SERVICE PLAN

CLIENT NAME (Last, First MI)	CLIENT ID	ASSESSMENT DATE
Brewer, Joan L	53156	4/25/2003

DATE	SPECIFIC PROBLEMS/NEEDS	SERVICES : WHO, WHAT, WHERE	Outcomes/Client Preferences/ Negotiated Service Agreement	CHANGED
	SPECIALIZED BODY CARE			
	Client needs help with some body care, skin care including the application of nonprescribed ointment or lotions. Washing and combing her hair and set up of hygiene equipment.	Needs Total Assistance. Caregiver will monitor pressure areas for redness and irritation. Report changes to client's health professional Caregiver will assist client to do range of motion exercises	Client's skin will remain free of redness or irritation Mobility of joints will be gained and maintained. Stiffness will be prevented	
	PERSONAL HYGIENE			
	Client needs set up of hygiene equipment and assistance with washing, drying and combing hair plus filing and cleaning nails due to upper body weakness and left arm fracture.	Needs Total Assistance. Caregiver will set up hygiene equipment for client Caregiver will wash and comb client's hair Caregiver will file and clean nails	Hair will be clean.	
	DRESSING ISSUES			
	Client needs assistance with dressing and undressing and with difficult tasks such as tying shoes and buttoning and assist with dressing lower extremities due tofracture to left arm plus muscularskeletal	Needs Total Assistance. Caregiver will assist client with buttons, snaps and ties. Caregiver will assist client with dressing lower extremities. Caregiver will assist client with dressing, as needed.	Client will be dressed comfortably Self-help skills will be maintained and improved Clothing will be clean, dry and free of odors	

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Brewer, Joan L	53156	4/25/2003

DATE	SPECIFIC PROBLEMS/NEEDS	SERVICES : WHO, WHAT, WHERE	Outcomes/Client Preferences/ Negotiated Service Agreement	CHANGED
	weakness and pain in arms and hands.			
	BATHING ISSUES			
	Client is at risk for falling and cannot safely get into or out of the tub alone, needs hands on assistance for safety. Client needs assist with washing and drying hair and other body parts including wash, rinse and drying due to left arm fracture andmuscularskeletal pain and weakness.	Needs Total Assistance. Caregiver will assist client with transfer, hair shampoo and other body parts, including wash, rinse and drying.	Client will bathe safety and good personal hygiene will be maintained.	
	TRAVEL TO MEDICAL SERVICES			
	Client needs to be accompanied or transported to a physician's office or clinic in the local area to obtain medical diagnosis or treatment.	Needs Total Assistance. Caregiver will arrange transportation. Caregiver will provide escort to medical appointments and provide assistance during the appointments.	Necessary medical treatment will be obtained. Medical appointments will be kept. Escort to appointments will be provided.	

COMPREHENSIVE ASSESSMENT (CA)

SERVICE PLAN

CLIENT NAME (Last, First MI)	CLIENT ID	ASSESSMENT DATE
Brewer, Joan L	53156	4/25/2003

DATE	SPECIFIC PROBLEMS/NEEDS	SERVICES : WHO, WHAT, WHERE	Outcomes/Client Preferences/ Negotiated Service Agreement	CHANGED
	ESSENTIAL SHOPPING WITH CLIENT			
	Client is dependent on being accompanied or helped by others to access community shops also needs assistance with the shopping. Client frequently uses her wheelchair due to muscularskeletal pain and weakness.	Needs Total Assistance. Caregiver will provide transportation and escort to store or pharmacy. Caregiver will shop or assist client to shop for food, prescriptions and other items.	Necessary food, prescriptions and household supplies will be obtained. Transport and escort to the store or pharmacy is provided	
	MEAL PREPARATION			
	Preparing Breakfast. Client needs total assistance to prepare meal due to left arm fracture and painful hands, poor balance and weakness.	Needs Total Assistance. Caregiver will prepare the meal of client's choice. Caregiver will clean kitchen after meal preparation Caregiver will follow prescribed diet in preparing meals	Client will eat a nutritionally balanced and varied evening meal. Kitchen will be clean, foods put away	
	MOWS is needed for main meal assistance and to maintain good nutrition.	MOWS will be set up and client will have adequate nutrition. Caregiver may also prepare a nutritionally balanced evening meal.		

