

Acknowledgement of Consumer Care Manual

I _____, 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 with regards to, among others, Non-discrimination and ADA, Civil Rights, Consumer Complaint Management, Recruitment, competency, and status of direct care workers, and provision of service to Consumers.

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 at that time.

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.

Consumer Signature: _____ Date: _____

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

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