CONSUMER CARE MANUAL

PRESTIGE
HOME CARE AGENCY

OFFICE INFORAMTION:

2884 Industrial Blvd. Suite 21 Bethel Park, PA 15102

Office Phone: (412) 347 – 0077 | Office Fax: (412) 219 – 5024

Office Email: contact@phcareagency.com | Web: https://phcareagency.com

HOURS OF OPERATIONS:

Monday – Friday: 9:00 am to 5:00 pm exclude Federal Holidays

Saturday and Sunday: CLOSED

Prestige Home Care Agency, LLC

Consumer Care Manual v2.0 – 01-01-2024

Welcome Letter

Dear Consumer,

On behalf of the entire *Prestige Home Care Agency* team, I would like to welcome you as a new consumer. We are thrilled to have you with us.

At *Prestige Home Care Agency*, we pride ourselves on offering our customers responsive, competent, and excellent service. Our customers are the most important part of our business, and we work tirelessly to ensure your complete satisfaction, now and for long as you are a customer. I am also happy to inform you that I will be your primary point of contact at the company, and I encourage you to contact me at any time with your questions, comments, and feedback. I can be reached during regular business hours in the following ways:

Phone number: (412) 347 – 0077 ext. 1001

Email: dkafley@phcareagency.com

Instant Message: (412) 347 – 0077

Thank you again for trusting PRESTIGE HOME CARE AGENCY with your most important personal assistance needs. We are honored to serve you.

Thank you.

Your Sincerely,

Dambar Kafley, President

2884 Industrial Blvd. Suite 21 Bethel Park, PA 15102

Office Phone: (412) 347 – 0077

Office Email: contact@phcareagency.com

PREFACE

We are pleased to present **PRESTIGE HOME CARE AGENCY**'s **CONSUMER CARE MANUAL** to our valued consumers. The Manual outlines our consumers and employees of the policies and practices that govern and guide the provision of service at our Agency.

This manual shall be available at all times for review by consumers and their designated representatives, employees, and potential applicants for home care services. A copy of this manual will be provided to the consumer at the time of admission.

President

Dambar Kafley, President

2884 Industrial Blvd. Suite 21 Bethel Park, PA 15102

Office Phone: (412) 347 – 0077

Office Email: contact@phcareagency.com

Website: https://phcareagency.com/

Note: We are licensed by the PA Department of Health to provide Home Care services to consumers in Allegheny, Beaver, Butler, Washington, and Westmoreland counties. Our licensure information can be checked at http://www.health.pa.gov/topics/facilities/Pages/Facilities-Licensing.aspx and compliance information can be verified with:

PA Dept. of Health
Quality Assurance
625 Forster Street, 8th Floor West, Health & Welfare Building
Harrisburg, PA 17120-0701
Phone 717-783-1078. Fax 717-525-5506. Email: RA-DHDEPSECQA@PA.GOV

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1. NON-DISCRIMINATION POLICY

Prestige Home Care Agency LLC is an equal opportunity company and it does not exclude, deny benefits to, or otherwise discriminate against any person on the grounds of race, color, or national origin or on the basis of disability , age or sexual orientation, in admission to, participation in or receipt of the services and benefits of any of its programs and activities, making referrals for services or in any kind of employment action, whether carried out by this Agency directly or through a contractor of any other entity with whom the Agency arranges to carry out its programs and activities.

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

AMERICANS WITH DISABILITIES ACT

Our company is also committed to follow the Americans with Disabilities Act as it relates to providing reasonable accommodations to consumers and employees, where appropriate. We ask you to notify us of your disability and we will take every reasonable measure to make sure your needs are accommodated, and you are not discriminated in any way, unless making such an accommodation puts undue hardship on the Agency.

In case of questions concerning this policy, or in the event of a desire to file a complaint alleging violations of the above, please let our office know immediately.