CLIENT NAME (Last, First MI)	CLIENT ID	ASSESSMENT DATE
Brewer, Joan L	53156	4/25/2003

DATE	SPECIFIC PROBLEMS/NEEDS	SERVICES : WHO, WHAT, WHERE	Outcomes/Client Preferences/ Negotiated Service Agreement	CHANGED
	Preparing Light Meal.	Needs Total Assistance. See Breakfast		
	Preparing Main Meal.	Needs Total Assistance. See Breakfast		
LAUNDRY - FACILITIES OUT HOME				
	Client is not able to use laundry facilities without physical assistane due to left arm fracture and limited use of hands and arms due to pain plus muscularskeletal weakness.	Needs Total Assistance. Caregiver will remove or assist client to remove bed linen, gather soiled linen and clothing. wash, dry, fold, and put away laundry.	Hygienic clothing and linen. Bed linen and clothing will be clean, folded, and put away.	
HOUSEWORK ISSUES				
	Client needs total assistance due to left arm fracture and limited physical ability due to muscularskeletal pain and weakness and needs weekly assistance of another with essential housework.	Needs Total Assistance. Caregiver will vacuum, wash dishes, dust, clean bathroom and kitchen, dispose of garbage, and mop floors.	Clean, safe environment will be maintained.	

COMPREHENSIVE ASSESSMENT (CA)
SERVICE PLAN

CLIENT NAME (Last, First MI)	CLIENT ID	ASSESSMENT DATE
Brewer, Joan L	53156	4/25/2003

DATE	SPECIFIC PROBLEMS/NEEDS	SERVICES : WHO, WHAT, WHERE	Outcomes/Client Preferences/ Negotiated Service Agreement	CHANGED
ASSISTIVE DEVICES				
	In case of an emergency client can call 911 or use the PERS device for help. She lives in a lst floor apartment.	Client could most likely exit independently in case of an emergency in the apartment. Client will be able to access her PERS Unit through Companion Call Light @253-630-5798.	Client will be safe in the event of an emergency or natural disaster.	
COPES CARE PLAN				
	Client continues to be eligible for Copes Services and meets the requirements for eligibility. Client is authorized for 184 hours per month.	Elite International Homecare will provide 80 hours per month as authorized and outlined in this service plan. General schedule is: 4 days a week, 4 hours a day. Chesterfield Health Services will provide 100 hours per month, 3 days a week <Fri, Sat, Sun>,8 hours a day. Report any changes in client's condition or needs to case manager including hospitalizations or ER visits.	Client's needs will be met in the least restricitive environment.	
UNIVERSAL PRECAUTION				
	Universal Precautions: All blood and body fluids should be regarded as potentially infectious. Appropriate protective action should be taken to minimize risk to both caregiver and client.	Caregiver will wash hands, wear gloves, protect skin lesions, dispose of sharps correctly, protect eyes and mouth, etc.	Risk of caregiver or client becoming infected will be minimized or eliminated.	

COMPREHENSIVE ASSESSMENT (CA)
SERVICE PLAN

CLIENT NAME (Last, First MI)	CLIENT ID	ASSESSMENT DATE
Brewer, Joan L	53156	4/25/2003

DATE	SPECIFIC PROBLEMS/NEEDS	SERVICES : WHO, WHAT, WHERE	Outcomes/Client Preferences/ Negotiated Service Agreement	CHANGED
UNSCHEDULED TASKS				
	Unscheduled Tasks: 91additional hours are added for personal care tasks for assistance with toileting, ambulation, positioning and transfers due to muscularskeletal pain and weakness plus poor balance.	91 additional hours are authorized in the Copes Care Plan to accommodate personal care tasks of toileting, ambulation, positioning and transfers.	Client's needs will be fully met within the home.	

