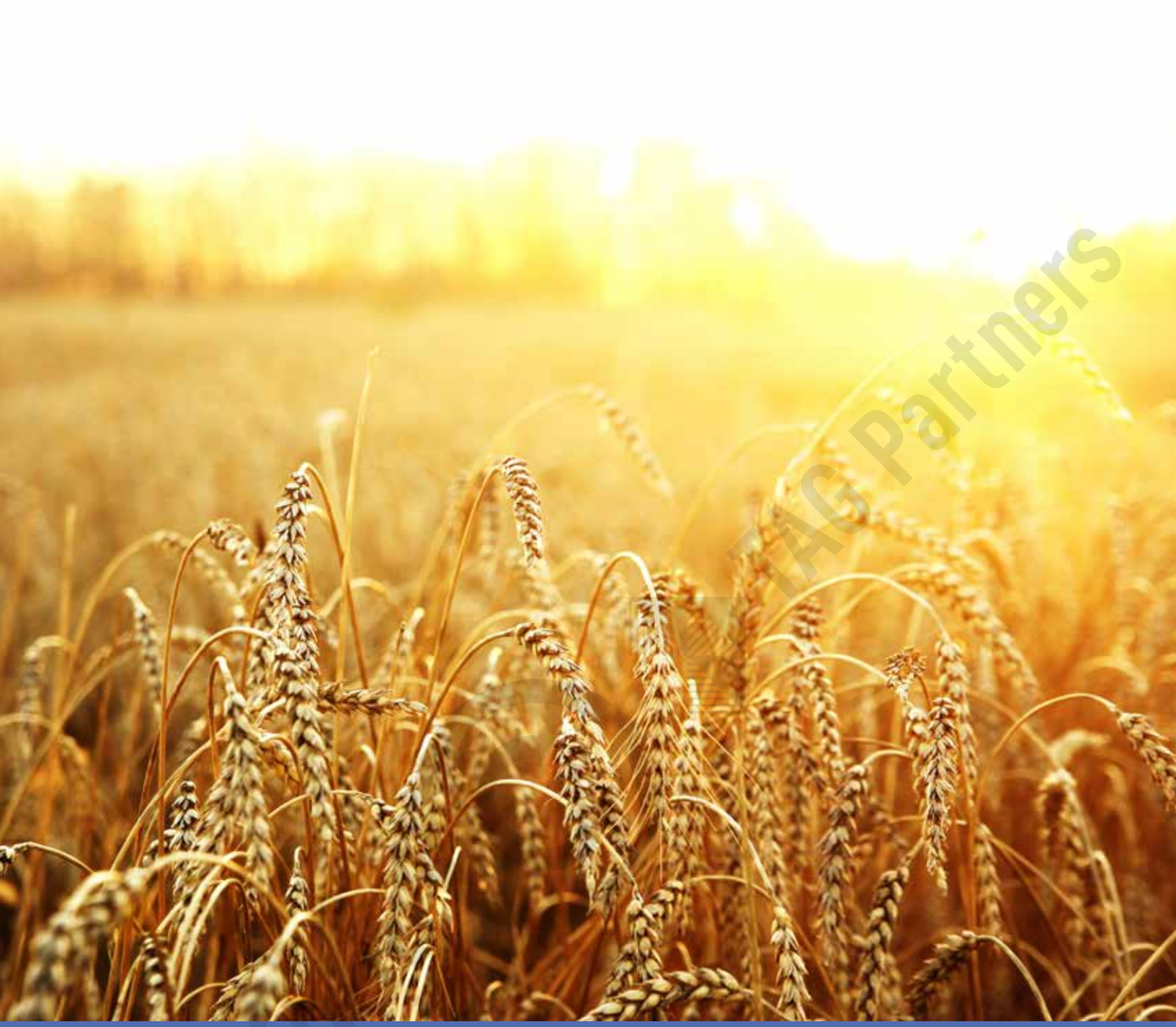


Admission Essentials
Home Care

Your Logo Here!

Important Phone Numbers

<<Your Agency Name>> Office:_____

 Ambulance: 911

 Hospital:_____

 *EMERGENCY* Police: 911

 Fire: 911

 *NON EMERGENCY* Police:_____

 Doctor: _____

 Doctor: _____

 Pharmacy: _____

 Poison Control: _____

 Durable Medical Equipment: _____

 Electric Company: _____

 Phone Company: _____

 Water Company: _____

 Taxi: _____

 Transportation: _____

 Family: _____

 Family: _____

 Family: _____

 Family: _____

 Other: _____

 Other:_____

Emergency Preparedness

1. Emergency telephone number for the fire department, police or ambulance service is 911.
2. The agency has 24-hour answering service. If you call after regular working hours or on weekends or holidays, the answering service will notify agency personnel to respond to your call.
3. In the event of an emergency or natural disaster:
   - **a.** Your care will be evaluated and visits will be scheduled on a priority basis. A family member, neighbor or other caregiver may be relied upon in emergency situations.
   - **b.** In the event of loss of phone service for an extended period of time, the local radio and television Emergency Broadcasting Service will be utilized to communicate the emergency plan.
   - **c.** If a home visit is not possible and care needs must be provided, the agency will contact the local sheriff's office, emergency operations center or local ambulance for transportation to an acute care facility or to a Red Cross Shelter.
4. In the event of icy or flooded roads preventing home visits, you will be notified and a plan formulated for the provision of care.

Your Logo Here!

Consent & Verification of Receipt of Information
Client's Consent for Care and/or Treatment

Client Name_____ Client #_____ Date_____

CONSENT TO TREATMENT. I hereby authorize <<Your Agency Name>> (the agency) to render appropriate home care services to the client named above. I recognize and agree that I have the right to refuse treatment or terminate home care services at any time. In addition, the agency may terminate home care services at any time, as outlined by agency policy, for Medicare Services or as outlined by the state's Department of Human Services.