Complaints of Discrimination may also be made to the following agencies:

a. The Bureau of Equal Opportunity

P.O. Box 2675
Health and Welfare Building Harrisburg, Room 223 PA 17105-2675
(717) 787-1127 (VOICE)
(717) 772-4366 412-881-7125
TrY: 1-800-654-5484

b. The Pennsylvania Human Relations Commission

PA Human Relations Commission
301 Chestnut Street, Suite 300 Harrisburg, PA 17101-1702

(717) 787-4410
(717) 787-4087 TfY users only

https://www.phrc.pa.gov/File-A-Complaint/ComplaintForms/Pages/default.aspx

c. The Pennsylvania Department of Health

301 Chestnut Street, Suite 300

Harrisburg, PA 17101 -2702 (717) 787-4410
(717) 787-4087 TfY users only Email: phrc@state.pa.us

Web: www.phrc.state.pa.us

2. CONSUMNER COMPLAINT MANAGEMENT

Consumer Complaints

Consumer complaints are a very important source of feedback to the Agency. They should be received and resolved in a respectful and timely manner. The Agency's policy with regards to consumer complaints is as follows:

1. The consumer or their representative will have the opportunity to voice grievances and recommend changes in Agency's services and/or policies without fear of discrimination, coercion, reprisal, or unreasonable interruption of services.

2. Consumer or their representative can submit the complaint either verbally or in writing to the Agency Manager or Supervisor.

3. The Agency Manager or Supervisor designee shall contact the consumer or their representative and will make every effort to resolve the complaint to their satisfaction. They will document all activities involved with the grievance/complaint/concern, investigation, analysis and resolution.

4. Consumer will be notified of the Agency Manager's decision within ten (10) business days.

5. If the complaint cannot be resolved to your satisfaction, the consumer may request that the Agency Manager escalate their complaint to the Agency's Governing Body.

6. Agency shall advise the consumer that they may lodge complaints with the State of Pennsylvania Department of Health hotline number 1-800-254-5164 24 hours per day.

Complaint Management

1. The Agency shall receive the complaint and record it in a log. As the complaint is managed, additional entries with regards to it shall be entered on the log. The log must contain the following information:

   a) The name of the participant.

   b) The nature of the complaint.

   c) The date of the complaint.

   d) The provider's actions to resolve the complaint.

   e) The participant's satisfaction to the resolution of the complaint.

2. The Agency shall review the complaint system at least quarterly to:

   a) Analyze the number of complaints resolved to the participant's satisfaction.

   b) Analyze the number of complaints not resolved to the participant's satisfaction.

   c) Measure the number of complaints referred to the Department for resolution.

3. The Agency shall develop a QMP when the numbers of complaints resolved to a participant's satisfaction are less than the number of complaints not resolved to a participant's satisfaction

Please be advised that you may lodge complaints with the State of Pennsylvania Department of Health by calling their hotline number 1-800-254-5164.

Dambar Kafley, President

2884 Industrial Blvd. Suite 21 Bethel Park, PA 15102

Office contact info: (412) 347 – 0077 | contact@phcareagency.com

3. CONSUMER RIGHT AND RESPONSIBILITY

Consumers Rights, Complaints and Grievance:

1. To be involved in the service planning process and to receive services with reasonable accommodation of individual needs and preferences, except where the health and safety of the direct care worker is at risk.

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

3. To have his/her property and person treated with respect, consideration and recognition of consumer dignity and individually.

4. To receive at least 10 Calendar days, advance written notice of the intent of the home care agency or home care registry to terminate services. Less than 10 days advance written notice may be provided in the event the consumer has failed to pay for services, despite notice, and the consumer is more than 14 days in arrears, or if the health and welfare of the direct care worker is at risk.

5. To expect confidentiality of the access to medical records according to HIPAA, Federal and State requirements.

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

    a. Payment may be expected from any federally funded or aided program known to the organization.

    b. Charges for services that will not be covered by payers.

    c. Charges that the individual may have to pay.

7. To be able to identify visiting staff members through proper identification.

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

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

10. To be free of physical and mental abuse, neglect and exploitation of any kind including in the hands of employees, volunteers and contractors.

11. To voice grievances regarding care, company policies, and staff, without restraint, interference, coercion, discrimination, or reprisal and to know that grievances will be resolved, and the consumer notified of its resolution within 10 days.

