STAY AT HOME

HOME CARE

Stay at Home Home Care

ADMISSION PACKET

2022

NON-MEDICAL ASSESSMENT pg. 1 of 3

Consumer Name:	**Phone:**
Address:	
Physician Name:	**Phone:**
Responsible Party Name:	**Phone:**
Emergency Contact Name:	**Phone:**

ASSESSMENT

General Topics	Subject Matter	Action(S) Indicated
	General Information	
Current Situation HX		
Recent Hospitalizations/ Health Problems		
Height & Weight	Weight Status: ____ Increase ____ Static ____ Decrease Recent WT Changes:	
Current Medications		
Need for Palliative Care	❑ Yes ❑ No	
Dental Care		
Vision		
Hearing		
Mental Health Status	❑ Alert ❑ Oriented ❑ Confused ❑ Disoriented ❑ Other: MEMORY: ❑ Intact ❑ Poor REASONING/JUDGMENT: ❑ Good ❑ Poor ❑ Unimpaired	
	LIVING HABITS	
Smoking Habits	Consumer Smokes: ❑ Yes ❑ No If yes, Issue/Problem: ❑ Yes ❑ No	
Alcohol Consumption	Consumer Drinks: ❑ Yes ❑ No Issue/Problem: ❑ Yes ❑ No	
Special Dietary Requirements		
Allergies	❑ No ❑ Yes- specify	
Eating Habits Appetite	❑ Good ❑ Fair ❑ Poor	
	COMMUNICATION	
Language/ Communication	Primary Language: Speaks/Understands English: ❑ Yes ❑ No Can make needs known: ❑ Yes ❑ No	
Speech		
Understanding	❑ Unimpaired ❑ Understands Simple Phrases Only ❑ Understands Key Words Only ❑ Understanding Unknown ❑ Not Responsive	

CONSUMER NAME:
Pg. 2 of 3

ABILITY TO COMPLETE ACTIVITIES OF DAILY LIVING		
Functional Limitations	❑ No ❑Yes- explain:	
Mobility	❑ Indep ❑ Unable ❑ Needs assist	
Ambulation	❑ Indep ❑ Unable ❑ Needs assist	
Transfers	❑ Indep ❑ Unable ❑ Needs assist	
Bathing	❑ Independent in Bathtub or Shower ❑ Independent with Mechanical Aids ❑ Requires Minor Assistance or Supervision: ❑ Getting In/Out of Tub/Shower ❑ Turning Taps On/Off ❑ Washing Back ❑ Requires Continued Assistance ❑ Resists Assistance	
Dressing	❑ Independent ❑ Supervision or Needs some occasional assist ❑ Periodic or Daily Assist Needed: Difficulty with:	
Grooming & Hygiene	❑ Independent ❑ Reminder, Motivation&/or Direction ❑ Assistance with Some Things ❑ Requires Total Assistance ❑ Resists Assistance	
Eating	❑ Independent ❑Independent with Special Provision for Disability ❑ Intermittent Assist With: ❑ Cutting Up/Pureeing Food ❑ Must Be Fed ❑ Resists Feeding	
Bladder Control	❑ Totally Continent ❑ Needs Routine Toileting or Reminder ❑ Incontinent occasionally ❑ Incontinent daily	
Bowel Control	❑ Total Control ❑ Needs Routine Toileting or Reminder ❑ No Bowel Control Due to Identifiable Factors ❑ Loses Bowel Control occasionally ❑ Loses Bowel Control daily	
Toileting	❑ Raised Toilet Seat or Commode ❑ Difficulty With Buttons, Zippers ❑ Needs Help with Aids (E.g. Catheter, Condom Drainage, etc.) ❑ Other:	
Movement	❑ Exercises Daily ❑ Type/Time/Distance: ❑ Recent Changes to Routine: ❑ Exercise Alone ❑ Exercises With Attendant	
ABILITY TO COMPLETE INSTRUMENTAL ACTIVITIES OF DAILY LIVING		
Meal Prep	❑ Independent ❑ Able if Ingredients Supplied ❑ Can Make/Buy Meals Diet is Inadequate ❑ Physically/Mentally Unable to Prepare Food ❑ Chooses Not to Prepare Food	
Housekeeping	❑ Independent ❑ Generally Independent But Needs Help With Heavier Tasks ❑ Can Perform Only Light Tasks Adequately ❑ Performs Light Tasks But Not Adequately ❑ Needs Regular Help and/or Supervision ❑ No Opportunity to Do Housework/Chooses Not to Do Housework	
Shopping	❑ Independent ❑ Can Shop if Accompanied ❑ Unable to Shop ❑ No Opportunity to Shop/Chooses Not to Shop	
Transportation	❑ Uses Private Vehicle ❑ Uses Taxi/Bus ❑ Independent ❑ Must be Accompanied ❑ Must be Driven ❑Physically or Mentally Unable to Travel ❑ Needs Ambulance for Transporting	
Telephone Use	❑ Independent ❑ Can Dial Well Known Numbers ❑ Answers Only ❑ Unable ❑ No Opportunity to Use Telephone/Chooses Not to	
ATTENDANT PROFILE		
Attendant	❑ Independent ❑ Needs Attendant: Frequency: ❑ Intermittent ❑ 24 hours ❑ Daytime ❑ Night ❑ Attendant Needs Met by: ❑Spouse ❑ Friend ❑ Family ❑ Not met	
SOCIAL PROFILE		
Living Arrangements	Where: With Whom: Adequate: ❑ Yes ❑ No	
Any Safety/health hazards	❑ No ❑ Yes- specify:	
Home Environmental Assessment:		

Living Companions	❑ Alone ❑ With Spouse/Partner ❑ With Adult Child ❑ With Child(ren) ❑ With Other Adult Male ❑ With Other Adult Female ❑ Principal Helper:	Page 3 of 3
Social Activities Involvement:		
Religion & Culture	Ethnicity: Religion: Actively Practicing: ❑ Yes ❑ No	
FINANCIAL PROFILE		
Financial Benefits	❑ Social Security ❑ State Income Supplement ❑ Veterans/Disability Pension ❑ Company Pension ❑ Other	
Managing Finances	❑ Self ❑ Spouse ❑ Family ❑ Friend ❑ Trustee ❑ Power of Attorney ❑ Other	
ADDITIONAL INFORMATION		
Other information that could impact the level of care/services required to meet needs.		

