A CARING LIFE HOME HEALTH INC.
35 E 10th Street, Suite H Tracy ,CA 95376
Tel. 209 205 9469 Fax 209 205 9523

Patient:____________________ **DOB:**________________ **MR#** __________

POC Physician:____________________ PH#:________________

POC Physician verified by agency/date: ____________________

Consent to treatment: I consent and authorize this agency; its agents/associates to provide care and treatment to/for me. I have been fully informed of the assessment and evaluation of my home health needs and the risk of declining these services if I may choose to do so. I accept the proposed plan of care in accordance with the orders of my physician. I understand that my treatment plan may change and if so, this will be discussed with me in advance of the treatment. I further understand that I and/or my family/caregiver will receive instructions to assist with my care and that my care will therefore become my responsibility in the absence of agency staff. I understand that the agency will provide supervision for all services rendered to me. I understand that I have the right to refuse care or treatment at any time and revoke this consent in writing at any time. I consent to medical photography, if needed and appropriate, during the course of my care.

Release of Information: I consent to the release or receipt of information contained in my home health clinical record to healthcare providers involved in my care, 3rd party payers involved in my care, utilization review and professional standards review organizations, regulatory review entities and any other organization or company that may assist me in my home health needs. I consent to the use or disclosure of my protected health in'ormation for the purpose of treatment, payment, or healthcare operations. I acknowledge that I may request restrictions or revoke this consent.

HIPAA: We honor all rights of patient privacy and HIPAA guidelines. I hereby allow A Caring Life Home Health Inc. to provide my health information to include changes in the plan of care to the personal, legal or other representatives named below:

Name:____________________ Relationship:________________ Ph:____________

Notice of Services Provided and Rates: Home Health Services available from the agency include the following (check all that apply):

Services	Expected Frequency and Duration		
Skilled Nursing (SN)	☐ Evaluation	☐ Treatment	$ 300 assessment & $250 per visit
Physical Therapy (PT)	☐ Evaluation	☐ Treatment	$ 300 assessment & visit
Occupational Therapy (OT)	☐ Evaluation	☐ Treatment	$ 300 assessment & visit
Speech Therapy (ST)	☐ Evaluation	☐ Treatment	$ 300 assessment & visit
Medical Social Worker (MSW)	☐ Evaluation	☐ Treatment	$ 300 assessment & visit
Home Health Aide (HHA)	☐ Evaluation	☐ Treatment	$ 100 per visit
High Tech Cases			$ 300 assessment &$150 per succeeding hour
			$ 250 skilled nurse visit then $100 per succeeding hour

Authorization for Payment/Liability for Payment: I hereby request that payment as authorized be made to A Caring Life Home Health Inc. on my behalf. I have been advised in advance of care being initiated as to the extent in which payment may be expected from Medicare, Medicaid, or other 3rd party payers and to the extent in which may I may be liable for payment. I understand that services provided by this agency will be billed as allows:

Traditional Medicare-Payment expected to be made in full by Medicare. Medicare#:________________

Medicaid-Payment to be made in full by Medicaid. Medicaid#:________________

Private Pay-I will be responsible for 100% of the charges billed to me in accordance with A Caring Life Home Health Inc. rate sheet given to me. Private Insurance-I will be responsible for all co-pays/deductibles and any amount not covered by my insurance carrier.

Primary Insurance: ____________________ ID/Group#:________________

Estimated Co-Pay:________________ Estimated Deductible:

Secondary Insurance:____________________ ID/Group#:________________

Estimated Co-Pay:________________ Estimated Deductible:________________

Clinician visualized Medicare/Medical ID Card: ☐ Yes ☐ No

Advanced Directives: I understand that the Advance Directive Act of 1999 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 understand the agency policy is to respect individual choice and to avoid discrimination based on whether or not I have an Advance Directive.

I have made a living will. ____Yes____No (if yes, please provide a copy)

I have made a Medical Power of Attorney for Health Care:____Yes____No If yes, write name and phone number of POA:

Name:____Ph:___________________________

I have made an out of hospital DNR____Yes____No (if yes, please provide copy)

Face To Face Encounter: I hereby understand that in order to be eligible for Home Health Services I should have a Face to Face Encounter with a Physician 90 days prior to start of care or within 30 days after home health start of care.

Transfer, Service Changes, and Discharge: I understand and have been informed of the regulations and requirements for transfer and discharge. I understand and have been informed about the ABN (advance beneficiary notice), HHCCN (home health change of care notice), and NOMNOC (notice of Medicare noncoverage) forms regarding discontinuation and changes in services provided.