12. To be advised of the toll-free home care agency hot-line for the State of Pennsylvania and the purpose of the hotline to receive complaints or questions about the organization. The State of Pennsylvania Home Care Hotline is 1-800-254-5164. The number is operated 8AM to 5PM daily to receive complaints or ask questions about Home Care Agencies. You may also register complaints in writing to:

Division of Nursing Care Facilities Department of Health
Room 526 Health and Welfare Building 625 Forster Street

Harrisburg, PA 17120-0701

13. To be provided with information of the PA Office of LTC Ombudsman Program, PA Department of Aging is at 717-783-8975 and the information of your local ombudsman program by county (**See attached ombudsman_program.pdf file**).

14. To be informed of the toll-free child abuse hot-line 1-800-932-0313 used to report abuse, neglect or exploitation and 1-800-490-8505 used to report abuse, neglect or exploitation of adults.

15. To receive a return call from the Agency within 24 hours of the consumer's call to the Agency that went unanswered.

Consumer's Responsibility:

1. To provide, to the best of his/her knowledge, accurate and complete information about:

    a. Past and present medical histories.

    b. Unexpected changes in his/her condition.

c. Whether he/she understands a course of action selected.

2. To ensure the financial obligations of his/her health care are fulfilled as promptly as possible, including paying for care not covered by 3rd party.
3. To respect the rights of all staff providing service.
4. To truthfully certify the timecard of your caregivers.
5. To notify the agency promptly in advance of an appointment or visit you must cancel.
6. To become independent in care to the extent possible, utilizing self, family and other sources.
7. To comply with the rules and regulations established by the agency and any change thereof.

4. SCOPE OF SERVICE

Prestige Home Care Agency LLC will provide high quality home care services to its consumers at the comfort of their own homes. The agency provides non-medical home care services including but not limited to:

Personal Assistance Services

Respite Care

5. HOUR OF WORK

Consumer Care Services will be provided to consumers 24 hours a day, 7 days a week without regard to holidays. Administrative office hours will be 10 AM to 4 PM Monday through Friday.

6. COST OF SERVICE

The Agency accepts different payer sources for the services it provides, including Medicaid, Medicare, private insurance, and private pay.

1. Private Pay:

   The Agency's current applicable charges for private services are as follows:

Personal Assistance Services	$35/hour
Respite Care	$35/hour

These rates are subject to change at any time. We will provide you a minimum of 30 days' notice if a proposed rate change affects you.

2. MCOs:

   The Agency accepts negotiated reimbursement rates from MCOs that may be different from the above rates. If you qualify for the PA Medicaid Waiver Program for Home and Community-Based Services, your payments and billings will be processed directly by your chosen Managed Care Organization, including UPMC, PA Health & Wellness, and/or AmeriHealth Caritas.

   If you do not meet the eligibility criteria for the PA Medicaid Waiver Program for Home and Community-Based Services (HCBS), the agency will inform you of an automatic termination from all LTSS services provided. Nevertheless, if you wish to continue receiving services from the agency, you can opt for either Private Pay or utilize Private Insurance. If this is your preference, please reach out to the agency at your earliest convenience. For more information, refer to *Termination of Services.*

3. Private Insurance:

   The Agency accepts negotiated reimbursement rates from Private Insurance Companies (Restrictions may apply)[1] that may be different from the above rates.

[1] Restrictions may apply

7. DIRECT CARE WORKER STATUS

The Agency hires and employees competent and trained Direct Care Workers that come to your homes to provide services to you. The following applies to all DCW's assigned to your care:

1. DCW are employees of PRESTIGE HOME CARE AGENCY LLC and their wages and benefits, including applicable federal, state, and local taxes are the responsibility of the company. You DO NOT owe anything to the DCW for services provided according to the Plan of Care agreed with us.

2. DCW's assigned to you will identify themselves as employees of the Agency. You should call the Agency's office immediately if you have doubts about their identity and they refuse to show their employee badges to you.

[1] Contract and Credentialing may be required prior to enrolling.

