Admission Packet

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My initials above indicated that I have received the information listed.

Signature: _____ Date: _____

Welcome Letter and Hours of Operation

Thank you for your interest in Care Help Homecare. We are a premier provider of quality homecare services in Montgomery, AL. We are the answer to helping seniors with their needs, whether the services are for you or a loved one. Care Help Homecare offers a variety of services which include: patient care services, homemaker services, and respite care to family caregivers.

Our philosophy and mission are driven by our passion to help seniors extend and enhance living at their chosen place of residence, by providing a safe and comfortable alternative without the stress of interrupting routines and changes in daily habits. While Care Help Homecare cannot replace the love and support of an elderly person's family, our caregivers are dedicated to providing helpful and necessary services needed to brighten the day, lighten the workload, and ensure peace of mind.

Care Help Homecare, LLC is located at:

4758 Woodmere Blvd. Suite B
Montgomery, Alabama 36106

Hours of Operation: 8:00 am to 5:00 pm Monday thru Friday.
A member of our nursing staff is available 7 days a week via telephone at 334-676-1400

Admission Criteria

Admission to Care Help Homecare, LLC can only be made under the direction of a physician based on your health care needs and homebound status.

Care Help Homecare, LLC will provide a service or a combination of services in your home under the direction of your physician. Our services include the following:

- ♥ Skilled Nursing
- ♥ Home Health Aide

Patient and family participation is very important when we plan and coordinate for your health care. There must be a willing and able patient or caregiver to be responsible for continual care between visits. Qualified medical personnel will visit and assess your needs; together we will discuss the services and the plan that would best benefit you.

We accept payment for services from Private Pay, Insurance, Workers Compensation, or other means determined appropriate by the Administrator. Some insurers may require Pre-Certification and may limit the number and type of home visits we can provide.

This agency does not provide the following services:

- Insert your restrictions here (such as no IV therapy, no dialysis patients, etc.)

Your Rights & Responsibilities as a Health Care Patient

As a home care provider, we have an obligation to protect the rights of our patients and explain these rights to you before treatment begins. Your family or your designee may exercise these rights for you in the event that you are not competent or able to exercise them for yourself.

As a client you have the right to:

1. Competent, individualized health care without regard to race, color, creed, sex, age, national origin, handicap, ethical/political beliefs, ancestry, religion or sexual orientation or whether or not an advance directive has been executed.
2. Receive appropriate care without discrimination in accordance with physician orders.
3. Exercise your rights, a client of this agency or, if appropriate, the client representative with legal authority to make health care decisions has the right to exercise your rights.
4. Be treated with consideration, respect, and full recognition of the client's human dignity and individuality, including privacy in treatment and care for personal needs.
5. Receive treatment, care, and services that are adequate, appropriate, and in compliance with relevant State, local, and federal laws and regulations.
6. Participate, either yourself or your designated representative, in the consideration of ethical issues that arise in your care.
7. Have your property treated with respect.
8. Be free from mental, verbal, sexual, and physical abuse, neglect, involuntary seclusion, and exploitation including humiliation, intimidation or punishment.
9. Be admitted for service only if the agency has the ability to provide safe, professional care at the level of intensity needed.
10. Expect all personnel caring for you will be current in knowledge, duly licensed or certified as applicable and have completed a training –program or competency evaluation regarding his/her respective areas of employment.
11. Be informed that you may participate in the development of the client's care plan and medical treatment, the periodic review and update, discharge plans, appropriate instruction and education in the plan of care and be informed of all treatments the agency is to provide, the disciplines to prove care and the frequency of visits/shifts to be furnished and to be advised of any change in the plan of care before the change is made.
12. Know when and how each service will be provided and coordinated, the agency ownership, name and functions of any person and affiliated agency personnel providing care and services.
13. Choose care providers, to communicate with those providers and to reasonable continuity of care.
14. Be fully informed, orally and in writing, at the time of admission and in advance of care provided, a statement of services available by the agency, care and treatment provided by

the agency and related charges. This must include those items and services for which you may be responsible for reimbursement. The agency will advise you of changes orally and in writing as soon as possible, but no later than five (5) calendar days from the date that the agency becomes aware of a change.

15. Be informed of any financial benefits.

Your Rights & Responsibilities as a Health Care Patient

16. Be informed about the nature and/or purpose of any technical procedure that will be performed including information about both the potential benefits and burdens to him/her, as well as, who will perform the procedure.
17. Be taught and have your family members taught the treatment plan, so that you can, to the extent possible, assist yourself and your family or other designated party can also understand and assist you.
18. Request information regarding the diagnosis, prognosis and treatments including alternatives to care risk(s) involved. This information will be given in a language or format so that you and your family members can readily interpret and understand so that informed consent may be given.
19. Refuse treatment after the possible consequences of refusing treatment have been fully explained.
20. The agency shall allow a client, or client representative with legal authority to make health care decisions, to accept or reject, at the client's or client representative's discretion without fear of retaliation from the agency, any employee, independent contractor, or contractual employee that is referred by the agency
21. A cognitively capable adult client or a client representative with legal authority to make health care decisions, to refuse any portion of planned treatment or other portions of the treatment plan, except where medical contraindications to partial treatment exist.
22. A cognitively capable adult client to have an individual who is not certified to provide assistance with activities of daily living and treatments of a routine nature if the client signs a waiver of skilled services detailing the potential risks and benefits of waiver.
23. Review all of your health records during normal business hours.
24. Assistance in the locating appropriate community resources before you run out of funds. However, in keeping with proper fiscal responsibility, uncompensated care may not be provided.
25. Be informed of anticipated outcomes of care/services and of any barriers in outcome achievement.
26. Privacy including confidentiality of all record communications, personal information and to transfer to a health care facility, as required by law or third party contracts. You shall be informed of the policy and procedure regarding disclosure of your clinical records.
27. Receive the care necessary to assist you in attaining optimal levels of health, and if necessary, cope with death. To know that a patient / client does not receive experimental treatment or participate in research unless he / she gives documented voluntary informed consent.

28. Provide information to a client about advance directives and the right to have an advance directive and this agency request information regarding the client's advance directives to determine whether the advance directive information has an impact on care provided.