Homebound Status: I understand that Medicare's definition of homebound is that there exists a normal inability to leave home or leaving home would require a considerable and taxing effort. I attest that, should my condition so improve that I am no longer confined to my residence, I will promptly report this change in condition to the agency.

Multiple Home Health Agency Prevention Questionnaire/Beneficiary Elected Transfer

I have received home health services in the last 60 days.____Yes____No If yes, Dates:___________Agency:_____________
I am electing transfer of my home health services to A Caring Life Home Health Inc. effective this date. I am revoking my consent to treatment and discontinue care with the above named agency. I understand that as of the date of this consent that A Caring Life Home Health Inc. will be providing my home health services as long as I remain qualified for home health benefits according to my health insurance condition and policy. I understand that my prior home health agency will no longer receive Medicare payment and will no longer provide Medicare covered services on my behalf after the effective transfer date. I request that my records be released to the receiving agency to ensure continuity of care.

Designation of Primary Caregiver/Patient Representative: I understand that A Caring Life Home Health Inc. encourages the active involvement of a Primary Caregiver/Patient Representative-someone to assist with my personal care and activities of daily living when home health staff are not available and to assist me with communicating with the agency regarding my home health needs.

____will be my Primary Caregiver/Patient Representative.

____

Address/Phone Number of Primary Caregiver/Patient Representative

Emergency Preparedness: Emergency: If the Client's condition changes significantly or for medical emergencies such as chest pain, difficulty in breathing, paralysis, bleeding, or falls, please call your physician, 911, or your appropriate emergency access for immediate attention. The Agency does not operate as an emergency service, therefore valuable time may be lost by contacting the Agency.

Non-Emergency: The Agency has a representative "on-call" 24 hours per day, seven days per week. PH: 209 205 9469

Do you have transportation to evacuate? [ ] Yes [ ] No

By Whom?____ Phone Number:_______________________________

Client Name:____Sex: [ ] Female [ ] Male

Physical Address:____

City:____________________________________Zip:__________ Phone Number:_______________________________

Your Physician:___________________________ Phone Number:_______________________________

Pharmacy:__________________________________ Phone Number:_______________________________

DME:_______________________________________ Phone Number:_______________________________

In case of emergency contact:____

Relationship:______________________________ Phone Number:_______________________________

Do you have a pet or service animal? [ ] Yes [ ] No Others involved in your care: Name:___________________Ph:___________

Natural Disaster: In the event of a natural disaster (e.g., to include tornadoes, hurricanes, winter storms/blizzards, nuclear power plant disaster, floods, chemical toxicity, pollution, and fire) the Agency will prioritize visits according to the following: What category describes your special needs?

Code III/ Low Risk:Services could be postponed 72-96 hours without adverse effect to the patient. Ambulatory and can evacuate or manage in home alone for short periods of time or has fully capable caregiver. For example: new insulin dependent diabetic but able to inject self, cardiovascular and/or respiratory assessment, sterile wound care with minimal to no drainage, terminal patient with predictable deterioration and family coping adequately

Evacuation Risk Level: ______

Acknowledgment of Information: I have received verbal and written information and explanation regarding the following:

• Notice of services provided and rates • Statement of Patient Privacy Rights/Privacy Practices/ Privacy Act Statement-Health Care Records • Receipt of notices of Privacy Practices/HIPAA • OASIS Statement of Privacy Practices, OASIS Notice About Privacy, OASIS Privacy Act Statement • Patient Handbook (agency contact information/hours of operation/interpreter services/grievance procedure/abuse, neglect, exploitation/agency drug testing policy • Basic Home Safety/Infection Control/Emergency & Disaster Planning/Oxygen Safety	**Rights and Responsibilities:** I acknowledge that I have received a copy of my Rights and Responsibilities prior to care. I have had these rights explained to me in a manner and language that I understand, and I have had the opportunity to ask questions. Included in the Rights and Responsibilities is my right to elect an Advance Directive.

I have been provided the opportunity to discuss concerns or ask questions I may have regarding the above stated information. I have had the opportunity to review the information with my family, primary caregiver/representative. I have reviewed this entire consent form. The purpose and content of this consent form was explained to me prior to signing.

Signature of Patient/Authorized Representative: ______________________________ **Date:** __________

Print Name and Relationship of Authorized Rep. (if applicable): ______________________ **Relationship:** __________

Agency Representative: ______________________________ **Date:** __________

THIS COPY IS COMPLETED AND REMAINS IN THE PATIENT HOME FOLDER.