RECEIPT OF CLIENT INFORMATION

I have read, understand and received a copy of:

- ❑ Access Notice
- ❑ Communication L.E.P.
- ❑ Communication — Sensory Impairments
- ❑ Patient Rights (OBRA)
- ❑ Rights of the Elderly (60+ Only)
- ❑ Complaint Procedure
- ❑ Privacy Rights (OASIS)
- ❑ Client Rights/Responsibilities/Conduct
- ❑ Security of Client Property/Valuables
- ❑ Abuse, Neglect and Exploitation Policy
- ❑ Advance Directives/Patient Promise
- ❑ "Do Not Resuscitate" Policy
- ❑ Agency Drug Testing Policy
- ❑ Proper Prescription Drug Disposal
- ❑ HIV/AIDS
- ❑ Disposal of Sharps in the Home
- ❑ Infection Control
- ❑ Home Safety Guidelines
- ❑ Emergency Procedures
- ❑ Disaster Preparedness Information
- ❑ Agency Information
- ❑ Emergency Information Data

RELEASE OF INFORMATION AND RECORDS

A. I hereby request and give my consent for copies of my pertinent medical records to be released to the agency.
❑ I Accept This ❑ I Decline Consent

B. I hereby authorize the agency to disclose and/or release copies of my medical records and/or relevant reports to any person or entity for the purpose of processing claims or coordinating home care services, Q.I., or any other aspect of my care.
❑ I Accept This ❑ I Decline Consent

ASSIGNMENT OF BENEFITS. I hereby assign to the agency any and all benefits from any insurance plans or any other protection maintained by me and/or for me or my benefit and authorize and direct such benefits to be paid directly to the agency for home care services provided to me by the agency. I certify that the Medicare/Medicaid insurance plans or other protection is correct and complete. I authorize release of all records required to act on this release and assignment.

BENEFICIARY PAYMENT LIABILITY. I have been informed by the home care agency, both orally and in writing, that there is a possibility of payment liability if I obtain care/services from anyone other than my home care provider.

AUTHORIZATION FOR EMERGENCY SERVICES AND TREATMENT. In the event of any medical emergency, I authorize the agency's employees to provide or obtain necessary medical care and I agree to assume sole responsibility for any and all charges resulting from said care.

ADVANCE DIRECTIVES. I certify that I have received information on Advance Directives. I certify that I **❑ Do Have ❑ Do Not Have** an Advance Directive in place. I **❑ Do Authorize ❑ Do Not Authorize** the agency to receive a copy of my Advance Directives.

NOTICE OF PRIVACY PRACTICES. I have received a copy of the agency's Notice of Privacy Practices. I further acknowledge and agree that the agency may leave my care plan and/or portions of my medical chart in my home for use by agency staff in providing treatment for me.

FREEDOM OF CHOICE. I have been offered a choice of other home care agencies and it is my decision to have <<Your Agency Name>> provide my care.

PHOTOGRAPHY/VIDEOGRAPHY CONSENT. I hereby give consent for photographs/videos to be taken of my medical condition for the purpose of documentation and teaching if needed. All information will be held in confidence, and will not be released without my written consent or that of my authorized representative/agent.

Client Signature	If client is unable to sign, signature of client's representative and relationship to client.
Date Signed	Date Signed
Witness Signature	State reason client is unable to sign.

WHITE — CLIENT FILE YELLOW — CLIENT

FOR REVIEW ONLY (THIS TEXT AND BACKGROUND WILL NOT PRINT)

Back of NCR Form

Get to Know Me

Name:_____

I like to be called:_____

Occupation:_____

Important people (family and friends):

_____

_____

_____

_____

_____

_____

Favorites

Movie:_____

TV show:_____

Book:_____

Music:_____

Sport:_____

Color:_____

Foods:_____

Activities/hobbies:_____

Quote or saying:_____

_____

Pets too!:_____

At home I use:

☐ Glasses ☐ Contact Lenses

☐ Hearing Aid ☐ Dentures

Other:_____

I understand information best when:

_____

_____

Achievements of which I am proud:_____

_____

_____

Things that stress me out:_____

_____

Things that cheer me up:_____

_____

_____

Other things I'd like you to know about me:_____

_____

_____

_____

_____

FOR REVIEW ONLY (THIS TEXT AND BACKGROUND WILL NOT PRINT)

Back of Get to Know Me

Your Logo Here!

What We Do

<<Your Agency Name>> would like to thank you, your family, and friends for allowing us into your home to provide personal care, and companionship.

We treat each patient according to a personalized care plan created by our team of professionals. We incorporate the personal wishes of each client into their care plan.

<<Your Agency Name>> is dedicated to promoting the well-being of our patients/clients. Because of this commitment, we strive to demonstrate our belief in the dignity and worth of everyone. We have the utmost respect for your personal rights and property and provide this admission booklet as a reference of our service agreement and your rights as our patient.

Mission Statement

Our Mission at <<Your Agency Name>> is to furnish our clients personal care services that promote health, dignity, and the freedom of independence. To kindly provide the care each client wants, where they want it, when they want to receive it.

"Too often we underestimate the power of a touch, a smile, a kind word, a listening ear, an honest compliment, or the smallest act of caring; all of which have the potential to turn a life around."—Leo Buscaglia

**We are closely monitoring and adhering to the CDC recommendations and guidelines for avoiding COVID-19 transmission. All caregivers are screened regularly, use standard CDC precautions, and wear the appropriate PPE paraphernalia.

NOTE: Every reference to "the agency" or "agency" or "Home Care Agency (HCA)" means <<Your Agency Name>>.

CONFIDENTIAL: Access to the information in this booklet is your right. Share it only if you choose to do so.

Table of Contents

Communication and Access

<<Your Agency Name>> recognizes that many clients face communicati
hearing, speech or visual impairment. In addition, we recognize that so
municate in a language other than English.

This agency and all of its programs and activities are accessible to and
persons, including persons with impaired hearing and vision. Access fea

- Convenient, off-street parking.
- Curb cuts and ramps between parking areas and buildings.
- Level access into first floor level with elevator access to all other flo
- Fully accessible offices, meeting rooms, bathrooms and public wa

In some cases, <<Your Agency Name>> personnel may be able to com
in a language other than English. When this is not the case, <<Your Ag
made arrangements to provide interpreter services.

