Cover Page

Patient Name: _____

Date of Birth: ___ /___ /_____

Gender: ○ Male ○ Female

Admission ID#: CHR - _____

Phone#: _____

Visit Date: ___ /___ /_____

Visit Type: _____

RN Name: _____

RN CODE #: CHR - _____

Services To Be Provided

1. Community Home Health Care ("Community") can provide the following services. The current rate for each service is attached hereto. The duration and frequency of the services will be in accordance with your current medical order:

☐ **PCA Frequency, Hours:**

_____

☐ **HHA Frequency, Hours:**

_____

☐ **Nursing Frequency, Hours:**

_____

☐ **Therapy - Occupational Frequency, Hours:**

_____

☐ **Therapy - Physical Frequency, Hours:**

_____

☐ **Therapy - Speech Language Pathology Frequency, Hours:**

_____

☐ **HCSS Frequency, Hours:**

_____

☐ **Other Frequency, Hours:**

_____

10. In addition to the above, RN clinical supervision will be conducted: a) at the start of care; b) when there is a change in personnel providing care if the aide does not have documented training and experience in performing the tasks prescribed in the plan of care; and c) at least the following intervals unless otherwise required by your payor contract:

a. PCA, HCSS cases:

- ○ Every 3 months and PRN
- ○ Every 6 months and PRN

b. RN, LPN, HHA PT, OT, SLP, other therapists/counselors cases: every 6 months and PRN

11. Published Rates

For private pay Community will bill you directly and you will be expected and required to pay the following for the above services:

PCA $33 x Per Hour

PCA Live in $429 x Per Day

RN Assessment $150 x Per Visit

RN Supervision $120 x Per Visit

Third Party Insurance

1. **a.** ☐ Public or Private Third Party Health Insurance

   b. You have coverage through traditional Medicaid, a Medicaid managed care plan, or a commercial health insurance plan.

   These carriers will be primarily responsible, and directly billed, for services provided by Community. As such, there is no payment to Community expected directly from you and you will be responsible only for applicable cost-sharing amounts charged by your carrier (e.g., authorized co-payments, deductibles, etc.).

   - To pay the applicable private pay rate(s) reflected on the attached statement: a) during any elimination period(s) established by your carrier; b) in the event of non-payment of any and all charges not covered by your carrier, to the extent allowable under Medicaid or insurance plan rules; and c) should you lose your coverage eligibility;
   - All payments, to the extent required, for services provided by Community should be made payable to Community Home Health Care and sent to 49 North Airmont Road, Montebello New York 10901. If this is not possible, you expressly agree that payments are to be made payable to both you and Community and you grant Community an irrevocable right to endorse such payments over exclusively to Community;
   - If you receive payment directly from your insurance plan you will immediately forward it to Community; and
   - Community has not warranted, represented, or guaranteed that your carrier will authorize or pay for any services provided to you
   - I must inform the Agency of any changes regarding my insurance
   - I will pay any service or supply charge not reimbursed by my insurance company on a weekly basis. I will pay all charges incurred on a weekly basis if I do not have insurance coverage. If a claim is denied for home health services which Community Health Care has submitted on my behalf, I hereby elect not to appeal the denial myself, but I do hereby authorize Community Health Care to resubmit the claim for me and represent me in any negotiations. I authorize the Agency to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
   - If payment is denied I understand that I will be responsible for unpaid services, and agree to make payment within 15 days of final denial.

2. Changes in service:

Community will advise you of any changes in information provided herein (e.g., rates and/or the extent to which payment may be expected from you and others) as soon as possible, but no later than thirty (30) calendar days from the date the agency becomes aware of the change. Additionally, if after services begin, a change occurs to your status that necessitates the provision of new/additional services, we will notify you regarding the extent of payment and liability prior to the initiation of those new/additional services. A new Agreement for Service will not be required. If you accept services after receiving notice of a rate change, the new rate shall be applicable. You may discontinue receipt of services at any time.

Client Rights and Responsibilities

1. Client Rights and Responsibilities

a. Client Rights and Responsibilities

You have a number of important rights as a Community patient. These rights are described for you in a separate document contained in your admission packet. You are encouraged to familiarize yourself with these rights and avail yourself of them, as necessary. You also have a number of responsibilities as a Community patient. These include, but are not limited, to the following:

- Notifying the office of any changes to your scheduled hours as soon as possible. Cancellations must be communicated at least twenty-four (24) hours in advance and if such notice is not provided, or you otherwise refuse the services of a scheduled worker, you will be billed for four (4) hours of service as permitted by applicable law;
- Providing cleaning supplies and equipment needed by caregivers;
- Securing personal items and valuables;
- Securing any dogs or cats in the residence throughout the duration of any shift, by crating or containment in a separate room, if requested;
- Maintaining a smoke-free environment throughout the duration of any shift, if requested;
- Allowing Community to assign caregivers in a non-discriminatory manner; and
- Treating caregivers with respect.
- **I have been notified of my right to voice a complaint and understand that I may first file a complaint with the Administrator or Director of Patient Services at 845-425-6555. I understand that this is not an emergency line. I will Call 911 in an emergency.**
- I am aware that instructions for filing a complaint are included in the Client Rights provided at onboarding. I can also contact the New York New York State Department of Health, Office of Health Systems Management, Phone 1-800-628-5972, Contact by Mail: Department of Health Metropolitan Regional Office, Complaint Intake Program Address: 90 Church street, New York, New York 10007
- I have been informed what to do in an emergency /natural disaster. I have been informed verbally and in writing regarding Agency policy on abuse, neglect and exploitation, agency drug testing policy and hazardous waste disposal in the home.
- HIPAA - I have received a Notice of Privacy Practices and consent to the agency's use and/or disclosure of protected health information for payment, treatment and Agency's Health care operations.

b. Community may discontinue services to you if you:

a) do not meet the above patient responsibilities

b) for non-payment of applicable fees

c) if you become ineligible for third party coverage and do not agree to continue as a private pay patient. In such event, you agree to make appropriate alternate arrangements for your continued care

c. I have been informed that Community Home Health Care is my primary, home health agency and is licensed to provide home health services under a Plan of Care authorized by my physician. I accept treatment from Community Home Health Care and authorize the agency to release medical information to my physician, the facility of my choice, payer source or accrediting/regulatory/consulting organizations, as appropriate. I authorize the release of the Plan of Care and Discharge Summary upon my transfer to another health care facility. I understand that this is my right and responsibility to be involved in my care and that I will be informed as to the nature and purpose of any technical procedure.

d. ● I have received a copy and explanation of my Patients' Rights & Patients' Responsibilities and Conduct, as appropriate.

● I acknowledge receipt of information pertaining to Palliative Care, Advance Directives, Do Not Resuscitate Order, Living Will and Health Care Proxy. I understand my rights and responsibilities as they have been explained.

e. I have signed a Living Will/Advanced Directive out Hospital DNR

○ Yes -> I am providing a copy for my record: ○ Yes ○ No

○ No

2. Medical Power of Attorney

a. Name

_____

b. Phone number

_____

Confirm Receipt of Admission Package

1. **The agency is committed to informing all clients of Agency policies and procedures at the start of care. Clients are encouraged to ask questions and participate in this interaction. Community has provided me with an Admission package which includes but is not limited to the following:**

- Agency Mission Statement
- What I Need to Know About EVV Fact Sheet
- Available Services and Rates
- Geographic Service Area
- Hours of Operation
- Patient Bill of Rights and Responsibilities
- Emergency Numbers and Agency Emergency after Hours Information
- Assignments of Benefits
- Financial Responsibilities
- Consent & Charges
- Advance Directives including Out of Hospital DNR
- HIPAA and Notice of Privacy Practices
- Safety Tips to Prevent Falls
- Hazardous Waste Disposal
- Abuse and Neglect
- Palliative Care
- Admissions Criteria
- On-Call Guidelines
- Plan for Care
- Medical Records
- Discharge, Transfer & Referral
- Cell phone use
- Ethics
- Drug Free Workplace
- Patient Satisfaction
- Problem-Solving & Complaint Procedure
- Home & Fire Safety
- Preventing Hospitalizations
- Infection Control at Home
- Disaster Planning & Emergency Preparedness
- Advance Directives
- Living Will
- Medical Power of Attorney for Health Care
- Non-Hospital Order Not to Resuscitate
- Notice of Privacy Rights and Practice

2. These documents have been verbally explained to me and copies have been left with me to refer to as needed. My signature below indicates that I acknowledge that the above mentioned was reviewed with me by the Registered Nurse or Agency designee at the start of care. I was given an opportunity to ask questions and I fully understand this information.

The undersigned acknowledges that he/she has read the foregoing (which was also explained verbally) and accepts the terms set forth herein.

3. Copy of Form Given to Patient

a. ☐ A copy of this form has been given to the patient by…

b. Name:

_____

c. Given on:

__/__/____

4. Signatures

a. Today's date:

_____

q. Agency Rep/Nurse signature:

X_____

r. Agency Rep/Nurse print name:

_____

t. Patient Signature:

X_____ **OR** ☐ Patient is unable to sign. Authorized agent signing on the patient's behalf:

Reason that patient is unable to sign:

_____

Authorized agent signature:

X _____

Print name:

_____

Relationship to patient:

_____