Patient Orientation For Home Health Care

STATEMENT OF CONFIDENTIALITY
This booklet may contain protected health information. Persons other than you and your health care providers must have your permission to view this booklet.

Revival Homecare Agency
6066 Leesburg Pike, Suite 630A
Falls Church, VA 22041
Phone: (703) 341-6670
E-mail: info@rha-va.com
OFFICE HOURS/AFTER HOURS COVERAGE

THIS BOOKLET BELONGS TO: ____________________________

INSTRUCTIONS: This information is provided to you as a quick reference source in case an emergency occurs. Keep this information where it can be easily found. Inform other persons close to you (relative, neighbor, etc.) of its location.

• OFFICE HOURS: Our office hours are Monday through Friday from 8:30 a.m. to 5:00 p.m., except during company holidays. During normal business hours, please call (703) 341-6670.

• AFTER HOURS COVERAGE: We have a nurse on call 24 hours a day, 7 days a week to ensure that you receive necessary home care services. You can reach the nurse by calling (703) 341-6670. After office hours and on weekends, an answering service will reach the nurse and he/she will return your call, answer any questions or concerns you may have or come to see you, if necessary.

We do not carry medications with us and cannot give medication unless it is ordered by a physician. Medical supplies or equipment are not usually delivered after regular office hours.

Please let us know if you have any questions about our after hours coverage.

MEDICAL EMERGENCIES

Revival Homecare Agency does not operate an emergency service and does not want you to waste valuable time should you have a serious medical emergency.

In case of a serious medical emergency call 9-1-1 or take the patient to the hospital emergency room.

There are instances when an emergency room visit or hospitalization can be avoided. If you call us at the first sign of a problem, we can often prevent you from being readmitted to the hospital. Our staff will work with you and your caregivers to identify your treatment options.

Please refer to our Emergency Care Plan section of the booklet for additional information.

NOTE: Please call our office if the patient is admitted to the hospital or taken to the emergency room.
I. Welcome, Mission and Philosophy

II. Home Health Agency Overview
   - Policies
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Welcome and Philosophy

Dear Sir/Madam,

Our agency would like to welcome you to our organization. We are glad you have chosen us as your homecare provider. We believe that providing quality homecare services to you is a privilege and a commitment. Our staff consists of highly qualified and competent professionals, whose expertise and knowledge of healthcare will give you peace of mind that comes from being cared for in a familiar and comfortable setting.

Our staff will work with you to develop a home care program that will help meet your needs.

We are committed to ensuring your rights and privileges as a home care patient. Many aspects of our services and procedures may be new to you. We have prepared this booklet to assist you in becoming better acquainted with us, to help you understand the home health care process, and explain your rights as a patient. If you have additional questions, please do not hesitate to ask us.

Revival Homecare Agency is accredited by The Joint Commission which means that our agency is nationally recognized as having the “Gold Seal of Approval” in healthcare. We are certified by Medicare and Medicaid and licensed in the state of Virginia.

Our entire health care team joins in wishing you a rapid recovery.

Sincerely,

The Management and Staff of Revival Homecare Agency

Revival Homecare Agency is in compliance with Title VI of the Civil Rights Act of 1964, with Section 504 of the Rehabilitation Act of 1973 and with the Age Discrimination Act of 1975. We do not discriminate on the basis of race, color, religion, sex, national origin, age or disability with regard to admission, access to treatment or employment. We will make every effort to comply with these and similar statutes.
SECTION II. Agency Overview

POLICIES

This book contains general information regarding your rights and responsibilities as a patient. As state and federal regulations change, there may be additions or changes to this book as necessary. Our complete policy and procedure manual regarding your care and treatment is available upon request for your viewing at the agency office at any time during normal business hours.

CRITERIA FOR ADMISSION

Admission to this agency can only be made under the direction of a physician, based upon the patient’s identified care needs, homebound status and the type of services required that we can provide directly or through coordination with other organizations. If we cannot meet your needs or your home environment will not support our services, we will not admit you or will not continue to provide services to you.

SERVICES

Revival Homecare Agency can provide a service or a combination of services in your home— all under the direction of a physician. Working with your doctor, our qualified staff will plan, coordinate and provide care tailored to your needs. Our services include:

Skilled Nursing, Physical Therapy, Occupational Therapy, Speech Therapy, Medical Social Services, Home Health Aides, Personal Care Services and Private Duty Companion Services.

- **Skilled Nursing** is provided by an RN or LPN with training and experience in providing care in the home. The nurse communicates frequently with your physician to update your plan of care. Services may include evaluation of patient needs; performance of skilled nursing procedures; education of patient, family members and caregivers on disease processes; self-care techniques and prevention strategies; and coordination of patient care and services with your physician and other health care team members.

- **Physical, Occupational and Speech Therapy** services are provided by a licensed therapist or licensed therapy assistant under the direction of the therapist. Your therapist will provide specific information about the services and treatments you will receive.

- **Medical Social Services** are provided by a Medical Social Worker. Services may include short-term counseling services, referral to and coordination with community resources and assistance with living arrangements, finances and long-range planning.
• **Home Health Aide** services are delivered under the supervision of a registered nurse or licensed therapist. Our aides have experience and training in providing care in the home. An aide is assigned when there is a specific need for personal care on a part-time basis at home. Any duties the home health aide performs will be planned by you and the nurse and added to your plan of care. Typical duties include bathing, shampooing hair, changing bed linen and assistance with other activities of daily living.

• **Supplies/Therapy:** Medical supplies and therapy services may be required to carry out your plan of care. All medically necessary therapy services or medical supplies must be coordinated with the home health agency while you are receiving Medicare covered home health services. If you arrange for these services or supplies on your own while under our plan of care, Medicare will not reimburse you or the other suppliers.

• **DME:** Durable medical equipment (walker, wheelchair, hospital bed, etc.) is covered separately and may be supplied by the home health agency or an outside Medicare-certified supplier of your choice.

Check with our office to verify whether or not we presently participate in any specific programs pertaining to your needs. Eligibility for these programs is determined by state and/or federal agencies.

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**EMERGENCY PREPAREDNESS PLAN**

In the event of a natural disaster, inclement weather or emergency (including emergencies that result in a state-ordered call for evacuation), we have an emergency plan to continue necessary patient services. We will make every effort to continue home care visits. However, the safety of our staff must be considered. When roads are too dangerous to travel, our staff will contact you by phone, if possible, to let you know that they are unable to make your visit that day. Every possible effort will be made to ensure that your medical needs are met by the agency or through any previously agreed upon arrangements made with you or your family caregiver. Should you decide to stay in your home during a state ordered evacuation, there may be a temporary disruption of services.

All patients are assigned a priority level code that is updated as needed. The code assignment determines agency response times in case of a disaster or emergency. These codes are maintained in the agency office, along with a list of patients who need continued services, how their services will be continued, if the patient is to be transported to a shelter and their medication and equipment needs. This information will be shared with Emergency Management Services in case of an area disaster/emergency.
You will be contacted for medical attention:

☐ Level I  - Within 24 hours
☐ Level II  - Within 24-48 hours
☐ Level III  - Within 48-72 hours

In case of bad weather or other situations that might prevent our staff from reaching you, turn to your local radio and/or TV station(s). If you evacuate to another location or emergency shelter, please notify our office.

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We accept payment for services from Medicare, Medicaid, Tricare, Self Pay and Private Insurance (United Health and CareFirst BCBS). Some insurers may limit the number and type of home care visits that they will pay for and may require pre-certification and/or co-payments. We will inform you, your family, caregiver or guardian of all charges and methods of payment before or upon admission.

Our agency will bill Medicare and Medicaid for our services on your behalf. We will accept Medicare assigned payment as payment in full for the services we provide as long as you meet the qualifying requirements and the services are covered by the Medicare program. If services are ordered which are not covered by the Medicare or Medicaid programs, you will be notified by the agency before these services are provided so that you can make other financial arrangements for the necessary care.

Please notify the agency immediately if you decide to enroll in a Medicare Advantage plan, or in a private HMO or Hospice. The Original Medicare plan may not pay for the services we are providing if you are enrolled in a Medicare Advantage plan, HMO or Hospice.

If you are receiving Medicare benefits, you may receive a Medicare Summary Notice (MSN) after we have submitted a final claim for services. The MSN lists services and charges billed to Medicare on your behalf and the amount Medicare paid. **This is not a bill.**

Should any change be made in this policy regarding services or charges, you or your responsible party will be advised. If you have questions about charges or insurance billing, please call our office.
MEDICARE GUIDELINES USED TO ESTABLISH COVERAGE

The following items are required for Medicare to pay for your home health care services:

- You are **homebound**. This means that due to your illness or injury it takes a **considerable taxing effort** for you to leave your home and your absences are **infrequent** or of relatively **short duration**.

You can still be considered homebound if you leave home to attend a religious service; to receive health care treatment, including regular absences to participate in therapeutic, psychosocial or medical treatment in a state licensed/certified and/or accredited adult day-care program; or to attend unique or infrequent special events *(family reunion, funeral, graduation, etc.)*. If you are able to drive, then you probably **do not** meet the homebound requirement.

- You have had a **recent** illness or injury *(or worsening of a condition)* which requires **Skilled Nursing Care** on an intermittent basis *(other than solely venipunctures)*, or **Physical Therapy, Speech-Language Pathology** or have a continuing need for **Occupational Therapy**.

- You are an **eligible Medicare beneficiary** and **under the care of a doctor** who has ordered the treatment or services we are providing. If the services are not reasonable or medically necessary and specifically ordered by your doctor, Medicare will not pay for those services.

- Care is provided on an **intermittent basis**. This means Medicare will not pay for our health care staff to stay with you for an extended period of time. We will only visit you for the length of time it takes to provide the specific treatment ordered by your doctor.

If all of these requirements are met, Medicare will also pay for medically necessary Occupational Therapists, Medical Social Services, Home Health Aides and medical supplies.

PATIENT SATISFACTION

You, our customers, are very important to us. Please ask questions if something is unclear regarding our services or the care you receive or fail to receive. At intervals, our agency sends out a Patient Satisfaction Survey. When you receive one, please complete the survey and return it immediately. Your answers help us to improve our services and ensure that we meet your needs and expectations.
PLAN FOR CARE, TREATMENTS AND SERVICES

We involve you, your caregiver or designee, key professionals and other staff members in developing your individualized plan for care, treatment and services. Your plan is based upon identified problems, needs and goals, physician orders for medications, care, treatments and services, timeframes, your environment and your personal wishes whenever possible. The plan is designed to increase your ability to care for yourself. Effective pain management is an important part of your treatment.

The plan may include the following interventions and goals:

- Nursing Care
- Personal Care
- Psychosocial Needs
- Medication Management
- Rehabilitation Therapy
- Discharge Planning

The plan is reviewed and updated as needed, based on your changing needs. We encourage your participation and will provide necessary medical information to assist you.

With your help, on admission and at discharge, we will create an updated list of your medications. We will compare this list to the medications ordered by the physician. Our staff will continue to compare the list to the medications that are ordered, administered or dispensed to you while under our care so any discrepancies (such as omissions, duplications, potential interactions) can be resolved.

You have the right to refuse any medication or treatment procedure. However, such refusal may require us to obtain a written statement releasing the agency from all responsibility resulting from such action. Should this happen, we would encourage you to discuss the matter with your physician for advice and guidance.

We fully recognize your right to dignity and individuality, including privacy in your treatment and in the care of your personal needs. We will notify you if an additional individual needs to be present for your visit for reasons of safety, education or supervision.

We do not participate in any experimental research connected with patient care except under the direction of your physician and with your written consent.

There must be a willing, able and available caregiver to be responsible for your care between agency visits. This person can be you, a family member, a friend or a paid caregiver.
MEDICAL RECORDS

Your medical record is maintained by our staff to document physician orders, assessments, progress notes and treatments. Your records are kept strictly confidential by our staff and are protected against loss, destruction, tampering or unauthorized use.