Admission Criteria

Admission: Admission to this agency is based on client needs, and the
required that can be provided by this company. In order to make a det
suitability for home care, it is important to provide relevant information
sions process thus, your cooperation is imperative. We encourage you to
your family and those assisting you in your home to share relevant info
order to complete a comprehensive admission process.

Policies: This book contains general information regarding your right
as a client. As state and federal regulations change, there may be additi
this book, as necessary. The complete policy and procedure manual reg
treatment is available, upon request, for your viewing during normal bu

Ownership: This agency is owned by <<Your Agency Name>> and is
Title VI of the Civil Rights Act of 1964; section 504 of the Rehabilitati
Americans with Disabilities Act; and the Age Discrimination Act of 19
Name>> does not discriminate on the basis of race, creed, color, age, ge
or disability in admission, access to treatment or employment. Adminis
nate all efforts to comply with these laws and relevant regulatory requir
Agency Name>> is an EQUAL OPPORTUNITY EMPLOYER.

Payment: Reimbursement for services may be provided through Medi
Worker's Compensation, Veterans Administration Insurance, Private In
Care Organization or Private Pay. For some services, there is no charge
are eligible for Medicare or Medicaid. Any charges for services not cov
XVIII and XIX of the Social Security Act or nonreimbursable charges
you prior to rendering these services. Prior to, or on admission, the cli
or family member will be informed of all charges for services to be pro
of payment. Should any change be made in this policy regarding servic
your responsible party will be advised in writing.

Client needs: Our policy is to admit only those individuals for whom
meet demonstrated needs in care and service. On an on-going basis, w
When situations occur in which client needs can no longer be accom
<<Your Agency Name>> personnel or through service provided by
develop a discharge or transfer plan for the individual.

Safety and Security: The safety and security of clients and our perso
ations. As such, in instances where safety and security are in jeopardy, w
withdraw service without prior notification to either the client or referra

Client and Caregiver Information

We encourage your input. The goal of <<Your Agency Name>> is to
quality home care services. To assist us in meeting this goal, we encour
office to voice your suggestions for improving our services.

In addition, we want you to know that you may be asked to participate
tion surveys that are designed to assist us in improving our home care p
chosen at random for this purpose. You do not have to take part in thes
we value your input in our effort to continuously improve our home ca
we encourage your participation in our client satisfaction surveys.

How to Work Effectively with Home Care Personnel: Having ho
with you or a family member may be a new experience. Home care staf
vide care or service in a manner that is as least disruptive as the situatio
will look to you to orient them to your home. Please feel free to share w
tion that may impact your care.

Although efforts will be made to assign the same staff to assist you durin
not always be possible to achieve. <<Your Agency Name>> reserves the ri

In addition, just as we respect your cultural and religious beliefs, we have
the beliefs of our staff. Therefore, we may substitute personnel in those si
services required conflict with the individual's philosophical or religious

We ask all our clients to refrain from asking our staff to perform services be
plan of care. Repeated requests may result in a decision to terminate servic
dence of abuse, harassment, or threatened assault will result in prompt disc

Recommendations for Security of Client Property and Valuables:
possible to place an employee in your home who is polite, honest and reliab
nal history background checks on our employees in an attempt to prote
results of these background checks are confidential and cannot be shared
recommendations are intended to help with the security of your prop

PLEASE:

- Do not loan or give money or gifts to any <<Your Agency Name>>
- Keep money, checks, credit or bank cards, jewelry and other valua
  SECURE, CONFIDENTIAL location in your home.
- Report any request by your worker to borrow money or other items to y

During the admissions process, a member of <<Your Agency Name>> w
of matters with you, including the plan of care, diagnosis, medications,
requirements.

Between visits by <<Your Agency Name>> staff, there may be changes
condition that are of concern to you. DO NOT WAIT until the next v
conditions to the staff.

Client Bill of Rights

<<Your Agency Name>> recognizes that the client has the right:

- To competent, professional individualized care without regard to rac
  gender, physical handicap or national origin.
- To have his/her privacy respected and to know all case-related inform
  confidential to the extent permitted by law.
- To a written plan of care designed to meet individual needs.
- To know the names and titles of those individuals responsible for co
  or supervising his/her care.

- To participate in all decisions regarding the plan of treatment and to
or treatment.
- To examine, question, and receive a full explanation of any invoice a
record of his/her care at any time.
- To be fully informed of the policies of <<Your Agency Name>> and th
- To receive care from qualified personnel who are experienced in the
necessary at levels of understanding in their respective field of employ
- To expect recommended services, evaluations and referrals appropria
of his/her diagnosis and rehabilitation plan.
- To contact a designated <<Your Agency Name>> supervisor 24 hours
- To report abusive, neglectful or exploitative practices of health care

What to Expect from Your Care Provider

Personal Attendant Services — Instructions to Worker

PERSONAL ATTENDANT WILL DO THE FOLLOWING:

Bathing

1. Assist in/out of tub/shower
2. Assist on/off tub/shower chair
3. Give complete bed bath
4. Assist with sponge bath (partial or total)
5. Wash private area with warm, sudsy water
6. Wash areas the client cannot reach
7. Rinse and dry skin w
8. Dry well between to
9. Allow client to do as as possible
10. Stay in or near bathr

Dressing

1. Assist with dressing
2. Assist client to dress appropriately, according to the weather and comfort
3. Assist with closure of
4. Match clothes to we
5. Take clothes off han

Grooming

1. Assist with grooming
2. Shave client as requested
3. Apply deodorant, powder as desired
4. Clean dentures daily
5. Assist with mouth c
6. Comb and brush ha
7. Clean nails

Routine Hair/Skin Care

1. Wash and/or dry hair as requested
2. Observe skin for changes, dryness, red areas, tender places, discoloration, swelling, breakdown, open areas/sores and report to supervisor
3. Apply lotion to dry s
4. Dry skin well especi
5. Apply non-med. lotio or desired