Your Rights & Responsibilities as a Health Care Patient

29. Be informed in writing of policies and procedures for implementing advance directives, including any limitations if the provider cannot implement an advance directive on the basis of such as living wills or the designation of a surrogate decision-maker, are respected to the extent provided by law.
30. Know that Do – Not – Resuscitate orders shall not constitute a directive to withhold or withdraw medical treatment other than CPR. Withdrawal of life sustaining treatment is done only after the physician has ordered it and the family / significant other is notified.
31. Be informed of the procedures for submitting client complaints with respect to client care, that is, or fails to be furnished or regarding the lack of respect for property by anyone who is furnishing services on behalf of the agency with suggested changes in services without coercion, discrimination, reprisal or unreasonable interruption of services.
32. Choose a health care provider, including choosing an attending physician
33. The consumer or authorized representative has the right to be informed of the consumer's rights through an effective means of communication.
34. The client has the right to be informed about the individuals providing his or her care The client has the right to be informed of the full name, licensure status, staff position and employer of all persons with whom the consumer has contact and who is supplying, staffing or supervising care or services. The client has the right to be served by agency staff that is properly trained and competent to perform their duties. Be able to identify visiting staff through proper identification.
35. The telephone number where a client or the client representative can contact the agency 24 hours a day, 7 days a week regarding care is 334-676-1400.
36. This agency shall disclose of any sub contractual relationship with any individual or agency to be assigned or referred to provide care to the client.
37. Live free from involuntary confinement, and to be free from physical or chemical restraints.
38. Be provided with updates and state amendments on individual rights to make decisions concerning medical care within 90 days from the effective date of changes to state law.
39. Receive information about the care/services.
40. A patient has the right to receive information about the scope of services that the organization will provide and specific limitations on those services.
41. Be informed of the procedure for submitting a written complaint / grievance to the home health agency. All complaints / grievances may be given to any agency member. If not satisfied with the response or any step in chain of command, continue to the next person. Contact, Care Help Homecare, LLC and speak to the following:
    1. Case Manager
    2. Director of Nurses
    3. Administrator

Your Rights & Responsibilities as a Health Care Patient

42. Receive a prompt response, through an established complaint or grievance procedure, to any complaints, suggestions, or grievances the participant may have. Administrator or designee documents and investigates the grievance/complaint within 10 calendar days of receipt of the complaint. The Administrator or designee must complete the investigation and documentation within 30 calendar days after the Agency receives the complaint unless the Agency has and documents reasonable cause for delay. You may appeal the administrator findings to the Governing Board by submitting a written complaint to:

    Attention Governing Body
    Care Help Homecare, LLC
    3086 Woodley Road Suite D
    Montgomery, AL 36116

43. Be informed of your state's home health agency hotline and the agencies contact information make suggestions or complaints, or present grievances on behalf of the client to the agency, government agencies, or other persons without the threat or fear of retaliation.

Accreditation Commission for Health Care, Inc. 4700 Falls of Neuse Rd., Suite 280 Raleigh, NC 27609 E-mail: customerservice@achc.org Phone: (919) 785-1214 Fax: (919) 785-3011	Care Help Homecare, LLC 3086 Woodley Road Suite D Montgomery, AL 36116 334-676-1400

Your Rights & Responsibilities as a Health Care Patient

Patient Responsibilities:

- To ask questions of the staff about anything they do not understand concerning their treatment or services provided.
- To provide complete and accurate information concerning their present health, medication, allergies, etc.
- To inform staff of their health history, including past hospitalization, illnesses, injuries.
- To involve themselves and/or Caregiver, as needed and as able, in developing, carrying out, and modifying their home care service plan.
- To review the Agency's information on maintaining a safe and accessible home environment in their residence.
- To request additional assistance or information on any phase of their health care plan they do not fully understand.
- To inform the staff when a health condition or medication change has occurred.
- To notify the Agency when they will not be home for a scheduled home care visit.
- To notify the Agency prior to changing their place of residence or telephone.
- To notify the Agency when encountering any problem with equipment or services.
- To notify the Agency if they are to be hospitalized or if a physician modifies or ceases their home care prescription.
- To make a conscious effort to comply with all aspects of the plan of care.
- To notify the Agency when payment source changes.
- To notify the Agency of any changes in or the execution of any advanced directives.
- To inform staff of their health history, including past hospitalization, illnesses.

Agency Responsibilities

Before the care is initiated, the agency must inform a patient orally and in writing of the following:

1. The extent to which payment may be expected from third party payers;
2. The charges for services that will not be covered by third party payers;
3. Services to be billed to third party payers;
4. The method of billing and payment for services;
5. The charges that the patient may have to pay;
6. A schedule of fees and charges for services;
7. The nature and frequency of services to be delivered and the purpose of the service;
8. Any anticipated effects of treatment, as applicable;
9. The agency must inform a patient orally and in writing of any changes in these charges as soon as possible, but no later than five (5) days from the date the home health agency provider becomes aware of the change;
10. If an agency is implementing a scheduled rate increase to all clients, the agency shall provide a written notice to each affected consumer at least 30 days before implementation;
11. The requirements of notice for cancellation or reduction in services by the organization and the client; and
12. The refund policies of the organization.
13. The agency shall not assume power of attorney or guardianship over a consumer utilizing the services of the agency, require a consumer to endorse checks over to the agency or require a consumer to execute or assign a loan, advance, financial interest, mortgage or other property in exchange for future services.

Complaints and Grievances

You may report a complaint or grievance at anytime without reprisal or disruption of services.

Any staff member may receive a complaint or grievance about services or care that is or is not furnished or about the lack of respect for the consumer's person or property by anyone furnishing services on behalf of the agency.

