CLIENT INFORMATION BOOKLET

My Home Nurses LLC

5113 S Harper Ave., Ste. 2C
Chicago, IL 60615
708-801-8662

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SERVICE OUTLINE

Welcome to My Home Nurses LLC. We believe those needing home health care should get the very best. Our goal is to provide quality personalized care through appropriate coordination of services to meet your specific healthcare needs. Under the direction of your physician, our team of qualified health care professionals will provide on-going case management, if needed that is appropriate, competent, and consistent. I am here to assist you and to ensure that our staff meets your needs.

Sincerely,

_____, Administrator

Our services include:

- Skilled Nurse (RN, LPN/LVN)
- Home Health Aide/Companion/Homemaker
- Approved Therapy Services

Nursing visits will consist of a complete physical assessment and evaluation of the client condition. The skilled nurse will also instruct the client and family/caregiver in disease process and management, medications and other pertinent topics. With case management, usually nursing visits will be frequent at first. Then as acute medical problems are resolved and home instruction completed, visit frequencies will decrease and discharge planning and teaching will begin. In some cases, the skilled nurse will make an initial visit only for admission assessment and evaluation.

Home Health Aides (HHA's) are assigned by the skilled nurse and can provide personal care, light-housekeeping duties for the client and other care as appropriate and mandated by the state regulations for HHA's.

Your plan of care will most likely, at this time, include the following professional services and visit frequencies.

Skilled Nurse: _____

Home Health Aide: _____

Other Services: _____

Other Services: _____

Other Services: _____

Other Services: _____

NON-DISCRIMINATION POLICY

As a recipient of federal financial assistance, this Agency does not exclude, deny benefits to, or otherwise discriminate against any person on the grounds of race, color, or national origin or on the basis of disability, AIDS or AIDS related conditions, age or sexual orientation, in admission to, participation in or receipt of the services and benefits of any of its programs and activities or in employment therein, whether carried out by this Agency directly or through a contractor of any other entity with whom the Agency arranges to carry out its programs and activities.

This statement is in accordance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Regulations of the U.S. Department of Health and Human Services issued pursuant to the Acts, Title 45 Code of Federal Regulations Part 80, 84, 91. (Other Federal Laws and Regulations provide similar protection against discrimination on grounds of sex and creed.)

In case of questions concerning this policy, or in the event of a desire to file a complaint alleging violations of the above, please contact:

_____, Administrator

My Home Nurses LLC
5113 S Harper Ave., Ste. 2C
Chicago, IL 60615
708-801-8662

CLIENT GRIEVANCE

Your complaints or problems are important to the Agency. We will give full consideration to a problem or complaint and make an effort to resolve the issue in an agreeable manner. We assure you that you will have the opportunity to voice grievances and recommend changes in services and/or policies without discrimination, coercion, reprisal, or unreasonable interruption of services or in any manner from the Agency.

If you have a complaint, please:

1. Submit the complaint either verbally or in writing to the Administrator or supervising nurse. If you call after normal business hours, you will be contacted by the Administrator on the next business day.
2. The Administrator or supervising nurse will contact you or your representative and will make every effort to resolve the complaint to your satisfaction. They will document all activities involved with the grievance/complaint/concern, investigation, analysis and resolution. You will be notified of the Administrator's decision within thirty (30) days.
3. If the complaint cannot be resolved to your satisfaction, you may request that the Administrator submit your complaint to the Agency's Governing Body.

Please be advised that you may lodge complaints with the Illinois hotline number at 1-800-252-4343 during regular business hours. Leave a message after regular business hours.

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Annie Tchinjo, RN, Administrator
My Home Nurses LLC
5113 S Harper Ave., Ste. 2C
Chicago, IL 60615
708-801-8662

THANK YOU FOR SHARING YOUR CONCERNS WITH US

PROCEDIMIENTOS PARA PRESENTAR UNA QUEJA

Sus quejas y problemas son importantes para nuestra Agencia. Vamos a tener plenamente en cuenta cualquier problema o queja y hacer un esfuerzo para resolver el problema de una manera conveniente. Nosotros le aseguramos que tendrá la oportunidad de expresar sus quejas y podrá recomendar cambios a los servicios y/o pólizas sin ningún tipo de discriminación, coerción, represalias o interrupción injustificada de los servicios o de cualquier forma por parte de la Agencia.

Si usted tiene una queja, por favor:

1. Presentar la queja, ya sea verbalmente o por escrito al Administrador o Supervisor de Enfermería. Si usted llama después de las horas normales de trabajo, usted será contactado por el Administrador en el siguiente día hábil. El nombre, dirección y numero de teléfono del Administrador es:

2. El Administrador o Supervisor de Enfermería se pondrá en contacto con usted o su representante, y harán todos los esfuerzos para resolver la queja a su satisfacción. Ellos documentarán todas las actividades involucradas en el reclamo / queja / preocupación, la investigación, el análisis y resolución de la queja. Usted recibirá una respuesta por escrito de parte del Administrador de la Agencia dentro de 10 días y la queja será resuelta dentro de 30 días.

3. Si la queja no es resuelta a su satisfacción, usted puede pedir al Administrador que presente su queja presentar su queja a la Junta de Directores de la Agencia.

4. Por favor, tenga en cuenta que usted puede presentar una queja con la Línea Estatal “gratis” al 1-800-252-4343. El horario de operaciones es de 8:30 AM a 5:00 PM. Después de horario normal de oficina, por favor dejar un mensaje.

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Annie Tchinjo, RN, Administrator
My Home Nurses LLC
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Chicago, IL 60615
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GRACIAS POR COMPARTIR SUS PREOCUPACIONES CON NOSOTROS

CLIENT BILL OF RIGHTS

Client Rights and Responsibilities

Statement of Purpose:

It is anticipated that observance of these rights and responsibilities will contribute to more effective care and greater satisfaction for the patient as well as the staff. The rights will be respected by all personnel and integrated into all Home Health Care programs. A copy of these rights will be given to patients and their families or designated representative. If the patient or his/her designated representative is unable to read the Bill of Rights and Responsibilities, it will be read to them. If the patient or his/her representative does not speak English, a copy of these rights will be provided in a language that is understood. The patient or his/her designated representative has the right to exercise these rights. In the case of a patient adjudged incompetent, the rights of the patient are exercised by the person appointed by law to act on the patient's behalf. In the case of a patient who has not been adjudged incompetent. Any legal representative may exercise the patient's rights to the extent permitted by law.

The Patient has the right:

1. To be fully informed and knowledgeable of all rights and responsibilities before providing pre-planned care and to understand that these rights can be exercised at any time.

2. To appropriate and professional care without discrimination relating to physician orders.

3. To choose a health care provider, including choosing an attending physician.

4. To request services from the Home Care Agency of their choice and to request full information from their agency before care is given concerning services provided, alternatives available, licensure and accreditation requirements, and organization ownership and control.

5. To be informed in advance about care to be furnished and of any changes in the care to be furnished before the change is made.

6. To be informed of the disciplines that will furnish care and the frequency of visits proposed to be furnished and to know that all staff providing care is properly trained and competent to perform their duties.

7. To information necessary to give informed consent prior to the start of any procedure or treatment and any changes to be made.

8. To participate in the development and periodic revision of the plan of care and to make changes to the plan of care.

9. To access to their record and to expect confidentiality and privacy of all information contained in the patient record and of Protected Health Information.

10. To refuse care or treatment after the consequences of refusing care or treatment are fully presented.

11. To treatment with utmost dignity and respect by all agency representatives, regardless of the patient's chosen lifestyle, marital status, cultural mores, political, religious, ethical beliefs,

having or not having executed an advance directive and source of payment without regard to race, creed, color, sex, age or handicap.

12. To have his/her property and person treated with respect, consideration and recognition of patient.

13. To receive and access services consistently and in a timely manner from the agency to his/her request for service.

14. To receive information about the scope of services that the agency will provide and specific limitations on those services.

15. To be admitted for service only if the agency has the ability to provide safe professional care at the level of intensity needed and to be informed of the agency's limitations.

16. To reasonable continuity of care.

17. To an individualized plan of care and teaching plan developed by the entire health team including the patient and/or family.

18. To be advised on the agency’s policies and procedures regarding the disclosure of patient records.

19. To be informed of patient rights under HIPAA, Federal, State and Accreditation regulations to formulate advanced care directives without fear of reprisal whether or not an advance directive is prepared and to know that the agency will follow the patient’s requests regarding the advance directive in providing care.

20. To be informed of anticipated outcomes of service/care and of any barriers in outcome achievement.

21. To be informed within a reasonable time of anticipated termination of service of plans for transfer to another health care facility/provider and the reason for termination/transfer from service.

22. To be informed verbally and in writing and before care is initiated of the organization's billing policies and payment procedures and the extent to which:

    a. Payment may be expected from Medicaid, or any other federally funded or aided program known to the organization
    b. Charges for services that will not be covered by payer
    c. Charges that the individual may have to pay

23. To be able to identify visiting staff members through agency generated photo identification.

24. To be informed orally and in writing of any changes in payment information as soon as possible, but no later than 30 days from the date that the organization becomes aware of the change.

25. To honest, accurate, forthright information, regarding the home care industry in general and his/her chosen agency in particular, including cost per visit, employee qualifications, names and titles of personnel, etc.

26. To access necessary professional services 24 hours a day, 7 days a week.

27. To be referred to another agency if he/she is dissatisfied with the agency or the agency cannot meet the patient's needs.

28. To receive disclosure information regarding any beneficial relationship the organization has that may result in profit for the referring organization.

29. To education, instruction and a list of requirements for continuity of care when the services of the agency are terminated.

30. To be free of abuse, neglect and exploitation of any kind including agency employees, volunteers or contractors.

31. To privacy to maintain his/her personal dignity and respect.

32. To know that the agency has liability insurance sufficient for the needs of the agency.

33. To be advised that the agency complies with Subpart 1 of 42 CFR 489 and receive a copy of the organization's written policies and procedures regarding advance directives, including a description of an individual's right under applicable state law.

34. To receive advance directives information prior to or at the time of the first home visit, as long as the information is furnished before care is provided and to know that the Hotline number 1-800-252-4343 may be used to lodge complaints regarding the implementation of the Advance Directive requirement.

35. To voice grievances regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect of property or recommend changes in policy, staff, or service/care without restraint, interference, coercion, discrimination, or reprisal and to know that grievances will be resolved and the client notified of the resolution within 30 days.

36. To be advised of the toll-free home health agency hot-line for the State of Illinois and the purpose of the hotline to receive complaints or questions about the organization. The State of Illinois Home Health Hotline is 1-800-252-4343. The number is operated 8:0f0AM to 5PM daily to receive complaints or questions about local Home Health Agencies. You may also register complaints in writing to:

Central Complaint Registry
Illinois Department of Public Health
525 W. Jefferson Street
Springfield, IL 62761

37. To not be denied equal opportunity because they or their family are from another country, because they have a name or accent associated with a national origin group because they participate in certain customs associated with a nation origin group, or because they are married to or associate with people of a certain national group.

38. To be informed of the toll-free elder abuse hot-line 1-866-800-1409 used to report abuse, neglect or exploitation.

39. To be informed of the toll-free child abuse hot-line 1-800-252-2873.

The Client has the responsibility:

1. To provide, to the best of his/her knowledge, accurate and complete information about:
    a. Past and present medical histories.
    b. Unexpected changes in his/her condition.
    c. Whether he/she understands a course of action selected.
2. To follow the treatment recommended by the particular handling of the case.
3. For his/her actions if he/she refused treatment or does not follow the physician's orders.
4. For accruing that the financial obligations of his/her health care are fulfilled as promptly as possible.
5. To respect the rights of all staff providing service.
6. To notify the agency promptly in advance of an appointment or visit you must cancel.
7. To become independent in care to the extent possible, utilizing self, family and other sources.
8. To pay for care or services not covered by 3rd party payers.
9. To comply with the rules and regulations established by the agency and any changes subsequent to the rules

_____ _____
Signature of Client Date

_____ _____
Nurse/Therapist Signature Date

CLIENT NAME(Last, First)	**MEDICAL RECORD #**

DERECHOS Y RESPONSABILIDADES DEL CLIENTE

Derechos y Responsabilidades del Cliente

Declaración de propósitos:

Se prevé que la observancia de estos derechos y responsabilidades contribuirá a una atención más eficaz y una mayor satisfacción para el paciente, así como el personal. Los derechos serán respetados por todo el personal y se integran en todos los programas de atención médica domiciliaria. Una copia de estos derechos se le dará a los pacientes y sus familias o representante designado. Si el paciente o su / su representante designado es incapaz de leer la Declaración de Derechos y Responsabilidades, se lee a ellos. Si el paciente o su representante / no habla Inglés, se proporcionará una copia de estos derechos en un idioma que se entienda. El paciente o su / su representante designado tiene el derecho de ejercer estos derechos. En el caso de un paciente declarado incompetente, los derechos del paciente son ejercidas por la persona designada por la ley para actuar en nombre del paciente. En el caso de un paciente que no ha sido juzgado incompetente. Cualquier representante legal podrá ejercer los derechos del paciente en la medida permitida por la ley.

El paciente tiene derecho a:

1. Para ser plenamente informados y conocedores de todos los derechos y responsabilidades antes de proporcionar atención pre-planificada y de entender que estos derechos se pueden ejercer en cualquier momento.

2. Para la atención adecuada y profesional, sin discriminación en relación con las órdenes del médico.

3. Para elegir un proveedor de atención de la salud, incluyendo la elección de un médico de cabecera.

4. Solicitar a los servicios de la Agencia de Atención Domiciliaria de su elección y solicitar información completa de su agencia antes de concederse la atención en relación con los servicios prestados, las alternativas disponibles, la licencia y los requisitos de acreditación, y la propiedad de la organización y control.

5. Ser informado con antelación acerca de la atención que se proporcione y de cualquier cambio en la atención que se deben suministrar antes de hacer el cambio.

6. Ser informado de las disciplinas que proporcionará cuidado y la frecuencia de las visitas propuestas para ser amueblada y saber que todo el personal de la prestación está debidamente capacitado y competente para llevar a cabo sus funciones.

7. Para información necesaria para dar su consentimiento informado antes del inicio de cualquier procedimiento o tratamiento y los cambios que se harán.

8. Participar en la elaboración y revisión periódica del plan de cuidados y realizar cambios en el plan de atención.

9. Para el acceso a su expediente y esperar la confidencialidad y privacidad de toda la información contenida en la historia clínica del paciente y de la información de salud protegida.

10. Para rechazar la atención o el tratamiento después de que las consecuencias de la atención o tratamiento negarse totalmente presentada.

11. Para el tratamiento con la máxima dignidad y respeto por todos los representantes de las agencias, independientemente del estilo de vida elegido por el paciente, el estado civil, las costumbres culturales, creencias políticas, religiosas, éticas, tener o no haber ejecutado una directiva anticipada y fuente de pago independientemente de la raza , credo, color, sexo, edad o discapacidad.

12. Para que su / su propiedad y las personas tratadas con respeto, consideración y reconocimiento del paciente.

13. Recibir y servicios de acceso consistente y en tiempo y forma de la agencia a su / su solicitud de servicio.

14. Para recibir información sobre el alcance de los servicios que la agencia proveerá y limitaciones específicos sobre esos servicios.

15. Para ser admitido para el servicio sólo si la agencia tiene la capacidad de proporcionar atención profesional de seguridad en el nivel de intensidad necesario y estar informado de las limitaciones de la agencia.

16. Para una continuidad razonable de la atención.

17. Para un plan individualizado de atención y enseñanza plan desarrollado por todo el equipo de salud, incluyendo el paciente y / o familia.

