I acknowledge and agree that while Help at Home is providing services to me under Medicaid PA, my caregiver must strictly follow the schedule as determined by agency and within MD orders. A schedule will be provided to me by the agency, and I will abide by that schedule. If I have a need for an adjustment to my schedule, I will communicate that to the agency and work with them to make the necessary changes within my approved plan of care. This agreement applies to any caregiver assigned to my schedule regardless if they are a preferred caregiver of my choosing or not.

Client Signature: _____

Date: _____

CLIENT INDIVIDUALIZED EMERGENCY PLAN

RISK LEVEL: ○ High (1) ○ Medium (2) ○ Low (3) **CODE STATUS:** ○ Full Code ○ DNR ○ Other _____

DATE/Visit type: _____ Name: _____ MR#: _____

ADDRESS: _____

PHONE: _____ DATE OF BIRTH: _____ AGE: _____ ○ Male ○ Female

PRIMARY LANGUAGE: _____ PRIMARY DIAGNOSES: _____

MENTAL STATUS: ○ Alert ○ Oriented ○ Disoriented ○ Forgetful ○ Dementia ○ Alzheimer's ○ Anxious ○ Memory Impair. ○ Depression

Copy of medication list ○ _____ALLERGIES: ○ _____

INFORMATION OBTAINED FROM: _____

POA/HEALTHCARE REPRESENTATIVE/CAREGIVER

Name:_____ Phone:_____ Relationship: _____

Name:_____ Phone: _____ Relationship: _____

EMERGENCY CONTACT(S):

Name:_____ Phone:_____ Relationship: _____

Name:_____ Phone: _____ Relationship: _____

PRIMARY PHYSICIAN:

Name:_____ Phone:_____

IN CASE OF EMERGENCY, CALL 911 In Case of Nursing Related Problem, please call the Agency Office _____

IN THE EVENT OF TORNADO: The best place to take shelter in the home is _____

FIRE EXTINGUISHER LOCATION _____ SMOKE DETECTOR LOCATION _____

IN THE EVENT OF FIRE, NEAREST EXIT/EVACUATION ROUTE_____

IN THE EVENT OF EMERGENCY EVACUATION: Client will:

○ Stay at home (Who will provide assistance?) _____

○ Stay with family/friend: Name and Address: _____

○ Go to Local Shelter: Address: _____

○ Go to Preferred Hospital: Name and Address: _____

TRANSPORTION: ○ Not Needed, N/A ○ Client will be driven by Family/Friend ○ Client will take Public Transportation

○ Client will be picked up by special needs transportation service ○ Other _____

MOBILITY LEVEL: (Independent, up with assistance, bed bound, etc.) _____

CLIENT SPECIFIC INFOMATION: (Language/communication aides, Service animal, Precautions, Dementia, etc.)

_____

_____

DME/SUPPLIES: (PERs, Oxygen, Walker, Cane, W/C, Catheter supplies, Diabetic Supplies, Hearing Aides, Glasses, etc.)

_____

_____

CLIENT INDIVIDUALIZED EMERGENCY PLAN

Name: _____ MR#: _____

EMERGENCY PHONE NUMBERS:

SERVICE TYPE	NAME	PHONE#
Police – Non-Emergency		
Fire Dept – Non-Emergency		
Preferred Hospital		
Preferred Ambulance Co.		
Pharmacy #1		
Pharmacy #2		
Heating/Cooling Company		
Electric Company		
Equipment Company		
Supply Company (diabetic, incontinence)		
Apartment Complex Contact		
Local Radio Stations		
Local TV News Stations		

ITEMS NEEDED FOR EMERGENCY KIT:

Assistive devices, battery powered radio, flashlight and extra batteries, blankets, cell phone with charger, extra clothing, jacket, shoes, first aid kit, diabetic supplies, incontinence supplies, extra medications, non perishable food, water (one gallon per person, per day). Other items not listed:

_____

ACCESS TO GENERATOR? __YES/ NO _____

NATIONAL DISASTER RELIEF ASSISTANCE: FEMA (FEDERAL EMERGENCY MANAGEMENT AGENCY)
PHONE 800-621-3362
https://www.fema.gov/about/contact

