L&C CONSENT FORM

Agency 24 Hour Number:

CONSENT FOR SERVICE/RELEASE OF RECORDS

I, _____, have been informed that the above named Agency, referred to in this consent as the Agency, is my primary home health agency and is licensed to provide home health services according to the Plan of Care established by the home health staff and authorized by the physician. I accept treatment from the Agency. I can call the Agency 24 hours a day regarding my health care at the above referenced phone number. This is not an emergency line. I understand I should call 911 in an emergency. It is the policy of the Agency to protect all clinical records against loss, defacement, tampering and use by unauthorized persons. I authorize the Agency to release medical information to my physician, the facility of my choice, payor source, or accrediting/regulatory/ consulting organizations, as appropriate. I authorize the release of the Plan of Care and Discharge Summary upon my transfer to another health care facility.

FINANCIAL AUTHORIZATION

I authorize benefits to be made on my behalf.

Bill Medicare 100% - Medicare #: _____ Effective Date: Part A _____ Part B _____
All Medicare-covered services, including therapies and supplies, will be paid by Medicare. I understand I may be liable for payment of services provided by anyone other than the Agency, while the Agency is rendering services.

Bill HMO/MCO:_____% HMO/MCO:_____

Bill Medicaid 100% - Medicaid #: _____ Effective Date: _____

Bill Primary Insurance: _____% Insurance Co: _____

Bill Secondary Insurance: _____% Insurance Co: _____

Bill Patient: Co-payment _____ Payment of _____ ❑ Per Visit ❑ Per Hour

I am responsible for informing the Agency if I change to an HMO, Medicare Advantage/HMO or MCO. I understand I am responsible for the home health charges incurred for failure to notify the Agency of the change or if the HMO/MCO refuses coverage.

I will pay any service or supply charge not reimbursed by my insurance company on a monthly basis. I will pay all charges incurred on a monthly basis if I do not have insurance coverage. If a claim for home health services which the Agency has submitted on my behalf is denied, I hereby elect not to appeal the denial myself, but I do hereby authorize the Agency to resubmit the claim for me and represent me in any negotiations. I authorize the Agency to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

FREQUENCY/RIGHTS/HOTLINE/PROCEDURES

I understand that an RN will supervise all services unless only therapy services are ordered.

I understand the proposed frequency of services may change according to need. Skilled Nursing: _____,

Home Health Aide: _____, PT Evaluation: _____, OT Evaluation:_____,

SP Evaluation: _____, MSW Evaluation:_____, Other:_____

I have received a copy and an explanation of my Patient Bill of Rights and the Rights of the Elderly, as appropriate.

I have been notified of my right to voice a complaint to the Agency Administrator or designee at the above referenced phone number. An investigation of the complaint will be initiated within 10 calendar days and resolved within 30 calendar days of receipt. I may also contact the Department of Aging and Disability Services, DADS' Consumer Rights and Services Division, Mail Code E249, PO Box 149030, Austin, TX 78714-9030, or by calling 1-800-458-9858. The line is open 24 hours a day. This includes a complaint regarding advance directives.

Complaints regarding any health insurance services can be mailed to MC 1111A, Consumer Protection, Texas Department of Insurance, PO Box 149091, Austin, TX 78714, or by calling the Consumer Help Line at 1-800-252-3439, online at http://www.tdi.texas.gov/consumer/complfrm.html, or by email to ConsumerProtection@tdi.texas.gov.

When a managed care organization (MCO) member wants to file a complaint, he or she must first contact the MCO, following procedures specified in the MCO's member handbook. If the member is not satisfied with the outcome of the MCO complaint process, he or she sends a written request to HHSC to investigate the complaint. The request is sent to: Texas Health and Human Services Commission, Managed Care Operations – STAR+PLUS, Mail Code H320, P. O. Box 13247, Austin, TX 78711.

In addition I may contact The Joint Commission's Office of Quality & Patient Safety to report any concerns about patient care and safety. The complaint can be mailed to: Office of Quality and Patient Safety, The Joint Commission, One Renaissance Blvd., Oakbrook Terrance, IL 60181, or by calling 1-800-994-6610, faxing 630-792-5636, emailing patientsafetyreport@jointcommission.org or online at https://apps.jointcommission.org/OMSInternet/IncidentEntry.aspx

My legally authorized representative and I have been informed verbally and in writing regarding the Agency's policies on abuse, neglect, and exploitation (ANE) and how to report complaints and allegations of ANE; my legally appointed representative or I may report complaints and allegations of abuse neglect or exploitation by calling the Abuse Hotline, 24 hours a day, 7 days a week, toll-free 1-800-252-5400 from anywhere in the US , or reporting on the secure internet website at https://www.txabusehotline.org.

I have received the Agency policy on Advance Directives. I have ❑ or have not ❑ signed a ❑ Living Will/Directive to Physician;

❑ Out of Hospital DNR; ❑ Medical Power of Attorney ❑ Declaration of Mental Health. I am ❑ am not ❑ providing a copy for my record.

Medical Power of Attorney: _____ Phone: _____

I understand that it is my right and responsibility to be involved in my care and that I will be informed as to the nature and purpose of any technical procedure.

I have been informed what to do in an emergency/natural disaster and have received education on completing an emergency preparedness plan for myself and my family. I understand the importance of completing this plan and know that agency staff may assist in this process. I have been informed of how to register with 2-1-1.

I have been informed verbally and in writing regarding the Agency's policies on drug testing; as well as information about hazardous waste disposal in the home.

I have been advised verbally and in writing the purpose of and my rights pertaining to the collection of OASIS information and the OASIS Privacy Act.

HIPAA - I have received the Notice of Privacy Practices and consent to the Agency's use and/or disclosure of protected health information for payment, treatment and the Agency's Health care operations.

_____	_____	_____
Patient/Client/Authorized Representative Signature	Relationship	Date
_____	_____	_____
Agency Representative Signature	Reason patient/client is unable to sign	Date

INDIVIDUALIZED EMERGENCY PLAN

Important Phone Numbers

Emergency: 911 or appropriate emergency access

Patient/Client Name:_____

Primary Physician:_____ Phone#: _____

Usual Pharmacy: _____ Phone#: _____

Health Insurance: _____ Policy#: _____

Home Health Agency:_____ Phone#: _____

Legal or Patient/Client-selected representative (this is a person who can make decisions if the patient/client is not able):

Name: _____ Phone#: _____

Family or Caregiver Contact(s) available to assist the patient/client in an emergency or disaster:

Name: _____ Phone#: _____

Name: _____ Phone#: _____

Name: _____ Phone#: _____

Safety and Natural and Manmade Disasters

See the Home Safety Checklist for guidance on types of disasters and actions to take. See the Family Emergency Preparedness Information Booklet for patient/client and family specific emergency information.

In case of emergency, the Agency's responsibilities to you are based on your triage status, but would include:
☐ Call ☐ Visit ☐ Call EMS ☐ Other: _____

In the event of a natural or manmade disaster (such as flood, tornado, ice storm, earthquake, nuclear disaster, or industrial accidents), the Agency will prioritize visits according to the following:

☐ I - Life-threatening (or potentially life-threatening) - requires ongoing medical treatment/care. Any equipment dependent upon electricity should be listed with the power company. Oxygen-dependent patients/clients should be supplied with a back-up tank from the supplier. Does not have a caregiver capable of providing care. Requires assistance with transportation to a hospital or specialized shelter.

☐ II - Not life-threatening but the patient/client might suffer severe adverse effects from interruption of services, i.e., daily insulin, IV meds, sterile wound care with large amounts of drainage, symptoms are controlled with difficulty, death appears imminent. A capable caregiver is present. Will require transportation assistance to a hospital or specialized shelter if necessary.

☐ III - Visits could be postponed 24-48 hours without adverse effects, i.e., sterile wound care with a minimal amount to no drainage, symptoms need intervention, but are fairly well controlled. Able to care for self or a willing and able caregiver is available. Transportation is available from family, friends, or others.

☐ IV - Visits could be postponed 72-96 hours without adverse effects, i.e., symptoms are well-controlled. Able to care for self or a willing and able caregiver is available. Transportation is available from family, friends, or others.

If the patient/client will need assistance during an emergency or disaster, they may register ahead of time with the local and/or state authorities, United Way-211, and/or Access to Disaster Help and Resources www.disasterassistance.gov. This will provide them with information on local shelter and transportation.

Patient/Client transportation or evacuation plan: _____

_____

Registrations completed: _____

_____

2-1-1 Texas Registration

Patient/Client Name: _____Medical Record #:_____

Is the patient/client registered with the State of Texas Emergency Assistance Registry (STEAR)? ☐ Yes ☐ No

Does the patient/client want to register with STEAR? ☐ Yes ☐ No

NOTE: Check boxes are not sufficient documentation for the following- each question requires a narrative explanation.

Is the patient/client able to provide or arrange for his or her transportation? ☐ Yes ☐ No
Describe arrangements: _____

_____

_____

_____

Does the patient/client have special health care needs requiring special transportation assistance? ☐ Yes ☐ No
Describe health care needs for special transportation: _____

_____

_____

_____

_____

If the patient/client may need evacuation assistance, is not registered and wants to be registered, agency personnel must provide the client with the amount of assistance the client requests to complete the registration process for evacuation assistance. Describe the assistance provided to register:

_____

_____

_____

_____

_____ _____

Signature of Admitting Clinician Date

Medicare Patient Choice Statement

(To be completed for all new patients/guardians)

I, _____ (patient name), the undersigned, patient/guardian understand that it is my right to select the home care provider of my choice.

I have selected _____ (further referred to as Agency) free of any undue pressure or solicitation by any officer, director, employee, agent or contractor of Agency. I have been advised by Agency that I may request information concerning its scope of practice, services available and telephone numbers. I was encouraged to ask specific questions concerning my individual needs to assess whether Agency is a good fit for me. I have been able to ask questions and express concerns, which have been satisfactorily responded to by Agency's staff. I further declare that my receipt of home care services from Agency is by choice. I have been advised by the admitting professional that if for any reason I wish to change services to another home care agency, it is my right to do so.
I have not selected a Medicare HMO provider. If I decide to select such a provider, I will notify this Agency immediately.

Beneficiary Elected Transfer Statement

(To be completed by all patients transferring from other agencies)

Discovery efforts:

☐ HIQH Query /Customer Service indicates patient under an established home health plan of care

I, _____, the undersigned patient/guardian choose to transfer to

_____ (Agency),

from _____(Initial home health agency). Effective transfer date

_____.

My reason(s) for this request is:

☐ I believe I will be better served by Agency

☐ I wish to be served by _____, a nurse/aide/therapist employed by Agency.

☐ Other (explain) _____.

I am making this request of my own free will and have not been coerced, solicited, or pressured to do so by any employee of Agency.
I understand if Medicare is the payer of services, the initial home health agency will no longer receive Medicare Payment on my behalf and will no longer provide Medicare covered services to me after the effective date of transfer. I request that my records be released to the receiving agency to ensure continuity of care.

_____ _____

Signature of Patient/Guardian Date

_____ _____

Signature of Agency Representative Date

For Agency Use Only

Coordination of Transfer:

☐ Phone call to _____ (initial home health agency) for coordination of transfer on _____. Contact person:_____

☐ "Beneficiary Elected Transfer/Right of Choice" form sent /faxed to Initial agency on_____

Figure: 25 TAC §157.25 (h)(2)

OUT-OF-HOSPITAL DO-NOT-RESUSCITATE (OOH-DNR) ORDER

Print form

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

STOP DO NOT RESUSCITATE

This document becomes effective immediately on the date of execution for health care professionals acting in out-of-hospital settings. It remains in effect until the person is pronounced dead by authorized medical or legal authority or the document is revoked. Comfort care will be given as needed.

Person's full legal name _____ Date of birth _____ ☐ Male ☐ Female

A. Declaration of the adult person: I am competent and at least 18 years of age. **I direct that none of the following resuscitation measures be initiated or continued for me: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Person's signature _____ Date _____ Printed name _____

B. Declaration by legal guardian, agent or proxy on behalf of the adult person who is incompetent or otherwise incapable of communication:

I am the: ☐ legal guardian; ☐ agent in a Medical Power of Attorney; OR ☐ proxy in a directive to physicians of the above-noted person who is incompetent or otherwise mentally or physically incapable of communication.

Based upon the known desires of the person, or a determination of the best interest of the person, **I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Signature _____ Date _____ Printed name _____

C. Declaration by a qualified relative of the adult person who is incompetent or otherwise incapable of communication: I am the above-noted person's:

☐ spouse, ☐ adult child, ☐ parent, OR ☐ nearest living relative, and I am qualified to make this treatment decision under Health and Safety Code §166.088.

To my knowledge the adult person is incompetent or otherwise mentally or physically incapable of communication and is without a legal guardian, agent or proxy. Based upon the known desires of the person or a determination of the best interests of the person, **I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Signature _____ Date _____ Printed name _____

D. Declaration by physician based on directive to physicians by a person now incompetent or nonwritten communication to the physician by a competent person: I am the above-noted person's attending physician and have:

☐ seen evidence of his/her previously issued directive to physicians by the adult, now incompetent; OR ☐ observed his/her issuance before two witnesses of an OOH-DNR in a nonwritten manner.

I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.

Attending physician's signature _____ Date _____ Printed name _____ Lic# _____

E. Declaration on behalf of the minor person: I am the minor's: ☐ parent; ☐ legal guardian; OR ☒ managing conservator.

A physician has diagnosed the minor as suffering from a terminal or irreversible condition. **I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Signature _____ Date _____

Printed name _____

TWO WITNESSES: (See qualifications on backside.) We have witnessed the above-noted competent adult person or authorized declarant making his/her signature above and, if applicable, the above-noted adult person making an OOH-DNR by nonwritten communication to the attending physician.

Witness 1 signature _____ Date _____ Printed name _____

Witness 2 signature _____ Date _____ Printed name _____

Notary in the State of Texas and County of _____. The above noted person personally appeared before me and signed the above noted declaration on this date: _____

Signature & seal: _____ Notary's printed name: _____ *Notary Seal*

[Note: Notary cannot acknowledge the witnessing of the person making an OOH-DNR order in a nonwritten manner]

PHYSICIAN'S STATEMENT: I am the attending physician of the above-noted person and have noted the existence of this order in the person's medical records. **I direct health care professionals acting in out-of-hospital settings, including a hospital emergency department, not to initiate or continue for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Physician's signature _____ Date _____

Printed name _____ License # _____

F. Directive by two physicians on behalf of the adult, who is incompetent or unable to communicate and without guardian, agent, proxy or relative: The person's specific wishes are unknown, but resuscitation measures are, in reasonable medical judgment, considered ineffective or are otherwise not in the best interests of the person. **I direct health care professionals acting in out-of-hospital settings, including a hospital emergency department, not to initiate or continue for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Attending physician's signature _____ Date _____ Printed name _____ Lic# _____

Signature of second physician _____ Date _____ Printed name _____ Lic# _____

Physician's electronic or digital signature must meet criteria listed in Health and Safety Code §166.082(c).

All persons who have signed above must sign below, acknowledging that this document has been properly completed.

Person's signature _____ Guardian/Agent/Proxy/Relative signature _____

Attending physician's signature _____ Second physician's signature _____

Witness 1 signature _____ Witness 2 signature _____ Notary's signature _____

This document or a copy thereof must accompany the person during his/her medical transport.

A. Notifier:

B. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for D._____ 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 D._____ below.

D.	E. Reason Medicare May Not Pay:	F. 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 D._____ 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.

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

☐ OPTION 1. I want the D._____ 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 D._____ 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 D._____ listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

H. 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.

I. Signature:	J. Date:

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