

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: _____

Patient name:
Identification number: (optional)

Notifier name Help at Home
Notifier address 1515 Union Street, Lafayette, IN. 47904
Notifier phone (including TTY) 765-448-6029

Advance Beneficiary Notice of Non-coverage (ABN)

Medicare doesn't pay for everything, even some care you or your health care provider think you need. **We expect Medicare may not pay for the item, test, service or care listed below.** If Medicare doesn't pay, you may have to pay.

Item, test, service or care	Reason Medicare may not pay	Estimated cost

What to do now

- Read this notice to make an informed decision about your care.
- Ask any questions you have.
- Choose one option below to let us know if you still want to get the item, test, service or care.

Choose ONE option below. We can't choose for you.

If you choose Option 1 or 2, we may help you use any other insurance you might have, but Medicare can't require us to do this.

- Option 1: I want the item, test, service or care listed above, and I want Medicare to be billed for an official decision on payment, which I'll get on a Medicare Summary Notice (MSN).** You can ask to be paid now. I understand that if Medicare doesn't pay, I'm responsible to pay, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you'll refund any payments I made to you, minus co-pays or deductibles.
- Option 2: I want the item, test, service or care listed above, but don't bill Medicare.** You can ask to be paid now and I'm responsible to pay. I understand that I can't appeal, since Medicare isn't billed.
- Option 3: I don't want the item, test, service or care listed above.** I understand I'm not responsible for payment and I can't appeal to see if Medicare would pay.

Additional information:

This notice gives our opinion, not an official Medicare decision. For other questions about this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. Signing below means you received and understand this notice. You can ask to get a copy.

Signature	Date (mm/dd/yyyy)
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You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit [Medicare.gov/about-us/accessibility-nondiscrimination-notice](https://www.medicare.gov/about-us/accessibility-nondiscrimination-notice).

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. This information collection is for providers, suppliers, Hospice and Religious Non-medical HealthCare Institutes and Home Health Agencies to notify original Medicare beneficiaries of their potential financial liability under specific conditions. The time required to complete this information collection is estimated to average less than 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, to review and complete the information collection. This information collection is mandatory under Section 1879 of the Social Security Act, 42 CFR 411.404(b) and (c) and 411.408(d)(2) and (f). If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Patient Information Release Form

Date: _____ Medical Record # _____

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

Patient name (printed)

Patient/ Legal Rep Signature

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

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Name: _____

Relationship: _____



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

Client Signature: _____

Date: _____

CLIENT INDIVIDUALIZED EMERGENCY PLAN

RISK LEVEL: High (1) Medium (2) Low (3)

CODE STATUS: Full Code DNR Other _____

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

ADDRESS: _____

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

PRIMARY LANGUAGE: _____ PRIMARY DIAGNOSES: _____

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

Copy of medication list _____ ALLERGIES: _____

INFORMATION OBTAINED FROM: _____

POA/HEALTHCARE REPRESENTATIVE/CAREGIVER

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

EMERGENCY CONTACT(S):

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

PRIMARY PHYSICIAN:

Name: _____ Phone: _____

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

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

FIRE EXTINGUISHER LOCATION _____ SMOKE DETECTOR LOCATION _____

IN THE EVENT OF FIRE, NEAREST EXIT/EVACUATION ROUTE _____

IN THE EVENT OF EMERGENCY EVACUATION: Client will:

Stay at home (Who will provide assistance?) _____

Stay with family/friend: Name and Address: _____

Go to Local Shelter: Address: _____

Go to Preferred Hospital: Name and Address: _____

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

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

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

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

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

CLIENT INDIVIDUALIZED EMERGENCY PLAN

Name: _____ MR#: _____

EMERGENCY PHONE NUMBERS:

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

ITEMS NEEDED FOR EMERGENCY KIT:

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

ACCESS TO GENERATOR? YES/ NO _____

NATIONAL DISASTER RELIEF ASSISTANCE: FEMA (FEDERAL EMERGENCY MANAGEMENT AGENCY)

PHONE 800-621-3362

<https://www.fema.gov/about/contact>

AMERICAN RED CROSS

PHONE 800-733-2767

DISASTER RELIEF & RECOVERY SERVICES: <https://www.redcross.org/get-help/disaster-relief-and-recovery-services/find-an-open-shelter.html>

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

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

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

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



APPOINTMENT OF REPRESENTATIVE AUTHORIZATION

I, _____, appoint Help at Home, LLC to act on my behalf in connection with any Claim pertaining to coverage, benefits or appeals (“Claims”), including receipt of any approval(s) or authorization(s) that may be required as part of this process.

Help at Home, LLC is authorized to receive information related to any disputed Claims, approvals or authorizations including all medical and financial information related to my Claims. This document is not intended to authorize access to any personal health information not related to the disputed Claims, approvals or authorizations.

I understand that any privileged information is confidential and will only be released as specified in this authorization. I will not be charged by Help at Home for actions taken on my behalf related to any Claims.

I understand that I may cancel this authorization at any time by providing written notice to Help at Home.

Member signature

Member ID number (HICN)

Member printed name

Date

Health Plan Name

Client Education: Reporting Other Agencies in the Home

Purpose:

To ensure compliance with Medicaid regulations and prevent duplicate billing or overlapping care.

Important Information for Clients and Families:

Our agency is committed to providing safe, compliant, and high-quality care. It is very important that you notify our agency immediately if:

- You are receiving services from another home care agency, nurse, or caregiver at the same time.
- Another company or provider begins coming into your home for care or support services.

Having more than one agency providing Medicaid-funded services at the same time can cause duplicate billing, which is considered Medicaid fraud. Notifying us right away helps protect your care, your eligibility, and ensures all services remain compliant with Medicaid requirements.

If you have any questions or changes in your services, please contact our office immediately.

Client Acknowledgment:

I have read and understand the above education. I agree to notify the agency if any other provider or caregiver begins providing services in my home.

Client/Responsible Party Name: _____

Signature: _____ Date: _____

Staff Name (if applicable): _____

Signature: _____ Date: _____