3. DCW's assigned to your care are competent and trained to provide the care agreed upon with you. They meet the requirements of Title 28, Regulation 611.55 **Competency Requirement** and are tested for the same. Additionally, they undergo regular in-house trainings to keep themselves abreast with new development and care standards. Additionally,

    a. Individuals working for the agency must furnish proof of certification as required by law, policy or standards of practice.

    b. The agency has a hiring and training program that allows for objective, measurable, assessment of the person's ability to perform required activities.

    c. All new employees will be assessed for competency based on the expected requirements for the position before providing independent consumer services. The qualifications for the positions will be identified in the position description given at the time of hire. Resumes and reference checks will verify the education and professional experience of each individual prior to accepting the position with the agency.

    d. Each home service worker will demonstrate competency to perform tasks prior to providing care in the home setting. Competency evaluations will be completed by individuals who have the knowledge and skills to assess performance and ability.

    e. All competencies will be documented, and actions will be taken when opportunities for improvement are identified. When improvement activities determine that person with performance problem is unable and/or unwilling to improve, the agency will modify job assignments or take other appropriate actions.

    f. Home service workers will be assigned to you based on the training and demonstrated competencies that matches the services listed on your individual service plan.

    g. Home service worker are re-evaluated when a new task is assigned and at least yearly to ensure ongoing competency.

4. You are required to sign and return the attached *PA Consumer Notice of Direct Care Worker Status* form to us.

8. PLAN OF CARE

Upon admission, after a thorough review of the intake questionnaire and interviews with the Consumer and their representative, a Plan of Care is prepared. The following applies to the Plan of Care:

1. The consumer has the right to be involved in the service planning process and to receive services with reasonable accommodation of individual needs and preferences, except where the health and safety of the direct care worker is at risk.

2. Plan of Care will outline the different services assessed to be provided to the consumer, in as much detail as possible. It should also spell out the Diagnosis, Functional limitations if any, Assistive Devices used/required, Frequency of visits, and Goals, among other things.

3. If the Plan of Care is already approved under a funded program, for instance under PA CHC Waiver, the Agency will review the approved Plan of Care with the Consumer and their representative and adopt it. The Agency will function within the boundaries set by the authorization provided to it by the MCO's and Service Co-ordinating Agency under the approved plan. Apart from changes in timing of different activities as appropriate, no other change is required.

   If the consumer requests a change in their Plan of Care, the Agency will contact the MCO's and/or Service Co-ordinating Agency and inform them about the request.

   If the Agency comes to the conclusion at any time that the Plan of Care approved by the funded program is inadequate or inappropriate, it will, after seeking the consumer's approval, communicate with the MCO's and/or Service Co-ordinating Agency about the need for change in the Plan of Care.

4. DCW's are instructed to follow the Plan of Care strictly. Any change should be pre- approved by the supervisor.

9. TERMINATION OF SERVICES

Prestige Home Care Agency LLC will try our best to provide you with uninterrupted care at all times. However, there may be instances when we'll have to terminate your services.

Termination of services may happen when we are unable to take care of your specific needs and circumstances, in which case we'll refer you to a provider who can take care of your requirements. Termination can also happen if we are forced to close operations on our facilities because of reasons beyond our control or for business reasons. Again, we will try hard to transition your care to other providers. Your care can also be stopped if you fail to pay for the services per our agreement.

Under state law, you have the right to receive at least 10 calendar days advance written notice of our intent to terminate services. Less than 10 days advance written notice may be provided in the event the consumer has failed to pay for services, despite notice, and the consumer is more than 14 days in arrears, or if the health and welfare of the direct care worker is at risk.

10. USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. It is the policy of the Agency to securely store all consumer records and limit access to only those people who are required and permitted to have access to those records. Consumer information can only be accessed, used, or disclosed for a legitimate healthcare or business need or with a proper consumer authorization. One may only access the minimum amount of information necessary to do their job.
2. Staff members are not permitted to access consumer information of their family members (including spouse, children, and relatives) and friends.
3. The consumer or their designee has the right to access, inspect, and obtain copies of the information contained in their record.
4. The Agency will obtain written consent from all consumers that Agency admits for service for the lawful use of the consumers protect health information. The consent will be obtained prior to using or disclosing Protected Health Information to carry out services, payments, or health care operations.
5. If the consent cannot be obtained prior to treatment due to communication barriers or emergency situations, it will be obtained as soon as possible. Reasons why it is not signed must be documented.