Physician Orders for Life-Sustaining Treatment (POLST)

EMSA #1118
(Effective 4/1/2017)*

First follow these orders, then contact Physician/NP/PA. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. **POLST complements an Advance Directive and is** not intended to replace that document.

Patient Last Name:	Date Form Prepared:
Patient First Name:	Patient Date of Birth:
Patient Middle Name:	Medical Record #: (optional)

A — Check One

CARDIOPULMONARY RESUSCITATION (CPR): If patient has no pulse and is not breathing.
If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.

☐ **Attempt Resuscitation/CPR** (Selecting CPR in Section A requires selecting Full Treatment in Section B)

☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)

B — Check One

MEDICAL INTERVENTIONS: If patient is found with a pulse and/or is breathing.

☐ **Full Treatment - primary goal of prolonging life by all medically effective means.**
In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.

☐ **Trial Period of Full Treatment.**

☐ **Selective Treatment - goal of treating medical conditions while avoiding burdensome measures.**
In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.

☐ Request transfer to hospital only if comfort needs cannot be met in current location.

☐ **Comfort-Focused Treatment - primary goal of maximizing comfort.**
Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. Request transfer to hospital only if comfort needs cannot be met in current location.

Additional Orders: ______________________________

____

C — Check One

ARTIFICIALLY ADMINISTERED NUTRITION: Offer food by mouth if feasible and desired.

☐ Long-term artificial nutrition, including feeding tubes. Additional Orders: ______________
☐ Trial period of artificial nutrition, including feeding tubes. ______________
☐ No artificial means of nutrition, including feeding tubes. ______________

D

INFORMATION ADMINISTERED NUTRITION:

Discussed with: ☐ Patient (Patient Has Capacity) ☐ Legally Recognized Decisionmaker

☐ Advance Directive dated ____ available and reviewed → Health Care Agent if named in Advance Directive:
☐ Advance Directive not available — Name: ______________
☐ No Advance Directive — Phone: ______________

Signature of Physician / Nurse Practitioner / Physician Assistant (Physician/NP/PA)
My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences.

Print Physician/NP/PA Name:	Print Physician/NP/PA Name:	Physician/PA License #, NP Cert. #:
Physician/NP/PA Signature: (required)		Date:

Signature of Patient or Legally Recognized Decisionmaker
I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

Print Name:		Relationship: (write self if patient)
Signature: (required)	Date:	Your POLST may be added to a secure electronic registry to be accessible by health providers, as permitted by HIPAA.
Mailing Address (street/city/state/zip):	Phone Number:	

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

*Form versions with effective dates of 1/1/2009, 4/1/2011, 10/1/2014 or 01/01/2016 are also valid

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Patient Information		
Name (last, first, middle):	Date of Birth:	Gender: M F

NP/PA's Supervising Physician	Preparer Name (if other than signing Physician/NP/PA)	
Name:	Name/Title:	Phone #:

Additional Contact ☐ None		
Name:	Relationship to Patient:	Phone #:

Directions for Health Care Provider

Completing POLST

- **Completing a POLST form is voluntary.** California law requires that a POLST form be followed by healthcare providers, and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by a physician, or a nurse practitioner (NP) or a physician assistant (PA) acting under the supervision of the physician, who will issue appropriate orders that are consistent with the patient's preferences.
- **POLST does not replace the Advance Directive.** When available, review the Advance Directive and POLST form to ensure consistency, and update forms appropriately to resolve any conflicts.
- POLST must be completed by a health care provider based on patient preferences and medical indications.
- A legally recognized decision maker may include a court-appointed conservator or guardian, agent designated in an Advance Directive, orally designated surrogate, spouse, registered domestic partner, parent of a minor, closest available relative, or person whom the patient's physician/NP/PA believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known.
- A legally recognized decision maker may execute the POLST form only if the patient lacks capacity or has designated that the decision maker's authority is effective immediately.
- To be valid a POLST form must be signed by (1) a physician, or by a nurse practitioner or a physician assistant acting under the supervision of a physician and within the scope of practice authorized by law and (2) the patient or decision maker. Verbal orders are acceptable with follow-up signature by physician/NP/PA in accordance with facility/community policy.
- If a translated form is used with patient or decision maker, attach it to the signed English POLST form.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid. A copy should be retained in patient's medical record, on Ultra Pink paper when possible.

Using POLST

- Any incomplete section of POLST implies full treatment for that section.

Section A:

- If found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressions should be used on a patient who has chosen "Do Not Attempt Resuscitation."