18. A tener en cuenta en las políticas y procedimientos de la agencia en cuanto a la divulgación de los registros de pacientes.

19. Ser informado de los derechos de los pacientes bajo HIPAA, federales, estatales y regulaciones de acreditación para formular directivas anticipadas sin temor a represalias si se prepara una directiva anticipada y saber que la agencia seguirá peticiones del paciente en relación con la directiva anticipada en la prestación de atención.

20. Ser informado de los resultados anticipados de servicio / atención y de los obstáculos en el logro de resultados.

21. A ser informado en un plazo razonable de terminación anticipada del servicio de los planes para el traslado a otro centro de atención médica / proveedor y el motivo de la terminación / transferencia del servicio.

22. Ser informado verbalmente y por escrito y antes de que se inicie la atención de las políticas de facturación de la organización y los procedimientos de pago y la medida en que:

a. El pago se puede esperar de Medicaid, o cualquier otra federalmente financiado o programa asistido conocido por la organización

segundo. Los cargos por servicios que no serán cubiertos por el pagador

do. Cargos que el individuo puede tener que pagar

23. Ser capaz de identificar a los miembros del personal que visitan a través de la identificación apropiada.

24. Ser informado oralmente y por escrito de cualquier cambio en la información de pago tan pronto como sea posible, pero no más tarde de 30 días a partir de la fecha en que la organización se da cuenta del cambio.

25. Para,, información honesta precisa franca, con respecto a la industria de la vivienda en general y su / su agencia elegida, en particular, incluyendo el costo por visita, la cualificación del personal, nombres y títulos del personal, etc.

26. Para acceder a los servicios profesionales necesarios 24 horas al día, 7 días a la semana.

27. Para ser referido a otra agencia si él / ella no está satisfecho con la agencia o la agencia no puede satisfacer las necesidades del paciente.

28. Para recibir la revelación de información con respecto a cualquier relación beneficiosa la organización tiene que puede resultar en beneficios para la organización de referencia.

29. Para la educación, instrucción y una lista de requisitos para la continuidad de la atención cuando se terminan los servicios de la agencia.

30. Estar libre de abuso, negligencia y explotación de cualquier tipo, incluyendo las agencias empleados, voluntarios o contratistas.

31. A la privacidad para mantener su / su dignidad personal y respeto.

32. Saber que la agencia tiene un seguro de responsabilidad suficiente para las necesidades de la agencia.

33. A tener en cuenta que la agencia cumpla con la Subparte 1 de 42 CFR 489 y recibir una copia de las políticas y procedimientos escritos de la organización en relación con las directivas anticipadas, incluyendo una descripción del derecho de un individuo bajo la ley estatal aplicable.

34. Recibir información directivas anticipadas antes o en el momento de la primera visita a la casa, siempre y cuando se suministra la información de que se proporciona la atención y saber que el número 1-800-252-4343 Línea Directa se puede utilizar para presentar denuncias respecto a la aplicación del requisito de instrucción anticipada.

35. Para expresar quejas sobre el tratamiento o cuidado que es (o se abstiene de ser) amuebladas, o por la falta de respeto de la propiedad o recomiendan cambios en la política, personal, o servicio / cuidado sin restricciones, interferencia, coerción, discriminación o represalia y saber que las quejas se resolverán y el cliente notificará la resolución dentro de los 30 días.

36. A tener en cuenta de la agencia de salud en el hogar caliente línea telefónica gratuita para el Estado de Illinois y el propósito de la línea telefónica para recibir quejas o preguntas sobre la organización. El Estado de Illinois Home Health Hotline es 1-800-252-4343. El número se opera de 8:30 am a 17:00 todos los días para recibir quejas o preguntas sobre agencias de salud locales. Usted también puede presentar quejas por escrito a:

Registro de Quejas central

Departamento de Salud Pública de Illinois

525 W. Jefferson Street

Springfield, IL 62 761

37. Para no ser negado la igualdad de oportunidades, porque ellos o sus familias son de otro país, porque tienen un nombre o un acento relacionado con un grupo de origen nacional porque participan en ciertas costumbres asociadas con un grupo de origen nacional, o porque están casados o asociarse con personas de un determinado grupo nacional.

38. Ser informado del hot-line maltrato a personas mayores a la línea gratuita 1-866-800-1409 utilizado para reportar abuso, negligencia o explotación.

39. Ser informado del hot-line abuso de menores a la línea gratuita 1-800-252-2873.

El Paciente tiene la responsabilidad de:

1. Suministrar según su conocimiento, información completa y precisa sobre:
    a. Su historia clínica pasada y presente.
    b. Cambios inesperados en su condición.
    c. Si él/ella entiende los procedimientos a seguir.
2. Seguir el tratamiento recomendado por el profesional que lo atiende.
3. Decidir si él/ella rechaza el tratamiento o no sigue las órdenes del médico.
4. Asegurar el pago de sus gastos médicos lo más pronto posible.
5. Respetar los derechos del personal que provee el servicio.
6. Notificar a las agencia con anticipación de la cancelación de una visita.
7. Independizarse en cuanto a su cuidado en la forma que le sea posible, bien por sí mismo a través de un familiar u otro recurso.
8. Pagar por los servicios que no estén cubiertos por una tercera parte.
9. Acatar las reglas y regulaciones establecidas por la agencia y/o cualquier modificación de las mismas.

_____ _____

Firma del Cliente Fecha

_____ _____

Firma del Enfermero /Terapista Fecha

NOMBRE DEL CLIENTE (Apellido, Nombre)	**EXPEDIENTE #**

ABUSE, NEGLECT AND FINANCIAL EXPLOITATION

The following policy will be provided to all clients admitted to this Agency:

Client information regarding the mandatory reporting of Abuse, Neglect, Exploitations and Reportable Conduct

If the Agency has reason to believe that a client has been abused, neglected and/or exploited by an Agency employee, the Agency must report the information within 24 hours to:

Elder Abuse Services at 1-866-800-1409

Domestic Abuse/Violence Hotline at 800-799-7233

Definitions:

Violence: Implies use of great force, intense vehemence, physical force exerted for the purpose of violating, damaging or abusing people or things

Abuse: Generally carries with it a sense of harm and takes the form of physical, verbal, sexual, psychological and emotional injury; it is generally repetitive and escalating

Neglect: Failure to care for or, to disregard or pay no attention to. Neglect can be passive (unintentional), or active (intentional failure to fulfill a caretaking obligation to inflict physical or emotional stress or injury)

Child Neglect: Leaving a child in a situation where the child would be exposed to a substantial risk of physical or mental harm; failure to arrange for necessary care for the child and demonstration of intent not to return by a parent, guardian, or managing/ possessory conservator of the child

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

Policy:

1. All employees and independent contractors of the Agency shall report suspected abuse, neglect and/or exploitation of a client to an Agency supervisor and the appropriate state agency. Failure to report is considered a Class A misdemeanor.
2. When victims of alleged or suspected domestic violence, abuse, neglect or exploitation, are admitted to the service of this Agency, appropriate care cannot be provided by the Agency unless victims are identified and assessed.
3. Evidence of crimes involving abuse, neglect or exploitation shall be reported to the appropriate law enforcement agency.

Procedure:

1. If any Agency employee or contractor is suspected of abuse, neglect or exploitation, the employee or contractor will be suspended immediately and an investigation conducted by the Agency and the appropriate agency. If the Agency finds that kind of abuse, neglect or exploitation occurred, the employee or contractor will be terminated and the incident(s) reported to the appropriate state department, licensing board, or law enforcement official.

2. The Agency's director and physician shall be notified of the Agency's intent to report.

3. All health care professionals, whether employed or contracted by the Agency, who suspect neglect or abuse or exploitation have the legal obligation to report such to the Domestic Abuse/Violence Hotline at 800-799-7233.

4. All Agency employees and contractors are required to report any unprofessional conduct by a licensed health care professional to the professional's licensing board and to his or her supervisor, if any.

5. All Agency employees and contractors will report immediately any suspected abuse, neglect and exploitation to their agency supervisors and to Protective Services or other state agency as required by law.

6. Not withstanding any other provision of this policy to the contrary, reports of child abuse or child neglect will be filed with Protective Services or other state agency as required by law.

7. Any nurse or other professional who suspects that a client is a victim of family violence has the legal obligation to provide information in the form of a written notice mandated by the state of Illinois. The provision of the completed notice plus documentation of reasons(s) why abuse is suspected shall be documented by the Agency.

8. All reports of suspected abuse, neglect or exploitation shall be documented by the Agency and such documentation will be kept confidential by the Agency to the extent required by Illinois law. Documentation shall report only observations and statements by the persons involved. The report shall not document conclusions or opinions. Copies of reports filed with Protective Services or local law enforcement will be tracked and kept by the Agency.

9. Incidents of family violence shall be reported to a local law enforcement agency.

WHAT TO EXPECT IF YOU HAVE A HOME HEALTH AIDE

If it is determined you need a Home Health Aide, your home health aide will be a certified and educated individual who assists you during your time of recovery. He/she will provide personal care which is needed to facilitate treatment or to prevent deterioration of your health. Things you can expect:

1. This home health agency employs both male and female aides.
2. The number of visits per week is determined after the Registered Nurse makes an assessment of your needs and we receive orders from your physician.
3. The Registered Nurse will write a care plan specific to your needs and a copy will stay in your home folder.
4. To assure proper care is being given, the home health aide is supervised by a Registered Nurse. If at any time a problem arises concerning your aide, such as the care or services being provided, please call and ask for the Agency Supervisor or the Registered Nurse.
5. Every effort will be made to provide consistent assignment of personnel to your service. However, other work schedules and personal needs of the Agency may create the need for a replacement.
6. The main purpose of the home health aide is to provide personal care. Each visit will be approximately 20 minutes to one hour. Personal care includes:
    a. Bath (may be bed, partial, tub or shower as determined by the RN)
    b. Hair care (comb, brush, shampoo, dry roll/style)
    c. Nail care: clean, file, polish. (Aides do not cut nails)
    d. Skin care with lotion and/or powder
    e. Foley catheter care (Change, empty and/or clean bag. Aides do not irrigate the foley)
    f. Colostomy bag (rinse, empty bag).
    g. Help with dressing, grooming
    h. Assistance with ambulation
    i. Assist with transfers (in and out of bed, wheelchair and bedside commode)
    j. Remind you to take your medications (Aides do not administer medications)
    k. Take and record your vital signs (temperature, pulse, blood pressure) and report them to your nurse
    l. Range of motion exercise as ordered by the nurse
7. Time permitting, the aide may also help with light housekeeping tasks in the client's immediate area:
    a. Bath area - sink, tub, commode (including emptying bedside commode), urinals, trash, place wet towels in appropriate place
    b. Your bedroom - light dusting, vacuum, sweep/mop, leave personal items within reach, empty trash
    c. Kitchen - when necessary, meals are prepared for clients only, wash dishes for client, clean kitchen sink, sweep, empty trash
    d. Laundry – client's laundry to include client's bed linens and towels

PREVENTING INFECTIONS AT HOME

Hand Hygiene Procedure

EQUIPMENT

1. Paper towels
2. Lotion
3. Liquid soap
4. Alcohol-based hand sanitizer or wipes,
5. Antiseptic hand scrub (optional), and an impermeable plastic trash bag

PROCEDURE

1. Use alcohol-based hand sanitizer.
2. Pour small amount of sanitizer into palm and spread over hands and fingers and rub thoroughly until dry.
4. Clean and replace equipment.
5. Discard disposable items according to Standard Precautions.

PRACTICE GOOD PERSONAL HYGIENE	•Regular bathing and hair washing •Daily tooth brushing/mouth cleaning •Preventative dental care once or twice a year •Regular trimming of finger/toe nails (not too short) •Keeping clothes clean/laundered •No sharing of toothbrushes •No sharing of razor blades
MAINTAIN A CLEAN ENVIRONMENT	•Keep all surfaces clean where food is prepared •Keep food containers properly closed or covered •Refrigerate foods requiring cold storage promptly •Clean up spills/messes right away •Mop kitchen/bathroom floor weekly or as needed •Clean all areas of bathroom, especially around the toilet base •Avoid using the same supplies for bathroom and kitchen •Do not pouring used mop water in the kitchen sink •Draining off liquid before putting garbage in a plastic lined pail •Keep garbage in plastic-lined covered cans •Keep yard cleared of areas where water can collect and stagnate
LIMIT EXPOSURE	•Wear gloves when cleaning bird cages, litter boxes, etc. •Avoid crowds, especially in flu season •Avoid close contact of people with contagious infections •Avoid sharing food or drinks •Cover nose/mouth with tissue when sneezing/coughing •Avoid licking fingers or tasting from mixing spoon or bowl when cooking

ACCIDENT PREVENTION

If you are over age 65, your chances of dying from an accident are almost twice as likely as that of any other age group.

By taking the right precautions, you can protect yourself and those around you and prevent serious injury.

Why is injury a common problem among older people?

1. During the aging process certain physical, mental and emotional changes occur:
2. Less physical strength
3. Impaired eyesight
4. Impaired hearing
5. Slower physical reaction
6. Poor balance and coordination

What was considered a "minor" accident in your younger years may be serious now due to:

1. Lower resistance to disease
2. Slower healing
3. Bones that are brittle
4. Your particular illness or disease
5. Physical limitations

The most common and dangerous cause of injury is falls.

Here are measures you can take to reduce falls:

1. Remove scatter rugs or use non-skid tape or backing on throw rugs
2. Tack down the edges of all carpets
3. Never leave articles around beds, stairs, or in hallways
4. Do not use a doorway, halls or stairs for storage
5. Keep pathways clear of furniture, electric cords, space heaters, etc.
6. Don't rush when climbing up or down stairs
7. Stairs should have non-skid treads and a solid, easy to grasp handrail
8. If you must climb, use a solid step or ladder rather than a chair or box
9. When carrying objects, make sure you:
    a. Can see
    b. Get a firm grip
    c. Move slowly and evenly
    d. Lift with your legs (knees bent, back straight)
    e. Ask for help with heavy or awkward objects

General Safety Tips:

1. Avoid wearing only socks, smooth-soled shoes or slippers on non-carpeted floors
2. Avoid wet floors – wipe all spills up immediately
3. Keep kitchen floor free of grease and scraps
4. Household pets should be kept under control and out of pathways
5. To avoid dizziness, get out of your bed or chair slowly.
6. In the bathroom:
    a. Be sure mats are non-skid and there are treads in the tub or shower to prevent slips.
    b. Install "grab bars". Towel racks should not be used as grab bars as they are not secure enough to support body weight.

Adequate lighting will help prevent accidents

1. Keep a lamp near the bed so you will not have to get up in the dark.
2. Keep a night light in the bathroom.
3. Keep hallways and steps well-lit.
4. Keep a flashlight handy in case of power failure.

Additional Important Safety Tips:

1. Post Emergency Numbers By Your Phone
2. If you live alone, ask a neighbor, friend, or family member to check on you each day
3. Take your time
4. Be safe
5. Do not take unnecessary risks

MEDICATION INFORMATION

MEDICATIONS ARE MEANT TO HELP…TAKE THEM SAFELY.

1. Use caution and be aware of what you are taking.
2. Tell your physician, pharmacist and nurse about all the medications you are taking (prescription and over-the-counter) to prevent dangerous combinations or duplications.
3. Take a list of your medications to the doctor on each visit.
4. Read your medication labels and take as directed.
    a. Always take the exact dosage prescribed.
    b. Take at the times indicated.
    c. If you miss a dose, do NOT double your next dose.
    d. Always keep medication in the original container and out of reach of children.
    e. Organize your containers in one area.
    f. Appropriately discard any expired medications or those that have been discontinued by your doctor. Ask your nurse or doctor about proper disposal. DO NOT PUT IN TRASH!
    g. Never take another person's medications.
    h. BEWARE of the precautious on the label. Some drugs do not mix with alcohol, certain foods or other medications.