6. The signed consent gives permission to the agency and its business associates to use and disclose consumer's Protected Health Information only for the purposes of services/payment operations.

7. The signed consent is effective indefinitely or until/unless it is revoked in writing by the consumer.

8. Agency will agree to the consumer request for restrictions on the use and disclosure of their health information if it is reasonable and deemed to be in the consumer's best interest.

11. CONSUMER FINANCE

1. The agency and its employees may not accept powers of attorney or guardianship from consumers for any purpose.

2. The agency must provide a consumer with receipts for all transactions and purchases paid with the consumer's funds. When receipts are not available, the transaction or purchase must be documented.

3. The Agency specifically prohibits its consumers from endorsing a check or other financial instruments over to the Agency. Agency staff will face disciplinary action, including up to termination from employment if they are found to be in violation of this policy.

4. Agency staff may not borrow a consumer's property, nor in any way convert a consumer's property to the agency's possession, except in payment of a fee at the fair market value of the property. Agency personnel are encouraged to exercise care when handling consumer property and to obtain consumer approval when using any property belonging to the consumer.

5. Gifts and Donations: The agency and its employees may accept bona fide gifts of minimal value (under $20), donations, or bequests made to the agency that are exempt from income tax under section 501(c) of the Internal Revenue Code of 1986.

12. EMERGENCY PLAN

It is the policy of Prestige Home Care Agency staff to implement emergency action for patients in critical situations in their homes, as appropriate. Office hours are 9:00 a.m. – 5:00 p.m. Monday through Friday except holidays, but services are offered 24 hours a day, 7 days a week.

Purpose:

- To alleviate life-threatening situations for the patient.
- To stabilize the patient condition, as able.
- To ensure patient safety.

Procedure:

1. At the time of patient admission to the agency, the patient and family members are given detailed instruction by agency staff regarding procedures for emergency action in the absence of caregiver.
2. General provision of services:
    A. The agency's services are available 24 hours a day/7 day a week with regular visits provided based on patient family need and physician orders.
    B. Calls coming in after hours will be forwarded to one of our office staff. The staff will respond by telephone call.
    C. Emergent needs out of the scope of home care agency are referred to the attending physician and emergency management personnel.
3. In the event of a medical emergency during a caregiver visit, the caregiver may take the following actions:
    A. Contact Emergency Management Personnel by dialing 911.
    B. Continue to monitor the patient until help arrives.
    C. Report agency.

4. In the event of a behavioral emergency during a caregiving time, the caregiver may take the following actions:

    A. Assess the situation.

    i. If the situation is life-threatening for the patient, immediately contact Emergency Management Personnel by dialing 911.

    ii. If the situation is not life-threatening, talk to the patient and attempt to stabilize and/or calm him/her down.

    B. Contact agency for further direction.

    C. Continue to monitor the patient until help arrives.

5. Once the emergency situation has been resolved, the caregiver is to immediately notify the patient's family member or legal representative.

13. LIMITED ENGLISH PROFICIENCY POLICY

Purpose:

To ensure that individuals with limited English proficiency have meaningful access to services and information provided by our organization.

Policy:

1. Our organization will take appropriate steps to ensure that individuals with limited English proficiency can effectively communicate with us and receive our services.
2. We will provide language assistance services, such as interpreters and translated materials, to individuals with limited English proficiency at no cost to them.
3. We will provide training to our staff to ensure that they are able to communicate effectively with individuals with limited English proficiency.
4. We will make our translated materials, such as brochures and forms, available on our website and in our offices.

5. We will post notices in prominent locations in our office informing individuals with limited English proficiency of the availability of language assistance services.
6. We will keep records of the requests for language assistance services and the type of services provided.
7. We will review and update this policy on an annual basis to ensure that it continues to meet the needs of individuals with limited English proficiency.