Section B:

- When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort-Focused Treatment," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- IV antibiotics and hydration generally are not "Comfort-Focused Treatment."
- Treatment of dehydration prolongs life. If a patient desires IV fluids, indicate "Selective Treatment" or "Full Treatment."
- Depending on local EMS protocol, "Additional Orders" written in Section B may not be implemented by EMS personnel.

Reviewing POLST

It is recommended that POLST be reviewed periodically. Review is recommended when:

- The patient is transferred from one care setting or care level to another, or
- There is a substantial change in the patient's health status, or
- The patient's treatment preferences change.

Modifying and Voiding POLST

- A patient with capacity can, at any time, request alternative treatment or revoke a POLST by any means that indicates intent to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writing "VOID" in large letters, and signing and dating this line.
- A legally recognized decisionmaker may request to modify the orders, in collaboration with the physician/NP/PA, based on the known desires of the patient or, if unknown, the patient's best interests.

This form is approved by the California Emergency Medical Services Authority in cooperation with the statewide POLST Task Force.
For more information or a copy of the form, visit www.caPOLST.org.

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

Home Health Agency Name: A Caring Life Home Health		
Home Health Agency Street Address: 35 E 10TH STREET STE #H, TRACY, CA 95376		
City: Tracy	State: CA	Zip Code: 95376

Patient Name : ________________________________ Patient Identification: ____________________________

Home Health hange of Care Notice (HHCCN)

Your home health care is going to change. Starting on _______/_______/_______ your home health agency will change the following items and/or services for the reasons listed below.

Items/services:	Reason for change:

Read the information next to the checked box below. Your home health agency is giving you this information because:

☐ **Your doctor's orders for your home care have changed.**

The home health agency must follow physician orders to give you care.

The home health agency can't give you home care without a physician's order.

If you don't agree with this change, discuss it with your home health agency or the doctor who orders your home care.

☐ **Your home health agency has decided to stop giving you the home care listed above.**

You can look for care from a different home health agency if you have a valid order for home care and still think you need home care.

If you need help finding a different home health agency to give you this care, contact the doctor who ordered your home care.

If you get care from a different home health agency, you can ask it to bill Medicare.

If you have questions about these changes, you can contact your home health agency and/or the doctor who orders your home care.

You cannot appeal to Medicare about payment for the items/services listed above unless you both receive them and a Medicare claim is filed.

Additional Information:

Please sign and date below to show that you received and understand this notice. Return this signed notice to your home health agency in person or by mailing it to them at the address listed at the top of this notice.

Signature of the Patient or of the Authorized Representative*	Date

*If a representative signs for the beneficiary, write "(rep)" or "(representative)" next to the signature. If the representative's signature is not clearly legible, the representative's name must be printed.

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

Provider Name:		Phone #:
Provider Street Address:		
City:	State:	Zip Code:

Patient Name : ____ Patient Identification: ____________________________

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for ________________________ below, you may have to pay.
Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need.
We expect Medicare may not pay for the _____________________ below.

___________________________________	Reason Medicare May not Pay:	Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the _______________ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

Options: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the _______________________ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the _______________________ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the __________________________ listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY**: 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

Signature:	Date

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

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. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Wound Care Supply Order Form

Patient Name: ______________________ RN Name: ______________________

SOC Date: ______________________ Duration of supplies: 90 days / other

Does this patient have any supplies at home at time of SOC?

	Wound 1	Wound 2	Wound 3
ICD 10 Code:			
Location:			
Type of wound (ie: pressure, venous stasis, surgical)			
Color of wound			
Wound Bend Tissue (circle one)	Bloody Granular Sloughing Weeping Necrotic Healthy Eschar Other:	Bloody Granular Sloughing Weeping Necrotic Healthy Eschar Other:	Bloody Granular Sloughing Weeping Necrotic Healthy Eschar Other:
Has the wound been debrided? (circle one)	yes no	yes no	yes no
Stage (if pressure ulcer) Or Thickness (other wound types) (circle one)	II III IV Partial Full Thickness	II III IV Partial Full Thickness	II III IV Partial Full Thickness
Size in cm: (L x W x D)	cm X cm X cm X	cm X cm X cm X	cm X cm X cm X
Undermining			
Tunneling			
Frequency of dressing change			
Exudate (circle one)	Light Moderate Heavy	Light Moderate Heavy	Light Moderate Heavy