Our Notice of Privacy Practices describes how your protected health information may be used by us or disclosed to others, as well as how you may have access to this information.

DISCHARGE, TRANSFER AND REFERRAL

Discharge, transfer or referral from this agency may result from several types of situations including the following:
- treatment goals are achieved;
- the level of care you need changes;
- agency resources are no longer adequate to meet your needs;
- situations may develop affecting your welfare or the safety of our staff;
- failure to follow the attending physician's orders;
- nonpayment of charges;
- failure to meet Medicare and other insurance coverage guidelines.

You will be given at least a five days notice if our agency determines that services should be terminated (except in case of an emergency). If you are referred, transferred or discharged to another organization, we will provide them with a list of your current medications and information necessary for your continued care, including pain management.

All transfers or discharges will be documented in the patient chart. When a discharge occurs, an assessment will be done. You will receive an updated list of your current medications along with any instructions needed for ongoing care or treatment. We will coordinate your referral to available community resources as needed.

If you elected to transfer from another agency and were under an established plan of care, Medicare requires us to coordinate the transfer. The initial home health agency will no longer receive Medicare payment on your behalf and will no longer provide you with Medicare covered services after the date of your elected transfer to our agency.
**Notice of Medicare Provider Non-Coverage:** You or your authorized representative will be asked to sign and date a Notice of Medicare Provider Non-Coverage (*included in the back of this book*) at least two days before your covered Medicare services will end. If you or your authorized representative are not available, we will make contact by phone, and then mail the notice.

If you do not agree that your covered services should end, you must contact the Quality Improvement Organization (QIO) at the phone number listed on the form no later than noon of the day before your services are to end and ask for an immediate appeal.

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**PROBLEM SOLVING PROCEDURE**

We are committed to ensuring that your rights are protected. If you feel that our staff has failed to follow our policies or has in any way denied you your rights, please follow these steps without fear of discrimination or reprisal.

1. Notify the Director of Nursing or the Administrator by phone at **703-341-6670**, Monday through Friday from 8:30 a.m. to 5:00 p.m. You may also submit your complaint in writing to 6066 Leesburg Pike, Suite 630A, Falls Church, VA 22041. You will receive our proposed resolution to your complaint within 30 days after we receive your complaint. Most problems can be solved at this level.

2. You may also contact the State’s home care hotline which receives complaints, questions and/or comments about local home care agencies and complaints regarding the implementation of advance directive requirements:

   **The Department for Aging**
   **Long Term Care Ombudsman**
   24 East Cary St., Suite 100
   Richmond, VA 23219
   **1-800-552-3402**
   8:30 a.m. to 5:00 p.m.

   **Virginia Department of Health**
   **Office of Licensure and Certification**
   9960 Mayland Drive, Suite 401
   Richmond, VA 23233
   **1-800-955-1819**
   8:00 a.m. to 4:30 p.m.

3. You may also contact The Joint Commission’s Office of Quality Monitoring to report any concerns or register complaints about a Joint Commission – accredited health care organization by either calling 1-800-994-6610 or emailing complaint@jointcommission.org.
SECTION III. Patient Rights and Responsibilities

As a home care provider, we have an obligation to protect your rights and explain these rights both orally and in writing to you in a way you can understand before treatment begins or during the initial evaluation visit and on an ongoing basis, as needed. Your family or your guardian may exercise these rights for you in the event that you are not competent or able to exercise them for yourself.

YOUR RIGHTS

YOU HAVE THE RIGHT TO:

• Receive information about organization ownership and control.
• Have a relationship with our staff that is based on honesty and ethical standards of conduct and to have ethical issues addressed. You have the right to be informed of any financial benefit we receive if we refer you to another organization, service, individual or other reciprocal relationship.
• Be free from mental, physical, sexual and verbal abuse, neglect and property exploitation.
• Respect, courtesy, consideration, personal dignity and to have cultural, psychosocial, spiritual and personal values, beliefs and preferences respected. You will not be discriminated against based on social status, political belief, sexual preference, race, color, religion, national origin, age, sex or handicap. Our staff is prohibited from accepting gifts or borrowing from you.
• Receive information in a manner that you can understand and have access to interpreters as indicated and necessary to ensure accurate communication.
• Lodge complaints and have your complaints as well as your family or your guardian’s complaints heard, reviewed and, if possible, resolved regarding treatment or 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 organization. You also have the right to know about the results of such complaints. The organization must document both the existence of a complaint and the resolution of the complaint. Our complaint resolution process is explained in our problem solving procedure.
• Voice grievances/complaints or recommend changes in policy, staff or service/care without fear of coercion, discrimination, restraint, interference, reprisal or an unreasonable interruption in care, treatment or services for doing so.
• Be advised when you are accepted for treatment or care, of the availability of the State’s toll-free home care "Hotline" number, its purpose and hours of operation. The hotline receives complaints or questions about local home care agencies and is also used to lodge complaints concerning the implementation of the advance directives requirements. Hotline hours are 8:00 a.m. to 4:30 p.m., Monday through Friday. The hotline may be reached at 1-800-955-1819.
DECISION MAKING - YOU HAVE THE RIGHT TO:

- Choose your health care providers and communicate with those providers.
- Be informed in advance about the care that is to be furnished, the purpose of the service(s) to be provided, name(s) and responsibilities of staff members who are providing and supervising for your care, treatment or services, the planned frequency of visits proposed to be furnished, expected and unexpected outcomes, potential risks or problems and barriers to treatment.
- Actively participate in planning your care, treatment and services; and to participate in changing the plan whenever possible and to the extent that you are competent to do so.
- Be advised of any change in your plan of care or reduction in services, before the change is made.
- Have family involved in decision making as appropriate concerning your care, treatment and services, when approved by you or your surrogate decision maker and when allowed by law.
- Be given five days written notice before the home care agency terminates your services.
- Participate or refuse to participate in research, investigational or experimental studies or clinical trials. Your access to care, treatment and services will not be affected if you refuse or discontinue participation in research.
- Formulate advance directives. Prior to the start of care, you have the right to receive written information regarding Advance Directives and Durable Do Not Resuscitate Orders and the agency’s policies and procedures on advance directives, including a description of applicable state law. You will be informed if we cannot implement an advance directive on the basis of conscience.
- Have your wishes concerning end of life decisions addressed and to have health care providers comply with your advance directives in accordance with state laws. You have the right to receive care without conditions or discrimination based on the execution of advance directives.
- Accept, refuse or discontinue care, treatment and services without fear of reprisal or discrimination and to be informed of the consequences for doing so. You may refuse part or all of care/services to the extent permitted by law. However, should you refuse to comply with the plan of care and your refusal threatens to compromise our commitment to quality care, then we or your physician may be forced to discharge you from our services and refer you to another source of care.

PRIVACY AND SECURITY - YOU HAVE THE RIGHT TO:

- Personal privacy and security during home care visits and to have your property treated with respect. Our visiting staff will wear proper identification so you can identify them.
• Confidentiality of written, verbal and electronic information including your medical and financial records, information about your health, social and financial circumstances or about what takes place in your home.

• Refuse filming or recording or revoke consent for filming or recording of care, treatment and services for purposes other than identification, diagnosis or treatment.

• Access, request changes to and receive an accounting of disclosures regarding your own protected health information as permitted by law.

• Request us to release information written about you only as required by law or with your written authorization and to be advised of our policies and procedures regarding accessing and/or disclosure of clinical records. Our Notice of Privacy Practices describes your rights in detail.

**FINANCIAL INFORMATION - YOU HAVE THE RIGHT TO:**

• Be advised orally and in writing before care is initiated, of our billing policies and payment procedures and the extent to which payment may be expected from Medicare, Medicaid, any other Federally or State funded or aided program, third party payors, or any other sources known to us; charges for services that will not be covered by Medicare or third party payors; and the charges that you may have to pay. You have a right to receive a schedule of charges and the refund policies of the home care agency.

• Be advised orally and in writing of any changes in payment, charges and patient payment liability as soon as possible when they occur but no later than 30 calendar days from the date that we become aware of a change.

• Have access to all bills, upon request, for the services you have received regardless of whether the bills are paid out-of-pocket or by another party.

**QUALITY OF CARE - YOU HAVE THE RIGHT TO:**

• Receive care of the highest quality in accordance with physician orders by individuals who are properly trained and competent to perform their duties.

• Pain assessment and management and to receive education about your role and your family’s role in managing pain when appropriate, as well as potential limitations and side effects of pain treatments.

• Be admitted only if we can provide the care you need. A qualified staff member will assess your needs. If you require care or services that we do not have the resources to provide, we will inform you, and refer you to alternative services, if available; or admit you, but only after explaining our care/service limitations and the lack of a suitable alternative.

• Receive emergency instructions and be told what to do in case of an emergency.
YOUR RESPONSIBILITIES

YOU HAVE THE RESPONSIBILITY TO:

- Provide complete and accurate information to the best of your knowledge about your present complaints and past illness(es), hospitalizations, medications, allergies and other matters relating to your health.
- Remain under a doctor's care while receiving skilled agency services.
- Notify us of perceived risks or unexpected changes in your condition (e.g., hospitalization, changes in the plan of care, symptoms to be reported, pain, homebound status or change of physician).
- Follow the plan of care and instructions and accept responsibility for the outcomes if you do not follow the care, treatment or service plan.
- Ask questions when you do not understand about your care, treatment and service or other instruction about what you are expected to do. If you have concerns about your care or cannot comply with the plan, let us know.
- Report and discuss pain, pain relief options and your questions, worries and concerns about pain medication with staff or appropriate medical personnel.
- Tell us if your visit schedule needs to be changed due to medical appointment, family emergencies, etc.
- Tell us if your Medicare or other insurance coverage changes or if you decide to enroll in a Medicare or private HMO (Health Maintenance Organization) or hospice.
- Promptly meet your financial obligations and responsibilities agreed upon with the agency.
- Follow the organization’s rules and regulations.
- Tell us if you have an advance directive or if you change your advance directive.
- Tell us of any problems or dissatisfaction with the services provided.
- Provide a safe and cooperative environment for care to be provided (such as keeping pets confined, not smoking or putting weapons away during your care).
- Show respect and consideration for agency staff and equipment.
- Carry out mutually agreed upon responsibilities.
Home Health Agency
Outcome and Assessment Information Set (OASIS)

STATEMENT OF PATIENT PRIVACY RIGHTS (Medicare/Medicaid)

As a home health patient, you have the privacy rights listed below.

- **You have the right to know why we need to ask you questions.**
  We are required by law to collect health information to make sure:
  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 information kept confidential.**
  You may be asked to tell us information about yourself so that we will know which home health services will be best for you. We keep anything we learn about you confidential. This means, only those who are legally authorized to know, or who have a medical need to 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 choose not to answer, we will fill in the information as best we can.
  You do not have to answer every question to get services.

- **You have the right to look at your personal health information.**
  — We know how important it is that the information we collect about you is correct.
    If you think we made a mistake, ask us to correct it.
  — If you are not satisfied with our response, you can ask the Centers for Medicare & Medicaid Services, the federal Medicare and Medicaid agency, to correct your information.

You can ask the Centers for Medicare & Medicaid Services to see, review, copy, or correct your personal health information which that Federal agency maintains in its HHA OASIS System of Records. See the back of this Notice for CONTACT INFORMATION.

If you want a more detailed description of your privacy rights, see the back of this Notice: (on facing page) PRIVACY ACT STATEMENT - HEALTH CARE RECORDS.

NOTICE ABOUT PRIVACY
For Patients Who DO NOT Have Medicare or Medicaid Coverage

- As a home health patient, there are a few things that you need to know about our collection of your personal health care information.
  — Federal and State governments oversee home health care to be sure that we furnish quality home health care services, and that you, in particular, get quality home health care services.
  — We need to ask you questions because we are required by law to collect health information to make sure that you get quality health care services.
  — We will make your information anonymous. That way, the Centers for Medicare & Medicaid Services, the federal agency that oversees this home health agency, cannot know that the information is about you.

