Company Name

PATIENT SERVICE AGREEMENT

Date: _____ Time: _____

Patient: _____ ID#: _____

CONSENT TO TREAT

I hereby authorize this agency to render services as prescribed by my physician, or by any other physician who may be treating me, including all diagnostic and therapeutic treatments that may be considered advisable or necessary in the judgment of the physician.

Initial _____

EMERGENCY MEDICAL SERVICES/TRANSFER

I understand that during the course of my therapy the need for emergency treatment and/or transfer to a hospital may become necessary and appropriate. I understand that the agency does not provide emergency medical care and therefore should the need for such treatment and/or transfer be deemed necessary and appropriate by my physician, agency staff will call 911. I consent to such emergency treatment and/or transfer to a hospital and I hereby indemnify the agency and its owners, staff and physician who may be in attendance from any loss resulting from such emergency treatment and/or transfer. I agree to assume full responsibility for all charges incurred for such treatment.

Initial _____

RELEASE OF PATIENT HEALTH INFORMATION

I authorize all physicians, hospitals, nursing homes, clinics and other health care providers to release medical information relevant to my care to the agency.

I hereby authorize the release of any medical information from my records to any licensed institutions, case management, accreditation and regulatory bodies and other health providers for the purpose of providing continuity of care. I place no limitations on history of illness or diagnostic/therapeutic, information including any treatment for substance abuse, psychiatric disorders, acquired immune deficiency syndrome.

Initial _____

INSURANCE BENEFITS

I hereby authorize my private insurance carrier to pay insurance benefits due to me directly to the agency and agree to release of medical information to my insurance carrier. If I should be required by my carrier, I also agree to be personally responsible for my deductible, co-insurance, or other co-payments.

Initial _____

ASSIGNMENTS OF BENEFITS

I authorize the agency to bill Medicare, Medicaid, or HMO for any services provided by the agency and authorize Medicare, Medicaid or HMO to make direct payment to the agency for said services. I understand that I am liable for payment for any services not covered by Medicare, Medicaid, and/or HMO.

Initial _____

NOTICE OF CHARGES

Episode: _____

Agency will provide the following services:

☐ SN ☐ Aide ☐ PT ☐ OT ☐ ST ☐ MSW Other: _____

Frequency of Services: _____

☐ Medicare Program, no charges expected

☐ Medicaid Program, responsible for $2.00 co-pay/visit with maximum of one co-pay per day

☐ Other insurance as per your contract with payer. You are responsible for any co-payment, deductible as stipulated by policy as well as for any non-covered services.

☐ Private Pay. You are responsible for all charges. Method of payment will be _____

☐ You will be billed at a rate of $_____ per _____ for services.

Initial _____

PATIENT SERVICE AGREEMENT

Date: _____ Time: _____

Patient: _____ ID#: _____

STATEMENT OF PATIENT RIGHTS AND RESPONSIBILITY AND ABUSE REGISTRY

Initial _____

I certify that I have read, understand and received a copy of the statement of Patients Rights and Responsibility which has been explained to me orally by a representative of the agency.

ADVANCED DIRECTIVES AND LIVING WILLS

I have received written information regarding my rights to make decisions concerning medical care, including the right to accept or refuse medical treatment and the right to formulate advance directives under state law.

I have a Living Will: ☐ Yes ☐ No

If yes, location of Living Will: _____

I have a "Patient Advocate/Proxy": ☐ Yes ☐ No

My Patient Advocate/Proxy is: _____

Name:_____

Address:_____

City, State, Zip: _____

Initial _____

Phone: _____

CERTIFICATION REGARDING HMO MEMBERSH

Initial _____

I hereby declare that at t pr nt I do not belong to an HMO. I will notify agency immediately should I se to e ll in HMO in the future. I agree to pay for all services rendered to me by agency s ul l t notify agency of my enrollment.