Complaints and Grievances Procedure:

1. Patient or patient representative reports a complaint/grievance to any staff member.
2. Staff members receiving complaints or grievances report them to the Administrator or designee.
3. Administrator or designee documents the complaint and investigates the grievance/complaint within 5 business days of receipt of the complaint. The Administrator or designee must complete the investigation and documentation within 30 calendar days after the Agency receives the complaint unless the Agency has and documents reasonable cause for delay.
4. If the Administrator or designee is unable to resolve the complaint/grievance, the Governing Body is notified and takes action toward resolution.
5. Notify the patient when appropriate action has been taken or that the problem has been resolved.
6. Document the action taken and resolution on the Complaint Form.
7. You may appeal the administrator findings to the Governing Body by submitting a written complaint to:

   Attention Governing Body
   Care Help Homecare, LLC
   3086 Woodley Road Suite D
   Montgomery, AL 36116

The patient may contact at anytime without reprisal or disruption in services the:

Accreditation Commission for Health Care, Inc. 4700 Falls of Neuse Rd., Suite 280 Raleigh, NC 27609 E-mail:	Care Help Homecare, LLC 3086 Woodley Road Suite D Montgomery, AL 36116 334-676-1400

customerservice@achc.org Phone: (919) 785-1214 Fax: (919) 785-3011	

HIPAA Notice of Privacy Practices

In compliance with HIPAA - The Health Insurance Portability and Accountability Act of 1996

If you are a client of Care Help Homecare, LLC, this notice describes how your medical information may be used and disclosed and how you can get access to this information. Please review this notice carefully.

I. USES AND DISCLOSURES

The Agency will not disclose your health information without your authorization, except as described in this notice.

Plan of Care/Treatment. The Agency will use your health information for the plan of care/treatment; for example, information obtained by a nurse/therapist will be recorded in your record and used to determine the course of treatment. Your nurse/therapist and other health care professionals will communicate with one another personally and through the case record to coordinate care provided. You may receive more than one service (program) during your treatment period with such information shared between programs.

Payment. The Agency will use your health information for payment for services rendered. For example, the Agency may be required by your health insurer to provide information regarding your health care status so that the insurer will reimburse you or the Agency. The Agency may also need to obtain prior approval from your insurer and may need to explain to the insurer your need for home care and the services that will be provided to you.

Health Care Operations. The Agency will use your health information for health care operations. For example, Agency therapist, nurses, field staff, supervisors and support staff may use information in your case record to assess the care and outcomes of your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of services we provide. Regulatory and accrediting organizations may review your case record to ensure compliance with their requirements.

Notification. In an emergency, the Agency may use or disclose health information to notify or assist in notifying a family member, personal representative or another person responsible for your care, of your location and general condition.

Workers´ Compensation. The Agency may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers´ compensation or other similar programs established by the law.

Public Health. As required by federal and state law, the Agency may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Law Enforcement. As required by federal and state law, the Agency will notify authorities of alleged abuse/neglect; and risk or threat of harm to self or others. We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Charges against the Agency. In the event you should file suit against the Agency, the Agency may disclose health information necessary to defend such action.

HIPAA Notice of Privacy Practices

Duty to Warn. When a client communicates to the Agency a serious threat of physical violence against himself, herself or a reasonably identifiable victim or victims, the Agency will notify either the threatened person(s) and/or law enforcement.

The Agency may also contact you about appointment reminders, treatment alternatives or for public relations activities.

In any other situation, the Agency will request your written authorization before using or disclosing any identifiable health information about you. If you choose to sign such authorization to disclose information, you can revoke that authorization to stop any future uses and disclosures.

II. INDIVIDUAL RIGHTS

You have the following rights with respect to your protected health information:
1. You may request in writing that the Agency not use or disclose your information for treatment, payment or administration purposes or to persons involved in your care except when specifically authorized by you, when required by law, or in emergency situations. The Agency will consider your request; however, the Agency is not legally required to accept it. You have the right to request that your health information be communicated to you in a confidential manner such as sending mail to an address other than your home. Patients may request a copy of their electronic medical record in an electronic form. The Agency will charge you a reasonable amount, as allowed by statute for providing a copy of the electronic medical record.

2. Within the limits of the statutes and regulations, you have the right to inspect and copy your protected health information. If you request copies, the Agency will charge you a reasonable amount, as allowed by statute.

3. If you believe that information in your record is incorrect or if important information is missing, you have the right to submit a request to the Agency to amend your protected health information by correcting the existing information or adding the missing information.

4. You have the right to receive an accounting of disclosures of your protected health information made by the Agency for certain reasons, including reason related to public purposes authorized by law and certain research. The request for an accounting must be made in writing to Privacy Officer. The request should specify the time period for the accounting starting on or after April 14, 2003. Accounting request may not be made for periods of time in excess of six (6) years. The

Agency would provide the first accounting you request during any 12-month period without charge. Subsequent accounting request may be subject to a reasonable cost based fee.

5. If this notice was sent to you electronically, you may obtain a paper copy of the notice upon request to the Agency.

6. When patients pay by cash they can instruct this agency not to share information about their treatment with their health plan/ insurance provider.

7. This agency will not disclose genetic information.

8. This agency will not use patient information for the purpose of fundraising or marketing. This agency will not sale patient health information.

III. AGENCY´S DUTIES

1. The Agency is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices with respect to protected health information.

2. The Agency is required to abide by the terms of this Notice of its duties and privacy practices. The Agency is required to abide by the terms of this Notice as may be amended from time to time.

3. The Agency reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all protected health information that it maintains. Prior to making any significant changes in our policies, Agency will change its Notice and provide you with a copy. You can also request a copy of our Notice at any time. For more information about our privacy practices, please contact the office 334-676-1400.

4. It is the duty of this agency to notify the patient of a breach of their protected health information. This agency will notify the patient within 15 business days of discovery of any breach in the patients protected health information. Notification will occur regardless of whether the breach was accidental or if a business associate was the cause. A “breach” of PHI is any unauthorized access, use or disclosure of unsecured PHI, unless a risk assessment is performed that indicates there is a low probability that the PHI has been compromised. The risk assessment must be performed after both improper uses and disclosures, and include the nature and extent of

the PHI involved, a list of unauthorized persons who used or received the PHI, if the PHI was in fact acquired or viewed, and the degree of mitigation. This agency and if any business associate was involved must consider all the following factors in assessing the probability of a breach:

- the nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification;
- the unauthorized person who used the protected health information or to whom the disclosure was made;
- whether the protected health information was actually acquired or viewed; and
- the extent to which the risk to the protected health information has been mitigated.

"Unsecured" protected health information means protected health information that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology.

5. If the breach is determined to have no or low probability of risk to the patient then the patient will not be notified. Any other risk factor requires the agency to notify the patient in writing within 15 business days of the conclusion of the determination.

