Help at Home®

Care to Live Your Life.

Patient Orientation for Home Health Care

STATEMENT OF CONFIDENTIALITY

This booklet may contain protected health information. Persons other than you and your health care providers must have your permission to view this booklet.

Help at Home

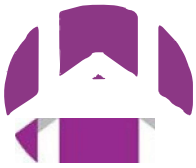
Your Administrator is: Lydia Gadd

Phone Number: 812-239-9013

I have received and reviewed a copy of Patient Orientation for Home Health Care with effective date of April 1, 2025

Name: _____

Signature: _____ Date: _____



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Your Clinical Manager is: Lydia Gadd

Phone Number: 812-239-9013

Administrator: Lydia Gadd

Phone Number: 812-239-9013

EMERGENCY PLAN

Revised 4/1/2025

THIS BOOKLET BELONGS TO: -_____

INSTRUCT1ONS: This information is provided to you as a quick reference source in case an emergency occurs. Keep this information where it can be easily found. Inform other persons close to you (relative, neighbor, etc.) of its location.

Help at Home, Inc. has a nurse on call 24 hours a day. After office hours and on weekends, your call will go to the nurse on-call and he/she will return your call, answer any questions you may have, or come to see you if necessary.

In case of a serious medical emergency, 911 should be called by present personnel and the Patient to the hospital emergency room. **Help at Home, Inc.** does not operate as an emergency service; therefore, valuable time may be lost by contacting the agency if a medical emergency occurs.

EMERGENCY SERVICE NUMBER: (911) or _____

PHYSICIAN'S NAME: _____ PHONE: _____

NAME OF CLOSE RELATIVE: _____ PHONE: _____

HOSPITAL: _____ PHONE: _____

Notify the appropriate person for the following conditions: (Not all inclusive)

PHYSICIAN:
- Extended/increased pain
- abnormal bleeding
- High fever over 101◦

Help at Home, Inc.:
- Unsure of treatment
- New unidentified problems
- Scheduling Issues

AMBULANCE: Call for distress and for emergency situations such as:
- Excessive difficulty breathing-
- Severe/unrelieved chest pain
- Loss of consciousness
- Excessive bleeding/hemorrhage

PATIENT ADMISSION BOOKLET

I. Welcome

II. Home Health Agency Overview

- Mission Statement
- Criteria for Admission
- Hours of Operation
- Charges
- Patient Satisfaction
- Medical Records
- Problem Solving Procedure
- Policies
- Services
- Emergency Preparedness Plan
- Medicare Guidelines
- Plan for Care, Treatments and Services
- Discharge, Transfer and Referral

III. Patient Rights and Responsibilities

- OASIS Statement of Privacy Rights
- Notice of Privacy Practices

IV. Advance Directives

V. Safety

- Home Safety
- Fire Safety
- Disaster Planning

VI. Infection Control at Home

- Universal Precautions and Patient Rights

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Welcome

Help at Home, Inc. extends a warm welcome to you, our patient, and to your family and friends. Your medical treatment, safety and satisfaction are most important to us. We will do our best to answer any questions you may have concerning your care and treatment.

Our office is dedicated to providing quality, safe, reasonable, cost effective and ethical health care in the patient's or caregiver's home. Help at Home, Inc. is proactive in educating community health care professionals, patients and caregivers. Our office provides leadership in home health practice and performs any other activities deemed appropriate in order to better serve the community, the institution, and the profession.

The home health practitioner (Registered or Licensed Nurse and Home Health Aide) will assure high quality, cost-effective services through the application of specialized knowledge, skills and professional judgment. Each practitioner contributes to the promotion of health and independence by education and training of the patient and their caregivers.

The home health practitioner will serve as a patient advocate when planning and implementing care by considering the patient's disease, condition, psychosocial and/or cultural background, as well as the patient's need to understand and participate in therapy, without regard to ability to pay for services directly or through a provider.

Home health practitioners will actively pursue ongoing improvement in delivery of care through personal continuing education, collaborative problem solving and research and active participation in the department's quality management program.

The home health practitioner will contribute to the development of home health care services and the enhancement of patient care through community education and participation in hospital, community and professional organizations.

Many aspects of our services and procedures may be new to you. We have prepared this booklet to assist you in becoming better acquainted with us, to help you understand the home health care process and to explain your rights as a patient. If you have any additional questions, please do not hesitate to ask.

Help at Home, Inc. is committed to ensuring your rights and privileges as a health care patient.

Our entire health care team joins together to wish you better health and happiness at home!!

Sincerely,

The Management and Staff of Help at Home, Inc.!!

This agency is in compliance with Title VI of the civil Rights Act of 1964, with Section 504 of the Rehabilitation Act of 1973 and with the Age Discrimination Act of 1975. We do not discriminate on the basis of race, color, religion, sex, national origin, age or disability with regard to admission, access to treatment or employment. We will make every effort to comply with these and similar statutes.

SECTION II. Agency Overview

MISSION STATEMENT

"Positively impact as many lives as possible through the delivery of exceptional homecare services."

VISION STATEMENT

"To be the number 1 provider of homecare services in as many markets as possible throughout Indiana, while creating a vibrant culture where exciting opportunities, professional development, and operational excellence equal unparalleled client, customer and staff satisfaction".

STRATEGIC GOALS

Our goal is to provide excellent service by incorporating hard work, professionalism, and respect along with continual improvement and building partnerships throughout the community.

POLICIES

This book contains general information regarding your rights and responsibilities as a patient. As State and Federal regulations change, there may be additions or changes to this book as necessary. Our complete policy and procedure manual regarding your care and treatment is available upon request for your viewing at the agency office at any time during normal business hours.

CRITERIA FOR ADMISSION

Home Health Care: At the initial visit, the admitting nurse will assess the patient for appropriateness or eligibility of services based on the following criteria:

- The patient is under the care of a physician for services.
- The care needed is within the scope of the services provided by the home health agency.
- The home care services ordered are necessary and reasonable for treatment of the patient's illness or injury.
- The services can be provided safely and effectively in the home.
- The services will be rendered within the geographic service area of the agency.
- The services to be provided must meet the eligibility criteria established by the patient's payer including patients receiving care under the Medicare and Medicaid programs.

The decision to admit the patient is made following the initial assessment visit when the determination is made that the patient meets the admission criteria.

If the patient is not admitted for care, the attending physician, the appropriate facility and the patient/caregiver will be notified of the decision not to admit. Any other options for care will be discussed with the patient.

Admission Criteria

PURPOSE

To establish criteria for admission to the Agency.

POLICY

The Agency will evaluate each individual for the appropriateness of admission without regard to age, color, creed, sex, national origin or handicap.

PROCEDURE

The Staff determines appropriateness for admission. He/she may consult with other staff members if necessary.

1. Clients are accepted for Home Health Services based on a reasonable expectation that the client's health care needs can be met adequately by the home health agency in the client's residence.

    a. The agency must accept a client for home health services based on a reasonable expectation that the client's medical, nursing, and social needs can be met adequately in the client's residence. An agency has made a reasonable expectation that it can meet a client's needs if, at the time of the agency's acceptance of the client, the client and the agency have agreed as to what needs the agency would meet; for instance, the agency and the client could agree that some needs would be met but not necessarily all needs.

    b. The agency must start providing licensed home health services to a client within a reasonable time after acceptance of the client and according to the agency's policy. The initiation of licensed home health services must be based on the client's health service needs, or based on approved authorization through Medicaid PA.

    c. An initial health assessment must be performed in the client's residence by a Registered Nurse prior to or at the time that licensed home health services are initially provided to the client. The assessment must determine whether the agency has the ability to provide the necessary services.

        I. If a practitioner orders skilled treatment, then the Registered Nurse must prepare a plan of care. The plan of care must be signed and approved by a practitioner in a timely manner. The plan of care must be developed in conjunction with agency staff and must cover all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits at the time of admission, prognoses, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, and any other appropriate items. The appropriate health care personnel must perform services as specified in the plan of care. The plan of care must be revised as necessary, but it must be reviewed and updated at least every sixty days.

    d. The comprehensive assessment must be completed in a timely manner, consistent with the client's immediate needs, but no later than five days after the start of care. Services must be provided within five days after a comprehensive assessment completed by an RN.

2. Considerations relevant to acceptance of a patient may include:
    a. Adequacy and suitability of Agency personnel and resources to provide the services required by the patient.
    b. Attitudes of patient and family members toward home care.
    c. Comparative benefits of home care to institutional care.
    d. Adequate physical facilities in the patient's residence.
    e. Availability and willingness of family members or substitute family members to participate in care.
    f. Availability and cooperation of the patient's personal physician in establishing and managing the plan of care.
    g. Conditions of coverage, including homebound status, if applicable.
    h. Safety of staff related to patient's housing, neighborhood and attitude of members in the home.
3. The decision regarding acceptance for admission to the Agency is not based solely on the physician's referral or the patient's request. It is based on the determined need for skilled intervention.

4. Upon referral, the decision regarding acceptance of and initiation of service by licensed staff will be made within 48 hours of the referral or within 48 hours of the patients return home or knowledge of return home or on the physicians ordered start of care date.

5. No patient is admitted for services without an order from a physician. However, a visit may be made by the Agency's staff without a physician's order for the purpose of:
    a. Evaluation of patient meeting criteria of home health services.
    b. Offering guidance to the individual regarding the selection of a physician.

c. The use of community resources.

6. If the client cannot be admitted, appropriate persons are notified and the Agency attempts to refer the individual to other community resources related to the client's needs.

7. All patients shall be under the care of a doctor of medicine, osteopathy, podiatry medicine. It is expected that the patient will be seen by the doctor when medically indicated, but at least every six months if possible.

8. During admission to the agency, the patient will be given the "Patient Orientation for Home Health Care" handbook. This book is reviewed to cover; agency policies, patient rights and responsibilities, advance directives, safety of the patient, infection control, pain education, on-call guidelines, agency and state grievance numbers, and consents. Upon reviewing the handbook, the patient signs a handbook acknowledgement that is placed in the office clinical record. The actual handbook remains in the patient's home chart.

9. The following forms are signed, by the patient, during the admission process with a copy remaining in the patient's home chart and the original will be maintained in the office clinical record.

- Agreement for Home Care Services
- Home Safety Evaluation
- Handbook Acknowledgement

SERVICES

A variety of services are available to meet your health care needs. Discussed below are the types of staff members that may visit your home. All disciplines work together to provide a coordinated care plan.

- ***Skilled Nursing:*** Skilled nurses include both Registered Nurses and Licensed Practical Nurses working under the supervision of the Registered Nurse. As a team, they provide the treatments and clinical teaching that will assist you in managing your health care needs.

- ***Home Health Aides:*** Home Health Aides work under the direction of the Registered Nurse. Staff is assigned based on the patient's needs related to their personal care. An aide plan of care is developed with your input. The Registered Nurse will periodically visit your home to evaluate how well the plan is meeting your health care needs.

Some common duties that aides perform include:

1. Assistance with personal care
   - bathing
   - hair care
   - shaving
   - dressing
   - oral hygiene
   - skin care
   - nail care
2. Preparation of simple meals
3. Assistance with simple exercises and ambulation
4. Assistance with transfer to the bedpan, commode or toilet
5. Maintaining a clear, safe environment at the bedside

Be aware that some payers have only specific home health aide tasks that they will pay for. If you should have a change in your health care needs, please call the office to discuss your request.

HOURS OF OPERATION

- **OFFICE HOURS:** Our office hours are Monday through Friday from 9:00 a.m. to 5:00 p.m., except on the following holidays: Memorial Day, July Fourth, Labor Day, Thanksgiving, Christmas Day and New Year's Day.

- **AFTER HOURS COVERAGE:** We provide 24-hour on-call service, 7 days per week to ensure that you receive necessary home care services. In case of a medical emergency, go to the nearest hospital emergency room or call Emergency Medical Services (911). Please refer to the Emergency Plan on the inside cover of the booklet and our On-Call Guidelines section of the booklet.

- **WEATHER CONDITIONS:** During the snow, ice and flood season we will make every effort to continue home care visits. However, the safety of our staff must be considered. When roads are too dangerous to travel, our staff will, if possible, contact you by phone to let you know that they are unable to make your visit that day.

EMERGENCY PREPAREDNESS PLAN

LEVEL 1 HIGH
- Home visit within 24 hours
- High Priority
- Requires uninterrupted services
- Condition unstable, may deteriorate or require inpatient admission if not seen.

LEVEL 2 MEDIUM
- Home visit within 48-72 hours
- Moderate priority
- Caregiver available to provide basic care
- May postpone visit if telephone contact made
- Condition somewhat unstable, but could be postponed without harm to patient

LEVEL 3 LOW
- Home visit can be deferred longer than 72 hours
- Low priority
- Condition stable with access to informal resources for help
- Can safely miss a scheduled visit with basic care provided by family or informal support

In cases of environmental/natural disaster (earthquake, blizzard, flood) or emergency, we have an emergency plan to continue necessary patient services. Every possible effort will be made to ensure that your medical needs are met.

All patients are assigned a priority level code that is updated as needed. The code assignment determines agency response priority in case of a disaster or emergency. These codes are maintained in the agency office, along with information which may be helpful to Emergency Management Services in case of an area disaster or emergency.

CHARGES

Help at Home, Inc. is able to receive reimbursement from several different funding sources including insurance companies, Medicaid, Medicaid Waiver Programs, and VA benefits.

PATIENT SATISFACTION

You, our customers, are very important to us. Please ask questions if something is unclear regarding our services or the care you receive or fail to receive. At intervals, our agency may send out a Patient Satisfaction Survey. Your answers help us to improve our services and ensure that we meet your needs and expectations. When you receive one, please complete the survey and return it immediately.

The Survey will ask you to rate our services on a "yes" or "no" scale. **If, at any time during the course of your care, you feel that your services are not meeting expectations, we would like for you to feel comfortable to tell us immediately so that we can not only meet your expectations and needs but exceed them.**

PLAN FOR CARE, TREATMENTS AND SERVICES

We involve you, your caregiver or designee, key professionals and other staff members in developing your individualized plan for care, treatment and services. Your plan is based upon identified problems, needs and goals, physician orders for medications, care, treatments and services, timeframes, your environment and your personal wishes whenever possible. The plan is designed to increase your ability to care for yourself. Effective pain management is an important part of your treatment.

The plan may include the following interventions and goals:

- Nursing Care, Medication Management, Personal Care, Rehabilitation Therapy, Psychosocial Needs, Discharge Planning

The plan is reviewed and updated as needed, based on your changing needs. We encourage your participation and will provide necessary medical information to assist you.