CONSENT FOR OASIS

Initial _____

I rstand that the agency is required to collect health care data on all patients admitted for and at this data is then transmitted to the Agency for Health Care Administration then to the CMS (Medicare Program). Agency personnel have discussed the OASIS ms and answered all my questions. I authorize the agency to release to CMS or its l information included in the OASIS form. I permit a copy of the authorization to be place of the original. I have been assured that all information will be kept in strictest co ence.

PHOTOGRAPHY PERMISSION

Initial _____

I understand and authorize photographs of myself to be taken and kept on file at the agency. These photographs will be used as deemed appropriate by the agency,

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the agency's Notice of Privacy Practices

OR

Initial _____

acknowledgment not signed because: _____

PERMISSION FOR SUPERVISORY VISITS: NOT SKILLED SERVICES

☐ N/A

Initial _____

I hereby give permission for agency to perform supervisory visits for aides, companions and/or homemakers as per agency policy and procedures.

PATIENT SERVICE AGREEMENT

Date: _____ Time: _____

Patient: _____ ID#: _____

AUTHORITY TO SIGN ON BEHALF OF PATIENT

Patient is unable to sign documents because:

_____

Name of person authorized to sign:

_____

Relative: _____

___ Guardianship (attach copy of order)

___ Other: (specify authority empowering signature)

Initial _____ _____

ONE AGENCY ONLY TO PROVIDE SERVICES

I have voluntarily chosen the agency as my sole provider for my home care services.

I am aware that Medicare will only pay for services to one agency during any period of time. I will not enter into any agreement for services with any other home care provider while receiving services by the agency. I will notify the home health agency if I choose to transfer to another provider. Failure to do so may result in me being responsible for any charges denied by my insurer to the agency due to the fact another agency was providing home care services simultaneously.

Initial _____

PATIENT HANDBOOK

I have received the Patient Handbook for the agency and it has been verbally explained to me by a representative of the agency. All of my questions/concerns have been addressed to my total satisfaction.

Initial _____

By my signature, I attest that I have read and received a copy of the Patient's Service Agreement and have had all questions and concerns addressed to my complete satisfaction. I am fully aware that I may contact the agency should any questions/concerns arise while I am a patient or thereafter.

_____ _____

Signature of Patient/Authorized Representative Date

_____ _____

Witness Date

Company Name

MEDICARE SECONDARY PAYOR QUESTIONNAIRE (MSP)

Beneficiary Name: _____DOB: _____

HIC No: _____ Medicare Record No. _____

Start of Care: _____

1. Is the patient covered by Veterans Administration, Black Lung or Worker Compensation? *(Please circle applicable one)*
   ☐ Yes ☐ No

   If yes, give name, address, group #, and phone # of employer/insurance company _____

   _____

   Date of Worker Comp. Accident: _____

2. Was illness due to an injury? ☐ Yes ☐ No

   A. Date of Accident _____

   B. What type of accident caused the illness/injury? If fall, explain in detail _____

   _____

   _____

   C. Is the patient filing or intending to file a liability suit? ☐ Yes ☐ No

   If yes, give name, address, and phone # of attorney: _____

   _____

3. Is the patient employed (Medicare disable beneficiaries under age 65 or Medicare beneficiaries over 65) and covered by a group health plan? ☐ Yes ☐ No

   A. Date of Retirement: _____

   B. Is the patient married? ☐ Yes ☐ No

   C. Is the spouse employed? ☐ Yes ☐ No Spouse's date of retirement _____

   D. Does the spouse have group coverage? ☐ Yes ☐ No

   E. Does the patient have coverage through a spouse, parent or guardian's employer group health plan? ☐ Yes ☐ No

   F. Is patient receiving benefits from a health plan of an employer for whom he/she used to work actively? ☐ Yes ☐ No

   G. If patient is covered by a group health plan, does it qualify as a large group health plan (100 employees or more)?
   ☐ Yes ☐ No

   If you answered yes to either 3, 3D, 3E, 3F, or 3G, give name, address, group # and phone # of employer:

   _____

   _____

   If you answered yes to either 3, 3D, 3E, 3F, or 3G, give name, address, group # and phone # of insurance company handling the group coverage:

   _____

   _____

4. Is the patient entitled to benefits solely on the basis of end stage renal disease? ☐ Yes ☐ No

   A. Has the patient been undergoing kidney dialysis for more than 12 months? ☐ Yes ☐ No

Patient Signature: _____ Date: _____

Company Name

EMERGENCY / DISASTER PLAN FOR HOME HEALTH CARE PATIENTS

(Keep this plan where it can be easily located)

Date: _____ Time: _____

Patient: _____ ID#: _____

Information obtained by: ☐ Client ☐ Caregiver If caregiver, relationship to patient: _____

The Emergency Medical Service will need to know (caregiver):

Name: _____ Phone: _____

Address: _____

Client's Emergency Classification (check one): ☐ D1 ☐ D2 ☐ D3 ☐ D4 *(see back for instructions)*

PATIENT'S DATA

Allergies: _____ Special needs: _____

Medications: _____

_____

Supplies/DME: _____

Pharmacy/Phone: _____

Doctor: _____ Phone: _____

In case of medical emergency, dial 911

In case of nursing or related problem, call your Home Health Care agency: _____

To contact your nurse directly, you may page her/him: _____

Name: _____

In case of emergency notify:

Name: _____ Phone: _____

Address: _____

In the event of a hurricane (other disaster) I will:

☐ Stay at home

☐ Stay with family. Phone: _____

☐ Go to shelter (shelter address): _____

☐ Go to a hospital, if medically necessary (hospital name): _____

Please contact your Home Health Care agency _____ for alternate service options in case of disaster.

Signature of Client: _____ Date: _____

Signature of Nurse: _____ Date: _____

GENERAL INSTRUCTIONS TO CLIENT ON USE OF THIS FORM:

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

1. _____ has a nurse on call 24 hours a day. You can reach the nurse through _____ . After office hours and on weekends an answering service will reach the nurse and he/she will return your call and come to see the client if necessary, or simply answer any questions you may have.
2. In case of a serious medical emergency, the client should be taken to the hospital _____ does not operate as an emergency service, therefore valuable time may be lost by contacting the Agency for a serious emergency such as diabetic coma, severe chest pain, unconsciousness, etc.
3. Ambulance service number is _____.

CLASSIFICATION

(Please circle the correct classification for client)

D1 – Category 1

Clients cannot safely forgo care: high risk clients with high probability of inpatient admissions if home care is not provided; IV therapy, highly skilled wound care, with no family/caregiver, life sustaining medication or equipment.

D 2 – Category 2

Client whose condition worsens, moderate level of skilled care. That should be provided that day, but could postpone visit until condition improves. Client with untrained families/caregivers who could provide basic care in an emerge

D3 – Category 3

Client who can safely forgo care or a scheduled visit including Home Health Aide visits, Clients receiving routine supervisory visits, evaluation visits. Clients with 1 or 2 visits/week, or Clients who have a competent family/caregiver.

D4 – Category 4

Patient who refused information, or signed the registration release form releasing the Agency from evacuation responsibilities.

Company Name

MEDICINE SCHEDULE

PART OF EMERGENCY DISASTER PLAN

Da[illegible] ____________ [illegible]e: ____________

Patient's Name: ______________________________ ID#: ______________

Pharmacy Name: ______________________________ Pharmacy Phone: ______________

Address: ______________________________

MD Name: ______________________________ MD Phone: ______________

N C O	Date Ordered *Fecha*	Medications Dose, Route, Frequency *Medicinas, Dosis, Ruta, Frecuencia*	[illegible]eakfast *Des[illegible]*	[illegible]rzo	Di[illegible] *Comi[illegible]*	Bedtime *[illegible]ostarse*	[illegible]ssification *[illegible]asificación*	Side Effects *Efectos*	D/C Date *Alta*	Level of Understanding (Good - Fair - Poor)

Key to Side Effects / *Guia de Efecto[illegible]cundarios*

A - Nausea / Vomiting *Vómito*
B - Constipation *Estreñimiento*
C - Diarrhea *Diarrhea*
D - Hypertension *Presión Alta*
E - Hypotension *Presión Baja*

