



Maplewood Home Care

seniorhomeinc.com

1736 Cope Ave E | Suite 2 | Maplewood, MN 55109

Telephone: (952) 456-6561 | Fax: (952) 777-1668

RECIPIENT SERVICES AGREEMENT

Last Name		First Name, Middle Name		Date of Birth
Address				
City		State		Zip Code
Telephone	Alternate Telephone		E-Mail	

Responsible Party Information (NOTE: Responsible Party cannot be the Personal Care Assistant)				
Last Name		First Name		Middle Name
Relationship to Care Recipient				
Address				
City		State		Zip Code
Telephone	Alternate Telephone		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 care recipient financially responsible for co-payments: Yes No (If yes, please complete information below)

Financially Responsible Party			Date	
Last Name		First Name		Middle Name
Address				
City		State		Zip Code
Telephone	Alternate Telephone		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 30- 60 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 manner in which 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: A caregiver is not allowed to work more than 40 hours per work week. Our work week starts on Sunday 12:01 A.M. and end on Saturday. If the same Caregiver works more than 40 hours per week at your request, the rate will be at time and one-half and you will be responsible for the overtime charge.

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 and washing or sweeping the kitchen floor. Bathroom cleaning may include the tub and or shower, wiping spill 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 Client Recipient and/or Responsible Party of any changes in the schedule, services, or fees.
- Have a representative available by phone 24 hours per day.
- 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 development of Plan of Care.
- 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 in advance**. If frequent cancellations 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. In the event that 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 may be 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 of 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: <input type="checkbox"/> Written information has been provided to client
Code Status: <input type="checkbox"/> DNI/DNR <input type="checkbox"/> FULL CODE
In the event of medical or situational emergency please contact: Name: _____ Telephone: _____ 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 will 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: Director, Yong 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 no way take 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 in my home.

AGENCY INFORMATION: Agency's Director/Owner is: Kongmeng Yang. The Agency's Supervising Nurse is: Anna Fieser. Agency's phone number is: (952) 456-6561. Office hours are 8:30 AM – 5:00 PM, Monday-Friday, excluding major holidays. Our office is located at 1736 Cope Ave E, Suite 2, Maplewood, MN 55109.

AGENCY REPRESENTATIVES ARE ON CALL 24 HOURS A DAY. After hours phone is to be used solely for emergency situations – such as a caregiver did not show up or an unexpected illness has occurred. Calls should not be placed to the after hour number for schedule changes, questions regarding care etc. Please conduct that business during business hours.

DISPUTE RESOLUTION: Any monetary controversy or claim arising out of or relating to this Agreement, or the breach thereof, in excess of 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.

ACKNOWLEDGMENTS:

MINNESOTA HOMECARE BILL OF RIGHTS: The Minnesota Homecare Bill of Rights has been explained to me and I have received a copy to retain in my home file. Initial _____

PRIVACY RIGHTS: I have been advised of my privacy rights and have received a copy of Maplewood Homecare’s Notice of Privacy Rights. Initial _____

ACCESS TO HEALTH RECORDS NOTICE OF RIGHTS: I have received a copy of the “Access to Health Records Notice of Rights”. Initial _____

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 any and 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: _____

Client Name: _____

Date of Birth: _____ Social Security #: _____

Address: _____

City: _____ State: Minnesota Zip Code: _____

MA #: _____ HMO #: _____

I am notifying _____ to bill my services up to _____

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

Responsible Party Name (Print) & Relationship: _____

Client/Responsible Party Signature

Date

Maplewood Home Care

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Agreement for Personal Care Assistance Services

Between

Maplewood Home Care (MHC), 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. <u>Senior Home Living, Inc. DBA Maplewood Home Care</u>
Print 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 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 of my questions answered.

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

As a Personal Care Attendant 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 Standardize Training requirement as a condition of your employment. You are required to complete annual training 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 if as a result 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 consumers by completing time sheets on a **daily basis** and accurately recording the activities performed during the visit according to the care plan.
- Submit time sheets each Monday to obtain pay on a regularly scheduled basis. Pay is only based on time sheets, 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.

Recipient/Responsible Party Responsibilities

- Notify Maplewood Home Care if you have a spend down or are ever notified that you have a spend down in the future.

Do you have a spend down? No_____ Yes_____ 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 will regularly visit and who is required to visit the recipient at least every 180 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 time cards and submit time cards 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.

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, and 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 time cards on alternate weeks according to the pay schedule. Submit time cards 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. Time cards 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.

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, who will visit every 90 days and who is required to visit the recipient at least every 180 days.

Minnesota Home Care Bill of Rights

A person who receives home care services has these rights:

1. The right to receive written information about rights in advance of receiving care or during the initial evaluation visit before the initiation of treatment, including what to do if rights are violated.
2. The right to receive care and services according to a suitable and up-to-date plan, and subject to accepted medical or nursing standards, to take an active part in creating and changing the plan and evaluating care and services
3. The right to be told in advance of receiving care about the services that will be provided, the disciplines that will furnish care, the frequency of visits proposed to be furnished, other choices that are available, and the consequences of these choices, including the consequences of refusing these services.
4. The right to be told in advance, of any changes in the plan of care and to take an active part in any changes; and
5. The right to refuse services or treatment.
6. The right to know, in advance, any limits to the services available from a provider, and the provider's grounds for a termination of services.
7. The right to know, in advance of receiving care whether the services are covered by health insurance, medical assistance, or other health programs, the charges for services that will not be covered by Medicare, and the charges that the individual may have to pay.
8. The right to know what the charges are for services, no matter who will be paying the bill.
9. The right to know that there may be other services available in the community, including other home care services and providers, and to know where to go for information about these services.
10. The right to choose freely among available providers and to change providers after services have begun, within limits of health insurance, medical assistance, or other health programs.
11. The right to have personal, financial, and medical information kept private, and to be advised of the provider's policies and procedures regarding disclosure of such information.
12. The right to be allowed access to records and written information from records in accordance with section 144.335.
13. The right to be served by people who are properly trained and competent to perform their duties.
14. The right to be treated with courtesy and respect, and to have the patient's property treated with respect.
15. The right to be free from physical and verbal abuse.
16. The right to reasonable, advance notice of changes in services or charges, including at least 10 day's advance notice of the termination of a service by a provider, except in cases where:
 - (i) The recipient of services engages in conduct that alters the conditions of employment as specified in the employment contract between the home care provider and the individual providing home care services,
 - (ii) The recipient, person who lives with the recipient, or others create an abusive or unsafe work environment for the individual providing home care services; or
 - (ii) An emergency for the informal caregiver or a significant change in the recipient's condition has resulted in service needs that exceed the current service provider agreement and that cannot be safely met by the home care provider.
17. The right to a coordinated transfer when there will be a change in the provider of services.
18. The right to voice complaints regarding treatment or care that is, or fails to be, furnished, or regarding the lack of courtesy or respect to the patient or the patient's property.
19. The right to know how to contact an individual associated with the provider who is responsible for handling problems and to have the provider investigate and attempt to resolve the grievance or complaint.
20. The right to know the name and address of the state or county agency to contact for additional information or assistance.
21. The right to assert these rights personally, or have them asserted by the patient's family or guardian when the patient has been judged incompetent, without retaliate.

IF YOU HAVE A COMPLAINT ABOUT THE AGENCY OR PERSON PROVIDING YOU 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.

<p>Office of Health Facility Complaints (651) 201-4201 1-800-369-7994 Fax: (651) 281-9796 Mailing Address: Minnesota Department of Health Office of Health Facility Complaints 85 East Seventh Place, Suite 300 P.O. BOX 64970 St. Paul, MN 55164</p>	<p>Ombudsman for Long-Term Care (651) 431-2555 1-800-657-3591 Fax: (651) 431-7452 Mailing Address: Home Care Ombudsman Ombudsman for Long-Term Care PO BOX 64970 St. Paul, MN 55164</p>	<p>You may also contact: (952) 456-6561 Fax: (952) 456-6563 Maplewood Home Care Mailing Address: 1736 Cope Ave E Ste. 2 Maplewood, MN 55109 Complaints may be directed to: Kongmeng Yang, Executive Director</p>
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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Recipient's Name: _____ Date of Birth: _____

Previous Name: _____ PMI #: _____

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

Name: SENIOR HOME LIVING, INC. DBA MAPLEWOOD HOME CARE

Address: 1736 COPE AVENUE EAST SUITE 2

City: MAPLEWOOD State: MN Zip Code: 55109

This request and authorization applies 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 venereum, 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.

Yes No 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.

Recipient/Responsible Party Signature: _____ Date Signed: _____

NOTICE OF PRIVACY RIGHTS

Name of Organization:
Senior Home Living, Inc.

THIS NOTICE DESCRIBES 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 Yong Yang, Director-Owner, 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 Yong Yang, Director-Owner, 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.

Recipient/Responsible Party Signature

Date

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



Maplewood Home Care
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”

Signature _____ Date _____

Print Name _____

Office Use Only:

Signed form received by: _____ Date _____

Good faith effort to obtain receipt: (Describe)



Maplewood Home Care
seniorhomeinc.com

1736 Cope Ave E | Suite 2 | Maplewood, MN 55109
Telephone: (952) 456-6561 | Fax: (952) 777-1668

Grievance Policy

Licensee Information: Maplewood Home Care

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

Yong Yang – Executive Director
Yeng Xiong- 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