- **We keep anything we learn about you confidential.**

This is a Medicare & Medicaid Approved Notice
I. AUTHORITY FOR COLLECTION OF YOUR INFORMATION, INCLUDING YOUR SOCIAL SECURITY NUMBER, AND WHETHER OR NOT YOU ARE REQUIRED TO PROVIDE INFORMATION FOR THIS ASSESSMENT. Sections 1102(a), 1154, 1861(o), 1861(z), 1863, 1864, 1865, 1866, 1871, 1891(b) of the Social Security Act.

Medicare and Medicaid participating home health agencies must do a complete assessment that accurately reflects your current health and includes information that can be used to show your progress toward your health goals. The home health agency must use the “Outcome and Assessment Information Set” (OASIS) when evaluating your health. To do this, the agency must get information from every patient. This information is used by the Centers for Medicare & Medicaid Services (CMS, the federal Medicare & Medicaid agency) to be sure that the home health agency meets quality standards and gives appropriate health care to its patients. You have the right to refuse to provide information for the assessment to the home health agency. If your information is included in an assessment, it is protected under the federal Privacy Act of 1974 and the “Home Health Agency Outcome and Assessment Information Set” (HHA OASIS) System of Records. You have the right to see, copy, review, and request correction of your information in the HHA OASIS System of Records.

II. PRINCIPAL PURPOSES FOR WHICH YOUR INFORMATION IS INTENDED TO BE USED

The information collected will be entered into the Home Health Agency Outcome and Assessment Information Set (HHA OASIS) System No. 09-70-9002. Your health care information in the HHA OASIS System of Records will be used for the following purposes:

- support litigation involving the Centers for Medicare & Medicaid Services;
- support regulatory, reimbursement, and policy functions performed within the Centers for Medicare & Medicaid Services or by a contractor or consultant;
- study the effectiveness and quality of care provided by those home health agencies;
- survey and certification of Medicare and Medicaid home health agencies;
- provide for development, validation, and refinement of a Medicare prospective payment system;
- enable regulators to provide home health agencies with data for their internal quality improvement activities;
- support research, evaluation, or epidemiological projects related to the prevention of disease or disability, or the restoration or maintenance of health, and for health care payment related projects; and
- support constituent requests made to a Congressional representative.

III. ROUTINE USES

These “routine uses” specify the circumstances when the Centers for Medicare & Medicaid Services may release your information from the HHA OASIS System of Records without your consent. Each prospective recipient must agree in writing to ensure the continuing confidentiality and security of your information. Disclosures of the information may be to:

1. the federal Department of Justice for litigation involving the Centers for Medicare & Medicaid Services;
2. contractors or consultants working for the Centers for Medicare & Medicaid Services to assist in the performance of a service related to this system of records and who need to access these records to perform the activity;
3. an agency of a State government for purposes of determining, evaluating, and/or assessing cost, effectiveness, and/or quality of health care services provided in the State; for developing and operating Medicaid reimbursement systems; or for the administration of Federal/State home health agency programs within the State;
4. another Federal or State agency to contribute to the accuracy of the Centers for Medicare & Medicaid Services’ health insurance operations (payment, treatment and coverage) and/or to support State agencies in the evaluations and monitoring of care provided by HHA’s;
5. Quality Improvement Organizations, to perform Title XI or Title XVIII functions relating to assessing and improving home health agency quality of care;
6. an individual or organization for a research, evaluation, or epidemiological project related to the prevention of disease or disability, the restoration or maintenance of health, or payment related projects;
7. a congressional office in response to a constituent inquiry made at the written request of the constituent about whom the record is maintained.

IV. EFFECT ON YOU, IF YOU DO NOT PROVIDE INFORMATION

The home health agency needs the information contained in the Outcome and Assessment Information Set in order to give you quality care. It is important that the information be correct. Incorrect information could result in payment errors. Incorrect information also could make it hard to be sure that the agency is giving you quality services. **If you choose not to provide information, there is no federal requirement for the home health agency to refuse you services.**

**NOTE:** This statement may be included in the admission packet for all new home health agency admissions. Home health agencies may require you or your representative to sign this statement to document that this statement was given to you. **Your signature is NOT required.** If you or your representative sign the statement, the signature merely indicates that you received this statement. You or your representative must be supplied with a copy of this statement.

**CONTACT INFORMATION**

If you want to ask the Centers for Medicare & Medicaid Services to see, review, copy, or correct your personal health information that the Federal agency maintains in its HHA OASIS System of Records:

- Call 1-800-MEDICARE, toll free, for assistance in contacting the HHA OASIS System Manager.
- TTY for the hearing and speech impaired: 1-877-486-2048.
NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

“THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.”

Our Agency is required by law to maintain the privacy of protected health information and to provide you adequate notice of your rights and our legal duties and privacy practices with respect to the uses and disclosures of protected health information. [45 CFR § 164.520] We will use or disclose protected health information in a manner that is consistent with this notice.

The agency maintains a record (paper/electronic file) of the information we receive and collect about you and of the care we provide to you. This record includes physicians’ orders, assessments, medication lists, clinical progress notes and billing information.

As required by law, the agency maintains policies and procedures about our work practices, including how we provide and coordinate care provided to our patients. These policies and procedures include how we create, maintain and protect medical records; access to medical records and information about our patients; how we maintain the confidentiality of all information related to our patients; security of the building and electronic files; and how we educated staff on privacy of patient information.

As our patient, information about you must be used and disclosed to other parties for purposes of treatment, payment and health care operations. Examples of information that must be disclosed:

- **Treatment:** Providing, coordinating or managing health care and related services, consultation between health care providers relating to a patient or referral of a patient for health care from one provider to another. For example, we meet on a regular basis to discuss how to coordinate care to patients and schedule visits.

- **Payment:** Billing and collecting for services provided, determining plan eligibility and coverage, utilization review (UR), precertification, medical necessity review. For example, occasionally the insurance company requests a copy of the medical record be sent to them for review prior to paying the bill.

- **Health Care Operations:** General agency administrative and business functions, quality assurance/improvement activities, medical review; auditing functions; developing clinical guidelines; determining the competence or qualifications of health care professionals; evaluating agency performance; conducting training programs with students or new employees; licensing, survey, certification, accreditation and credentialing activities; internal auditing and certain fundraising and marketing activities. For example, our agency periodically holds clinical record review meetings where the consulting professional of our record review committee will audit clinical records for meeting professional standards and utilization review.

The following uses and disclosures do not require your consent, and include, but are not limited to, a release of information contained in financial records and/or medical records, including information concerning communicable diseases such as Human Immune Deficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), drug/alcohol abuse, psychiatric diagnosis and treatment records and/or laboratory test results, medical history, treatment progress and/or any other related information to:

1. Your insurance company, self-funded or third-party health plan, Medicare, Medicaid or any other person or entity that may be responsible for paying or processing for payment any portion of your bill for services;
2. Any person or entity affiliated with or representing us for purposes of administration, billing and quality and risk management;
3. Any hospital, nursing home or other health care facility to which you may be admitted;
4. Any assisted living or personal care facility of which you are a resident;
5. Any physician providing you care;
6. Licensing and accrediting bodies, including the information contained in the OASIS Data Set to the state agency acting as a representative of the Medicare/Medicaid program;
7. Contact you to provide appointment reminders or information about other health activities we provide;
8. Contact you to raise funds for the Agency; and

We are permitted to use or disclose information about you without consent or authorization in the following circumstances:

1. In emergency treatment situations, if we attempt to obtain consent as soon as practicable after treatment;
2. Where substantial barriers to communicating with you exist and we determine that the consent is clearly inferred from the circumstances;
3. Where we are required by law to provide treatment and we are unable to obtain consent;
4. Where the use or disclosure of medical information about you is required by federal, state or local law;
5. To provide information to state or federal public health authorities, as required by law to: prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify persons of recalls of products they may be using; notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence (if you agree or when required or authorized by law);
6. Health care oversight activities such as audits, investigations, inspections and licensure by a government health oversight agency as authorized by law to monitor the health care system, government programs and compliance with civil rights laws;
7. Certain judicial administrative proceedings if you are involved in a lawsuit or a dispute. We may disclose medical information about you in response to a court or administrative order, a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested;
8. Certain law enforcement purposes such as helping to identify or locate a suspect, fugitive, material witness or missing person, or to comply with a court order or subpoena and other law enforcement purposes;
9. To coroners, medical examiners and funeral directors, in certain circumstances, for example, to identify a deceased person, determine the cause of death or to assist in carrying out their duties;
10. For cadaveric organ, eye or tissue donation purposes to communicate to organizations involved in procuring, banking or transplanting organs and tissues (if you are an organ donor);
11. For certain research purposes under very select circumstances. We may use your health information for research. Before we disclose any of your health information for such research purposes, the project will be subject to an extensive approval process. We will usually request your written authorization before granting access to your individually identifiable health information;
12. To avert a serious threat to health and safety: To prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public, such as when a person admits to participation in a violent crime or serious harm to a victim or is an escaped convict. Any disclosure, however, would only be to someone able to help prevent the threat;
13. **For specialized government functions**, including military and veterans' activities, national security and intelligence activities, protective services for the President and others, medical suitability determinations, correctional institution and custodial situations; and

14. **For Workers' Compensation purposes**: Workers' compensation or similar programs provide benefits for work-related injuries or illness.

We are permitted to use or disclose information about you without consent or authorization provided you are informed in advance and given the opportunity to agree to or prohibit or restrict the disclosure in the following circumstances:

1. Use of a directory (includes name, location, condition described in general terms) of individuals served by our Agency; and

2. To a family member, relative, friend, or other identified person, the information relevant to such person's involvement in your care or payment for care; to notify family member, relative, friend, or other identified person of the individual's location, general condition or death.

Other uses and disclosures will be made only with your written authorization. That authorization may be revoked, in writing, at any time, except in limited situations.

**YOUR RIGHTS - You have the right, subject to certain conditions, to:**

- **Request restrictions on uses and disclosures of your protected health information** for treatment, payment or health care operations. However, we are not required to agree to any requested restriction. Restrictions to which we agree will be documented. Agreements for further restrictions may, however, be terminated under applicable circumstances (e.g., emergency treatment).

- **Confidential communication of protected health information**. We will arrange for you to receive protected health information by reasonable alternative means or at alternative locations. Your request must be in writing. We do not require an explanation for the request as a condition of providing communications on a confidential basis and will attempt to honor reasonable requests for confidential communications.

- **Inspect and obtain copies of protected health information** which is maintained in a designated record set, except for psychotherapy notes, information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding, or protected health information that is subject to the Clinical Laboratory Improvements Amendments of 1988 [42 USC § 263a and 45 CFR 493 § (a)(2)]. If you request a copy of your health information, we will charge a reasonable fee for copying in accordance with applicable state and federal regulations.

  If we deny access to protected health information, you will receive a timely, written denial in plain language that explains the basis for the denial, your review rights and an explanation of how to exercise those rights. If we do not maintain the medical record, we will tell you where to request the protected health information.

- **Request to amend protected health information** for as long as the protected health information is maintained in the designated record set. A request to amend your record must be in writing and must include a reason to support the requested amendment. We will act on your request within sixty (60) days of receipt of the request. We may extend the time for such action by up to 30 days, if we provide you with a written explanation of the reasons for the delay and the date by which we will complete action on the request.
We may deny the request for amendment if the information contained in the record was not created by us, unless the originator of the information is no longer available to act on the requested amendment; is not part of the designated medical record set; would not be available for inspection under applicable laws and regulations; and the record is accurate and complete. If we deny your request for amendment, you will receive a timely, written denial in plain language that explains the basis for the denial, your rights to submit a statement disagreeing with the denial and an explanation of how to submit that statement.