HIPAA Notice of Privacy Practices

IV. COMPLAINTS

If you are concerned that the Agency has violated your privacy rights, or you disagree with a decision the Agency made about access to your records, you may contact the office at 334-676-1400. You may also send a written complaint to the Federal Department of Health and Human Services. The Care Help Homecare, LLC office staff can provide you with the appropriate address upon request. Under no circumstances will you be retaliated against for filing a complaint.

V. CONTACT INFORMATION

The Agency is required by law to protect the privacy of your information, provide this Notice about our information practices, and follow the information practices that are described in this Notice. If you have any questions or complaints, please contact the Agency Administrator

You may contact this person at:

Care Help Homecare, LLC
3086 Woodley Road Suite D
Montgomery, AL 36116
334-676-1400

Medicaid Fraud Reporting

If you have reason to believe that, someone is defrauding the Medicaid program please report to the appropriate agency listed below.

Medicaid	Office of Inspector General Hotline
By Telephone: 1-800-HHS-TIPS (1-800-447-8477) TTY Toll-Free: 1-877-486-2048	By Us Mail: Office of the Inspector General HHS TIPS Hotline P.O. Box 23489 Washington, DC 20026 By Fax: 1-800-223-2164 By email: HHSTips@oig.hhs.gov

Abuse, Neglect, Exploitation Policy & Drug Testing Policy

Agency employees and independent contractors shall report all actual or suspected cases of abuse, neglect or exploitation of a patient/child to an agency supervisor and the appropriate state agency. If agency personnel detect any signs of family violence, the information required by law is give to the victim and suspected family violence is reported to the employee's supervisor.

Abuse means: the negligent or willful inflection of injury, unreasonable confinement, intimidation, or cruel punishment with resulting physical or emotional harm or pain to an elderly or disabled person by the person's caretaker, family member or other individual who has an ongoing relationship with the person; or sexual abuse of an elderly or disabled person, including any involuntary or nonconsensual sexual conduct that would constitute an offense, (indecent exposure, assault offenses), committed by the person's caretaker, family member, or other individual who has an ongoing relationship with the person.

Neglect means: the failure to provide for one's self the goods or services, including medical services which are necessary to avoid physical or emotional harm or pain or the failure of a caretaker to provide such goods or services.

Exploitation means: the illegal or improper act or process of a caretaker, family member, or other individual who has an ongoing relationship with an elderly or disabled person using the resources of such person for monetary or personal benefit, profit, or gain without the informed consent of such person.

Adult Protective Services	Child Protective Services
(205) 324-2135	(205) 324-2135

YOUR RESPONSIBILITY AS A CLIENT

1. Remain under a physician's care while receiving agency services.
2. Provide the agency with a complete and accurate health history.
3. Provide the agency with all requested insurance and financial records.
4. Sign the required consents and releases for insurance billing.
5. Participate in your Plan of Care.
6. Accept the consequences for any refusal of treatment or choice of non-compliance
7. Provide a safe home environment in which your care can be given.
8. Cooperate with your physician, agency staff and other caregivers.
9. Treat agency personnel with respect and consideration.
10. Advise the agency of any problems or dissatisfaction with the care being provided without being subject to discrimination or reprisal.
11. Notify the agency when unable to keep an appointment.

AGENCY'S DRUG TESTING POLICY

Care Help Homecare, LLC is a drug free workplace. The use of drugs or alcohol in the workplace or being under the influence while on duty is prohibited. Drug screening or testing may be requested as a condition of employment, conducted on a random basis, or in the event an associate is involved in a major accident during working hours. Alcohol use or chemical substance abuse during working hours and eight (8) hours prior to reporting for duty is prohibited and is considered grounds for immediate termination of employment. Any associate suspected of impairment or substance abuse is to be relieved of duty immediately. The associate is to undergo drug screening within 2 hours adhering to the appropriate lab protocol. Refusal to consent to drug testing is considered grounds for termination of employment.

Advance Directives

It is your right to decide about the medical care you will receive. You have the right to be informed of treatment options available before giving consent for medical treatment. You also have the right to accept, refuse or discontinue any treatment at any time.

All of us who provide you with health care services are responsible for following your wishes. However, there may be times when you may not be able to decide, or make your wishes known.

Many people want to decide ahead of time what kinds of treatment they want to keep them alive. Advance Directives let you make your wishes for treatment known in advance.

Our agency complies with the Advance Directives Act of 1999 which requires us to:

- Provide you with written information describing your rights to make decisions about your medical care;
- Document advance directives prominently in your medical record and inform all staff;
- Comply with requirements of State law and court decisions with respect to Advance Directives; and
- Provide care to you regardless of whether or not you have executed an Advance Directive.

An Advance Directive is a document written before a disabling illness. The Advance Directive states your choice about treatment and may name someone to make treatment choices if you cannot.

There are generally four types of advance directives.

A Directive to Physician (Living Will) is a legal document that allows you to make your wishes known concerning the provision, withdrawal or withholding of artificial life supporting treatment. This is executed in advance of the time when you may not be able to participate in those decisions due to your medical condition. It only goes into effect when you can no longer make decisions and you are certified in writing by your attending physician as suffering from a terminal or irreversible condition.

A Medical Power of Attorney is a legal document, which allows you to designate a particular person to make decisions regarding your medical care when you are not able to do so. This person should be someone you trust to carry out your wishes. It may also be canceled or changed at any time.

An Out-of-Hospital Do-Not-Resuscitate Order is a document, prepared and signed by your physician, which directs health care professionals acting in an out-of hospital setting, such as your

home, not to initiate or continue a life-sustaining treatment. A diagnosis of a terminal condition is no longer required for the execution of the Out-of-Hospital Do-Not-Resuscitate Order.

Declaration for Mental Health Treatment is a document which allows an adult who is not incapacitated to list instructions for consent to or refusal of mental health treatment. It allows a competent person to proclaim their preference for mental health treatment with psychoactive medications, electroconvulsive or convulsive treatments, or emergency medical care should the person be declared incapacitated.

Effective Period: Properly signed and witnessed, the Directive to Physician, Medical Power of Attorney and/or Out-of-Hospital Do-Not-Resuscitate Order must be properly executed and witnessed by two competent adults.