Your nurse will explain what each drug is for, how to take it and the side-effects you need to be aware of.

Your nurse will assist you with setting up a safe system for taking medications, if necessary. You can use a chart or container system to help you remember what medications to take, how much to take and when to take it.

REMEMBER – ALWAYS READ THE LABEL BEFORE TAKING ANY DRUG!

OXYGEN IS ALSO A PRESCRIPTION!

Make sure the equipment company instructs you in safety precautions and the correct use of ALL equipment (oxygen, walkers, monitors, Hoyer lifts, wheelchairs, etc.) If you do not understand its use, let your nurse or therapist know and they can review safety instructions with you.

In the event that narcotics are being taken, they must be monitored as closely as possible and checked to be sure that they are being taken appropriately. If the narcotic is discontinues, the client/family have the responsibility to dispose of the used narcotics by either destroying the narcotics or arranging for the RN to dispose of the medication in the home.

Keep an updated list of your medications for emergency situations.

Have a Disaster Plan

FIRE

Protect yourself, your family and your home against fire or burns.

- Be prepared!
- Make a fire escape route and practice it.
- Make sure fire exits are free of clutter.
- Keep a fire extinguisher charged and handy. Know how to use it.
- Install smoke detectors and keep them in working order.
- Don't smoke in bed or when sleepy.
- Use space heaters according to manufacturer's instructions. Keep them free from clutter, paper, curtains, etc.
- Keep flammable liquids outside of home in approved safety containers.
- Have your home electrical system checked if there are signs of a wiring problem.
- Keep all electrical appliances in good working order.
- Use extension cords properly. Do not overload them and keep them away from sinks or water.
- Keep towels, curtains, and other flammables a safe distance from the stove.

To prevent burns:

- Always check hot water temperature. Experts suggest setting hot water heaters at 120 degrees F or below.
- Wear tight fitting or short sleeves when cooking.
- Keep pot handles away from the front of the stove.
- Use potholders.

BIOMEDICAL WASTE DISPOSAL IN THE HOME

Recent changes in the state regulations have expanded the application of the federal OSHA (OCCUPATIONAL SAFETY AND HAZARD ADMINISTRATION) regulations regarding the disposal of biomedical waste to include the home setting. It is now illegal to put home-generated biomedical waste out with the regular trash for pick up.

Biomedical waste generated in the home must be packaged and disposed of properly to reduce the risk of exposure to waste handlers and the public at large.

What is Biomedical Waste?

Biomedical waste is defined as any solid or liquid waste that may present a threat to infection of humans. These include, but are not limited to:

1. Used, absorbent materials saturated with blood or body fluids, secretions, excretions, which are contaminated with blood, whether wet or dried. Absorbent materials include such items as bandages, gauze and sponges.
2. Non-absorbent disposable devices that have been contaminated with blood or body fluids, secretions or excretions which are contaminated with blood. Non-absorbent disposable devices include such items as sharps, syringes, lancets, IV tubing, etc.

Your home care agency is responsible for collection and removal of all biomedical waste generated while they are providing home care services. This is done through the use of OSHA approved containers: a rigid container (usually red, but not always) for sharps; and a red bag for absorbent materials. Both of these containers will be marked with a fluorescent orange biohazard or biomedical waste symbol. Upon discharge from the home care services, you will be provided with the name and phone number of local sharps and biomedical waste disposal programs in your area.

REMEMBER! IN NO CASE SHOULD A RED BAG OR A SHARPS CONTAINER EVER BE PUT OUT WITH HOUSEHOLD TRASH.

RESUSCITATION AND EMERGENCY SERVICES

Our agency supports your right to self-determination. Advance Directives such as Living Wills and Do Not Resuscitate (DNR) orders will be followed when provided in writing.

If documentation has not been provided then every person admitted to the Agency shall be presumed to consent to the administration of cardio-pulmonary resuscitation in the event of cardiac or respiratory arrest unless another decision has been made by the patient/client or surrogate-decision maker.

Emergency Protocols

Emergency protocols are used only when it is impossible to immediately contact your attending physician and your physician has not specified treatment to be followed.

The 911/EMS number is activated in emergency situations including but not limited to:

- Cardiac Arrest
- Choking
- Convulsions/Seizures
- Anaphylactic Reactions

In addition, if you do not respond to the doorbell or knocking our employee will obtain assistance to enter your home by superintendent if you live in an apartment or a family member/caregiver. If we are unable to obtain assistance to enter your home then the employee will use their own judgement in calling the police. If the employee is able to look inside your home and identify that you are on the floor, they will immediately call 911.

CLIENT INSTRUCTIONS IN THE EVENT OF AN EMERGENCY

Emergencies include natural and manmade disasters. This may include hurricanes, tornadoes, earthquakes, severe weather or other natural disasters or it may include manmade disasters such as bio-terrorism, Terrorism, Radiation, Chemical Spills, Nuclear Accidents and Hazardous Material.

We are faced with many types of emergency situations that may cause an interruption in services.

In the event you are faced with a natural disaster, inclement weather, and/or other emergency situation, to ensure the highest level of client care & continuity of services, it is the policy of the agency that a client immediately call the agency to advise of the emergency situation. Please utilize the following to contact the agency:

AGENCY PHONE NUMBER: 214-407-3791

If you choose to evacuate during an emergency, you must take provisions with you. The following suggested items will make your temporary stay more comfortable:

- Foods that do not need cooking and Drinking water (1 gallon per person per day)
- Special dietary food if required
- Identification, valuable papers and photos, including medical information
- Personal hygiene items, such as: soap, deodorant, shampoo, toothbrush, toothpaste, aspirin, antacid, incontinent supplies, washcloth, towels etc.
- Utensils, such as: manual can opener, disposable plates, cups, forks, knives, spoons, napkins
- Prescription medicines, written prescription for refills & list of medications
- Books, magazines, cards, toys, and games for adults and children
- Infant care items such as formula, food, disposable diapers and toys
- Battery operated radio flashlight & lantern, extra batteries & earphones
- First aid kit including: betadine solution, bandages, adhesive tape, band-aids, bandages, safety scissors, non-prescription medicines
- Personal aids such as: eyeglasses, hearing aids & prosthetic devices
- Change of clothing and rainwear; Sleeping bag or blanket, sheet & pillow

REMEMBER:

ALL ALCOHOLIC BEVERAGES, ILLEGAL DRUGS, PETS, AND WEAPONS

ARE PROHIBITED WITHIN EMERGENCY PUBLIC SHELTERS.

For more information, see the community reference pages in your telephone directory, or call:

COOK COUNTY

69 W. Washington St. Suite 2630

Evergreen Park, Illinois 60602
Telephone: (312) 603-8180
Fax: (312) 603-9883

LAKE COUNTY

1303 N. Milwaukee Ave

Libertyville, Illinois 60048
847-377-7100
24 HR 847-549-5200

DUPAGE COUNTY
136 North County Farm Rd.
Wheaton, IL 60187
630-682-7925

COMMUNITY RESOURCES

DUPAGE COUNTY

Village of Downers Grove Counseling	630-434-5595
DuPage Community Clinic	630-682-0639
Access and Crisis Center	630-627-1700
Adult Psychiatric Services	630-627-1700
Family Shelter Service	630-469-5650
Elmhurst Memorial guidance	630-941-4577
Helping Hands Special Needs Registration	630-682-7925
County Health Department	630-682-7400
American Red Cross of Greater Chicago	708-547-6516
Crisis Intervention Unit	630-627-1700
Food Pantries	630-407-6500
Catholic Charities	800-941-8681
Senior Services	630-407-6500
Love Christian Clearinghouse	630-512-8665
Peoples Resource Center	630-682-5402
St. Vincent de Paul Thrift Store	630-628-9008
The Salvation Army	773-725-1100
Sharing Connections Furniture Bank	630-971-0565
Walk-in Ministry of Hope	630-322-9803
Social Security	800-772-1213
Low Income Home Energy Assistance	800-942-9412
Nicor Gas Sharing Program	630-629-4948
Access DuPage (health insurance help)	630-510-8720
Medical Assistance Program	630-407-6500
HomeCare Physicians	630-614-4960
Home Physicians	773-292-4800
Mobile Doctors	800-362-2968
Al-Anon	630-627-4441
Alzhiemer’s Association	800-272-3900
DuPage Center for Independent Living	630-469-2300
American Cancer Society DuPage Area Office	630-932-1141
Dial-A-Hearing Screening Test Hotline	800-222-3277
DuPage CommunityDental Clinic	630-690-7450

Illinois Guardianship and Advocacy Commission	847-294-4264
Office of Public Guardian	630-355-1700
DuPage Bar Legal Aid Service	630-653-6212
Property Tax Deferral	630-407-5900
Senior Citizen Assessment Freeze Homestead Exemption	630-407-5858
DuPage County Veterans Assistance Commission	630-407-5655

LAKE COUNTY

Catholic Charities	847-782-4000
Attorney General	312-814-3000
Lake County Housing Authority	847-223-1170
Jewish Family & Community Service	847-272-2882
Lutheran Home and Services	847-253-3710
Northeastern Illinois Area Agency on Aging	800-528-2000
Social Security Administration	800-772-1213
Veteran's Administration	847-688-1990
Al-Anon	847-680-4640
Highland Park Hospital-Behavioral Services	847-480-3720
Lake county Community Health Department	847-377-8200
Northeast Council on Alcohol/Substance Abuse	847-244-4434
PADS Crisis Services	847-689-4357
American Red Cross	847-782-4000
Poison Center	800-942-5969
Medicare Hotline	800-638-6833
Cancer Hotline	800-422-6237
Prairie State Legal Services	847-662-6925
Lake county Crisis Center Hotline 24HR	847-249-4450
American Lung Association of Lake County	847-295-5864
Compassionate Friends (for Bereaved)	630-990-0010
Lake County Mental Health	847-377-8000

COOK COUNTY

Ambulatory & Community Health Network	312-864-0706
Animal Control	708-974-6140
Bureau of Human Resources	312-603-6598
Human Rights Commission	312-603-1100
Veteran's Assistance Commission	312-603-0130
American Dental Association	312-440-2500
Communicable Diseases	312-744-5000
Chicago Police Department	312-746-6000
Department of Consumer Services	312-744-9400
CTA Chicago Transit Authority	312-836-7000
Chicago Chamber of Commerce	312-494-6700
Fire Department	312-744-6666
Arthritis Foundation	312-372-2080
Illinois Dept. of Aging	312-744-3221
American Heart Assoc	312-346-4675
Family Rescue Hotline	312-375-8400
American Diabetes Assoc.	312-346-1805
YWCA-Woman's Services	312-372-6600
Mujeres Latinas En Accion	312-226-1544
The Salvation Army	773-725-1100
Catholic Charities	312-655-7700
CDBG Elder Violence Prevention	312-744-4016
Department of Public Health	312- 814-2608
Commonwealth Edison	312-394-4321
Goodwill Industries	312-212-1290
Jewish United Fund	312-346-6700

Chicago Cares	312-780-0800
Department of Social Services	312-744-4016
Senior Link Alliance	312-744-9057
Senior Companion Program	800-424-8867
Salvation Army	815-726-4834
Taxpayer Assistance	800-732-8860
Little Brothers-Friends of the Elderly	312-455-1000
Consumer Fraud	800-386-5438
Help A Pet	630-986-9504

EMERGENCY/DISASTER INFORMATION – HOME HEALTH PATIENTS

KEEP THIS PLAN WHERE IT CAN EASILY BE LOCATED.

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 other persons close to you (relative, neighbor, etc.) of its location.

1. My Home Nurses LLC has a nurse on call 24 hours a day. You can reach the nurse through 214-407-3791. After office hours and on weekends and answering service will reach the nurse and he/she will return your call, come see the client if necessary, or simply answer any questions you may have.
2. In case of a serious medical emergency, call 911. My Home Nurses LLC does not operate as an emergency service, therefore, valuable time may be lost by contacting The Agency for an emergency such as a diabetic coma, severe chest pain, unconsciousness, etc.

Name:	Date:
Allergies: NKA	EDP Classification:

In case of Medical Emergency Dial 911

The Emergency Medical Service Dispatcher will need to know:

- Your Name: _____
- Your Telephone Number: _____
- Your Address:

List of My Current Medications	**List of My Supplies / DME**

Emergency contact Information

In Case of Emergency Please Notify the Following Individual:

Name: _____ Phone: _____ Relationship: _____

Disaster Plan Code

Level 1 – 1: Must be seen and/or evacuated ASAP.

Emergency contact Information

I Will:	☐ Stay Home	
	☐ Stay with Family or Friend	Name and Telephone #:
	☐ Evacuate to a Shelter ☐ Standard ☐ Special Needs Registry ☐ MMF	Shelter's Name and Address:
	☐ Evacuate to hospital	

Comments

Describe how services will continue in the event of an emergency:

Physician	**Pharmacy**
Name:	Name:
Telephone Number:	Telephone Number:
Address:	Address:

SNOW STORMS/ BLIZZARDS/SNOW EVENTS

Definitions:

Winter Storm Watch: This mean a winter storm is possible.
Winter Storm Warning: This means a storm is occurring or soon will.

Before the Storm:

- Know your risk.
- Make sure your disaster kit is available including emergency phone numbers.
- Charge your cell phone.
- Get some food and water into your home to sustain you for a few days.
- Ensure that you have back up batteries, flashlights and if you are using an oxygen concentrator, have your back up system accessible.
- If you have oxygen, contact your oxygen provider and arrange for back up supplies. If you have backup tanks, check your back up tanks make sure they are full and that you can switch over to the back up.
- Listen to a local radio and television station for official announcements issued from the Emergency Operations Center.
- If the storm is reported to actually be happening, obtain assistance from family and friends to stay with you and assist you or make arrangements to stay with them. If you change your location, let the Agency know the address at which you will be staying.
- Place a shovel at the door to your home and make sure you have made arrangements for someone to assist you with snow removal.

During the Disaster:

- STAY CALM
- Inside: Keep the home warm and avoid the use of kerosene heaters inside the house.
- Stay indoors and dress warmly. Dressing in layers of loose fitting clothing is best.
- Make sure that you keep you keep up your nutrition and hydration status.
- Outside: winds and snow accumulation can build up on the tops/peaks of home, avoid walking under these. Stay inside and warm. You can take care of issues outside after the storm.
- On the road: Be safe and stay home. If you need to be removed from the home you are encouraged to be in a vehicle that has 2-4 wheel drive and snow tires.

After the Disaster:

- Call for assistance from snow removal personnel.
- If you have to go out, dress warmly and be careful not to over exert if shoveling snow.

- Turn on radio and listen for instructions on travel and safety instructions.

Other Important Information:

- Plan for reuniting family.
- Contact your insurance company regarding damage.

HURRICANE INFORMATION

HURRICANE: IT'S NOT JUST ANOTHER STORM

Hurricane Survival Checklists

Before the Storm:

- Know your risk
- How high is your home from sea level? Consult your home's building for your first floor elevation.
- Listen to a local radio and television station for official announcements issued from the Emergency Operations Center.