Exercise

1. Exercise the client by walking daily
2. Accompany on daily walks (inside or outside)
3. Assist with climbing
4. Reach high shelves c

Feeding

1. Assist the client with feeding (Does not include tube feeding)
2. Encourage client to drink fluids
3. Spoon feed
4. Feed client small prevent choking
5. Orient client on posi utensils on plate

Toileting

1. Assist the client onto and off of commode
2. Cleanse private area and keep skin clean and dry to prevent skin breakdown
3. Assist client into dry clothing
4. Change adult diaper when necessary
5. Wipe and clean well a
6. Empty colostomy ba remove and replace)
7. Empty catheter bags drainage bags

Transfer/Walking

1. Assist with transfer as needed
2. Assist with safe walking as needed
3. Assist into and out of bed or chair
4. Assist with safe transfer into and out of wheelchair locking wheels
5. Position client in bed, turning
6. Use good body mechanics
7. Remove furniture, t passageways clear
8. Remind client to use times when needed
9. Remind client to kee when swollen
10. Assist with braces/p

Cleaning

1. Dust, sweep, vacuum, and mop as needed
2. Clean only area that client occupies
3. Clean bathroom after personal care
4. Wash dishes
5. Take out the trash
6. Make bed daily
7. Change bed linen as
8. Clean and empty bed
9. Throw away spoiled
10. Wipe stove, counter

Laundry

1. Wash client's laundry as needed
2. Dry, fold, and put clothes away
3. Assist client with hand washable clothing

* **Make a note if laundry**
or laundromat
* **If done with family's**
appropriate!

Meal Prep

1. Prepare the meal(s) using freshly prepared, well-balanced foods allowed on client's diet
2. *Low sodium:* Avoid salt, salty foods, cured meats, canned soups, sodas, chips, canned vegetables unless rinsed
3. *Diabetic:* Avoid sugar, sweets and increased carbohydrates
4. *Low fat:* Avoid oils, fried foods, potato chips, peanuts
5. *Low cholesterol:* Avoid dairy products, eggs, organ meats, and shellfish
6. *High-fiber diet:* Bran, breads, cereals, celery, broccoli, spinach, lettuce, beans, corn, nuts
7. *Potassium-rich foods:* juices, bananas, carr spinach, tomatoes
8. *Soft diet:* Chop or st
9. Follow diet as spe
10. Select foods fro so diet is nutriti
11. Prepare enough so it can be accessibl meals
12. Avoid spicy foods
13. Cut up food into sm avoid choking
14. Serve meal where cli

Escort

1. Accompany client to doctor's office as needed
2. Arrange for transportation

3. Accompany on publ
4. Attendant may not t

NOTE: ATTENDANT WILL NOT ABANDON CLIENT WHILE

Shopping

1. Shop for groceries one time a week
2. Store groceries properly
3. Give receipt and change to client

4. Prepare a list and di
5. Pick up medications

Assist with Self Meds*

1. Assist client with bottles, reading labels, and reminding of medicati
2. Retrieve water for client

*NOT APPROPRIATE IF CLIENT NOT ALERT, FORGETFUL/C

Consents and Authorizations

Part of the admissions process consists of you giving <<Your Agency Na
treat you, to release medical information concerning your care to appro
collect payment for services directly from your payor source.

Treatment Authorization: Before we can treat you, we must obtain y
any time, you may refuse any or all treatment. If you refuse any treatme
advised of the possible medical consequences of your actions and we ma
statement indicating that you have been informed of the medical conse
releasing <<Your Agency Name>> from any responsibility.

Release of Information: <<Your Agency Name>> maintains clien
manner. No information will be released without your permission, u
required under applicable state and/or federal law. In order for us to pr
information concerning your care and to communicate with your doctor
agencies involved in your care, we will need your signed authorization to

Authorization for Payment: <<Your Agency Name>> will bill your i
directly for any services that we have provided. This authorization allow
cal records as required by your insurance company and collect payment

Advance Directives: If you have an advance directive you will need to sh
with us so we can follow your wishes to the extent permitted by law. In the
directive that directs us to refrain from performing certain procedures, you
treatment consistent with your plan of care and treatment orders issued by

Non-Covered Services: <<Your Agency Name>> will provide for you
our agency specialities. Arrangements for any services that we cannot p
responsibility or that of your legal representative. We will, however, assi
list of possible resources.

Scheduling Home Care Visits: <<Your Agency Name>> strives to m
a timely manner. However, there may be situations in which this is not
including when a scheduled staff member suddenly becomes ill or sever
road conditions make travel perilous or impossible. When a disruption
is anticipated or recognized, <<Your Agency Name>> will attempt to no
four hours in advance of a scheduled appointment.

Client Responsibilities

<<Your Agency Name>> also recognizes that the client has certain r
These include the following:

- To carry out the plan of care, as instructed, to arrive at the highest le and independence as can be achieved, within the context of the clien
- To treat agency personnel with courtesy, respect and without regard t gender, physical disability or national origin.
- To provide the agency with current, accurate and timely information needs and reimbursement information essential to the provision of situations to report are: hospitalization, emergency room visits, cha and change in health condition.
- To participate to the fullest extent possible in decisions regarding t mentation, and revision of the plan of care.
- To inform the agency on a timely basis of any dissatisfaction or question
- To make prompt payment for agency services in accordance with his sibility or to inform the agency on a timely basis of any difficulty in to request a satisfactory payment schedule.

It is understood and agreed that in instances in which family mem the care, assistance or supervision of the client, they share the resp described above.

