Organization listed below to release the following information about the above Client name to EWCC for the purpose of: Assessment, Evaluation, Treatment, and delivery of Care Services.

1. Allergies
2. Dietary Requirements
3. Code Status
4. List of Diagnosis and Surgical Procedures
5. Notes from last physician office visit
6. List of Medications (Routine and PRN)
7. List of Treatments
8. List of Functional Abilities and Limitations
9. Durable Medical Equipment / Supply Needs
10. Safety Measures
11. Care plan
12. Other

Name of Person	Service	Location	Phone	Fax

Client/Representative Signature

Date:

EWCC Representative Name

Signature

Date



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CLIENT'S INITIAL INTAKE, EVALUATION & CONTINUING CARE NEEDS ASSESSMENT

SECTION A: CLIENT INITIAL INTAKE/SCREENING FORM

Contact Date:	Mode of Contact: Phone	Email	Referral Name:
Date of Intake:	Intake Done By:		
Initial Evaluation/Assessment Scheduled			
Date:	Time:	Address:	Comment/Notes:

CLIENT'S PERSONAL INFORMATION			
Client's Full Name (Last, First Middle):	Date of Birth:	Age:	Gender:
Client's Address:			Phone #: Email:
Client's Current Diagnosis:			
Allergies/Sensitivities:	Special Diet:	Diet List:	
Language spoken by Client:	Environment:	Marital Status	
Client Live with:			



Client's Family Contacts

Primary Support Person: _____ **Relationship:** _____

Address: _____

Home Phone: _____ **Cell:** _____ **Email:** _____

Secondary Support Person: _____ **Relationship:** _____

Address: _____

Home Phone: _____ **Cell** _____ **e-mail** _____

Client's Physician Information

Primary Physician Name: _____

Physician Clinic/Hospital Name: _____

Address of Hospital/Clinic : _____

E-mail _____

Physician Phone #: _____

Fax: _____

Client's Billing Information (Only For Private Paying Clients)

Name: _____

Address: _____

Phone: _____ **Fax:** _____ **E-mail:** _____

Billing Instructions (if any): _____

Estimated Days and Times for Services

Days	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Time:From							
Time:To							
Total Hours							

Services Needed/Requested				
Personal Care Service (Activities of Daily Living - ADL)	Independent	Needs Assistance	Dependent	Required
Bathing				
Dressing/Undressing				
Feeding/Drinking				
Medication Reminding (Only if Client's Know Medications)				
Medication Service (RN Clients Only)				
i) Medication Reminder				
ii) Medication Assist				
iii) Medication Administration				
Mental/Cognitive-Orientation				
Mobility				
Nursing Services, Description:				
Personal Hygiene				
Shaving (We Only Used Electric Razor) O ₂ Off				
Shave Face				
Shave Legs				
Toileting				
Homemaking/Companion Services (Instrumental Activities of Daily Living - IADL)	Independent	Needs Assistance	Dependent	Required
Arranging Appointments				
Companionship/Activities				
House Cleaning: (Clean Bathroom, Kitchen, Bedroom, Living room)				
Laundry (Wash, dry, fold, and put away)				
Meal Preparation				
Pet Care				
Shopping				
Transportation				
Any Other Services Needed:				
Please Describe:				

Additional Notes/Comment:





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Client Assessment Form

Initial client evaluation for physical, mental, and emotional needs.

EWCC CLIENT IN-HOME SERVICES INTAKE FORM

Client Information		Provided by: <input type="checkbox"/> Client <input type="checkbox"/> Other	
Client's Full Name (Last, First, Middle):			
Gender:		DOB:	
Age:			
Address:			
Phone: _____		Living Alone: Yes No	
Marital Status: Single Married Divorced		Primary Language: _____	
Partnered Separated Widowed			
Legal Status: Responsible for self		Power of Attorney Guardian	
Name: _____		Phone Number: _____	
Eligibility: _____ Age			
Veteran: Yes No		Branch: _____	
Discharge Date: _____			
Spouse/widow of Veteran? Yes No			
Ethnicity: Hispanic/Latino Not Hispanic/Latino		Citizenship Status	
Race (mark more than one if necessary)		U S Citizen Permanent Resident	
African-American Am. Indian/Native Alaskan Asian			
Native Hawaiian/Pacific Islander White Other: _____			
Income: Subsidized/Low Income Housing Medicaid SSI Food Stamps			
Low Income Other: _____			
Primary Emergency Contact:			
Name: _____		Aware of being emergency contact? Yes No	
Relationship: _____		Home Number: _____ Work Phone: _____	
Cell: _____		Email: _____	
Address:			

Second Emergency Contact:

Name: _____ Aware of being emergency contact? Yes No

Relationship: _____ Home Number: _____ Work Phone: _____

Cell: _____ Email: _____

Address: _____

Referral Information

☐ Abuse/Neglect ☐ Adult Day Care ☐ Advocacy ☐ Animal Services ☐ Case Management
☐ Caregiver Services ☐ Property Tax Credit ☐ Dental ☐ Disabilities ☐ Food ☐ Funeral
☐ Health Centers ☐ Hearing ☐ Home Health ☐ Homemaker ☐ Home Repairs
☐ Home Del. Meals ☐ Housing Options ☐ Legal Services ☐ Mental Health Services
☐ Ombudsman ☐ Personal Care ☐ Senior Center ☐ Transportation ☐ Veterans
☐ Vision ☐ Other: _____