Special Circumstances (anything requiring additional preparation and/or evacuation time):

- Mobile Home/recreational vehicle
- People with special needs (medical or physical condition)
- Pets
- Boats

Know the Strength of the Hurricane:

- Category One: 74-95 mph sustained winds
- Category Two: 96-110 mph sustained winds
- Category Three: 111 -130 mph sustained winds
- Category Four 131-155 mph sustained winds
- Category Five: above 155 mph sustained winds

Determine where you will seek shelter if you have to leave and select an alternate:

- Friend’s house, if located away from risk area
- Hotel or Motel located Inland
- Emergency Public Shelter operated by the American Red Cross

OTHER IMPORTANT THINGS TO CONSIDER:

- Take a drive to your shelter choice so you know where it is located. Time the trip and multiply the time by three (3) to account for pre-storm road traffic conditions.
- Make the commitment now to evacuate when you told to do so by local or state officials.
- If you do not have flood insurance, consult your insurance agent purchase. There is a five day waiting before coverage begins.
- Prepare your hurricane evacuation kit.

DURING THE STORM, REMAIN INSIDE:

- Blowing debris can injure or kill. Travel is extremely dangerous. Stay inside until authorities have announced your area is safe.
- Stay away from windows. Avoid using all electrical appliances. Seek refuge in a small interior, windowless area such as a closet, hallway or bathroom.

AFTER THE STORM:

- Expect the worst. Be careful of downed power lines, gas leaks weakened structures and dangerous animals.
- Do NOT drink the water. Eat only foods you're sure are absolutely safe.
- Be extra careful in handling power tools, generators, candles, matches and gas lanterns.
- Ask your Insurance Company for financial help. Listen to local radio stations for official relief information and instructions.

STAY SAFE

EARTHQUAKES/TORNADOES/OTHER DISASTERS

You may face potential threats from Earthquakes, Tornadoes or Other Disasters

Disaster Information:

We are constantly aware of the potential of an earthquake/tornado/other disasters creating damage and creating dangerous conditions. We need to properly prepare so that a disaster of any type will not cause greater personal damage than necessary. The items listed below may help you survive the disaster in a better way.

During the Disaster:

- STAY CALM
- Inside: Stand in an internal hallway or crouch under a desk or table, away from windows or glass dividers
- Outside: Stand away from buildings, trees, telephone and electric lines
- On the road: Drive away from underpasses/overpasses; stop in a safe area; stay in vehicle. Be aware of road conditions and do not take risks.

After the Disaster:

- Check for injuries - provide first aid
- Check for safety - check for gas, water, sewage breaks, downed electric lines and shorts; turn off appropriate utilities; check for building damage and potential safety problems
- Aftershocks from an earthquake or storm resurgence can cause cracks around the chimney, foundation, stairs
- Clean up dangerous spills
- Wear shoes
- Turn on radio and listen for instructions on travel and safety instructions
- Don't use the telephone except for emergency use

Other Important Information:

- How to turn off gas, water and electricity
- Do NOT drink water. Eat only foods you are sure are safe
- Plan for reuniting family
- Contact your insurance company regarding damage

Privacy Rights

STATEMENT OF PATIENT PRIVACY RIGHTS

As a home health client, you have the privacy rights listed below:

1. **You have the right to know why we need to ask you questions.**

   We are required by law to collect health information to make sure:

   a. you get quality health care, and

   b. payment for insurance clients is correct.

2. **You have the right to have your personal health care information kept confidential.**

   You may be asked to tell us information about yourself so that we will know which home health services will be best for you. We keep anything we learn about you confidential. This means, only those who are legally authorized to know, or who have a medical need to know, will see your personal health information.

3. **You have the right to refuse to answer questions.**

   We may need your help in collecting your health information. If you choose not to answer, we will fill in the information as best we can. You do not have to answer every question to get services.

4. **You have the right to look at your personal health information.**

   We know how important it is that the information we collect about you is correct. If you think we made a mistake, ask us to correct it.

PRIVACY ACT STATEMENT – HEALTH CARE RECORDS

THIS STATEMENT GIVES YOU ADVICE REQUIRED BY LAW (the Privacy Act of 1974).

THIS STATEMENT IS NOT A CONSENT FORM. IT WILL NOT BE USED TO RELEASE OR TO USE YOUR HEALTH CARE INFORMATION.

We are required by law to maintain the privacy of individually identifiable client health information (this information is "protected health information" and is referred to herein as "PHI"). We are also required to provide you of a copy of this policy. We will abide by the terms of this notice and notify you if we cannot agree to a requested restriction. We will accommodate requests you may have to communicate health information by alternative means or at alternative locations.

We will only use or disclose your PHI as permitted or required by applicable state law. This Notice applies to your PHI in our possession including the medical records generated by us.

Our agency understands that your health information is highly personal, and we are committed to safeguarding your privacy. Please read this Notice of Privacy Practices thoroughly. It describes how we will use and disclose your PHI.

This Notice applies to the delivery of health care by our Agency. This Notice also applies to the utilization review and quality assessment activities of our Agency.

This summary describes how we use and share information about you. This summary describes how you may see and get copies of this information.

We might use or share information about you for:

Treatment. Such as when our staff discuss your care.

Payment. Such as when we bill your insurance company for services provided to you.

Operations. Such as when we work to make the quality of the care we provide better. When we give out information about the different services we provide.

Other ways. Such as when we send disease reports to county and state health officials (this is required by law). When we provide information to law enforcement agencies, funeral directors, organ donation groups and researchers. When we share information to protect the health and safety of others or you. Or when we respond to court requests. We also may send you appointment reminders, greeting cards and newsletters.

How you may see and get copies of this information:
You have the right to:

- Ask for restrictions on the ways we use and give out your information.
- Get and inspect a copy of your health record.
- Add information to your health record.
- Ask that your health information be sent to an alternate address or that you be called at an alternate phone number.
- Change your mind if you told us we could use or share your information for reasons other than those listed above.
- Get a list of the times we gave out your information. It will be a list of the times that the law

requires us to keep a record of giving out your information.

Our Commitment to Respect Privacy

Our Agency is required to:

- Keep your information private.
- Let you know if we cannot do what you have asked us to do with your information.
- Try to reach you at another location or phone number, if you ask us to do so.
- Use and / or give out your information as listed above and as the law permits, unless we have your permission to do more.

If there are any changes regarding what we do with your information, we will give you a new notice at the next visit but not later than 30 days.

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

PATIENT ADMISSION FORMS

PATIENT ADMISSION FORMS LIST

1. Admitting Staff Checklist
2. Intake Information Form
3. Physical Referral Orders
4. Directions to Client's Home from the Office
5. Consent for Treatment and Financial Agreement **(IN DUPLICATE)**
6. Authorization Agreement and Acknowledgements **(IN DUPLICATE)**
7. Advance Directive / HIPAA Acknowledgement **(IN DUPLICATE)**
8. Authorization for Release and Disclosure of Protected Health Information
9. Patient/Client Rights and Responsibilities **(IN DUPLICATE)**
   a. English
   b. Spanish
10. Client Emergency and Contact Information **(IN DUPLICATE)**
11. Client Acknowledgment – Receipt of Client Information Booklet
12. Home Safety Assessment **(IN DUPLICATE)**
13. Client Data Sheet
14. Physician' Order/Verbal/Telephone Order
15. Nursing Assessment
16. Skilled Nurses Note
17. Home Aide Plan of Care **(IN DUPLICATE)**
18. Home Aide Visit Notes
19. Discharge
20. Coordination of Care
21. Post Admission Client Satisfaction Survey
22. 60 Day Summary Report
23. Notice of Privacy Rights

ADMITTING STAFF CHECKLIST AND FORM INSTRUCTION

Agency Name: My Home Nurses LLC

Client Name: _____ Start of Care Date: _____

Client Social Security #: _____ Medical Record #: _____

Primary Physician: _____Insurance #: _____

All items marked duplicate must have a copy of the form left in the client's home chart.

I. For the office to fill out:

- ☐ Intake Information Form
- ☐ Physician Referral Orders (Verbal Referral Orders should have been received and this should have been faxed to MD before initial visit)
- ☐ Directions to Client's Home From the Office

II. Give these items to Client on initial visit:

- ☐ Client Information Booklet
- ☐ Advance Directive Forms (Duplicate)

III. Client to Sign Forms *(Upon admission client signs copy for agency and keeps a copy in home)*:

- ☐ Consent for Treatment and Financial Agreement (Duplicate)
- ☐ Authorization, Agreement and Acknowledgements (Duplicate)
- ☐ Advance Directive Acknowledgement / HIPAA / Home Care Privacy Rights Acknowledgement
- ☐ Authorization for Use & Disclosure of Protected Health Information
- ☐ Patient/Client Rights & Responsibility- English/Spanish *(Signature indicates receipt of Information Booklet)*
- ☐ Client Emergency and Contact Information
- ☐ Home Safety Assessment *(Walk around home; Do not just ask) (Duplicate)*
- ☐ Client Data Sheet (One copy only, stays with the client in the home to serve as communication to the other disciplines seeing the client)

IV. Admitting Professional, Review with Client and get signatures as applicable:

- ☐ Authorization for Use and Disclosure of Protected Health Information
- ☐ Client Acknowledges Receipt of Client Information Booklet
- ☐ Nursing Assessment
- ☐ Medication Record *(Not included…See MedPass)*
- ☐ Home Aide Plan of Care

INTAKE INFORMATION FORM

Agency Name: My Home Nurses LLC

PATIENT INFORMATION	
Client's Name	
Address:	
City:	ZIP:
County:	
Phone:	
DOB:	Sex: Male ☐ Female ☐
Race:	Marital Status:

PHYSICIAN INFORMATION	
Physician Name:	
Phone:	
NPI:	
Address:	
City:	ZIP:

CARE PERSON	
Name:	
Relationship:	
Phone:	
Address:	
City:	ZIP:

REFERRAL BY
☐ Physician Office
☐ Hospital
☐ Others
Name:
Phone:
Taken By: Date:

INSURANCE INFORMATION	
Admit ☐ Reject	Admitted Date:
Insurance:	
Insurance#	
Medicaid#	
Social Security:	
Private Insurance:	

HOSPITAL INFORMATION			
Hospital Admission Date:			
Hospital Discharge Date			
Surgical Procedures:			

DIAGNOSIS	ICD-10	Services:
Primary:		☐ SN
		☐ LPN/LVN
Secondary:		☐ HHA
		☐ PT
3rd:		☐ OT
4th:		☐ MSW
5th:		☐ SLP

Medications:
Allergies:
Diet:
Equipment Needed:
Assigned to:

PHYSICIAN REFERRAL ORDERS

AGENCY NAME: My Home Nurses LLCAGENCY PHONE NUMBER: 214-407-3791

AGENCY ADDRESS: 924 East Hyde Park Blvd., Unit 3W, Chicago, IL, 60615

Patients Name: _____ Insurance #_____

Address: _____ ____CITY:_____ ST: _____ ZIP:_____

HOME Phone: _____CELL PHONE: _____ DOB: _____

TELEPHONE/ADDITIONAL OR CHANGE OF ORDERS ON YOUR PATIENT

Date: _____Time: _____

Client Problem/Diagnosis:

_____

_____

Intervention/Order:

☐ **Admit** client to _____ for Home Health Care Services from _____ through _____
SN to assess, evaluate, and instruct client on disease process, knowledge deficit of medication, safety and diet.

Frequency:

_____

☐ **Recertify** client to _____for Health Care services for a period of 60 days, from _____ through _____. SN to monitor, re-evaluate & manage client's medical Regimen.

Frequency:

_____

☐ **Discharge** client from home health services due to:

☐ Client/Physician Request
☐ Client moved from service area
☐ All goals have been met
☐ Client moved to Healthcare Facility
☐ Client is non-compliant

Goals: To meet client's medical needs.
Client Informed: ☐ Yes ☐ No

Nurse's Signature _____ Date _____ Time _____

Physicians Signature _____ Date _____ Time _____

** **Doctor, please sign this form immediately and return it. Thank you****

DIRECTIONS TO CLIENT'S HOME FROM OFFICE

Agency Name: Client's

Client's Name: _____ Client's Phone: _____

Directions (see attached map):

_____

_____

_____

_____

_____

_____

_____

_____

_____

Which door to use: ☐ Front ☐ Side ☐ Back

Pets in home? ☐ Yes ☐ No

Special Comments (area, precautions, etc.)

_____

_____

_____

_____

_____

_____

Person completing this form: _____

CONSENT FOR TREATMENT AND FINANCIAL AGREEMENT

PATIENT NAME (Last, First, MI): _____ PATIENT MR #_____
CONSENT TO RECEIVE SERVICES: I, _____ hereby, authorize the Agency to render, appropriate home health services to me. I have been fully informed of the Agency's assessment and evaluation of my home care needs, the risk of receiving the care of declining the home care services. I understand that the Agency does not do drug testing on its employees. I accept the proposed Plan of Care and authorize services to be provided by the Agency in accordance with the orders of my physician and supervision to be done by agency personnel. I recognize that I have the right to refuse treatment or terminate services at any time by notifying the agency office. Also, the Agency may terminate service by notifying me of termination and reason. I believe my service needs to be:

_____

AUTHORIZATION FOR PAYMENT TO PROVIDER: I certify that information given by me in applying for payment under title XVIII or title XIX of the Social Security ACT, or other third party pay or coverage is correct. I authorize any holder of medical or other information about me to be released to third party payers any information needed for this or other related claims. I request that payment as authorized be made on my behalf to the Agency. This authorization and request shall apply to the period starting _____, 20 _____ until the order is discontinued by my physician.

CHARGE FOR SERVICES: Your initial services from the Agency will include the following services and initial frequency of visits and charge per visit if private insurance or private pay.

SERVICES AND/OR SUPPLIES	FREQUENCY OF VISITS	CHARGE PER VISIT	SERVICES AND/OR SUPPLIES	FREQUENCY OF VISITS	CHARGE PER VISIT
Skilled Nursing			Occupational Therapy		
Speech Therapy			Medical Social Worker		
Home Health Aide			Companion/PCW		
Physical Therapy			Other		

PATIENT LIABILITY FOR PAYMENT: You have the right to be advised, before care is initiated, of the extent to which payment for services may be expected from Insurance or other sources and the extent to which payment may be required from you, the client. We are advising you, orally and in writing, about the cost of items and services to be provided. You will receive a bill monthly for charges incurred and not covered by Insurance. Medicaid: Services provided are paid in full by MEDICAID NUMBER: _____ as the client, you will be notified of any change in the charges for items or a service provided through Insurance, Medicaid or other relevant Federal Programs as soon as possible, but no later than 30 days from the date the home health agency becomes aware of a change. Please Circle one of the following: Black Lung Veteran Administration, Worker's Compensation, or Private Insurance. Your Insurance Company is _____. This insurance Company covers _____% of the charges. You are responsible for $_____._____ per visit, which is the balance after insurance pays. The deductible amount of $_____.____ will be billed to you. You will be responsible for charges related to the services provided to you by this agency. Charges related to supplies used in providing care to you before these charges are implemented. Payment if rendered with my signature below. This assignment shall not extinguish or diminish the client's obligation to pay the full fee to the company for services rendered but the client shall receive credit for all sums collected pursuant to the agreement. If the enrolled client is in another insurance plan, it is the client's responsibility to notify the Agency or the client will be held responsible for payment. This agency is responsible for all payments to any caregiver assigned to your service.

PATIENT'S RIGHTS/EMERGENCY PLAN/COMPLAINT PROCEDURE: I have been informed of my rights and received a copy of the Client's Bill of Rights prior to the start of care procedure, "Advanced Directives, Emergency Plan, Out-of-Hospital, Do-Not-Resuscitate, Client's Conduct & Responsibilities, Abuse/Neglect/Exploitation". I have been allowed to participate in planning my care and have received a copy of the State's Toll Free Home Health Agency Hotline Number for Illinois, 1-800-252-4343 which receives complaints or grievances 24 hours a day, seven days a week.