Implementation:

1. Identify and assess the language needs of our limited English proficient population.
2. Develop and implement a language assistance plan that addresses the identified language needs.
3. Provide training to our staff on the provision of language assistance services.
4. Make translated materials available to our limited English proficient population.
5. Monitor and evaluate the effectiveness of our language assistance services and make necessary improvements.

***Policy revised and approved by the Ethics Committee on 12/01/2023 ***

14. SIGNATORY FORMS

The forms are attached below. Please refer the specific form as needed.

1. Acknowledgement of Consumer Care Manual
2. Authorization For Use and Disclosure of Protected Health Information.
3. PA Consumer Notice of Direct Care Worker Status
4. Home Safety Assessment
5. Direct Care Worker Care Plan
6. Intake Information Form
7. Report of Changes

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.

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.

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

- 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 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. 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 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 HHAs;
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 Assessment Information 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 System of Records: Call 1-800-MEDICARE, toll free, for assistance in contacting the HHA System Manager. TTY for the hearing and speech impaired: 1-877-486-2048

Receipt and Acknowledgement of Consumer Care Manual

I _____ (Consumer Name), hereby affirm that I have received a copy of *Prestige Home Care Agency LLC's* CONSUMER CARE MANUAL. I understand and agree, as a condition of my admission as a consumer of the Agency, that I'm entitled to the *Consumer Rights* and bound to the *Consumer Responsibilities* enumerated in this Manual.

The management of *Prestige Home Care Agency LLC* has oriented me to all of its policies and procedures and has provided me with all the signatory documents necessary.

I or my representative were involved in the Service Planning process and I agree that the finalized Plan of Care is the best care plan for me at this time. I understand that my Plan of Care may be revised by my Service Coordinator/MCOs, at any time and the Agency will work with me to adjust my Care Plan accordingly.

The Agency and I have mutually worked out hours of service that would be provided to me. I have been provided with information about cost of services that would be provided to me and the timing and manner in which services will be billed to me (if services are not funded by under a Government Program or paid for by a third party). I also understand the terms under which my services may be terminated by the Agency and I agree to those terms.

[____] (Initials) I, the undersigned, hereby acknowledge and understand that this manual has been interpreted for me by the agency, and I have been given the opportunity to use my own representative as an interpreter.

[____] (Initials) By signing this document, I agree to the following:

- I have received and reviewed the Consumer Care Manual.
- The contents of the manual have been explained to me through interpretation.
- I had the opportunity to use my own interpreter if I preferred.

Consumer Signature: _____ Date: _____

Name: _____ Relationship: _____

Consumer's Representative Signature: _____ Date: _____

---------- **Agency Use Only** ----------

Staff Name and Title: _____ _____

Staff Signature _____ Date: _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

You may decline to sign this Authorization

I, _____ (Consumer / Consumer's Representative Name), hereby authorize *Prestige Home Care Agency, LLC* (hereafter collectively referred to as "Agency") to use and disclose in any form or format, a copy of records concerning _____ (Consumer Name) but only as follows. A copy of this signed, dated Authorization shall be as effective as the original.

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

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

_____ HIV records (including HIV test results) and sexually transmissible diseases
_____ Alcohol and substance abuse diagnosis and treatment records
_____ Psychotherapy records
_____ Other: Specify: _____

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

Consumer Signature: _____ Date: _____
OR
Consumer's Representative Signature: _____ Date: _____

Name: _____ Relationship: _____

---------- **Agency Use Only** ----------

Staff Name and Title: _____ _____

Staff Signature _____ Date: _____

PA Consumer Notice of Direct Care Worker Status

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

I _____ understand that:
(Consumer Name)

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

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

_____ (Initials) I have been informed that the Agency (Check one of the boxes):

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

Consumer Signature: _____Date: _____

Staff Name and Title: _____ _____

Staff Signature _____ Date: _____

Persons with a disability who require an alternative format of this Notice (for example, large print, audiotape, Braille) should contact Janice Staloski, Director, Bureau of Community Program Licensure and Certification, 132 Kline Plaza, Suite A, Harrisburg, PA 17104, (717) 783-8665, or for speech and/or hearing-impaired persons V/TT (717) 783-6514, or the Pennsylvania AT&T Relay Services at (800) 654-5984. EVERETTE JAMES, Secretary