- **Receive an accounting of disclosures of protected health information** made by our Agency for up to six (6) years prior to the date on which the accounting is requested for any reason other than for treatment, payment or health operations and other applicable exceptions. The written accounting includes the date of each disclosure, the name/address (if known) of the entity or person who received the protected health information, a brief description of the information disclosed and a brief statement of the purpose of the disclosure or a copy of your written authorization or a written request for disclosure. We will provide the accountings within 60 days of receipt of a written request. However, we may extend the time period for providing the accounting by 30 days if we provide you with a written statement of the reasons for the delay and the date by which you will receive the information. We will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee.

- **Obtain a paper copy of this notice**, even if you had agreed to receive this notice electronically, from us upon request.

**COMPLAINTS** - If you believe that your privacy rights have been violated, you may complain to the Agency or to the Secretary of the U.S. Department of Health and Human Services. There will be no retaliation against you for filing a complaint. The complaint should be filed in writing, and should state the specific incident(s) in terms of subject, date and other relevant matters. A complaint to the Secretary must be filed in writing within 180 days of when the act or omission complained of occurred, and must describe the acts or omissions believed to be in violation of applicable requirements. [45 CFR § 160.306] For further information regarding filing a complaint, contact:

  Privacy Official  
  Revival Homecare Agency  
  6066 Leesburg Pike, Suite 630A  
  Falls Church, VA 22041  
  (703) 341-6670

**EFFECTIVE DATE** - This notice is effective December 1, 2009. We are required to abide by the terms of the notice currently in effect, but we reserve the right to change these terms as necessary for all protected health information that we maintain. If we change the terms of this notice (while you are receiving service), we will promptly revise and distribute a revised notice to you as soon as practicable by mail, e-mail (if you have agreed to electronic notice) or hand delivery.

If you require further information about matters covered by this notice, please contact:

  Privacy Official  
  Revival Homecare Agency  
  6066 Leesburg Pike, Suite 630A  
  Falls Church, VA 22041  
  (703) 341-6670
SECTION IV. Advance Directives

In 1990, Congress passed the Patient Self-Determination Act. It requires health care institutions to tell patients and the people in their communities about their rights under Virginia law to make decisions about their medical care. These rights include the right to accept or refuse care and the right to make advance directives about their care.

How Do I Exercise My Health Care Rights? Under Virginia law, “every human being of adult years and sound mind has a right to determine what shall be done with his own body.” Your doctor helps you exercise this right by giving you information about health care he or she is recommending. If you agree to the recommended health care, you have given your informed consent. You also have the right to refuse the recommended health care.

What Happens If I Cannot Give My Consent? Many people worry about what would happen if, due to physical or mental problems, they are unable to understand the possible outcomes of a proposed health care decision and cannot tell their doctor whether they want or don’t want recommended health care. Under a Virginia law called the “Health Care Decisions Act,” if you are an adult you may sign a document that makes your choices about health care known to your doctor and family in advance. In that document, you also can name someone you trust to make these decisions for you if you become unable to express your wishes yourself. This document is known as an advance directive.

The Health Care Decisions Act became law in 1992. It has been revised from time to time, most recently in 2009. However, any valid advance directive you have made under the old laws remains valid even after the law changes unless you revoke it.

This section describes advance directives and answers some questions about them. It is not intended as legal advice. If you have questions about advance directives that it does not answer, you may ask doctor or other individuals in charge of your health care or call your local hospital for more information. You also may wish to talk about advance directives with your family or a lawyer.

What Decisions Can I Make With An Advance Directive? The Health Care Decisions Act permits you to name someone, called your “agent”, to make health care decisions—to accept or refuse health care—for you if, at some point, you cannot make them yourself. This type of advance directive is often called a “health care power of attorney,” a “durable power of attorney for health care” or a “health care proxy.” Unless you say otherwise in your advance directive, the person named in this type of advance directive can make all health care decisions for you that you could have made for yourself if you were able, whether or not you are terminally ill. This includes decisions about medication, surgery, mental health treatment, health facility admission or any other health care. If you want to limit your agent’s authority, you may direct that your agent make only those decisions you list.
The law says that your agent cannot make decisions that he or she knows go against your religious beliefs, basic values and stated preferences. You also may name a person who will see that your organs or your body are donated, as you wish, after your death.

Whether you name an agent in your advance directive or not, you also may use your advance directive to give specific instructions about the health care you do or do not want. Specifically, your advance directive can address all forms of health care for any time that you cannot make decisions yourself. For example, your advance directive can address things such as mental health (psychiatric) care, dialysis and the use of antibiotics or other drugs at any time.

**What If I Have A Terminal Condition?** One type of instruction you may give in your advance directive is how to care for you if you ever have a terminal condition and you are unable to make decisions for yourself. This is often called a “living will.” A terminal condition is an incurable condition in which death is imminent. It also means a persistent vegetative state, which some people call a permanent coma, even when death is not imminent. In either case, a doctor has determined that there is no medically reasonable hope for recovery. Signing this type of advance directive permits you to decide in advance whether you want doctors to give you what the law calls “life-prolonging procedures.”

**What Are “Life Prolonging Procedures?”** These are treatments that aren't expected to cure a terminal condition or make you better and that only prolong dying. They include hydration (giving water) and nutrition (giving food) by tube, machines that breathe for you, and other kinds of medical and surgical treatment. Life-prolonging procedures do not include health care needed to make you comfortable or to ease pain. Your doctor will give you drugs or other health care to ease pain and make you comfortable unless you specifically say in your advance directive that you do not want them. You can also say in this type of advance directive that you want to have particular life-prolonging procedures given to you. For example, if you want to have all life-prolonging procedures except tube feeding withdrawn, you may say that in your advance directive.

**What Do I Need To Say In My Advance Directive?** Whatever your choices are, you can put them in your own words. You do not need to use any specific medical or legal words. You may just describe as best you can what medical care you do and do not want.

**Will My Advance Directive Be Followed In An Emergency If I Cannot Make My Wishes Known?** Usually emergency medical personnel, such as rescue squads or ambulance teams, cannot follow your choices in an advance directive if they are called to help you in an emergency. Also, hospital emergency room providers may not know your choices in an emergency. But you can make decisions in advance about refusing one type of emergency medical care—resuscitation or “CPR” if your heart stops beating or you stop breathing. You do this by having your doctor complete a “Durable Do Not Resuscitate Order” (often called a “Durable DNR order”) for you on a form approved by the state. This order is valid unless you revoke it — that is, you change your mind and tell your doctor that you do want to be resuscitated.
If I Die Because I Refused Life-Prolonging Treatment Under the Health Care Decisions Act, Will My Death Be Considered Suicide? No. The Health Care Decisions Act specifically says that, if it is followed and the patient dies, the death is not suicide. Creating an advance directive that says you do not want life-prolonging procedures will not void a life insurance policy even if the policy says otherwise.

Must An Advance Directive Be In Writing? The Health Care Decisions Act allows people who have a terminal condition and who have not signed an advance directive to make an oral advance directive. They may say what they want, or name a person to make decisions for them, in front of witnesses. However, if you are not in a terminal condition, your advance directive must be in writing, signed by two witnesses.

Who Can Be A Witness? A husband or wife can be a witness. Other blood relatives also can be witnesses as long as they are adults. A health care provider can also be a witness. Finally, even your agent can be a witness, but it may be better to have someone who is not your agent (or your alternate agent) be a witness. In Virginia, you do not need a notary to witness your advance directive in order for it to be a valid advance directive.

Must I Have An Advance Directive? No. An advance directive is just one way of being sure your doctors and your loved ones know what health care you want when you can't tell them yourself. You may have any or all types of advance directives that are allowed under the Health Care Decisions Act. The law requires that health care providers not discriminate against people based on whether they have or do not have an advance directive.

What Happens If I Can't Make Decisions And I Have No Advance Directive? Virginia law lists persons such as guardians or family members who may make decisions about your health care even if you do not have an advance directive. In this situation, there may be multiple people who can make your health care decisions, and this can lead to conflicts. For this reason, naming a single agent in an advance directive may prevent conflicts about your decisions. If no listed person is available to decide for you, a judge can decide what health care is best.

Do I Need A Lawyer To Help Me Make An Advance Directive? A lawyer is helpful, but you don't have to have a lawyer prepare either type of advance directive. In fact, the Health Care Decisions Act suggests a form that you may use.

What If I Change My Mind After I Sign An Advance Directive? You can revoke it by saying so in writing or orally or by destroying it or having someone else destroy it in front of you. If you want to, you can make a new one. If you are a patient or resident in a health care facility, tell your doctor or nurse that you want to revoke or change your advance directive.
**How Will My Doctor Know I Have an Advance Directive?** Hospitals and other health care facilities must ask patients or residents if they have an advance directive and, if so, must see that a patient’s or resident’s health record shows that they have one. You should give copies of your advance directive to your family and to your doctor, and to anyone else you think needs to know what medical treatment you do or don’t want. In Virginia, photocopies, faxes and digital scans of advance directives are valid.

**Is A Financial Or General Power Of Attorney The Same As An Advance Directive?** A financial power of attorney gives another person power to make decisions about money for you. If the power of attorney document does not mention health care, it is not an advance directive. If you are in doubt, you may wish to consult a lawyer.

**Where Can I Go For More Information About Advance Directives?** There are many sources of additional information on advance directives, including your local hospital. You also may wish to talk this over with your physician and/or lawyer.

*The Virginia Department of Health and the Virginia Department for the Aging have approved this information (brochure) for distribution under the requirements of federal law. Revised 7/09*

**What Is A Durable Do Not Resuscitate Order?** Emergency medical services (EMS) personnel are not authorized to follow advance directives when called in an emergency, but Virginia law does permit residents to direct EMS personnel to withhold one type of treatment - cardiopulmonary resuscitation. This is done when the physician issues a written Durable Do-Not-Resuscitate (DNR) Order on a form approved by the Board of Health. A doctor may issue the order only with the consent of the patient or the patient’s legal representative. The order remains valid and in effect until it is revoked by the patient or the representative.

Our agency complies with the Patient Self-Determination Act of 1990 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.

Patients have the right to accept or refuse medical/surgical treatment and to formulate Advance Directives. Complaints concerning noncompliance regarding Advance Directives may be filed with the Virginia State Department of Health, Office of Licensure and Certification, 9960 Mayland Drive, Suite 401, Richmond, Virginia 23233; telephone number 1-800-955-1819.
SECTION V. Safety

All patients need to take special precautions to ensure a safe living environment. Most accidents in the home can be prevented by eliminating hazards. This checklist will help you find potential hazards in your home. Check each statement that you need to work on to make your home a safer place. **Please speak with your nurse/therapist or call the agency at any time if you have any concerns or questions about patient safety.**

### PREVENTING FALLS

At least half of all falls happen at home. Each year, thousands of older Americans experience falls that result in serious injuries, disability and yes, even death. Falls are often due to hazards that are easily overlooked but easy to fix. Use the following **SELF-ASSESSMENT**. Check all of the risk factors below that apply to you and your home. The more factors checked, the higher your risk for falling.

- **History of Falling** - 2 or more falls in last 6 months.
- **Vision Loss** - changes in ability to detect and discriminate objects; decline in depth perception; decreased ability to recover from a sudden exposure to bright light or glare.
- **Hearing Loss** - may not be as quickly aware of a potentially hazardous situation.
- **Foot Pain/Shoe Problems** - foot pain; decreased sensation/feeling; skin breakdown; ill-fitting or badly worn footwear.
- **Medications** - taking four or more medications; single or multiple medications that may cause drowsiness, dizziness or low blood pressure.
- **Balance and Gait Problems** - decline in balance; decline in speed of walking; weakness of lower extremities.
- **High or Low Blood Pressure** that causes unsteadiness.
- **Hazards Inside Your Home** - tripping and slipping hazards, poor lighting, bathroom safety, spills, stairs, reaching, pets that get under foot.
- **Hazards Outside Your Home** - uneven walkways, poor lighting, gravel or debris on sidewalks, no handrails, pets that get under foot, hazardous materials (snow, ice, water, oil) that need periodic removal and clean up.