F - Skin Rash/[illegible] *Erupción*
G - Head[illegible] *Dol[illegible]*
H - D[illegible]

[illegible] Edema *[illegible]dema*
[illegible]phoresis *[illegible]ación*
[illegible]age *[illegible]as*

P - [illegible]radycardi[illegible] *Bradicardi[illegible]*
[illegible] - Tachycar[illegible] *Taqui[illegible]a*
[illegible]blores
S - Tinitus *Zumbidos en oidos*

T - Fluid / Electrolyte Imbalance *Desbalance liquido*
U - Anorexia
V - Malaise *Malestar*
W - Dyspnea *Falta de Aire*
X - Confusion

Y - Flushing / Blurred Vision *Enrojecimiento / Visión borrosa*
Z - Other / *Otros:*
____
____
____
____

Allergies / *Alergias:*
____
____

____
Nurse Signature/Date *Firma/Fecha*

Update on__________ ______________________ Update on______________ By:______________________

Update on__________ ______________________ Update on______________ By:______________________
Actualizado en *Actualizado en* *Por*

Company Name

AIDE ASSIGNMENT SHEET

Date: _____ Time: _____

Patient: _____ ID#: _____

Care Manager _____ Phone # _____

Frequency/Duration: Aide visits_____ Super. Visits _____

Patient/Client problem: _____

_____

Goals for care: ☐ Effective and safe personal care ☐ Patient/Client clean, comfortable

☐ Other (specify): _____

PARAMETERS TO NOTIFY CARE MANAGER

T _____ BP _____

P _____ R _____

Urine _____

Other (pain) _____

_____

PRECAUTIONARY AND OTHER PERTINENT INFORMATION: *Check all that apply. Circle the appropriate item if separated by slash.*

Patient/Client Address _____ Phone _____

Directions to Home _____

☐ Lives alone
☐ Lives, with other
☐ Alone during the day
☐ Bed Bound
☐ Bed rest ☐ BRPs ☐ Up as tolerated
☐ Amputee (specify):_____
☐ Partial weight bearing: ☐ Right ☐ Left
☐ Non weight bearing: ☐ Right ☐ Left
☐ Hip precautions
☐ Special equipment:_____

☐ Speech/Communication deficit
☐ Vision deficit: ☐ Glasses ☐ Contacts
☐ Other:_____
☐ Hearing deficit: ☐ Hearing Aid
☐ Dentures: ☐ Upper ☐ Lower ☐ Partial
☐ Oriented x 3 ☐ Alert
☐ Forgetful / Confused
☐ Urinary catheter
☐ Prosthesis (specify):_____
☐ Allergies (specify): _____

☐ Diab[illegible] ☐ Do not [illegible]t nails
☐ Diet[illegible] _____
☐ Seizure pre[illegible]tion
☐ [illegible]
☐ Watch f[illegible] hyperglycemia / hypoglycemia
☐ Ble[illegible]g Precautions
☐ [illegible]one to fractures
☐ [illegible]ther (specify):_____
☐ _____
☐ _____

ASSIGNMENT: *Check all applicable tasks. Specify by circling the applicable activity or those items separated by slashes. Write additional precautions, instructions, etc., as needed beside the appropriate items.*

BATH
- ☐ Bath: Tub / Shower (F1)
- ☐ Bed Bath: Partial / Complete (F2)
- ☐ Assist Bath – Chair

HYGIENE/GROOMING
- ☐ Personal Care (F4)
- ☐ Assist with Dressing
- ☐ Hair Care: Brush / Shampoo / Other:
- ☐ Skin Care / Foot Care (Hygiene) Check Pressure Areas
- ☐ Shave / Groom / Deodorant
- ☐ Nail Hygiene: Clean / Fi[illegible]
- ☐ Oral Care: Brush / Sw[illegible]
- ☐ Elimination Assist

PROCEDURES
- ☐ Catheter care (F6)
- ☐ Ostomy care
- ☐ Record output
- ☐ Inspect / Reinforce Dressing *(see below)
- ☐ Assist with Medications *(see below)