[**Pa.B. Doc. No. 10-234. Filed for public inspection February 5, 2010, 9:00 a.m.**]

Consumer Freedom of Choice

Participant Name (Last, First, Middle): _____

Address: _____

Before you choose who will be providing your home and community-based services, please be advised of the following information:

1. *You may decide who will provide the services listed in your Individual Service Plan as long as they are an enrolled provider and are qualified to provide those services.*
2. *You may talk to or interview providers before making your choice of providers. This can be a long process and may result in a delay of services.*
3. *You will not be forced to choose a particular provider.*
4. *You can decide on a different provider for each service.*
5. *You may choose more than one service provider to provide a service.*
6. *You can self-direct certain services depending on your waiver.*
7. *You can change your mind about who provides your services, including PAS Agency, at any time by telling your current Service Coordinator.*
8. *If there are issues you have been unable to resolve or it would be difficult discussing them with your Service Coordinator, you may call the OLTL Participant Helpline at 1-800-757-5042. There is no charge for calling this number.*

Please acknowledge the following statements by checking each box and signing at the bottom of the form:

□ I understand my rights to choose my provider(s) and my responsibilities in making those choices.

□ I understand that I may talk to someone from any service provider before making my decision in selecting a provider.

□ I have freely chosen the provider for each service listed in my Individual Service Plan on the back of this form.

□ I have made these choices without being pressured or forced.

□ I have been involved in developing my Individual Service Plan.

□ I understand if I have concerns or complaints about my services that I should contact office at 412-347-0077

Service Provider Choice Form

Service	**Provider**	**Rank**

If you have someone who is helping you or supporting with this discussion, please ask that person to sign to show that they have taken part by helping you.

_____ _____

Participant Signature Today's Date

_____ _____

Representative Signature (Paticipant) Today's Date

_____ _____

Agency Representative Signature Today's Date

PENNSYLVANIA LAWS REQUIRES CERTAIN PARTICIPANT NOTICES REGARDING SERVICES AND DIRECT CARE WORKERS PRIOR TO HOME CARE AGENCIES PROVIDING SERVICES TO PARTICIPANTS. PLEASE MAKE SURE TO REVIEW PROVIDER'S NEW WELCOME PACKAGE FOR SUCH PARTICIPANT NOTICES.

The following information has been provided to and/or discussed with the Patient:

_____Welcome Letter
_____Consumers Rights & Responsibilities
___Complaint and Grievance
___Ombudsman Program
_____Cost of Service
_____Termination of Service
_____Consumer Finance
_____Confidentiality of Patient Information (PHI)
_____Contact Information
_____Participant Notice of Direct Care Worker Status
_____Emergency Planning
_____Non-Discrimination Policy
_____Hours of Operation
_____Hiring or Rostering of Direct Care Workers
_____Advance Directives
_____Freedom of Choice
_____Limited English Proficiency Policy
_____Plan of Care

Documentation & Information: I acknowledge that the information and documentation as noted above has been discussed with me and I will be provided with a copy.

Monitoring and Follow-up: I understand that my service requests/needs will be reviewed by the Supervisor at least every (60) days, or as needed, and that the service(s) may be changed according to my needs, wants or wishes.

☐ I acknowledge receipt of the information noted above:
☐ Patient's Signature Date
☐ Patient's Representative's Signature Date
☐ Print Patient Representative's Name & Relationship ☐ Supervisor Signature Date

In Witness Whereof, the parties hereto have executed this Agreement on the date first above written.

PRESTIGE HOME CARE AGENCY LLC. **CLIENT**

_____ _____
Print Name Print Name Client or *Authorize Person*

_____ _____
Title Signature of *Client or Authorized Person*

_____ _____
Signature Phone

REPORT OF CHANGES

Consumer Name: _____ DOB: _____

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

Report the following changes to the Supervisor (List): _____

_____

The consumer or legal representative participated in development of the care plan. ☐ Yes ☐ No

If No, Explain: _____

The care plan was discussed with the discipline(s) that will be providing care. ☐ Yes ☐ No

If No, Explain: _____