Advance Directives

At least one of the witnesses must be a person who is not:

1. Designated by the declarant to make a treatment decision;
2. Related to the declarant by blood or marriage;
3. Entitled to any part of the declarant's estate after declarant's death;
4. The attending physician;
5. An employee of the attending physician;
6. An employee of a health care facility in which the declarant is a patient if the employee is: providing direct patient care to the declarant is a patient if the employee is: providing direct patient care to the declarant or is an officer, director, partner or business office employee of the facility or any parent organization of the facility; or
7. Who, at the time the advance directive is executed, has a claim against any part of the declarant's estate after the declarant's death.

The Declaration for Mental Health Treatment must be signed by the person, called the principal, in the presence of two or more subscribing witnesses. A witness may not be, at the time of execution:

1. The principal's health or residential care provider or an employee of that provider;
2. The operator or employee of the operator of a community health care facility providing care to the principal;
3. A person related to the principal by blood, marriage or adoption;
4. A person entitled to any part of the principals estate upon death; or
5. A person who has a claim against the estate of the principal.

If you executed a living will or durable power of attorney for health care before July 1, 1991, you may want to review it, since new laws have gone into effect which gives you more options and information. Even if you decide not to update it, the old documents are still legal.

We must document in your medical record whether or not you have executed an Advance Directive. We will abide by your Advance Directives. Care will be provided to you regardless of whether or not you have executed an Advance Directive. It is our policy to honor Advance Directive to the extent permitted by law and to support your right to actively participate in making health care decisions.

An ethics committee is available to serve in an advisory capacity when ethical issues, such as the withdrawal or withholding of life-sustaining treatments arise during the care of patients with or without an Advance Directive. Discussion shall involve the patient and/or designated representatives, the home care staff involved in the patient's care and the patient's physician.

Unless the physician has written the specific order “Do Not Resuscitate”, it is our policy that every patient will receive cardiopulmonary resuscitation (CPR). If you do not wish to be resuscitated, you, your family, or person(s) holding your Medical Power of Attorney must request “Do Not Resuscitate” (DNR) orders from your physician. These orders are documented in your medical record and routinely reviewed; however, you may revoke your consent to such an order at any time. If CPR is initiated the agency policy is call 911.

Advance Directives

Procedures Agency Is Unable to Honor: The Agency recognizes each individual's right to make decisions concerning his/her care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives as permitted under law. The Agency will honor an individual's Advance Directive with the following exceptions:

1. The Agency will not honor a request to withhold comfort measures and/or pain management medications or treatments.
2. The Agency will not honor an Advance Directive of an individual who has been diagnosed as pregnant.

If other treatment decisions or directives are identified during the course of care that the Agency and/or the individual's physician are unwilling to honor, treatment will be provided until a reasonable opportunity to transfer the individual to another physician, facility, or agency has been afforded.

Infection Control

The following instructions will help control the spread of infection and protect others form illness and/or injury.

Hand washing:

Hand washing is the single most effective technique in the prevention of the spread of disease and infection. Hands should be washed thoroughly with soap and water before and after eating or food preparation, after using the bathroom, before and after performing medical procedures and immediately following contact with blood or other potentially infections materials.

Disposal of Medical Waste:

Used, disposable supplies such as diapers, incontinence pad, non-blood saturated dressings, IV tubing and gloves should be placed in a heavy-duty plastic bag and securely fastened at the top to close. If a heavy-duty bag is not available, the items should be double-bagged and disposed of with the client's regular garbage.

Items heavily contaminated with blood or body fluids contaminated with blood should be placed in a leak-proof heavy duty bag or tied securely at the neck and double-bagged. All bags should be appropriately labeled as biohazardous or color-coded and securely colored prior to removal from the home. The nurse will transport to the office or arrange for pick-up by a biohazardous waste disposal company.

Liquids such as betadine and irrigating solutions may be flushed down the toilet.

Sharp items including hypodermic needles and syringes, scalpel blades, razor blades, disposable razors, lancets, scissors, knives, staples, IV stylets and rigid introducers are placed directly in a hard plastic or metal container with a screw-on or tightly secured lid. The lid should be reinforced with heavy-duty tape prior to discarding in regular trash. Sharps are not to be placed in any container planned for recycling or to be returned to a store. Glass or clear plastic containers are not to be use.

Used needles and syringes should not be recapped, bent or removed from disposable syringes or manipulated by hand.

Sanitation in the Home:

Linens soiled with infectious wastes should be placed directly into the washer and prewashed with cool water and 1 cup bleach.

Dishes should be washed in a dishwasher or soaked and cleaned in hot, soapy water.

Family Disaster Plan

Families should be prepared for all hazards that affect their area and themselves. NOAA's National Weather Service, the Federal Emergency Management Agency, and the American Red Cross urge each family to develop a family disaster plan. Where will your family be when disaster strikes? They could be anywhere-at work, at school, or in the car. How will you find each other? Will you know if your children are safe? Disasters may force you to evacuate your neighborhood or confine you to your home. What would you do if basic services-water, gas, electricity or telephones- were cut off?

Follow these Basic Steps to Develop a Family Disaster Plan

I. Gather information about hazards. Contact your local National Weather Service office, emergency management office or civil defense office, and your local American Red Cross chapter. Find out what type of disasters could occur and how you should respond. Learn your community's warning signals and evacuation plans.

II. Meet with your family to create a plan. Discuss the information you have gathered. Pick two places to meet: (1) a spot right outside your home for an emergency, such as fire, and (2) a place away from your neighborhood in case you can not return home. Choose an out-of-state friend as your "family check-in contact" for everyone to call if the family gets separated. Discuss what you would do if advised to evacuate.

