ASPIRATION IN LIFE

HOME HEALTHCARE

Admission Package

Medicaid

Admission Agreement / Consent to Services

Nature and Frequency of Services: At ASPIRATION IN LIFE HOME HEALTHCARE LLC our goal is to help achieve the best quality of life possible. We understand that one solution does not fit every situation, so we take the time to listen and learn about each client's needs and preferences. This enables us to tailor a care program that maximizes the client's independence and dignity. Services will be rendered based on your initial assessment made bythe Director of Nursing. At that time, the amount of hours you will receive will be determined.

At the Director of Nursing's discretion, the frequency of your supervisory visits may be determined for you based on your needs/assessment. In the even the nature of your visits is not set for you, you will be allowed to choose from the following:

Frequency of visits: 30 days____60 days_____90 days

Anticipated effects of Treatment as Applicable:

As Applicable

Schedule of Fees and Charges for Services:

Before care is initiated, the organization shall inform the client of the extent to which payment for the home care services may be expected from federal or state programs, and the extent to which payment may be required from the client or third party.

The client shall be advised orally and in writing of any changes in fees for services that are the clients responsibility. The home care organization shall advise the client of these changes as soon as possible, but no later than 30 calendar days from the date the home care organization became aware of the change.

The client shall be notified of a schedule of fees and charges for services as well anyreduction of services by the organization

SERVICE AGREEMENT

Please review this agreement carefully, as it sets forth the understanding between you ("Client") and ASPIRATION IN LIFE HOME HEALTHCARE LLC ("Agency ") regarding the services you have requested, and we will provide for you. If you have any questions, concerns, or issues about the content of this Agreement please contact us for clarification before signing it,

THIS AGREEMENT made this ____day of_____("Effective Date') by and between ASPIRATION IN LIFE HOME HEALTHCARE LLC

_____

Name of Client and/ or Responsible Person

_____

Street Address City State Zip Code

_____

Home Phone Cell Other

_____

Emergency Contact Name Relationship Phone No.

("Client ") on the terms and conditions set out below:

1. **Term of Agreement** The term of this agreement will start on the Effective Date and will continue on an as-needed basis until the Agreement is terminated by either party, as provided hereunder.
2. **Services Requested**. We will provide the services ("Services") requested and agreed upon as set out in the Service Plan enclosed. The preferred day, time and duration of services will be mutually agreed upon by you and/or your representative and the agency. If a reduction in the duration of services is necessary, the Agency will notify the client within five days of the change.
3. **Rates, Fees, Deposits and Refunds**. We will provide the services at the rates set out in the current Rate/Fee of $22 per hour. A deposit of 25% is required prior to commencing services. Any fees not covered by a third-party insurer will be the responsibility of the client. Service fees are non-refundable once services have been rendered. Only prepaid service fees may be refunded in the case of termination of services. Clients will be notified of any changes in fees or rates within 30 calendar days.

   Percentage/Amount billed to third party insurance.

   Percentage/Amount billed to client

4. **Payment and Overdue Accounts**. Fees for services rendered will be billed monthly and are payable upon receipt of invoice. Payment may be made by check or money order. An account is considered overdue if not paid within 3 days of the billing date.

   Interest will be charged on account balances which remain unpaid for 90 days or more after the same becomes due at the rate of 2.5% per month, until paid. We reserve the right to discontinue providing services until the account is paid in full, including any additional charges and accrued interest. A $35.00 returned check fee will be charged. Checks are to be made payable to ASPIRATION IN LIFE HOME HEALTHCARE LLC.
5. **Cancellations**. Cancellations may be made up to 2 days in advance of a scheduled visit without charge. We reserve the right to charge for a scheduled visit if insufficient notice is not given, (if the Agency has to cancel a scheduled visit, the Agency will contact the client as soon as it becomes aware that the client cannot be serviced.
6. **Termination / Referral**. The "Client may terminate this agreement at any time upon written notice to the Agency. The Agency shall notify the client orally and in writing within five days of its intent to withdraw/terminate services or refer the client to another agency or organization. If the client is referred to another agency or organization, the Agency will issue the client the name, address, telephone number and contact name of thereferral organization. The Agency may withdraw/terminate services in the followingsituations:
   a. Agency is no longer able to meet a client's needs.
   b. Client's home environment is no longer safe or healthy.
   c. Client no longer requires the services.
   d. Client is admitted to a care facility.
   e. Client dies.
   f. Client does not comply with the Service Agreement; or,
   g. Client, or other individual living in the household, threatens or abuses an employee(s),

   If either party terminates this Agreement, all fees due at time of termination will be due and payable by you immediately. We will immediately refund any prepaid fees.
7. **Governing Law**. The laws of the State of Virginia shall govern this agreement.
8. **Agency's Responsibilities** ASPIRATION IN LIFE HOME HEALTHCARE LLC responsibilities are outlined on the enclosed "Rights and Responsibilities" form.
9. **Client's Responsibilities**. Your responsibilities are outlined on the enclosed "Rights and Responsibilities Form. You will be required to sign it.
10. **Transportation**, if an employee of the Agency transports a client in their own, company vehicle or the client's vehicle, the client will release the Agency and/or that employee from ail liability should an injury or accident occur.
11. **Private / Direct Hiring**, you may not privately / directly hire an Agency employee for a period of one year following the date that employee last provided services for you in the event you break this condition, a replacement fee of $1000 is due to the Agency immediately upon your employment of that individual.