Stale date prior to the accident is add 91 Additional hours

271 hours total

Please sign, date and return this page

I am aware of all alternatives available to me, and I agree with the above service plan. I authorize the Department of Social and Health Services (DSHS) and/or the Aging Network Representative to obtain or release information necessary to the development of my service plan.

CLIENT/REPRESENTATIVE SIGNATURE	DATE	**OR** Date of verbal consent by client/representative	DATE
DSHS REPRESENTATIVE SIGNATURE	DATE	AGING NETWORK REPRESENTATIVE SIGNATURE	DATE
NEXT SCHEDULED REVIEW DATE	DATE	PROVIDER SIGNATURE Sharon McDaniel, MHP	4/25/03

KENT CASE MANAGEMENT *
525 4TH AVE N
KENT WA 98032

071-4-AAS

973907

08-18-2003
DATE

CONSIDINE KAYLEEN
650 NW JUNIPER ST APT 101
ISSAQUAH WA 98027-2402

4811940-02
AUTH NBR

0002183508
BREWER,JOAN

HIS IS TO NOTIFY YOU THAT:

AUTHORIZATION FOR CONSIDINE KAYLEEN TO PROVIDE COPES PER CARE-INDIV-HR FOR BREWER,JOAN IS CHANGED OR UPDATED TO THE FOLLOWING:
SERVICE IS APPROVED FROM 08-01-03 THROUGH 04-30-04. THE RATE IS $7.68 PER HOUR FOR UP TO 20 HOURS PER MONTH AND A MAXIMUM OF $153.60 PER MONTH.

- YOU WILL RECEIVE A SERVICE INVOICE EACH MONTH. FILL OUT THE INVOICE ACCORDING TO THE INSTRUCTIONS.
- SOCIAL SECURITY AND MEDICARE TAXES WILL BE WITHHELD FROM EMPLOYEE WAGES. THE STATE OF WASHINGTON PAYS THE EMPLOYER'S SHARE ON BEHALF OF BREWER,JOAN, THE EMPLOYER.
- PAYMENT OF THIS SERVICE WILL GENERATE A W-2. FICA TAXES WILL BE REFUNDED AFTER YEAR-END WHEN ANNUAL PAYMENT FOR SERVICE TO ANY ONE CLIENT IS UNDER THE YEARLY FICA LIMIT. INCOME TAX IS NOT WITHHELD.

IF YOU HAVE ANY QUESTIONS PLEASE CALL SHARON MCDANIEL AT 206-615-1852.

Millennia Healthcare, Inc.
"Quality Care is Our Product"

Larry Ude
Director of Finance & Admin.

Pacific Financial Center
23003 Pacific Hwy S., Suite 207
Des Moines, WA 98198

Phone (206) 878-0909
Fax (206) 878-5259
milhear@seanet.com

Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES

SOCIAL SERVICES AUTHORIZATION

DATE

INPUT OPERATOR INITITALS

2. AUTHORIZATION NUMBER	3. CASE NUMBER	4. AUTHORIZING AGENCY	5. RU NUMBER	6. WORKER'S N
	0.01012.1.8.3.5.0.8	King Case Mgmt	071	02M5c

7. TO BE PROVIDED BY:	8. PROVIDER NUMBER	12. WARRANT TO BE ISSUED TO:	13. PROVIDER NUM
Elite Home Care	972376	King County AAT	45238

9. ADDRESS	14. ADDRESS

10. CITY / STATE	11. ZIP CODE	15. CITY / STATE	16. ZIP CODE

17. PRIMARY RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL)	18. DATE OF BIRTH MONTH DAY YEAR	19. SOCIAL SECURITY NUMBER	20. GOAL	21.	22. AFFIRM. ACTION
Brewer, Joan	01 11 1957	546-84-9942	4	001	6