Dressing (Please circle requested size)	Wound 1 QTY:	Wound 3 QTY:	Wound 3 QTY:
Gauze, Sterile (2 units/package) 2 x 2 or 4 x 4			
ABD Pads 5x9 or 8 x 10			
Conform Bandage Roll 3' width			
Kerlix Rolled Gauze 4.5" width			
Micropore Paper Tape 1" or 2"			
Waterproof Fixation Cloth Tape 2"			
Alginate 2 x 2 or 4 x 4			
Silver Alginate 2 x 2 or 4 x 4			
Non-Adherent Oil Emulsion Dressing 3x3			
Adhesive Foam 3 x 3 or 4 x 4			
Foam 3 x 3 or 4 x 4			
Hydrocolloid 4 x4			
Xeroform Dressing 4 x4			
Wound Cleanser			
Adaptic non- adhering dressing 4x4			
Allevyn Dressing border or non-border			
Sterile Q-tips			
Alginate Rope / Silver Alginate Rope .75 x 1 2"			
Bordered Gauze 4 x 4 or 6 x 6			
Other:..			

ACL HOME HEALTH

SKIN CHECK

Resident Name ________________________ **MR #** ____________

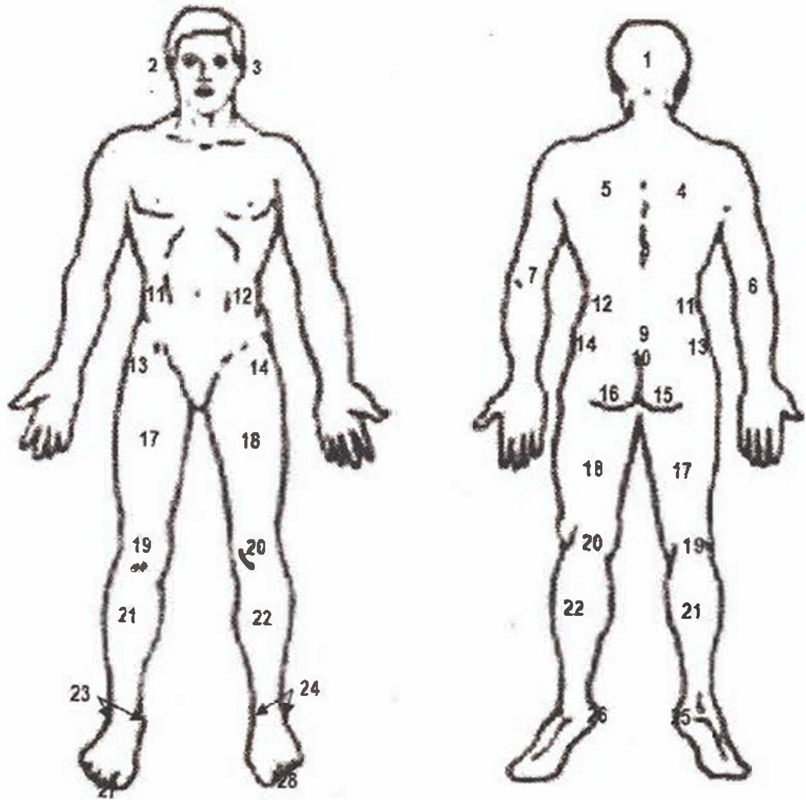
Date of Assessment ________________

Assessment Timeframe **Admission Braden** **Weekly** **Quarterly** **Change in Condition**

score __________ **Level of Risk:** **High Risk** **Low Risk**

Resident ________________________

1 = Back of head
2 = Right ear
3 = Left ear
4 = Right scapula
5 = Left scapula
6 = Right elbow
7 = Left elbow
8 = Vertebrae (upper-mid)
9 = Sacrum
10 = Coccyx
11 = Right iliac crest
12 = Left iliac crest
13 = Right trochanter (hip)
14 = Left trochanter (hip)
15 = Right ischial tuberosity
16 = Left ischial tuberosity
17 = Right thigh
18 = Left thigh
19 = Right knee
20 = Left knee
21 = Right lower leg
22 = Left lower leg
23 = Right ankle (inner/outer)
24 = Left ankle (inner/outer)
25 = Right heel
26 = Left heel
27 = Right toe(s) (1,2,3,4,5)
28 = Left toe(s) (1,2,3,4,5)
29 = Other (specify)



Anatomical # (s)

Pressure Ulcer ________________________

Venous Dicer __________ Abrasion __________

Diabetic Ulcer __________ Bum __________

Arterial Ulcer __________ Rash __________

Surgical wound __________ Blister __________

Bruise/Hematoma __________ Trauma/Laceration______

Maceration __________ Ostomy/Peg Tube ______

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Provider Name:______________ Address/Phone:__________________________________

Notice of Medicare Non-Coverage

Patient name: ____________________________ **Patient number:** ______________

The Effective Date Coverage of Your Current _______________________ (insert type) Services Will End: ______________ (insert effective date)

- Your Medicare provider and/or health plan have determined that Medicare probably will not pay for your current ____________________ (insert type) services after the effective date indicated above.
- You may have to pay for any services you receive after the above date.