_____

Assessor Name/Title (Print)

_____

Assessor Signature Date

_____

Client or Client's Representative's Signature Date

SERVICE PLAN

CONSUMER SERVICE PLAN

Name: _____ DOB: _____ ❑ Male ❑Female MR #: _____
SOC Date: _____
Address: _____ Phone: _____
Lives with: _____ Relationship: _____
Advance Directive: ❑ Yes ❑ No
Emergency contact: _____Evacuation plan: _____
(name, relationship, phone number) Disaster Class: ❑ I ❑ II ❑ III ❑ IV
Diagnosis:

Identified Problems:

Allergies: _____ Diet (specify): _____

Assistive devices:

Psychosocial: ❑Alert ❑ Oriented ❑ Confused ❑ Forgetful ❑ Wanders

Functional limitations:

Discipline/s to provide care:	❑ Personal Care Worker	❑ Respite Care	❑ Companion	❑ Specialized Care

Duration of services: _____ Frequency of visits: _____

Special requests from Consumer or family:

Supervisor name and number:

Frequency of supervisory visits:

Goals for care:

Staff completing POC: _____ Date: _____
Signature/Title

Service plan reviewed with Consumer/family: _____Date: _____
Consumer Signature

Reviewed with Staff at SOC: _____Date: _____
Staff Signature/Title

Reviewed with Staff at Reassessment: _____Date: _____
Staff Signature/Title

Consumer Name: **Service Plan Page 2 of 2**

Personal Care Tasks								Nutrition tasks							
Days to be performed	**M**	**T**	**W**	**Th**	**F**	**Sa**	**Su**	**Days to be performed**	**M**	**T**	**W**	**Th**	**F**	**Sa**	**Su**
1. Total bed bath								29. Prepare meal ❑ B ❑ L ❑ D							
2. Assist bed bath								30. Total feed							
3. Assist shower								31. Assist with feeding							
4. Assist tub								32. Snacks							
5. Sponge bath								**Mobility tasks**	**M**	**T**	**W**	**Th**	**F**	**Sa**	**Su**
6. Shampoo								33. Bedrest							
7. Conditioner								34. Assist to transfer							
8. Comb/brush hair								35. Assist to ambulate							
9. Brush teeth								36. Wheelchair							
10. Clean dentures								37. Walker							
11. Apply lotion to skin								38. Cane							
12. Dress								39. Crutches							
13. Shave: ❑ safety razor ❑ electric								40. ❑ Exercise ❑ Range of motion							
14. Nail care: ❑ clean ❑ file								**Precautions**	**M**	**T**	**W**	**Th**	**F**	**Sa**	**Su**
15. Medications ❑ remind ❑ assist with self-administered meds								41. Infection control: Hand washing; Standard Precautions							
16. Apply:								42. Choking							
17. Remove:								43. Bleeding							
Toilet/Elimination tasks	**M**	**T**	**W**	**Th**	**F**	**Sa**	**Su**	44. Oxygen safety							
18. Urinal								45. Fall prevention							
19. Bedpan								**Other tasks**	**M**	**T**	**W**	**Th**	**F**	**Sa**	**Su**
20. Commode								46. Assist w/Self-Admin meds: locating, remind, read label, open store, provide liquids							
21. Toilet								47. Change bed linens							
22. Incontinence brief								48. Make Consumer bed							
23. Incontinence care								49. Consumer laundry							
24. Empty urinary bag								50. Shopping for:							
25, ❑ Empty ostomy bag ❑ Rinse ostomy bag								51. Errands to:							
Specialized Care	**M**	**T**	**W**	**Th**	**F**	**Sa**	**Su**	52. Transportation to:							
26.								53. Other							
27.															
28.															

Report the following changes to the Supervisor (list):

The Consumer or legal rep participated in development of the service plan. ❑ Yes ❑ No
Explain if no:
The service plan discussed with the discipline(s) that will be providing service. ❑ Yes ❑No
Explain if no:

STAY AT HOME
HOME CARE

Welcome Letter

We would like to thank you for choosing our Agency to service your homecare needs. The owners of our Agency are experienced in the home services industry. We are dedicated to working diligently to find better solutions for your unique homecare situations.

The Agency's mission is to provide quality, reliable services to you. Our staff delivers the highest standards in home services. Our administrative and office staffs coordinate all these services to provide seamless, effortless service for you. There is always someone for you to call when you have changes or need questions answered.

At Stay at Home Home Care, we collaborate with you and your family members to provide the services you need when you need them.

Our Agency maintains a Consumer record of the services we provide. Your record is secured and its privacy protected at all times. You may request a copy of your record by sending your request to us in writing. By signing your admission documents you are authorizing our Agency to collect and maintain that record by either paper charts or electronic medical record.

You can contact us Monday to Friday during business hours at our office phone. After normal business hours, should you need assistance you can call us through our answering service by calling our regular phone number which is forwarded to on call after hours. Either our on call Supervisor or on call scheduler will return your call.

Although we fully expect you to be extremely pleased with our services, if ever you should have a complaint, please feel free to call our office directly at: (215) 355-9999 and the PA State Hotline & Ombudsman as listed in your Consumer Rights.

We evaluate our Agency on an annual basis, reviewing all aspects of our services. A summary of the evaluation report is available to consumers/general public upon written request.

Although the medical record is the property of our Agency, should you ever need access to your medical record, you may obtain copies by submitting a written request to the office that provides your services.