III. Implement your plan. (1) Post emergency telephone numbers by phones; (2) Install safety features in your house, such as smoke detectors and fire extinguishers; (3) Inspect your home for potential hazards, such as items that can move, fall, break, or catch on fire, and correct them; (4) Have your family learn basic safety measures, such as CPR and first aid, how to use a fire extinguisher, and how and when to turn off the water, gas, and electricity in your home; (5) Teach children how and when to call 9-1-1 or your local Emergency Medical Services number; (6) keep enough supplies in you home to meet your needs for at least three days. Assemble a disaster supplies kit with items you may need in case of an evacuation. Store these supplies in sturdy easy-to-carry containers, such as backpacks or duffle bags. Keep important family documents in a waterproof container. Keep a smaller disaster supplies kit in the trunk of your car. A Disaster Supplies Kit should include:

- A three day supply of water (one gallon per person per day) and food that will not spoil
- One change of clothing and footwear per person
- One blanket or sleeping bag per person
- A first-aid kit, including prescription medicines
- Emergency tools, including a battery-powered NOAA Weather radio and a portable radio, flashlight, and plenty of extra batteries

- An extra set of car keys and cash
- Special items for infant, elderly, or disabled family member.

Practice and maintain your plan. Ask questions to make sure your family remembers meeting places, telephone numbers, and safety rules.

IV. Conduct drills. Test your smoke detectors monthly and change the batteries at least once a year. Test and recharge your fire extinguishers(s) according to manufacturer's instructions. Replace stored water and food every six months.

Emergency Telephone Numbers

In case of a medical emergency, you should contact emergency medical services by telephone at:

911

POISON CONTROL

1-800-222-1222

Home Safety Guidelines

* General Information:

- Install proper locks and keep doors locked. Ask visitors to identify themselves before opening the door. Open the door only if you know the person, or if you are expecting that person
- Be cautious with sharp objects
- Mark glass doors and windows with decals

* Medication Safety:

- Keep all medications in original containers and label clearly.
- Write medication schedule and take only as prescribed.
- Be aware of side effects of medications

* Poison Prevention:

- Label all poisons.
- Keep all substances in their original containers.
- Do not mix cleaning products, such as chlorine and ammonia.
- Have syrup or IPECAC on hand.
- Store cleaning agents away from foods and medications.

* Fall Prevention:

- Remove all scatter rugs forever.
- Tack down the edges of all carpets.
- Never leave articles of clothing on the floor.
- Keep boxes out of hallways or stairwells.
- Keep electric cords, telephone cords, newspaper, magazines and other clutter away from walking areas.
- Use handrails that are sturdy and strong.
- Avoid use of extension cords.
- Lift feet when walking
- Wear proper fitting shoes with non-ski soles.
- Do activities and exercises to improve balance and strengthen legs.
- Do not attempt to climb or use ladders.
- Be careful if using tranquilizers.
- Have sufficient lighting throughout house.

* Bathroom:

- Install grab bars or handrails by toilet and tub.
- Place skid-proof floor covers and tub/shower mats in bathroom.
- Install a stable tub/shower seat.

* Kitchen:

- Store commonly used items within easy reach.
- Use a cart to move heavy or awkward objects.
- Avoid the use of floor wax. Use the non-skid type and never walk on wet floors.

Home Safety Guidelines

* Stairs:
  - Install handrails and always use them.
  - Place a strip of bright tape on the top and bottom step on each staircase.
  - Place non-skid threads on steps.

* Bedroom:
  - Use nightlight in hall between bedroom and bathroom.
  - Take your time, get up from bed or chair slowly to avoid dizziness.
  - Sit on the edge of the bed or in a chair when putting on socks, shoes, or slacks.
  - Ensure that side rails are in upright position on hospital beds.

* Living Room:
  - Avoid sharp-cornered furniture.
  - Utilize proper transfer techniques (ex. Chair to bed or toilet).
  - Utilize proper ambulation techniques; use walker, cane or crutch as prescribed.
  - Utilize wheelchair safety:
    Install ramps; 12 foot ramp for 1 foot rise.
    Rearrange furniture placement and always lock wheels.

* Fire Safety:
  - Make an escape plan; then practice it.
  - Keep at least one fire extinguisher; check the charge often.
  - Be aware that nylon catches fire.
  - Do not every smoke in bed!
  - Be very careful with space heaters; do not tip them!
  - Make sure your electrical wiring is not frayed and is free of shorts.
  - Keep electrical appliances away from water and unplug after use.
  - Have smoke detectors properly located; check battery monthly.
  - Store flammables properly.
  - Turn off oven and stove; clearly mark controls on stove.
  - Be cautious around any open flame heater or fireplace.
  - Do not use lighted matches or lighters around any suspected natural gas leaks.

* Burn Prevention:
  - Always check hot water for temperature; label hot and cold faucets.
  - Keep pot handles turned to the back of the stove.

- Keep flammable towels away from the stove.
- Open lids away from you to avoid steam burns.
- Use heating pads with caution:
  - Use only on low (unless Doctor/Nurse states otherwise)
  - Check area frequently for redness
  - Do not apply directly to skin.

Home Safety Guidelines

* Medical Equipment Safety:

- The company that supplies your medical equipment should instruct you in the safe use of each item.
- If you have question or need assistance with any item, please ask your nurse!
- If a piece of equipment breaks or seems not to work correctly, notify the company that brought the item to you immediately!
- Do not use an item unless you are sure it is working properly.
- Never smoke when Oxygen is in use.

* Cold Weather Precautions:

- Avoid icy sidewalks and porch steps.
- Always cover head, hands and feet if you are going out.
- Use warm blankets, clothes and socks.

Plan and Get Ready

Anything. Anytime. Anywhere.

Forget The Wizard of Oz notion that "twisters" only happen in Kansas! Tornadoes have been reported in every state. In addition, while they general occur during spring and summer, they can happen anytime during the year.

With winds, swirling at 200 miles per hour or more, a tornado can destroy just about anything in its path. Generally, weather signs and warnings will alert you to take precautions.

Be prepared by having various family members do each of the items on the checklist below. Then get together to discuss and finalize your Home Tornado Plan.

___ Pick a safety spot in your home where family members could gather during a tornado. (If you have a basement, make it your safety spot.) Make sure there are no windows or glass doors in the area. Keep this place uncluttered.
Basement: ___Yes ___No (If yes, basement is your safety spot.) If No (or you are in a high-rise building), choose another safety spot.
Location of Safety Spot:_____

___ If you live in a mobile home, choose another safety spot in a sturdy, nearby building.
Location of Safety Spot:_____

___ Put together a Tornado Safety Kit in a clearly labeled, easy-to-grab box.
Location of Safety Kit:_____

___ Write instructions on how and when to turn off your utilities-- electricity, gas, and water.
Written Instructions (date):_____

___ Make sure all family members know the name of the county or parish where you live or are traveling since tornado WATCHES AND WARNINGS are issued by county.