Your Right to Appeal This Decision

- You have the right to an immediate, independent medical review (appeal) of the decision to end Medicare coverage of these services. Your services will continue during the appeal.
- If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
- If you choose to appeal, you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should not continue. You will receive this detailed notice only after you request an appeal.
- If you choose to appeal, and the independent reviewer agrees services should no longer be covered after the effective date indicated above;
  - Neither Medicare nor your plan will pay for these services after that date.
- If you stop services no later than the effective date indicated above, you will avoid financial liability.

How to Ask For an Immediate Appeal

- You must make your request to your Beneficiary and Family-Centered Care Quality Improvement Organization (BFCC-QIO). A BFCC-QIO is the independent reviewer authorized by Medicare to review the decision to end these services.
- Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above.
- The BFCC-QIO will notify you of its decision as soon as possible, generally no later than two days after the effective date of this notice if you are in Original Medicare. If you are in a Medicare health plan, the BFCC-QIO generally will notify you of its decision by the effective date of this notice.
- Call your BFCC-QIO at: Livanta, 1- 866-815-5440, TTY: 1-866-868-2289, to appeal, or if you have questions.

See page 2 of this notice for more information.

If You Miss The Deadline To Request An Immediate Appeal, You May Have Other Appeal Rights:

- If you have Original Medicare: Call the BFCC-QIO listed on page 1.
- If you belong to a Medicare health plan: Call your plan at the number given below.

Plan Contact Information:

UPMC *for You* Advantage
UPMC *for Life* Options
UPMC *Community Care*
APPEALS & GRIEVANCES
PO BOX 2939
PITTSBURGH, PA 15230

CALL: 1-800-606-8648 **TTY/TDD:** 1-866-407-8762
8 a.m. to 8 p.m., Monday through Friday and 8 a.m. to 3 p.m. on Saturday

FAX: 1-412-454-7920

Additional Information (Optional):

Please sign below to indicate you have received this notice.

I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO.

_______________________________________ ____________________
Signature of Patient or Representative Date

DISCHARGE PLANNER/SOCIAL SERVICE SATISFACTION SURVEY

Referral Source: ____

Patient Name: ____________________________________

Date:______________________________________

We were privileged to participate in the care of the above patient. We are interested in rendering quality care to our patients and would appreciate your answering the following questions. Your feedback is important and is utilized in planning and improving our services.

1. Was your initial referral/intake information handled in a timely manner?

   ________Yes ________No

2. Was our staff courteous?

   ________Yes ________No

3. Was the initial patient contact by the Agency made in a timely manner?

   ________Yes ________No

4. Were alternate services offered if our Agency was unable to accept the patient to service?

   ________Yes ________No

5. If requested by you, was adequate information sent to you upon patient's discharge from service?

   ________Yes ________No

6. Do you have brochures of the services offered by our Agency?

   ________Yes ________No

7. Is there anything else that we could have done for you or your patient to improve our services?

   ________Yes ________No

   If yes, please describe

   ____

PLEASE USE THE SPACE BELOW FOR ANY ADDITIONAL COMMENTS YOU WISH TO MAKE; ESPECIALLY IF YOU HAVE ANSWERED NO TO ANY OF THE QUESTIONS. WE THANK YOU FOR YOUR VALUABLE TIME AND PARTICIPATION.

PLEASE MAIL YOUR RESPONSE IN THE ENCLOSED, SELF-ADDRESSED, STAMPED ENVELOPE.

____

____

____

Agency name: ____

Discharge Instructions

Patient Name: ____ D.O.B: _____ / _____ /______

Date of Discharge:

Thank you for the opportunity you have given A Caring Life Home Health Inc. to provide you with home health services.

The following discharge instructions are explained to you to help you maintain your independence and safety at home. (Put a check mark for all that apply).

- ☐ Medication list reviewed with patient/caregiver and understood instructions.
- ☐ Patient/caregiver was educated and understood wound care management.
- ☐ Patient/caregiver was educated and understood when to call MD for any concerns.
- ☐ Patient/caregiver was educated and understood the following (put check mark for all that apply):
  - ☐ Home exercise program
  - ☐ Weight bearing precautions
  - ☐ Safety precautions
  - ☐ Use of assistive DME
  - ☐ Fall precautions
  - ☐ Stairs activity

Please follow up with your primary care physician regularly and as needed.

Discharge Notes: ____

____

Call 911 if you start experiencing these symptoms: chest pain, difficulty in breathing, shortness of breath, chest pain radiating to the left arm and left shouldere, jaw pain, epigastric pain, facial droop, slurred speech, numbness or weakness of one side of the body, severe headache, and/or severe abdominal pain.

By signing this form you acknowlegde that you understood the discharge instructions given.

Patient/Representative signature: ________________________________ Date:

Clinican signature: ________________________________ Date:

Title: ________________________

Month [ ] Year [ ]

SOC: ____________________________

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Nurse: ______________________

Physical Therapist: ____________________

Occupational Therapist: ________________

Speech Therapist: ____________________

Medical Social Worker: ________________

Home Health Aid: ____________________

Notes:

A Caring Life Home Health Inc.

STAFF DAILY ROUTE SLIP

Pay Period: ______________________

DATE	CLIENTS NAME Last Name, First Name	TIME IN	TIME OUT	PATENT/AUTHORIZED PERSON SIGNATURE	RELATIONSHIP TO PATIENT
					☐ Self ☐ Daughter/Son ☐ Caregiver ☐ Spouse ☐ Other ________
					☐ Self ☐ Daughter/Son ☐ Caregiver ☐ Spouse ☐ Other ________
					☐ Self ☐ Daughter/Son ☐ Caregiver ☐ Spouse ☐ Other ________
					☐ Self ☐ Daughter/Son ☐ Caregiver ☐ Spouse ☐ Other ________
					☐ Self ☐ Daughter/Son ☐ Caregiver ☐ Spouse ☐ Other ________
					☐ Self ☐ Daughter/Son ☐ Caregiver ☐ Spouse ☐ Other ________
					☐ Self ☐ Daughter/Son ☐ Caregiver ☐ Spouse ☐ Other ________
					☐ Self ☐ Daughter/Son ☐ Caregiver ☐ Spouse ☐ Other ________
					☐ Self ☐ Daughter/Son ☐ Caregiver ☐ Spouse ☐ Other ________
					☐ Self ☐ Daughter Son ☐ Caregiver ☐ Spouse ☐ Other ________
					☐ Self ☐ Daughter/Son ☐ Caregiver ☐ Spouse ☐ Other ________

________	________	________	________	________	________
PRINT EMPLOYEE'S NAME	EMPLOYEE'S SIGNATURE	TITLE	DATE	PROCESSED BY: AUDIT & DATA ENTRY	DATE

A CARING LIFE HOME HEALTH INC.
209-205-9469

Patient's Copy

PATIENT AND FAMILY EDUCATION HANDOUT
INDIVIDUAL EMERGENCY MANAGEMENT PLAN

Patient Name:____, **Date**___________________________

Your Physician's Name:_________________________________, **Phone number**____________________

Your family/friend to contact during emergency:

Name:____________________________, **Phone Number:**______________________________

The following are the instructions for you, please review:

✓ Always be prepared for a sudden emergency. Be sure to have enough necessities on hand and ask family and/or friends for any help.

✓ You may be notified of a possible emergency by NOAA weather radio, text message, commercial radio and television stations and/or door-to-door warning from local emergency officials. **Follow their instructions!**

✓ Call 911 for any medical emergencies.

✓ Select an emergency contact to provide transportation if you need medical emergency care.

✓ Assemble a survival kit which should include the following at a minimum:

- First aid kit
- Three (3) days worth of medications, including a list of the medications you take regularly and their dosages, the name of the physician prescribing it and a list of any allergies
- If you use insulin, pre-fill syringes for three (3) days
- If you use medical supplies, have an extra three (3) day supply available
- List of physicians and relatives/friends who should be notified should you be injured
- List of important documents, including any documents for your pets, in a water-proof container
- Store a flashlight, battery operated radio and extra batteries in case of a power loss
- Whistle
- Manual can opener
- Have cash (including coins) on hand to help you through the emergency period
    - ATM machines and banks will not be in operation without electricity and stores will not be able to accept credit cards.
- Keep important documents together

☐ If you use oxygen, arrange for a back-up unit.

ACL HOME HEALTH

PROBLEM	CALL NURSE AT A CARING LIFE HOME HEALTH	CALL 9-1-1
Breathing/ Lungs	• Increased shortness of breath • Worsening cough & change in sputum characteristics • Restlessness or ag-Jtation • Fatigue/Weakness • Loss of appetite or weight • Fever (oral temperature greater than 100.5)	• Difficulty breathing • Severe shortness of breath and wheezing • Change in color of skin to gray or blue or area around iips become blue • Confusion
Heart Failure	• Abnormal weight gain • Increased shortness of breath • Productive, frothy cough or new coughing at night • New congestion, not related to a cold • Swelling of feet & legs than usual fatigue/weakness • Dizziness/lightheadedness • Irregular or rapid heartbeat	• Severe shortness of breath • Fainting • Sudden or severe chest pain or pressure • Frothy sputum
Chest Pain	• Chest pain or tightness RELIEVED by rest or medication	• Chest pain, pressure, or tightness not relieved by medication • Chest pain that goes away and comes back • Pain/discomfort in neck, jaw, back, one or both arms, or stomach • Chest discomfort with shortness of breath, sweating, or nausea
Blood Pressure Stroke	• Abnormal blood pressure readings above • ______________________________ • Symptoms including headaches, nose bleeds, blurred vision, ringing in ears, lightheadedness, heart palpitations (fluttering)	• Sudden numbness or weakness of the face, arm or leg - may be on one side of the body • Sudden confusion, trouble talking, or understand ing • Sudden trouble seeing in one or both eyes • Sudden trouble walking, dizziness, loss of balance or coordination • Sudden, severe headache with no known reason
Blood Thinner/ Bleeding	• Black/dark or blood-tinged stool • Vomiting blood • Bleeding from gums, nose, mouth, or surgical site • Unusual bruising • Blood in urine	• Bleeding you cannot control
Urinary Catheter Urinary Infection	• Leaking, blocked or dislodged catheter • Urge to urinate frequently, in small amounts, or unable to urinate • Burning sensation when urinating • Bloody, cloudy, or change in urine color or foul odor • Low back pain • Fever greater than 100.5 degrees or chills	
Wound/Skin	• Change in amount, color, or odor of wound drainage • Increase in pain at wound site • Increase in redness/warmth at wound site • Fever greater than 100.5 degrees/chills • New skin problem	
Diabetes	• High blood sugar symptoms: increases thirst, frequent urination, increased hunger, blurred vision, weakness, dry, itchy skin • Repeated blood sugars greater than__________mg/dl	• Nausea and vomiting, shortness of breath, fruity breath • Blood sugar greater than 450 mg/dl
	• Low blood sugar symptoms: Shaking, sweating, hunger, headache, fast heartbeat, confusion, changes in vision, irritability • Repeated blood sugars less than____________mg/dl	• Unconsciousness • Unable to treat low blood sugar at home • Seizures • Low blood sugar not responding to treatment
Fall	• Fall with no serious injury	• Fall with suspected injury (broken bone or wound)
Other	• New symptoms • Pain, no bowel movement for 3 days	• Unable to wake patient • Severe or prolonged pain

❑ If you have an intravenous catheter you will need extra sterile water to clean the catheter site.

✓ Store three (3) days worth of non-perishable food and water; you will need one (1) gallon of water per day per person.

❑ Store pet food, if applicable. You will also need:

- Change of clothing
- Blanket or sleeping bag
- Personal hygiene supplies
- Phone numbers of relatives and/or friends
- Insurance agent's name and telephone number

✓ Have your supplies packed and ready in one place before an emergency/natural disaster strikes. Be sure the container that you put your emergency supplies into has an ID tag or is marked with your name.

✓ Label any equipment, such as wheelchairs, canes or walkers.

✓ Arrange for a back-up power source for any medical equipment that operates on electricity.

✓ Make arrangements to stay with relatives or friends in the event of an emergency.

✓ If necessary, make arrangements in advance for special transportation and/or to stay at a shelter.

✓ If you are told to stay indoors:

- Close all windows and doors in your home
- Turn off all fans, heating and air conditioning systems
- Go to a room with the fewest windows and doors
- Stay away from all windows to avoid injury from flying glass and/or any other projectiles

✓ If you are instructed to evacuate your home:

- Call A Caring Life Home Health Inc and give the address and telephone number where you can be reached
- Turn off electricity and water.
- Leave immediately, even if the weather is nice
- Stay away from any electrical wires
- Remember to lock your windows and doors when you evacuate

✓ Other special instructions for you:

____

____

____

____

A Caring Life Home Health Inc will arrange or help arrange delivery of extra supplies, back-up equipment, i.e., generators for patients with oxygen, "gravity" equipment for infusion of intravenous fluids.