Review each of the following safety tips. Check the ones you need to work on:

- Keep emergency numbers in large print near each phone.
- Put a phone near the floor in case you fall and can't get up.
- Wear shoes that give good support and have thin, non-slip soles. Avoid wearing slippers and athletic shoes with deep treads.
- Remove things you can trip over (such as papers, books, clothes and shoes) from stairs and places where you walk.
- Keep outside walks and steps clear of snow and ice in the winter.
- Remove small throw rugs or use double-sided tape to keep them from slipping.
- Ask someone to move any furniture so your path around the house is clear.
- Clean up spills immediately.
Be aware of where your pets are at all times.
Do not walk over or around cords or wires, i.e., cords from lamps, extension cords or telephone cords. Coil or tape cords and wires next to the wall so you can't trip over them. Have an electrician add more outlets if needed.
Keep items used often within easy reach (about waist high) in cabinets.
Use a steady step stool with a hand bar. Never use a chair as a step stool.
Improve the lighting in your home. Replace burned out bulbs. Lamp shades or frosted bulbs can reduce glare.
Make sure stairways, halls, entrances and outside steps are well lit. Have a light switch at the top and bottom of the stairs.
Place a lamp, flashlight and extra batteries within easy reach of your bed.
Place night-lights in bathrooms, halls and passageways so you can see where you're walking at night.
Make sure the carpet is firmly attached to every step. If not, remove the carpet and attach non-slip rubber treads on the stairs. Paint a contrasting color on the top front edge of all steps so you can see the stairs better.
Fix loose handrails or put in new ones. Make sure handrails are on both sides of the stairs and are as long as the stairs. Fix loose or uneven steps.
Install grab bars next to your toilet and in the tub or shower.
Use non-slip mats in the bathtub and on shower floors.
Use an elevated toilet seat and/or shower stool, if needed.
Exercise regularly. Exercise makes you stronger and improves your balance and coordination. Talk to your doctor about what exercise is right for you.
Have your nurse, doctor or pharmacist look at all the medicines you take, even over-the-counter medicines. Some medicines can make you sleepy or dizzy.
Have your vision checked at least once a year by an eye doctor. Poor vision can increase your risk of falling.
Get up slowly after you sit or lie down.
Use a cane or assistive device for extra stability, if needed.
Think about wearing an alarm device that will bring help in case you fall and can't get up.

**FIRE SAFETY/BURN PRECAUTIONS**

The fire department number is posted on every telephone. All family members and caregivers are familiar with emergency 911 procedures.
Notify the fire department if a disabled person is in the home.
**Do not smoke in bed or where oxygen is being used.** Never leave burning cigarettes unattended. Do not empty smoldering ashes in a trash can. Keep ashtrays away from upholstered furniture and curtains.
Install smoke alarms on every floor of your home, including the basement. Place smoke alarms near rooms where people sleep. Test smoke alarms every month to make sure they are working properly.
Install new smoke alarm batteries twice a year or when you change your clocks for daylight savings time in the spring and fall.
Fire extinguishers are checked frequently for stability.
Make a family fire escape plan and practice it every six months. At least two different escape routes are planned from each room for each family member. If your exit is through a ground floor window, make sure it opens easily.

If you live in an apartment building, know where the exit stairs are located. Do not use an elevator during a fire emergency.

Designate a safe place in front of the house or apartment building for family members to meet after escaping a fire.

If your fire escape is cut off, remain calm, close the door and seal cracks to hold back smoke. Signal for help at the window.

A bedbound patient can be evacuated to a safe area by placing him/her on a sturdy blanket and pulling/dragging them out of the home.

Remember, life safety is first, but if the fire is contained and small, you may be able to use your fire extinguisher until the fire department arrives.

Have your heating system checked and cleaned regularly by someone qualified to do maintenance.

Wood burning stoves are properly installed, chimney is inspected and cleaned by a professional chimney sweep and trash is not burned in stove because this could overheat the stove. Gasoline or other flammable liquids should never be used to start wood stove fires.

Portable heaters (electric or kerosene) are placed out of the path of traffic areas. The heater is operated at least three feet away from upholstered furniture, drapes, bedding and other combustible materials. The heater is used on the floor and is turned off when family members leave the house or are sleeping. A kerosene heater is only used in a well ventilated room. Kerosene is stored outdoors in a tightly sealed, labeled container.

Make sure electrical appliances and cords are clean, in good condition and not exposed to liquids.

Electrical outlets are grounded. "Octopus" outlets with several plugs are not used.

Keep cooking areas free of flammable objects (potholders, towels, etc.).

Keep storage area above the stove free of flammable/combustible items.

Wear short or tight fitting sleeves while cooking; don't reach over stove burner.

Do not leave the stove unattended when cooking, especially when the burner is turned to a high setting.

Turn pan handles away from burners and the edge of the stove.

Avoid cooking on high heat with oils and fat.

Puncture plastic wrap before heating foods in the microwave.

Never place hot liquids/solids at edge of counter.

Place layered protection between skin and heating pad.

Keep electrical appliances away from the bathtub or shower area.

Never leave patient alone in the shower/tub.

Set water heater thermostat below 120°F to prevent accidental scalding.

Store flammable liquids in properly labeled, tightly closed, non-glass containers. Store away from heaters, furnaces, water heaters, ranges and other gas appliances. Make sure the garage is adequately ventilated.
MEDICATION SAFETY

- Do not take medications that are prescribed for someone else.
- Create a complete list of current medications (including prescription, over-the-counter, vitamins, herbals). Review the list for discrepancies and make changes immediately as they occur. Show the list to your doctor or pharmacist to keep from combining drugs inappropriately.
- Know the name of each of your medicines; why you take it; how to take it; potential side effects; and what foods or other things to avoid while taking it.
- Report medication allergies or side effects to your healthcare provider.
- Take medications exactly as instructed. If the medication looks different than you expected, ask your healthcare provider or pharmacist about it.
- Drug names can look alike or sound alike. To avoid errors, check with your healthcare provider if you have questions.
- Do NOT use alcohol when you are taking medicine.
- Do not stop or change medicines without your doctor’s approval, even if you are feeling better. If you miss a dose, do not double the next dose later.
- Use a chart or container system (washed egg carton or med-planner) to help you remember what kind, how much and when to take medicine.
- Take your medicine with a light on so you can read the label.
- Read medicine labels (including warnings) carefully and keep medicines in their original containers.
- Store medications safely in a cool, dry place according to instructions on the label of the medication.
- Keep medicines away from children and confused adults.
- **Federal disposal guidelines for medications:** Remove drugs from their original containers. Conceal or remove personal information and Rx number using a black marker, duct tape or by scratching it off. Mix drugs with an undesirable substance like coffee grounds or kitty litter. Put the mix in an empty margarine tub or sealable bag. Throw it and the empty containers in the trash. Some medications can be flushed down the toilet, but check the prescription label, patient information insert or FDA’s website before doing so. If your community has a pharmaceutical take-back program, take your unused drugs to them for proper disposal.

HAZARDOUS ITEMS AND POISONS

- Know how to contact your poison control team.
- Carefully store hazardous items in their original containers.
- Do not mix products that contain chlorine or bleach with other chemicals.
- Insecticides are only bought for immediate need and excess is stored or disposed of properly.
- Keep hazardous items, cleaners and chemicals out of reach of children and confused or impaired adults.
- Dispose of hazardous items and poisons only as directed.
MEDICAL EQUIPMENT SAFETY

- Keep manufacturer's instructions for specialized medical equipment with or near the equipment.
- Perform routine and preventive maintenance according to the manufacturer's instructions.
- Keep phone numbers available in the home to obtain service in case of equipment problems or equipment failure.
- Have backup equipment available, if indicated.
- Provide adequate electrical power for medical equipment such as ventilators, oxygen concentrators and other equipment.
- Test equipment alarms periodically to make sure that you can hear them.
- Have equipment batteries checked regularly by a qualified service person.
- Bed side rails are properly installed and used only when necessary. Do not use bed rails as a substitute for a physical protective restraint.
- If bed rails are split, remove or leave the foot-end down so the patient is not trapped between the rails.
- Mattress must fit the bed. Add stuffers in gaps between the rail and mattress or between the head and foot board and mattress to reduce gaps.
- Register with your local utility company if you have electrically powered equipment such as oxygen or ventilator.

OXYGEN SAFETY

- Use oxygen only as directed.
- **No smoking around oxygen.** Post “No Smoking” signs in the home.
- Store oxygen cylinders away from heat and direct sunlight. Do not allow oxygen to freeze or overheat.
- Keep oil/petroleum products (such as Vaseline®, oily lotions, face creams or hair dressings), grease and flammable material away from your oxygen system. Avoid using aerosols (such as room deodorizers) near oxygen.
- Dust the oxygen cylinder with a cotton cloth and avoid draping or covering the system with any material.
- Keep open flames (such as gas stoves and lighted candles) at least 10 feet away from the oxygen source.
- Have electrical equipment properly grounded and avoid operating electrical appliances such as razors and hairdryers while using oxygen. Keep any electrical equipment that may spark at least 10 feet from the oxygen system.
- Use 100% cotton linens and clothing to prevent sparks and static electricity.
- Place oxygen cylinders in appropriate stand to prevent tipping, or secured to the wall or placed on their side on the floor. Store in a well-ventilated area and not under outside porches or decks or in the trunk of a car.
- Have a back-up portable oxygen cylinder in case of a power or oxygen concentrator failure.
**POWER OUTAGE**

If you require assistance during a power outage and our phone lines are down:
- Call 911 or go to the nearest hospital emergency room if you are in a crisis or have an emergency situation.
- Call your closest relative or neighbor if it is not an emergency.

**FLOODS**

Floods are the most common and widespread of all natural hazards. Some floods can develop over a period of days, but flash floods can result in raging waters in just a few minutes. Be aware of flood hazards, especially if you live in a low-lying area, near water or downstream from a dam.

Assemble a disaster supplies kit. Include a battery-operated radio, flashlights and extra batteries, first aid supplies, sleeping supplies and clothing. Keep a stock of food and extra drinking water.

**If local authorities issue a flood watch, prepare to evacuate:**
- Secure your home. Move essential items to the upper floors of your house.
- If instructed, turn off utilities at the main switches or valves. Do not touch electrical equipment if you are wet or standing in water.
- Fill a clean bathtub with water in case water becomes contaminated or services are cut off.
- Six inches of moving water can knock you off your feet. If you must walk in a flooded area, do not walk through moving water.
- Use a stick to check the firmness of the ground in front of you.

**TORNADO**

Tornadoes are nature's most violent storms. When a tornado has been sighted, go to your shelter immediately. Stay away from windows, doors and outside walls.

- In a house or small building: Go to the basement or storm cellar. If there is no basement, go to an interior room on the lower level (closets, interior hallways). Get under a sturdy table, hold on and protect your head. Stay there until the danger has passed.
- If the patient is bedbound, move the patient’s bed as far away from windows as possible. Cover the patient with heavy blankets or pillows being sure to protect the head and face. Then go to a safe area.
- In a school, nursing home, hospital, factory or shopping center: Go to predesignated shelter areas. Interior hallways on the lowest floor are usually safest. Stay away from windows and open spaces.
- In a high-rise building: Go to a small, interior room or hallway on the lowest floor possible.
- In a vehicle, trailer or mobile home: Get out immediately and go to a more substantial structure.
- If there is no shelter nearby, lie flat in the nearest ditch, ravine or culvert with your hands shielding your head. In a car, get out and take shelter in a nearby building. Do not attempt to out-drive a tornado. They are erratic and move swiftly.
**LIGHTNING**

**Inside a home:**
- Avoid bathtubs, water faucets and sinks because metal pipes can conduct electricity.
- Stay away from windows.
- Avoid using the telephone, except for emergencies.