You have the right to refuse any medication or treatment procedure. However, such refusal may require us to obtain a written statement releasing the agency from all responsibility resulting from such action. Should this happen, we would encourage you to discuss the matter with your physician for advice and guidance.

We fully recognize your right to dignity and individuality, including privacy in your treatment and in the care of your personal needs. We will notify you if an additional individual needs to be present for your visit for reasons of safety, education or supervision.

We do not participate in any experimental research connected with patient care except under the direction of your physician and with your written consent.

There must be a willing, able and available caregiver to be responsible for your care between agency visits. This person can be you, a family member, a friend or a paid caregiver.

MEDICAL RECORDS

Your medical record is maintained by our staff to document physician orders, assessments, progress notes and treatments. Your records are kept strictly confidential by our staff and are protected against loss, destruction, tampering or unauthorized use. Our Notice of Privacy Practices describes how your protected health information may be used by us or disclosed to others, as well as how you may have access to this information.

DISCHARGE, TRANSFER AND REFERRAL

We will give you, your legal representative or other individual responsible for your care at least a fifteen (15) calendar days notice before services are stopped, **except** under the following situations:

- The health, safety and/or welfare of our staff would be in immediate and significant risk if we were to continue to provide services to the patient;
- Patient refuses our services;
- Patient's services are no longer reimbursed based on applicable reimbursement requirements. *(The home health agency will inform the patient of community resources to assist the patient following discharge);* or
- Patient no longer meets applicable regulatory criteria, such as lack of physician's order. *(The home health agency will inform the patient of community resources to assist the patient following discharge,).*

During the fifteen (15)-day notice period, we will try to continue your home care services; however, it may not be possible to do so.

Discharge, transfer or referral from this agency may also result from other types of situations including the following:

- Treatment goals are achieved;
- The level of care you need changes;
- Agency resources are no longer adequate to meet your needs;
- Failure to follow the attending physician's orders; and
- Nonpayment of charges.

If you should be transferred or discharged to another organization, we will provide the information necessary for your continued care, including pain management. All transfers or discharges will be documented in the patient chart. When a discharge occurs, an assessment will be done and instructions provided for any needed ongoing care or treatment. We will coordinate your referral to available community resources as needed.

Client Discharge Process

POLICY

Discharge Planning is initiated for every home care client at the time of the client's admission for home care. The transfer process is based on the client's assessed needs.

PURPOSE

To facilitate the client's discharge or transfer to another entity.

To ensure continuity of care, treatment and services when needed.

To assure collaboration with the physician, client, family and other disciplines in planning for discharge from the agency.

SPECIAL INSTRUCTIONS

Discharge Procedure:

1. Planning for discharge is provided as part of the ongoing assessment of needs and in accordance with expected care outcomes. The client/family will participate in this process beginning with the initial assessment visit.

2. Client's needs for continuing care to meet physical and psychological needs are identified and clients are told in a timely manner of the need to plan for discharge or transfer to another level of care/organization. Clients are informed of the reason for discharge and anticipated needs for services after discharge.

3. The physician will be involved in the discharge plan and specific ongoing care needs will be identified and addressed as part of the plan.

4. The impending discharge will be reviewed with other members of the home care team to assure coordination and continuity with the client and family/caregivers.

5. The Registered Nurse or Therapist shall review the clinical record to assure accuracy and completion. A Discharge Plan shall be developed that is documented in writing and includes all written/verbal instruction regarding the client's ongoing care needs and available resources provided to the client and family.

6. The Registered Nurse/Therapist shall ensure that the treatment goals and client outcomes have been met or, if unmet needs are present, appropriate referrals are made to agencies/institutions to meet continuing client needs.

7. Refer to the Client Transfer Policy for additional information on the transfer referral process.

8. Upon discharge to self care, the client will receive verbal/written information regarding community services, medication use, any procedures/treatments to be performed, and follow up visits for physician care.

9. To avoid charges of "abandonment" at the time of discharge agency documentation will include the following:

    a. Evidence that the decision was not made unilaterally. The client, family and physician participated in the decision to discharge client from the agency.

    b. Evidence that the client no longer qualifies for home care services or there is no payer source for ongoing services.
    c. If there are unmet needs and the agency is no longer able to meet those needs, documentation will demonstrate that appropriate notice was given (verbal and written) and referrals made as indicated.
    d. Documentation of all communication with the client, including the rationale for discharge, will be kept in the client file with copies sent to the primary physician.

Discharge Criteria:

1. Criteria for discharge may include, but are not limited to the following:

a. The client has reached defined goals and is no longer in need of home care.
b. The client's care has become such that it is unsafe and medically inappropriate to maintain the client in his/her home.
c. Client is non-compliant with the established plan of care.
d. Medical approval or supervision has been terminated. Or the physician fails to give or sign orders in a timely manner.
e. The contracting payer terminates authorization for service.
f. The client terminates payment for service.
g. The client chooses to use another home health care company.
h. The client is hospitalized and the hospitalization period is greater than sixty (60) days or exceeds the current home care episode of care.
i. Client moves out of the agency's service area.
j. Services needed by the client are not provided by the agency.
k. No funding is available to provide the care.
l. The patient and/or family have threatened agency staff, have weapons in the home or the home is in some other way an unsafe environment for agency staff.

2. Clients that require discharge from the agency are given at least a 15-calendar day notice. The client, MD and case manager, if applicable, will receive a copy of the DC. Exceptions to the 15-day discharge notice could include but are not limited to the following:
(1) The health, safety, and/or or welfare of the home health agency's employees would be at immediate and significant risk if the home health agency continued to provide services to the patient. (2) The patient refuses the home health agency's services. (3) The patient's services are no longer reimbursable based on applicable reimbursement requirements and the home health agency informs the patient of community resources to assist the patient following discharge. or (4) The patient no longer meets applicable regulatory criteria, such as lack of physician's order, and the home health agency informs the patient of community resources to assist the patient following discharge.

This agency will continue, in good faith, to attempt to provide services during the 15 calendar day period. If the home health agency cannot provide such services during that period, its continuing attempts to provide the services must be documented.

3. Criteria for transferring a patient to an acute or sub-acute care facility:

a. The patient has demonstrated deterioration, appearance of acute symptoms, adverse effects of medical treatment, or other change in status.
b. There is a threat to patient safety due to unsafe home environment, absence of physician, family, or caregiver involvement.

4. The patient and caregiver will be informed of the change in status and be encouraged to provide input to the physician regarding the Plan of Care.

5. The physician will order the patient to be transferred, as appropriate.

6. A discharge OASIS assessment will be completed as appropriate.

7. Agency staff will complete a discharge summary that includes the following information:

a. Patient status at the time of admission to the agency.
b. Statement of care and interventions provided and outcomes of care.
c. Status at discharge/last visit/current medications, therapies, and continuing care needs.
d. Name of person or organization assuming responsibility for care.
e. Instructions and referrals given to the patient/family/caregiver.
f. Reason for discharge and date of discharge.

8. A copy of the discharge summary is sent to the MD for signature.

TRANSFER AND DISCHARGE

The patient and representative (if any) have a right to be informed of Help at Home's policies and transfer and discharge. Help at Home will only transfer or discharge the patient from services if:

1. The transfer or discharge is necessary for the patient's welfare because Help at Home and the physician who is responsible for the home health plan of care agree that Help at Home can no longer meet the patient's needs, based on the patient's acuity.
2. The patient or payer will no longer pay for the services provided by Help at Home.
3. The transfer or discharge is appropriate because the physician who is responsible for the home health plan of care and Help at Home that the measurable outcomes and goals set forth in the plan of care in accordance with 484.60(a)(2)(xiv) have been achieved, and Help at Home and the physician who is responsible for the home health plan of care agree that the patient no longer needs Help at Home's services.
4. The patient refuses services, or elects to be transferred or discharged.
5. Help at Home determines, under a policy set by Help at Home for the purpose of addressing discharge for cause that meets the requirements of paragraphs (d)(5)(iii) of this section, that the patient's for other persons in the patient's home behavior is disruptive, abusive or uncooperative to the extent that delivery of care to the patient or the ability of Help at Home to operate effectively is seriously impaired. Help at Home will do the following before it discharges a patient for cause:
    i. Advise the patient, rep (if any), the physician (s) issuing orders for the home health plan of care and the patient's primary care practitioner or other health care professional who will be responsible or providing care and services to the patient after discharge from Help at Home (if any) that a discharge for cause is being considered.

    ii. Make efforts to resolve the problem(s) presented by the patient's behavior the behavior of the other persons in the patient's home or situation;

    iii. Provide the patient and representative (if any), with contact information for other agencies or providers who may be able to provide care; and

    iv. Document the problem(s) and efforts made to resolve the problem(s), and enter this documentation into its clinical records

6. The patient dies; or
7. Help at Home ceases to operate
8. Help at Home will provide physical or electronic documents for the patient's keeping that outline the acceptable reasons for discharge or transfer.
9. Help at Home will facilitate and coordinate efforts of the patient and the physician to ensure that a face to face encounter occurs timely. In cases where a face to face encounter cannot be met, Help at Home will not hold a patient financially liable for services provided.
10. Once a patient is admitted, Help at Home will not abruptly discharge a patient unless the patient is properly notified and there is a valid reason for the discharge.

IMPACT ACT – TRANSFER AND DISCHARGE

The improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) requires Help at Home to take into account patient goals and preferences in discharge and transfer planning.

On Nov 2, 2015, published a proposed rule, "Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning and Hospitals, Critical Access Hospitals, and Home Health Agencies" 80FR68126 that would implement this section of the IMPACT Act.

Help at Home patients have the right to refuse a transfer to any provider or supplier and Help at Home would be expected to document the refusal and communicate with the patient and representative/caregiver to help meet their healthcare needs to the best of Help at Home's ability.

CLIENT TRANSFER

POLICY

Home care services shall not be arbitrarily terminated. A client may be transferred as determined by the Director of Clinical Operations or designated Clinical Manager in response to the client's request and/or identified need that cannot be met by the agency.

A transfer from the agency to another provider will be documented as a discharge from the agency.

PURPOSE

To assure continuity of care by providing pertinent information to another home health care company or facility when a client chooses another provider

SPECIAL INSTRUCTIONS

1. The client/caregiver shall be informed by the Clinical Manger of the need for transfer from the agency, or the client will inform the agency of his/her desire to transfer to another service provider.

2. The client/caregiver will be active participants in selecting another provider and communicating the decision to the agency.

5. The plan for transfer shall be discussed with the physician and orders obtained approving the client's transfer.

6. The agency must have a signed Client Authorization for the release of pertinent information on file in order to provide the receiving health care provider with the appropriate client information.

8. The receiving health care provider shall be responsible for obtaining new physician's orders from a physician licensed to practice in the state in which care is to be provided.

9. If the client is transferred to another home care provider, the agency will complete a discharge order and a discharge summary. The discharge summary will be sent to the physician

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11. The transfer or discharge is necessary for the patient's welfare because Help at Home and the physician who is responsible for the home health plan of care agree that Help at Home can no longer meet the patient's needs, based on the patient's acuity.
12. The patient or payer will no longer pay for the services provided by Help at Home.
13. The transfer or discharge is appropriate because the physician who is responsible for the home health plan of care and Help at Home agree that the measurable outcomes and goals set forth in the plan of care in accordance with 484.60(a)(2)(xiv) have been achieved, and Help at Home and the physician who is responsible for the home health plan of care agree that the patient no longer needs Help at Home's services.
14. The patient refuses services, or elects to be transferred or discharged.
15. Help at Home determines, under a policy set by Help at Home for the purpose of addressing discharge for cause that meets the requirements of paragraphs (d)(5)(iii) of this section, that the patient's for other persons in the patient's home behavior is disruptive, abusive or uncooperative to the extent that delivery of care to the patient or the ability of Help at Home to operate effectively is seriously impaired. Help at Home will do the following before it discharges a patient for cause:
    j. Advise the patient, rep (if any), the physician (s) issuing orders for the home health plan of care and the patient's primary care practitioner or other health care professional who will be responsible or providing care and services to the patient after discharge from Help at Home (if any) that a discharge for cause is being considered.

ii. Make efforts to resolve the problem(s) presented by the patient's behavior the behavior of the other persons in the patient's home or situation;

iii. Provide the patient and representative (if any), with contact information for other agencies or providers who may be able to provide care; and

iv. Document the problem(s) and efforts made to resolve the problem(s), and enter this documentation into its clinical records

16. The patient dies; or
17. Help at Home ceases to operate
18. Help at Home will provide physical or electronic documents for the patient's keeping that outline the acceptable reasons for discharge or transfer.
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The improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) requires Help at Home to take into account patient goals and preferences in discharge and transfer planning.

On Nov 2, 2015, published a proposed rule, "Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning and Hospitals, Critical Access Hospitals, and Home Health Agencies" 80FR68126 that would implement this section of the IMPACT Act.

Help at Home patients have the right to refuse a transfer to any provider or supplier and Help at Home would be expected to document the refusal and communicate with the patient and representative/caregiver to help meet their healthcare needs to the best of Help at Home's ability.

PROBLEM SOLVING PROCEDURE

Our goal is to assist you in returning to your maximum level of functioning and to provide all services possible to help you stay at home in your usual and customary surroundings. We are committed to assuring that your rights are protected. If you feel that our staff has failed to follow our policies or has in any way denied you your rights, please follow these steps without fear of discrimination or reprisal.

While you are not required to follow the steps below in any particular order, if you have a complaint, we would appreciate the opportunity to address your issue at the Director of Nursing or Administrator level prior to your calling the state hotline.

1. Any concern or grievance may be made in writing or by a telephone call to the Lafayette Parent Office Administrator, Lydia Gadd at 812–239–9013 or at the following address, Monday through Friday from 9:00 a.m. to 5:00 p.m.