Nutritional Status

	Yes	Comment
I have an illness or condition that made me change the kind or amount of food I eat.		
I eat fewer than 2 meals per day.		
I eat few fruits, vegetables, or milk products		
I have 3 or more drinks of beer, liquor, or wine almost everyday.		
I have tooth or mouth problems that make it hard for me to eat.		
I don't always have enough money to buy the food I need.		
I eat alone most of the time.		
I take 3 or more different prescribed or over-the-counter drugs a day.		
Without wanting to, I have gained or lost 10 pounds in the past 6 months		Change:
I am not always physically able to shop, cook or feed myself.		Which:
Total score for each Yes response (0-2: low risk; 3-5 moderate risk; 6 or more high risk)		Risk level:

Client Signature: _____ Date: _____

Intake Worker Signature: _____ Date: _____

Referral Source: _____ Telephone Number: _____

Notes: _____



Levels of Assistance:

FUNCTIONAL ASSESSMENT

0 = Independent - Completes the task independently

3 = Minimum Assistance - Occasional assistance or supervision may be necessary

6 = Moderate Assistance - Assistance or supervision is always necessary

9 = Maximum Assistance - Totally dependent on others

1. For each activity check the box indicating the assistance needed.
2. If assistance is needed, indicate the source of help (be specific: spouse, family, friend, paid help, volunteer, professional)
3. In the comments section indicate the type of assistance provided and how often it is provided.
Also indicate if the client needs further help.

ACTIVITIES OF DAILY LIVING

Activity	Ind 0	Min. Assist 3	Mod. Assist 6	Max Assist 9	Primary Source of Help	Comments / Other Sources
Eating						
Bathing						
Grooming						
Dressing						
Toilet Use						
Mobility						
Transferring						

INSTRUMENTAL ACTIVITIES OF DAILY LIVING

Activity	Ind 0	Min. Assist 3	Mod. Assist 6	Max Assist 9	Primary Source of Help	Comments / Other Sources
Laundry						
Shopping						
Light Housework						
Heavy Housework						
Telephone						
Financial Management						
Transportation						
Meal Preparation						
Medication Management						

Adaptive Equipment	Has	Has, Does Not Use	Needs	Comments
Bathing Equip (bath bench, grab bars, etc)				
Brace (leg, back) prosthesis				
Cane, Crutches, Walker				
Diabetic Supplies				
Dentures				
Railings				
Hospital Bed				
Medical Phone Alert				
Toilet Equipment (i.e., raised commode)				
Wheelchair (manual, power)				
Other (specify)				



HOUSEHOLD CONVENIENCES

	Client Has	Client Needs	Observation: Does the client's home have health and safety issues related to any of the following?		
Electricity			General repair of home exterior		
Gas, Propane			Yard Condition		
Heating System (type?)			Sidewalk, exterior stairs		
Air Conditioner (window or central)			Exterior Lighting		
Fan			Odors (urine, garbage, pets)		
Flush Toilets			General Repair of Home Interior		
Tub, Shower			Interior Clutter		
Piped water, hot/cold			Interior Lighting		
Stove, hotplate, oven, toaster			Room Temperature		
Can opener (electric/manual)			Accessibility of Phone(s)		
Microwave			Food Storage		
Blender			Accessibility of fire exits and smoke detectors		
Radio, television			Bugs or rodents inside home		
Telephone			Accessibility of emergency phone numbers		
Refrigerator			Unsafe Pathways		
Washer and Dryer			Pets		
Comments:			No Problems:		

PLACE OF RESIDENCE

What floor does the client live on? _____ Is the bathroom on the same floor? ☐ Yes ☐ No

If the client lives on other than the main floor: Is there an elevator, lift or stair lift? ☐ Yes ☐ No

Number of steps to enter the home? _____ Are steps a problem within the home? ☐ Yes ☐ No

Ask the Client the following: Do you have difficulty getting into your home? ☐ Yes ☐ No

Do you have difficulty getting into any room in your home? ☐ Yes ☐ No

Comments:

FALL RISK SCREENING (ask the client the following questions)

How many times have you fallen in the past year? _____

Are you worried you might have a fall? ☐ Not at all ☐ A little ☐ Somewhat ☐ Very

Do you limit activities now because of fall-related concerns? ☐ Never ☐ Occasionally ☐ Sometimes ☐ Often

If client has NOT fallen in the past year, skip the next 2 questions below.

Where have you fallen?

☐ Getting in & out of bed ☐ Bathroom ☐ Outside the home

☐ Between the bed & the bathroom ☐ Kitchen ☐ Other:

Can you say what makes you more likely to fall?