ACTIVITY
- ☐ Ambulation Assist (F8) WC / Walker / Cane
- ☐ Mobility Assist: Chair / Bed / Dangle / Commode / Shower / Tub
- ☐ ROM: Active / Passive; Arm: R / L; Leg: R / L
- ☐ Positioning: Encourage / Assist to Turn every _____ Hrs.
- ☐ Exercise – Per: PT / OT / SLP Care Plan (F10)

NUTRITION
- ☐ D[illegible] Order
- ☐ [illegible]ood Allergies:
- ☐ Meal Preparation (F11)
- ☐ Assist with Feeding
- ☐ Fluids: Limit / Encourage
- ☐ Grocery Shopping (F12)

OTHER
- ☐ Wash Clothes (F13)
- ☐ Light Housekeeping (F14): Bedroom / Bathroom / Kitchen / Change Bed Linen
- ☐ Equipment Care
- ☐ Pain Management

VITALS
- ☐ T: O / A / R – Record _____ / week – Report
- ☐ P: Wrist / Pedal, R / L Record _____ / week – Report
- ☐ R: Record _____ / week
- ☐ BP: Record _____ / week
- ☐ Weight: Record _____ / week – Report
- ☐ Pain/Location:
- ☐ Other (specify):

*Wound Care – Inspect/Reinforce Dressing: _____

*Assist with Meds (describe): _____

Special instructions/Safety Measures: _____

INITIAL ASSIGNMENT: Signature/Title: _____ Date:_____ Time:_____

THIS ASSIGNMENT SHEET MUST BE REVIEWED AND/OR REVISED AT LEAST EVERY 60 DAYS.

REVIEWED/REVISED: Signature/Title: _____ Date:_____ Time:_____

Company Name

COMMUNICATION LOG

Date: _____ Time: _____

Patient: _____ ID#: _____

DATE	COMMUNICATION	SIGNATURE/ Discipline

Company Name

NOTICE OF MEDICARE NON-COVERAGE

Date: _____ Time: _____

Patient: _____ ID#: _____

The Effective Date Coverage of Your Current _____

_____ **Services Will End:** _____**(Date)**

- Your Medicare provider and/or health plan have determined that Medicare probably will not pay for your current _____ services after the effective date indicated above.
- You may have to pay for any services you receive after above date.

YOUR RIGHT TO APPEAL THIS DECISION

- You have the right to an immediate, independent medical review (appeal) of the decision to end Medicare coverage of these services. Your services will continue during the appeal.
- If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will 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 services should no longer be covered after the effective date indicated above;
  o Neither Medicare nor your plan will pay for these services after that date.
- If you stop services on 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 no later than two days after the effective date of this notice if you are in Original Medicare. If you are in a Medicare health plan, the QIO generally will notify you of its decision by the effective date of this notice.
- Call your QIO _____ at: _____ to appeal, or if you have questions.

See page 2 of this notice for more information.

Date: _____ Time: _____

Patient: _____ ID#: _____

IF YOU MISS THE DEADLINE TO REQUEST AN IMMEDIATE APPEAL, YOU MAY HAVE OTHER APPEAL RIGHTS:

- If you have Original Medicare: Call the QIO listed on page 1.
- If you belong to a Medicare health plan: Call your plan at the number given below.

Plan contact information

_____

_____

_____

ADDITIONAL INFORMATION (OPTIONAL)

Please sign below to ind[illegible] you received and understood 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 Authorized Representative Date

Form CMS 10123-NOMNC (Approved 12/31/2011) OMB approval 0938-0953

According to the Paperwork Reduction Act of 1995, no persons are required to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is xxxx-xxxx. The time required to distribute this information collection is 60-90 minutes per notice, including the time to select the preprinted form, gather the needed information, complete the form, and deliver it to the enrollee. If you have any comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to MS, PRA Clearance Officer, 750 Security Boulevard, Maryland 21244-1850.