Help at Home, Inc.
1515 Union St
Lafayette, IN 47905
765-448-6029

Indiana State Department of Health
2 North Meridian St.
Indianapolis, IN 46204
800-246-8909

Help at Home, Inc.
6602 E 75th Street, Suite 230
Indianapolis, IN 46250
317-558-9227

Help at Home, Inc.
4101 W Clara Lane
Muncie, IN 47304
765-254-1391

Help at Home, Inc.
122 S Meridian St.
Winchester, IN 47394
765-584-7557

Help at Home, Inc.
1815 S. Walnut St.
Bloomington, IN 47401
812-339-8678

Help at Home
2120 E Market St
Logansport, IN 46947
574-722-9358

Help at Home, Inc.
650 Progress Drive
Richmond, IN 47374
765-935-9101

Help at Home, Inc.
1425 Corporate Way
Seymour, IN 47274
812-524-7110

Help at Home, Inc.
2901 Ohio Boulevard, Suite 277,
Terre Haute, IN 47803
812-250-9476

Help at Home
5281 Fountain Dr
Suite F
Crown Point, In
46307
219-322-2730

Help at Home Inc
225 South Emerson #195
Greenwood, Indiana 46143
317-884-7266

Quality Improvement Organization Livanta LLC
10820 Guilford Road, Suite 202
Annapolis Junction, MD 20701-1105
Toll Free Beneficiary Helpline: 1-888-524-9900, TTY 1-888-985-8775
Website: https://www.livantaqio.com/en/states/indiana

We will respond to your complaint within 24 hours of the date of receipt of your complaint. In the event you feel your concern was not addressed promptly or correctly you may contact the Home Care Administrator at the above number.

2. If you feel satisfactory action has not been taken, you may contact the state's home care hotline which receives complaints or questions about local home care agencies. Their hours are 8:00 a.m. to 4:30 p.m., Monday to Friday and they may be reached at 1-800-227-6334. An answering machine is available 24 hours a day and will record your call after 4:30 p.m. You may also lodge complaints with the Consumer Protection Division of the Attorney General's office, the Commissioner of the State Department of Public Health or with any other person or agency.

3. Help at Home will take action to prevent further violations, including retaliation while your complaint is being investigated. Be free from any discrimination or reprisal for exercising your rights or for voicing grievances to Help at Home or an outside entity.

SECTION III. Patient Rights and Responsibilities

Note: For ease of reference the term patient may include the patient's primary caregiver or significant other when the patient is unable to fully participate, temporarily or permanently, in any aspect of the comprehensive plan of care.

The patient or the patient's legal representative has the right to be informed of the patient's rights through effective means of communication. The home health agency must protect and promote the exercise of these rights as follows:

DIGNITY AND RESPECT

- Have his or her property and person treated with respect (HH2-2C)
- Be free from verbal, mental, sexual, and physical abuse, including injuries of unknown source, neglect and misappropriation of property; (HH2-3A)
- Make complaints to Help at Home regarding treatment or care that is (or fails to be) furnished, and the lack of respect for property and/or person by anyone who is furnishing services on behalf of Help at Home; (HH2-4A)
- Participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to: (HH2-6A)
    - Completion of all assessments;
    - The care to be furnished, based on the comprehensive assessment;
    - Establishing and revising the plan of care;
    - The disciplines that will furnish the care;
    - The frequency of visits;
    - Expected outcomes of care, including patient-identified goals, and anticipated risks and benefits;
    - Any factors that could impact treatment effectiveness; and
    - Any changes in the care to be furnished
- Receive all services outlined in the plan of care.(HH5-3B)
- Have a confidential clinical record. Access to or release of patient information and clinical records is permitted in accordance with 45 CFR parts 160 and 164.(HH2-5A)
- Be advised of: (HH3-4C)
    - The extent to which payment for HHA services may be expected from Medicare, Medicaid, or any other federally funded or federal aid program known to Help at Home;
    - The charges for services that may not be covered by Medicare, Medicaid, or any other federally-funded or federal aid program known to Help at Home;
    - The charges the individual may have to pay before care is initiated; and
    - Any changes in the information provided in accordance with 42 CFR 484.50(c)(7) of this section when they occur. Help at Home must advise the patient and representative (if any), of these changes as soon as possible, in advance of the next home health visit. Help at Home must comply with the patient notice requirements at 42 CFR 411.408(d)(2) and 42 CFR 411.408(f)
- Receive proper written notice, in advance of a specific service being furnished, if Help at Home believes that the service may be noncovered care; or in advance of Help at Home reducing or terminating on-going care. Help at Home must also comply with the requirements of 42 CFR 405.1200 through 405.1204.(HH5-6A)
- Be advised of the state toll free home health telephone hot line, its contact information, its hours of operation, and that its purpose is to receive complaints or questions about local Agencies.(HH2-4B)
- Be advised of the names, addresses, and telephone numbers of the following federally-funded and state-funded entities that serve the area where the patient resides: (HH2-4B)
    - Agency on Aging
    - Center for Independent Living
    - Protection and Advocacy Agency
    - Aging and Disability Resource Center
    - Quality Improvement Organization
- Be free from any discrimination or reprisal for exercising his or her rights or for voicing grievances to Help at Home or an outside entity. (HH2-4A)
- Be informed of the right to access auxiliary aids and language services as described in paragraph (f) of this section, and how to access these services (HH2-8A)
- Be able to identify visiting personnel members through agency generated photo identification (HH2-2C)
- Choose a health care provider, including an attending physician (HH2-2C)
- Receive appropriate care without discrimination in accordance with physician orders (HH2-2C)
- Be informed of any financial benefits when referred to an HHA (HH2-2C)

- Help at Home does not discriminate against any person on the basis of race, color, national origin, disability, age or any other legally protected status under applicable local, state, and federal laws in admission, treatment, or participation in its programs, services and activities, or in employment. For further information about this policy, contact: the Administrator Section 504 Coordinator at .....
- The patient has the right to have his or her property and person treated with respect, consideration and recognition of client/patient dignity and individuality.
- The Agency shall respect the patient's personal privacy and security during home care visits.

- The patient has the right to be free from verbal, physical and psychological abuse and to be treated with dignity, and to be free from sexual abuse, neglect and exploitation.
- The patient has the right to have a relationship with our staff that is based on honesty and ethical standards of conduct. The Agency shall have ethical issues addressed, and inform patients of any financial benefit we receive if we refer them to another organization, service, individual or other reciprocal relationship.
- The patient has the right to have cultural, psychosocial, spiritual and personal values, beliefs and preferences respected. Patients will not be discriminated against based on social status, political belief, sexual preference, race, color, religion, national origin, age, sex or handicap.
- The patient has the right to receive information in a manner that is understandable and to have access to interpreters as indicated and necessary to ensure accurate communication.
- The patient has the right to voice grievances without fear of coercion, discrimination or reprisal and to expect no unreasonable interruption of care, treatment or services for voicing grievances.
- The patient has the right to receive care of the highest quality.
- The patient has the right to be educated about their and their family's role in managing pain when appropriate, as well as any potential limitations and side effects of pain treatments.
- The patient shall be told what to do in case of an emergency.

DECISION MAKING

- The patient shall be admitted only if we can provide the care needed. A qualified staff member will assess these needs. If the patient requires care or services that we do not have the resources to provide, we will inform them, and refer them to alternative services, if available; or admit them, but only after explaining our limitations and the lack of a suitable alternative.
- The patient has the right to be able to identify staff members through proper identification.
- The patient has the right to choose health care providers and communicate with those providers, and to be informed about the care to be furnished and of any changes in the care to be furnished as follows:

  * The Agency shall advise the patient in advance of the disciplines that will furnish care, and the frequency of visits proposed to be furnished.

  * The patient has the right to participate in the planning of care. The Agency shall advise the patient in advance of the right to participate in planning the care or treatment and in planning changes in the care or treatment.

  * The Agency shall advise the patient of any change in the plan of care, including reasonable discharge notice. (We will give you, your legal representative or other individual responsible for your care at least fifteen (15) calendar days' notice before services are stopped, except under the situations outlined in the Discharge, Transfer and Referral section of this Patient Admission Booklet.)

- The Agency must inform and distribute written information to you, in advance, concerning its policies on advance directives, including a description of applicable State law. The Agency may furnish advance directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.
- The patient has the right to have their wishes regarding end-of-life care decisions addressed; to have health care providers comply with advance directives in accordance with state laws; to receive care without condition or discrimination based on the execution of advance directives; and to be informed if the Agency cannot implement an advance directive on the basis of conscience.
- The patient has the right to be informed of the names and responsibilities of caregivers providing care, expected and unexpected outcomes, potential risks or problems and barriers to treatment.
- The patient has the right to have family involved in decision making as appropriate, concerning their care, treatment and services, when approved by them or their surrogate decision maker and when allowed by law. The patient's family or legal representative may exercise the patient's rights as permitted by law.
- The patient has the right to participate or refuse to participate in research, investigational or experimental services or clinical trials. Access to care, treatment and services will not be affected if they refuse or discontinue participation in research.
- The patient has the right to refuse or discontinue care, treatment and/or services without fear of reprisal or discrimination. However, should they refuse to comply with the plan of care and their refusal threatens to compromise our commitment to quality care, then

we or their physician may be forced to discharge them from our services and refer them to another source of care.

- The Agency shall make available to the patient upon request, a written notice in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment, a listing of all individuals or other legal entities who have an ownership or controlling interest in the agency as defined in 42 CFR §420.201, §42 CFR 420.202, and §42 CFR 420.206.
- The patient has the right to receive information regarding the organization's liability insurance upon request and information regarding organization ownership and control.
- The patient has the right to receive information on Indiana universal precautions.

The patient has the right to, make decisions regarding medical care including the following: participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to:

(i)Completion of all assessments
(ii) The care to be furnished, based on the comprehensive assessment
(iii) Establishing and revising the plan of care
(iv) The disciplines that will furnish the care
(v) The frequency of visits
(vi) Expected outcomes of care, including patient-identified goals, and anticipated risks and benefits
(vii) Any factors that could impact treatment effectiveness
(viii) Any changes in the care to be furnished

PRIVACY

- The patient has the right to confidentiality of the clinical records maintained by the home health agency. The Agency shall advise the patient of the its policies and procedures regarding disclosure of clinical records and of Protected Health Information (as defined under HIPAA).
- The patient or patient's legal representative have the right under Indiana law to access the patient's clinical records unless certain exceptions apply. The Agency shall advise the patient or the patient's legal representative of its policies and procedures regarding the accessibility of clinical records.
- The patient has the right to confidentiality of written, verbal and electronic information about the health, social and financial circumstances of the patient or about what takes place in their home.
- The patient has the right to request us to release information written about them only as required by law or with their written authorization and to be advised of our policies and procedures regarding accessing and/or disclosure of clinical records. Our Notice of Privacy Practices describes the rights in detail.
- All confidential client information, whether it be paper or electronic, is stored in a secure data base or behind two locks.

HIPAA (Health Insurance Portability and Accountability Act) Omnibus Rule NOPP(Notice of Privacy Practices)

1. Sale of PHI (Protected Health Information) is prohibited.
2. Use of PHI in marketing or fundraising is prohibited except with prior authorization (as noted within the new HIPAA Patient Acknowledgement Form).
3. Restrict disclosures of PHI to Insurance Plans for services paid for "out of pocket".
4. In-office of display of HIPAA Omnibus Rule NOPP is required.
5. Wed-posting of HIPAA Omnibus Rule NOPP is required.
6. Written permission from patient to send PHI to non-authorized 3rd parties is required.
7. Health Plans that underwrite cannot include genetic info.
8. Health Plans must web-post Omnibus Rule NOPP & send written notice of Omnibus Rule changes to all members.
9. Psychotherapy Notes: Use & Disclosure requires patient authorization.

Now excluded from NOPP: You do not have to have patient consent to send: Appointment reminders, treatment information, and insurance benefit notifications. Now it's considered the course-of-doing-business.

Additional Revisions:

- Out of pocket payment privacy provision to restrict PHI disclosures to health insurer when it pertains to items or services for which an individual has paid. Since this is a business office procedure, your billing department or receptionist needs to set in place protocols for complying with such requests.
- Access to PHI is electronic format upon request from patient. If you store PHI on a computer, you must supply designated record sets electronically to the patient.
- Disclose PHI to family members of a deceased patient who were involved with the patient's care or payment for their care, as long as there is no written restriction on file.
- Establishment of a 50 year limit on the obligation to protect the PHI of deceased individual.
- Disclose immunization records provision to schools if required by law.
- Genetic information provision in accordance with the Nondiscriminational Act of 2008 (GINA) by prohibiting the use of genetic information for underwriting purposes, such as eligibility determinations and the computation of premiums.

Authorizations

A. All authorizations must be written, dated and currently signed by the patient or his/her authorized representative.

   a. A current authorization is one that is signed within the last year.

   b. If the authorization has not been dated, it must be returned to the sender with the statement: "The authorization which you sent was not dated. In order to be valid, the patient's/client's authorization must be dated prior to the signing of the authorization. If you wish to resubmit a properly dated and signed authorization, we will be happy to process your request."

B. Authorizations may not be accepted when they are addressed to another party, such as a hospital, physician, or third party payer.

C. Authorizations may be accepted if they are not addressed to the Agency but are addressed "To Whom It May Concern."

D. Authorization must state the name of persons or entities to whom medical information is to be released.

   Persons who may sign include:

   a. The competent patient, 18 years or older.

   b. Conservator or attorney-in-fact of an incompetent adult (must produce papers of guardianship, etc.)

   c. Minors, only if they could have consented to treatment without parent's consent.

   d. Parent or guardian of minor patient (must produce letters of guardianship stepparents may not consent.)

   e. Patient's spouse, for a limited purpose of processing an application for a health insurance plan.

   f. Executor or administrator of estate, or an heir of a deceased patient.

E. All patient or legally qualified patient representative authorizations, as well as the original requests for information, are retained in the patient's clinical record.

- The patient has the right to be informed of rights regarding the collection and reporting of OASIS information.

FINANCIAL INFORMATION

- The patient has the right to be informed of the extent to which payment may be expected from any payer known to us before any care is delivered and of the charges that will not be covered by such payer before any care is delivered; to be informed of the actual dollar amount of charges, if any, for which they may be liable; and to receive this information verbally and in writing, before care is initiated and within thirty (30) calendar days of the date the home care provider becomes aware of any changes in charges.
- The patient has the right to have access, upon request, to all bills for services you have received regardless of whether the bills are paid out-of-pocket or by another party.