We look forward to providing you with excellent home care service and thank you for choosing Stay at Home Home Care.

Best Regards,
Karapet Kankanian,
Agency Director

Guide to Safety in the Home

People of all ages have accidents. Please take a few minutes to review the safety guide; you can protect yourself and those around you by taking some precautions.

Falls: Falls are the most frequent and most serious accidents in the home. There are several things you can do to prevent falls:

- Remove throw rugs when Consumer is relying on ambulatory aides such as walkers and canes or has a shuffling gait
- Use nonskid tape or backing on throw rugs. Tack down the edges of all carpets
- Be sure there are firmly anchored non-slip treads, good lighting and a solid, easy-to grasp handrail that is rounded or knobbed at the end of stairs.
- Consider painting or taping the top and bottom steps so they'll be easily noticed.
- Make sure there is a clear walkway through every room. Avoid using halls/stairways for storage.
- Be sure halls/stairways are well lit.
- Don't walk on a freshly washed or waxed floor until it is dry.
- Wipe up any spills immediately to avoid slips.
- Avoid wearing only socks, smooth-soled shoes, or slippers on uncarpeted floors.
- In the bathroom, be sure mats are nonskid and there are treads in the tub or shower.
- Keep outdoor stairs, porches, and walkways free of wet leaves, snow, and ice.
- Make sure stairs and walkways are in good repair.

Protect Yourself and Your Family from Fire and Burns

- Don't smoke in bed or when sleepy.
- Use portable heaters according to manufacturer's instructions. Turn off before going to bed.
- Have your home checked if there are signs of any wiring problems.
- Check hot water temperature. Experts suggest setting hot water at 120 degrees Fahrenheit or lower.
- Keep pot handles turned away from front of stove. Use pot holders when necessary.
- Never leave unattended food cooking on the stove

Be Prepared

- Install smoke detectors and check them regularly
- Keep multipurpose fire extinguisher charged and handy
- Make a fire escape plan. Check fire exits to be sure they open easily and are free of clutter
- If you live in an area where weather conditions change suddenly, make sure you have an evacuation plan or call your city hall regarding the emergency evacuation plan

PA COMMUNITY RESOURCES

PA Department of Aging
Health Insurance Counseling and Assistance
400 Market Street
Rachel Carson State Office Building
Harrisburg, PA 17101
(800)783-7067

Pennsylvania Department of Public Welfare
(717) 787-1870

State Ombudsmen
State LTC Ombudsman
Pennsylvania Department of Aging
555 Walnut Street, 5th Floor
P.O. Box 1089
Harrisburg, PA 17101
(717) 783-7247

PA AGING AND DISABILITY RESOURCE CENTER: (800) 753-8827

PA Insurance Counseling: APPRISE Helpline is (800) 783-7067

Pennsylvania Free Transit Program: PA Department of Aging (717) 783-1550

Allegheny County AAA: 2100 Wharton St. 2nd FL., Pittsburgh, PA 15203, 412-350-4234

Bucks County AAA: 55 E Court St, 3rd FL., Doylestown, PA 18901, 267-880-5700

Chester County AAA: 601 Westtown Rd. Ste. 320, West Chester, PA 19380, 610-344-6350

Delaware County AAA: 206 Eddystone Ave., Eddystone, PA, 19022, 610-490-1300

Montgomery County AAA: 1430 DeKalb St., Norristown, OA, 19404, 610-278-3601

Philadelphia County AAA: 642 N. Broad St., Philadelphia, PA, 19130, 215-765-9000

Westmoreland County AAA: 200 S. Main St., Greensburg, PA, 15601, 724-830-4444

Home Care Services

Stay at Home Home Care
295 Buck Road, Suite 104, Holland PA 18966
(215) 355-9999

Personal Care Services

Assistance with self-administered medications, feeding, oral, skin and mouth care, shaving, assistance with ambulation, bathing, hair care and grooming, dressing, toileting and transfer activities.

Companion Services

Socialization, support and assistance with instrumental activities of daily living.

Respite Care Services

Personal care and assistance with instrumental activities of daily living on a short term basis because of the absence or need for relief for those persons normally providing the services.

Specialized Services

Non-skilled services unique to the consumer's care/service needs that facilitate the consumer's health, safety & welfare and ability to live independently.

If you have any questions, or need further information, please call our office.

ADVANCE DIRECTIVES - YOUR RIGHT TO DECIDE

Under federal law, you have the right to complete an "advance directive' which outlines one's desire in advance on what type of treatment you want or do not want under special, serious medical conditions (conditions that would prevent you from telling your doctor how you want to be treated)

There are different kinds of Advance Directives, including, but not limited to those listed below.

• *Living Will* • *Health Care Surrogate/Proxy* • *Durable Power of Attorney for Health Care*
If you have executed any of these documents, please advise your Admission clinician and they will make a copy of the document for our records.

If you do not currently have an advance directive in place, we encourage you to consult an attorney or the state Department of Aging for additional information and forms. If you create an Advance Directive, please advise us immediately.

The agency has adopted policies regarding the implementation of your advance directive. It includes the incorporation of the document into your clinical record, communication of the directive to caregivers, and the assurance that the provision of your care is in no way conditional upon an advance directive or the refusal of medical or surgical treatments.
The agency will in no way place conditions on the provision of care, or in any way discriminate against clients, based on their right to refuse medical treatments or the creation of an Advance Directive.

Our objective is to assure that the client's rights are respected and that any such decisions or documents will not place conditions on the provision of care.

Our Agency Advance Directive (AD) Procedures:

1. The existence of an AD will be asked about upon admission to our agency.
2. Clients who are cognitively impaired shall have AD information provided to family or a surrogate.
3. If an AD has been executed, the record will indicate such and efforts will be made to obtain a copy for placement in the record.
4. At the time an AD takes effect, care will continue in compliance with said instructions to the extent permitted by law.
5. Care shall continue according to the established plan of care and the client's wishes unless the client's refusal negates the only service being provided, at which time, after client notification, care would cease or client would be referred to appropriate agency.
6. Clients are informed in writing in the Admission Packet, of their right to register complaints concerning AD requirements through the toll-free home care hotline in the Client Rights.