Name of County Where You Live:_____

Name of County Where You Are Traveling:_____

And remember… when tornado, earthquake, flood, fire, or other emergency happens in your community, you can count on your local American Red Cross chapter to be there to help you and your family. That has been their role for more than 100 years.

Attention Emergency Information

*Complete this form and **ATTACH IT TO YOUR FRIDGE**. This information could help save your life in an emergency.*

NAME_____

ADDRESS_____

_____

DATE OF BIRTH _____

PHONE NUMBER _____

SEX _____

RELIGION _____ BIRTH PLACE_____

HAIR COLOUR _____ EYE COLOUR _____

ANY DISTINGUISHING FEATURES

_____

_____

_____

DOCTOR'S NAME _____ PHONE NUMBER _____

SPECIAL MEDICAL CONDITIONS/ALLERGIES

_____

_____

_____

IN CASE OF EMERGENCY PLEASE CONTACT:

NAME_____ NAME _____

PHONE _____PHONE _____

ANY ADDITIONAL INFORMATION (INCLUDING PETS REQUIRING CARE)

_____
_____

_____
_____

_____
_____

_____
_____

Please contact Care Help Homecare, LLC as we may be able to provide addition medical information.

Care Help Homecare, LLC
3086 Woodley Road Suite D
334-676-1400

Payment of Services

Medicaid Patients:

Medicaid covers 100% of home health services including nursing, therapy, and home health aide assistance. You should not be responsible for any part of the bill for services.

In the event that we suspect any services or goods will not be covered by Medicaid, we will notify you prior to delivery of said goods and services.

Insurance Patients:

We will bill your insurance company for all services that we provide. We will bill secondary insurance policies as well. Please provide all insurance information to the nurse during the admission process.

The patient/guardian will be responsible for any fees that have not been paid by the patient's insurance company. For example, if your insurance policy covers home health 80%, then you will be billed for the other 20% of services.

Overpayment/Refund:

In the event of overpayment or billing error that results in overcharging the overage in payment will be refund to the payer within 5 business days of detecting the overpayment. An itemized statement will be included with the refund.

Fee Schedule

$18.00-$20.00 per hour; depends on the level of care needed.

Plan of Care Supervision

All services provided to you will be directly supervised by a RN. The RN will monitor your plan care by direct visits or case conferences or both.

If an Employee Fails to Arrive:

Employees are required to notify Director of Nursing and you if they will fail to make their scheduled appointment. Employees are required to make the notification prior to the scheduled arrival time.

If an employee is more than 10 minutes past their scheduled arrival time Care Help Homecare, LLC asks that you please call the office so that we can make sure the employee has not had mechanical issues while in route to your residence or some other sort of event that has prevented them from contacting you and the office.

You can contact the office by calling 334-676-1400 and asking for the Director of Nursing.

If an employee retaliates against you for being reported as late, the employee will be subject to possible termination.

If the employee fails to make the scheduled visit, please notify the agency and the Director of Nursing will attempt to find a replacement for the same day and to arrive as soon as possible. If the Director of Nursing is not able to find a replacement the supervisor will offer to fill the shift personally.

Service Provider Authorization

I hereby consent to admission and to care. I acknowledge and consent to the following:

I understand my care is based on a treatment plan and/or ordered by my physician per agency policy. I have participated in the development of, and am in agreement with, the treatment plan outlined. My treatment plan may change as my care needs change and I will be informed.

I understand that this is the initial plan and I will be notified by the agency each time there are changes made in my plan of care.
I understand that the agency will provide supervision for all services rendered to me.
I understand that I have the right to refuse care or treatment at any time.

I have read, understand and received a copy of:

- Welcome Letter / Hours of Operation
- Client Rights, Responsibilities and Grievance Procedure
- HIPAA Notification of Privacy Rights
- Abuse, Neglect, Exploitation Policy and Drug Testing Policy
- Advance Directive Information
- Infection Control Guidelines and Sharps Disposal
- Emergency Procedures / Disaster Plan / Emergency Numbers
- Reimbursement for Services Rendered
- Fee Schedule per discipline
- Consent & Verification of Receipt of Information

Disciplines Proposed to Provide Care and Frequency (Circle those that apply and enter the frequency)

SN_____, HHA_____,

Number of units:_____ Frequency:_____ Begin date:_____ Activities to be performed:

_____

_____

_____

Total Estimated Cost of Care:_____

HIPAA: We honor all rights of patient privacy and HIPAA Guidelines. I hereby restrict Care Help Homecare, LLC to provide my health care information to the following person(s):
Name: _____ Phone:
_____

Name: _____ Phone: _____

Name: _____ Phone: _____

Release of Information: I hereby authorize your agency to release to or receive from hospitals, physicians or other agencies involved in my care all medical records and information pertinent to my care. I herby give permission for the review of my medical record by the agency's accrediting and/or other regulatory bodies.

Authorization for Payment: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits from Insurance, Workers Compensation, Medicaid, or other responsible payer sources be made in my behalf to the above named Certified Home Health Agency. I understand that I am responsible for all amounts not paid by my insurance. If I am a private pay patient, I agree to pay for all services rendered by the agency.

Advanced Directives: I understand that the Advance Directive Act of 1999 requires that I be made aware of my right to make healthcare decisions for myself. I understand that I may express wishes in a document called an Advanced Directive so that my wishes may be know when I am unable to speak for myself.