QUALITY OF CARE

- The patient has the right to voice grievances regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for property by anyone who is furnishing services on behalf of the home health agency, or recommend changes in policy, staff or service/care, without restraint, interference, coercion, discrimination or reprisal.
- The patient has the right to direct any complaints/concerns made by a patient or the patient's family or legal representative about the care or service(s) furnished (or which agency fails to furnish) or regarding the lack of respect for the patient's property by anyone furnishing services on behalf of the Agency, including implementation of advance directive requirements. Complaints should be directed to the Administrator at 812-239-9013The Administrator/Director shall document both the existence of the complaint and the resolution of the complaint, investigate the complaint and report the outcome of the investigation to the patient or their representative. The patient may appeal to the Administrator if they are not satisfied with the manner in which the complaint/concern is resolved. The Administrator will respond to the appeal request within two weeks after receipt of the appeal.
- The patient has the right to place a complaint with the State Department of Health regarding treatment or care furnished by a home health agency. The patient shall be advised of the availability of the toll-free Home Health Agency (HHA) complaint hotline in the State. When the agency accepts the patient for treatment or care, the HHA must advise the patient in writing of the telephone number of the home health hotline established by the State, the hours of operation and that the purpose of the hotline is to receive complaints or questions about local HHAs and complaints regarding the implementation of advance directives. The Indiana State Department of Health's toll-free complaint hotline number is 1-800-227-6334. The hotline is available 24 hours a day, seven (7) days a week. The Department is open from 8:00 a.m. to 4:30 p.m., Monday through Friday. After hours, an answering machine is available to record your call.

YOUR RESPONSIBILITY

YOU HAVE THE RESPONSIBILITY TO:

- Provide complete and accurate information to the best of your knowledge about your present complaints, past illness(es), hospitalizations, pain, medications, allergies and other matters relating to your health.
- Remain under a doctor's care while receiving skilled Agency services.
- Notify us of perceived risks or unexpected changes in your condition (e.g., hospitalization, changes in the plan of care, symptoms to be reported, pain, homebound status or change of physician).
- Follow the plan of care and instructions and accept responsibility for the outcomes if you do not follow the care, treatment or service plan.
- Ask questions about your care, treatment and service or other instruction when you do not understand what you are expected to do. If you have concerns about your care or cannot comply with the plan, let us know.
- Discuss pain, pain relief options and your questions, worries and concerns about pain medication with staff or appropriate medical personnel.
- Tell us if your visit schedule needs to be changed due to medical appointment, family emergencies, etc.
- Tell us if your insurance coverage changes or if you decide to enroll in a Medicare or private HMO (Health Maintenance Organization) or Hospice.
- Promptly meet your financial obligations and responsibilities agreed upon with the agency.
- Follow the organization's policies and procedures.
- Inform us of the existence of, and any changes made to advance directives.
- Tell us of any problems or dissatisfaction with the services provided.
- Provide a safe and cooperative environment for care to be provided *(such as keeping pets confined, not smoking or putting weapons away during your care)*.
- Show respect and consideration for agency staff and equipment.
- Carry out mutually agreed responsibilities.

Home Health Agency
Outcome and Assessment Information Set (OASIS)

STATEMENT OF PATIENT PRIVACY RIGHTS *(Medicare/Medicaid)*

As a home health patient, you have the privacy rights listed below.

- **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:
  1) you get quality health care, and
  2) payment for Medicare and Medicaid patients is correct.
- **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.
- **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.
- **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.
  - If you are not satisfied with our response, you can ask the Centers for Medicare & Medicaid Services, the federal Medicare and Medicaid agency, to correct your information.

You can ask the Centers for Medicare & Medicaid Services to see, review, copy, or correct your personal health information which that Federal agency maintains in its HHA OASIS System of Records. See the back of this Notice for CONTACT INFORMATION.

If you want a more detailed description of your privacy rights, see The back of this Notice: (on facing page)

PRIVACY ACT STATEMENT. HEALTH CARE RECORDS.

- **T**his is a Medicare & Medicaid approved Notice

CMS

CENTERS for MEDiCARE & MEDICAID SERVICES

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.

I. **AUTHORITY FOR COLLECTION OF YOUR INFORMATION, INCLUDING YOUR SOCIAL SECURITY NUMBER, AND WHETHER OR NOT**

YOU ARE REQUIRED TO PROVIDE INFORMATION FOR THIS ASSESSMENT. Sections 1102(a), 1154, 1861(o), 1861(z), 1863, 1864, 1865, 1866, 1871, 1891(b) of the Social Security Act.

Medicare and Medicaid participating home health agencies must do a complete assessment that accurately reflects your current health and includes information that can be used to show your progress toward your health goals. The home health agency must use the "Outcome and Assessment Information Set" (OASIS) when evaluating your health. To do this, the agency must get information from every patient. This information is used by the Centers for Medicare & Medicaid Services (CMS, the federal Medicare & Medicaid agency) to be sure that the home health agency meets quality standards and gives appropriate health care to its patients. You have the right to refuse to provide information for the assessment to the home health agency. If your information is included in an assessment, it is protected under the federal Privacy Act of 1974 and the "Home Health Agency Outcome and Assessment Information Set" (HHA OASIS) System of Records. You have the right to see, copy, review, and request correction of your information in the HHA OASIS System of Records.

II. PRINCIPAL PURPOSES FOR WHICH YOUR INFORMATION IS INTENDED TO BE USED

The Information collected will be entered Into the Home Health Agency Outcome and Assessment Information Set (HHA OASIS) System No. 09-70-9002. Your health care information in the HHA OASIS System of Records will be used for the following purposes:

- support litigation involving The Centers for Medicare & Medicaid Services;
- support regulatory, reimbursement, and policy functions performed within the centers for Medicare & Medicaid Services or by a contractor or consultant;
- study the effectiveness and quality of care provided by those home health agencies;
- survey and certification of Medicare and Medicaid home health agencies;
- provide for development, validation, and refinement of a Medicare prospective payment system;
- enable regulators to provide home health agencies with data for their internal quality improvement activities;
- support research, evaluation, or epidemiological projects related to the prevention of disease or disability, or the restoration or maintenance of health, and for health care payment related projects; and
- support constituent requests made to a Congressional representative.

III. ROUTINE USES

These "routine uses" specify the circumstances when the Centers for Medicare & Medicaid Services may release your information from the HHA OASIS System of Records without your consent. Each prospective recipient must agree in writing to ensure the continuing confidentiality and security of your information. Disclosures of the information may be to:

1. the federal Department of Justice for litigation involving the Centers for Medicare & Medicaid Services;
2, contractors or consultants working for the Centers for Medicare & Medicaid Services to assist in the performance of a service related to this system of records and who need to access these records to perform the activity;
3. an agency of a State government for purposes of determining, evaluating, and/or assessing cost, effectiveness, and/or quality of health care services provided in the State; for developing and operating Medicaid reimbursement systems; or for the administration of Federal/State home health agency programs within the State;
4. another Federal or State agency to contribute to the accuracy of the Centers for Medicare & Medicaid Services' health Insurance operations (payment, treatment and coverage) and/or to support state agencies in the evaluations and monitoring of care provided by HHA's;
5. Quality Improvement Organizations, to perform Title XI or Title XVIII functions relating to assessing and Improving home health agency quality of care;
6. an individual or organization for a research, evaluation, or epidemiological project related to the prevention of disease or disability, the restoration or maintenance of health, or payment related projects;
7. a congressional office in response to a constituent inquiry made at the written request of the constituent about whom the record is maintained.

IV. EFFECT ON YOU, IF YOU DO NOT PROVIDE INFORMATION

The home health agency needs the information contained in the Outcome and Assessment Information Set 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 federal requirement for the home health agency to refuse you services.**

NOTE: This statement may be included in the admission packet for all new home health agency admissions. Home health agencies may request you or your representative to sign this statement to document that this statement was given to you. **Your signature is NOT required.** If you or your representative sign the statement, the signature merely indicates that you received this statement. You or your representative must be supplied with a copy of this statement.

CONTACT INFORMATION

If you want to ask the centers for Medicare & Medicaid Services to see, review, copy, or correct your personal health information that the Federal agency maintains in Its HHA OASIS System of Records:
Call 1-800-MEDICARE, toll free, for assistance in contacting the HHA OASIS System Manager.

TTY for the hearing and speech impaired: 1-877-486-2048.

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

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.

This Notice of Privacy Practices for Help at Home describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully. If you have any questions about this Notice, please contact:

Administrator, Help at Home.

Who Will Follow This Notice
The Notice of Privacy Practices describes information about privacy practices followed by the employees, staff, directors and other members of the workforce employed by Help at Home.

Each of the health care providers listed above must comply with the terms of this Notice of Privacy Practices for all services provided to you by Help at Home. These facilities will share your medical information with each other in order to efficiently provide hospital services to you, including services related to your treatment, payment for services provided to you and health care operations of the hospitals. These services are described in more detail on the following pages.

What Locations Are Covered
This Notice of Privacy Practices applies to all services provided to you by Help at Home. It does not cover services provided to you at your doctor's or dentist's office.

Your Protected Health Information
We are legally required to protect the privacy of your medical information and provide you with this Notice. This Notice of Privacy Practices describes how we may use and disclose your medical information to provide health care services to you. It also describes your rights to access and control your medical information. Your medical information includes your medical records, billing records and any other information we have or receive that may identify you and relates to your physical or mental health condition or health care services provided to you.

How We May Use and Disclose Your Protected Health Information

We use and disclose medical information for many different reasons. For some of these uses or disclosures, we need your specific authorization. Below, we describe the different categories of our uses and disclosures and give you some examples of each category.

We may use and disclose your medical information for treatment, payment and health care operations without your prior authorization:

- **For treatment.** We may use and disclose your medical information in order to provide medical treatment to you. For example, we may provide your medical information to your doctors or their nurses and staff in order to assist with your treatment once you leave the hospital. We may also provide information to pharmacies or other health care providers as needed for your treatment.
- **To obtain payment for treatment.** We may use and disclose your medical information in order to bill and collect payment for the treatment and services provided to you. For example, we give portions of your medical information to our billing department and your health plan to get paid for the health care services we provided to you. We may also provide your medical information to billing companies, claims processing companies and others that process our health care claims.
- **For health care operations.** We may disclose your medical information in order to operate our agency. For example, we may use your medical information in order to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided health care services to you. We may also send portions of your medical information to our accountants, attorneys, consultants and others in order to comply with legal or other matters that affect us. Your medical information may also be used for health care operations such as quality assessment activities, employee review activities, training of staff, and conducting or arranging for other business activities.

We may also use and disclose your medical information without your authorization for the following reasons:

- **Required by law.** We may disclose your medical information when we are required by federal, state or local law, judicial or administrative proceedings or law enforcement. For example, we make disclosures when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect or domestic violence; when dealing with gunshot and other specific types of wounds; or when ordered in a legal proceeding.
- **Public health activities.** We may disclose your medical information for public health reasons. For example, we report information about births, deaths and various diseases to government officials in charge of collecting that information, and we provide coroners, medical examiners and funeral directors necessary information relating to an individual's death.
- **Health oversight activities.** We will provide medical information to assist health oversight agencies for audits, investigations, inspections or licensing purposes.
- **Organ donation.** We may disclose medical information to assist organ procurement organizations with organ, eye or tissue donation and transplants.
- **Research.** In limited circumstances, we may provide medical information for research projects which are subject to a special approval process. We will ask for your written authorization if the researcher will have access to your name, address or other information that reveals who you are.
- **To avoid a serious threat to health or safety.** In order to avoid a serious threat to the health or safety of a person or the public, we may provide medical information to law enforcement personnel or persons able to prevent or lessen such harm.

- **Certain government functions.** We may disclose medical information of military personnel and veterans in certain situations. We may provide medical information about a patient's condition to the American Red Cross for the Red Cross to provide emergency communication services for members of the U.S: military, such as notification of family illness or death. We may also disclose medical information for national security purposes, such as protecting the President of the United States or assisting with intelligence operations.
- **Workers' Compensation.** We may provide medical information in order to comply with workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Appointment reminders and alternative treatment or benefits.** We may also use your medical information to send you appointment reminders or to provide you with information about alternative treatments which may be available to you or other health-related benefits and services that may be of interest to you.
- **To business associates.** We will share your medical information with other businesses that help us provide our services. For example, we may provide your medical information to a business that transcribes medical information for us. Whenever an arrangement between our health care organization and a business associate involves the use or disclosure of your medical information, we will have a written agreement that contains terms that will protect the privacy of your medical information.

You have the right to object to the following disclosures:

- **Disclosures to family, friends or others.** We may provide your medical information to a family member, friend or other person that you indicate is involved in your care or the payment for your health care, unless you object.

All other uses and disclosures require your prior written authorization. In any other situation not described above, we will ask for your written authorization before using or disclosing any of your medical information. If you choose to sign an authorization to disclose your medical information, you can revoke that authorization in writing to stop any future uses and disclosures to the extent that we have not already taken action relying on the authorization. This written decision to revoke that authorization will be filed and implemented immediately.

What Rights You Have Regarding Your Medical Information

You have the following rights with respect to your medical information:

- **The right to request limits on uses and disclosures of your medical information.** You have the right to ask that we limit how we use and disclose your medical information. We will consider your request but we are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations where the information is needed. You may not limit the uses and disclosures that we are legally required to make.
- **The right to choose how we send medical information to you.** You have the right to ask that we send information to you at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means. We must agree to your request so long as we can easily provide it in the format you requested.
- **The right to see** and **get copies of your medical information.** In most cases, you have the right to look at or get copies of your medical information that we have, but you must make the request in writing. If we don't have your medical information, but we know who does, we will tell you how to get it. We will respond to you within 30 days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed, if you request copies of your medical information, we will charge you a reasonable fee as permitted by Indiana law. Instead of providing the medical information you requested, we may provide you with a summary or explanation of the medical information as long as you agree in advance to pay the reasonable cost of preparing the summary or explanation.
- **The right to get a list of certain disclosures we have made.** You have the right to request a list of instances in which we have disclosed your medical information. The list will not include uses or disclosures made for treatment, payment and health care operations. The list will also not include information given to your family, printed in our facility directory, released for national security purposes or given to correctional institutions. It will also not include disclosures made directly to you or when you have given us a written authorization for the release of medical information. To obtain this list, you must make a request in writing to the Manager identified on the first page of this Notice. The list we will give you will include disclosures made Help at Home. We will provide the list to you at no charge, but if you make more than one request in the same year, we will charge you a reasonable fee for each additional request.
- **The right to correct or update** your medical information. If you believe that there is a mistake in your medical information or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. You must provide the request and your reason for the request in writing to the Administrator identified on the first page of this Notice. We may deny your request in writing if the medical information is:

    - correct and complete;
    - not created by us;
    - not allowed to be disclosed; or
    - not part of our records.

Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you do not file a statement of disagreement, you have the right to ask that your request and our denial be attached to all future disclosures of your medical information. If we approve your request, we will make the change to your medical information, tell you that we have done it, and tell others that need to know about the change to your medical information.