AMERICAN RED CROSS
PHONE 800-733-2767
DISASTER RELIEF & RECOVERY SERVICES: https://www.redcross.org/get-help/disaster-relief-and-recovery-services/find-an-open-shelter.html

Find your local chapter: https://www.redcross.org/find-your-local-chapter.html

*Please keep this information in a safe place where you can grab it quickly, including your emergency kit. You may also consider putting important papers with it in the event you are evacuated to a safe place. For example, a copy of your insurance papers, advance directive and identification papers, etc. Consider placing these important documents in a plastic zip lock bag for protection from any damage.

COPIES OF IEP GIVEN TO: ○ **Client** ○ **Caregiver** ○ **POA/Healthcare Representative** ○ **Other** _____

Clinician Signature/Title:_____ Date: _____ Time:_____

Patient Information Release Form

Date:_____ Medical Record #_____

The undersigned acknowledges receipt of the currently effective Notice of Privacy Practices for this healthcare facility.

_____ _____

Patient name (printed) Patient/ Legal Rep Signature

Please list any other parties who may have access to your health information:

Name:_____ Relationship: _____

Name:_____ Relationship: _____

Name:_____ Relationship: _____

Client Agreement

Help at Home®
Care to Live Your Life.

Client Information	MR #:	Date:

Last Name	First Name	Middle Initial
Address		
City	State	Zip
Date of Birth	Social Security #	
Telephone	Alternate Phone	

Emergency Contact or Personal Representation

Last Name	First Name	Middle Initial
Address		
City	State	Zip
Telephone	Alternate Phone	

Do you have Power of Attorney? ☐ Yes ☐ No

Term and Termination

This agreement shall begin on or about_____/_____/_____. This agreement shall continue for one year and shall renew automatically each year. This agreement may be terminated by either party upon written notice. This agreement shall automatically terminate upon my death.

Services to be Provided -

☐ Hourly Nursing ☐ Hourly HHA ☐ _____percentage paid by funding source

☐ Other:_____ ☐ Intermittent Nursing ☐ $_____private pay rate for services**

**Additional charges will occur if care is requested on holidays.

Verification of Service

I agree to provide my signature on a service record(s) or time document(s) necessary to verify that the employee(s) of Help at Home, Inc. has/have provided planned services on a given date. I agree to not withhold my signature on the time/service record unless I disagree with the documentation or representation made therein.

Payments to made in the following manner:

Name of Insurance Company:_____ **Name of Insured:** _____

Policy Number:_____ **Phone number on card:** _____

Secondary Insurance:_____ **Policy #:** _____

Indiana Medicaid Number:_____ **Name of member:** _____

Financial Responsibility (if applicable)

I agree to be responsible for payment of services, including those not paid by my insurer, if applicable.

Method of Payment: ☐ Credit Card ☐ Check ☐ Cash ☐ N/A

Type of Card_____ Card Number_____

Expiration Date_____ Security Code_____

Deposit for Services: A deposit of 1 week of anticipated services will be paid at signature of this Client Agreement. Deposit Amount: $_____

Deposit will be applied to any outstanding amounts stated on the invoice after termination of this agreement.

***Invoices will be sent weekly unless it is agreed upon to send them less regularly. I agree to pay within 14 days receipt of invoice. If my account is not paid within 30 days, I agree to pay late fees of an additional $100 and interest of 5% each week after 60 days. In the event Help at Home, Inc. is required to take action to collect any amounts, I agree to pay Help at Home, Inc. reasonable attorney fees and costs incurred in collecting these amounts. Upon my death, my estate will or heirs will pay any unpaid amounts due to Help at Home, Inc.

Hiring Employees

I agree not to employ the employee(s) Help at Home, Inc. assigns to Client for a period of 180 days following the last day the employee(s) rendered services to Client. In the event that I violate this condition, I agree to pay $10,000, or the equivalent billing rate for 6 months, as a finder's fee and any reasonable attorney's fees and costs associated with collecting those liquidated damages. This amount reflects the costs of recruiting, screening, and training the employees.