I have made a Directive to Physician (Living Will): Yes No

I have made a Medical Power of Attorney: Yes No

To: _____ Phone: _____

I have made an Out of Hospital DNR: Yes No

I have made a Declaration of Mental Health: Yes No

Location of the above COPIES if Yes_____

Patient Signature: _____ Printed: _____

Legal Guardian: _____ Printed: _____

Relationship to Patient: _____

Agency Staff: _____ Printed: _____

Date: _____

Patient's Copy of the Service Provider Authorization

I hereby consent to admission and to care. I acknowledge and consent to the following:

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Location of the above COPIES if Yes_____

Patient Signature: _____ Printed: _____
Legal Guardian: _____ Printed: _____
Relationship to Patient: _____
Agency Staff: _____ Printed: _____
Date: _____

Emergency Preparedness / Risk / Disaster

ADDRESS:
_____
_
PHYSICIAN: _____
PHONE:_____
NEAREST HOSPITAL: _____
EMERGENCY CONTACT PERSON: _____
PHONE:_____

PATIENT DISASTER CODE

(Check the one that applies)

☐ I Services required today as scheduled. For example:

- New insulin dependent diabetic, unable to inject self
- IV medications
- Sterile wound care with moderate to large amount of drainage
- Patient's activity dying and family unable to cope
- Other:_____
  _____

☐ II Services could be postponed 24-48 hours without adverse effect to the patient. For example:

- New insulin dependent diabetic, but able to inject self
- Cardiovascular and/or respiratory assessment
- Sterile wound care with minimal amount to no drainage
- Terminal patient with predictable deterioration, family coping adequately
- Other:_____
  _____

☐ III Services could be postponed 72-96 hours without diverse effect to the patient. For example:

- Post-operative with no open wound
- Anticipated discharge within next 10-14 days
- Routine catheter changes
- Observation/Assessments on frail, elderly, case management patients
- Other:_____
  _____

RISK LEVEL

☐ High Risk Needs high level assistance to evaluate or stay in home. Dependent on homecare. Blind or oxygen dependent with no capable caregiver. Bed bound or wheelchair bound with no caregiver.

Other:_____ _

☐ Moderate Risk Blind or oxygen dependent, but has elderly caregiver or is able to ambulate with assistance. Other: _____

☐ Low Risk Ambulatory. Can evacuate or manage in home alone for short periods of time, or has fully capable caregiver. Other: _____

POWER CODE

If electricity were lost, would there be any risk to life?

N = No risk Y = Yes Risk to Life

SIGNATURE/TITLE:_____ DATE: _____

Patient's Copy

Emergency Preparedness / Risk / Disaster

ADDRESS:
_____
_
PHYSICIAN: _____
PHONE:_____
NEAREST HOSPITAL: _____
EMERGENCY CONTACT PERSON: _____
PHONE:_____

PATIENT DISASTER CODE

(Check the one that applies)

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☐ Low Risk Ambulatory. Can evacuate or manage in home alone for short periods of time,

or has fully capable caregiver. Other:

_____

POWER CODE

If electricity were lost, would there be any risk to life?

N = No risk Y = Yes Risk to Life

SIGNATURE/TITLE:_____ DATE:

_____

MEDICATION PROFILE

Pharmacy: _____ Pharmacy Phone#_____

Allergies: _____

Medication	Dosage	Route	Freq.	Start/DC	N	C	E.M.	H.A.

☐ Oxygen ___ L/M Cont. / PRN N/C / Ventimask

Key: N=New, C=Change, E.M.=Emergency Medication, H.A.= High Alert Medication

Signature: _____ Date: _____

COMMUNICATION

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

_____ _____
SIGNATURE Date

3086 Woodley Road Suite D
Montgomery, AL 36116
Phone: 334-676-1400 Fax: 1-855-710-6364

Vital Signs

Date:	Temp.	B/P	Pulse	Resp.	02 Sat.	Weight	LBM	Initials

Patient Calendar

S.O.C. Certification Period:

SN: HHA:

Therapies: Other:

WK							
I							
II							
III							
IV							
V							
VI							
VII							
VIII							
IX							

HHA Care Plan and Progress Note

Case Manager / Nurse: _____ HHA Freq: _____

Diagnosis: _____

Goals for care: □ effective and safe personal care □ patient clean, comfortable □ other (specify)

_____

Date:_____ □ Initial □ Recertification □ Change in Pt. Condition □ other

R.N. Signature: _____ Certification Period: _____

Notify Nurse:
Temp: >101 < 95
Pulse: >100 < 60
Resp: >30 <12
B/P: >180/100
<90/50
Weight gain or loss > 5 lbs.
Notify RN if care is refused or change in Pt.

Safety and Other Pertinent Information – Check all that apply

□ Lives alone □ Lives with other □ Alone during the day □ Bed bound □ Up as tolerated □ Amputee specify_____ □ Special equipment _____ □ Speech problem □ Vision problem □ Glasses □ Contacts	□ Hard of hearing □ Hearing aid □ Dentures □ Upper □ Lower □ Partial □ Oriented □ Alert □ Forgetful □ Confused □ Urinary catheter □ Artificial limb □ Diabetic □ Food Allergies _____ □ Other _____	Environment □ Inadequate plumbing □ Inadequate heat / cooling □ Inadequate refrigeration □ Pest / rodent infested □ Presence of animals □ Supplies_____ _____ _____ _____

Activities Ordered by RN	Frequency	Special Instructions QV=Every visit CC=Client Choice A=Assist	HHA Initial when done
□ Bath □ Bed □ Shower □ Tub □ Shower	□QV □CC □A		
□ Shampoo □ Hair care/comb/brush	□QV □CC □A		
□ Catheter care □ Empty catheter bag	□QV □CC □A		
□ Oral hygiene □ Brush □ Swab □ Dentures	□QV □CC □A		
□ Ambulation assist □ W/C □ W/A □ Cane	□QV □CC □A		
□ Mobility/Transfer Assist □ Chair □ Bed □ Dangle □ Commode □ Shower/Tub	□QV □CC □A		
□ Skin Care □ Foot Care □ Back Rub □ Deodorant □ Nails: Clean/File □ Shave	□QV □CC □A		
□ Assist with dressing	□QV □CC □A		
□ Fluids □ Limit □ Encourage □ Record I/O	□QV □CC □A		
□ Linens □ Change □ Wash □ Make bed	□QV □CC □A		
□ Clean: □ Bathroom □ Kitchen □ Pt. laundry	□QV □CC □A		
□ Vacuum □ Sweep □ Mop floors	□QV □CC □A		
□ Safety check □ Universal Precautions	□QV □CC □A		
□ Other	□QV □CC □A		

Comments_____

_____

Vital Signs: Temp_____ Pulse_____ Resp_____ B/P_____/_____ Last BM_____

Pt. Signature:_____Date:_____

HHA Signature:_____Time in:_____ Time out:_____