- **The right to get this Notice by e-mail.** You have the right to get a copy of the Notice by e-mail. Even if you have agreed to receive the Notice via e-mail, you also have the right to request a paper copy of this Notice.

What to Do If You Believe Your Privacy Rights Have Been Violated
If you think that we may have violated your privacy rights, or you disagree with a decision we made about your medical information, you may file a complaint with the Manager at the address shown on the first page of this Notice. You also may send a written complaint to the Secretary of the Department of Health and Human Services. Further information about how to file a complaint is available from the Manager. We will not take any action to retaliate against you and you will not be penalized if you file a complaint about our privacy practices.

Changes to This Notice
We may change the terms of this Notice at any time. The new Notice provisions will be effective for all protected health information we maintain. If we revise this Notice, a copy of the new Notice will be posted and made available. You may also request a copy from the Administrator.

Effective Date of This Notice
This Notice applies to uses and disclosures of your medical information beginning on September 1, 2009

INDIANA STATE DEPARTMENT OF HEALTH

2 North Meridian Street Indianapolis, Indiana 46204
March 1999
Revised May 2004
Revised July 1, 2013
Revised November 1, 2018

ADVANCE DIRECTIVES

YOUR RIGHT TO DECIDE

The purpose of this brochure is to inform you of ways that you can direct your medical care and treatment in the event that you are unable to communicate for yourself. This brochure covers:

- What is an advance directive?
- Are advance directives required?
- What happens if you do not have an advance directive?
- What are the different types of advance directives?

THE IMPORTANCE OF ADVANCE DIRECTIVES

Each time you visit your physician, you make decisions regarding your personal health care. You tell your doctor (generally referred to as a "physician") about your medical problems. Your physician makes a diagnosis and informs you about available medical treatment. You then decide what treatment to accept. That process works until you are unable to decide what treatments to accept or become unable to communicate your decisions. Diseases common to aging such as dementia or Alzheimer's disease may take away your ability to decide and communicate your health care wishes. Even young people can have strokes or accidents that may keep them from making their own health care decisions. Advance directives are a way to manage your future health care when you cannot speak for yourself.

WHAT IS AN ADVANCE DIRECTIVE?

"Advance directive" is a term that refers to your spoken and written instructions about your future medical care and treatment. By stating your health care choices in an advance directive, you help your family and physician understand your wishes about your medical care. Indiana law pays special attention to advance directives.

Advance directives are normally one or more documents that list your health care instructions. An advance directive may name a person of your choice to make health care choices for you when you cannot make the choices for yourself. If you want, you may use an advance directive to prevent certain people from making health care decisions on your behalf.

Your advance directives will not take away your right to decide your current health care. As long as you are able to decide and express your own decisions, your advance directives will not be used. This is true even under the most serious medical conditions. Your advance directive will only be used when you are unable to communicate or when your physician decides that you no longer have the mental competence to make your own choices.

ARE ADVANCE DIRECTIVES REQUIRED?

Advance directives are not required. Your physician or hospital cannot require you to make an advance directive if you do not want one. No one may discriminate against you if you do not sign one. Physicians and hospitals often encourage patients to complete advance directive documents. The purpose of the advance directive is for your physician to gain information about your health care choices so that your wishes can be followed. While completing an advance directive provides guidance to your physician in the event that you are unable to communicate for yourself, you are not required to have an advance directive.

WHAT HAPPENS IF YOU DO NOT HAVE AN ADVANCE DIRECTIVE?

If you do not have an advance directive and are unable to choose medical care or treatment, Indiana law decides who can do this for you. Indiana Code § 16-36-1-5 establishes a priority list. If you cannot communicate and do not have an advance directive, your physician will try to contact a representative using the priority list. Your health care choices will be made by the representative that your physician is able to contact. The order of priority is:

1. A judicially appointed guardian of the person or a representative appointed by a probate court.
2. A spouse (unless legally separated or there is a pending petition for separation, dissolution, annulment, protective order or no contact order [Indiana Code § 16-36-1-9.5]).
3. An adult child
4. A parent
5. An adult sibling
6. A grandparent
7. An adult grandchild
8. An adult friend (special conditions apply)
9. The nearest other adult relative in the next degree of kinship not listed in 2 through 7

Note 1: If there are multiple individuals in any priority group and the group cannot achieve consensus, then a majority of the available individuals at the same priority level controls.

Note 2: You may disqualify one or more individuals. The disqualification must be in writing, designates those disqualified and signed by you [Indiana Code § 16-36-1-9].

WHAT TYPES OF ADVANCE DIRECTIVES ARE RECOGNIZED IN INDIANA?

- ☐ Talking directly to your physician and family
- ☐ Organ and tissue donation

- ☐ Health care representative
- ☐ Living Will Declaration or Life-Prolonging Procedures Declaration
- ☐ Psychiatric advance directives
- ☐ Out of Hospital Do Not Resuscitate Declaration and Order
- ☐ Physician Orders for Scope of Treatment (POST)
- ☐ Power of Attorney

TALKING TO YOUR PHYSICIAN AND FAMILY

One of the most important things to do is to talk about your health care wishes with your physician. Your physician can follow your wishes only if he or she knows what your wishes are. You do not have to write down your health care wishes in an advance directive. By discussing your wishes with your physician, your physician will record your choices in your medical chart so that there is a record available for future reference. Your physician will follow your verbal instructions even if you do not complete a written advance directive. Solely discussing your wishes with your physician, however, does not cover all situations. Your physician may not be available when choices need to be made. Other health care providers would not have a copy of the medical records maintained by your physician and therefore would not know about any verbal instructions given by you to your physician. In addition, spoken instructions provide no written evidence and carry less weight than written instructions if there is a disagreement over your care. Writing down your health care choices in an advance directive document makes your wishes clear and may be necessary to fulfill legal requirements.

If you have written advance directives, it is important that you give a copy to your physician. He or she will keep it in your medical chart. If you are admitted to a hospital or health facility, your physician will write orders in your medical chart based on your written advance directives or your spoken instructions. For instance, if you have a fatal disease and do not want cardiopulmonary resuscitation (CPR), your physician will need to write a "do not resuscitate" (DNR) order in your chart. The order makes the hospital staff aware of your wishes. Because most people have several health care providers, you should discuss your wishes with all of your providers and give each provider a copy of your advance directives.

It is difficult to talk with family about dying or being unable to communicate. However, it is important to talk with your family about your wishes and ask them to follow your wishes. You do not always know when or where an illness or accident will occur. It is likely that your family would be the first ones called in an emergency. They are the best source of providing advance directives to a health care provider.

ORGAN AND TISSUE DONATION

Increasing the quality of life for another person is the ultimate gift. Donating your organs is a way to help others. Making your wishes concerning organ donation clear to your physician and family is an important first step. This lets them know that you wish to be an organ donor. Organ donation is controlled by the Indiana Uniform Anatomical Gift Act found at Indiana Code § 29-2-16.1. A person that wants to donate organs may include their choice in their will, living will, on a card, or other document. If you do not have a written document for organ donation, someone else will make the choice for you. A common method used to show that you are an organ donor is making the choice on your driver's license. When you get a new or renewed license, you can ask the license branch to mark your license showing you are an organ donor.

HEALTH CARE REPRESENTATIVE

A "health care representative" is a person you choose to receive health care information and make health care decisions for you when you cannot. To choose a health care representative, you must fill out an appointment of health care representative document that names the person you choose to act for you. Your health care representative may agree to or refuse medical care and treatments when you are unable to do so. Your representative will make these choices based on your advance directive. If you want, in certain cases and in consultation with your physician, your health care representative may decide if food, water, or respiration should be given artificially as part of your medical treatment.

Choosing a health care representative is part of the Indiana Health Care Consent Act, found at Indiana Code § 16 -36 -1. The advance directive naming a health care representative must be in writing, signed by you, and witnessed by another adult. Because these are serious decisions, your health care representative must make them in your best interest. Indiana courts have made it clear that decisions made for you by your health care representative should be honored.

LIVING WILL

A "living will" is a written document that puts into words your wishes in the event that you become terminally ill and unable to communicate. A living will is an advance directive that lists the specific care or treatment you want or do not want during a terminal illness. A living will often includes directions for CPR, artificial nutrition, maintenance on a respirator, and blood transfusions. The Indiana Living Will Act is found at Indiana Code § 16-36-4. This law allows you to write one of two kinds of advance directive.

Living Will Declaration: This document is used to tell your physician and family that life - prolonging treatments should not be used so that you are allowed to die naturally. Your living will does not have to prohibit all life-prolonging treatments. Your living will should list your specific choices. For example, your living will may state that you do not want to be placed on a respirator but that you want a feeding tube for nutrition. You may even specify that someone else should make the decision for you.

Life-Prolonging Procedures Declaration: This document is the opposite of a living will. You can use this document if you want all life-prolonging medical treatments used to extend your life.

Both of these documents can be canceled orally, in writing, or by destroying the declaration yourself. The cancellation takes effect only when you tell your physician. For either of these documents to be used, there must be two adult witnesses and the document must be in writing and signed by you or someone that has permission to sign your name in your presence.

PSYCHIATRIC ADVANCE DIRECTIVE

Any person may make a psychiatric advance directive if he/she has legal capacity. This written document expresses your preferences and consent to treatment measures for a specific diagnosis. The directive sets forth the care and treatment of a mental illness during periods of incapacity. This directive requires certain items in order for the directive to be valid. Indiana Code § 16-36-1.7 provides the requirements for this type of advance directive.

OUT OF HOSPITAL DO NOT RESUSCITATE DECLARATION AND ORDER

In a hospital, if you have a terminal condition and you do not want CPR, your physician will write a "do not resuscitate" order in your medical chart. If you are not in a hospital when an emergency occurs, the emergency medical personnel or the hospital where you are sent likely would not have a physician's order to implement your directives. For situations outside of a hospital, the Out of Hospital Do Not Resuscitate Declaration and Order is used to state your wishes. The Out of Hospital Do Not Resuscitate Declaration and Order is found at Indiana Code § 16-36-5.

The law allows a qualified person to say they do not want CPR given if the heart or lungs stop working in a location that is not a hospital. This declaration may override other advance directives. The declaration may be canceled by you at any time by a signed and dated writing, by destroying or canceling the document, or by communicating to health care providers at the scene your desire to cancel the order. Emergency Medical Services (EMS) may have procedures in place for marking your home so they know you have an order. You should contact your local EMS provider to find out their procedures.

PHYSICIAN ORDERS FOR SCOPE OF TREATMENT (POST)

A "Physician Orders for Scope of Treatment" (also referred to as a POST form) is a direct physician order for a person with at least one of the following:

1. An advanced chronic progressive illness.
2. An advanced chronic progressive frailty.
3. A condition caused by injury, disease, or illness from which, to a reasonable degree of medical certainty there can be no recovery and death will occur from the condition within a short period without the provision of life prolonging procedures.
4. A medical condition that, if the person were to suffer cardiac or pulmonary failure, resuscitation would be unsuccessful or within a short period the person would experience repeated cardiac or pulmonary failure resulting in death.

In consultation with you or your legal representative, your physician will write orders that reflect your wishes with regards to cardiopulmonary resuscitation (CPR), medical interventions (comfort measures, limited additional interventions, or full treatment), antibiotics and artificially administered nutrition. You additionally have the option on the POST form to designate a "Health Care Representative" [see the section "Health Care Representative" above for additional information]. Note that if you have previously

designated a health care representative and you name a different person on your POST form, the person designated on the POST form replaces (revokes) the person named in the previous health care representative advance directive. The Indiana POST form is available on the Indiana State Department of Health website at www.in.gov/isdh/25880.htm.

The POST form must be signed and dated by you (or your legal representative) and your physician, physician's assistant, or advanced practice registered nurse to be valid. The original form is your personal property and you should keep it. Paper, facsimile (fax), or electronic copies of a valid POST form are as valid as the original. Your physician is required to keep a copy of your POST form in your medical record or; if the POST form is executed in a health facility, the facility must maintain a copy of the form in the medical record. The POST form may be used in any health care setting. The Physician Orders for Scope of Treatment statute is found at Indiana Code § 16-36-6.

Executed POST forms may be revoked at any time by any of the following:

1. A signed and dated writing by you or your legal representative.
2. Physical cancellation of destruction of the POST form by you or your legal representative.
3. Another individual at the direction of you or your legal representative.
4. An oral expression by you or your legal representative of intent to revoke the POST form.

The revocation is effective upon communication of the revocation to a health care provider.

POWER OF ATTORNEY

A "power of attorney" (also referred to as a "durable power of attorney") is another kind of advance directive. This document is used to grant another person say-so over your affairs. Your power of attorney document may cover financial matters, give health care authority, or both. By giving this power to another person, you give this person your power of attorney. The legal term for the person you choose is "attorney in fact." Your attorney in fact does not have to be an attorney. Your attorney in fact can be any adult you trust. Your attorney in fact is given the power to act for you only in the ways that you list in the document. The document must:

1. Name the person you want as your attorney in fact;
2. List the situations which give the attorney in fact the power to act;
3. List the powers you want to give; and
4. List the powers you do not want to give.

The person you name as your power of attorney is not required to accept the responsibility. Prior to executing a power of attorney document, you should talk with the person to ensure that he or she is willing to serve. A power of attorney document may be used to designate a health care representative.

Health care powers are granted in the power of attorney document by naming your attorney in fact as your health care representative under the Health Care Consent Act or by referring to the Living Will Act. When a power of attorney document is used to name a health care representative, this person is referred to as your health care power of attorney. A health care power of attorney generally serves the same role as a health care representative in a health care representative advance directive. Including health care powers could allow your attorney in fact to:

1. Make choices about your health care;
2. Sign health care contracts for you;
3. Admit or release you from hospitals or other health facilities;
4. Look at or get copies of your medical records; and
5. Do a number of other things in your name.

The Indiana Powers of Attorney Act is found at Indiana Code § 30-5. Your power of attorney document must be in writing and signed in the presence of a notary public. You can cancel a power of attorney at any time but only by signing a written cancellation and having the cancellation delivered to your attorney in fact.

WHICH ADVANCE DIRECTIVE OR DIRECTIVES SHOULD BE USED?

The choice of advance directives depends on what you are trying to do. The advance directives listed above may be used alone or together. Although an attorney is not required, you may want to talk with one before you sign an advance directive. The laws are complex and it is always wise to talk to an attorney about questions and your legal choices. An attorney is often helpful in advising you on complex family matters and making sure that your documents are correctly done under Indiana law. An attorney may be helpful if you live in more than one state during the year. An attorney can advise you whether advance directives completed in another state are recognized in Indiana.

