Patient Form Export

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Assigned Forms

Form Title	Status	Submitted
AFC Caregiver Application Checklist	Completed	2025-10-09 18:14:37.223000
Advanced Directive/HIPAA/Home Care Privacy Rights	Completed	2025-10-07 15:54:27.797000
Care Plan	Completed	2025-10-06 14:28:25.713000
AFC Caregiver Application	Pending	-
Adult TB Risk Assessment and Screening	Pending	-
Stakeholder Satisfaction Survey	Pending	-
Adult Foster Care Program Member Acknowledgement of Receipt	Pending	-
Service Plan	Pending	-
Service Plan\Care Assessment Form	Pending	-

1. AFC Caregiver Application Checklist Completed

Submission #15 • Submitted: 2025-10-09 18:14:37.223000

Caregiver First Name	dfgdfhafsgdaf
Date	—
Request received by	sdvsf
Received Date	—
Request approved by	—
Approved date	—
Caregiver Last Name	—
Caregiver Phone Number	—
Today’s Date	—
Member’s Name	—
Alternate Caregiver’s Name	—
From	—
TO	—
Signature	—

Checklist	No
Caregiver First Name	rahul
Caregiver Last Name	kumar
Patient Name	Vijay

2. Advanced Directive/HIPAA/Home Care Privacy Rights Completed

Submission #5 • Submitted: 2025-10-07 15:54:27.797000

Client's Name	Vijay
Medicare HIC #	N/A
Living Will	N/A
Signature of Statutory Power of Attorney for Health Care	N/A
Providing tht documents	N/A
Living Will	N/A
Statutory Power of Attorney for Health Care	N/A
Signature of Client or Representative	vijay
Agency Witness	Ravi

3. Care Plan Completed

Submission #6 • Submitted: 2025-10-06 14:28:25.713000

First Name	—
6) In the past 1 year, have you injected drugs that your doctor did not prescribe?	—
7) Have you ever lived or worked in a prison, jail, homeless shelter or long-term care facility?(example: nursing home, substance abuse treatment, rehabilitation facility)	—
1) Coughing for more than 2-3 weeks?	—
2) Coughing up blood?	—
3) Weight loss of more than 10 pounds for no known reason?	—
4) Fever of 100°F (or 38°C) for over 2 weeks?	—
5) Unusual or heavy sweating at night?	—
6) Unusual weakness or extreme fatigue?	—
Completed by	—
Signature	—
Last Name	—
Name	—
MRN	—
DOB	—
Date	—
1) Has the person had a TB test (skin test or blood test)?	—
TB test result	—
Where: (Facility)	—
TB test date	—

2) Did the person get a chest x-ray after the TB test?	—
X-ray result	—
DOB	—
X-ray date	—
3) Did the person take medication for TB infection?	—
4) Does the person remember being sick with TB?	—
If yes, when	—
Where: Country	—
Where: State	—
Tuberculin Skin Test (TST) plant date	—
TST read date	—
TST Result: (Millimeters of Induration)	—
TST Interpretation	—
Date	—
Interferon-Gamma Release Assay (IGRA) performed	—
IGRA Interpretation	—
Medical Provider Name	—
Medical Provider Signature	—
Medical Provider Date	—
1) Were you born in Africa, Asia, Central America, South America, Mexico, Eastern Europe,Caribbean or the Middle East?	—
2) In the past 5 years, have you lived or traveled in Africa, Asia, Central America, South America,Mexico, Eastern Europe, Caribbean or the Middle East for more than one month?	—

3) In the last 2 years, have you lived with or spent time with someone who has been sick with TB?	—
4) Do you have (or have you had) any of these medical conditions? (Check any that apply)	—
5) Are you taking any medications that your doctor said could weaken your immune system orincrease your risk for infections?	—
Patient/Client Name	Vijay
Goal of Care	No
If other, please specify	Varma
Nutrition	No
Nutrition - Specify Type of Diet	—
Body Mechanics/Mobility - Transfer:	No
Body Mechanics/Mobility - Ambulation:	No
Body Mechanics/Mobility - Ambulation - other:	—
Personal Care/Assistance with ADLs (Attendant) - Bathing	No
Personal Care/Assistance with ADLs (Attendant) -General:	No
Personal Care/Assistance with ADLs (Attendant)- other:	—
Date	—
Personal Care/Assistance with ADLs (Attendant) - Hair	No
Personal Care/Assistance with ADLs (Attendant) - Oral Hygiene	No
Personal Care/Assistance with ADLs (Attendant) - Toileting	No
Personal Care/Assistance with ADLs (Attendant)- Toileting -other:	—
Homemaking	No

Other/Record	No
Oral Temp Above:	—
Pulse Above	—
Pulse Below	—
Safety Instructions	—
DOB	—
Infection Control Instructions	—
Special Instructions	—
Dates	—
Reviewed By	—
For Period	—
Other	—
Prepared By	—
Date	—
Patient/Responsible Party Signature	—
Relationship to Client	—
Sex	No
Physician Name	—
Physician Signature	—
Client SS	—
Address	—
City	—
State	—
Zip	—

4. AFC Caregiver Application Pending

Submission #None

No responses captured for this form.

5. Adult TB Risk Assessment and Screening Pending

Submission #None

No responses captured for this form.

6. Stakeholder Satisfaction Survey Pending

Submission #None

No responses captured for this form.

7. Adult Foster Care Program Member Acknowledgement of Receipt Pending

Submission #None

No responses captured for this form.

8. Service Plan Pending

Submission #None

No responses captured for this form.

9. Service Plan\Care Assessment Form Pending

Submission #None

No responses captured for this form.