**If outside:**
- Do not stand underneath a natural lightning rod, such as a tall, isolated tree in an open area.
- Get away from anything metal.

**WINTER STORMS**

Heavy snowfall and extreme cold can immobilize an entire region. Even areas which normally experience mild winters can be hit with a major snow storm or extreme cold. The results can range from isolation due to blocked roads and downed power lines to the havoc of cars and trucks sliding on icy highways.

**Gather emergency supplies:**
- Battery powered radio, flashlights, battery-powered lamps, extra batteries.
- Food that doesn’t require cooking and a manual can opener.
- Your medications.
- Extra blankets.
- Extra water in clean soda bottles or milk containers.
- Rock salt to melt ice on walkways and sand to improve traction.
- Make sure you have enough heating fuel as regular fuel sources may be cut off.

**Dress for the season:**
- Wear several layers of loose-fitting, light-weight, warm clothing rather than one layer of heavy clothing.
- Outer garments should be tightly woven and water repellent.
- Mittens are warmer than gloves.
- Wear a hat since most body heat is lost through the top of the head.

**HURRICANE**

A hurricane can immobilize an entire region. Heavy rains and high winds cause flooding and damage to structures and surrounding landscapes. Preparation is the key to surviving a hurricane: keeping informed of the storm’s path and anticipated arrival, assembling disaster supplies, securing your home and evacuating to a shelter if necessary.

**Gather emergency supplies:**
- Battery powered radio, flashlights, battery-powered lamps, extra batteries.
- Food that doesn’t require cooking and a can opener, utensils, cup and plate.
- Extra water in clean milk gallon containers; fill a clean bathtub with water.
Secure your home:
- Cover windows with plywood, shutters or masking tape.
- Move lawn furniture and other outdoor items inside.
- Move essential personal items to an interior, waterproof location.

Evacuate to a shelter (if indicated) bringing:
- A two week supply of medications/supplies.
- Non-perishable special dietary foods and a manual can opener.
- Air mattress, cot, lightweight folding chair, sleeping bag, blankets, pillow.
- Extra clothing, personal hygiene items, glasses.
- Important papers and valid ID with your name and current address.
- Home Health folder.
- Assistive devices such as wheelchair, walker, cane and portable oxygen.
- If you are electrically dependent and have been assigned to a Special Needs Shelter, you must bring your electrical device (such as oxygen concentrator) with you. Special Needs Shelters have electric power from a generator.

NOTE: In most cases, pets are not allowed in shelters.

EMERGENCY PREPAREDNESS/SHELTER EVACUATION

NOTE: A shelter is intended to be an option of last resort, as the evacuee will not receive the same level of care as in their home and the conditions of the shelter may be stressful.

If you have a caregiver, the caregiver should accompany you and remain with you at the shelter. Caregivers who regularly assist patients in the home are expected to continue to do the same in the shelter. You should check with local emergency management regarding service dogs or family pets in the shelter. Be prepared to bring personal snacks, drinks, and any special dietary foods for 72 hours.

The following is a recommended list of supplies to accompany you to a shelter:
- Bed sheets, blankets, pillow, folding lawn chair, air mattress;
- Medications, supplies and equipment, including phone, beeper, pager and emergency numbers for your physician, pharmacy and, if applicable, oxygen supplier; supplies and medical equipment for your care; advance directives including a Do Not Resuscitate Order (DDNR), if applicable;
- Contact name and phone number of the home health agency;
- Prescription and non-prescription medication needed for at least 72 hours; oxygen for 72 hours, if needed;
- A copy of your plan of care (from your home health agency);
- Patient identification and current address;
- Special dietary items, non-perishable food for 72 hours and at least 1 gallon of water per person per day;
- Eye glasses, hearing aids and batteries, prosthetics and any other assistive devices;
- Personal hygiene items for 72 hours;
- Extra clothing for 72 hours;
- Flashlight and batteries; and
- Self-entertainment and recreational items, e.g., books, magazines, quiet games.
PEDIATRIC SAFETY

☐ There are no small loose objects and toys that can fit into the toddler’s mouth. Hanging crib toys and mobiles are kept out of the infant’s reach. Only one-piece approved pacifiers are used.

☐ The infant is restrained while in highchair, walker, etc. Crib rails and playpen rails are raised to full height.

☐ Safety gates are placed on the top and bottom of staircases and elevated areas such as porches or fire escapes. Guardrails are placed on upstairs windows and all windows have locks that limit size of opening.

☐ Toilet seats, bathroom doors, oven doors, trunks, dishwashers, refrigerators and front-loading clothes washers and dryers doors are kept closed at all times.

☐ Plastic bags are stored away from a young child’s reach. Large plastic garment bags are tied and discarded.

☐ Pails, buckets and wading pools are kept empty when not in use. Swings, slides and play equipment are kept in safe condition.

☐ Medicines/chemicals/batteries/cleaning fluids and supplies are kept out of the child’s reach. Cabinets and drawers have safety locks.

☐ Knives, power tools and firearms are stored safely out of the reach of the child and/or placed in a locked cabinet.

☐ Infants/toddlers are not left alone in the home, car and/or while bathing.

☐ Infants are not left unattended with bottles propped. Soft pillows or bean bags are not used to prop the infant.

☐ The infant’s head is elevated during feeding and the infant is burped frequently. Infant is not placed flat on back or stomach during or immediately after feeding.

☐ Formula temperature is always tested prior to feeding the infant. The child's food is served in appropriate bite size pieces.

☐ Pot handles face inward on the stove while cooking.

☐ Electrical outlets have outlet covers over them when not in use. Electric cords are kept out of the child’s reach.

☐ Children under the age of 5 or 40 pounds (or as required by law) are placed in approved car seats. The car seat is not placed in the front seat of the vehicle.

☐ Emergency phone numbers (e.g., Poison Control, pediatrician, police, fire and nearest relative) and the address of your home and the nearest cross street are kept handy and by the telephone for easy access.
SECTION VI. Infection Control at Home

Cleanliness and good hygiene help prevent infection. “Contaminated materials” such as bandages, dressings or surgical gloves can spread infection, and harm the environment. If not disposed of properly, these items can injure trash handlers, family members and others who could come in contact with them.

Certain illnesses and treatments (i.e., chemotherapy, dialysis, AIDS, diabetes, burns) can make people more susceptible to infection. Your nurse will instruct you on the use of protective clothing (gowns/gloves) if they are necessary.

Notify your physician and/or home care staff if you develop any of the following signs and symptoms of infection:

- pain/tenderness/redness or swelling of body part
- inflamed skin/rash/sores/ulcers
- painful urination
- confusion
- nausea/vomiting/diarrhea
- fever or chills
- sore throat/cough
- increased tiredness/weakness
- pus (green/yellow drainage)

You can help control infection by following these guidelines:

### HANDWASHING

**Wash your hands** (even if wearing gloves) before and after tending to someone who is sick or when treating a cut or wound; before preparing or eating food; and after using the toilet, changing a diaper or cleaning up a child who has gone to the bathroom, handling soiled linens, handling garbage, handling animals or animal waste, coughing, sneezing or blowing your nose. Handwashing needs to be done frequently and correctly.

**Soap and Water Procedure:** When hands are visibly dirty or contaminated or soiled with blood or other body fluids, wash your hands with soap and running water. Remove jewelry; use warm running water and soap (liquid soap is best); place hands together under water and rub your hands together for at least 20 seconds. Wash all surfaces (wrists, palms, back of hands, between fingers, under fingernails) and clean any dirt from under nails. Rinse soap from hands and dry with a clean towel. Air dry if a clean towel is not available or if the towel is shared with others. Use a paper towel to turn off the faucet. Pat hands dry to avoid chapping and cracking. Apply hand lotion to help prevent and soothe dry skin.

**Waterless Antiseptic Hand Cleanser Procedure:** If hands are not visibly dirty or contaminated or soiled with blood or other body fluids, an alcohol-based hand rub may be used for routinely decontaminating hands. The antiseptic agent should contain 60-90% ethyl or isopropyl alcohol. When using a waterless antiseptic hand cleanser, make sure the cap or spout is open. Place a quantity of the liquid or gel (about the size of a dime or the amount recommended by the product manufacturer) in the palm of one hand; and rub hands vigorously, covering all surfaces of hands and fingers, until hands are dry.

Washing your hands is the single most important step in controlling the spread of infection.
**COVER YOUR COUGH**

Cover your mouth and nose with a tissue when you cough or sneeze; or cough or sneeze into your upper sleeve, not your hands. Put your used tissue in the waste basket. You may be asked to put on a surgical mask to protect others.

**Clean your hands after coughing or sneezing.** Wash hands with soap and warm water for 20 seconds or clean with alcohol-based hand cleanser.

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**DISPOSABLE ITEMS AND EQUIPMENT**

*Items which are not sharp* including: paper cups, tissues, dressings, soiled bandages, plastic equipment, urinary/suction catheters, disposable diapers, Chux, plastic tubing, medical gloves, etc.

Store medical supplies in a clean, dry area. Dispose of used items in waterproof (plastic) bags. Fasten securely and dispose of bag in the trash.

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**NON-DISPOSABLE ITEMS AND EQUIPMENT**

*Items which are not thrown away* including: soiled laundry, dishes, thermometer, commode, walker, wheelchair, bath seat, suction machine, oxygen equipment, mattress, etc.

**Soiled laundry** should be washed apart from other household laundry in hot, soapy water. Handle these items as little as possible to avoid spreading germs. Household liquid bleach should be added if viral contamination is present (*a 1 part bleach to 10 parts water solution is recommended*).

**Equipment** used by the patient should be cleaned immediately after use. Small items (except thermometers) should be washed in hot, soapy water, rinsed and dried with clean towels. Household cleaners such as disinfectant, germicidal liquids or diluted bleach may be used to wipe off equipment. Follow equipment cleaning instructions and ask your nurse/therapist for clarification.

**Thermometers** should be wiped with alcohol before and after each use. Store in a clean, dry place.

**Liquids** may be discarded in the toilet and the container cleaned with hot, soapy water, rinsed with boiling water and allowed to dry.

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**SHARP OBJECTS**

*Items which are sharp* including: needles, syringes, lancets, scissors, knives, staples, glass tubes or bottles, IV catheters, razor blades, disposable razors, etc.

Place used "sharps" directly into a clean, rigid container with a screw-on or tightly secured lid. Use a hard plastic or metal container. Never overfill the containers or recap needles once used. **DO NOT use glass** or clear plastic containers and never put "sharps" in containers that will be recycled or returned to a store. Seal the container lid with heavy-duty tape and place it in the trash can or dispose of it according to area regulations.

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**SPILLS IN THE HOME**

**Blood and other body fluids**

Blood and body fluid spills are cleaned by putting on gloves and wiping fluid with paper towels. Use a cleaning solution of household bleach and water (*1 cup of bleach to 10 cups of water*) to wipe the area again. Double bag the used paper towels and dispose of them in the trash.
ADMISSION CONSENT

CONSENT FOR TREATMENT

I consent to receive treatment from RHA consistent with a plan of care authorized by my physician and other services agree to by myself and RHA and authorized by my payer(s). Any services that are not authorized by the payer(s) will be billed to me and will be my sole financial responsibility, unless RHA has a contract with my health plan with other conditions. RHA services delivered to me include:

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I agree and acknowledge that time records reflect the service provided and constitute the basis of billing. I authorize to sign the time records.

AUTHORIZATION FOR PAYMENT

I authorize RHA to bill for services and receive payment from:

- Medicare/Medicaid: Policy # ____________________________ I certify that the information I have provided in applying for payment under Medicare and/or Medicaid is correct. I request that payment of authorized benefits be made on my behalf to RHA. OASIS data will be collected for purpose of financial reimbursement and will not be disclosed except for purpose allowed by the Federal Privacy Act. I have the right to refuse to answer OASIS questions and I may request a change in data on the agency's OASIS data set.