Jurisdiction and Venue

If it is necessary to litigate a dispute arising out of or relating to this agreement, I agree to Jurisdiction in the State of Indiana and the Venue in the Court of Clark County, Indiana.

Help at Home

ADMISSION CONSENT

INSTRUCTIONS: This form is used to acknowledge receipt of our Orientation Booklet and confirm your understanding and agreement with its contents. Your signature below indicates your approval.

PATIENT RIGHTS & RESPONSIBILITIES

I acknowledge receipt of my rights and responsibilities as a patient (including OASIS rights) and I understand them. The State home health hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency.

CONSENT FOR TREATMENT

I hereby give my permission for authorized personnel of your agency to perform all necessary procedures and treatments as prescribed by my physician for the delivery of home health care. I understand that the Agency will supervise services provided, I may refuse treatment or terminate services at any time, and the agency may terminate their services as explained in my orientation. I agree and consent to the home care plan and payment as outlined in this admission booklet. I understand that this is the initial plan of care. I will be notified by the agency in advance each time there is a change made to my plan of care. The initial service(s) and visit frequencies are as follows:

SN: _____hours/day_____days/week_____ HHA: _____hours/day_____days/week____

RELEASE OF INFORMATION

I acknowledge receipt of the Notice of Privacy Practices and was given an opportunity to ask questions and voice concerns. I understand that the Agency may use or disclose protected health information about me to carry out treatment, payment or health care operations. The agency may release information to or receive information from insurance companies, health plans, Medicare, Medicaid, or any other person or entity that may be responsible for paying or processing for payment any portion of my bill for services; any person or entity affiliated with or representing for purposes of administration, billing, and quality and risk management; any hospital, nursing home, or other health care facility to which I may be/have been admitted; any assisted living or personal care facility of which I am a resident; any physician providing my care; family members and other caregivers who are part of my plan of care; licensing and accrediting bodies, and other health care providers in order to initiate treatment.

AUTHORIZATION FOR PAYMENT

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I consent to the release of all records required to act on this request. I request that payment of authorized benefits from Medicare, Medicaid, or other responsible pay or be made in my behalf to the above named Certified Home Health Agency.

If I have Medicare Part A benefits, I understand that Medicare payments will be accepted as payment in full and I have no financial liability, unless I have been notified in writing that service(s) will not be covered by Medicare and wish to receive the care or service. I understand that while I am under the agency's plan of care, the agency will coordinate all medically necessary therapy services and medical supplies for me. Should I arrange for these services or supplies on my own, I understand that Medicare will not reimburse me or my supplier and I will be responsible for their cost.

If I have other insurance, I may be responsible for the co-payment and any charges that my insurance will not cover. I will refer to the Rates for Service Schedule for maximum dollar amounts that I may be required to pay. I understand that I am responsible for all amounts not paid by my insurance. If I am a Private Pay patient, I agree to pay for all services rendered by the agency.

CONSENT TO FILM OR RECORD

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

ASSIGNMENT OF BENEFITS

Client hereby authorizes Help at Home, Inc. to bill Client's insurance company ("Insurer") for any amounts related to this Agreement and hereby assigns to Help at Home, Inc. all benefits received from Insurer related to this Agreement.

INCIDENT REPORTING

Client acknowledges that Help at Home, Inc. has provided Client with a copy of "Incident Reporting Regulations" and, further, that Help at Home, Inc. is required by state regulation to report any incidents that are defined as an "unusual occurrence affecting the health and safety of clients" within 48 hours of knowledge of the event or within 24 hours of knowledge if the incident involves suspicion or evidence of abuse, neglect, exploitation, or death.

RELEASE OF INFORMATION

Client authorizes Help at Home, Inc. to release all information about Client to healthcare providers, third party payors, government surveyors, accrediting bodies, auditors, or any other organizations that may assist Client in meeting or improving Client's activities of daily living or independence.