☐ Feeling dizzy/lightheaded ☐ Getting up too quickly ☐ Walking in darkness

☐ Certain Shoes ☐ Turns ☐ Walking on certain surfaces ☐ Stairs ☐ Dim Lighting

Other:



MEDICAL CONDITIONS

What are your medical problems? (use the following codes to answer)

Height: _____

1 - had previously

2 - under control

3 - has currently/being treated

4 - has currently/ not being treated

Weight: _____

Category	Code	Category	Code	Category	Code	Category	Code
Cardiovascular		Hearing/Vision		Respiratory		Skin	
Ankle edema		Deaf		Asthma		Pressure/other ulcer	
By-pass surgery/ Angioplasty		Hearing deficit		COPD		Rashes	
Chest pain		Hearing aid		Cough (dry/productive)		Shingles	
Circulation problems		Hearing Other		Difficulty breathing		Stasis dermatitis	
Congestive heart failure		Hearing No Problem		Emphysema		Other	
Heart attack		Blind		Oxygen		No problem	
Hypertension		Blurred Vision		Bronchitis		Genitourinary	
Hypotension		Cataracts		Pneumonia		Dialysis	
Pacemaker		Glaucoma		Other		Difficulty/ frequent urination	
Shortness of breath		Macular Degeneration		No Problem		Dribbling / incontinence	
Other		Vision Other				Frequent bladder infections	
No problem		Vision No Problem				Night-time urination/ Nocturia	
Endocrine		Infectious Disease				Other	
Diabetes		AIDS					
Thyroid		HIV positive				No Problem	
Other		Hepatitis				Neurological	
No problem		Tuberculosis				Alzheimer's disease	
		Other				Cerebral Palsy	
Gastrointestinal		No Problem		Other		CVA/Stroke	
Abdominal pain				Reduced Physical Stamina		Dementia	
Colitis		Musculoskeletal		Dehydration		Dizziness	
Constipation		Amputation of:		Allergies - food/ medicine		Paralysis of:	
Diarrhea		Arthritis - rheumatoid or osteo		Anemia		Parkinson's Disease	
Difficulty swallowing		Back pain		Autism		Seizures/epilepsy	
Diverticular disease		Contractures		Cancer		Multiple Sclerosis (MS)	
Frequent use of laxatives		Fracture of:		Developmental disability		Amyotrophic lateral sclerosis	
Gall bladder problems		Joint replacement of		Depression		Other	
Indigestion		Polio/Post Polio		Drug use/abuse		No Problem	
Irritable bowel syndrome		Other		Mental retardation		PAIN	
Ulcers		No problem		Tobacco use		Are you in pain now? If yes, rate your level of pain on a scale of 1 - 10 (1 indicates no pain, 10 indicates the most intense level of pain) PAIN LEVEL: _____	
Other				Obesity			
No problem				Chronic pain			
				Other			

MEDICAL PERSONNEL

Phone: (____)____-____

Primary Doctor: _____

Other In-home provider name: _____

Phone: (____)____-____

☐ Short-term ☐ Long-term

HEALTH CARE UTILIZATION

1. Overall, how would you rate your health at the present time? ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Do not know/Refused
2. During the past 12 months, were you admitted to the hospital for a stay that included at least one night? ☐ Yes ☐ No If yes, indicate number of times admitted _____ (If yes, ask the following question).
3. During the past 12 months, how many nights did you spend in the hospital? _____
☐ Indicate # of nights ☐ Do not know/Refused
4. During the past 12 months, how many trips did you make to the emergency room? (respondent as patient)
☐ Indicate number of trips ☐ None (skip to question 6) ☐ Do not know/Refused (skip to question 6)
5. What was the main reason you went to the Emergency Room?
(if more than one visit, ask about most recent visit, one response only)
☐ Medical Condition was Serious ☐ No Other Source of Medical Care Was Available When Needed
☐ Referred by Health Professional/Caregiver ☐ Do not know/Refused
☐ Other (Record Reason:) _____
6. How many primary care doctor visits (your main doctor, not including specialists) did you have during the past 12 months? _____ # of visits ☐ None ☐ Do not know/Refused
7. During the past 12 months, how many doctor visits did you have with specialist(s) (doctors other than your primary care doctor)? _____ Indicate number of visits ☐ None ☐ Do not know/Refused
8. During the past 12 months, did you receive a flu shot? ☐ Yes ☐ No ☐ Do not know/Refused
9. How long ago was your last doctor visit?
☐ During the past 60 days ☐ During the past 3 to 12 months ☐ Between 1 and 2 years ago
☐ 2 to 4 years ago ☐ More than 4 years ago ☐ Never seen a doctor ☐ Do not know/Refused
10. During the past year, were you ever unable to see a doctor when you needed to?
☐ Yes ☐ No (skip to question 12) ☐ Do not know/Refused (skip to question 12)
11. If you were unable to see a doctor when you needed to, was it because of (check all yes responses):
☐ Cost too much ☐ Lack of transportation ☐ Could not get appointment ☐ Doctor would not accept Medicaid
☐ Limited hours of service ☐ Other reason ☐ Do not know/Refused
12. During the past 12 months, were you admitted to a nursing home? (all levels of care). ☐ Yes ☐ No ☐ Do not know/Refused
If yes, indicate number of admissions _____ and indicate # of nights _____
13. Overall, how satisfied are you with the quality of the medical care you received during the past year?
☐ Very satisfied ☐ Somewhat satisfied ☐ Somewhat dissatisfied
☐ Very dissatisfied ☐ Do not know/Refused
14. Are finances a factor in obtaining adequate health/medical care?
☐ Yes ☐ No
15. Is transportation a factor in obtaining adequate health/medical care?
☐ Yes ☐ No