Advance Directives

Under state law, you have the right to make decisions concerning your m rights include the right to accept or refuse medical or surgical treatmen formulate advance directives. An advance directive is a written legally b your health care providers, concerning the type of health care that you become incompetent, incapable of communication, or otherwise incapa types of advance directives are 1) Do-Not-Resuscitate Order (DNR Or health care provider to withhold the provision of certain life-sustaining cardiopulmonary resuscitation (CPR); 2) the Medical Power of Attorne Durable Power of Attorney for Health Care, under which you appoint serve as your agent for making health care decisions on your behalf sho incapacitated; and 3) Living Will, which provides instruction on admi or withdrawing life-sustaining treatment in the event of a terminal or i

<<Your Agency Name>> will strive to comply with the requirements of
advance directives. Furthermore, if you have an advance directive, our
physician to coordinate the physician's orders with any advance directive
Patient Rights Under OBRA 1987 OBRA 1990 form to be executed by
patient's duly appointed representative. With respect to medical powers
bill for services provided pursuant to your agent's instructions just as if
sions were made directly by you.

<<Your Agency Name>> will not recognize an advance directive unless
law. Prior to commencing service, a <<Your Agency Name>> staff mem
have prepared an advance directive, and if you have, we will need to ob
advance directive if you wish us to follow that directive. Our staff will
medical record whether or not an advance directive has been executed
obligated to comply with an advance directive unless we have kno
Similarly, if you revoke an advance directive, you must communicat
to us so that we may make the appropriate adjustments in our servic

Even if you provide us with a copy of your advance directive, there may
extent to which <<Your Agency Name>> can and will act in accordance
directive. Certain limitations are imposed by law. However, <<Your Ag
may also limit our ability to comply with an advance directive. If <<You
policies preclude our compliance with your advance directive, we will
legally authorized representative and will take reasonable steps to arran
transferred to another facility if necessary. Similarly, if we find that we
the instructions given by your agent designated under a Medical Power
notify the agent so that appropriate arrangements can be made.

<<Your Agency Name>> will not condition the provision of care or othe
against you based on whether or not you have executed an advance dire
refuse health care or other services to you or charge you a different rate
because you have executed an advance directive.

Policies and Procedures Concerning Do-Not-Resuscitate Orders

The agency will comply with state law whether statutory or as recognized by the courts respecting out-of-hospital do-not-resuscitate orders (DNR Orders).

1. A DNR Order must be on the standard form specified by your State Department of Health. The form must be completed entirely. Only a competent person or a person diagnosed by a physician as having a terminal condition may execute a DNR Order. The DNR Order must be signed by the attending physician. The declarant signs the Order in the presence of two witnesses and the witnesses must sign the Order.
2. The desire of a competent patient, including a competent minor, supersedes a DNR Order.
3. The agency will honor a DNR Order by withholding life-sustaining functions if the agency has an actual written copy of the DNR Order signed by the physician.
4. The agency will not withhold life-sustaining functions if the person is pregnant.
5. The existence of a DNR Order shall be noted in the medical records.
6. If doubt exists as to the existence, validity or interpretation of a DNR Order, agency personnel should contact the appropriate physician. If at such time there is need of life-sustaining procedures, such life-sustaining procedures shall be provided according to the policies of the agency. If there are any indications of suspicious circumstances, the provider shall begin resuscitation efforts unless the physician directs otherwise.

Statement of Client Privacy Rights

DISCLAIMER: Some services may be reimbursed by Medicare or Me
eligibility. Patient Privacy Rights shall apply regardless of payment sou

Home Care Agency Outcome Studies

STATEMENT OF CLIENT PRIVACY RI
As a home care patient, you have the privacy righ

- **You have the right to know why we need to ask you questions.**
  We are required by law to collect health information to make sur
  1) you get quality health care, and
  2) payment for Medicare and Medicaid patients is correct.
- **You have the right to have your personal health care informa**
  You may be asked to tell us information about yourself so that we will
  care services will be best for you. We keep anything we learn about yo
  means, only those who are legally authorized to know, or who have
  know, will see your personal health information.
- **You have the right to refuse to answer questions.**
  We may need your help in collecting your health information. If you c
  we will fill in the information as best we can. You do not have to answ
  get services.
- **You have the right to look at your personal health information.**
  - ➤ We know how important it is that the information we collect abo
    If you think we made a mistake, ask us to correct it.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATI
MAY BE USED AND DISCLOSED AND HOW YOU CA
TO THIS INFORMATION. PLEASE REVIEW IT CA

<<Your Agency Name>> is providing this Notice of Privacy Practices be
your health information is very important to you and to us, and in com
regulations.

By "your health information" we mean the information that we ma cally identifies you and your health status.

Summary

This Notice describes how we use your health information within <<Yo and disclose it outside <<Your Agency Name>>, and why.

The Notice covers:

- Uses or disclosures which do not require your written authorization.
  - Treatment, payment, and health care operations.
  - Uses or disclosures of your health information to which you may
  - Uses or disclosures required or permitted by law.
- Uses or disclosures which require your written authorization.
- Your rights as a client regarding privacy of your health information.
- Our duties in protecting your health information.
- Complaints, contact person, effective date, and acknowledgement.

Uses or Disclosures Which Do Not Require Your Written Autho Treatment, Payment and Health Care Operations

We use or disclose your health information to carry out your treatment; payment for your treatment; and to conduct health care operations.

- For treatment, we use your health information to plan, coordinate, a We disclose your health information for treatment purposes to physi care professionals outside our agency who are involved in your care.
- For payment, we use your health information to prepare documenta insurance company or HMO or by Medicare or Medicaid. We disclo health information that these organizations require in order to pay u
- For health care operations, we use or disclose your health information, fo the quality of our services, to plan better ways of treating patients, and performance, and to our business associates for health care operations
- To confirm our visits to your home or other appointments.
- For treatment, we may leave your care plan and small portions of you for use by our staff in providing treatment to you.

Uses or Disclosures of Your Health Information to Which You M

We may use or disclose your health information for the following purp
us not to.

- **Informing family and friends.** We may disclose your health informa
  or others identified by you who are involved in your care.
- **Assistance in disaster relief efforts.**
- **Informing you about treatment alternatives** or other health-related b
  that may be of interest to you.

If you object to our use of your health information for any of these purp
<<Your Agency Name>>'s administrator or privacy officer (contact inf
of this booklet).

