Greeley Center for Independence, Inc. (GCI)
2780, 28th Avenue, Greeley, CO 80634
Phone: 970-339-2444 Fax: 970-339-0033

HOME HEALTH SERVICES AT GCI

GCI currently offers Home Health Services ONLY to tenants of Hope Apartments (2730 28th Avenue, Greeley, CO), Camelot Apartments (1726 8th Avenue, Greeley, CO) and Stephens Farm (2774 Reservoir Road, Greeley, CO). We do not offer home health anywhere else in the community.

Description of Services

The following services are offered under Medicare/Medicaid home health care guidelines:

1. Private Duty Skilled Nursing- Face to face skilled nursing provided by a Registered Nurse (RN) which is more individualized and continuous than nursing care available under routine home health benefits, hospitals, or nursing facilities. Appropriate clients may be technology dependent (i.e. prolonged IV administration and nutrition support). Private duty skilled nursing requires a specific level of approval.
2. Skilled Nursing – Skilled nursing services provided by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) under the direction of a RN.
3. Skilled Certified Nurse Aide - Licensed Certified Nurse Aide (CNA) provides skilled personal care for activities of daily living under the direction of a RN.
4. Personal Care and Home-making: Unskilled care such as laundry, housekeeping, meal preparation and shopping is provided under Home and Community Based Services (HCBS). (Clients must have money for groceries, and quarters up to $2.00 per load of laundry)

The following services are NOT provided under home health care:

Apartment rent, utilities, phone, cable, furniture and/or home furnishings, clothing, medication, medical equipment, lab testing, home care supplies, cleaning or laundry supplies, groceries, social entertainment, transportation, school tutoring, or accompaniment to outside activities.

Our Mission: GCI serves people with disabilities by providing affordable, accessible housing and supportive services tailored to meet individual needs.
Our Vision: People with disabilities live connected, interdependent lives.

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APPLICANT INFORMATION

Applicant Name:_____Date of Birth_____

Preferred name:_____

Current Address:_____

City:_____ State:_____ Zip:_____

Phone Number:_____

E-Mail:_____

Gender (circle): M F Height: _____ Weight:_____

Primary Language: _____ Secondary Language: _____

Primary Diagnosis: _____

Date of injury (if applicable):_____

Current employer (if applicable):_____

Level of Education:_____

Job status (current or before injury):_____

Marital Status:_____

Children: Yes____ No____

Name of Person filling out Form:_____

Relationship:_____

Phone Number:_____

E-Mail:_____

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FAMILY/RESPONSIBLE PARTY'S INFORMATION

Who would you want us to contact on your behalf when necessary?

Name:_____

Relationship:_____

Current Address:_____

City:_____ State:_____ Zip:_____

Phone Number:_____

E-Mail:_____

Do you have a Legal Guardian? Yes No

Guardian's Name:_____

Relationship:_____

Current Address:_____

City:_____ State:_____ Zip:_____

Phone Number:_____

E-Mail:_____

Do you have a Conservator? Yes No

Conservator's Name:_____

Relationship:_____

Current Address:_____

City:_____ State:_____ Zip:_____

Phone Number:_____

E-Mail:_____

Do you have a Durable Power of Attorney? Yes No

POA's Name:_____

Relationship:_____

Current Address:_____

City:_____ State:_____ Zip:_____

Phone Number:_____

E-Mail:_____

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Who will assist you in case of an emergency, such as being sent to the hospital or needing to see a doctor quickly?

Name: _____

Current Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

E-Mail: _____

Who will assist you to pick up after hours medications?

Name: _____

Current Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

E-Mail: _____

Who will assist you if you need to see a doctor after hours?

Name: _____

Current Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

E-Mail: _____

Who will assist you to ensure that you have all the supplies you need (medical, household, cleaning)?

Name: _____

Current Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

E-Mail: _____

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PAYOR INFORMATION

Do you have Medicaid? Yes___ No___ If yes, Medicaid #_____ State:_____

Do you have Home and Community Based Services (HCBS)? Yes___ No___

If yes, in what county?_____ Phone number:_____

Who is your HCBS Case Manager?_____

Do you have Medicare? Yes___ No___ Part A____ Part B____

If yes, what is your Medicare #:_____

MEDICAL INFORMATION

Do you require assistance with medication? Yes____ No____

Have you had or do you currently experience seizures? Yes____ No____ If yes, what type of seizures? _____

Are they controlled by medication? Yes____ No____

Have you been injured as a result of a seizure? Yes____ No____

Do you use any safety devices related to seizures? Yes____ No____

If yes, what device? _____

Can you go into the community unassisted and be safe? Yes____ No____

Date of last seizure: _____

Do you see normally with both eyes? Yes____ No____

If no, please explain: _____

Do you hear normally? Yes____ No____

If no, please explain: _____

Do you use hearing aids? Yes____ No____

If yes, can you manage them yourself? Yes____ No____

Can you have control your bladder? Yes____ No____

If no, please explain: _____

How often do you require a bed/or clothing change? _____

Do you have a catheter? Yes____ No____

If yes, what kind (suprapubic, indwelling, condom)? _____

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Can you control your bowels? Yes____ No____

If no, please explain: _____

Do you have an ostomy for bowel elimination? Yes____ No____

Do you currently use a bowel program? Yes____ No____

Do you have any eating/swallowing concerns? Yes____ No____

If yes, please explain: _____

Have you choked in the past? Yes____ No____

Do you have a history of Aspiration Pneumonia? Yes____ No____

If yes, provide the date of the most recent episode _____

Do you use any communication devices? Yes____ No____

If yes, please explain: _____

What forms of communication do you use? _____

Do you experience chronic pain? Yes____ No____

If yes, please explain: _____

Do you experience muscle spasms? Yes____ No____

If yes, please explain: _____

Do you smoke? Yes____ No____

Do you drink alcoholic beverages? Yes____ No____

If yes, how much and how often? _____ Do you have a history of alcohol or drug abuse including medical and/or recreational marijuana? Yes____ No____

If yes, please explain: _____

Have you received treatment for alcohol and or drug abuse? Yes____ No____

If yes, where and when? _____

Do you use illegal street drugs? Yes____ No____

If yes, what and how often? _____

Surgical History for past 1 year, or relevant_____

Number of ER visits in the past 1 year_____

Please explain: _____

Number of inpatient hospital stays in past 1 year_____

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Do you have a pacemaker? Yes____ No____

Do you have any implanted medical devices? Yes____ No____

Do you have Diabetes? Yes____ No____

If yes, Type 1 or Type 2? _____

Managed with medications? If yes, what kind? _____

Do you require daily Blood Sugar monitoring? Yes____ No____

Can you do this yourself? Yes____ No____

Do you have any chronic infections: Urinary, pneumonia? Yes____ No____

Can you identify if you are getting sick? Yes____ No____

Do you require 24hr/day support? Yes____ No____

Do you go into the community unassisted? Yes____ No____

Do you receive any mental health supports? Yes____ No____

If yes, please explain:_____

Which of the following equipment do you use?

( ) Hospital bed ( ) Commode/Shower Chair ( ) Manual Wheelchair

( ) Adaptive eating device ( ) Communication Device ( ) Electric Wheelchair

( ) Fireman's pole ( ) Electric Medication Minder

Document Check List:

These documents must be provided in order to be considered for our Home Health services.

____ Latest History and Physical from your doctor

____ Discharge Summary (if applicable)

____ Current Medication list provided by your pharmacy or physician

____ List of regularly used Over-the-Counter medications