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PA Consumer's Rights and Responsibilities

Home Care Consumers

Consumers have a right to be notified in writing of their rights and obligations before treatment is begun. The consumer's family or guardian may exercise the consumer's rights when the consumer has been judged incompetent. All healthcare providers have an obligation to protect and promote the rights of their consumers, including the following rights.

Privacy

Consumers have the right:

- To confidentiality of information about their health, social, and financial circumstances, and about what takes place in the home; and
- To expect the home care provider to release information only as required by law or as authorized by the consumer.
- The consumer or legal representative has the right under Pennsylvania state law to access the consumers' clinical record is unless certain exceptions apply. The consumer or legal representative may have access to the records any time during normal business hours.
- To be able to identify visiting Agency personnel members through proper identification (ID badge).

Financial Information

Consumers have the right:

- To be informed of the extent to which payment may be expected from any 3rd party payer known to the home care agency;
- To be informed of the charges that will not be covered by 3rd party payers;
- To be informed of the charges for which the consumer may be liable;
- To receive this information, orally and in writing, before care is initiated and within thirty (30) calendar days of the date the home care provider becomes aware of any changes in the charges; and
- To have access, upon request, to itemized statements listing each of the services and items the consumer has received regardless of whether they are paid out-of-pocket or by another party within thirty (30) calendar days of the request.
- The right to receive a disclosure from the agency addressing the employee independent contractor status of direct care workers- "Consumer Notice of Direct Care Worker Status": (form created by the Department).
- Effective communication from every worker at the Agency.

Quality of Care

Consumers have the right:

- To receive care of the highest quality;
- In general, to be admitted by a provider only if the provider has the resources needed to provide care safely and at the required level of intensity, as determined by a professional assessment; a provider with less than optimal resources may nevertheless admit the consumer if a more appropriate provider is not available, but only after fully informing the consumer of the provider's limitations and the lack of suitable arrangements;
- To receive information containing a listing of the available home care services that will be provided by the direct care worker and the identity of the worker who will provide the services, the hours when those services will be provided and the fees and total costs for those services on an hourly or weekly basis.
- To be served by individuals who are properly trained and competent to perform their duties and to know those hiring & competency requirements applicable to the Home Care Agency;
- To be advised of the workers who will be providing the home services.

- To be told what to do in the case of an emergency.
- To the hiring and competency requirements of direct service workers employed by the agency.
- To participate in the planning of the service, and be involved in the service planning process and in planning changes in the services, and to be advised they have a right to do so and receive reasonable accommodation of individual needs and preferences, except where the health and safety of the direct care worker is at risk.
- To be informed in writing of rights under state law to make decisions concerning medical care, including the right to accept or refuse treatment, and the right to formulate advance directives;
- To be informed in writing of policies and procedures for implementing advance directives, including any limitations if the provider cannot implement an advance directive on the basis of conscience;
- To have home care agencies comply with advance directives in accordance with state laws;
- To receive care without condition on, or discrimination based on, the execution of advance directives;
- To refuse services or request a change in caregiver without fear of reprisal, coercion, unreasonable interruption of care, treatment or services, or discrimination;
- Not to receive experimental treatments or to participate in research unless he/she has given voluntary informed consent;
- To receive a copy of his/her plan of care if requested;
- To be given reasonable notice, in writing, of ten (10) calendar days before terminating services Less than 10 days may be provided in the event the consumer failed to pay for services, despite notice, and the consumer is more than 14 days in arrears, or if the health and welfare of the direct care worker is at risk.
- To be provided with a list of resources before the termination date if continued service is requested or medically necessary; and
- To have assistance in making alternative arrangements for continued service.
- To be free from mistreatment, neglect, or verbal, mental, sexual and physical abuse, including injuries of unknown source, and misappropriation of client property.

<u>Decision Making</u>

Consumers have the right:

- To be notified of the service that is to be furnished, the types (disciplines) and names of the caregivers who will furnish the service, and the frequency of the visits that are proposed to be furnished;
- To be advised of any change in the plan of service before the change is made.

<u>Dignity and Respect</u>

- Home care consumers and their caregivers have a right to mutual respect and dignity.
- To have one's property and person treated with respect & consideration.
- Agency employees are prohibited from accepting personal gifts, borrowing from consumers or entering into any power of attorney, guardianship or any other financial arrangement. The Agency will not require a consumer to endorse checks over to the home care agency. The organization respects the safety and security of our consumers and their property.

Consumers have the right:

- To have relationships with the Agency and staff that are based on honesty and ethical standards of conduct;
- To have his/her cultural, psychosocial, spiritual, and personal values, beliefs, and preferences respected;
- To be informed of the procedure to follow to lodge concerns/complaints/grievances with the home care provider about the care that is, or fails to be, furnished, and regarding lack of respect for property and to voice grievances without fear of discrimination or reprisal and to know about the disposition of

such complaints; To lodge complaints with the Agency by calling the Agency Director at (215) 355-9999.

- To be advised of the telephone and hours of operation of the state's home health "hotline." And the purpose of the hotline: to lodge concerns/complaints or ask questions about the agency. To report a complaint or ask questions regarding the services you receive call:
  - PA Home Care Complaint/Compliance Hotline at: 866-826-3644 24 hours
  - PA Ombudsman Office at: 717-651-2001

You can also file in writing at:

PA DOH
Division of Home Health
555 Walnut St.
7th Floor, Suite 701
Harrisburg, PA 17101

The PA State Hotline number may also be used to lodge complaints concerning the implementation of Advance Directive requirements.
For questions/information regarding licensing or compliance requirements contact:
The Department of Health, Division of Home Health at 717-783-1379.