Uses or Disclosures Required or Permitted By Law

Where we are required or permitted by law to do so, we may use or disc
information in the following circumstances without your written author

- Federal government investigation, when required by the Secretary of
  Services to investigate or determine our compliance with federal regu
  privacy of health information.
- Federal, state or local law requirements.
- Public health activities, for example to report communicable diseases
  matters involving the Food and Drug Administration.
- Reporting of abuse, neglect or domestic violence.
- Health oversight activities by a health oversight agency. (A health ove
  organization authorized by the government to oversee eligibility and
  enforce civil rights laws.)
- Judicial or administrative proceedings, for example responding to a co
- Law enforcement purposes, for example to report certain types of wo
  cal injuries or to identify or locate a suspect, fugitive, material witne
- Use by coroners, medical examiners, or funeral directors.
- Facilitating organ, eye, or tissue donation.
- Research, provided that very strict controls are enforced.
- Averting a serious threat to your health or safety or that of the public
- Specialized government functions such as military or veterans' affair
  and intelligence activities.
- Workers' compensation.

Uses or Disclosures Which Require Your Written Authorization

Your written authorization, which you may revoke (in writing), is requi
close your health information for any other purpose, in particular:

- Marketing of goods or services to you.

If you revoke an authorization, the revocation is only effective for uses a
the date you revoke in writing.

Your Rights as a Client to Privacy of Your Health Information

- **Right to Request Restrictions**
  You have the right to request restrictions on our uses and disclosure
  mation; however, we may refuse to accept the restriction.
- **Right to Request Confidential Communications**
  You have the right to request that we communicate with you confi
  speak with you only in private; to send mail to an address you desig
  you at a number you designate. Your request must be in writing. We
  attempt to honor your request, if it is reasonable.
- **Right to Request Access to Your Health Information**
  You have the right to request access to your health information in ord
  it. Your request must be in writing. We may deny your request and, if
  entitled to request a review of the denial. However, we will make eve
  your request.
- **Right to Request an Amendment of Your Health Information**
  You have the right to request an amendment to your health informat
  must be in writing and must provide a reason for the amendment. W
  request and, if so, you may submit a statement of disagreement. How
  every attempt to honor your request.
- **Right to Request an Accounting of Disclosures of Your Health In**
  You have the right to request an accounting of our disclosures of you
  There are certain disclosures that we are not required to include in an a
  ple, disclosures made to you about your own health information, disclo
  authorization, and disclosures for treatment, payment, and health care
  make every attempt to honor your request.
- **Right to Obtain a Paper Copy of this Notice**
  If you received this Notice electronically, you have the right to receiv
  To exercise any of these rights please write or telephone the agency's
  privacy officer.

Our Duties in Protecting Your Health Information

- We are required by law to maintain the privacy of your health inform
- We must inform patients or their legal representatives of our legal du practices with respect to health information. This Notice discharges
- We must abide by the terms of the Notice currently in effect.
- We reserve the right to change the terms of this Notice and to make provisions effective for all health information that we maintain. At a obtain a copy of the current notice from the agency's administrator o

Complaints, Contact Person, Effective Date, and Acknowledge

- We do not have a rigid set of requirements for you to file a compla ask that you provide us with the necessary information to pro on your concerns/complaint, so that we may be able to address it effective manner.
- You may complain to us and to the Secretary of Health and Human your privacy rights have been violated.
- You will not be retaliated against for filing a complaint.
- For further information you may write or call the agency's adminis
- You may file a complaint with the Secretary of Health and Human U.S. Department of Health and Human Services
  200 Independence Avenue, S.W.
  Washington, DC 20201
  1-877-696-6775

Consumer Concerns and Complaint Procedur

Complaint Investigation by the Company

At the time of admission, <<Your Agency Name>> will provide each pe home care or personal assistance services with a written statement that a complaint against <<Your Agency Name>> may be directed to your l administrator.

Any complaints regarding privacy issues or disclosures are addressed in Name>>'s Privacy Policies.

The Agency will investigate complaints made by a client or the client's f
the client's health care provider regarding treatment or care that is (or fa
regarding the lack of respect for the client's property by anyone furnishi
of the agency. Complaints received by the Center will be recorded and
are received. Investigation will be initiated within 10 calendar days of r
within 30 days. The investigation and resolution will be documented in
taken. The documentation will be maintained by the Center. When re
associated investigation, and resolution will be sent to the appropriate s
ment within 30 days of the receipt of the complaint, unless the agency
reasonable cause for delay.

The Agency may not retaliate against a person for filing a complaint,
or providing in good faith information relating to home care or perso
provided by the agency.

The Agency is not prohibited from terminating an employee for a reas

Reportable Conduct: Abuse and Neglect

Any staff member suspecting that a client is being abused, neglected, ex
any way must immediately report the specifics to the supervisor. The su
cise good judgment in verifying the details. In all cases, if the suspicion
within 24 hours the appropriate state agency is to be notified.

Abuse is defined as the negligent or willful infliction of injury, unreasona
intimidation, or cruel punishment with resulting physical or emotional h
elderly or disabled person by the person's caretaker, family member, or o
has an ongoing relationship with the person.

Sexual abuse of an elderly or disabled person includes any involuntary or
sexual contact, committed by the person's caretaker, family member, or
has an ongoing relationship with the person.

Exploitation means the illegal or improper act or process of a caretaker,
other individual who has an ongoing relationship with the elderly or di
the resources of an elderly or disabled person for monetary or personal b
without the informed consent of the elderly or disabled person.

Neglect means the failure to provide for one's self the goods or services,
services, which are necessary to avoid physical or emotional harm or pa
caretaker to provide such goods or services.

Reportable conduct includes:

- Abuse or neglect that causes or may cause death or harm to an indiv
  pany services;
- Sexual abuse of an individual receiving company services;
- Financial exploitation to an individual receiving company services; a
- Emotional, verbal, or psychological abuse that causes harm to an indivi

**A commitment to excellence, quality outcomes, and integrity
commitment to compliance…**

**If you have knowledge of or suspect employee misconduct and
code of conduct, the law, or the company compliance plan, plea
concerns to the administrator of this office.**

Telephone: <<555–555–1212>>

Website: <<www.yourwebsite.com>>

YOUR COMMENTS ARE COMPLETELY ANONYMOUS.

