Nutrition and Aging
Resource Center

WeCare Services™

Personal Health Nursing for Seniors receiving Title III Home-Delivered Meals

Appendix Documents

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Appendix A – WeCare Welcome Letter

Milford Wellness Village
Suite 1030
21 W. Clarke Avenue
Milford, DE 19963

WELCOME LETTER

Dear Member,

We at WeCare Services would like to welcome you to the WeCare program. You can be assured that WeCare will provide the following services to you at no cost to you.

- Provide a Personal Health Nurse to manage your healthcare needs
- Help members connect with their primary care doctors to manage sudden change in condition
- Help members avoid unnecessary ER visits and hospitalization
- Calls members weekly to check on their well-being
- Connect members to resources such as Home Health Care, Rehabs, Transportation to their doctors' office, adult daycare, Hospice, PACE
- Provide ongoing healthcare services
- Complete medical necessity papers
- Provide Medical Homes for members with no Family Doctors
- Complete Power of Attorney papers if needed

Again, welcome to WeCare. We look forward to serving you.

Sincerely,

Kemi Sanni, DNP, MSN, APRN, CRNP, FNP-BC
Program Director
302-265-8686 (Cell)
302-459-3900 (Office)
302-503-7197 (Fax)
ksanni@wecareservices.org (Email).

This project was supported, in part by grant number 90INNU0030-01-00 from the U.S. Administration for Community Living, Department of Health and Human Services, Washington, D.C. 20201.

Appendix B – Individual Member Participation and Release Form

PARTICIPATION AND RELEASE OF INFORMATION AGREEMENT

I, _____, agree to participate as a client in the WeCare Services, a service offered by Education Health and Research International, Inc. (EHRI).

I understand that this means:

1. WeCare, a program of EHRI, offers healthcare coordination services **AT NO COST** to me. Participation in the WeCare program is voluntary; I am not obligated to participate in the WeCare program or accept this service and do so voluntarily.

2. Once enrolled, the WeCare Coordinator may contact me, and/or my authorized representative, and my healthcare providers (hospitals, doctors, therapists, etc.) to discuss my healthcare needs and to access my health information. WeCare will use and disclose any personally identifiable information about me only to provide healthcare coordination services as authorized by me, or as otherwise set forth herein. Otherwise, WeCare will keep all individually identifiable information about me confidential.

3. By signing where indicated below, I hereby authorize the WeCare Coordinator to obtain healthcare information about me from the providers described below, and to use and disclose the health information so received to create and update a Care Plan uniquely for me. My Care Plan will be used as a planning tool by WeCare to help coordinate my healthcare needs, which will be based on the treatment prescribed by my medical providers.

4. WeCare may use information about services rendered to WeCare clients to review and evaluate the effectiveness of the WeCare Program. By signing where indicated below, I authorize the WeCare Program to use and disclose medical and other information for such survey, study, or research related to the WeCare Program as long as individually identifiable information about me is not made public.

5. I can withdraw from the WeCare Program at any time, for any reason, without any reprisal or interruption to any of my other services.

CLIENT RIGHTS

- Receive all WeCare Program services without discrimination based on gender, sexual orientation, religion, age, race, or culture.
- Be treated with courteous consideration, respect, dignity, and recognition of individuality.
- Be assured of confidential treatment of records, including but not limited to, my Care Plan, maintained by WeCare. Except with respect to the healthcare coordination services

provided by WeCare and as otherwise described herein, the release of any records about me outside of WeCare is not permitted without my prior written authorization.

- Voice a complaint or suggest a change in services without being threatened or discriminated against, and without the fear of any impact on any WeCare or MMC services that I am receiving.

CLIENT RESPONSIBILITIES

- Provide complete, accurate, and up-to-date contact and health status information.
- Participate and express opinions and priorities in the development of a personal WeCare Care Plan.
- Follow medical advice and treatment recommendations provided by my personal physicians or other health personnel.
- Ask questions and seek information when something is not clear or understandable.

A copy of this form is as valid as the original. My name and signature below acknowledge my receipt and review of this information. This Agreement is active until I am no longer a participant in the WeCare Program.

_____ _____

Client Name (please print) Date

_____ _____

Client Signature Date

To voice a complaint or concern about the services received, please contact:
WeCare Services Program Director, Kemi Sanni, at (302) 265-8686

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Authorization to Disclose Information

I hereby authorize the disclosure of my individually identifiable health information as described below. I understand this authorization is voluntary. I understand that if the organization or persons authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

WeCare Client Name:	
WeCare Client Address:	

Persons/organizations providing the information:	**Persons/organizations receiving the information:**
	WeCare, a program of EHMC **[Address]** **[Phone]** **[email]**

Specific description of information to be used and disclosed (including date(s)):

Any and all healthcare information about me maintained by Provider from (date):_____ to (date):_____, including but not limited to mental health treatment information, substance use disorder information, HIV status.

Reason for use or disclosure of information:

WeCare will help me to create a personal Care Plan, and will assist me in coordinating my healthcare needs.

- I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it.
- I understand that this authorization will expire one year after the date that appears on this form.
- I understand that I may revoke this authorization at any time by notifying the person or organization providing the information in writing, but if I do, it will not affect any actions taken before the revocation is received.
- A photocopy of the original of this authorization shall have the same effect as the original.

_____ _____

Signature of WeCare Program Client or Client's representative Date

Printed name of Client or Client's representative: _____ (Relationship)

Appendix C – WeCare Individual Intake Form

WECARE
Partnering for a healthier tomorrow.

WECARE INDIVIDUAL INTAKE FORM

This form is obtained verbally on every client immediate to their signed WeCare consent.

Member's Name, Phone, and Address	
Date Consent signed	
Member's DOB	
Emergency Contact, Phone, Relationship	
PCP Name Address Phone Date of Last MAWV	
Insurance Policy# Primary and Supplemental (Information is for health services research only, not for billing.)	
Home Health: Company name Phone Staff Info	
Diagnosis	
Pharmacy Address/Phone	
Covid Vaccine Y/N Date received Flu Vaccine Y/N/Date	
Comments	

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Appendix D – Physician Information Release Form

Milford Wellness Village
Suite 1030
21 W. Clarke Avenue
Milford, DE 19963

Date: _____

Dear Provider,

Your patient, _____ is a member of WeCare Services. WeCare serves as the Personal Health Nurse to Modern Maturity Center meal recipients, Cheer meal recipients, La Red patients, and Polaris Discharged Patients.

Your patient has signed the authorization to disclose medical information to WeCare to enable us to familiarize ourselves with their medical conditions and to discuss their conditions with their providers.

WeCare Personal Health Nurses call your patients weekly to check on their well-being with the intention to prevent unnecessary hospital admissions and deescalate acute medical conditions. During the calls, any change in conditions will be communicated to your office for prompt interventions.

WeCare does not treat, diagnose, or prescribe to their members, but act as a liaison between the members and their providers.

We will appreciate your collaboration to help ensure that your patients' well-being remained our top priority. You can reach out to me below for any further questions or concerns.

Thank you.

Kemi Sanni, DNP, MSN, RN
Program Director
Cell: 302-265-8686
Office: 302-459-3900
Fax: 302-503-7197
Email: ksanni@wecareservices.org

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