Consumers of Stay at Home Home Care have the responsibility to:

- Notify our Agency of changes in their condition or situation (hospitalization, symptoms, etc.).
- Follow the plan of service.
- Notify our Agency if the visit schedule needs to be changed.
- Keep appointments and notify our Agency if unable to do so.
- Inform our Agency of the existence of, and any changes to, advance directives.
- Advise our Agency of any problems or dissatisfaction with the service.
- Provide a safe environment for services to be provided.
- Carry out mutually agreed responsibilities.

A reasonable attempt has been made and documented that the Consumer and family understand these rights and responsibilities which have been reviewed with the Consumer prior to or at the start of service visit and periodically thereafter.

NOTICE OF HIPAA PRIVACY PRACTICES FOR PHI page 1 of 3

[*45 CFR 164.520*] **OCR HIPAA Privacy** December, **2002**

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION IS PROTECTED & MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

We are required by law to maintain the privacy of your health information; to provide you this detailed Notice of our legal duties and privacy practices, and to abide by the terms of the Notice that are currently in effect.

You have the right to:

Advise our Agency to limit what information is utilized or shared:

- Ask our Agency not to use or share certain health information for treatment, payment, or operations. Our Agency is not required to agree to your request, and may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. Our Agency will say "yes" unless a law requires us to share that information.

Choose someone to act on your behalf:

- If you have designated an individual medical power of attorney or have a legal guardian, that individual may exercise your rights and make choices about your health information.
- Our Agency will make ensure the person has this authority and can act for you before we take any action.

Obtain a list of those with whom we've shared information:

- You can ask for a list (accounting) of the times the Agency has shared your health information for six (6) years prior to the date you ask, who the Agency shared it with, and for what purpose.
- Our Agency will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). Our Agency will provide one accounting a year at no charge, but will charge a reasonable fee if you ask for another within 12 months.

Request confidential communications:

- You can ask our Agency to contact you in a specific way (i.e. at home/work phone) or send mail to a specific address. Our Agency will comply with all reasonable requests.

Get an electronic or paper copy of your medical record:

- You can ask to see or receive an electronic or paper copy of your medical record and other health information the Agency has about you. Ask our Agency how to do this.
- The Agency will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record:

- You can ask our Agency to correct health information about you that you think is incorrect or incomplete. Ask our Agency how to do this.
- Our Agency may say "no" to your request, but we will explain why in writing within 60 days.

Get a copy of this privacy notice:

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. Our Agency will provide you with a paper copy promptly.

For certain health information, you can tell us your choices about what we share: If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care.
- Share information in a disaster relief situation.

NOTICE OF HIPAA PRIVACY PRACTICES FOR PHI page 2 of 3

- Include your information in a hospital directory.

If you are not able to tell us your preference, we may share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

USES AND DISCLOSURES:

For Treatment. Our Agency will use and disclose your health information in providing you with treatment/services and coordinating your care and may disclose information to other providers involved in your care. Your health information may be used by doctors involved in your care and by nurses and health aides as well as by therapists, pharmacists, suppliers of medical equipment, or other persons involved in your care.

For Payment/Billing for Services. Our Agency may use and disclose your health information for billing and payment purposes. We may disclose your health information to your representative, or to an insurance or another third party payer. We may contact your health plan to confirm your coverage or to request prior approval for services that will be provided to you.

For Health Care Operations. Our Agency may use and disclose your health information as necessary for operating our Agency, such as management, personnel evaluation, education and training, and to monitor our quality of care. We may disclose your health information to another entity with which you have or had a relationship if that entity requests your information for certain of its health care operations or health care fraud and abuse detection or compliance activities.

To Do Research: Our Agency can use or share your information for health research.

To Comply with the law: Our Agency will share information about you if state or federal laws require it, including with the US Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

To Respond to organ and tissue donation requests: Our Agency can share health information about you with organ procurement organizations.

To Work with a medical examiner or funeral director: Our Agency can share health information with a coroner, medical examiner, or funeral director when an individual dies.

To Address workers' compensation, law enforcement, and other government requests:

Our Agency can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, etc.

To Respond to lawsuits and legal actions: Our Agency can share health information about you in response to a court or administrative order, or in response to a subpoena.

We will never share your information for the following purposes unless you give written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes
- We may contact you for fundraising efforts, but you can tell us not to contact you again

We are allowed to use or share your health information in other ways **that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.**

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

NOTICE OF HIPAA PRIVACY PRACTICES FOR PHI page 3 of 3

To help with public health and safety issues:

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

SPECIFIC USES/DISCLOSURES OF YOUR HEALTH INFORMATION

Individuals Involved in Your Care or Payment for Your Care: Unless you object, our Agency may disclose health information about you to a family member, close personal friend, or other person you identify, including clergy, who is involved in your care.

Emergencies: Our Agency may use or disclose your health information as necessary in emergency treatment situations.

As Required By Law: We may use or disclose your health information when required by law to do so.

Business Associates: Our Agency may disclose your protected health information to a contractor or business associate that needs the information to perform services for our Agency. Our business associates are committed to preserving the confidentiality of this information.

RESPONSIBILITIES OF OUR AGENCY:

Our Agency is required by law to maintain the privacy and security of your protected health information.

- **We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.**
- **We must follow the duties and privacy practices described in this notice and give you a copy.**
- **We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.**

You have the right to express concerns/complaints, without fear of retaliation, to our Agency or the US Department of Health & Human Services, regarding any act that you consider a violation of these privacy rights.

If you feel your privacy rights have been violated, please direct concerns to our agency at:

Stay at Home Home Care
Karapet Kankanian
295 Buck Road, Suite 104, Holland PA 18966
(215) 355-9999

Our agency will never retaliate against you for filing a complaint.