Client Rights Regardless of Age

The client has the right to exercise his or her rights as a client of the Hom

(1) Notice of rights.

(a) The HCA must provide the client with a written notice of the cl
advance of furnishing care to the patient or during the initial ev
the initiation of treatment.

(b) The HCA must maintain documentation showing that it has co
requirements of this section.

(c) Your family or guardian may exercise your rights if you have be
incompetent.

(d) The client's family or guardian may exercise the client's rights wh
been judged incompetent.

(e) You have the right to have your property treated with respect.

(f) The client has the right to have his or her property treated with

(g) You have the right to voice grievances regarding treatment or ca
be) furnished, or regarding the lack of respect for property by a

furnishing services on behalf of this agency and must not be sub
tion or reprisal for doing so. The patient has the right to voice g
treatment or care that is (or fails to be) furnished, or regarding
property by anyone who is furnishing services on behalf of the
and must not be subjected to discrimination or reprisal for doing

(h) You have the right to be informed in advance about the care to be
changes in the care to be furnished. The client has the right to be
about the care to be furnished, and of any changes in the care to

(i) You have the right to participate in the planning of the care and
the care or treatment.

(j) You have the right to confidentiality of your clinical records
agency. Information from your clinical records will not be
unless required by law. The patient has the right to confi
records maintained by the Home Care Agency.

(1) The right to be informed that outcome studies information
the purpose of collection;

(2) The right to have the information kept confidential and se

(3) The right to be informed that outcome studies information
except for legitimate purposes allowed by the Federal Privac

(4) The right to refuse to answer questions; and

(5) The right to see; review; and request changes on their assess

(2) You have the right to be informed before care is initiated both orally
(a) The extent to which payment may be expected from Medicare,
other federally funded program or private insurance known to
to which payment may be expected from Medicare, Medicaid, e
funded or aided program known to the Home Care Agency.

(b) The charges for services that will not be covered by Medicare or
The charges for services that will not be covered by Medicare.

(3) You have the right to be informed orally and in writing of any know
charges as soon as possible, but no later than 30 working days from
becomes aware of the change. The client has the right to be advised
of any changes in the information provided in accordance with par
section when they occur.

(4) You have the right to lodge complaints against this agency. The Ho
investigate complaints made by a client or the client's family or gu
treatment or care that is (or fails to be) furnished, or regarding the
client's property by anyone furnishing services on behalf of the Ho
must document both the existence of the complaint and the resolu

Services We Offer

Our services may include but are not limited to:

Personal Care

- Bathing
- Skin care and make-up
- Continence care
- Dressing and grooming
- Personal hygiene
- Oral hygiene
- Shampoo, comb, and brush hair
- Encourage proper nutrition
- Assistance with toileting

Companionship

- Attend social events
- Go shopping and run errands
- Write correspondence and record memoirs
- Provide prompts and reminders
- Incidental transportation

Homemaking

- Plan, prepare, and serve nutritious meals
- Wash dishes and organize the kitchen

Safety

Most accidents in the home can be prevented by the elimination of haz
attached checklists to determine the safety level of your home. Check e
applies to your home or to your habits in your home. Then review the
determine what else you can do to make your home a safer place to live

Agreement for the Provision of Home Care Services

Your Logo Here!

Client's Last Name _____ First Name _____ M.I. _____

Person Who is Financially Responsible If Not The Client _____ Relationship of Person _____ Phone _____

By signing this agreement, I, the undersigned agree to the following regarding any and all services provided to me by _____,

which shall be known as THIS COMPANY in this agreement, which COMPANY is located at _____.

I understand that a properly signed reproduction of this agreement shall be as valid and binding on the parties as the original.

AGREEMENT FOR THE PROVISION OF HOME CARE SERVICES

I agree and fully understand that I will be charged for all services rendered to me at the prevailing rate for said services.

Today, the rate for the following services is:_____ SERVICE:_____

Today, the rate for the following services is:_____ SERVICE:_____

Today, the rate for the following services is:_____ SERVICE:_____

Pursuant to Federal law, THIS COMPANY is required to and will pay its employees overtime for hours worked in excess of forty hours per week and in some states the law also requires that employees be paid overtime for any hours worked in excess of eight hours per pay. I understand and agree that for the holidays of New Year's Eve, New Year's Day, Easter, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, Christmas Eve, Christmas Day and _____,
I will be billed for overtime at the rate of time and a half for each employee working on those days.

I understand and agree that If an employee uses his or her personal vehicle on my behalf to either transport me or run errands for me, I understand and agree that I will be charged at the rate of _____ per mile. However, I understand and agree that mileage rates are subject to change at any time and that I may obtain updated rates by contacting THIS COMPANY. I understand and agree that in order to cancel any scheduled service that has not been performed, except in the case of emergency which is to be determined solely by THIS COMPANY, I must give at least five (5) hours notice to cancel the scheduled services without being billed. If an employee of THIS COMPANY arrives and is not needed and I have not notified THIS COMPANY, I understand and agree that I will be billed for five (5) hours of service.

I understand and agree that THIS COMPANY cannot guarantee that my services will not be interrupted due to emergencies or other factors beyond the control of THIS COMPANY. If THIS COMPANY cannot provide a service, I understand that I must make other provisions for that service such as from a family member or friend.

FINANCIAL RESPONSIBILITY FOR PAYMENT. I understand and agree that my signature on this agreement means that I am solely responsible for payment for any and all services rendered by THIS COMPANY and that my responsibility includes any amount that is not paid by my insurance, if insurance is applicable. If it becomes necessary to enforce payment of this account I understand and agree to pay all costs reasonably associated with the collection, including late fees, interest, and reasonable attorney fees incident to enforcing this agreement. Strictly as a service to me, THIS COMPANY will submit insurance claims but such submission does not relieve me of my financial responsibility.