CAN I CHANGE MY MIND AFTER I WRITE AN ADVANCE DIRECTIVE?

It is important to discuss your advance directives with your family and health care providers. Your health care wishes cannot be followed unless someone knows your wishes. You may change or cancel your advance directives at any time as long as you are of sound mind. If you change your mind, you need to tell your family, health care representative, power of attorney, and health care providers. You might have to cancel your decision in writing for it to become effective. Always be sure to talk directly with your physician and tell him or her your exact wishes.

ARE THERE FORMS TO HELP IN WRITING THESE DOCUMENTS?

Advance directive forms are available from many sources. Most physicians, hospitals, health facilities, or senior citizen groups can provide you with forms or refer you to a source. These groups often have the information on their web sites. You should be aware that forms may not do everything you want done. Forms may need to be changed to meet your needs. Although advance directives do not require an attorney, you may wish to consult with one before you try to write one of the more complex legal documents listed above.

Several of the forms are specified by statute. Those forms may be found on the Indiana State Department of Health (ISDH) Advance Directives Resource Center at www.in.gov/isdh/25880.htm. The following forms are available on that web site:

- Living Will Declaration
- Life-Prolonging Procedures Declaration
- Out of Hospital Do Not Resuscitate Declaration and Order
- Physician Orders for Scope of Treatment (POST)

WHAT SHOULD I DO WITH MY ADVANCE DIRECTIVE IF I CHOOSE TO HAVE ONE?

Make sure that your health care representative, immediate family members, physician, attorney, and other health care providers know that you have an advance directive. Be sure to tell them where it is located. You should ask your physician and other health care providers to make your advance directives part of your permanent medical chart. If you have a power of attorney, you should give a copy of your advance directives to your attorney in fact. You may wish to keep a small card in your purse or wallet that states that you have an advance directive, where it is located, and who to contact for your attorney in fact or health care representative, if you have named one.

ADDITIONAL INFORMATION

For additional information on advance directives, visit the Indiana State Department of Health Advanced Directives Resource Center located at www.in.gov/isdh/25880.htm. The site includes links to state forms, this brochure, links to Indiana statutes, and links to other web sites.

The ISDH Web site contains a wealth of information about public health. Visit the ISDH Home Page at www.in.gov/isdh.

SUMMARY OF ADVANCE DIRECTIVES

You have the right to choose the medical care and treatment you receive. Advance directives help make sure you have a say in your future health care and treatment if you become unable to communicate.

Even if you do not have written advance directives, it is important to make sure your physician and family are aware of your health care wishes.

No one can discriminate against you for signing, or not signing, an advance directive. An advance directive is, however, your way to control your future medical treatment.

This information was prepared by the Indiana State Department of Health as an overview of advance directives. The Indiana State Department of Health attorneys cannot give you legal advice concerning living wills or advance directives. You should talk with your personal lawyer or representative for advice and assistance in this matter.

Indiana State Department of Health
2 North Meridian Street
Indianapolis, Indiana 46204
http://www.in.gov/isdh

SECTION V. Safety

All patients need to take special precautions to ensure a safe living environment. Most accidents in the home can be prevented by eliminating hazards. This checklist will help you find potential hazards in your home. Check each statement that you need to work on to make your home a safer place. **Please speak with your nurse/therapist or call the agency at any time if you have any concerns or questions about patient safety.**

PREVENTING FALLS

At least half of all falls happen at home. Each year, thousands of older Americans experience falls that result in serious injuries, disability and yes, even death. Falls are often due to hazards that are easily overlooked but easy to fix. Use the following **SELF-ASSESSMENT.** Check all of the risk factors below that apply to you and your home. The more factors checked, the higher your risk for falling.

- ☐ **History of Falling** - 2 or more falls in last 6 months.
- ☐ **Vision Loss** - changes in ability to detect and discriminate objects; decline in depth perception; decreased ability to recover from a sudden exposure to bright light or glare.
- ☐ **Hearing Loss** - may not be as quickly aware of a potentially hazardous situation.
- ☐ **Foot Pain/Shoe Problems** - foot pain; decreased sensation/feeling; skin breakdown; ill-fitting or badly worn footwear.
- ☐ **Medications** - taking four or more medications; single or multiple medications that may cause drowsiness, dizziness or low blood pressure.
- ☐ **Balance and Gait Problems** - decline in balance; decline in speed of walking; weakness of lower extremities.
- ☐ **High or Low Blood Pressure** - that causes unsteadiness.
- ☐ **Hazards Inside Your Home** - tripping and slipping hazards, poor lighting, bathroom safety, spills, stairs, reaching, pets that get under foot.
- ☐ **Hazards Outside Your Home** - uneven walkways, poor lighting, gravel or debris on sidewalks, no handrails, pets that get under foot, hazardous materials (snow, ice, water, oil) that need periodic removal and clean up.

Review each of the following safety tips and check the ones you need to work on:

- ☐ Keep emergency numbers in large print near each phone.
- ☐ Put a phone near the floor in case you fall and can't get up.
- ☐ Wear shoes that give good support and have thin non-slip soles. Avoid wearing slippers and athletic shoes with deep treads.
- ☐ Remove things you can trip over (such as papers, books, clothes, and shoes) from stairs and places where you walk.
- ☐ Keep outside walks and steps clear of snow and ice in the winter.
- ☐ Remove small throw rugs or use double-sided tape to keep the rugs from slipping.
- ☐ Ask someone to move any furniture so your path around the house is clear.
- ☐ Clean up spills immediately.
- ☐ Be aware of where your pets are at all times.
- ☐ Do not walk over or around cords or wires, i.e., cords from lamps, extension cords, or telephone cords. Coil or tape cords and wires next to the wall so you can't trip over them. Have an electrician add more outlets if needed.
- ☐ Keep items used often within easy reach (about waist high) in cabinets.
- ☐ Use a steady step stool with a hand bar. Never use a chair as a step stool.
- ☐ Improve the lighting in your home. Replace burned out bulbs. Lamp shades or frosted bulbs can reduce glare.
- ☐ Make sure stairways, halls, entrances and outside steps are well lighted. Have a light switch at the top and bottom of the stairs.
- ☐ Place a lamp, flashlight and extra batteries within easy reach of your bed.
- ☐ Place nightlights in bathrooms, halls and passageways so you can see where you're walking at night.
- ☐ Make sure the carpet is firmly attached to every step. If not, remove the carpet and attach non-slip rubber treads on the stairs. Paint a contrasting color on the top front edge of all steps so you can see the stairs better.
- ☐ Fix loose handrails or put in new ones. Make sure handrails are on both sides of the stairs and are as long as the stairs. Fix loose or uneven steps.
- ☐ Install grab bars next to your toilet and in the tub or shower.
- ☐ Use non-slip mats in the bathtub and on shower floors.
- ☐ Use an elevated toilet seat and/or shower stool, if needed.
- ☐ Exercise regularly. Exercise makes you stronger and improves your balance and coordination. Talk to your doctor about what exercise is right for you.
- ☐ Have your nurse, doctor or pharmacist look at all the medicines you take, even over-the-counter medicines. Some medicines can make you sleepy or dizzy.
- ☐ Have your vision checked at least once a year by an eye doctor. Poor vision can increase your risk of falling.
- ☐ Get up slowly after you sit or lie down.
- ☐ Use a cane or assistive device for extra stability, if needed.
- ☐ Think about wearing an alarm device that will bring help in case you fall and can't get up.

FIRE SAFETY/BURN PRECAUTIONS

- ☐ The fire department number is posted on every telephone. All family members and caregivers are familiar with emergency 911 procedures.
- ☐ Notify the fire department if a disabled person is in the home.
- ☐ **Do not smoke in bed.** Never leave burning cigarettes unattended. Do not empty smoldering ashes in a trash can. Keep ashtrays away from upholstered furniture and curtains.
- ☐ Do not smoke where oxygen equipment is being used.
- ☐ Install smoke alarms on every floor of your home, including the basement. Place smoke alarms near rooms where people sleep. Test smoke alarms every month to make sure they are working properly.
- ☐ Install new smoke alarm batteries when you change your clocks for daylight savings time in the spring and fall.
- ☐ Fire extinguishers are checked frequently for stability.
- ☐ Make a family fire escape plan and practice it every six months. At least two different escape routes are planned from each room for each family member. If your exit is through a ground floor window, make sure it opens easily.
- ☐ If you live in an apartment building, know where the exit stairs are located. Do not use an elevator during a fire emergency.
- ☐ Designate a safe place in front of the house or apartment building for family members to meet after escaping a fire.
- ☐ If your fire escape is cut off, remain calm, close the door and seal cracks to hold back smoke. Signal for help at the window.
- ☐ **A bedbound patient can be** evacuated to a safe area by placing him/her on a sturdy blanket and pulling/dragging them out of the home.
- ☐ Remember, life safety is first, but if the fire is contained and small, you may be able to use your fire extinguisher until the fire department arrives.
- ☐ Have your heating system checked and cleaned regularly by someone qualified to do maintenance.
- ☐ Wood burning stoves are properly installed, chimney is inspected and cleaned by a professional chimney sweep and trash is not burned in stove because this could overheat the stove. Gasoline or other flammable liquids should never be used to start wood stove fires.
- ☐ Portable heaters (electric or kerosene) are placed out of the path of traffic areas. The heater is operated at least three feet away from upholstered furniture, drapes, bedding and other combustible materials. The heater is used on the floor and is turned off when family members leave the house or are sleeping. A kerosene heater is only used in a well-ventilated room. Kerosene is stored outdoors in a tightly sealed, labeled container.
- ☐ Make sure electrical appliances and cords are clean, in good condition and not exposed to liquids.
- ☐ Electrical outlets are grounded. "Octopus" outlets with several plugs are not used.
- ☐ Keep cooking areas free of flammable objects (potholders, towels, etc.).
- ☐ Keep storage area above the stove free of flammable/combustible items.
- ☐ Wear short or tight fitting sleeves while cooking; don't reach over stove burner.
- ☐ Do not leave the stove unattended when cooking, especially when the burner is turned to a high setting.
- ☐ Turn pan handles away from burners and the edge of the stove.
- ☐ Avoid cooking on high heat with oils and fat.
- ☐ Puncture plastic wrap before heating foods in the microwave.
- ☐ Never place hot liquids/solids at edge of counter.
- ☐ Place layered protection between skin and heating pad.
- ☐ Keep electrical appliances away from the bathtub or shower area.
- ☐ Never leave patient alone in the shower/tub.
- ☐ Set water heater thermostat below 120◦ F to prevent accidental scalding.
- ☐ Store flammable liquids in properly labeled, tightly closed, non-glass containers. Store away from heaters, furnaces, water heaters, ranges and other gas appliances. Make sure the garage is adequately ventilated.

MEDICATION SAFETY

- ☐ Do not take medications that are prescribed for someone else.
- ☐ Write down all of your medications (including prescription, over-the-counter, vitamins, herbals) and show the list to your doctor or pharmacist to keep from combining drugs inappropriately. Add any changes to the list immediately.
- ☐ Know the name of each of your medicines; why you are taking it; how to take it; what foods to avoid or other things to avoid while taking it; and its potential side effects.
- ☐ Report medication allergies and any medication side effects to your health care provider.
- ☐ Take medications exactly as instructed. If the medication looks different than you expected, ask your health care provider or pharmacist about it.
- ☐ Drug names can look alike or sound alike. To avoid errors, check with your health care provider if you have questions.
- ☐ Do NOT use alcohol when you are taking medicine.
- ☐ Do not stop or change medicines without your doctor's approval, even if you are feeling better.
- ☐ Use a chart or container system (washed egg carton or med-planner) to help you remember what kind, how much, and when to take medicine.
- ☐ Take your medicine with a light on so you can read the label.
- ☐ Read medicine labels (including warnings) carefully and keep medicines in their original containers.
- ☐ Store medications safely in a cool/dry place according to instructions on the label of the medication.

- ☐ If you miss a dose, do not double the next dose later.
- ☐ Dispose of old medications safely by flushing them down the toilet or as directed.
- ☐ Keep medicines away from children and confused adults.

HAZARDOUS ITEMS AND POISONS

- ☐ Know how to contact your poison control team.
- ☐ Use care in storing hazardous items. Only store hazardous items in their original containers.
- ☐ Do not mix products that contain chlorine or bleach with other chemicals.
- ☐ Understand the risk of insecticides. They are only bought for immediate need and excess is stored or disposed of properly.
- ☐ Keep hazardous items, cleaners and chemicals out of reach of children and confused or impaired adults.
- ☐ Dispose of household trash in a covered waste receptacle outside the home.

MEDICAL EQUIPMENT

- ☐ Manufacturer's instructions for specialized medical equipment are kept with or near the equipment.
- ☐ Routine and preventive maintenance is performed according to the manufacturer's instructions.
- ☐ Phone numbers are available in the home to obtain service in case of equipment problems or equipment failure.
- ☐ Backup equipment is available if indicated.
- ☐ Manufacturer's instructions are followed for providing a proper environment for specialized medical equipment.
- ☐ Adequate electrical power is provided for medical equipment such as ventilators, oxygen concentrators and other equipment.
- ☐ Test equipment alarms periodically to make sure that you can hear them.
- ☐ Equipment batteries are checked regularly by a qualified service person.
- ☐ Bed side rails are properly installed and used only when necessary. Do not use bed rails as a substitute for a physical protective restraint.
- ☐ If bed rails are split, remove or leave the foot-end down so the patient is not trapped between the rails.
- ☐ Mattress must fit the bed. Add stuffers in gaps between the rail and mattress or between the head and foot board and mattress to reduce gaps.
- ☐ If you have electrically powered equipment such as oxygen or ventilator, you are registered with your local utility company.