17A. ADDRESS	CITY / STATE	ZIP CODE	ELIGIBILITY STOPS ON THIS DATE ⇒	24. ELIGIBILITY END DATE MONTH DAY YEAR
650 West Juniper #103	Issaquah WA	98027		04 30 04

26. NAME (LAST, FIRST, MIDDLE INITIAL)	27. DATE OF BIRTH MONTH DAY YEAR	28. TIE BRAKR	29. AFFIRM. ACTION	SPEC. PROG. AREA 30A. 30B. 30C.	31. SOURCE	32. BEGIN DATE MONTH DAY YEAR	33. END DATE MONTH DAY
Brewer, Joan	01 11 1957		6	AA 04 V3		06 10 03	04 30

34. TERM CODE	35. SERVICE NAME	36. SERVICE CODE	37. REASON	38. OBJ.	39. HRS/DAY	40. DAY/WK	41. RATE/UNIT	42. NO. UNITS	43. AUTH. AMOUNT
	Copes Per Case-Agency	5257					13.46 HR	80	1075.

26. NAME (LAST, FIRST, MIDDLE INITIAL)	27. DATE OF BIRTH MONTH DAY YEAR	28. TIE BRAKR	29. AFFIRM. ACTION	SPEC. PROG. AREA 30A. 30B. 30C.	31. SOURCE	32. BEGIN DATE MONTH DAY YEAR	33. END DATE MONTH DAY

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RS/DAY	40. DAY/WK	41. RATE/UNIT	42. NO. UNITS	43. AUTH. AMOUNT
		/		

Hi Joan,
Here is your service authorization. IA-159 form indicating that service has been authorized for 80 hrs/mo effective 06-01-03 through 04-30-04. I have not got any other authorizations so far. Thanks. Vasily

to _____ DATE

SIGNATURE

RECEIVED
JUL 3 2003
VK

EARING SCREEN.

WORKER'S SIGNATURE	DATE SERVICE REQUESTED	DATE SERVICE AUTHORI

CMS CENTERS for MEDICARE & MEDICAID SERVICES

Medicare Summary Notice

September 08, 2003

JOAN L. BREWER
650 NW JUNIPER ST
APT 103
ISSAQUAH WA 98027-2402

CUSTOMER SERVICE INFORMATION

Your Medicare Number: 566-84-9942A

If you have questions, write or call:
United Government Services,LLC CA
MEDICARE
P.O.BOX 9140
OXNARD, CA. 93031-9140
Local: (866) 804-0684
Hawaii and U.S Territories, Please call:
(866) 264-4990

BE INFORMED: Read your Medicare Summary Notice carefully for accuracy of dates, services, and amounts billed to Medicare.

This is a summary of claims processed on 08/28/2003.

HOME HEALTH CARE

Dates of Service	Number of Services Provided		Amount Charged	Non-Covered Charges	Coinsurance	You May Be Billed	See Notes Section
Control number 20323801764602							
Providence Marianwood Homecare							a
3707 Providence Point Dr Se #h							
Issaquah, WA 98029							
Referred by: Nasima Vira							
05/23/03-06/27/03	1	Physical Therp	$140.00	$0.00	$0.00	$0.00	
	9	Occupation Ther	1,260.00	0.00	0.00	0.00	
	4	Skilled Nursing	528.00	0.00	0.00	0.00	
	3	Med Social Svs	525.00	0.00	0.00	0.00	
	5	Aid/Home Health	325.00	0.00	0.00	0.00	
Claim Total			**$2,778.00**	**$0.00**	**$0.00**	**$0.00**	

Notes Section:

Medicare paid All

a The amount Medicare paid the provider for this claim is $4,246.92.

THIS IS NOT A BILL - Keep this notice for your records.