Company Name

OMB APPROVAL NO. 0938-0781

HOME HEALTH ADVANCE BENEFICIARY NOTICE (HHABN)

We,_____, your home health agency, are letting you know that we will be providing you with the following items and/or services:

_____

_____

Because: _____

_____

If you have questions about these changes, you can call us at: (_____) _____.

TTY users should call: (_____) _____.

The estimated cost of the items and/or services listed above is $ _____

_____

If you have other insurance, please see number 3 below.

You have three options available to you. You must choose only one of these options by checking the box next to the option and then signing below:

☐ 1. I don't want the items and/or services listed above. I understand that I won't be billed and that I have no appeal rights since I will not receive those items and/or services.

☐ 2. I want the items and/or services listed above, and I agree to pay myself since I don't want a claim submitted to Medicare or any other insurance I have. I understand that I have no appeal rights since a claim won't be submitted to Medicare.

☐ 3. I want the items and/or services listed above, and I agree to pay for the items and/or services myself if Medicare or my other insurance doesn't pay. Send the claim to **(please check one or both boxes):**

☐ Medicare

☐ My other insurance _____

Please note: If you check box 3 and a claim is submitted to Medicare, you will get a Medicare Summary Notice (MSN) showing Medicare's official payment decision. If the MSN indicates that Medicare won't pay all or part of your claim, you may appeal Medicare's decision by following the appeal procedures in the MSN. If you don't receive a MSN for your claim, you can call Medicare at: 1-800-633-4227. TTY: 1-877-486-2048.

You may have to pay the full cost at the time you get the items and/or services. If Medicare or your other insurance decides to pay for all or part of the items and/or services that you have already paid for, you should receive a refund for the appropriate amount.

By signing below, I understand that I received this notice because this Home Health Agency believes Medicare will not pay for the items/services listed, and so I chose the option checked above.

Patient's Name _____ Patient Identification _____

Signature of the Patient
or of the Authorized Representative _____ Date_____

Please read and sign this notice. Return it to us or mail it to our address listed above.

Company Name

FORMAL PATIENT NOTIFICATION OF DISCHARGE

Date: _____ Time: _____

Patient: _____ ID#: _____

Your discharge from our service is planned for (Date) _____

Reason for discharge _____

GENERAL DISCHARGE INSTRUCTIONS

- Continue to follow _____ diet instructions you received.
- Take only medications prescribed by your doctor. Follow your written medication schedule.
- Discard all outdated medications.
- Keep doctor's name and phone number and your address clearly printed next to your phone or on your refrigerator.
- Keep names and numbers of individuals to be contacted in case of emergency next to your phone or on your refrigerator.
- Call 911 in the event of an emergency.
- Remember to plan on routine medical check-ups. Next doctor's visit is _____

Instruction for continued care / needs:

- ☐ Contact your doctor for a follow-up appointment
- ☐ Contact your doctor for any signs of symptoms of a change in your condition
- ☐ **Continue as taught** (until your physician changes the plan or instructs otherwise):
  - ☐ Medications (see medicine schedule)
  - ☐ Diet: _____
  - ☐ Treatments
  - ☐ Exercises
  - ☐ Procedures
  - ☐ Activities permitted
- ☐ **Contact your equipment company for:**
  - ☐ Problems or questions about equipment
  - ☐ Pick up of equipment that is not needed
  - ☐ Additional supplies (ie: test strips, etc.)
- ☐ Referrals made by the Social Worker for your continuing needs are listed on the Social Services Information Checklist (telephone numbers provided are for follow-up questions).
- ☐ Needles, syringes and finger-stick sharps are to be placed directly into a no-clear, puncture resistant, plastic container with a screw-type lid. When the container is full, tape the lid securely and place the container in the center of your regular garbage for pick-up.

Other special instructions: _____

_____

_____

_____

_____

If we can be of service to you in the future, or should you need further explanation, please feel free to contact us at

_____.

I, _____

Signature of Patient

acknowledge and understand the above instructions and discontinuation of services.

_____ _____

Nurse/Therapist Signature Date

_____ _____

Patient Signature Date