OXYGEN

- ☐ Keep oxygen containers away from any flames, including matches, cigarette lighters, candles, gas stoves and any other flame source.
- ☐ Keep oxygen away from any source of heat including curling irons.
- ☐ Keep all electrical equipment ten feet from oxygen equipment if possible. Electrical equipment which gets hot or throw sparks, including radios, televisions, electric razors, and don't forget friction toys, or toys that spark.
- ☐ All equipment should be properly grounded with a 3-prong plug. Do not use extension cords or plug multipliers.
- ☐ Do not attempt to lubricate oxygen equipment and never handle any oxygen equipment with oily hands or rags.
- ☐ Do not use aerosol cans near oxygen.
- ☐ Do not allow oxygen to freeze or overheat. Cylinders should not be left in areas over 125°F or below 32°F.
- ☐ Cylinders, when used, must always be in carriers. When cylinders are not in use, it is recommended that the main valve (found directly on top of the oxygen cylinder) be closed and cylinders laid flat. Turn valve clockwise until very tight. This rule also applies when transporting. Do not cover with a blanket or coat.
- ☐ Never set the flow rate higher or use oxygen more than your doctor has ordered. Too much oxygen can damage your lungs and even slow your breathing.
- ☐ Your oxygen tank will not explode or burn. Oxygen does not burn, but it does help other things burn faster.
- ☐ There should be no smoking in the room where oxygen is being used.
- ☐ Keep the tank at least 10 feet from an open flame, gas stoves, pilot lights in water heaters and furnaces, and wood-burning stoves.
- ☐ Do not tamper with your equipment or try to fix it. Notify our office or the supplier immediately with any problems.
- ☐ If you have any questions about appropriate use of equipment or transporting it, please contact our office.
- ☐ Keep oxygen concentrators at least 12 inches from the wall. Store in a well-ventilated area and not in small closets, under outside porches or decks or in trunk of car.

This agency assumes no liability for patients/families who continue to smoke in the presence of oxygen.

POWER OUTAGE

In case of a power outage, if you require assistance and our agency phone lines are down, do the following:

- ☐ If you are in a crisis or have an emergency situation, call 911 or go to the nearest hospital emergency room.
- ☐ If it is not an emergency, call your closest relative or neighbor.

Our agency will get in touch with you as soon as possible.

FLOODS

Floods are the most common and widespread of all natural hazards. Some floods can develop over a period of days, but flash floods

can result in raging waters in just a few minutes. Be aware of flood hazards, especially if you live in a low-lying area, near water or downstream from a dam.

Assemble a disaster supplies kit. Include a battery-operated radio, flashlights and extra batteries, first aid supplies, sleeping supplies and clothing. Keep a stock of food and extra drinking water.

If local authorities issue a flood watch, prepare to evacuate:

- ☐ Secure your home. Move essential items to the upper floors of your house.
- ☐ If instructed, turn off utilities at the main switches or valves. Do not touch electrical equipment if you are wet or standing in water.
- ☐ Fill the bathtub with water in case water becomes contaminated or services are cut off. Clean the bathtub first.
- ☐ Six inches of moving water can knock you off your feet. If you must walk in a flooded area, do not walk through moving water.
- ☐ Use a stick to check the firmness of the ground in front of you.

TORNADO

Tornadoes are nature's most violent storms. When a tornado has been sighted, go to your shelter immediately. Stay away from windows, doors and outside walls.

- ☐ **In a house or small building:** Go to the basement or storm cellar. If there is no basement, go to an interior room on the lower level (closets, interior hallways). Get under a sturdy table, hold on and protect your head. Stay there until the danger has passed.

  If the patient is bedbound, move the patient's bed as far away from windows as possible. Cover the patient with heavy blankets or pillows being sure to protect the head and face. Then go to a safe area.

- ☐ **In a school, nursing home, hospital, factory or shopping center:** Go to predesignated shelter areas. Interior hallways on the lowest floor are usually safest. Stay away from windows and open spaces.

- ☐ **In a high-rise building:** Go to a small, interior room or hallway on the lowest floor possible.

- ☐ **In a vehicle, trailer or mobile home:** Get out immediately and go to a more substantial structure.

- ☐ **If there is no shelter nearby,** lie flat in the nearest ditch, ravine or culvert with your hands shielding your head. In a car, get out and take shelter in a nearby building. Do not attempt to out-drive a tornado. They are erratic and move swiftly.

- ☐ Have emergency equipment and medical supplies readily available.

LIGHTNING

Inside a home, avoid bathtubs, water faucets and sinks because metal pipes can conduct electricity. Stay away from windows. Avoid using the telephone, except for emergencies. If outside, do not stand underneath a natural lightning rod, such as a tall, isolated tree in an open area. Get away from anything metal, including tractors, farm equipment, bicycles, etc.

WINTER STORMS

Heavy snowfall and extreme cold can immobilize an entire region. Even areas which normally experience mild winters can be hit with a major snow storm or extreme cold. The results can range from isolation due to blocked roads and downed power lines to the havoc of cars and trucks sliding on icy highways.

Gather emergency supplies:

- ☐ Battery powered radio, flashlights, battery-powered lamps, extra batteries.
- ☐ Food that doesn't require cooking and a manual can opener.
- ☐ Your medications.
- ☐ Extra blankets.
- ☐ Extra water in clean soda bottles or milk containers.
- ☐ Rock salt to melt ice on walkways and sand to improve fraction.
- ☐ Make sure you have enough heating fuel; regular fuel sources may be cut off.

Dress for the season:

- ☐ Wear several layers of loose-fitting, light-weight, warm clothing rather than one layer of heavy clothing. The outer garments should be tightly woven and water repellent.
- ☐ Mittens are warmer than gloves.
- ☐ Wear a hat: most body heat is lost through the top of the head.

Helpful Emergency Numbers

INDIANA DISABILITY RIGHTS
4701 NORTH KEYSTONE AVENUE, SUITE 222
INDIANAPOLIS, INDIANA 46205

LOCAL PHONE: 317.722.5555
TOLL FREE PHONE: 800.622.4845

LOCAL TTY: 317.722.5563
TOLL FREE TTY: 800.838.1131
WEBSITE: www.IndianaDisabilityRights.org
EMAIL: info@IndianaDisabilityRights.org
OUR OFFICE MAY BE ACCESSED THROUGH THE INDYGO BUS SYSTEM, VIA Route 26 (Keystone Crosstown) AND Route 19 (Castleton).

Figure 2 – Location and Contact Information for Local AAA Offices

16 Area Agencies

AREA 1
Northwest Indiana Community Action Corporation
5240 Fountain Dr.
Crown Point, IN 46307
219-794-1829 or 800-826-7871
TTY: 888-814-7597
Fax: 219-794-1860
nwi-ca.com

AREA 2
REAL Services, Inc.
1151 S. Michigan St.
South Bend, IN 46601-3427
574-284-2644 or 800-552-7928
Fax: 574-284-2642
realservices.org

AREA 3
Aging & In-Home Services of Northeast Indiana, Inc.
8101 W. Jefferson Blvd.
Fort Wayne, IN 46804
260-745-1200 or 800-552-3662
Fax: 260-422-4916
agingihs.org

AREA 4
Area IV Agency on Aging & Community Action Programs, Inc.
660 N. 36th St.
Lafayette, IN 47903-4727
765-447-7683 or 800-382-7556
TDD: 765-447-3307
Fax: 765-447-6862
areaivagency.org

AREA 5
Area Five Agency on Aging & Community Services, Inc.
1801 Smith St., Suite 300
Logansport, IN 46947-1577
574-722-4451 or 800-654-9421
Fax: 574-722-3447
areafive.com

AREA 6
LifeStream Services, Inc.
1701 Pilgrim Blvd.
Yorktown, IN 47396-0308
765-759-1121 or 800-589-1121
TDD: 866-801-6606
Fax: 765-759-0060
lifestreaminc.org

AREA 7
Thrive West Central
2800 Poplar St., Suite 9A
Terre Haute, IN 47803
812-238-1561 or 800-489-1561
TDD: 800-489-1561
Fax: 812-238-1564
thrivewestcentral.com/

AREA 8
CICOA Aging & In-Home Solutions
8440 Woodfield Crossing Blvd., Suite 175
Indianapolis, IN 46240-4359
317-254-5465 or 800-432-2422
TDD: 317-254-5497
Fax: 317-254-5494
cicoa.org

AREA 9
LifeStream Services, Inc.
2404 National Road W.
Richmond, IN 47374
765-966-1795 or 800-589-1121
Fax: 765-759-1121
lifestreaminc.org

AREA 10
Area 10 Agency on Aging
631 W. Edgewood Dr.
Ellettsville, IN 47429
812-876-3383 or 800-844-1010
Fax: 812-876-9922
area10agency.org

AREA 11
Thrive Alliance
1531 13th Street, Suite G900
Columbus, IN 47201
812-372-6918 or 866-644-6407
Fax: 812-372-7846
thrive-alliance.org

AREA 12
LifeTime Resources, Inc.
13091 Benedict Dr.
Dillsboro, IN 47018
812-432-6200 or 800-742-5001
Fax: 812-432-3822
lifetime-resources.org

AREA 13
Generations
Vincennes University Statewide Services
1019 N. 4th St.
Vincennes, IN 47591
812-888-5880 or 800-742-9002
Fax: 812-888-4566
vinu.edu/web/generations

AREA 14
LifeSpan Resources, Inc.
33 State St., Third Floor
New Albany, IN 47151-0995
812-948-8330 or 888-948-8330
TTY: 812-542-6895
Fax: 812-948-0147
lsr14.org

AREA 15
Hoosier Uplands / Public Service Area 15 Agency on Aging and Disability Services
521 W. Main St.
Mitchell, IN 47446
812-849-4457 or 800-333-2451
TDD: 800-473-3333
Fax: 812-849-4467
hoosieruplands.org

AREA 16
SWIRCA & More
16 W. Virginia St.
Evansville, IN 47737-3938
812-464-7800 or 800-253-2188
Fax: 812-464-7843 or 812-464-7811
swirca.org

To contact your local Area Agency on Aging toll-free, call **800-713-9023.**

Centers for Independent Living

accessABILITY
9105 E. 56th Stree Suite 308
Indianapolis, IN 46216
317-926-1660
www.abilityIndiana.org

ATTIC
2735 Wash ngton Avenue
Vincennes, IN 47591
812-886-0575
www. ttlcin.org

Everybody Counts
9111 Broadway Suite A
Broadfield Center
Merrillville, IN 46410
219-769-5055
www.everybodycounts.org

Everybody Counts North
438 Fay tte St.
Hammond, IN 46231
219-937-5055
www.everybodycounts.org

Future Choices, Inc.
309 N High Street
Muncie, IN 47305
765-741-8332
www.futurechoices.org

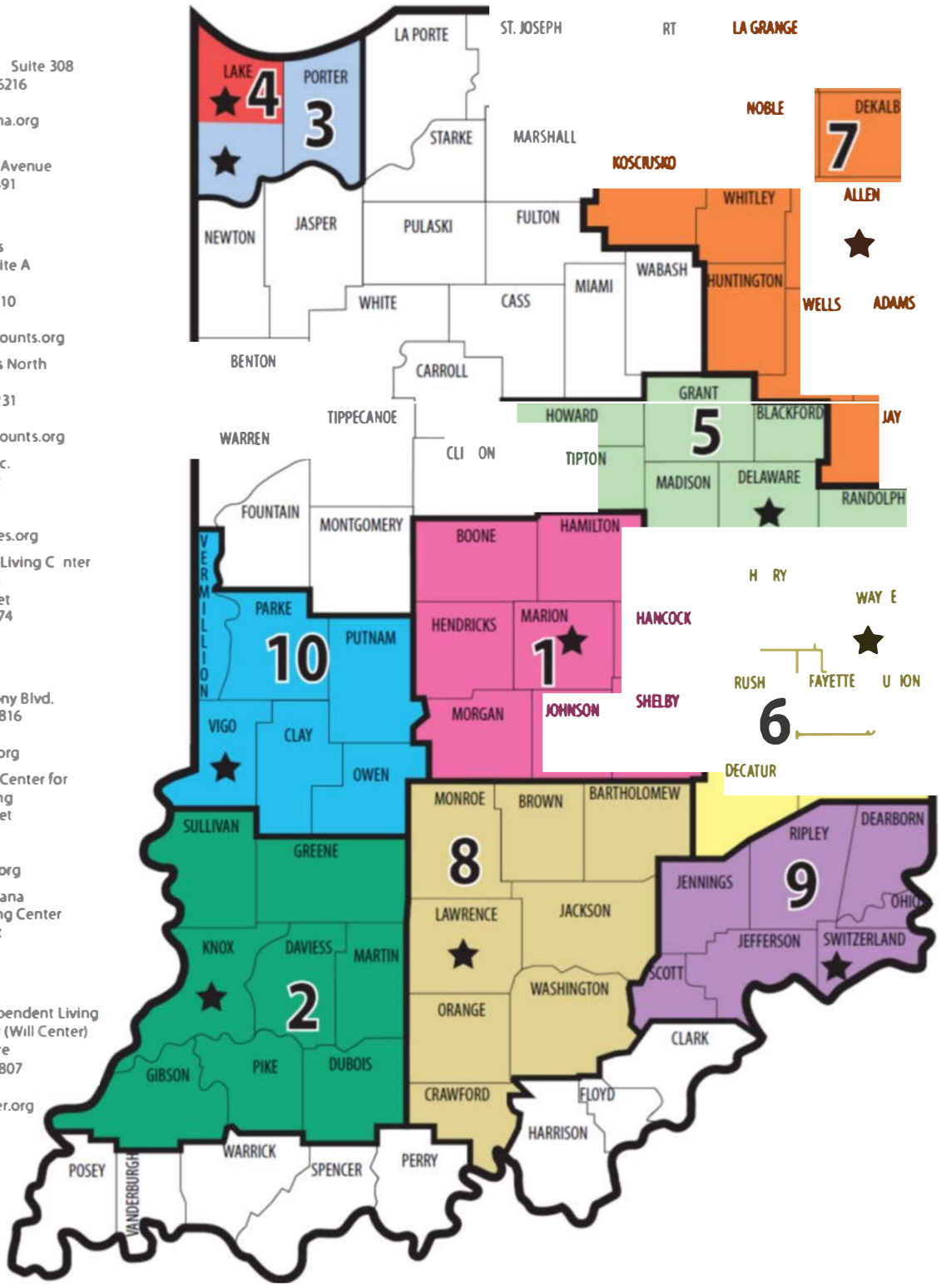
The Independent Living C nter
of Eastern Indiana
1818 W. Main Street
Richmond, IN 47374
765-939-9226
www.ilcein.org

Th League
5821 South Anthony Blvd.
Fort Wayne, IN 46816
260-441-0551
www.the-league.org

Southern Indiana Center for
Independent Living
1490 W. Main Street
Mitchell, I 47446
812-277-9626
www.sicilindiana.org

Southeastern Indiana
Independ nt Living Center
114 W. Ma n Street
Vevay, IN 47043
812-427-3333
www.siilc.org

The Wabash Independent Living
& Learn ng Center (Will Center)
One Dreiser Square
Terre Haute, IN 47807
812-298-9455
www.thewillcenter.org



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Emergency/Disaster Evacuation
Checklist

- ☐ Medications: Pack a two-week supply of all medications ordered by your Doctor
- ☐ Portable Oxygen (if required)
- ☐ Home admit folder including list of medications
- ☐ Important documents: valid photo ID or passport with your current address, health insurance card, house deed insurance papers, legal documents, social security card
- ☐ Non-perishable foods for your special dietary needs
- ☐ Personal hygiene items: deodorant, toothbrush, toothpaste, razors, shaving cream, soap, towel and wet wipes
- ☐ Extra pairs of eyeglasses or contacts, hearing aids, hearing aid batteries and denture needs
- ☐ Extra clothing including: jacket, sleepwear, undergarments, and an extra pair of comfortable shoes or boots
- ☐ Mobility assistance device as needed: wheelchair, walker, cane, etc.
- ☐ Flashlight with batteries
- ☐ Any other necessary medical supplies currently being used
- ☐ Electronic communication devices and their charging cords: phone, tablets, laptop
- ☐ Pet ID tags, portable crate, leash, medication, bowl and food
- ☐ Purse or wallet, cash, credit cards and checkbook

Revised 4/1/2025

SECTION VI. Infection Control at Home

Cleanliness and good hygiene help prevent infection. "Contaminated materials" such as bandages, dressings or surgical gloves can spread infection, and harm the environment. If not disposed of properly, these items can injure trash handlers, family members and others who could come in contact with them.