- Medicaid Waiver Programs: Medicaid # ______________________ I certify that the information I have provided in applying for payment under the Medicaid Waiver is correct. I request that payment of benefits be made on my behalf to RHA also understand that I am responsible for the co-pay amount that may be adjusted periodically by the Medicaid Program. This amount is due to be paid in full to RHA at the beginning of every month.

- Private Insurance/Assignment of Insurance Benefits: Policy # ____________________________ Group # ________________ I hereby authorize payment directly to RHA of any insurance benefits otherwise payable to me for services at a rate not to exceed RHA regular charges for such services. I understand that I am financially responsible to RHA for charges not covered by this assignment as documented under section on Self Pay. If RHA has a written contract with my health plan, I understand that the agreed health plan contract will govern.

- Self Pay/Co-payment: I agree to pay all invoices no later the seven (7) days after receipt of billing. All charges not paid within thirty (30) days of billing date shall be assessed a late charge in the amount of 18% or the maximum legal interest rate, whichever is lower. I am liable for all charges, including collection costs and attorneys fees, regardless of my insurance unless my agreement with my health plan holds me harmless.

BILLING RATE

The rate for caregiver's services provided: Monday 7:00 a.m. through Saturday 7:00 a.m. (weekday) $ __________ per hour __________ per visit The rate for caregiver's services provided Saturday 7:00 a.m. through Monday 7:00 a.m. (weekday) $ __________ per hour __________ per visit All rates are subject to change with two (2) weeks prior notice to be provided.

DEPOSIT

I agree to pay simultaneously with signing this agreement $ ____________________________ for services rendered. ☐ Not applicable Credit Card Type and #: ____________________________ Expiration Date: ____________________________

Client's or Personal Representative's Signature ____________________________ Relationship to Client ____________________________ Date ____________________________

Authority of Personal Representative (e.g., Health Care Power of Attorney, Guardian or Other Statutory Authorization) ____________________________ Client Name (Applicable only if Representative Signs for Client) ____________________________ Date ____________________________

☐ Client unable to sign due to: ____________________________

Revival Homecare Agency Representative’s Signature ____________________________ Date ____________________________
HOLIDAY RATES

All charges for service rendered on holidays or rendered by the same individual, at my request, in excess of 40 hours during any work week will be one and one-half (1½) times the applicable weekday or weekend rate. Holidays are: New year's Day, Memorial Day, Fourth of July, Labor Day, Thanksgiving Day, Christmas Eve and Christmas Day.

ENROLLING IN HMO/PPO

I agree to notify Revival Homecare Agency immediately if I have enrolled in a Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO). I understand that the enrollment in such programs may not cover the services provided in this agreement; therefore, I will be responsible for payment of non-covered services in full.

I understand that I am also liable for payment of uncovered services if I knowingly misrepresent information regarding receiving duplicate services that are covered in this agreement by other home health care providers.

SERVICE INTERRUPTION

I understand that RHA uses its best efforts to provide uninterrupted services; however, sometimes interruptions are unavoidable during any interruption of service. I agree to provide or arrange for back-up care or RHA will arrange for transfer to an appropriate emergency facility, or make the appropriate referral to another agency if necessary.

HIRING OF RHA EMPLOYEES

I understand that if I hire a RHA employee, I must give notice or pay a fee. I understand an employee is an individual who is currently employed by RHA or has been an employee within the last ninety (90) days. I also understand I must give sixty (60) days notice prior to hiring the individual or pay 15% of the employee's annualized billing rate to RHA.

RELEASE OF INFORMATION

I acknowledge receipt of the Notice of Privacy Practices and was given an opportunity to ask questions and voice concerns. I understand that the agency may use or disclose protected health information about me to carry out treatment, payment or health care operations. I consent to the release of information and/or disclosure of all or any part of my medical record by any physician, hospital, or other facility where I have been a client to RHA; checking my credit and financial rating and history with any person, firm or credit bureau; and release of information by RHA to individuals acting in official capacities as my advocate representing government or third party payers, case managers, accrediting organizations and other health care providers involved in my care; or oversight and accreditation agencies responsible for reviewing RHA's operations.

CONSENT TO FILM OR RECORD

I hereby consent for the agency to record or film my care, treatment and services and allow the agency to use the photographs/recordings for their internal use, for documenting my medical condition or for insurance providers to document my condition for payment purposes.

PATIENT RIGHTS & RESPONSIBILITIES

I acknowledge receipt of my rights and responsibilities as a patient (including OASIS rights) and I understand them. The State home health hotline number, its purpose and hours of operation have been provided and explained to me. I have received the agency's Problem Solving Procedure. I have been provided the opportunity to discuss any question or concern I may have with my RHA representative. I have also been given an agency contact number for the future concerns. I have been made aware of my right to make healthcare decisions for myself and that I may express my wishes in a document called an Advance Directive so that my wishes may be known when I am unable to speak for myself. I have received the agency’s policy regarding Advance Directives and state specific Advance Directive information.

TERMINATION

I understand I may terminate this agreement by giving at least four (4) hours notice. Additionally, RHA may terminate this agreement by providing at least seventy-two (72) hours (3 business days) or such other minimum notice require by applicable state law or by program guidelines. RHA requires payment of four (4) hour minimum bill on behalf of a caregiver who reports for duty should I decide to terminate services without proper notice. I understand paragraphs related to payment, late charges, hiring of employees, deposits, overtime, consents, releases and authorization for payment and assignment if insurance benefits remain effective after termination of this agreement.

ORIENTATION BOOKLET

I acknowledge that I have received RHA's Patient Orientation for Home Health Care booklet and confirm my understanding of its contents. I have received the agency’s after hours/on-call procedure, information regarding home safety, emergency preparedness and infection control in the home.

I understand a copy of this consent form shall be as valid as the original and shall remain in effect until I am discharged from the agency. I also understand that I may revoke this consent in writing at any time.

I certify that I have received and read a copy of this agreement and that I am the client or I am acting on the client’s behalf, and accept these terms. My signature on page 1 certifies my authorization.

I acknowledge receipt of the above information. My signature on page one of this form verifies that the above information has been verbally explained to my understanding and agreement.
CLIENT NAME: ___________________________  CLIENT ID: ___________________________

CONSENT FOR TREATMENT

I consent to receive treatment from RHA consistent with a plan of care authorized by my physician and other services agree to by myself and RHA and authorized by my payer(s). Any services I request that are not authorized by the payer(s) will be billed to me and will be my sole financial responsibility, unless RHA has a contract with my health plan with other conditions. **RHA services delivered to me include:**

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I authorize RHA to bill for services and receive payment from:

- **Medicare/Medicaid:** Policy # ___________________________ I certify that the information I have provided in applying for payment under Medicare and/or Medicaid is correct. I request the payment of authorized benefits be made on my behalf to RHA. OASIS data will be collected for purpose of financial reimbursement and will not be disclosed except for purpose allowed by the Federal Privacy Act. I have the right to refuse to answer OASIS questions and I may request a change in data on the agency's OASIS data set.

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Credit Card Type and #: ___________________________ Expiration Date: ___________________________

Client’s or Personal Representative’s Signature: ___________________________ Relationship to Client: ___________________________ Date: ___________________________

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Client Name (Applicable only if Representative Signs for Client): ___________________________ Date: __________________________

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ADMISSION CONSENT (Continued)

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I acknowledge receipt of my rights and responsibilities as a patient (including OASIS rights) and I understand them. The State home health hotline number, its purpose and hours of operation have been provided and explained to me. I have received the agency's Problem Solving Procedure. I have been provided the opportunity to discuss any question or concern I may have with my RHA representative. I have also been given an agency contact number for the future concerns. I have been made aware of my right to make healthcare decisions for myself and that I may express my wishes in a document called an Advance Directive so that my wishes may be known when I am unable to speak for myself. I have received the agency's policy regarding Advance Directives and state specific Advance Directive information.

TERMINATION

I understand I may terminate this agreement by giving at least four (4) hours notice. Additionally, RHA may terminate this agreement by providing at least seventy-two (72) hours (3 business days) or such other minimum notice require by applicable state law or by program guidelines. RHA requires payment of four (4) hour minimum bill on behalf of a caregiver who reports for duty should I decide to terminate services without proper notice. I understand paragraphs related to payment, late charges, hiring of employees, deposits, overtime, consents, releases and authorization for payment and assignment if insurance benefits remain effective after termination of this agreement.

ORIENTATION BOOKLET

I acknowledge that I have received RHA's Patient Orientation for Home Health Care booklet and confirm my understanding of its contents. I have received the agency's after hours/on-call procedure, information regarding home safety, emergency preparedness and infection control in the home.

I understand a copy of this consent form shall be as valid as the original and shall remain in effect until I am discharged from the agency. I also understand that I may revoke this consent in writing at any time.

I certify that I have received and read a copy of this agreement and that I am the client or I am acting on the client’s behalf, and accept these terms. My signature on page 1 certifies my authorization.

I acknowledge receipt of the above information. My signature on page one of this form verifies that the above information has been verbally explained to my understanding and agreement.
<table>
<thead>
<tr>
<th>PART 1</th>
<th>PART 2</th>
<th>PART 3</th>
<th>PART 4 - Age</th>
<th>PART 5 - Disability</th>
<th>PART 6 - ESRD</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes. Date benefits began:</td>
<td>☐ Yes. Date of accident:</td>
<td>☐ Age</td>
<td>☐ Yes.</td>
<td>☐ No.</td>
<td>If yes, complete payer information below.</td>
</tr>
<tr>
<td>☐ No.</td>
<td>☐ No</td>
<td>☐ Disability</td>
<td>☐ Never employed</td>
<td>☐ No.</td>
<td>2. Have you received a kidney transplant?</td>
</tr>
<tr>
<td>☐ BL IS PRIMARY ONLY FOR CLAIMS RELATED TO BL.</td>
<td>☐ What type of accident caused the illness/injury?</td>
<td>☐ Medicare GO TO PART 3</td>
<td>☐ No. Date of Retirement:</td>
<td>☐ Yes.</td>
<td>☐ Yes. Date of transplant:</td>
</tr>
<tr>
<td>☐ No.</td>
<td>☐ Automobile</td>
<td></td>
<td>☐ No.</td>
<td></td>
<td>☐ No.</td>
</tr>
<tr>
<td>☐ Non-automobile</td>
<td></td>
<td></td>
<td>☐ Never employed</td>
<td></td>
<td>☐ No.</td>
</tr>
<tr>
<td>☐ Other</td>
<td>☐ Was another party responsible for this accident?</td>
<td></td>
<td>☐ No.</td>
<td></td>
<td>☐ No.</td>
</tr>
<tr>
<td>☐ Yes; Complete payer information below. NO-FAULT INSURER IS PRIMARY PAYER ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT.</td>
<td>☐ Yes; Complete payer information below. LIABILITY INSURER IS PRIMARY ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT.</td>
<td></td>
<td>☐ No.</td>
<td></td>
<td>☐ Yes.</td>
</tr>
<tr>
<td>☐ No.</td>
<td>☐ IF THE PATIENT ANSWERED &quot;NO&quot; TO BOTH QUESTIONS 1 AND 2, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED &quot;YES&quot; TO QUESTIONS IN PART 1 OR 2. DO NOT PROCEED ANY FURTHER.</td>
<td></td>
<td>☐ No.</td>
<td></td>
<td>☐ No.</td>
</tr>
<tr>
<td>☐ GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.</td>
<td>☐ Do you have group health plan (GHP) coverage based on your own, or a spouse's, current employment?</td>
<td></td>
<td>☐ Yes</td>
<td></td>
<td>☐ GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.</td>
</tr>
<tr>
<td>☐ No.</td>
<td>☐ Never employed</td>
<td></td>
<td>☐ No.</td>
<td></td>
<td>☐ No.</td>
</tr>
<tr>
<td>☐ No.</td>
<td>☐ If the patient answered &quot;yes&quot; to the questions in part 1 or 2, Medicare is primary unless the patient answered &quot;yes&quot; to questions in part 1 or 2.</td>
<td></td>
<td>☐ Yes</td>
<td></td>
<td>☐ No.</td>
</tr>
<tr>
<td>☐ COMPLETE PAYER INFORMATION BELOW. WC IS PRIMARY PAYER ONLY FOR CLAIMS RELATED TO WORK RELATED INJURIES OR ILLNESS.</td>
<td>☐ If you participated in a self dialysis training program, provide date training started:</td>
<td></td>
<td>☐ Yes.</td>
<td></td>
<td>☐ No.</td>
</tr>
<tr>
<td>☐ Go to PART 3</td>
<td>☐ Yes. Date dialysis began:</td>
<td></td>
<td>☐ No.</td>
<td></td>
<td>☐ Yes.</td>
</tr>
<tr>
<td>☐ No.</td>
<td>☐ If yes,</td>
<td></td>
<td>☐ No.</td>
<td></td>
<td>☐ No.</td>
</tr>
<tr>
<td>☐ Yes.</td>
<td>☐ Are you within the 30-month coordination period that starts ?</td>
<td></td>
<td>☐ Yes.</td>
<td></td>
<td>☐ GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.</td>
</tr>
<tr>
<td>☐ No.</td>
<td>☐ Are you covered under the group health plan of a family member other than your spouse?</td>
<td></td>
<td>☐ No.</td>
<td></td>
<td>☐ No.</td>
</tr>
<tr>
<td>☐ Yes. Complete payer information below.</td>
<td>☐ GO TO PART 4</td>
<td></td>
<td>☐ No.</td>
<td></td>
<td>☐ No.</td>
</tr>
<tr>
<td>☐ No.</td>
<td></td>
<td></td>
<td>☐ No.</td>
<td></td>
<td>☐ No.</td>
</tr>
<tr>
<td>☐ No</td>
<td></td>
<td></td>
<td>☐ No.</td>
<td></td>
<td>☐ No.</td>
</tr>
<tr>
<td>☐ No</td>
<td></td>
<td></td>
<td>☐ No.</td>
<td></td>
<td>☐ No.</td>
</tr>
</tbody>
</table>