CONFIDENTIALITY: It is our policy to protect all clinical records against loss, defacement, tampering and use by unauthorized person(s). All client identifiable information in the clinical record, including assessment data, remains confidential and is not released to the public. The client's written consent shall be required for the release of medical information to persons not otherwise authorized by law (federal and state) to receive this information. Authorized persons who may review the clinical record include surveyors, physicians, Insurance payers, and external and internal auditing personnel.

RELEASE OF RECORDS: I understand the agency policy with regard to confidentiality and release of records prohibits access to my records by persons other than personnel involved in care. I therefore give written consent for release of medical records to health care providers in my treatment care.
The client has received written information regarding their right to make healthcare decisions.

_____ _____ _____
PATIENT OR AUTHORIZED AGENT SIGNATURE: **RELATIONSHIP TO PATIENT** **DATE**

_____ _____ _____
AGENCY REPRESENTATIVE SIGNATURE **TITLE** **DATE**

CONSENT FOR TREATMENT AND FINANCIAL AGREEMENT *(client copy)*

PATIENT NAME (Last, First, MI): _____ **PATIENT MR #**_____

CONSENT TO RECEIVE SERVICES: I, _____ hereby, authorize the Agency to render, appropriate home health services to me. I have been fully informed of the Agency's assessment and evaluation of my home care needs, the risk of receiving the care of declining the home care services. I understand that the Agency does not do drug testing on its employees. I accept the proposed Plan of Care and authorize services to be provided by the Agency in accordance with the orders of my physician and supervision to be done by agency personnel. I recognize that I have the right to refuse treatment or terminate services at any time by notifying the agency office. Also, the Agency may terminate service by notifying me of termination and reason. I believe my service needs to be:

_____

AUTHORIZATION FOR PAYMENT TO PROVIDER: I certify that information given by me in applying for payment under title XVIII or title XIX of the Social Security ACT, or other third party pay or coverage is correct. I authorize any holder of medical or other information about me to be released to third party payers any information needed for this or other related claims. I request that payment as authorized be made on my behalf to the Agency. This authorization and request shall apply to the period starting _____, 20 _____ until the order is discontinued by my physician.

CHARGE FOR SERVICES: Your initial services from the Agency will include the following services and initial frequency of visits and charge per visit if private insurance or private pay.

SERVICES AND/OR SUPPLIES	FREQUENCY OF VISITS	CHARGE PER VISIT	SERVICES AND/OR SUPPLIES	FREQUENCY OF VISITS	CHARGE PER VISIT
Skilled Nursing			Occupational Therapy		
Speech Therapy			Medical Social Worker		
Home Health Aide			Companion		
Physical Therapy			Other		

PATIENT LIABILITY FOR PAYMENT: You have the right to be advised, before care is initiated, of the extent to which payment for services may be expected from Insurance or other sources and the extent to which payment may be required from you, the client. We are advising you, orally and in writing, about the cost of items and services to be provided. You will receive a bill monthly for charges incurred and not covered by Insurance. Medicaid: Services provided are paid in full by MEDICAID NUMBER: _____ as the client, you will be notified of any change in the charges for items or a service provided through Insurance, Medicaid or other relevant Federal Programs as soon as possible, but no later than 30 days from the date the home health agency becomes aware of a change. Please Circle one of the following: Black Lung Veteran Administration, Worker's Compensation, or Private Insurance. Your Insurance Company is _____. This insurance Company covers _____% of the charges. You are responsible for $_____._____ per visit, which is the balance after insurance pays. The deductible amount of $_____.____ will be billed to you. You will be responsible for charges related to the services provided to you by this agency. Charges related to supplies used in providing care to you before these charges are implemented. Payment if rendered with my signature below. This assignment shall not extinguish or diminish the client's obligation to pay the full fee to the company for services rendered but the client shall receive credit for all sums collected pursuant to the agreement. If the enrolled client is in another insurance plan, it is the client's responsibility to notify the Agency or the client will be held responsible for payment. This agency is responsible for all payments to any caregiver assigned to your service.

PATIENT'S RIGHT/EMERGENCY PLAN/COMPLAINT PROCEDURE: I have been informed of my rights and received a copy of the Client's Bill of Rights prior to the start of care procedure, "Advanced Directives, Emergency Plan, Out-of-Hospital, Do-Not-Resuscitate, Client's Conduct & Responsibilities, Abuse/Neglect/Exploitation". I have been allowed to participate in planning my care and have received a copy of the State's Toll Free Home Health Agency Hotline Number for Illinois, 1-800-252-4343 which receives complaints or grievances 24 hours a day, seven days a week.

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RELEASE OF RECORDS: I understand the agency policy with regard to confidentiality and release of records prohibits access to my records by persons other than personnel involved in care. I therefore give written consent for release of medical records to health care providers in my treatment care.

Client copy (signature not required) ---------- ---------- ----------

PATIENT OR AUTHORIZED AGENT SIGNATURE: **RELATIONSHIP TO PATIENT** **DATE**

_____

AGENCY REPRESENTATIVE SIGNATURE **TITLE** **DATE**

AUTHORIZATION, AGREEMENT, AND ACKNOWLEDGEMENTS

I GRANT permission to the employees of My Home Nurses LLC herein referred to as "the Agency" to render skilled nursing care and other ancillary skilled professional home health services as required and ordered by my physician.

I ACKNOWLEDGE that the Agency has notified informed and explained to me the **PATIENT BILL OF RIGHTS**. I have received information on Advance Directives, Directives to Physician, Durable Power of Attorney for Home Health Care, and Out of Hospital DNR orders, the services to be provided, the supervision of the services, and charges for services rendered will be the responsibility of the client/family to pay.

I AUTHORIZE the Agency to release any medical information requested by representatives of local, state or federal agencies, accrediting bodies, insurance companies, or other organizations or entities as may be required by said representatives for payment of claims out of this home health care which are due**.** The agency has notified me of the Policies and Procedures regarding Disclosure of Clinical Records.

I REALIZE that Agency staff may not be present in my house at all time and I, my caregiver or legal guardian will assume responsibility for my care when agency staffs are not present.

I UNDERSTAND that the Agency does not routinely perform drug testing on its employees but may do so at their discretion using urine samples.

I UNDERSTAND that the Agency will notify me in writing and orally, no later than 30 days from the date they become aware of charges not covered by Insurance or other sources.

I UNDERSTAND that in the event of an emergency during which the Agency cannot meet my needs, the Agency can transfer me to another Agency that can provide the care I require.

I FURTHER UNDERSTAND that Agency employees may not be employed by me without first compensating the Agency $1100.00 or employee's annual wages, which is even greater.

INSURANCE ASSIGNMENT: In consideration of any services rendered, I hereby assign and transfer to the Agency any benefits payable to or for my benefit under the rules and regulations prescribed by Insurance & third party payers. I agree to cooperate, aid and assist the Agency in the process of billing insurance for these services. I certify that no home health agency is currently providing home health care and understand the misrepresentation of this fact shall cause me to be liable financially for care rendered by the Agency. If home health services provided by another home health agency in the past, I have requested discharge from those services prior to my start of care date with this Agency. I request that payment of Client benefits in my behalf are made directly to the Agency**.**

I HAVE BEEN INFORMED of the Agency's policies for resuscitation, medical emergencies and accessing 911 services. (EMS)

I AM AWARE that a Registered Nurse will be supervising my care and if I have complaints regarding services rendered, I am to contact the RN in charge of my care.

I HAVE BEEN INFORMED of my rights and that I may file complaints about the Agency with the Illinois Home Health Hotline at 1-800-252-4343, during regular business hours. After hours/ holiday calls will be answered by machine and responded to the next business day.

Client Name: _____ **Date:** _____

Client Signature: _____ **Responsible Party:** _____

AUTHORIZATION, AGREEMENT, AND ACKNOWLEDGEMENTS *(client copy)*

I GRANT permission to the employees of My Home Nurses LLC herein referred to as "the Agency" to render skilled nursing care and other ancillary skilled professional home health services as required and ordered by my physician.

I ACKNOWLEDGE that the Agency has notified informed and explained to me the **PATIENT BILL OF RIGHTS**. I have received information on Advance Directives, Directives to Physician, Durable Power of Attorney for Home Health Care, and Out of Hospital DNR orders, the services to be provided, the supervision of the services, and charges for services rendered will be the responsibility of the client/family to pay.

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INSURANCE ASSIGNMENT: In consideration of any services rendered, I hereby assign and transfer to the Agency any benefits payable to or for my benefit under the rules and regulations prescribed by Insurance & third party payers. I agree to cooperate, aid and assist the Agency in the process of billing insurance for these services. I certify that no home health agency is currently providing home health care and understand the misrepresentation of this fact shall cause me to be liable financially for care rendered by the Agency. If home health services provided by another home health agency in the past, I have requested discharge from those services prior to my start of care date with this Agency. I request that payment of Client benefits in my behalf are made directly to the Agency**.**

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I HAVE BEEN INFORMED of my rights and that I may file complaints about the Agency with the Illinois Home Health Hotline at 1-800-252-4343, during regular business hours. After hours/ holiday calls will be answered by machine and responded to the next business day.

Client Name: ***client copy (signature not required)*** _____ **Date:** _____

Client Signature: ***client copy (signature not required)*** _____ **Responsible Party:** _____

ADVANCED DIRECTIVE ACKNOWLEDGEMENT/HIPAA/HOME CARE PRIVACY RIGHTS ACKNOWLEDGEMENT

Client's name: _____ Insurance #_____

I, **_____,** acknowledge that the Agency has provided me with information which indicates that I may accept or reject any medical treatment, including any particular care specified:

- Living Will or Out of Hospital Do Not Resuscitate (DNR)
- Statutory Power of Attorney for Health Care decisions
- Advance Directives in Illinois – A Health Care Directive
- HIPAA/Home Care Privacy Rights

I also understand that it is my responsibility to ask question about the information provided by the Agency. They have offered to provide a copy of the state's illustrative forms under state law if I request. I have also been advised to consult with my physician, lawyer, family, clergy, social worker or other qualified personnel for additional information or contact with a lawyer should I need assistance in changing the forms to reflect my treatment wishes or in executing a living will or statutory Power of Attorney for health care decisions.

I understand that this Agency will honor the advance directives and is willing and able to provide any procedure specified on the advance directives.

I understand that the fact that I have or have not signed a living will or Statutory Power of Attorney for Home Care decisions does not affect the medical treatment and home care to be provided by the Agency. I understand that it is the Agency's written policy to fully comply through its healthcare providers with the terms of a client's Living Will or Statutory Power of Attorney for Healthcare decisions to fullest extent permitted by state statutory Power of Attorney for Healthcare decisions to fullest extent permitted by state law.

I have been given an explanation and acknowledge receipt of the HIPAA PRIVACY RIGHTS. I understand that I may contact the Agency at any time for questions or concerns.

PLEASE CHECK THE FOLLOWING:

_____ I Have _____ I Have not signed a Living Will

_____ I Have _____ I Have not signed a Statutory Power of Attorney for Health Care

_____ if I have the above documents, I will provide the Agency with copies for its records.

HIPAA PRIVACY RIGHTS

Patients have the right to give adequate notice concerning the use/disclosure of their PHI on the first date of service delivery, or as soon as possible after an emergency.

The Privacy Rule grants clients new rights over their PHI, including the following:

1. Receive a Privacy Notice at the time of the first delivery of service
2. Restrict use and disclosure, although the covered entity is not required to agree
3. Have PHI communicated to them by alternate means and at alternate locations to protect confidentiality
4. Inspect, correct and amend PHI and obtain copies, with some exceptions
5. Request a history of non-routine disclosures for six years prior to the request, and
6. Contact designated persons regarding any privacy concerns or breach of privacy within the facility or at HHS

Signature Client or Representative (Signed on behalf of client when authorized to the extent permitted by state law):

x_____ Date: _____

Agency Witness: _____ Date: _____

Federal law requires that this agency provide the above information.

ADVANCED DIRECTIVE ACKNOWLEDGEMENT/HIPAA/HOME CARE PRIVACY RIGHTS ACKNOWLEDGEMENT *(client copy)*

Client's name: _____ Insurance #_____

I, **_____,** acknowledge that the Agency has provided me with information which indicates that I may accept or reject any medical treatment, including any particular care specified:

- Living Will or Out of Hospital Do Not Resuscitate (DNR)
- Statutory Power of Attorney for Health Care decisions
- Advance Directives in Illinois – A Health Care Directive
- HIPAA/Home Care Privacy Rights

I also understand that it is my responsibility to ask question about the information provided by the Agency. They have offered to provide a copy of the state's illustrative forms under state law if I request. I have also been advised to consult with my physician, lawyer, family, clergy, social worker or other qualified personnel for additional information or contact with a lawyer should I need assistance in changing the forms to reflect my treatment wishes or in executing a living will or statutory Power of Attorney for health care decisions.

I understand that this Agency will honor the advance directives and is willing and able to provide any procedure specified on the advance directives.

I understand that the fact that I have or have not signed a living will or Statutory Power of Attorney for Home Care decisions does not affect the medical treatment and home care to be provided by the Agency. I understand that it is the Agency's written policy to fully comply through its healthcare providers with the terms of a client's Living Will or Statutory Power of Attorney for Healthcare decisions to fullest extent permitted by state statutory Power of Attorney for Healthcare decisions to fullest extent permitted by state law.

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1. Receive a Privacy Notice at the time of the first delivery of service
2. Restrict use and disclosure, although the covered entity is not required to agree
3. Have PHI communicated to them by alternate means and at alternate locations to protect confidentiality
4. Inspect, correct and amend PHI and obtain copies, with some exceptions
5. Request a history of non-routine disclosures for six years prior to the request, and
6. Contact designated persons regarding any privacy concerns or breach of privacy within the facility or at HHS

Signature Client or Representative (Signed on behalf of client when authorized to the extent permitted by state law):

x ***client copy (signature not required)*** _____ Date: _____

Agency Witness: ***client copy (signature not required)*** _____ Date: _____

Federal law requires that this agency provide the above information.

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

You may decline to sign this Authorization

I, _____, hereby authorize My Home Nurses LLC (hereafter collectively referred to as "Agency") to use and disclose in any form or format, a copy of records concerning _____ (**PRINT** client) but only as follows. A copy of this signed, dated Authorization shall be as effective as the original. Agency may use and disclose the following information

To(Agency):

_____

For the purpose(s) of (be specific):

I specifically authorize Agency to use and disclose the following types of confidential information (initial where appropriate):

_____ HIV records (including HIV test results) and sexually transmissible diseases

_____ Alcohol and substance abuse diagnosis and treatment records

_____ Psychotherapy records

_____ Other: Specify: _____

The undersigned does hereby release, hold harmless and agree to indemnify Agency, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this authorization. I understand that my records may be subject to re-disclosure by recipient(s) and unprotected by federal or state law; that this authorization remains effective until Agency is in actual receipt of a signed revocation or until the records retention period required under federal and state law has expired and the records have been destroyed; that I have the right to revoke this authorization at any time, provided I do so in writing; that I have been given an opportunity to ask questions; that I have received a copy of the signed authorization; that I may inspect a copy of my protected health information to be used or disclosed under this authorization; that the Agency has not conditioned provision of services to or treatment of me upon receipt of this signed authorization; and that I may refuse to sign this authorization.