Certain illnesses and treatments (i.e., chemotherapy, dialysis, AIDS, diabetes, burns) can make people more susceptible to infection. Your nurse will instruct you on the use of protective clothing (gowns/gloves) if they are necessary.

Notify your physician and/or home care staff if you develop any of the following signs and symptoms of infection:

- pain/tenderness/redness or swelling of body part
- Inflamed skin/rash/sores/ulcers
- painful urination
- confusion
- Nausea/vomiting/diarrhea
- fever or chills
- sore throat/cough
- increased tiredness/weakness
- pus (green/yellow drainage)

You can help control infection by following these guidelines:

HANDWASHING

Wash your hands before and after giving any care to the patient (even if wearing gloves), before handling or eating foods, and after using the toilet, changing a diaper, handling soiled linens, touching pets, coughing, sneezing or blowing nose. Handwashing needs to be done frequently and correctly.

Soap and Water Procedure: When hands are visibly dirty or contaminated or soiled with blood or other body fluids, use soap and running water for washing your hands. Remove jewelry; use warm running water and soap (liquid soap is best); place hands together under water; and rub your hands together for at least 20 seconds. Wash all surfaces (wrists, palms, back of hands, between fingers, under fingernails). Clean any dirt from under nails. Rinse soap from hands and dry with a clean towel. Air dry if clean towel is not available or if towel is shared with others. If using paper towel, throw it in the trash after use. Use a paper towel to turn off the faucet. Pat dry to avoid chapping and cracking. Apply hand lotion to help prevent and soothe dry skin.

Waterless Antiseptic Hand Cleanser Procedure: If hands are not visibly dirty or contaminated or soiled with blood or other body fluids, an alcohol-based hand rub may be used for routinely decontaminating hands. The antiseptic agent should contain 60-90% ethyl or isopropyl alcohol. When using a waterless antiseptic hand cleaner, make sure the cap or spout is open. Place a quantity of liquid or gel (about the size of a dime; or use the amount recommended by the product manufacturer) in the palm of one hand; rub hands vigorously, covering all surfaces of hands and fingers, until hands are dry.

Washing your hands is the single most important step in controlling thespread of infection.

DISPOSABLE ITEMS AND EQUIPMENT

Items which are not sharp *including: paper cups, tissues, dressings, soiled bandages, plastic equipment urinary/suction catheters, disposable diapers, Chux, plastic lubing, medical gloves, etc.*

Store medical supplies in a clean/dry area. Dispose of used items in waterproof (plastic) bags. Fasten securely and dispose of bag in the trash.

NON-DISPOSABLE ITEMS AND EQUIPMENT

Items which are not thrown away *including: soiled laundry, dishes, thermometer, commode, walker, wheelchair, bath seat, suction machine, oxygen equipment, mattress, etc.*

Soiled laundry should be washed apart from other household laundry in hot soapy water. Handle these items as little as possible to avoid spreading germs. Household liquid bleach should be added if viral contamination is present (a *1-part bleach to 10-parts* water *solution is recommended).*

Equipment used by the patient should be cleaned immediately after use. Small items (except thermometers) should be washed in hot, soapy water, rinsed and dried with clean towels. Household cleaners such as disinfectant, germicidal liquids or diluted bleach may be used to wipe off equipment. Follow equipment cleaning instructions and ask your nurse/therapist for clarification.

Thermometers should be wiped with alcohol before and after each use. Store in a clean, dry place.

Liquids may be discarded in the toilet and the container cleaned with hot, soapy water, rinsed with boiling water and allowed to dry.

SHARP OBJECTS

Items which are sharp *Including: needles, syringes, lancets, scissors, knives, staples, glass tubes or bottles, IV catheters, razor blades, disposable razors, etc.*

Place used **"sharps"** directly into a clean rigid container with a screw-on or tightly secured lid. Use a hard plastic or metal container. Before discarding a container, reinforce the lid with heavy-duty tape. Never overfill the containers or recap needles once used. **DO NOT use glass** or clear plastic containers and never put "sharps" in containers that will be recycled or returned to a store. Seal the container with tape and place in the trash can or dispose of according to area regulations.

SPILLS IN THE HOME

Blood and other body fluids.

Blood/body fluid spills are cleaned by putting on gloves and wiping fluid with paper towels. Use a cleaning solution of household bleach and water ***(1 cup of bleach to 10 cups of water)*** to wipe the area again. Double bag used paper towels and dispose of in the trash.

UNIVERSAL PRECAUTIONS AND PATIENT RIGHTS

Health care facilities providing services in which there is a risk of skin, eye, mucous membrane or parenteral contact to human blood or other potentially infectious materials must practice universal precautions.

Universal Precautions means the prevention of disease transmission through the use of infection control practices with all patients.

This Agency complies with the infection control practices required by Indiana State Department of Health (ISDH), which were adopted by Indiana law, Indiana Occupational Safety and Health Administration (IOSHA) standards and Centers for Disease Control and Prevention (CDC) recommendations. The following infection control practices include, but are not limited to, those required by the Universal Precautions Rule and are used to prevent transmission of bloodborne pathogens to patients and treating staff:

- Appropriate use of protective barriers, including gloves for hand contact, masks, gowns, laboratory coats and protective eyewear or face shields are used for procedures having the potential of creating a spray or splatter of blood or other potentially infectious materials.
- Gloves, when required, are changed and hands are washed after each patient.
- Heat stable, nondisposable instruments requiring sterilization that are contaminated with blood or other potentially infectious materials are heat sterilized after treatment of each patient.
- Precautions are taken to prevent injuries caused by needles, syringes and other contaminated sharp objects, which are discarded in puncture-resistant containers.
- Surfaces and equipment contaminated with blood or other potentially infectious materials that need not be sterilized are cleaned and disinfected after treatment of each patient. Disposable coverings may be used on some surfaces to prevent contamination.
- infectious waste is placed in containers labeled with the biohazard symbol, impervious to moisture and of sufficient strength to prevent expulsion.
- Containers of infectious waste are stored in a secure area prior to treatment and final disposal.
- Patient care staff receive training on infection control.

The infection control procedures listed, and others that are not readily observable, protect you from disease transmission. Indiana law requires that health care facilities be committed to appropriate use of Universal Precautions. Any deviation from this commitment should be brought to the attention of the Director at this facility. If you are not satisfied with the explanation of Universal Precautions provided by this facility, you may file an official complaint with the Indiana State Department of Health by writing to the following address:

Indiana State Department of Health
c/o Universal Precautions Coordinator
2 North Meridian St.
Indianapolis, IN 46204
(317) 233-7825

SECTION VII. Pain Education

Pain can only be defined by the person who is experiencing it and cannot be verified by someone else. Therefore, your nurse or physician can't help you unless you tell them about your pain. Unrelieved pain can harm you in several ways: it can keep you from sleeping or eating, prevent you from enjoying friends and family, cause loss of function, slow down healing and recovery from illness or surgery and can make you feel afraid or depressed. Your health care provider will work with you to find the right treatment to manage your pain, taking into account personal, cultural and/or ethnic beliefs.

Your report of pain will be believed and acted upon. Your health care provider will ask you to describe and rate your pain, and will instruct you in the use of a pain rating scale. You will be asked to rate the severity of your pain using the scale and also to describe the following elements about your pain:

1. where is it located?
2. when did it start/how long have you had it?
3. does it come and go or is it continuous?
4. what does it feel like-dull, throbbing, burning etc.?
5. what makes it better/worse?
6. how does it affect your day-to-day activities (eating, sleeping, mobility, etc.)?

Taking your medication as ordered by your physician is critical to achieving effective pain management. If you have pain most of the time, medications may be scheduled at regular intervals around the clock to prevent or control pain. You may have more than one medication scheduled at the same time to enhance the effectiveness. Additional, or "breakthrough" doses may be prescribed to take when the scheduled doses do not adequately relieve your pain. If you take a breakthrough dose, be sure to take your regular medications at the prescribed time.

Do not wait until the pain is very severe to take your medication. Trying to "tough it out" will only allow the pain to get worse and it will take much longer to get it under control.

If your pain increases or if your pain medication is no longer effective, report it to your health care provider right away. Some people are reluctant to report pain due to fears about addiction, side effects, or fear of appearing weak. Addiction is extremely rare among people being treated for pain. Using medication for pain relief does not make someone an "addict." All medications have some side effects, but not all people get them. Most occur in the first day or two of treatment and go away in a few days. You will be instructed in ways to prevent or relieve side effects; constipation is the most common one, and there are many treatments available.

There are other methods your health care provider may suggest to enhance pain control, such as massage, relaxation, deep breathing, imagery, and heat or cold. However, these methods are generally used in addition to pain medication and not in place of them. Ask for information about these techniques if you are interested.

Infants and children experience pain as intensely as adults; parents are usually the ones best able to pick up on signs of pain in children too young to speak, such as restlessness, refusal to eat, or rapid breathing.

If the person experiencing pain is an adult who is unable to speak or who has a cognitive impairment, every effort will be made to find a scale that the patient can use to report pain intensity and relief. Non-verbal signs, such as grimacing, withdrawal, restlessness, combativeness, moaning, or holding a body part will also be assessed in these individuals.

It may not always be possible to relieve all pain, but techniques are available to reduce pain to an acceptable level. You can help by learning how to communicate your pain and by taking an active part in your pain management or that of a loved one.

SECTION VIII. On-Call Guidelines

A licensed nurse is on call at our agency at all times. However, we are available after regular office hours for urgent conditions only. We do not carry medications with us and cannot give anything unless ordered by the physician. If you have a change in condition, please contact our office during regular office hours, if possible, so we can determine if a visit needs to be made and communicate with your physician, if necessary.

The following is a list of some reasons for which you may need to contact our agency after regular office hours. This list is not all inclusive.

CHEST PAIN: Chest pain usually requires that you be seen by your physician either in the office or emergency room for diagnostic studies.

TEMPERATURES: Elevations in temperatures above 101.5 should be called in (or according to your plan of care) and instructions may be given over the telephone. A home visit may be necessary.

RESPIRATORY DISTRESS: Severe respiratory distress usually requires evaluation by your physician. You may be instructed in ways to ease shortness of breath, proper use of respiratory aids or oxygen if these are ordered by your physician.

CATHETERS: Catheters are not an emergency unless you are unable to urinate. Usually someone can wait 6-8 hours at night without a catheter if they are not taking in liquids. If the catheter does not drain or comes out and you are unable to urinate, you may need to call. You will be taught to either irrigate or remove the catheter if it becomes stopped up. If it is leaking or comes out, pad yourself well with absorbent cloths and call early in the morning so someone can be scheduled to visit you.

FEEDING TUBES: If the feeding tube comes out partially, do not attempt to reinsert or remove it without a trained caregiver. Call the on-call nurse if necessary.

INTRAVENOUS (IV) LINES: The on-call nurse should be notified if:

- any leakage of fluid from the line or at the place where the line enters the body
- any pain with the flush or during the infusion time
- any problems at the exit site (where the line exits from the body), such as: redness, swelling, pain, drainage (clear and watery, yellow and watery, bloody, pus, etc.)
- line has partially or completely come out of the body
- the dressing over the exit site has come off
- the cap on the end of the line has come off
- the infusion stops before the medication bag is empty

FALLS OR INJURIES: Notify the on-call nurse or call 911.

Routine supplies or equipment cannot be delivered after regular office hours. Any questions you may have concerning these guidelines can be answered by your nurse or by calling the office during regular office hours.

SECTION IX. Consents

As part of the admission process, we ask for your consent to treat you, release information relative to your care, and allow us to collect payments directly from your insurer. You or your legal representative must sign this consent before we can admit you.

CONSENT FOR TREATMENT AND SERVICES - We require your permission before we can treat you. The treatments that we provide will be prescribed by your doctor and carried out by professional health care staff. Without you or your representative's consent, we cannot treat you.

You may refuse treatment at any time. If you decide to refuse treatment, we may ask you for a written statement releasing us from all responsibility resulting from such action.

RELEASE OF INFORMATION - Your medical record is strictly confidential and protected by federal law. We may release protected health information as explained in our Notice of Privacy Practices in order to carry out treatment, payment and/or health care operations. Protected health information may be received or released by various means including telephone, mail, fax, etc. Patient outcome data (OASIS) will be collected and may be electronically transmitted to the State for use by Medicare.

AUTHORIZATION FOR PAYMENT - We will directly bill your insurer for the services which we provide to you. You authorize us to collect payments on your behalf.

CONSENT TO FILM/RECORD - You consent for us to record or film your care, treatment and services and allow us to use the photographs/recordings for internal use (e.g., performance improvement, education), for documenting your medical condition or for insurers to document your condition for payment purposes.

ADVANCE DIRECTIVES - You must tell us if you have an advance directive so that we may obtain a copy to allow us to follow your directives. We will provide you care whether or not you have executed an advance directive, but having an advance directive may have an impact on the type of care provided during emergency situations.

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: _____ HHA: _____

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:* _____