Current Supports	
Home Environment: <input type="checkbox"/> Lives with family <input type="checkbox"/> Lives with spouse/partner <input type="checkbox"/> Lives with roommate <input type="checkbox"/> Lives Alone Informal Support: Who is involved?	
<input type="checkbox"/> Family <input type="checkbox"/> Friend(s) <input type="checkbox"/> Church How do they assist? (Please describe informal support)	
Behavior / Cognition / Psychosocial	
Behavior	
<input type="checkbox"/> No issue at present <input type="checkbox"/> Agitated <input type="checkbox"/> Verbally <input type="checkbox"/> Anxious <input type="checkbox"/> Cooperative behavior <input type="checkbox"/> Withdrawn <input type="checkbox"/> Abusive	Comments:
Cognition	
<input type="checkbox"/> Mentally alert <input type="checkbox"/> Confused at times Oriented to: <input type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time Able to: <input type="checkbox"/> Make decisions <input type="checkbox"/> Problem solve <input type="checkbox"/> Communicate <input type="checkbox"/> Comprehend <input type="checkbox"/> Concentrate <input type="checkbox"/> Initiate <input type="checkbox"/> Remember appointments	Comments:
Psychosocial	
<input type="checkbox"/> No issues at present <input type="checkbox"/> No social relationship <input type="checkbox"/> Staff <input type="checkbox"/> Involved in social activities interaction only Goes out: <input type="checkbox"/> Regularly <input type="checkbox"/> Occasionally <input type="checkbox"/> Rarely	Comments:



Current equipment / adaptive aids			
General			
<input type="checkbox"/> Manual Wheelchair <input type="checkbox"/> Power wheelchair <input type="checkbox"/> Bariatric wheelchair	<input type="checkbox"/> Walker with seat <input type="checkbox"/> Scooter <input type="checkbox"/> Stair lift	<input type="checkbox"/> Brace <input type="checkbox"/> Splints <input type="checkbox"/> Prosthesis	Comments:
<input type="checkbox"/> 2-wheeled Walker <input type="checkbox"/> 4-wheeled walker <input type="checkbox"/> Straight-legged walker			
<input type="checkbox"/> Cane <input type="checkbox"/> Crutches <input type="checkbox"/> Others			
Bedroom			
Bed <input type="checkbox"/> Normal <input type="checkbox"/> Hospital <input type="checkbox"/> Adjustable <input type="checkbox"/> Bariatric Mattress (<i>describe, including toppers/cushions</i>) <input type="checkbox"/> Lift (<i>ceiling/portable</i>) <input type="checkbox"/> Bed rail <input type="checkbox"/> Transfer bench			Comments:
Bathroom			
<input type="checkbox"/> Grab bars <input type="checkbox"/> Safety grips/bathmats <input type="checkbox"/> Tub bar <input type="checkbox"/> Commode <input type="checkbox"/> Hand-held shower <input type="checkbox"/> Bath board <input type="checkbox"/> Raised toilet seat <input type="checkbox"/> Lift (<i>Ceiling/portable</i>) <input type="checkbox"/> Bath Chair <input type="checkbox"/> Bath bench <input type="checkbox"/> Other			Comments:
Additional information or comments:			
I hereby certify that the information contained herein is complete and accurate to the best of my knowledge.			
Assessment completed by: (first & last name)	Title	Phone Number	Signature
Next Scheduled Visit:	By whom?		
Client Signature:		Date:	





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CLIENT'S SERVICE PLAN

Client's Full Name (Last, First Middle):	Date of Birth:	Age:	Gender:
Client's Address:		Phone #:	
Client's Diagnosis:			
Allergies:	Special Diet:		
Client's Condition/Prognosis:	Language spoken by Client:		
Current or Recent Health Problems:	Cognitive/Behavioral Factors:		
Mental Status:	Activities Permitted:		
Communication: i) Comprehension (Ability to understand auditory or visual communication): ii) Expression (Ability to communicate basic daily needs): iii) Usual Mode(s) of Communication:			
CARE NOTES:			
EMERGENCY INSTRUCTIONS:			



Client's Emergency Contact Person Information		
Primary Contact Person Full Name:	Address:	Phone #:
Relationship to Client:	Email Address:	
Secondary Contact Person Full Name:	Address:	Phone #:
Relationship to Client:	Email Address:	
Client's Physician Information		
Primary Physician Full Name:	Name of Hospital/Clinic:	Address of Hospital/Clinic:
Physician Phone #:	Fax Number:	Email Address:
Secondary Physician Full Name:	Name of Hospital/Clinic:	Address of Hospital/Clinic:
Physician Phone #:	Fax Number:	Email Address:

Client's Medical Conditions (Check box if NOT APPLICABLE)			
Medical Condition Name	Healthcare Provider for this condition	Medicine(s) Client take for it	Things that help (resting, exercising)
SPECIAL INSTRUCTION/NOTES/COMMENT:			



Client's Medications List (Check box if NOT APPLICABLE)			
Name of medicine	Medication instruction (Route, needs refrigeration, take on empty stomach, etc.)	Dose	When to take it

ADDITIONAL NOTE:



CLIENT'S PREFERENCES FOR CAREGIVER:

<input type="checkbox"/> Allergic to Pets	<input type="checkbox"/> Alzheimer & Dementia Experience	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Bathing & Showering Experience
<input type="checkbox"/> Bed Bath Experience	<input type="checkbox"/> Can Cook	<input type="checkbox"/> Car / Driver	<input checked="" type="checkbox"/> Cooking Skills
<input checked="" type="checkbox"/> Female PCA	<input type="checkbox"/> Hospice Experience	<input type="checkbox"/> Incontinent Experience	<input type="checkbox"/> Caregiver has received lift training to ensure back support and stability.
<input type="checkbox"/> Male PCA	<input type="checkbox"/> Has received medication training and can provide medication services	<input type="checkbox"/> Non-Smoker	<input type="checkbox"/> Personality- Outgoing
<input type="checkbox"/> Personality-Quiet	<input type="checkbox"/> Smoker	<input type="checkbox"/> Sports Fan	<input type="checkbox"/> Stroke Experience
<input type="checkbox"/> Transferring Experience			

CLIENT'S DIAGNOSIS CHECKLIST:

<input type="checkbox"/> ADD	<input type="checkbox"/> ADHD	<input type="checkbox"/> AIDs	<input type="checkbox"/> Alzheimer's
<input type="checkbox"/> Anxiety	<input checked="" type="checkbox"/> Arthritis	<input type="checkbox"/> Autism	<input checked="" type="checkbox"/> Back Pain
<input type="checkbox"/> Bilateral - Lower Extremities	<input type="checkbox"/> Bladder Infection	<input type="checkbox"/> Blind	<input type="checkbox"/> Blood Pressure - High
<input type="checkbox"/> Blood Pressure - Low	<input type="checkbox"/> Bursitis	<input type="checkbox"/> Cancer	<input type="checkbox"/> Cardiovascular Disease
<input type="checkbox"/> Cataracts	<input checked="" type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Circulation Issues	<input type="checkbox"/> Confusion - Extreme
<input type="checkbox"/> Confusion - Mild	<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Dementia	<input checked="" type="checkbox"/> Depression
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Dialysis	<input type="checkbox"/> Difficulty Swallowing	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Down Syndrome	<input type="checkbox"/> Encephalitis	<input type="checkbox"/> Enlarged Prostate	<input type="checkbox"/> Forgetfulness
<input type="checkbox"/> Functional Limitations - Hearing	<input type="checkbox"/> Functional Limitations - Speech	<input type="checkbox"/> Functional Limitations - Vision	<input type="checkbox"/> FX- Ankle (left)
<input type="checkbox"/> FX- Ankle (right)	<input type="checkbox"/> FX- Arm (left)	<input type="checkbox"/> FX- Arm (right)	<input type="checkbox"/> FX- Bone
<input type="checkbox"/> FX- Hip (left)	<input type="checkbox"/> FX- Hip (right)	<input type="checkbox"/> FX- Leg (left)	<input type="checkbox"/> FX- Leg (right)
<input type="checkbox"/> FX- Neck	<input type="checkbox"/> FX- Ribs	<input type="checkbox"/> FX- Wrist (left)	<input type="checkbox"/> FX- Wrist (right)
<input type="checkbox"/> Gall Bladder Issues	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Hammer Toes	<input type="checkbox"/> Heart Arrhythmia
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> High Blood Sugar	<input type="checkbox"/> High Fall Risk	<input type="checkbox"/> HX - Brain Surgery
<input type="checkbox"/> HX - Fall	<input type="checkbox"/> HX - FX Hip	<input type="checkbox"/> HX - Heart Attack	<input type="checkbox"/> HX - Intestinal Infection
<input type="checkbox"/> HX - Pneumonia	<input type="checkbox"/> HX - Stroke	<input type="checkbox"/> HX - Total Knee Replacement	<input type="checkbox"/> HX - UTI
<input type="checkbox"/> hydrocephalus	<input type="checkbox"/> Hypertension	<input type="checkbox"/> IBS	<input type="checkbox"/> Incontinence - Bladder
<input type="checkbox"/> Incontinence - Bowel	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Kidney Failure	<input type="checkbox"/> Legally Blind
<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Lung Infection	<input type="checkbox"/> Memory Loss	<input type="checkbox"/> Memory Loss - Long Term
<input type="checkbox"/> Memory Loss - Short Term	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Narcoleptic	<input type="checkbox"/> Non-Verbal
<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Osteoporosis	<input checked="" type="checkbox"/> Pain - Moderate - Unspecified Location	<input type="checkbox"/> Pain - Severe - Unspecified Location
<input type="checkbox"/> Pain - Slight - Unspecified Location	<input type="checkbox"/> Paralysis - Left Side	<input type="checkbox"/> Paralysis - Right Side	<input type="checkbox"/> Parkinson's Disease
<input type="checkbox"/> Pulmonary Embolism	<input type="checkbox"/> Pulmonary Fibrosis	<input type="checkbox"/> Renal Failure	<input type="checkbox"/> Schizophrenia
<input type="checkbox"/> Shingles	<input type="checkbox"/> Skin Tears Easily	<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> Staph Infection
<input type="checkbox"/> Sun Downers	<input type="checkbox"/> Thin or Thinning Skin	<input type="checkbox"/> Thyroid	<input type="checkbox"/> UTI
<input type="checkbox"/> Water Retention	<input type="checkbox"/> Weakness		

ADL's - ACTIVITIES OF DAILY LIVING SERVICES REQUESTED:

<input checked="" type="checkbox"/> Bathing	<input type="checkbox"/> Cooking	<input type="checkbox"/> Doctor Visits	<input checked="" type="checkbox"/> Dressing
<input checked="" type="checkbox"/> Errands	<input type="checkbox"/> Exercise Assistance	<input type="checkbox"/> Feeding	<input checked="" type="checkbox"/> Grooming
<input type="checkbox"/> Hair Care / Shampoo	<input type="checkbox"/> Oral Care	<input type="checkbox"/> Shaving	<input checked="" type="checkbox"/> Shopping
<input type="checkbox"/> Shower	<input type="checkbox"/> Skin Care	<input type="checkbox"/> Sponge Bath	<input checked="" type="checkbox"/> Transportation
<input type="checkbox"/> Walking			

Ambulation

<input checked="" type="checkbox"/> Ambulatory / Independent	<input type="checkbox"/> Bed Bound	<input type="checkbox"/> Non-Ambulatory	<input type="checkbox"/> Semi-Ambulatory / Stand By Assist
--	------------------------------------	---	--

Caregiver Accommodations **CHECK BOX IF NOT APPLICABLE**

<input type="checkbox"/> Bedroom	<input type="checkbox"/> Meals ARE NOT Provided	<input type="checkbox"/> Meals ARE Provided	<input type="checkbox"/> Private Bath
<input type="checkbox"/> Sofa Bed			

Client's Health Condition

<input type="checkbox"/> 1 - Poor	<input checked="" type="checkbox"/> 2 - Fair	<input type="checkbox"/> 3 - Good	<input type="checkbox"/> 4 - Excellent
-----------------------------------	--	-----------------------------------	--

Client's Home Condition

<input type="checkbox"/> 1 - Poor	<input checked="" type="checkbox"/> 2 - Fair	<input type="checkbox"/> 3 - Good	<input type="checkbox"/> 4 - Excellent
-----------------------------------	--	-----------------------------------	--

Coordinating Organizations

<input type="checkbox"/> Adult Day Care	<input type="checkbox"/> Grant Programs	<input type="checkbox"/> Home Health	<input type="checkbox"/> Hospice
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Equipments Use By Client:

<input type="checkbox"/> Commode	<input type="checkbox"/> Elevated Toilet Seat	<input type="checkbox"/> Gait Belt	<input type="checkbox"/> Grab Bars (shower)
<input type="checkbox"/> Oxygen Concentrator	<input type="checkbox"/> Shower Chair	<input type="checkbox"/> Walker / Cane	<input type="checkbox"/> Wheelchair
<input type="checkbox"/> Wheelchair (electric)			

Functional Limitations Of Client:

<input type="checkbox"/> Hearing	<input type="checkbox"/> Endurance	<input type="checkbox"/> Speech	<input type="checkbox"/> Ambulation	<input type="checkbox"/> Amputation	<input type="checkbox"/> Legally Blind	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Dyspnea	<input type="checkbox"/> Contracture	<input type="checkbox"/> Incontinence
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Client Medication Reminders Time:

<input type="checkbox"/> AM Meds (Between 8 am and 10 am)	<input type="checkbox"/> Before Bedtime	<input type="checkbox"/> Before Evening Meal	<input type="checkbox"/> Medications Set Up in Pill Box by Responsible Party
<input type="checkbox"/> Meds 30 Mins Before Breakfast	<input type="checkbox"/> No Medication Reminders	<input type="checkbox"/> PM Meds (Between 7pm & 9pm)	

Nutritional Services Needed For Client:

<input type="checkbox"/> Encourage Fluids	<input type="checkbox"/> Encourage Fluids	<input type="checkbox"/> Hands on Assist with Feeding	<input type="checkbox"/> Liquid Supplements
<input type="checkbox"/> Low Salt Diet	<input type="checkbox"/> Low Sugar/Carbohydrate Diet	<input type="checkbox"/> Prepare / Plan Breakfast	<input type="checkbox"/> Prepare / Plan Dinner
<input type="checkbox"/> Prepare / Plan Lunch	<input type="checkbox"/> Prepare / Plan Snack	<input type="checkbox"/> Pureed Foods	<input type="checkbox"/> Regular Diet - As Client Prefers
<input type="checkbox"/> Special Diet	<input type="checkbox"/> Thickened Liquids		

Personal Interests Of Client:

<input type="checkbox"/> Movies	<input type="checkbox"/> Music	<input type="checkbox"/> Reading	<input type="checkbox"/> Television
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Place of Service**SELECT WHERE EWCC STAFF WILL PROVIDE SERVICE FOR THE CLIENT**

- ☐ Apartment
 ☐ Client Lives Alone
 ☐ Client Lives with Family
 ☐ Condo
- ☐ Facility
 ☒ House
 ☐ Mobile Home

Service Level To Be Provided:

- ☐ Level 1 - Low
 ☒ Level 2 - Moderate
 ☐ Level 3 - Difficult

Skin Precautions

- ☐ Apply Lotion Daily to Arms and Legs
 ☐ Easily Bruises
 ☐ Reposition Every (2) Hours Whether in Chair or Bed
 ☐ Skin Tears Easily

Other Special Services

- ☐ Hospice
 ☐ Monitor / Observe
 ☐ Pet Care
 ☐ Reposition in Bed

Toileting

- ☒ Bathroom Assist
 ☐ Bedpan
 ☐ Bowel Incontinence
 ☐ Catheter
- ☐ Depends / Briefs
 ☐ Urinal
 ☐ Urinary Incontinence

Environmental Barriers to place of service selected above**Yes****No**

Comments:

Are there barriers to building entry / exit?

Are there internal barriers? (stairs, narrow doorway)

Are toilet / tub / shower accessible?

Is the Client able to access emergency assistance?

Other Barriers (specify):

ASSESSMENT NOTE:

CLIENT'S HOME SAFETY INSPECTION CHECKLIST

Description	NA	Y	N	Description	NA	Y	N	Description	NA	Y	N
Floors even, no clutter, furniture placed safely, good lighting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cleaning supplies stored safely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Call bell system or geriatric monitor in place	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fall risks- reviewed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Raised toilet seat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Antibacterial hand soap	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stairs/walkways are in good repair, uncluttered & have non-skid surfaces	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rubberized mat in tub/shower	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Separate sleeping quarters for 24 hour caregiver	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stairs have secure handrails	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Grab bar in bathroom by toilet/in shower	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sufficient groceries in home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nightlights are in place	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fire risk discussed/reviewed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If pet- are there supplies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The environment is adequately sanitary for the provision of care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exits are kept clear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Flea or bed bug problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Temperature (heating & cooling systems) & ventilation are adequate.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Working smoke detectors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cat box supplies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Electrical cords & outlets appear to be in good repair (cords not frayed & outlets are not overloaded)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Escape routes discussed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pet odors?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Washer and dryer available	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emergency Plan completed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kitchen is safe (hygienic area for food prep) & has working appliances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Door alarms in place	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fire extinguisher available & accessible	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ramp for wheelchairs in place	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can client use stove safely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Plastic gloves for caregivers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
For all items checked "No," specify action plan & document date client was instructed.									Date		
Action Plan:											
Action Plan:											



CLIENT'S MEDICATION SELF-DIRECT EVALUATION

In order to avoid medication errors, it is required of ALL EWCC CLIENTS to answer the following medication self-direct evaluation questionnaire. The purpose of this medication self-direct evaluation questionnaire is to determine the appropriateness of the client's medication management.

All clients are required to Complete the following questions:

1. Do you know what medications you are taking and for what reason you are taking it? YES
NO
2. Do you know how many of the medication you are supposed to take or the doses? YES NO
3. Do you know the route of these medication to be taken? YES NO
4. Do you know what time or how often you suppose to take your medications? YES NO

IF CLIENT ANSWER YES, COMPLETE THE TABLE BELOW:

Medication Name	Reason	Frequency	Verified



Determination of Client's Medication Self-direct Evaluation:

Medication Administration Required

Medication Assistance

Medication Reminding

Able to Self-Administer Medications. * If checked, have client attest to the information provided and have client sign form below

Client Acknowledgement of Medication Self-direct Evaluation

I _____, agreed with the information documented above and acknowledge that I understand what medications I am taking, why I am taking the medicine, and when I am supposed to take the medicine.

Client's/Representative Signature

Date

Additional Notes/Comment





Ease My Way Community Care Agency LLC.

4506 SE Belmont St. Suite 103. Portland, OR 97215

Office Phone: (503) 756 – 6123 Email: Info@ewccare.com

Website: www.ewccare.com

The following information has been provided to and/or discussed with the Client -
Roles and Responsibilities Code of Ethics Costs & Billing Confidentiality of Client
Information Contact Information Client Consent Other:

Documentation & Information

I acknowledge that the information and documentation as noted above, has been discussed with me and I will be provided with a copy.

Client Consent

I _____, consent to have the Non-Medical Home Services as requested and recorded in this **Service Plan**.

I understand that my service requests/needs will be reviewed by the Supervisor at least every **months**, or as required, and that the service(s) may be changed according to my needs, wants or wishes.

Client's/Representative Signature

Date



Emergency-supply checklist

USE THIS WORKSHEET, which features many recommendations from the American Red Cross, the Federal Emergency Management Agency (FEMA), and other organizations, to build a comprehensive emergency kit that will get you through most situations. Store as much of the following as possible in waterproof containers, such as lidded five-gallon paint drums (sold at hardware stores), in a cool, dry location that is easily accessible (near an exit or in the garage).

Food and Water

Three days' worth of nonperishable food and water per person (one gallon of water per person for each day)
Infant formula and baby food (if appropriate)
Manual can opener
Jackknife
Camp stove with fuel or another nonelectric cooking device
Pot or pan for cooking
Plastic utensils, plates, and bowls
Iodine tablets for water purification

Communication Needs

Portable battery-powered or hand-crank radio outfitted with the National Weather Service station, plus extra batteries
Cell phone and charger (ideally, one that works in the car)
Extra cell-phone battery
Copy of family disaster plan (addresses of two meeting places and a phone number for an out-of-area contact)
List of other family contact numbers (relatives who don't live in the immediate area)
Roll of quarters for pay phones

Medicine and First Aid

Bandages in assorted sizes
Gauze pads
Tweezers
Pain relievers (like ibuprofen and Tylenol) for both adults and children
Cough medicine
Antidiarrheal medicine (like Pepto-Bismol)
Prescription medications, or at least a list of medications, dosages, and notes on how to take them
Bug repellent, especially in flood- or hurricane-prone areas, where virus-carrying mosquitoes thrive
Special needs: contact-lens solution, hearing aid, hearing-aid batteries
Antibacterial hand sanitizer (like Purell)
Wet wipes (even if you don't have children)
Compression stockings, to prevent blood clots, which can develop when people sit for extended periods (available at medical-supply stores)
Basic hygiene products, such as toothpaste and soap

Important Documents

Account and service numbers for credit cards, bank accounts, insurance policies, mortgage or lease, phone, and utilities
CD or videotaped footage of valuable possessions
Copies of passports, licenses, and birth certificates
Copy of last year's tax return
Copies of recent medical records
Copies of will and emergency medical directive

Other Basics

Matches in waterproof containers
Whistle
Several flashlights, plus extra batteries
Cash for one or two weeks, based on your spending habits
Plastic garbage bags
Notebook and pen
Toilet paper
Chlorine bleach, for disinfection purposes
Extra clothing
Blankets, one per person. (The Space Emergency Blanket, available for \$4 at www.rei.com, weighs only three ounces and retains 80 percent of a person's body heat.)