**PRIMARY PAYER INFORMATION**

<table>
<thead>
<tr>
<th>EMPLOYER (Patient):</th>
<th>EMPLOYER (Spouse):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>Address:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INSURER/GHP:</th>
<th>Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy identification number: (this number is sometimes referred to as the health insurance benefit package number):</td>
<td></td>
</tr>
<tr>
<td>Group identification number:</td>
<td></td>
</tr>
<tr>
<td>Membership number (prior to HIPAA, this number was frequently the individual’s SSN; it is the unique identifier assigned to the policyholder/patient):</td>
<td></td>
</tr>
</tbody>
</table>

Name of policyholder/named insured: Relationship to patient: Date:

---

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# HOME ENVIRONMENT SAFETY CHECKLIST

**PATIENT NAME:**

**PATIENT ID:**

---

Check Yes if the item listed is Available, Safe & Adequate. For items checked No explain in comments below.

## HOME ENVIRONMENT ASSESSMENT

<table>
<thead>
<tr>
<th>No.</th>
<th>Item</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Telephone</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Water Supply</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Electricity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Refrigeration</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Storage Space</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Food Supply</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Stove</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Heat &amp; Ventilation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>Sufficient Outlets</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>Free of infestations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>Family involved in patient care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>Caregivers/Sitters</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>No Vicious Animals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td>Lifeline® or Patient Alert System</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>No Smoking signs if O₂ in use</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td>No visible weapons</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## HOME SAFETY

### BATHROOM:

<table>
<thead>
<tr>
<th>No.</th>
<th>Item</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are there handgrips by the tub/shower?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there a nonskid mat in the tub/shower?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there a seat by the sink?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### ELECTRICAL OUTLETS & DEVICES:

<table>
<thead>
<tr>
<th>No.</th>
<th>Item</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do electric cords run along walls?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are electric devices protected from water?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### LIGHTING:

<table>
<thead>
<tr>
<th>No.</th>
<th>Item</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is lighting adequate throughout the house?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are night lights used along routes and areas traveled after dark?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### FIRE SAFETY:

<table>
<thead>
<tr>
<th>No.</th>
<th>Item</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there a home fire safety plan?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are there smoke alarms?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are there exits from all areas of the house?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### FLOORS:

<table>
<thead>
<tr>
<th>No.</th>
<th>Item</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are scatter rugs secured by non-skid backs?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are pathways and hallways cleared of toys, excess furniture, etc.?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### STAIRWELLS:

<table>
<thead>
<tr>
<th>No.</th>
<th>Item</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are there non-skid surfaces on steps?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are handrails present &amp; securely fastened?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### BEDROOMS:

<table>
<thead>
<tr>
<th>No.</th>
<th>Item</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Bed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bed Rails</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bedside Commode</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walker</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cane</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### MISCELLANEOUS:

<table>
<thead>
<tr>
<th>No.</th>
<th>Item</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are hazardous items such as medications &amp; sharps placed in secure areas out of the reach of children or confused individuals?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### COMMENTS:

---

**SIGNATURE:**

**TITLE:**

**DATE:**

---
Patient Name: ___________________________ Patient ID Number: __________________

THE EFFECTIVE DATE COVERAGE OF YOUR CURRENT HOME HEALTH SERVICES WILL END: ________________

- Your provider has determined that Medicare probably will not pay for your current Home Health services after the effective date indicated above.
- You may have to pay for any Home Health services you receive after the above date.

YOUR RIGHT TO APPEAL THIS DECISION

- You have the right to an immediate, independent medical review (appeal), while your services continue, of the decision to end Medicare coverage of these services.
- If you choose to appeal, the independent reviewer will ask for your opinion and you should be available to answer questions or supply information. The reviewer will also look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
- If you choose to appeal, you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should not continue. You will receive this detailed notice only after you request an appeal.
- If you choose to appeal, and the independent reviewer agrees that services should no longer be covered after the effective date indicated above, Medicare will not pay for these services after that date.
- If you stop services no later than the effective date indicated above, you will avoid financial liability.

HOW TO ASK FOR AN IMMEDIATE APPEAL

- You must make your request to your Quality Improvement Organization (also known as a QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end these services.
- Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above.
- The QIO will notify you of its decision as soon as possible, generally by no later than two days after the effective date of this notice.
- Call your QIO at: Virginia Health Quality Center (VHQC), 1-866-263-8402 to appeal, or if you have questions.

See page 2 of this form for more information
OTHER APPEAL RIGHTS:

- If you miss the deadline for filing an immediate appeal, you may still be able to file an appeal with a QIO, but the QIO will take more time to make its decision.
- Contact 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486-2048 for more information about the appeals process.

ADDITIONAL INFORMATION (OPTIONAL)

Please sign below to indicate that you have received this notice.

I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO.

Signature of Patient or Representative ____________________________ Date ____________________________
NOTICE OF MEDICARE PROVIDER NON-COVERAGE

Patient Name: ____________________________________  Patient ID Number: ________________

THE EFFECTIVE DATE COVERAGE OF YOUR CURRENT HOME HEALTH SERVICES WILL END: ________________

- Your provider has determined that Medicare probably will not pay for your current Home Health services after the effective date indicated above.
- You may have to pay for any Home Health services you receive after the above date.

YOUR RIGHT TO APPEAL THIS DECISION

- You have the right to an immediate, independent medical review (appeal), while your services continue, of the decision to end Medicare coverage of these services.
- If you choose to appeal, the independent reviewer will ask for your opinion and you should be available to answer questions or supply information. The reviewer will also look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
- If you choose to appeal, you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should not continue. You will receive this detailed notice only after you request an appeal.
- If you choose to appeal, and the independent reviewer agrees that services should no longer be covered after the effective date indicated above, Medicare will not pay for these services after that date.
- If you stop services no later than the effective date indicated above, you will avoid financial liability.

HOW TO ASK FOR AN IMMEDIATE APPEAL

- You must make your request to your Quality Improvement Organization (also known as a QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end these services.
- Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above.
- The QIO will notify you of its decision as soon as possible, generally by no later than two days after the effective date of this notice.
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- Contact 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486-2048 for more information about the appeals process.

ADDITIONAL INFORMATION (OPTIONAL)

Please sign below to indicate that you have received this notice.

I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO.

Signature of Patient or Representative  
Date
### SECTION VII. Emergency Care Plan

Please call the nurse at 703-341-6670 if you experience any of the following symptoms/problems:

<table>
<thead>
<tr>
<th>Heart/Lung Problems:</th>
<th>Too Much Blood Thinner:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• New onset of a productive/frothy cough or new congestion</td>
<td>• Bleeding from the nose, mouth, gums, rectum, surgical site</td>
</tr>
<tr>
<td>• Change in color, thickness, odor of sputum</td>
<td>• Bruising</td>
</tr>
<tr>
<td>• Increased shortness of breath</td>
<td>• Leg pain</td>
</tr>
<tr>
<td>• New onset of irregular or rapid heartbeat</td>
<td>• Black tarry stools</td>
</tr>
<tr>
<td>• Chest pain relieved by rest or medication</td>
<td>• Blood in urine</td>
</tr>
<tr>
<td>• More swelling in your legs or feet</td>
<td></td>
</tr>
<tr>
<td>• Weight gain of _____ pounds in 24 hrs.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signs of Infection:</th>
<th>Urinary Problems:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Increased redness</td>
<td>• Foul odor to urine</td>
</tr>
<tr>
<td>• Wound gets bigger or more painful</td>
<td>• Catheter not draining</td>
</tr>
<tr>
<td>• Temperature of 100° F or more</td>
<td>• Low back or flank pain; body aches</td>
</tr>
<tr>
<td>• Change in amount, color or odor of wound drainage</td>
<td>• Unable to urinate; frequency of urination</td>
</tr>
<tr>
<td></td>
<td>• Increased weakness</td>
</tr>
<tr>
<td></td>
<td>• Bloody, cloudy or change in urine color</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diabetic Problems:</th>
<th>Other Problems:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Sudden weakness</td>
<td>• No bowel movement in 3 days</td>
</tr>
<tr>
<td>• Uncontrollable thirst or hunger</td>
<td>• New skin problems</td>
</tr>
<tr>
<td>• Increased urination</td>
<td>• Change in balance, coordination, strength</td>
</tr>
<tr>
<td>• Sweating spells</td>
<td>• Fall with small or no injury</td>
</tr>
<tr>
<td>• Sudden dizziness</td>
<td>• Change in mental status</td>
</tr>
<tr>
<td>• Frequent headaches</td>
<td>• Signs of high blood pressure or stroke: new onset of headache, dizziness, nosebleeds, blurred vision, ringing in ears, heart palpitations (fluttering)</td>
</tr>
<tr>
<td>• Itching</td>
<td></td>
</tr>
<tr>
<td>• Drowsiness</td>
<td></td>
</tr>
<tr>
<td>• Blood sugar level greater than _____ or less than _____</td>
<td></td>
</tr>
</tbody>
</table>

**Call 911 if you experience any of the following:**

- ☢️ A fall with a broken bone or bleeding
- ☢️ Chest pain that medication does not help
- ☢️ Severe or prolonged bleeding
- ☢️ Difficulty in breathing
- ☢️ Severe or prolonged pain
- ☢️ Unable to wake patient

---

This information was developed by Carolina Medical Review under a contract with the Centers for Medicare & Medicaid Services (CMS). The contents presented do not necessarily represent CMS policy.
Your professional home care staff

Nurse: ________________________
Supervisor: ____________________
Home Health Aide: ______________
Therapist: _____________________
Social Worker: _________________

Important Phone Numbers (Patient to complete)

Ambulance/Police/Fire
911 or ____________

Hospital

Doctor

Doctor

Non-Emergency Transportation

Pharmacy

Poison Control
1-800-222-1222 or 911

Medical Equipment (Oxygen)

Electric Company

Phone Company

Water Company

Family

Rev. 12/09