LIMITATION OF LIABILITY AND INDEMNIFICATION

Client hereby forever releases, discharges, acquits, and forgives any and all claims, actions, suits, demands, liabilities, judgment, and proceedings, both at law and in equity, arising or related to occurrences at any time prior to the termination of this Agreement to the extent that same were caused directly or indirectly by the acts or omissions by the employees of Help at Home, Inc. and resulted in bodily injury or property damage. Client intends for this release to be irrevocably binding upon Client and Client's estate, agents, attorneys, successors, heirs, executors, administrators, insurers, and assigns and to inure to the benefit of Help at Home, Inc. and the Help at Home Parties. **Nothing in this section shall limit the liability of an Help at Home, Inc. employee for his/her intentional or criminal actions. If you believe a crime has been committed, you should call the authorities immediately.**

IN NO EVENT SHALL HELP AT HOME OR ANY OF THEHELP AT HOME PARTIES BE LIABLE TO CLIENT OR ANY THIRD PARTY FOR ANY LOSS OF USE, REVENUE, OR PROFIT, OR FOR ANY CONSEQUENTIAL, INCIDENTAL, INDIRECT, EXEMPLARY, SPECIAL, OR PUNITIVE DAMAGES, WHETHER ARISING OUT OF BREACH OF CONTRACT, TORT (INCLUDING NEGLIGENCE) OR OTHERWISE, REGARDLESS OF WHETHER SUCH DAMAGE WAS FORESEEABLE AND WHETHER OR NOT HELP AT HOME HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES, AND NOTWITHSTANDING THE FAILURE OF ANY AGREED OR OTHER REMEDY OF ITS ESSENTIAL PURPOSE.

Client acknowledges and agrees that in the event of a workers' compensation claim resulting from an injury caused by an animal in Client's home, pet or otherwise, Adaptive's insurers shall have the right to fully exercise their rights to subrogation in accordance with applicable law, and that Client shall not take or fail to take any action that would in any way jeopardize, limit, or restrict that right.

ADVANCE DIRECTIVES

I understand that the Federal Patient Self-Determination Act of 1990 requires that I be made aware of my right to make healthcare decisions for myself I understand that I may express my wishes in a document called an Advance Directive so that my wishes may be known when I am unable to speak for myself. I also understand that I may discuss my wishes verbally with my physician and family but writing down my health care choices in an advance directive document will make my wishes clear and maybe necessary to fulfill legal requirements.

1. **I have a Living Will or Life-Prolonging Procedures Declaration ☐ No ☐ Yes: Copy provided? ☐ No ☐ Yes**
2. **I have made a (Durable) Power of Attorney ☐ No ☐ Yes**
3. **I have a Health Care Representative ☐ No ☐ Yes**
   (if Yes, *write the name of the person power of attorney/healthcare representative)* _____
4. **No written Advance Directive. My wishes have been discussed with family ☐ No ☐ Yes Physician ☐ No ☐ Yes**
5. **I have received a copy of the Indiana Department of Health Advance Directives Information ☐ YES ☐ NO**

BY SIGNING BELOW, EACH OF THE UNDERSIGNED PARTIES ACKNOWLEDGES TO HAVE READ THIS AGREEMENT, UNDERSTOOD THIS AGREEMENT, AND ENTERED INTO IT VOLUNTARILY AND WITH AN INTENT TO BE LEGALLY BOUND BY ITS TERMS.

Patient's Signature	Responsible Person or Legal Guardian Signature
Witness Signature/Agency Representative	Printed Name & Relationship of Person Above

☐ *Patient Unable to sign due to:* _____

A. Notifier: Help at Home, 1515 Union Street, Lafayette, IN 47904
B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for D. PA services **below, you may have to pay.**
Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** PA services below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
PA Services	Not covered by Medicare Benefits	HHA cost per day HHA cost per 26 weeks SN cost per day SN cost per 26 weeks

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** PA Services listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** PA Services listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☒ **OPTION 2.** I want the **D.** PA services listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the **D.** PA Services listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).
Signing below means that you have received and understand this notice. You may ask to receive a copy.

I. Signature:	J. Date:

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice.