Provider Toolkit

HCA

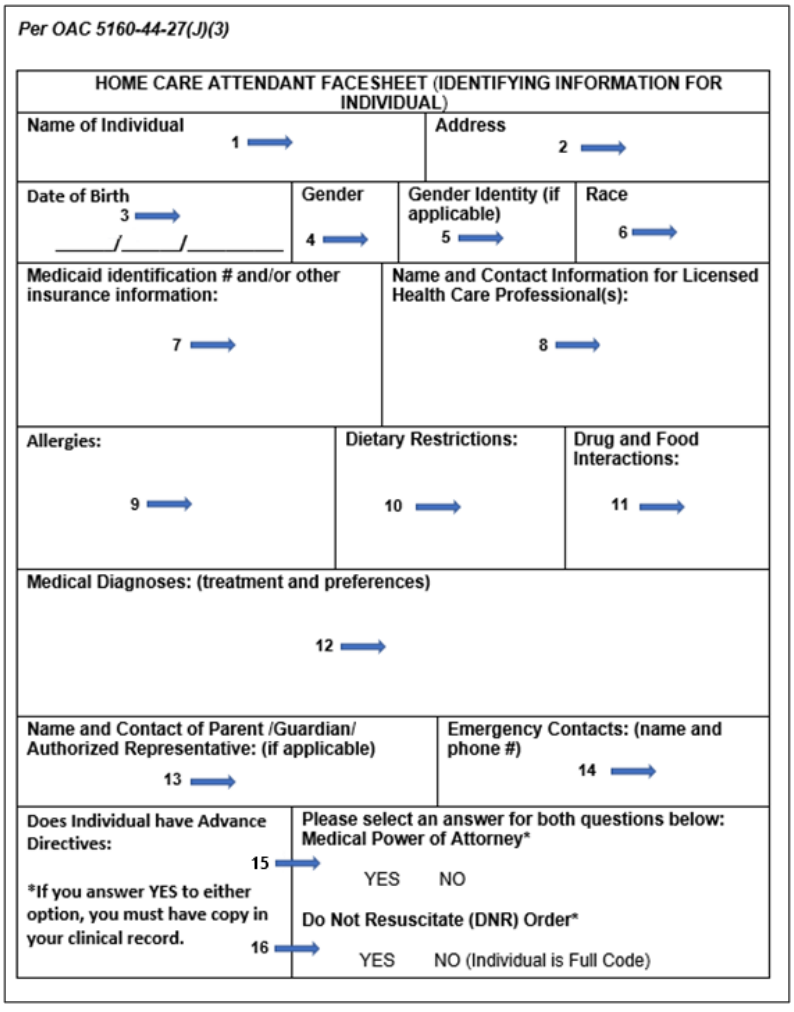
Home Care Attendant Facesheet

Document Overview

The Home Care Attendant Facesheet can be used to capture all the identifying information of the individual that must be maintained in the clinical record according to **OAC 5160-44-27(J)(3)**. All sections must be completed. If a section does not apply to the individual, write N/A (Not Applicable) or NONE. All the information on the form is specific to the individual you are serving.

Instructions

How to complete the Home Care Attendant Facesheet:



Per OAC 5160-44-27(J)(3)

HOME CARE ATTENDANT FACESHEET (IDENTIFYING INFORMATION FOR INDIVIDUAL)			
Name of Individual 1 →		Address 2 →	
Date of Birth 3 → _____/_____/_____	Gender 4 →	Gender Identity (if applicable) 5 →	Race 6 →
Medicaid identification # and/or other insurance information: 7 →		Name and Contact Information for Licensed Health Care Professional(s): 8 →	
Allergies: 9 →	Dietary Restrictions: 10 →	Drug and Food Interactions: 11 →	
Medical Diagnoses: (treatment and preferences) 12 →			
Name and Contact of Parent /Guardian/ Authorized Representative: (if applicable) 13 →		Emergency Contacts: (name and phone #) 14 →	
Does Individual have Advance Directives: 15 → *If you answer YES to either option, you must have copy in your clinical record.		Please select an answer for both questions below: Medical Power of Attorney* YES NO Do Not Resuscitate (DNR) Order* 16 → YES NO (Individual is Full Code)	

1. Enter the individual's name
2. Enter the individual's full address (Street Address; City, State, Zip Code)
3. Enter the individual's date of birth (month/day/year)
4. Enter the individual's gender
5. Enter the individual's gender identity (if applicable)
6. Enter the individual's race
7. Enter the individual's health insurance identification number
8. Enter the name and contact information for the licensed health care professional(s) serving the individual
9. List all the individual's allergies
10. List any dietary restrictions the individual has
11. List any drug and food interactions the individual has
12. Enter the medical diagnoses and preferences of the individual (treatment(s) should be documented on the ODM 02389 Home Care Attendant Medication Authorization Form and/or the ODM 02390 Home Care Attendant Skilled Task Authorization Form)
13. Enter the name of the individual's parent (if minor); guardian; or authorized representative (if applicable)
14. List the name and phone number of the individual's emergency contact(s)
15. Circle Y (Yes) or N (No) if the individual has an identified Medical Power of Attorney. If you circle Y, then you must have a copy of the Medical Power of Attorney in your clinical record.
16. Circle Y or N to indicate if the individual has a Do Not Resuscitate Order. If you circle Y, then you must have a copy in your clinical record.

Per OAC 5160-44-27(J)(3)

<table>
<tr><th colspan="4">HOME CARE ATTENDANT FACESHEET (IDENTIFYING INFORMATION FOR INDIVIDUAL)</th></tr>
<tr><td colspan="2">Name of Individual</td><td colspan="2">Address</td></tr>
<tr><td>Date of Birth

_____/_____/_____</td><td>Gender</td><td>Gender Identity (if applicable)</td><td>Race</td></tr>
<tr><td colspan="2">Medicaid identification # and/or other insurance information:</td><td colspan="2">Name and Contact Information for Licensed Health Care Professional(s):</td></tr>
<tr><td>Allergies:</td><td colspan="2">Dietary Restrictions:</td><td>Drug and Food Interactions:</td></tr>
<tr><td colspan="4">Medical Diagnoses: (treatment and preferences)</td></tr>
<tr><td colspan="2">Name and Contact of Parent /Guardian/ Authorized Representative: (if applicable)</td><td colspan="2">Emergency Contacts: (name and phone #)</td></tr>
<tr><td>Does Individual have Advance Directives:

*If you answer YES to either option, you must have copy in your clinical record.</td><td colspan="3">Please select an answer for both questions below:
Medical Power of Attorney*
YES NO

Do Not Resuscitate (DNR) Order*
YES NO (Individual is Full Code)</td></tr>
</table>