Client Signature: _____ Date: _____

OR

Client's Representative _____ Date: _____

(Print name and describe authority): _____

Agency Representative Signature & Title: _____ Date: _____

CLIENT RIGHTS AND RESPONSIBILITIES

The Client has the Responsibility:

1. To provide, to the best of his/her knowledge, accurate and complete information about:
    a. Past and present medical histories.
    b. Unexpected changes in his/her condition.
    c. Whether he/she understands a course of action selected.
2. To follow the treatment recommended by the particular handling of the case.
3. For his/her actions if he/she refused treatment or does not follow the physician's orders.
4. For accruing that the financial obligations of his/her health care are fulfilled as promptly as possible.
5. To respect the rights of all staff providing service.
6. To notify the agency promptly in advance of an appointment or visit you must cancel.
7. To become independent in care to the extent possible, utilizing self, family and other sources.
8. To pay for care or services not covered by 3rd party payers.
9. To comply with the rules and regulations established by the agency and any changes subsequent to the rules.

_____ _____

Signature of Patient Date of Signature

_____ _____

Nurse/Therapist Signature Date of Signature

PATIENT NAME(Last, First)	MEDICAL RECORD #

CLIENT RIGHTS AND RESPONSIBILITIES *(client copy)*

The Client has the Responsibility:

1. To provide, to the best of his/her knowledge, accurate and complete information about:
    d. Past and present medical histories.
    e. Unexpected changes in his/her condition.
    f. Whether he/she understands a course of action selected.
2. To follow the treatment recommended by the particular handling of the case.
3. For his/her actions if he/she refused treatment or does not follow the physician's orders.
4. For accruing that the financial obligations of his/her health care are fulfilled as promptly as possible.
5. To respect the rights of all staff providing service.
6. To notify the agency promptly in advance of an appointment or visit you must cancel.
7. To become independent in care to the extent possible, utilizing self, family and other sources.
8. To pay for care or services not covered by 3rd party payers.
9. To comply with the rules and regulations established by the agency and any changes subsequent to the rules.

Client copy (signature not required) _____ _____
Signature of Patient Date of Signature

Client copy (signature not required) _____ _____
Nurse/Therapist Signature Date of Signature

PATIENT NAME(Last, First)	MEDICAL RECORD #

DERECHOS Y RESPONSABILIDADES DEL PACIENTE

El Paciente tiene la responsabilidad de:

1. Suministrar según su conocimiento, información completa y precisa sobre:
    a. Su historia clínica pasada y presente.
    b. Cambios inesperados en su condición.
    c. Si él/ella entiende los procedimientos a seguir.
2. Seguir el tratamiento recomendado por el profesional que lo atiende.
3. Decidir si él/ella rechaza el tratamiento o no sigue las órdenes del médico.
4. Asegurar el pago de sus gastos médicos lo más pronto posible.
5. Respetar los derechos del personal que provee el servicio.
6. Notificar a las agencia con anticipación de la cancelación de una visita.
7. Independizarse en cuanto a su cuidado en la forma que le sea posible, bien por sí mismo a través de un familiar u otro recurso.
8. Pagar por los servicios que no estén cubiertos por una tercera parte.
9. Acatar las reglas y regulaciones establecidas por la agencia y/o cualquier modificación de las mismas.

_____ _____

Firma del Paciente Fecha

_____ _____

Firma del Enfermero /Terapista Fecha

NOMBRE DEL PACIENTE (Apellido, Nombre)	**EXPEDIENTE #**

DERECHOS Y RESPONSABILIDADES DEL CLIENTE *(client copy)*

El Paciente tiene la responsabilidad de:

1. Suministrar según su conocimiento, información completa y precisa sobre:
    a. Su historia clínica pasada y presente.
    b. Cambios inesperados en su condición.
    c. Si él/ella entiende los procedimientos a seguir.
2. Seguir el tratamiento recomendado por el profesional que lo atiende.
3. Decidir si él/ella rechaza el tratamiento o no sigue las órdenes del médico.
4. Asegurar el pago de sus gastos médicos lo más pronto posible.
5. Respetar los derechos del personal que provee el servicio.
6. Notificar a las agencia con anticipación de la cancelación de una visita.
7. Independizarse en cuanto a su cuidado en la forma que le sea posible, bien por sí mismo a través de un familiar u otro recurso.
8. Pagar por los servicios que no estén cubiertos por una tercera parte.
9. Acatar las reglas y regulaciones establecidas por la agencia y/o cualquier modificación de las mismas.

Client copy (signature not required) _____ _____
Firma del Paciente Fecha

Client copy (signature not required) _____ _____
Firma del Enfermero /Terapista Fecha

NOMBRE DEL PACIENTE (Apellido, Nombre)	**EXPEDIENTE #**

CLIENT EMERGENCY AND CONTACT INFORMATION

Client Name: _____SOC: _____

Address: _____

City_____State_____Zip:_____

Telephone Number: _____ Cell Phone: _____

Responsible Person's Name: _____ Relationship: _____

Home Telephone: _____ Work Phone: _____ Cell Phone: _____

Relative/Friend Not Living With You: _____ Relationship: _____

Home Telephone: _____ Work Phone: _____Cell Phone: _____

Primary Physician: _____ Telephone Number: _____

NATURAL DISASTER EMERGENCY PLAN

⇒ Class I – Patients with life threatening conditions that require ongoing medical treatment or a medical device to sustain life.

⇒ Class II – Patients with the greatest need for care will be seen as soon as possible. Patients requiring daily insulin injections, IV medications, sterile wound care of a wound with a large amount of drainage.

⇒ Class III – Services could be postponed 24-48hours without adverse effects. Diabetic clients able to self-inject, sterile wound care to a wound with minimal amount or not drainage.

⇒ Class IV – Service could be postponed 72-96 hours without adverse effects. Postoperative with no wound, routine catheter changes or discharge within 10-14 days.

CLIENT EMERGENCY AND CONTACT INFORMATION *(client copy)*

Client Name: _____SOC: _____

Address: _____

City_____State_____Zip:_____

Telephone Number: _____ Cell Phone: _____

Responsible Person's Name: _____ Relationship: _____

Home Telephone: _____ Work Phone: _____ Cell Phone: _____

Relative/Friend Not Living With You: _____ Relationship: _____

Home Telephone: _____ Work Phone: _____Cell Phone: _____

Primary Physician: _____ Telephone Number: _____

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⇒ Class IV – Service could be postponed 72-96 hours without adverse effects. Postoperative with no wound, routine catheter changes or discharge within 10-14 days.

CLIENT ACKNOWLEDGES RECEIPT OF CLIENT INFORMATION BOOKLET

Client Name: _____ MR#:_____

I _____, have received the following information from The Representative of My Home Nurses LLC prior to the beginning of care:

Client Information Booklet, which includes:

1. Service Outline
2. Emergency Contact Information
3. Non-Discrimination Polices
4. Client Rights and Responsibilities
5. Client Grievance
6. Abuse, Neglect, and Exploitation; Abuse and State Hotline numbers
7. Home Health Aide Duties
8. Accident Prevention
9. Notice of Privacy/Privacy Act Statement
10. Medication Information
11. Fire Safety
12. Biomedical Waste Disposal
13. Emergency Instructions, Resource numbers and Disaster Preparedness
14. Advance Directive Information Summary
15. Client Privacy Rights / HIPAA

Note: Please indicate person approved to receive information regarding care and medical information:

_____

Note: Please indicate person approved to receive information regarding payment for care:

_____

Client Signature_____ Date: _____

Witness Signature_____ Date: _____

HOME SAFETY ASSESSMENT

Client Name: _____ MR# _____

Address: _____Client Lives with: _____

Evaluation Completed By (PRINT): _____ Date: _____

Item No.	Description (ENVIRONMENT)	Yes	No	NA
1	Safe and adequate food and water supplies			
2	Stove and means for refrigeration present			
3	Adequate heat and ventilation			
4	Free from infestation			
5	Pathways free of obstacles such as loose rugs, furniture, etc.			
6	Clean area exists in which to store medical supplies			
7	Is cautious with heating pads			
8	Has a working smoke detector			
9	If uses oxygen, appropriate signs posted			
FIRE / ELECTRICAL				
1	Fire exits available; warning devices installed			
2	No overuse of extension cords / adequate electrical outlets available			
3	Turns off oven and stove burners			
4	Emergency telephone numbers posted by phone			
5	Turns pot handles to back of stove			
6	Uses space heaters cautiously			
7	Does not smoke in bed			
8	Oxygen precautions used			
BATHROOM SAFETY				
1	No throw rugs			
2	Safety bars present and in good condition			
3	Lighting is adequate			
4	Shower chair is sturdy and in good working condition			
MEDICATION USE				
1	Keeps all medications in original bottle or med box			
2	Has a medication schedule			
3	Home Safety Instructions Given			

Recommendations: _____

_____

As of the date of this evaluation, I attest that this home is safe environment for nursing care.

X_____ Date: _____

Agency Representative Signature

HOME SAFETY ASSESSMENT *(client copy)*

Client Name: _____ MR# _____

Address: _____Client Lives with: _____

Evaluation Completed By (PRINT): _____ Date: _____

Item No.	Description (ENVIRONMENT)	Yes	No	NA
1	Safe and adequate food and water supplies			
2	Stove and means for refrigeration present			
3	Adequate heat and ventilation			
4	Free from infestation			
5	Pathways free of obstacles such as loose rugs, furniture, etc.			
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MEDICATION USE				
1	Keeps all medications in original bottle or med box			
2	Has a medication schedule			
3	Home Safety Instructions Given			

Recommendations: _____

_____

As of the date of this evaluation, I attest that this home is safe environment for nursing care.

X_____ Date: _____

Agency Representative Signature

PATIENT DATA SHEET

Patient: _____ SOC Date: _____

Physician Name & Phone(s):

_____

Specific Orders:

_____

_____

_____

_____

Follow up with MD: _____

Date	BP (R)	BP (L)	T	P	R	BS	WT	Oxygen	INITIAL

Agency Representative Name: _____ Title: _____ INITIAL _____

Agency Representative Name: _____ Title: _____ INITIAL _____

Agency Representative Name: _____ Title: _____ INITIAL _____

Agency Representative Name: _____ Title: _____ INITIAL _____

Agency Representative Name: _____ Title: _____ INITIAL _____

Agency Representative Name: _____ Title: _____ INITIAL _____

ADDITIONAL FORMS

- ☐ Physician's Supplemental Order/Telephone orders / Verbal order form
  (Leave in home in case notifying MD from Home; at any time new orders received this must be faxed to MD for signature)

- ☐ Nursing Assessment

- ☐ Skilled Nursing Note (To be completed for any follow up visits after admission.)

- ☐ Home Aide Plan of Care (Complete if client to have HHA services. Client receives one copy and one copy for the office.)

- ☐ Home Aide Visit Notes
  (Leave in Home if client to receive HHA services and HHA Plan of Care was completed)

- ☐ Discharge Summary
  Complete after last visit, then must be faxed to MD; keep copy in office chart with fax confirmation sheet to show faxed to MD.

- ☐ Coordination of Care Progress note (to be completed and fax to MD; keep copy in office chart with fax confirmation sheet to show faxed to MD.)

- ☐ Post Admission Client Satisfactory Survey
  (**Put in Home Chart** and remind client to complete after last visit)

- ☐ 60 Day Summary Report
  (To be completed at 60 day Case Conference and Faxed to MD; keep copy in office chart with fax confirmation sheet to show faxed to MD.)

- ☐ Notice of Privacy Rights

- ☐ Front Chart Stickers: Must be placed on the front of client's chart

Admitting Professional's Name PRINTED:

_____**Title**_____

Admitting Professional's Signature & Title:

X_____ **Date:** _____

PHYSICIAN'S SUPPLEMENTAL ORDER/VERBAL/TELEPHONE ORDER

AGENCY NAME: My Home Nurses LLC AGENCY PHONE NUMBER: 214-407-3791

AGENCY ADDRESS: 924 East Hyde Park Blvd., Unit 3W, Chicago, IL, 60615

Patients Name: _____ Insurance #_____

Address: _____ CITY: _____ ST: _____ ZIP: _____

HOME Phone: _____CELL PHONE: _____ DOB: _____

PRIMARY DIAGNOSIS: _____ RELATED DIAGNOSIS: _____

Skilled Nursing: **YES/NO?** Frequency _____ Other Disciplines: Type _____ Frequency _____

Type _____ Frequency _____ Type _____ Frequency _____

Physician's Name: _____

Address: _____ CITY: _____ ST_____ ZIP: _____

Phone: _____ Fax: _____

PHYSICIAN'S ORDER
SIGNATURE AND TITLE OF PERSON TAKING ORDER:
DATE ORDER TAKE: _____ TIME ORDER TAKEN:_____

** **Doctor, please sign this form immediately and return it. Thank you** **

NURSING ASSESSMENT

Client Name: _____ Client Phone: _____

Client Address: _____

Doctor's Name: _____Doctor's Phone: _____

Contact Person: _____ Contact's Phone: _____

NURSING ASSESSMENT		
General Topics	**Subject Matter**	**Action(S) Indicated**
	Medical Information	
Medical Conditions	_____ _____ _____ _____ _____ _____	
Medical Background	Major Surgeries Illnesses _____ _____ _____ _____ _____ _____	
Hospitalizations	Recent (Last 2 Years) Previous _____ _____ _____ _____ _____ _____	
Height & Weight	Height: _____ Weight: _____ Weight Status: ____ Increase ____ Static ____ Decrease Reason for Any Weight Change:_____	
Vital Signs	_____ Blood Pressure _____ Pulse _____ Respirations _____ Temperature	
Medications	_____ _____ _____ _____ _____ _____ _____ _____	
Medication Allergies	_____ _____ _____ _____	

NURSING ASSESSMENT		
General Topics	**Subject Matter**	**Action(S) Indicated**
	_____ _____	
Current Treatments	_____ _____ _____ _____ _____ _____	
Current Therapy	_____ _____ _____ _____	
Dental Care	Does client have dental problems? ____ Yes ___No Is Client Under Care Of Dentist? ____ Yes ___No Dental State: ___No Dentures ____ Dentures Damaged ___Full Upper ____ No Dentures ___Full Lower ____ Not Wearing Dentures ___Partial Denture ____ No Teeth Can Client Chew Food Effectively? ____Yes ____No Dentist's Name:_____ Dentist's Phone Number :_____	
Vision	___ Unimpaired ___ Blind - Safe In Familiar Locale ___ Adequate For Personal Safety ___ Blind - Requires Assistance ___ Distinguishes Only Light Or Dark Wears Glasses: ___Yes ____No	
Hearing	___ Unimpaired ___ Mild Impairment ___ Moderate Impairment But Not a Threat to Safety ___ Impaired –Safety threat exists. ___ Totally Deaf Uses Hearing Aid(s): ____ Yes ____ Right Ear ____Left Ear _____ No	
Mental Health	<u>Attitude</u> ___Cooperative ___Indifferent ___Resistive ___Demanding ___Suspicious ___Hostile <u>Appearance</u> ___ Well Groomed ____ Adequate ____ Disheveled ____ Inappropriately Dressed ____ Not Dressed <u>Self-Direction</u> ___ Independent ___ Needs Motivation ___ Dependent ___ Needs Direction <u>Behavior</u> ____ Normal ____ Wandering ____Sun downing ____Restless ____Hostile ____ Withdrawn ____ Self Destructive ____ Safety Hazard ____ Aggressive _____Verbal <u>Influence</u> ____ Appropriate ____ Inappropriate ____ Anxious ____ Blunted ____ Euphoric ____ Depressed ___ Angry ____ Mood Swings <u>Thought Content</u> ____ Normal ____ Delusions ____ Obsessions ____ Phobias ____ Persecutory ____ Guilt ____ Can't Assess	