Or, you can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 877-696-6775, or **www.hhs.gov/ocr/privacy/hipaa/complaints/.**

For more information: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Our Agency can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request and be posted in our office.

CONSUMER CONCERNS/GRIEVANCE POLICY

Stay at Home Home Care

We strive to provide the highest quality services for our Consumers. That's why your concerns are our concerns.

To insure that our services meet your needs, we encourage you to make us aware of any complaints or concerns. Complaints should be addressed to the Agency Director who will promptly review the problem. Following that review, the Agency Director will make written or verbal contact with you to assure you that the problem has or is being addressed. It is in our agency policy to address the complaint within 30 days. If at any time you feel that a situation was not resolved to your satisfaction by this process, you may contact the office at (215) 355-9999.

We appreciate your candid comments as this helps us in the process of continually working to improve our services to our many and valued Consumers.

If you have information about unethical behavior, criminal activities, or other concerns regarding your services, please call the Agency Director at the office. Your confidentiality will be protected.

The following are examples of issues that should be brought to our attention immediately

- Potential criminal violations
- Health and safety issues
- Theft and fraud
- Bribes and kickbacks
- Conflicts of interest
- Insider trading
- Breach of confidentiality of company information
- Breach of confidentiality of Consumer records
- Antitrust laws
- Privacy of employee and Consumer records
- Harassment or discrimination
- On-the-job substance abuse
- Billing and documentation/insurance fraud
- Violation of Consumers' rights

Complaint & Grievance Process/Reporting Abuse

Our Agency is committed to providing excellence in Consumer service.
We will give full consideration to your issues and make an effort to resolve any issues to your satisfaction.
We will provide you every opportunity to voice grievances without discrimination, fear of reprisal, or any discrimination from our Agency or its employees.

If you have any concerns at all, please:
Tell us, either verbally or in writing, the Agency Director or Supervisor or any staff member you are comfortable with. They will ensure the concern is presented to the Agency Director. If you call after business hours, the Agency Director will be in contact with you the next business day.

The Agency Director will contact you within 10 days and will help to resolve the complaint/concern to your satisfaction. They will look at all aspects surrounding the grievance, investigation, and resolution. You will be notified of the Agency Director's decision within thirty (30) days.
If you are dissatisfied with the outcome of the complaint investigation, you may request that the Agency Director submit an appeal with the Agency's Governing Body.

You may also file a complaint with the following:
PA State Complaint Hotline at 800-254-5164
PA Ombudsman Office at 717-651-2001

You may file a grievance/concern with our Agency at any time without fear of reprisal.

Please contact us at:
AGENCY: Stay at Home Home Care
AGENCY DIRECTOR: Karapet Kankanian
AGENCY TELEPHONE: (215) 355-9999

REPORTING ABUSE

Are you aware of any instances of abuse, neglect or mistreatment of a client or misappropriation of a client's 'property? If so, you are encouraged to report these conditions to the Agency Manager of this agency and contact:
Elder Abuse Hotline: 800-490-8505
Child Abuse Hotline: 800-932-0313

Emergency Preparedness Info Sheet

To attempt to keep all our Consumers informed and educated Stay at Home Home Care wants to give you the best direction possible to be prepared. When your service began we assigned you a priority code based on your own unique situation at home.

As your safety is of great importance to us, if you relocate during an emergency situation, please let the agency know your location: (215) 355-9999

DISASTER EMERGENCY PRIORITY CLASS

- Priority Class I – **HIGHEST**-Consumers with serious situations that require ongoing care/service to remain safe.
- Class II – Consumers with the greatest need for service .Services could be postponed for 2-3 days without adverse effects.
- Class III – Services could be postponed 3-4 days without adverse effects.
- Class IV – **LOWEST**-Service could be postponed for at least of 5 days without adverse effects.

You have been assigned as priority code: _____

During an emergency situation, Stay at Home Home Care Consumers can expect that we will do everything within our means to continue servicing your emergent needs.

Some of the situations that may cause us to close an office and put the emergency plan in effect are:

- Severe winter storms
- Severe weather conditions (hurricane, tornado etc.)
- National Emergency status called for by the Governor
- Terrorist attack
- Pandemic threat such as Avian Influenza

In the event that we have some notification of the emergency situation, you can expect a phone call from our office explaining when we anticipate your next visit to be done and by whom. If you are a priority 2, 3 or 4 Consumer, we are likely to postpone your scheduled visit to another day in the same week. If you are a priority 1 Consumer we will make every effort to provide a visit.

We advocate that all persons create a 3 day supply of clean drinking water, canned/nonperishable food, and a flashlight with extra batteries, extra blanket, medication, and portable radio. Please take some time now to be sure these are in place BEFORE an emergency event should occur.

When an emergency condition occurs our office begins a specialized procedure to assure your care. The Agency Director will begin notifying their staff and the phone tree continues until all employees are contacted so that everyone knows what to do and when to do it.

Please refrain from calling the office unless you have a true emergency situation as our offices are likely to be very busy during the time of an emergency. We will be calling you to keep you informed.

Consumer Financial Authorization

Name *(Last, First):* _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____

Payer Information

❑Private Pay
❑ 3rd Party Payer to be billed for your services is: (expected amount payer will not pay_____)
Payer company will pay _____% of our charges and your portion is _____% or $_____per hour/per visit/per day. There is an out of pocket expense of $_____ and a deductible of $_____ The insurance company will pay (_____of visits).You will be notified of any changes to the charges as soon as the Agency becomes aware of them but at least no later than 30 days from the date we learned of the change.

Service Order

Service	Charge	Frequency	Days	AM/PM
Personal Care Worker	$ /hr $ /visit			
Respite Care	$ /hr $ /visit			
Companion	$ /hr $ /visit			
Specialized Care	$ /hr $ /visit			

Terms of service: The signature below acknowledges my acceptance of the following:
Consent & Full financial responsibility for service(s) rendered to the above named person.
Assignment of Payment of any benefits payable to/for me, be made payable to Stay at Home Home Care. That I have not been coerced or forced to sign this document.
Either side may terminate this agreement with Termination Notice of _____ days.

