



MEMBER RIGHTS

1. As the patient, you have the Right to be fully informed in advanced about the care/service(s) being provided. This includes disciplines that furnish care and the frequency of visits, as well as any modification to the plan of care.
2. You have the right to be informed both orally and written; in advance about the cost of care (Services selected). Including payments for services expected from a Third Party and any changes for which you will be responsible for.
3. You have the right to receive information about the care/services covered under Medicaid Home Health Benefits' or Private Pay non-medical guidelines.
4. You have the right to receive the information about the scope of services that the HHA/Caregiver will provide and specific limitations on the services being provided.
5. You have the right to participate in the development and periodic revision of the care plan.
6. You have the right to refuse care/treatment after you have been fully informed of the consequences presented, after terminating the Service Agreement signed on the "Effective Date".
7. You have the right to be fully informed of Your "patient rights" under State Law to formulate an Advanced Directive.
8. You have the right to be fully informed on one's property and persons' being treated with respect, consideration and recognition of patient dignity and individuality.
9. Your Family/Responsible Party/Legal Representative have the rights to exercise their judgment on deeming you the patient/care recipient as incompetent.
10. You have the right to identify or ask for identification of visiting personnel members staffed through Prestige Home Care Agency, LLC.
11. You have the right to be free from mistreatment, neglect, and or verbal, mental, physical, and sexual abuse. Including injuries of unknown source and misappropriation of patient property.
12. You have the right to voice grievances and complaints regarding treatment/care, that is (or fails to be) furnished, or lacks a respect of property. (This will be investigated as known to our company policy, it is not tolerated)
13. You have the right to voice grievances'/complaints regarding treatment or care, recommend changes in policies, personnel, or care/services without restraint, interference, coercion, discrimination or reprisal (fear of counterattack)
14. You have the right of confidentiality and privacy of all information contained in the patient record and of Protected Health Information.
15. You have the right to be advised on Prestige Home Care Agency, LLC, policies and procedures regarding the disclosures of clinical records.
16. You have the right to choose a health care provider, including the right to choose an attending physician.
17. You have the right to receive the appropriate care without discrimination in accordance with physician orders.
18. You have the right to be fully informed of any financial benefits when referred to an organization.
19. You have the right to be fully informed of your responsibilities as the care/recipient.



20. You have the right to be informed of your patient rights regarding the collection and reporting of OASIS information.
21. You have the right to be informed that OASIS Information will not be disclosed, except for legitimate purposes; allowed by the privacy act. (That is if this information is applicable)
22. You have the right be informed on the anticipated outcomes of care/treatment services and of any barriers in outcome achievement.
23. You as the patient have the right to be informed that you Family/Responsible Party/Legal Representative may exercise their rights when you the patient have been judged incompetent. This right includes choosing a health care provider, including choosing an attending Physician. Having the right to be fully informed of anticipated outcomes of care/treatment, any barriers in outcome achievement. Having the right to be informed of any financial benefits when referred out to an organization; and also having the right to be informed of any financial obligations listed in the Service agreement.

I have read and acknowledged my rights.

Full Name	Signature	Date
Member:		
Witness:		

AGENCY USE ONLY	
Supervisor Name: _____	
Supervisor Signature: _____	Date: ____/____/____