NURSING ASSESSMENT		
General Topics	**Subject Matter**	**Action(S) Indicated**
	____ Physical Perceptions: ____ Normal; ____ Hallucinations; ____ Auditory; ____ Visual; ____ Other Cognition: ____ Normal; ____ Impairment; ____ Mild; ____ Moderate; ____ Severe Insight: ____ Good; ____ Partial; ____ None Judgment: ____Good; ____ Adequate; ____ Poor	
	LIVING HABITS	
Smoking Habits	Client Smokes Yes: _____ No: _____ Degree of Problem _____ No Problem _____ Some Problem _____ Major Problem	
Alcohol Consumption	Client Drinks Yes: _____ No: _____ Degree of Problem _____ No Problem _____ Some Problem _____ Major Problem	
Current Diet	Regular _____ Diabetic _____ Low Fat _____ Low Salt _____ Vegetarian _____ Other _____ Takes Supplement (E.g. Ensure) _____	
Allergies Food & Other	_____ _____ _____ _____	
Eating Habits	_____ Good _____ Fair _____ Poor Comments: _____ _____	
	COMMUNCATION	
Language Spoken	___English; ____ Italian ___French; ____ Spanish ___Chinese; ____ Russian ___Japanese; ____ East Indian ____ Other _____	
Speech	___ Unimpaired. ___ Simple Phrases - Understandable ___ Simple Phrases - Partially Understandable ___ Isolated Words – Understandable ____Speech Not Understandable Or Does Not Make Sense ____ Does Not Speak If Client Cannot Speak, Indicate Method of Communicating_____ _____ Method is: ___Effective	

NURSING ASSESSMENT		
General Topics	**Subject Matter**	**Action(S) Indicated**
	___Partially Effective ___Moderately Effective ___Not Effective	
Understanding	___Unimpaired ___Understands Simple Phrases Only ___Understands Key Words Only ___Understanding Unknown ___Not Responsive	
ACTIVITIES OF DAILY LIVING		
Mobility Aids	___Uses Cane ___Uses Walker ___Uses Crutches ___Uses Wheelchair: ___Manual ___Electric ___Uses Grab Bars ___ Other Prosthesis Or Aid:_____	
Ambulation	___Independent In Normal Environments ___Independent Only In Specific Environment ___Requires Supervision ___Requires Occasional Or Minor Assistance ___Requires significant or Continued Assistance	
Transferring	____Independent ____ Needs Supervision transferring to : ____ Bed ____Chair ____Toilet ____ Needs Intermittent Assistance transferring to: ____ Bed ____Chair ____Toilet ____ Needs Continued Assistance transferring to : ____ Bed ____Chair ____Toilet ____ Completely Dependent for All Movements	
Bathing	____Independent in Bathtub or Shower ____ Independent with Mechanical Aids (E.g. bath seat) ____ Requires Minor Assistance or Supervision: ____Getting in and Out of Tub/Shower ____ Turning Taps On and Off ____ Washing Back ____ Requires Continued Assistance ____ Resists Assistance ____ Other _____	
Dressing	____ Independent ____ Supervision or Needs some help: ____ Selecting Appropriate Clothing ____ Coordinating Colors ____ Periodic or Daily Help Needed: ____ Putting on Clothing ____ Doing up Buttons, Laces, Zippers ____ Pulling on Trousers, Socks, Shoes ____ Determining Condition or Cleanliness of Clothing	
Grooming & Hygiene	____Independent ____Requires Reminder, Motivation&/or Direction ____Requires Assistance with Some Things ____Putting Toothpaste of Toothbrush ____ Using Electric Razor ____ Requires Total Assistance ____ Resists Assistance	
Eating	____ Independent ____ Independent with Special Provision for Disability ____ Requires Intermittent Help With: ____ Cutting Up/Pureeing Food ____ Must Be Fed	

NURSING ASSESSMENT		
General Topics	**Subject Matter**	**Action(S) Indicated**
	____ Resists Feeding	
Bladder Control	____Totally Continent ____ Needs Routine Toileting or Reminder ____ Incontinent Due to Identifiable Factors ____ Incontinent Once Per Day ____ Incontinent More than Once per Day	
Bowel Control	____ Has Total Control ____ Needs Routine Toileting or Reminder ____ No Bowel Control Due to Identifiable Factors ____ Loses Bowel Control Once Per Day ____ Loses Bowel Control More than Once per Day	
Toileting	____ Requires Raised Toilet Seat or Commode ____ Has Difficulty With Buttons, Zippers ____ Needs Help with Aids (E.g. Catheter, Condom Drainage, etc.) ____ Other: _____ _____	
Exercising	____ Exercises Regularly: ____ Daily ____ Alternate Days ____Twice a Week ____ Weekly ____ Other _____ ____ Time and/or Distance _____ ____ Recent Changes to Exercise Regime_____ ____ Exercise Alone ____ Exercises With Attendant ____ Other _____ _____	
INSTRUMENTAL ACTIVITIES OF DAILY LIVING		
Preparing Food	____ Independent ____ Adequate if Ingredients Supplied ____ Can Make or Buy Meals But Diet is Inadequate ____ Physically or Mentally Unable to Prepare Food ____ No Opportunity to Prepare Food or 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 or Chooses Not to Do Housework	
Shopping	____ Independent ____ Independent But For Small Items Only ____ Can Shop if Accompanied ____ Physically or Mentally Unable to Shop ____ No Opportunity to Shop or Chooses Not to Shop	
Transportation	____ Uses Private Vehicle ____ Uses Taxi or Bus ____ Independent ____ Must be Accompanied ____ Must be Driven ____ Physically or Mentally Unable to Travel ____ Needs Ambulance for Transporting	
Telephone	____ Independent ____ Can Dial Well Known Numbers ____ Answers Telephone Only	

NURSING ASSESSMENT		
General Topics	**Subject Matter**	**Action(S) Indicated**
	____ Physically or Mentally Unable to Use Telephone ____ No Opportunity to Use Telephone or Chooses Not to Use Telephone	
Medication/ Treatments	____ Completely Responsible for Self ____ Requires Reminder or Assistance ____ Responsible if Medications Prepared in Blistopax ____ Physically or Mentally Unable to Take Medications and Conduct Treatments ____ Resists Taking Medication or Conducting Treatments	
ATTENDANT PROFILE		
Attendant	____ Independent ____ Needs an Attendant ____ Frequency of Attendant Assistance ____ Intermittent ____ Constantly ____ During Day ____ During Night ____ Attendant Needs Met by: ____ Spouse ____ Friend ____ Family ____Other _____	
SOCIAL PROFILE		
Housing	____ House ____ Self Owned ____ Apartment ____ Rental ____ Condominium ____ Mobile Home ____ Room ____Urban ____ Facility ____Rural ____ Other_____	
Living Companions	____ Lives Alone ____ Lives with Spouse or Spousal Equivalent ____ Lives With Adult Children ____ Lives With Child(ren) ____Lives with Other Adult Male ____ Lives with Other Adult Female ____ Principal Helper: _____	
Religion & Culture	____ Ethnicity: _____ ____ Religion: _____	
FINANCIAL PROFILE		
Financial Benefits	Financial Benefits: ____ Old Age Security Pension ____ Guaranteed Income Supplement ____ Gains for Senior ____ War Veterans Allowance or Disability Pension ____ Company Pension ____ Other: _____ ____ Other: _____	
Financial Management	____ Self ____ Spouse ____ Family ____ Friend ____ Public Trustee ____ Power of Attorney ____ Other: _____ _____	
Financial Arrangements	____ Appropriate ____ Not Appropriate	

NURSING ASSESSMENT		
General Topics	**Subject Matter**	**Action(S) Indicated**
ADDITIONAL INFORMATION		

_____

Assessor Name & Position (Print)

_____ _____

Assessor Signature Date

_____ _____

Client/Client Representative's Signature Date

SKILLED NURSES NOTE

Date_____ Client Name _____

Client	Time Arrived	Time Left
Visit Type ☐ Admission ☐ Post Hospital ☐ Supervisory ☐ Scheduled Visit ☐ Unscheduled Visit (Explain)	**Supplies Used:** ☐ Prove Cover ☐ Gloves ☐ Alcohol Pads ☐ Glucose Strips ☐ Lancets ☐ Syringes ☐ 4x4's ☐ NS ☐ Kerilix ☐ Other:	

Purpose of Visit: _____SN Sig. /Title_____

Clinical Findings	T	AP	RP	Resp	Weight ☐ Actual ☐ Pt/Cg States	BP Lying R L	BP Sitting R L	BP Standing R L

NEUROLOGICAL

Orientation
☐ Alert
☐ Oriented
☐ Disoriented
☐ Confused
☐ Forgetful
☐ No Verbal Response
☐ No Response to pain
☐ Sedated but arouse
☐ Aphasic
☐ Dysphasic
☐ Other_____

Pupils
☐ ERL
☐ Legally Blind
☐ Tremors

Grip
☐ Strong Weak
☐ Weak Arm R ☐ L ☐
☐ Weak Leg R ☐ L ☐
☐ Pain _____

GASTROINTESTINAL

Abdomen
☐ Soft
☐ Firm
☐ Distended
☐ Tender
☐ Bowel Sounds
☐ Constipation
☐ Diarrhea
☐ Ostomy
☐ Rectal Bleeding
☐ Incontinent of Bowel
☐ Pain

Present (4 Quadrants)
☐ Nausea / Vomiting
☐ Black Tarry Stool
☐ Date Last BM _____
☐ Other_____
_____

INTEGUMENTARY

Skin
☐ Warm
☐ Cool
☐ Dry
☐ Moist
☐ Pink
☐ Pale
☐ Cyanotic
☐ Elastic turgor <3sec
☐ Poor turgor >2sec
☐ Rash
☐ Itching
☐ Bruises
☐ Incision
☐ Pain
☐ Mucous Membranes Pink
☐ Mouth Ulcer
☐ Normal For Race _____
☐ Other _____

CARDIOVASCULAR

Pulse Circulation
☐ Apical / radial
☐ Regular
☐ Irregular
☐ PP Present

Peripheral
☐ Sensation
☐ Paresthesia
☐ Tenderness
☐ Capillary refill
☐ Cyanosis
☐ Pink

Edema
☐ Pitting +1 +2 +3
☐ Non-Pitting
☐ Chest Pain
☐ Other:_____

AV Shunt ☐ Bruit ☐ Thrill

RESPIRATORY

Breathing
☐ Unlabored
☐ Labored
☐ Clear
☐ Wheezing
☐ Rhonchi
☐ Rales
☐ Secretion / Amt.
☐ SOB
☐ DOE

Cough
☐ Productive
☐ Non-Productive
☐ Moist
☐ Dry
☐ Pain
☐ Color of _____
☐ O2_____

☐ Other:_____

MUSCULOSKELETAL

☐ No Difficulty
☐ Weakness
☐ Pain
☐ Stiffness

Gait
☐ Steady
☐ Unsteady
☐ Contractures
☐ Amputation
☐ Other: _____
_____

GENITOURINARY

☐ No Difficulty
☐ Dysuria ☐ Pain
☐ Hematuria
☐ Odor
☐ Incontinent
☐ Color_____
☐ Clarity_____
☐ Nocturia_____
☐ Foley (size)_____
Last Changed_____

PSYCHO SOCIAL

☐ Cooperative
☐ Uncooperative
☐ Grieving
☐ Other
☐ Demanding
☐ Anxious
☐ Withdrawn
☐ Sad

NUTRITION

☐ Weight Gain Diet Type: _____
☐ Weight Loss _____
☐ Appetite ☐ Fair ☐ Poor ☐ Normal
☐ Blood Sugar ☐ WNL Results:_____
☐ Right ☐ Left _____Finger
☐ Performed by SN ☐ S/S Hyperglycemia ☐ YES ☐ NO
☐ Performed by ClientCaregiver ☐ S/S Hyperglycemia ☐ YES ☐ NO

☐ Foley Insert / Irrig	☐ Enema	☐ Prep / Adm. Insulin	☐ Trach Care	☐ Pain Control
☐ Wound Dsg Change	☐ Bowel/bladder Regimen	☐ Teaching	☐ Activity Restrictions	☐ Universal Precautions
☐ Decubitus Care	☐ C/P Instruction	☐ Ostomy / Ileo-condult	☐ Diet / Fluid Intake	☐ Assessment DX Process
☐ Venipuncture	☐ Injection	☐ Tube Feeding	☐ Medication AVSE's	☐ Sharps Disposal per protocol
☐ Dig. Exam & Removal	☐ Diabetic Care	☐ Inhalation RX	☐ Safety	☐ Soiled dressing disposal per protocol

RN / Supr Notified of _____
MD Notified of _____

☐ Orders Received
☐ No Orders Received

☐ Tolerate Procedure Well ☐ SQ ☐ LM
☐ Aseptic Technique
☐ STRL. Technique

RESPONSE TO TEACHING
☐ Verbalizes understanding
☐ Cannot verbalizes understanding
☐ Returns demonstration correctly
☐ Returns demonstration incorrectly
☐ Needs further supervision
☐ Needs further instruction
☐ Teaching Guide ☐ YES ☐ NO

SUPERVISORY VISIT
☐ HHA
☐ LPN/LVN
☐ Pt Satisfied with care
☐ Present
☐ Instruction given
☐ Following care plan
☐ Care plan Updated

ACTIVITY LEVEL
☐ Independent
☐ Dependent

Unable to self-inject due to:
☐ Poor Grip ☐ Hand Tremors
☐ Arthritic hands ☐ Phobia of needles

Homebound due to:
☐ Shortness of breath
☐ Dyspnea on exertion
☐ Poor endurance
☐ Req asst. of 1-2 other to leave home

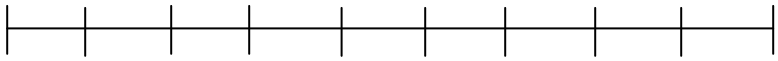
NEW MEDS / TREATMENT
_____
_____
_____
_____
_____
_____
_____
☐ **Update Client Med. Profile** ☐ YES ☐ NO
☐ **Meds Reviewed** ☐ YES ☐ NO

Available Caregiver: ☐ Yes ☐ No
Next Visit Planned _____ Are Visits? ☐ Inc ☐ Decr ☐ Same
Client aware of DC plans? ☐ Yes ☐ No

Pt Response / progress toward Goals_____
Client Notified? ☐ Yes ☐ No
Next MD Visit:_____

Pain Assessment
Wong-Baker FACES Pain Rating Scale

0	1	2	3	4	5
No Hurt	Hurts A little Bit	Hurts A Little More	Hurts even more	Hurts A whole Lot	Hurts Worst



0	2	4	6	8	10
No Pain		Moderate Pain			Worst Pain

Pain Assessment	Site 1	Site 2	Site 3
Location			
Onset			
Present Level (0-10)			
Worst Pain Gets (1-10)			
Best Pain gets (0-10)			
Pain Description (aching, radiating, throbbing, etc.)			