ASSIGNMENT OF BENEFITS. I, _____ (name of insured), insured by _____,
understands and agrees that I am hereby assigning to THIS COMPANY any and all benefits due to me and otherwise payable to me for any and all services rendered by THIS COMPANY on my behalf and that release of my records may be necessary to act on this request. I understand and agree that this assignment applies only to eligible charges submitted by THIS COMPANY and that I am financially responsible to pay any charge not paid for by my insurer.

VERIFICATION OF SERVICE. For the purpose of preparing bills and ensuring service, I understand and agree that each employee who renders service will request my signature on a time sheet which will specify the days or hours that the employee provided services to me. I agree to review and sign the time sheets when they are submitted to me and retain the client copy for my records. I agree and understand that by signing below, I am authorizing a waiver of my signature should I become unable to sign the time sheet.

I understand and agree that I will receive an invoice for the amount owed THIS COMPANY and that the payment of the amount owed is due upon receipt of the invoice. I understand and agree there is a delinquency charge of _____% on any unpaid balance of the amount owed not paid within _ days of receipt of the invoice. I agree and understand that the employees are paid by THIS COMPANY and I should not pay them directly or make loan, gift or money advice of any kind to them.

EMPLOYEE NON-COMPETE WITH CLIENT. I agree and understand that I am prohibited from employing any employee of THIS COMPANY for a no less than a period of _____ following the last day the employee rendered any service to me. I understand and agree that if I violate this condition, I will pay THIS COMPANY_____ in liquidated damages.

Client Signature _____ Address _____

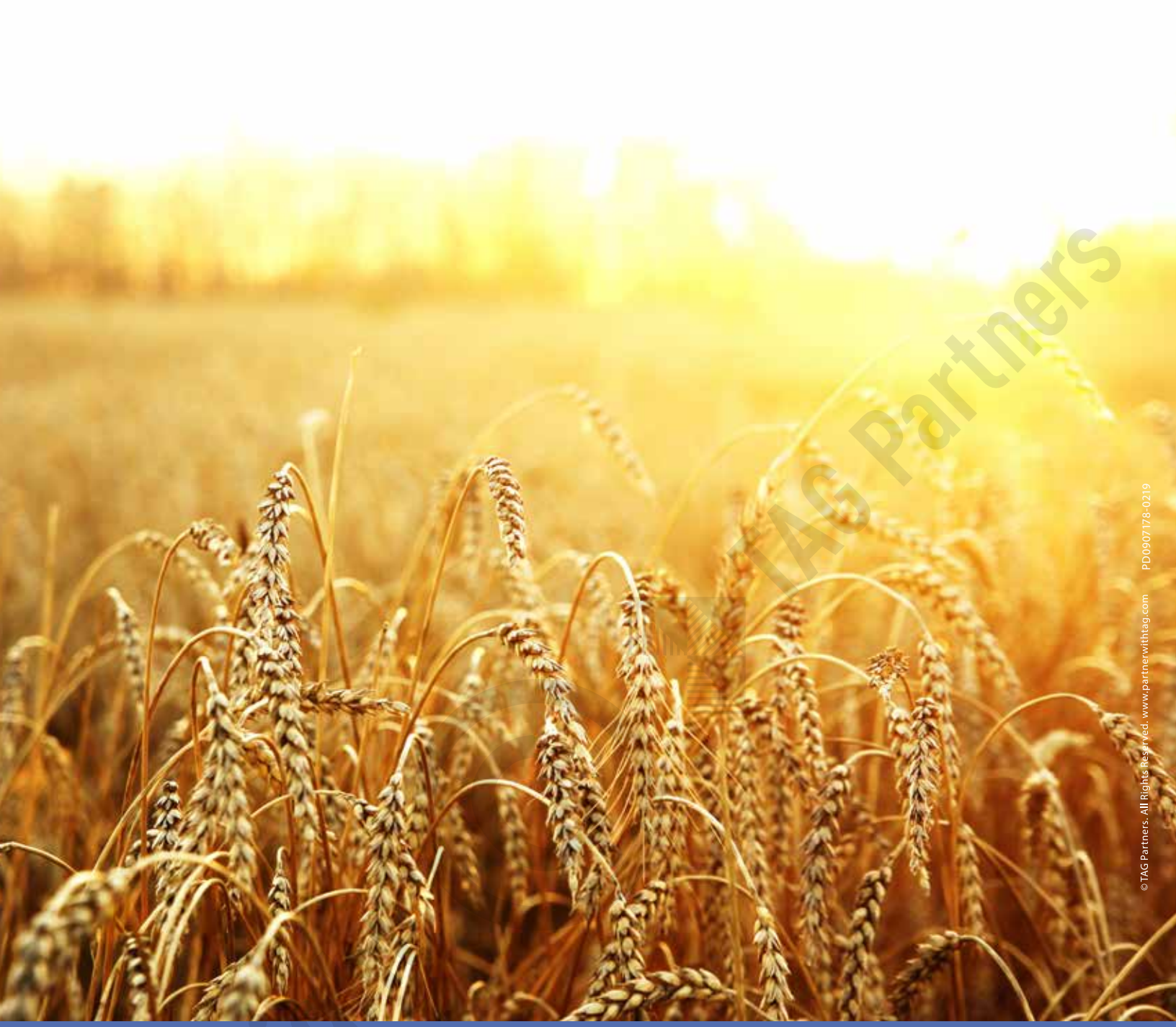
Financially Responsible Party and/or Insured Party Signature if Other Than Client _____ Address _____

Company Representative Signature_____

WHITE — CLIENT FILE YELLOW — CLIENT

FOR REVIEW ONLY (THIS TEXT AND BACKGROUND WILL NOT PRINT)

Back of NCR Form



Your Logo Here!

1234 Any Street
Anywhere, US 55555

Tel: 555–555–1212
Fax: 555–555–1212

www.yourwebsite.com