Pet Necessities

Three days of food, water, and medications
Leash and collar with ID and rabies-immunization info
Wire cage
Copy of latest immunizations



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CLIENT'S STATEMENT ACKNOWLEDGING THE RECEIPT OF THE EMERGENCY SUPPLY KIT CHECK LIST & RECOMMENDATION TO CREATE & MAINTAINING AN EMERGENCY SUPPLY KIT

To provide safe, appropriate, and ongoing services to our clients, EWCC has recommended to _____, to develop a three (3) days emergency supply kit.

This document confirms that EWCC has informed the client's name above and/or client representative, of the need for such an emergency supply kit and that the client and/or client representative understands the possible consequences of not having such a kit available. This further acknowledges that EWCC agency staff provided you with an *Emergency Supply Kit Check List*.

Client's/Representative Signature

Date Signed



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Office Phone: (503) 756 - 6123 Email: Info@ewccare.com

Website: www.ewccare.com

Code Status: DNR Full Code
Location in Home:

CLIENT'S CARE PLAN

Start Of Care Date:

Client's Full Name (Last, First Middle):	Date of Birth:	Age:	Gender:
Client's Address:		Phone #:	
Client's Diagnosis:			
Allergies:	Special Diet:		
Client's Condition/Prognosis:	Language spoken by Client:		
Current or Recent Health Problems:	Cognitive/Behavioral Factors:		
Mental Status:	Activities Permitted:		
FUNCTIONAL STATUS: (Minimal assistance defined as including the need for supervision, verbal cueing, or minimal physical assistance. Moderate assistance implies the need for physical assistance.)			
Most frequent mode of Ambulation:			
Equipment(s) Used:			
Any Assistive Devices Currently in use:			

Communication: i) Comprehension (Ability to understand auditory or visual communication): ii) Expression (Ability to communicate basic daily needs): iii) Usual Mode(s) of Communication:		
Ambulation:	Functional Limitations:	
Personal Interests:	Place of Service:	
Medication Determination:	Medication Reminders:	Skin Precautions:
Durable Medical Equipment (DME):	Nutritional Services:	Toileting:
Coordinating Organizations		

Services Needed/Requested				
Personal Care Service (Activities of Daily Living - ADL)	Independent	Needs Assistance	Dependent	Required
Bathing				
Dressing/Undressing				
Feeding/Drinking				
Medication Reminding (Only if Client's Know Medications)				
Medication Service (RN Clients Only) i) Medication Reminder ii) Medication Assist iii) Medication Administration				
Mental/Cognitive-Orientation				
Mobility				
Nursing Services, Description:				
Personal Hygiene				
Shaving (We Only Used Electric Razor) O ₂ Off Shave Face Shave Legs				
Toileting				
Homemaking/Companion Services (Instrumental Activities of Daily Living - IADL)	Independent	Needs Assistance	Dependent	Required
Arranging Appointments				
Companionship/Activities				
House Cleaning: (Clean Bathroom, Kitchen, Bedroom, Living room)				
Laundry (Wash, dry, fold, and put away)				
Meal Preparation				
Pet Care				
Shopping				
Transportation				
Any Other Services Needed: Please Describe:				



Any Special Instruction(s)/Comment:

CLIENT'S PREFERENCES FOR CAREGIVER:

PERSONAL CARE TASKS TO BE COMPLETED BY CAREGIVER(S):

HOUSEKEEPING TASKS TO BE COMPLETED BY CAREGIVER(S):

GOAL(S)s OF CARE PLAN:

EMERGENCY INSTRUCTIONS:

Client Contact Person Information		
Primary Contact Person Full Name:	Address:	Phone #:
Relationship to Client:	Email Address:	
Secondary Contact Person Full Name:	Address:	Phone #:
Relationship to Client:	Email Address:	
Client's Physician Information		
Primary Physician Full Name:	Name of Hospital/Clinic:	Address of Hospital/Clinic:
Physician Phone #:	Fax Number:	Email Address:
Secondary Physician Full Name:	Name of Hospital/Clinic:	Address of Hospital/Clinic:
Physician Phone #:	Fax Number:	Email Address:

Safety Instructions:**Infection Control Instructions:****"Caregiver Acknowledgment"**

My name and signature below confirms that I have read and understood the name client above CARE PLAN as of _____'s and promised to keep it confidential. I understand that if I have questions, at any time, regarding CARE PLAN, I will consult with my immediate supervisor or my Human Resources staff members.

Name of Caregiver: _____ Signature: _____ Date: _____

Name of Caregiver: _____ Signature: _____ Date: _____

Current Service Plan Review Date: _____ Last Service Plan Review Date: _____

EWCC Care Coordinator Name _____ Signature _____ Date _____