Consumer/Representative Signature_____ Date_____

Signature/Title of Agency Staff_____ Date_____

Printed Name of Agency Staff_____

Stay at Home Home Care
295 Buck Road, Suite 104, Holland PA 18966
(215) 355-9999

CONSUMER COPY

Consumer Financial Authorization

Name *(Last, First)*:_____
Address: _____
City: _____State:_____Zip Code:_____
Phone:_____ _____

Payer Information

❑Private Pay
❑ 3rd Party Payer to be billed for your services is: (expected amount payer will not pay_____)
Payer company will pay _____% of our charges and your portion is _____% or $_____per hour/per visit/per day. There is an out of pocket expense of $_____ and a deductible of $_____ The insurance company will pay (_____of visits).You will be notified of any changes to the charges as soon as the Agency becomes aware of them but at least no later than 30 days from the date we learned of the change.

Service Order

Service	Charge	Frequency	Days	AM/PM
Personal Care Worker	$ /hr $ /visit			
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Assignment of Payment of any benefits payable to/for me, be made payable to Stay at Home Home Care. That I have not been coerced or forced to sign this document.
Either side may terminate this agreement with Termination Notice of _____ days.

Consumer/Representative Signature ******* CONSUMER COPY NO SIGNATURE NEEDED***

Signature/Title of Agency Staff_____ Date_____

Printed Name of Agency Staff_____

Stay at Home Home Care
295 Buck Road, Suite 104, Holland PA 18966
(215) 355-9999

CONSUMER CONSENT FORM

RELEASE OF INFORMATION: I do hereby authorize Stay at Home Home Care to release information contained in my medical record and any other medical information about me in their possession in the following instances:

- ❑ To service/care providers who with my consent are involved in my care and in the transfer of my care and or in the co-ordination of my care.
- ❑ To my insurance company/third party payer for the purpose of obtaining payment for service provide (if applies).
- ❑ To peer review, utilization review or other organizations responsible for monitoring the quality or appropriateness of client care.

This authorization does not permit the disclosure of release of information that may arise out of communications with a psychotherapist, social worker or sexual assault counselor, HTLV-III (HIV or AIDS) test results, records from an alcohol or drug abuse treatment facility or records pertaining to sexually transmitted diseases. Release of any such information shall require an additional specific consent for disclosure. I understand that this authorization shall pertain to and remain in effect for the time I receive care from the Agency. I also understand that no further consent for release of information shall be required in the above circumstances, unless I notify the Agency otherwise in writing.

CONSENT TO TREAT: I hereby authorize this Agency and its agents full consent for the provision of care and services under the Service Plan and to abide by the Agency's specific policies and procedures relating to home care which have been reviewed with me and which include provisions for termination of home care services at my request and/or the Agency's request. I acknowledge that no guarantees have been made with respect to the outcome of this service or of any treatments or procedures.

PHOTO CONSENT: I hereby give the agency and its staff, consent to photograph me in relation to my care/services while under the care of the agency.

ELECTRONIC RECORDS/SIGNATURES CONSENT: if our agency utilizes an electronic medical record system, I give my consent to the use of electronic medical records & e-signature use.
I acknowledge that the Agency does not routinely perform drug testing on employees but may do so at their discretion.
I consent to the proposed Service Plan and authorize care be provided by the Agency under supervision of agency staff. I understand that I have the right to refuse treatment or terminate care at any time by providing the agency notification.

Stay at Home Home Care
295 Buck Road, Suite 104, Holland PA 18966
(215) 355-9999

Clients Printed Name _____ Date:_____

Client Signature /Authorized Representative_____

Client Emergency Contact: _____ Relationship: _____
Home Phone: _____ Cell Phone: _____

CONSUMER CONSENT FORM (CONSUMER COPY)

RELEASE OF INFORMATION: I do hereby authorize Stay at Home Home Care to release information contained in my medical record and any other medical information about me in their possession in the following instances:

- ❑ To service/care providers who with my consent are involved in my care and in the transfer of my care and or in the co-ordination of my care.
- ❑ To my insurance company/third party payer for the purpose of obtaining payment for service provide (if applies).
- ❑ To peer review, utilization review or other organizations responsible for monitoring the quality or appropriateness of client care.

This authorization does not permit the disclosure of release of information that may arise out of communications with a psychotherapist, social worker or sexual assault counselor, HTLV-III (HIV or AIDS) test results, records from an alcohol or drug abuse treatment facility or records pertaining to sexually transmitted diseases. Release of any such information shall require an additional specific consent for disclosure. I understand that this authorization shall pertain to and remain in effect for the time I receive care from the Agency. I also understand that no further consent for release of information shall be required in the above circumstances, unless I notify the Agency otherwise in writing.

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Stay at Home Home Care
295 Buck Road, Suite 104, Holland PA 18966
(215) 355-9999

Clients Printed Name _____ Date: _____

Client Signature /Authorized Representative _____

Client Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Stay at Home Home Care

PAYER INFORMATION FORM

CONSUMER NAME: _____

DOB_____ Social Security # _____

3rd Party Payer

Carrier's Name	Name	Customer Service PH #	Subscriber's Name
	Plan Name	**Policy #**	

3rd Party Payer

Carrier's Name	Name	Customer Service PH #	Subscriber's Name
	Plan Name	**Policy #**	

3rd Party Payer

Carrier's Name	Name	Customer Service PH #	Subscriber's Name
	Plan Name	**Policy #**	

NON-DISCRIMINATION/LEP STATEMENT 6.2016

Stay at Home Home Care complies with applicable Federal civil rights laws and does not discriminate in hiring or admissions, on the basis of race, color, national origin, age, disability, or sex. Our Agency does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Stay at Home Home Care:

- Provides free aids and services to clients with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters.
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).