Other Pertinent Factors:

_____

_____

PHLEBOTOMY

Labs _____

Venipuncture _____(# of attempts) to _____(site) with _____ ga. Needle / vacutainer using universal precautions. Applied pressure _____ minutes. Transport in cooler ☐Yes ☐No

Delivered to: ☐ Hospital ☐ MD ☐ Lab:_____

Comments:

_____

_____

☐ Sharps Disposal

SKIN ASSESSMENT

Wound #1

Location _____

Appearance _____

SIZE

L _____

W _____

D _____

Tunneling _____

Stage ☐ I ☐ II ☐ III ☐ IV

☐ Improved ☐ Worse ☐ No Change ☐ Healed

Comments: _____

Wound #2

Location _____

Appearance _____

SIZE L _____

W _____

D _____

Tunneling _____

Stage ☐ I ☐ II ☐ III ☐ IV

☐ Improved ☐ Worse ☐ No Change ☐ Healed

Comments: _____

IV NURSING

Client / Family willing / Able to administer Therapy ☐Yes ☐No (Explain) _____

Service Type / Location / Appearance

Peripheral ☐ Start ☐ Restart ☐ DC ☐ N/A

☐ Midline ☐ CVC ☐ PICC ☐ Groshong

☐ Port ☐ Subclavian

IV Dressing

Change ☐ YES ☐ NO

Intact ☐ YES ☐ NO

IV Medications _____

Line Access

Central / Peripheral with _____ ga. _____ in. needle

_____CC. Syringe(s).

Irrigated _____ ml. N/S pre & post draw

Flushed _____ ml. N/S heparin _____ u/cc

☐ Universal Precaution used ☐ Sharps Disposal

Site Assessment

☐ Sutures ☐ Heat

☐ Redness ☐ Pain

☐ Edema ☐ Skin Breakdown

☐ Leaking ☐ Cath Fully Insert

☐ Bleeding ☐ Infiltration

Pump / Setting

Teaching

☐ Bathing Care ☐ Self Administration ☐ Contraindication

☐ Univ. pre. / Bio Med Disposal ☐ Schedule / Dose ☐ Cath maintenance

☐ Safety Infection Control ☐ Action / SE ☐ Medication Change

☐ Energy Prep/ 24 hr avail ☐ S/S to Report ☐ Discharge Plan

Response to IV Teaching

☐ Verbalizes Understanding ☐ Needs further supervision

☐ Cannot verbalize understanding ☐ Needs further instruction

☐ Correct returns demonstration ☐ Teaching Guide ☐ Yes ☐ No

☐ Incorrect returns demonstration

Response to IV Therapy: _____

Agency Name:	**Time In:**	**Time Out:**
ClientName (Last, First, Middle)	**Date :**	
Nurse Signature:		**Title:**

HOME HEALTH AIDE PLAN OF CARE

The RN has defined that the client is cognizant and functionally able to determine what kind of bath he/she wants _____Yes _____No

[ ] Plan of care reviewed with the HHA. Initial Visit_____ Revisit_____

PATIENT NAME: _____ MEDICAL RECORD # _____

ADDRESS: _____ PHONE NO._____

PRIMARY NURSE:_____ ____PT ___ OT ___MSW ___Chokes Easily ___

DIAGNOSIS: _____ Diet_____ Seizure Precautions_____

FREQUENCY_____ Food Allergy _____ DNR _____

COMMUNICATION

Speech Clear _____ Speech Difficult to Follow _____ Uses Writing _____ Uses Gesture_____

ACTIVITY

_____ Bed Rest	_____ Full Wt. Bearing	_____ Walker
_____ Up Ad Lib	_____ Bed Rails Up	_____ PWB
_____ Cane Wt. Bearing	_____ Ambulate with Assist	_____ Other

PERSONAL CARE (Client / Caregiver/ to choose bath checked)

____ Complete Bed Bath	____Skin care/lotion	____Tidy work area
____ Assisted Tub Bath	____ Shave (electric only)	____ Change linen/make bed
____ Shower	____ oral care	____ Laundry personal
____ Sponge/chair Bath	____ assist ambulation	____ Others
____ Comb / Brush Hair	____Remind to take meds	
____ File Nails (no cutting/pedicure)	____Assist/transfer	
____ Shampoo	____ Assist to dress	

TREATMENTS

_____ **Vital Signs** – Notify Nurse: of the following **T:** <96 >101 **P:** <50 >120 **R:** <12 >30

_____Other (be specific and within scope of practice) :

ELIMINATION

____ Commode	____ Supra Pubic Catheter
____ Bathroom	____ Foley Catheter Care: Wash with soap and Water
____ Ostomy	____ Change / Date drainage bag PRN
____ Bathroom / Assist	____ Other _____
____ last BM	

NUTRITION / HYDRATION

____ Diet	____ Fluids Encouraged
____Meal Prep PRN	____ Tube Feeding per Caregiver
____ Feeding / Assist Meal PRN	____ Fluid Restriction

Other Instructions:

_____

_____

I gave input and participated in the development of this plan.

Client/Rep. Signature _____ Date: _____

Staff Signature _____ Date: _____

RN Signature _____ Date: _____

HOME HEALTH AIDE PLAN OF CARE *(client copy)*

The RN has defined that the client is cognizant and functionally able to determine what kind of bath he/she wants _____Yes _____No

[ ] Plan of care reviewed with the HHA. Initial Visit_____ Revisit_____

PATIENT NAME: _____ MEDICAL RECORD NO. _____

ADDRESS: _____ PHONE NO._____

PRIMARY NURSE:_____ ____PT ___ OT ___MSW ___Chokes Easily ___

DIAGNOSIS: _____ Diet_____ Seizure Precautions_____

FREQUENCY_____ Food Allergy _____ DNR _____

COMMUNICATION

Speech Clear _____ Speech Difficult to Follow _____ Uses Writing _____ Uses Gesture_____

ACTIVITY

_____ Bed Rest	_____ Full Wt. Bearing	_____ Walker
_____ Up Ad Lib	_____ Bed Rails Up	_____ PWB
_____ Cane Wt. Bearing	_____ Ambulate with Assist	_____ Other

PERSONAL CARE (Client / Caregiver/ to choose bath checked)

____ Complete Bed Bath	____Skin care/lotion	____Tidy work area
____ Assisted Tub Bath	____ Shave (electric only)	____ Change linen/make bed
____ Shower	____ oral care	____ Laundry personal
____ Sponge/chair Bath	____ assist ambulation	____ Others
____ Comb / Brush Hair	____Remind to take meds	
____ File Nails (no cutting/pedicure)	____Assist/transfer	
____ Shampoo	____ Assist to dress	

TREATMENTS

_____ **Vital Signs** – Notify Nurse: of the following **T:** <96 >101 **P:** <50 >120 **R:** <12 >30

_____Other (be specific and within scope of practice) :

ELIMINATION

____ Commode	____ Supra Pubic Catheter
____ Bathroom	____ Foley Catheter Care: Wash with soap and Water
____ Ostomy	____ Change / Date drainage bag PRN
____ Bathroom / Assist	____ Other _____
____ last BM	

NUTRITION / HYDRATION

____ Diet	____ Fluids Encouraged
____Meal Prep PRN	____ Tube Feeding per Caregiver
____ Feeding / Assist Meal PRN	____ Fluid Restriction

Other Instructions:

_____

_____

I gave input and participated in the development of this plan.

Client/Rep. Signature **Client copy, no signature needed----------** Date: _____

Staff Signature _____ Date: _____

RN Signature _____ Date: _____

HOME HEALTH AIDE VISIT NOTES

Client Name: _____ Medical Record # _____ Diagnosis _____

	HHA Frequency		DAYS	Sun.	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.
			Date							
			Time In							
Assigned Task	**Every Visit**	**Client Requests**	**Time Out**							
			Client Initials							
Bed Bath	☐	☐								
Tub bath	☐	☐								
Shower	☐	☐								
Chair/sponge Bath	☐	☐								
Comb /brush hair	☐									
File nails (no cutting)	☐									
Shampoo Hair	☐									
Skin Care /lotion	☐									
Shave	☐									
Oral care	☐									
Assist ambulation	☐									
Remind to take meds	☐									
Assist / Transfer	☐									
Assist to dress	☐									
Tidy work area	☐									
Linen change/make bed	☐									
Laundry personal	☐									
Bathroom assist	☐									
Foley catheter care	☐									
Change drainage bag	☐									
Feed/assist meal	☐									
Fluids encouraged	☐									
Fluids restricted	☐									
Blood Pressure	☐									
Pulse	☐									
Last BM	☐									
Respiration	☐									
Temperature	☐									

Comments / Special Inst.:
Notified supervisor client has: [ ] New Wound [ ] Bruises [ ] Skin Breakdown
[ ] Increase Pain [ ] Decrease mobility [ ] Swelling [ ] Decrease Appetite [ ] Others
Reported To: _____ Date Reported: _____

I certify that I have used universal precautions including proper hand washing techniques and that I know where I can get personal protective equipment from the company for my use.

HHA Signature: _____ Date: _____

Client Signature: _____ Date: _____

Additional Comments from Home Health Aide Visit Notes

Date	Comments	Staff Signature

DISCHARGE SUMMARY

Physician: _____ Fax number: _____

Agency Name: _____ Phone Number: _____

Client Name: _____ Clients':_____

Admission Date:_____Date of Discharge: _____

Primar Diagnosis: _____

Secundar Diagnosis (es):_____

Services Provided: _____

Met Goals (Specify): _____

_____

Unmet Goals (Specify and why not met: _____

_____

STATUS AT DISCHARGE

Mental Status: _____ Activity Level: _____

Support System: _____ Relationship: _____

Community Resources: _____

Adaptation/Equipment:_____

Diet & Appetite: _____Advanced Directives: _____

Reason for Discharge: _____

Additional Discharge Information:_____

_____

_____

Thank you for allowing us to assist you in the care of your client.
Please call us if we may be of further assistance.

Agency Staff Signature: _____Title:_____ Date: _____

COORDINATION OF CARE

Agency Name: My Home Nurses LLC Agency Phone: 214-407-3791

Client Name: _____ DOB: _____

Contact each member of the client's health care team and discuss the plan of care.

Contact:	Y/N	Comments/Concerns:
PCP		
OT		
PT		
ST		
Social Worker		
Dietician		

Narrative:

Signature and Title: _____ Date: _____

POST ADMISSION CLIENT SATISFACTION SURVEY

Client Name _____Date_____

We are privileged to participate in your care. We are interested rendering quality care to our clients and would appreciate your input by answering the following questions. Your evaluation will allow us to be more responsive to future client/family needs. Feel free to use back of form to expand on anything.

1. Were you notified that you were to receive an initial home visit in a timely manner?
   YES _____ NO_____

2. Did your admitting professional give you the telephone number and contact person
   At the agency in case you had any questions or concerns, including afterhour's information?
   YES _____ NO_____
3. Did you participate in your plan of care? YES_____NO_____

4. Did you receive information on your Bill of Rights including the State Hotline number to call if you have any complaints? YES_____NO_____

5. Did the agency admitting nurse present a professional appearance? YES _____ NO_____

6. Did the nurse wear a name tag and introduce himself/herself as a representative of the agency and explain his/her role? YES _____ NO_____

7. Did the nurse leave a folder with information about your care in your home? YES ____NO____

8. Do you understand the services that your doctor ordered? N/A ____ YES _____ NO_____

9. Did the staff tell you the date of your next visit and the frequency of visits? YES ____ NO ____

10. Did the nurse take your temperature, pulse, respirations and blood pressure? YES ___NO ___

11. Did the nurse wash her hands before and after caring for you? YES _____ NO _____

12. Did the nurse teach/talk to you about:

Your medications?	YES _____ NO_____
Signs and Symptoms to report to the doctor?	YES _____ NO _____
Your diet?	YES _____ NO _____
Wound Care (if applicable)?	YES _____ NO _____
Plans for discharge (if applicable)?	YES _____ NO _____

13. Did you feel the nurse answered your questions appropriately? YES _____ NO _____

COMMENTS:

Thank you

60 DAY SUMMARY REPORT

Agency Name: My Home Nurses LLC Agency Phone: 214-407-3791

Date: _____ Disciplines Present: ☐RN ☐LPN/LVN ☐PT ☐OT ☐ST ☐SW ☐HHA ☐OTHER: _____

PATIENT DATA:

Client Name _____ MR# _____

Start of Care Date: _____ Cert Dates: _____

Diagnosis for Current Home Care Services: _____

SERVICES PROVIDED/TO BE PROVIDED:

Discipline	Visit Freq	Problems Needing Intervention/Plans	* Disp.
Nursing		_____ _____ _____ _____	
Goals Met/Set? Y N P NA			
Home Health Aide		_____ _____ _____ _____	
Goals Met/Set? Y N P NA			
Physical Therapy		_____ _____ _____ _____	
Goals Met/Set? Y N P NA			
Occupational Therapy		_____ _____ _____ _____	
Goals Met/Set? Y N P NA			
Speech Therapy		_____ _____ _____ _____	
Goals Met/Set? Y N P NA			
Social Worker		_____ _____ _____ _____	
Goals Met/Set? Y N P NA			

Goals – Y = Yes, N = No, P = Partial, N/A = Not Applicable *Disposition – D = Discharged S = Still Open

RECOMMENDATIONS:

Discharge Reason: _____ Status at Discharge: _____			
DC Under Supervision of: _____ Needs Continued Care: ☐YES ☐NO			
Signature:			

Fax to MD when completed

NOTICE OF PRIVACY RIGHTS

Name of Organization: _____

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

1. Below is a description, including at least one (1) example, of the types of uses and disclosures that the above organization is permitted to make for each of the following purposes: treatment, payment and health care operations.

   Disclosures to other health care providers, including, for example, to clients' attending physicians. Submission of claims and supporting documentation including, for example, to organizations responsible to pay for services provided by the organization. Disclosures to conduct the operations of the organization, including, for example, sharing information to supervisors of staff members who provide care to clients.

2. Below is a description of each of the other purposes for which the organization is permitted or required to use or disclose protected health information without an individual's written consent or authorization.
   To clients, incident to another permitted use or disclosure, by agreement, to the Secretary of the U.S. Department of Health and Human Services, as required by law, for public health activities, information about victims of abuse, neglect or domestic violence, health oversight activities, for judicial and administrative proceedings, for law enforcement proceedings, about decedents, for cadaveric organ, eye or tissue donation, for research purposes, to avert a serious threat to health or safety, for specific government functions, to business associates of the organization, to personal representatives, de-identified information, to workforce members who are victims of crimes, to workers' compensation programs, for involvement in the individual's care and for notification purposes, with the individual present, for limited uses and disclosures when the individual is not present, and for disaster relief purposes.

3. Other uses and disclosures, such as disclosure of psychotherapy notes, use of protected health information for marketing activities and the sale of protected health information, will be made only with the individual's written authorization and the individual may revoke such authorization.

4. The organization may contact the individual to schedule visits and for other coordination of care activities.

5. The individual has the right to request further restrictions on certain uses and disclosures of protected health information, but the organization is not required to agree to any requested restriction(s), except disclosures must be restricted to health plans if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law and the protected health information pertains solely to a health care item or service for which the individual or person other than the health plan on behalf of the individual has paid the organization in full.

6. The individual has the right to receive confidential communications of protected health information, the right to inspect and copy protected health information, the right to amend protected health information, the right to receive an accounting of disclosures of protected health information and the right to obtain a paper copy of this Notice from the organization upon request.

7. The organization is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices with respect to protected health information and to notify affected individuals following a breach of unsecured protected health information.

8. The organization is required to abide by the terms of this Notice currently in effect.

9. The organization reserves the right to change the terms of its Notice and to make the new notice provisions effective for all protected health information that it maintains. Individuals may obtain a revised copy of this Notice upon request.

10. Individuals may complain to the organization and to the Secretary of the U.S. Department of Health and Human Services if they believe their privacy rights have been violated. Complaints should be directed to _____ (Name or title of person) at the organization at the following telephone number: _____. Individuals will not be retaliated against for filing a complaint.

11. For further information, individuals should contact _____ (Name or title of person) at the organization at the following telephone number: _____.

12. This Notice is in effect as of _____.

13. My signature below is an acknowledgement that I have received a copy of this notice.

_____ _____

Patient Date

Documentation of good faith efforts to obtain the client's signature if unable to obtain: