MAPLEWOOD
HOME CARE

1736 Cope Ave E Suite 2 | Maplewood, MN 55109 | P: 952-456-6561 | F: 952-777-1668 | seniorhomeinc.com

RECIPIENT SERVICE AGREEMENT

Date: _____

Recipient Information			
Last Name	First Name, Middle Initial		Date of Birth
Address			
City	State		Zip Code
Phone Number	Alternate Phone Number	E-Mail	

Responsible Party Information (NOTE: Responsible Party cannot be the caregiver.)			
Last Name	First Name		Middle Name
Relationship to Care Recipient			
Address			
City	State		Zip Code
Phone Number	Alternate Phone Number	E-Mail	
If you have Power of Attorney or Legal Guardianship, provide copy.			

Medical Assistance clients may have "Spend Down" contributions or "Co-payments". Please see your documentation from the county to define the co-payments and the amounts. If you are required to contribute to your care, the financially responsible party will be listed below.

Is recipient financially responsible for co-payments: ☐ Yes ☐ No (If yes, please complete information below)

Financial Responsible Party			
Last Name	First Name		Middle Name
Address			
City	State		Zip Code
Phone Number	Alternate Phone Number	E-Mail	
Current Spend Down Amount-subject to change		$	
Co-Payment – current rate based on County assessment		$	

Care Management / Supervisory Nurse Visits are required per MN Rule 4668.

The Supervisory Nurse visits are required when a Service Authorization is received by the Agency, fourteen days after the start of service and every 90 - 120 days going forward. Supervisory nurse visits are not scheduled in advance. They are meant to be a drop-in visit when the caregiver is scheduled to work so the nurse may supervise the work performed and the way it is performed.

SERVICES REQUESTED

Services to be provided. **See care plan for all service details.**	**Units per week allocated**	**Services provided by**

SCHEDULES:

Units authorized per week _____

INITIAL PRE-DETERMINED SCHEDULE (subject to change by verbal or written authorization)

DAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
TIME IN							
TIME OUT							

We will attempt to accommodate reasonable schedule requests. Based on staffing availability for the dates and times requested, not all schedules can be met. An initial weekly schedule will be set. All changes to the schedule are to be made via the office. Schedule changes should be kept to a minimum. Frequent changes may result in fewer units serviced or termination of our agency's services.

- Schedules are not to be less than 3 hours per shift.
- Client **MAY NOT** leave the premises while caregiver is on duty unless caregiver is accompanying client.

CONTINGENCY PLANS:

☐ **NONESSENTIAL SERVICES: If Agency is unable to keep a scheduled appointment that is not essential for medical or safety reasons. The Agency will provide a replacement person or notify the care recipient and reschedule the appointment.**

SCHEDULING TERMS: I understand that, in fairness to our caregivers, the Agency cannot adjust work schedules on short notices. If a schedule change is needed, I agree to contact the agency at least 24 hours in advance to reduce the number of hours or cancel a visit. Otherwise, I will be personally responsible for paying for the predetermined schedule time. Therefore, I agree to contact the Agency's office before making schedule changes (day or time) with the Caregiver.

OVERTIME SCHEDULES: Any overtime needs approval from the Agency. You may not work overtime without permission from the Agency.

Typically, a caregiver is not required to work on a holiday, unless the client is receiving essential services each day. The following holidays are: *New Year's Day, Memorial Day, Fourth of July, Labor Day, Thanksgiving Day, and Christmas Day.*

CAREGIVER PERMISSION: Under no circumstance is a caregiver allowed in care recipient's residence without the care recipient present.

TRANSPORTATION: In no way shall a caregiver provide transportation services. If the care plan requires the

caregiver to accompany the care recipient for doctor appointments or errands, the care recipient is responsible for lining up transportation and pay for the caregiver's share of the ride.

GIFTS OR TIPS: Caregivers are not permitted to accept gifts from the Care Recipient or the Responsible Party. Additionally, the caregiver is not permitted to borrow money from either party. **If caregiver requests money, please notify the Agency immediately.**

LIGHT HOUSEKEEPING: Agency's Caregivers may provide general housekeeping services and be responsible for tidying up rooms where the Care Recipient spends time. Kitchen assistance may include washing dishes after meals, cleaning the sink, washing, or sweeping the kitchen floor. Bathroom cleaning may include scrubbing the tub, shower, wiping spills, and general tasks. Other assistance may include vacuuming, laundry, making the bed and dusting. Please hire a cleaning service for tasks such as washing windows, dusting, and vacuuming behind and under furniture, drapery cleaning and heavy laundry. In addition, outside service providers must be used for all outdoor tasks such as lawn and maintenance or snow removal.

FEE FOR SERVICES: You are responsible for all spend down and co-payment fees. Spend down payments are due by the first of each month and must be paid in full to the Agency prior to receiving services. In addition, if you cancel without 24-hour notice or cut short the scheduled time, you will be charged based on the current reimbursement rate from the county or other service provided by Minnesota Department of Health.

AGENCY RESPONSIBILITIES:

- Send qualified staff.
- Notify Care Recipient and/or Responsible Party of any changes in the schedule, services, or fees.
- Respond to Care Recipient/Family concerns.
- Coordinate care to assure appropriate and timely services provided.
- Communicate changes in coverage and inform Care Recipient Party of rights in obtaining services.
- Maintain insurance for injury/harm to caregiver and employee dishonesty.

CARE RECIPIENT/RESPONSIBLE PARTY RESPONSIBILITIES:

- Participate in the development of a Care Plan.
- Provide a safe work environment free of harassment or abuse for Agency's personnel.
- Notify office if you need to cancel or reschedule services and provide **at least 24 hours advanced notice**. If frequent cancelations or "No-Shows" (caregiver arrives and client is not at home or will not let caregiver in) your service may be terminated, and the case manager notified.
- Pay agreed upon fee for services provided or arrange for payment to be made.
- Accept responsibility for actions if I choose not to follow the Care Plan, including any physician's orders if applicable.
- Contact the office immediately if you have a concern or problem.

SECURING PROPERTY: Care Recipient/Responsible Party is encouraged to secure all narcotic medicines, cash, and valuables in a secure place (such as a safe) or remove them from Care Recipient's premises. If the Care Recipient/Responsible Party suspects that any cash or valuable is found to be missing from their premises; the Care Recipient/Responsible Party must inform the Agency and if appropriate, file a police report.

In addition, the Care Recipient shall maintain insurance coverage for the theft or loss of cash or valuables.

RELEASE OF LIABILITY: Care Recipient/Responsible Party hereby releases Agency from liability for any act or omission of Agency's caregiver that may be harmful to Care Recipient and that arises from the provision of

services to Care Recipient pursuant to this Agreement, including those acts or omissions that arise from a caregiver's negligence. Care Recipient shall maintain homeowners/renters' insurance, medical insurance, and or other coverages as necessary to provide protection for the Care Recipient.

RELEASE OF INFORMATION: I authorize information in my medical record to be released to an authorized representative of Medicare, Medicaid, or another medical insurance carrier for use in determining home health care benefits payable to me or the Agency on my behalf. I authorize my hospital, nursing home, physician's office, or other health facility where I have been a client, to disclose any part or all my medical record to this Agency. Also, I authorize the release of medical and other related information to social, government, and other health care agencies and medical equipment/supply vendors whose services may be required in conjunction with the services provided by this Agency. I understand my medical information may be shared with my physician, Agency's Staff, insurers and representatives of accreditation and regulatory bodies as appropriate.

EMERGENCY PROCEDURE PLAN:

ADVANCED DIRECTIVES: Please place a copy of Advanced Directives in folder for Caregiver.

Advanced Directive: ☐ Written information has been provided to client

Code Status: ☐ DNI/DNR ☐ FULL CODE

In the event of medical or situational emergency please contact:

Name: _____ Phone number: _____

Relationship to Care Recipient: _____

Care Recipient and/or Responsible Party will be responsible for updating the Agency with changes to the Advanced Care Directive and emergency contact listed above. NOTE: In Emergencies, *the caregiver will call 911 and then contact the Agency. The Agency will contact the Responsible Party or individual stated above.

*Exceptions: If the Care Recipient is receiving hospice services, hospice is always called first –or-
If Care Recipient is receiving care in an Assisted Living Facility, the facility staff will be contacted first.

GREIVANCES/COMPLAINTS: Please report any problems or dissatisfaction as soon as possible to the office. We value your concerns and opinions as well as our reputation. We will make every attempt to promptly resolve your problem. Please contact our office at (952) 456-6561 or submit your concerns in writing and send them to: Office Manager, Kongmeng Yang, Maplewood Home Care, Inc., 1736 Cope Ave E, Suite 2, Maplewood, MN 55109. Upon receipt of your concern, the Director will contact the Care Recipient and/or Responsible Party to determine a resolution to the complaint. If at any time the Care Recipient and/or Responsible Party determine that the complaint was not resolved, they may contact the MN Department of Health. The Office of Health Facility Complaints is at (651) 201-4201 or toll free 1(800) 369-7994. The Agency will not take any action that negatively affects a client in retaliation because of a complaint made by the client.

CONSENT OF CARE: The services to be provided by Maplewood Home Care, Inc. staff have been explained to me. I hereby consent to Agency's Registered Nurse (RN), Administrative Staff and caregivers to visit my home periodically to render home care and/or provide oversight. I understand the plan of care may change and such changes will be discussed with me. Instructions for my care will be explained to me and will become my responsibility in the absence of a home care staff member.

AGENCY INFORMATION	
President:	**Gaolee Yang**
Office Manager:	**Kongmeng Yang ; (651) 307-3143**
Address:	**1736 Cope Ave E Suite 2, Maplewood, MN 55109**
Phone:	**Office: (952)-456-6561 , Fax: (952)-777-1668**
Business Hours:	**Monday – Friday, 9:00 AM – 5:00 PM**

DISPUTE RESOLUTION: Any monetary controversy or claim arising out of or relating to this Agreement, or the breach thereof, more than ten thousand dollars ($10,000) shall be settled by one arbitrator in arbitration administered by the American Arbitration Association or the National Arbitration Forum under the applicable Arbitration Rules. Judgment on the award rendered by the sole arbitrator may be entered in any court having jurisdiction thereof.

ACKNOWLEDGEMENTS	INITIAL
MINNESOTA HOME CARE BILL OF RIGHTS: The Minnesota Home Care Bill of Rights has been explained to me and I have received a copy to retain in my home file.	
PRIVACY RIGHTS: I have been advised of my privacy rights and have received a copy of Maplewood Home Care's Notice of Privacy Rights.	
ACCESS TO HEALTH RECORDS NOTICE OF RIGHTS: I have received a copy of the "Access to Health Records Notice of Rights".	

AGREED AND ACCEPTED

The information in this service agreement has been adequately explained to me and I agree to its term and conditions. I also agree to pay for all charges for services Agency provides pursuant to this Client Service Agreement. I also understand that the Service Agreement and the enclosed rate for services may be amended from time to time.

_____ _____

Signature of Care Recipient or Responsible Party Date

_____ _____

Signature of Agency Representative Date

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CHANGE OF AGENCY FORM

Notification Date: _____

Recipient Information					
Name:					
Date of Birth:		Social Security #:			
Address:					
City:		State:		Zip Code:	
PMI/MA #:		HMO#:			

I am notifying _____ to bill my services up to _____.

Effective _____, my services will be billed through the new agency Maplewood Home Care.

_____ _____

Recipient/Responsible Party Signature Date

☐ PCA Choice ☐ PCA Tradition

MAPLEWOOD HOME CARE

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AGREEMENT FOR PERSONAL CARE ASSISTANCE SERVICES
BETWEEN
MAPLEWOOD HOME CARE, RECIPIENT/RESPONSIBLE PARTY, PERSONAL CARE ASSISTANT,
AND QUALIFIED PROFESSIONAL

Personal care assistance choice is an option of the personal care assistance program that allows the recipient who receives personal care assistance services to be responsible for the recruiting, hiring, scheduling, and terminating of personal care assistants. This program offers greater control and choice for the recipient in who provides the personal care assistance service and when the service is scheduled.

This personal care assistance choice provider agency manages payroll, invoices the state, is responsible for all payroll-related taxes and insurance, and is responsible for providing the consumer training and support in managing the recipient's personal care assistance services.

PURPOSE

By signed bellow we acknowledge that we choose ☐**PCA Choice** ☐**PCA Tradition**. We enter into this agreement for the provision of personal assistance services to the consumer and as joint employers of record, this agreement is between (please print)

1. _____
   Print Name of Recipient

2. _____
   Print Name of Personal Care Assistant

3. Senior Home Living, Inc. DBA Maplewood Home Care
   Name of Agency

4. _____
   Print Name of Qualified Professional

REGULATORY COMPLIANCE

All parties are responsible for complying with all rules and regulations related to the PCA program (Minnesota State Law 256B.0659). This includes, but is not limited to state Vulnerable Adults Act, Data Privacy, PCA regulations, including medication administration, and Department of Labor laws governing overtime, etc. It is a federal crime to provide false information on PCA billings for medical assistance payment. Your signature verifies the time and services are accurate and that the services were performed as specified in the PCA Care Plan.

CANCELLATION AND AMENDMENTS

Provider agency or recipient may choose to cancel or amend this contract at any time with a 30-day notice. I have read and understand the entire agreement here within and agree to follow all duties and rules. Also, with this signature I agree that I have been provided with a copy of the Home Care Bill of Rights. I have read the Bill of Rights or had it explained to me. I understand the Bill of Rights and have had a chance to have all my questions answered.

Recipient/Responsible Party Signature	Date
Qualified Professional/MHC Representative Signature	Date
Personal Care Assistant Signature	Date

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As a Personal Care Assistant paid by Maplewood Home Care, you are an at-will employee. Remember that working as a PCA in the *Choice* program, your *Boss* is your recipient or the Responsible Party (the person directing care.)

You are required to complete the DHS Standardized Training requirement as a condition of your employment. You are required to complete annual trainings as per agency policy. Your employment is at the discretion of the recipient or responsible party, and they choose when you are hired or fired. If terminated, Maplewood Home Care is not responsible to transfer or re-assign any PCA to any other recipient. Employment is simply terminated.

Termination of PCA may also occur at any time if the recipient is deemed no longer eligible for PCA services according to the Department of Human Services, or because of a background study, or other reason, the PCA is deemed ineligible to provide services.

PERSONAL CARE ASSISTANT RESPONSIBILITIES

- Provide personal care services to recipient as stated on page one and as specified in their plan of care.
- Obtain training from recipient, with assistance from a qualified professional to ensure PCA can satisfactorily perform all responsibilities in the recipient's plan of care as a condition of my employment and is my responsibility.
- Complete all required forms and provide necessary information to recipient/agency, including background check verification, prior to working for this recipient.
- Pass a criminal background check prior to beginning employment as a PCA and as a requirement of eligibility to be a personal care assistant.
- Work at scheduled times as determined by the recipient, notifying the recipient of changes as early as possible to arrange for backup assistance.
- If PCA is unavoidably going to be late, make every attempt possible to notify the recipient.
- Accurately document time worked for recipients by completing timesheets daily and accurately recording the activities performed during the visit according to the care plan.
- Submit timesheets each Monday to obtain pay on a regularly scheduled basis. Pay is only based on timesheets, not scheduled hours.
- Give a minimum of a two week notice if PCA wants to terminate this employment agreement.
- Meet Minnesota Statutory Personal Care Assistant requirements including all Personal Care Assistant training requirements as a condition of employment.
- Understand that PCA's can only work 275 hours per month and no more than 16 hours per day or 40 hours per week regardless of the number of recipients served or agencies they are working for.
- Have a right to respond or document complaints in accordance with Maplewood Home Care Employee Policy.

☐ PCA Choice ☐ PCA Tradition

RECIPIENT/RESPONSIBLE PARTY RESPONSIBILITIES

- Notify Maplewood Home Care if you have a spenddown or are ever notified that you have a spenddown in the future.
  Do you have a spenddown? ☐ Yes ☐ No If yes, notify the office of amount.
- You are responsible for personal payments to providers. Payments are required to be automatically debited from personal account on the first of each month. See attached form for authorization.
- Develop a personal care assistance care plan based on the assessed needs and addressing the health and safety of the recipient with the assistance of a qualified professional as needed.
- Engage in an annual face-to-face reassessment to determine continuing eligibility and service authorization and be responsible to pay my PCA out of my personal funds if they are not eligible or I exceed my allotted PCA hours.
- Use the same personal care assistance choice provider agency if shared personal assistance care is being used.
- Accept responsibility for health and safety, including finding staff or supports that ensure needs for assistance are met.
- Responsibilities regarding procedures for hiring/firing personal care assistants:
  - Recruit, hire, schedule, and terminate personal care assistants and a qualified professional.
  - Orient and train the personal care assistant with assistance as needed from the qualified professional and ensure that PCA staff hired can adequately perform the tasks and care that are needed.
  - Ensure adequate backup staff or supports are in place in case a regularly scheduled PCA is unable to work scheduled shift.
  - Refer individuals to MHC to fill out necessary forms to be paid as PCAs.
  - Schedule PCA staff.
  - Supervise and evaluate the personal care assistant with the qualified professional, who is required to visit the recipient at least every 90 to 120 days.
  - Monitor and verify in writing to the personal care assistance choice agency the number of hours worked by the personal care assistant and the qualified professional. Monitor time worked, complete timesheets and submit timesheets for PCA staff to ensure staff are paid on time.
  - Provide ongoing supervision and evaluation of PCA staff with assistance as needed from a doctor or qualified professional.
  - If you are having difficulty with your PCA staff, contact your Qualified Professional.
  - Notify MHC prior to terminating PCA staff.

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PCA CHOICE PROVIDER RESPONSIBILITIES

- Be the employer of the personal care assistant and the qualified professional for employment law and related regulations including, but not limited to, purchasing, and maintaining workers' compensation, unemployment insurance, surety and fidelity bonds, liability insurance, and submit any or all necessary documentation including, but not limited to, workers' compensation and unemployment insurance.
    - Pay the PCA a minimum of 72.5% of the reimbursement rate in wages & benefits
    - The remaining amount goes to pay employers share of payroll taxes; Pay Unemployment & Workers Compensation Insurance; Pay costs of Legislatively Mandated PCA Program Requirements (billing, background checks, postage, telephone, payroll and other direct PCA program costs).
    - Upon request, we will provide you with an itemized breakdown of the current amounts as these typically change with each legislative session.
- Pay the qualified professional a minimum of 72.5% of the reimbursement rate - min in wages and benefits.
- Obtain releases and submit background checks for PCA staff referred.
- Pay the personal care assistant timely and after all signed documentation is returned
- Pay for the following benefits for personal care assistants: training time and training courses (specify cost of benefits if applicable)
- Process timesheets on alternate weeks according to the pay schedule. Submit timesheets for PCA staff or qualified professional to MHC on alternate weeks according to the MHC pay schedule to ensure payment occurs on the following alternate week according to the MHC pay schedule. Timecards may be submitted by U.S. mail, fax, or be dropped off at the MHC office.
- Withhold all applicable state and federal taxes from personal care assistant's paycheck.
- Arrange for and pay unemployment insurance, workers compensation, liability insurance for all staff.
- Paychecks will be issued on alternate weeks according to the pay schedule.
- Paychecks will be mailed via the U.S. mail or processed through direct deposit.
- If a problem occurs with a paycheck, contact the MHC payroll administrator.

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QUALIFIED PROFESSIONAL RESPONSIBILITIES

- All personal care assistants must be supervised by a qualified professional.
- Develop and monitor with the recipient a personal care assistance care plan based on the service plan and individualized needs of the recipient.
- Develop and monitor with the recipient a monthly plan for the use of personal care assistance services.
- Provide training and ensure competency for the personal care assistant in the individual needs of the recipient.
- Through direct training, observation, return demonstrations, and consultation with the staff and the recipient, the qualified professional must ensure and document that the personal care assistant is:
  - Capable of providing the required personal care assistance services.
  - Knowledgeable about the plan of personal care assistance services before services are performed.
  - Able to identify conditions that should be immediately brought to the attention of the qualified professional.
- Document all training, communication, evaluations, and needed actions to improve performance of the personal care assistants.
- Supervise and evaluate the personal care assistant with the qualified professional, and who is required to visit the recipient at least every 90-120 days.

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MINNESOTA HOME CARE BILL OF RIGHTS

Statement of Rights

A Client who receives home care services in the community has these rights:

1. Receive written information, in plain language, about rights before receiving services, including what to do if rights are violated.

2. Receive care and services according to a suitable and up-to-date plan, and subject to accepted health care, medical or nursing standards and person-centered care, to take an active part in developing, modifying, and evaluating the plan and services.

3. Be told before receiving services the type and disciplines of staff who will be providing the services, the frequency of visits proposed to be furnished, other choices that are available for addressing home care needs, and the potential consequences of refusing these services.

4. Be told in advance of any recommended changes by the provider in the service plan and to take an active part in any decisions about changes to the service plan.

5. Refuse services or treatment.

6. Know, before receiving services or during the initial visit, any limits to the services available from a home care provider.

7. Be told before services are initiated what the provider charges for the services: to what extent payment may be expected from health insurance, public programs, or other sources if known; and what charges the client may be responsible for paying.

8. Know that there may be other services available in the community, including other home care services and providers, and to know where to find information about these services.

9. Choose freely among available providers and to change providers after services have begun, within the limits of health insurance, long-term care insurance, medical assistance, other health programs or public programs.

10. Have personal, financial, and medical information kept private, and to be advised of the provider's policies and procedures regarding disclosure of such information.

11. Access the client's own records and written information from those records in accordance with the Minnesota Health Records Act, Minnesota Statute Sections 144.291 to 144.298.

12. Be served by people who are properly trained and competent to perform their duties.

13. Be treated with courtesy and respect, and to have the client's property treated with respect.

14. Be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act.

15. Reasonable, advance notice of changes in services or charges.

16. Know the provider's reason for termination of services.

17. At least ten calendar days' advance notice of the termination of the service by a home care provider. This clause does not apply in cases where:

- The client engages in conduct that significantly alters the terms of the service plan with the home care provider.
- The client, person who lives with the client, or others create an abusive or unsafe work environment for the person providing home care services.
- An emergency or a significant change in the client's condition has resulted in service needs that exceed the current service plan and that cannot be safely met by the home care provider.

18. A coordinated transfer when there will be a change in the provider of services.

19. Complain to staff and others of the client's choice about services that are provided, or fail to be provided, and the lack of courtesy or respect to the client or the client's property, and the right to recommend changes in policies and services, free from retaliation, including the threat of termination of services.

20. Know how to contact an individual associated with the home care provider who is responsible for handling problems and to have the home care provider investigate and attempt to resolve the grievance or complaint.

21. Know the name and address of the state or county agency to contact for additional information or assistance.

22. Assert these rights personally or have them asserted by the client's representative or by anyone on behalf of the client, without retaliation.

23. Place an electronic monitoring device in the client's or resident's space in compliance with state requirements.

Effective January 1,2020

IF YOU HAVE A COMPLAINT ABOUT THE AGENCY OR PERSON PROVIDING YOUR HOME CARE SERVICES, YOU MAY CALL, WRITE, OR VISIT THE OFFICE OF HEALTH FACILITY COMPLAINTS, MINNESOTA DEPARTMENT OF HEALTH. YOU MAY ALSO CONTACT THE OMBUDSMAN FOR LONG-TERM CARE.

Office of Health Facility Complaints Minnesota Department of Health P.O. Box 64970 Saint Paul, MN 55164-0970 1-800-369-7994 Fax: 651-281-9796	The Office of Ombudsman for Long-Term Care P.O. Box 64971 Saint Paul, MN 55164 Fax: 651-431-7452 Email: MBA.OOLTC@state.mn.us	Maplewood Home Care 1736 Cope Ave E Suite 2 Maplewood, MN 55109 Phone: 952-456-6561 Fax: 952-777-1668 Email. admin@seniorhomeinc.com

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Recipient's Name: _____ Date of Birth: _____

PMI#: _____

I request and authorize_____ to release healthcare information of the patient named above to:

SENIOR HOME LIVING, INC. DBA MAPLEWOOD HOME CARE
1736 COPE AVE E SUITE 2
MAPLEWOOD, MN 55109

This request and authorization apply to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

Yes	No	
☐	☐	I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.
☐	☐	I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

This authorization shall be valid for a period of one year, but I reserve the right to, at any time prior to that expiration, cancel the written authorization by providing written notice to Maplewood Home Care or to you that fact. Photocopies of this authorization will be treated in the same manner as the original release form.

_____

Responsible Party/Recipient Signature **Date**

NOTICE OF PRIVACY RIGHTS

Name of Organization:
Senior Home Living, Inc. DBA Maplewood Home Care

THIS NOTICE DESRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

WE ARE REQUIRED BY LAW TO MAINTAIN THE PRIVACY OF PROTECTED HEALTH INFORMATION, TO PROVIDE INDIVIDUALS WITH NOTICE OF OUR LEGAL DUTIES AND PRIVACY PRACTICES WITH RESPECT TO PROTECTED HEALTH INFORMATION AND TO NOTIFY AFFECTED INDIVIDUALS FOLLOWING BREACH OF UNSECURED PROTECTED HEALTH INFORMATION.

1. Below is a description, including at least one (1) example of the types of uses and disclosures that the above organization is permitted to make for each of the following purposes: treatment, payment, and health care operations.

   Disclosures to other health care providers, including, for example, to patients' attending physicians. Submission of claims and supporting documentation including, for example, to organizations responsible to pay for services provided by the organization. Disclosure to conduct the operations of the organization, including, for example, sharing information to supervisors of staff members who provide care to patients.

2. Below is a description of each of the other purposes for which the organization is permitted or required to use or disclose protected health information without an individual's written consent or authorization.

   To patients, incident to another permitted use or disclosure, by agreement, to the Secretary of the U.S. Department of Health and Human Services, as required by law, for public health activities, information about victims of abuse, neglect or domestic violence, health oversight activities, for judicial and administrative proceedings, for law enforcement proceedings, about decedents, for cadaveric organ, eye or tissue donation, for research purposes, to avert a serious threat to health or safety, for specific government functions, to business associates of the organization, to personal representatives, de-identified information, to workforce members who are victims of crimes, to workers' compensation programs, for involvement in the individual's care and for notification purposes, with the individual present, for limited uses and disclosures when the individual is not present, and for disaster relief purposes.

3. Other uses and disclosures, such as disclosure of psychotherapy notes, use of protected health information for marketing activities and the sale of protected health information, will be made only with the individual's written authorization and the individual may revoke such authorization.

4. The organization may contact the individual to schedule visits and for other coordination of care activities.

5. The individual has the right to request further restrictions on certain uses and disclosures of protected health information, but the organization is not required to agree to any requested restriction(s), except disclosures must be restricted to health plans if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law and the protected health information pertains solely to a health care item or service for which the individual or person other than the health plan on behalf of the individual has paid the organization in full.

6. The individual has the right to receive confidential communications of protected health information, the right to inspect and copy protected health information, the right to demand protected health information, the right to receive an accounting of disclosures of protected health information and the right to obtain a paper copy of this Notice form the organization upon request.

7. The organization is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices with respect to protected health information and to notify affected individuals following a breach of unsecured protected health information.

8. The organization is required to abide by the terms of this Notice currently in effect.

9. The organization reserves the right to change the terms of its Notice and to make the new notice provisions effective for all protected health information that it maintains. Individuals may obtain a revised copy of this Notice upon request.

10. Individuals may complain to the organization and to the Secretary of the U.S. Department of Health and Human Services if they believe their privacy rights have been violated. Complaints should be directed to Kongmeng Yang, Office Manager, at the organization at the following telephone number: (952) 456-6561. Individuals will not be retaliated against for filing a complaint.

11. For further information, individuals should contact **Kongmeng Yang,** *Office Manager*, at the organization at the following telephone number: (952) 456-6561.

12. The organization reserves the right to change the terms of this notice and to make the new notice provisions effective for all protected health information that it maintains. This notice is in effect as of September 23, 2013.

13. My signature below is an acknowledgement that I have received a copy of this notice.

_____

Responsible Party/Recipient Signature Date

Documentation of good faith efforts to obtain the recipient's signature if unable to obtain.

MAPLEWOOD
HOME CARE

1736 Cope Ave E Suite 2 | Maplewood, MN 55109 | P: 952-456-6561 | F: 952-777-1668 | seniorhomeinc.com

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE
Maplewood Home Care

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of Maplewood Home Care's "NOTICE OF PRIVACY PRACTICES".

Revision Date: _____

As required by the Privacy Regulations, _____from
Name of Staff Member

Maplewood Home Care has explained the "NOTICE OF PRIVACY PRACTICES" to my satisfaction.

As required by the privacy regulations, I am aware that Maplewood Home Care has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

Requests (if any):

- ☐ I wish to file a "Request for Restriction" of my Protected Health Information.
- ☐ I wish to file a "Request for Alternative Communications" of my Protected Health Information.
- ☐ I wish to object to the following in the "Notice of Privacy Practices:

_____

_____

I understand that this office is not required to honor any changes to the "Notice of Privacy Practices".

_____
Print Name

_____ _____
Signature Date

Office Use Only:

Signed form received by: _____ Date: _____

Good faith effort to obtain receipt: (Describe)

_____

_____

_____

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GRIEVANCE POLICY

Licensee Information: Maplewood Home Care

Name & Title of person to whom problems or complaints may be directed:

Gaolee Yang – President / Owner
Kongmeng Yang- Office Manager

Grievance Procedure:

1. Recipient will be provided with a copy of the Home Care Bill of Rights.
2. Agency requests that recipients contact the above designated agency representative to discuss their concerns and resolve issues.
3. If a complaint regarding services is received, the Director will contact the involved parties to discuss the situation and attempt to reconcile. If the complaint is not resolved verbally, it will be recorded on a Complaint Form.
4. A written response will be sent to the recipient as soon as possible, but no later than 15 days after receipt of the complaint.
5. If the complaint is not resolved, it may be appealed to the Governing Body within 30 days of receipt, with a written response of the appeals decision provided.
6. Client is informed both verbally and in writing of outside agency resources to assist client with grievance resolution including:

   The Office of Health Facilities Complaints – The Minnesota Department of Health
   Monday – Friday 8:00A.M – 5:00 P.M.
   Metro: (651) 201-4201
   Outside Metro Area: 1(800) 369-7994

7. Agency will not obtain any waiver of client rights and will not retaliate in any way if a complaint is filed.

By signing below, I acknowledge that this policy has been explained to me and I have had all my questions answered.

Recipient/Responsible Party Signature	Date
MHC Representative Signature	Date

ADULT DAYCARE RELEASE OF INFORMATION

To provide sufficient services to you, Maplewood Home Care may need to obtain information from the Adult Daycare center or share information with other individuals, programs, or providers. If Maplewood Home Care does not get requested information, or if we cannot share with others who work with you, then we might not be able to provide you services you may need.

☐ No, I do not attend adult day care.

☐ Yes, I attend adult day care.

(If you answered yes, please complete the sections below.)

I, _____ (name of Client/Responsible Party) authorize Maplewood Home Care to obtain information from the Adult Daycare center I attend.

Name of Adult Daycare Center:	
Address:	
Phone:	

CLIENT'S SCHEDULE:

Day	**Time**
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	

I know that state and federal privacy laws protect my records. I know:

- Why I am being asked to release this information.
- I do not have to consent to the release of this information. However, not doing so may affect Maplewood Home Care's ability to provide needed services to me.
- If I do not consent, the information will not be released unless the law otherwise allows it.
- The person(s) or agency(ies) who get my information may be able to pass it on to others.

_____ _____

Client/Responsible Party's Signature Date

_____ _____

MHC Representative's Signature Date

MAPLEWOOD
HOME CARE

MEDIA RELEASE CONSENT FORM

I/We, _____(**Client**) and _____(**Employee**) grant Maplewood Home Care the permission to use my/our photographs and/or videos for use in Media publications (e.g., agency website, brochures, social media, etc.).

Please initial the paragraph below which is applicable to your present situation:

_____I am 18 years of age or older and competent to contract in my own name. I have _____read this release before signing below and I fully understand the contents, meaning and impact of this release. I understand that I am free to address any specific questions regarding this release by contacting Maplewood Home Care. I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this release.

_____I am the parent/legal guardian of the above-named employee. I have read this release before signing below and I fully understand the contents, meaning and impact of this release. I understand that I am free to address any specific questions regarding this release by contacting Maplewood Home Care. I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this release.

Client/Responsible Party Signature Date

Employee Signature Date

Parent/Legal Guardian of employee under 18 years of age Date