- Provides free language services to clients whose primary language is not English (LEP) such as:
  - Qualified interpreters.
  - Information written in other languages.

If you need these services, contact Karapet Kankanian.

If you believe that Stay at Home Home Care has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Agency Name: Stay at Home Home Care
Agency Civil Rights Coordinator: Karapet Kankanian
Agency Address: 295 Buck Road, Suite 104, Holland PA 18966
Agency Phone: (215) 355-9999

You can file a grievance in person or by mail or fax. If you need help filing a grievance, Karapet Kankanian is available to help you.
You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,* or by mail or phone at:
U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F
HHH Building, 1-800-368-1019, 800-537-7697 (TDD)

PA Consumer Notice of Direct Care Worker Status

This form is to be completed by every consumer utilizing the services of a Home Care Agency

I _____ (print consumer name) understand that:

Please initial each of the *following* to acknowledge understanding.

_____ The direct care worker who will be providing services in my home is an employee of the Agency. The Agency is responsible for withholding and reporting State and Federal Income tax, Federal Unemployment tax, Social Security taxes and Medicare taxes on behalf of the direct care worker. The Agency is also responsible for paying workers compensation insurance to cover the direct care worker in the event of an accident or injury on the job.

__NA_ The direct care worker who will be providing services in my home is not an employee of the Home Care Registry, and therefore, may be considered my employee. Since the direct care worker may be my employee, I may be responsible for withholding and reporting State and Federal Income tax, Federal Unemployment tax, Social Security taxes and Medicare taxes on behalf of the direct care worker. I also understand that the direct care worker is not covered by Worker's Compensation Insurance.

_____ I have been informed that the Agency _____ maintains ____ does not maintain general and professional liability insurance covering the direct care worker. If the Agency does not maintain general and professional liability insurance, and the direct care worker is not covered under workers compensation, I have been advised to check my homeowner's or renter's insurance to determine if it covers any injury or accident involving the direct care worker while working in my home.

_____ _____

Signature of Consumer Date

_____ _____

Signature of Agency Representative Date

**** CONSUMER COPY ****

PA Consumer Notice of Direct Care Worker Status

This form is to be completed by every consumer utilizing the services of a Home Care Agency

I _____ (print consumer name) understand that:

Please initial each of the *following* to acknowledge understanding.

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_____ I have been informed that the Agency _____ maintains ____ does not maintain general and professional liability insurance covering the direct care worker. If the Agency does not maintain general and professional liability insurance, and the direct care worker is not covered under workers compensation, I have been advised to check my homeowner's or renter's insurance to determine if it covers any injury or accident involving the direct care worker while working in my home.

_____*** *Consumer copy… no signature required*****_____

Signature of Consumer Date

_____

Signature of Agency Representative Date

Review of Admission Documents

CONSUMER:
ADDRESS:

Stay at Home Home Care is pleased to have the opportunity to provide service for you. As part of your plan of service, we are giving you a Consumer Information Folder that includes important information about our services. Please review the contents of this folder with the Admitting Staff and sign below. We recommend that you keep your Consumer Information Folder handy and refer to it if you have questions about your service. We recognize your rights as a Consumer and asks that you assume certain responsibilities. I have received my Consumer Information Folder which has been reviewed with me and includes:

- Welcome Letter
- Advance Directive Information
- Abuse and State Hotlines
- HIPAA Notice of Privacy Rights
- Consumer Consent Form
- Consumer Authorization Form
- Agency Complaint/Grievance Process
- Home Safety Guidelines
- Disaster Plan Information
- Community Resources
- Non-Discrimination Statement/LEP
- 3rd Party Payer Info Sheet
- Consumer Rights & Responsibilities
- Emergency Information
- PA Consumer Disclosure Notice of Direct Care Worker Status

I have read and understand all of the written information as outlined above, as well as the verbal review offered by the Agency Staff. I agree to the terms presented in this material. I also agree to contact Stay at Home Home Care if I have questions about my service.

_____ _____

Signature of Consumer /Consumer's Legally Authorized Representative Date

_____

Signature/Title of Agency Representative Date

PA HEALTH CARE PROXY INFORMATION

(Staff: Please check all that apply)

❑ Health Care Proxy in place ❑ NO Health Care Proxy in place
❑ Agrees to provide Agency a copy of the proxy.
If A Health Care Proxy is in place:

Health Agent Name: _____ Phone: _____

_____

Agency Representative Signature/Title Date

Review of Admission Documents (CONSUMER COPY)

CONSUMER:
ADDRESS:

Stay at Home Home Care is pleased to have the opportunity to provide service for you. As part of your plan of service, we are giving you a Consumer Information Folder that includes important information about our services. Please review the contents of this folder with the Admitting Staff and sign below. We recommend that you keep your Consumer Information Folder handy and refer to it if you have questions about your service. We recognize your rights as a Consumer and asks that you assume certain responsibilities. I have received my Consumer Information Folder which has been reviewed with me and includes:

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- 3rd Party Payer Info Sheet
- Consumer Rights & Responsibilities
- Emergency Information
- PA Consumer Disclosure Notice of Direct Care Worker Status

I have read and understand all of the written information as outlined above, as well as the verbal review offered by the Agency Staff. I agree to the terms presented in this material. I also agree to contact Stay at Home Home Care if I have questions about my service.

****** *CONSUMER COPY NO SIGNATURE REQUIRED*** _____

Signature of Consumer /Consumer's Legally Authorized Representative Date

_____

Signature/Title of Agency Representative Date

PA HEALTH CARE PROXY INFORMATION

(Staff: Please check all that apply)

- ❑ Health Care Proxy in place
- ❑ NO Health Care Proxy in place
- ❑ Agrees to provide Agency a copy of the proxy.

If A Health Care Proxy is in place:

Health Agent Name: _____ Phone: _____

_____

Agency Representative Signature/Title Date