12. **Severe/Bad Weather**. In severe weather, we may determine it is not safe for our Home Care Worker to travel and provide services to your home that day and may have to cancel that day's service. When this occurs, we will notify you and reschedule. We appreciate your understanding regarding this matter.
13. **Supplies and Equipment.** You are responsible for supplying all supplies (i.e., cleaning, personal care etc.) and equipment which may be necessary in the provision of services. Extra chafes will apply if the Agency provides the supplies and/or equipment.
14. **General information**. You will be provided with a list of contact names and numbers in the event you have any questions or concerns, or should an emergency arise.

Your signature and /or your representative's signature below indicate that you and/or your representative have read, understand and are in agreement with the terms and conditions of this Service Agreement

_____ _____

Client/Client's Representative Signature Date

_____ _____

Agency Authorized Signature & Position Date

Methods of Billing and Payment for Services:

ASPIRATION IN LIFE HOME HEALTHCARE LLC has a standard for billing of services others involved in your care, such as your attending physician and other health care ASPIRATION IN LIFE HOME HEALTHCARE LLC who have agreed to assist ASPIRATION IN LIFE HOME HEALTHCARE LLC.

To Obtain Payment: ASPIRATION IN LIFE HOME HEALTHCARE LLC may include your health information on invoices to collect payment from third parties for the care you receive from ASPIRATION IN LIFE HOME HEALTHCARE LLC. ASPIRATION IN LIFE HOME HEALTHCARE LLC currently accepts the following forms of payment:

Private Pay____ Veterans Affairs ___ Private Insurance___

Medicare ____ Long-Term Insurance ____ Medicaid __X__

*** Some patients are required to pay a co-pay which will be determined during your intake process. Medicaid funded patients co-pay will be determined during the initial screening through the Department of Social Services. In the event you are required to make a co-pay, ASPIRATION IN LIFE HOME HEALTHCARE LLC will require this payment to be made the first (1st) of each month no later than the fifteenth (15th) of each month.**

Co-Pay required; Y_____N_____If yes please enter amount $ _____

Notice of Cancellation or Reduction IE Services: ASPIRATION IN LIFE HOME HEALTHCARE LLC shall not terminate a client's services without just cause. Once termination is determined, the client will be notified 48 hours in advance of actual termination. The client will also receive a list of other agencies available to provide care. In the event reduction of service is required, client will be notified within 48 hours of the reduction.

Refund Policy: ASPIRATION IN LIFE HOME HEALTHCARE LLC will issue a refund for any overpayment made on your behalf in the form of a credit applied to your balance for services rendered.

I have read and understand all information provided regarding admissions and is authorizing ASPIRATION IN LIFE HOME HEALTHCARE LLC as my personal care provider. I also acknowledge that if there are any payments not covered by my insurance company or any co-payments, that I am accepting responsibility for payments to ASPIRATION IN LIFE HOME HEALTHCARE LLC.

Print Name_____

Signature_____

Date _____

MISSION, VISION & VALUES STATEMENT

MISSION

Our values are simple. ASPIRATION IN LIFE HOME HEALTHCARE LLC strives to offer excellent and affordable personal care services to individuals and families of Hampton Roads Virginia. It is our goal to employ competent, caring, and well-trained individuals who are responsive to the needs of our patients, their families, and the communities we serve. Each staff member will meet the State of Virginia educational and training requirements for the services they provide.

VISION

- To be a choice provider for its clients in the community.
- To provide the highest standard of in-home health care services.
- To provide comprehensive health care services.
- To be a viable agency provider.

VALUES

Our mission and vision will be achieved through the application of our core values, which include:

- Keeping our client's health, well-being, and quality of life in the design and delivery of services.
- Treating and interacting with our clients with respect, dignity, compassion, empathy, honesty, and integrity while recognizing and maintaining confidentiality of client information.
- Showing respect for all cultures, religions, ethnicities; sexual orientation, ages, gender, and disabilities.
- Recruiting, training, and retaining competent staff.
- Valuing, supporting, recognizing, and appreciating our staff as an integral aspect of service delivery.
- Developing and maintaining positive relationships with the community, including local Home Care and Health Care personnel/organizations.
- Exercising and maintain the highest code of ethics of the Home Care industry; and,
- Implementing continuous quality improvement measures throughout our Agency.

I_____A PATIENT OF ASPIRATION IN LIFE HOME HEALTHCARE LLCHAVE FREELY CHOSEN THE FOLLOWING FREQUENCY FOR MY SUPERVISORY VISIT:

PLEASE CHECK ONE OF THE CHOICES BELOW:

_____EVERY 30 DAYS

_____EVERY 60 DAYS

_____EVERY 90 DAYS

_____MANDATORY EVERY 30 DAYS DUE TO ALTERED MENTAL STATUS

SIGNATURE_____

DATE_____

ASPIRATION IN LIFE HOME HEALTHCARE LLC
ADMISSIONS FORM

NAME:

ADDRESS:

AIDE(S) NAME:

HOURS PER WEEK:

ASPIRATION IN LIFE HOME HEALTHCARE LLC

- **WELCOME LETTER**
- **AGENCY PHONE NUMBER**
- **HOURS OF OPERATION**
- **ADVANCE DIRECTIVE QUESTIONNAIRE**
- **CLIENTS RIGHTS & RESPONSIBILITIES**
- **INFECTION CONTROL/UNIVERSAL PRECAUTIONS**
- **SERVICE AGREEMENT**
- **COMMUNITY RESOURCE NUMBERS**
- **REFUND PROCEDURE**
- **RESPONSIBLE PARTY FORM**
- **DMAS ADMISSION DOCS**
- **AIDE NOTES (NURSE TO GIVE INSTRUCTION TO CLIENT)**
- **CONSENT & VERIFICATION OF RELEASE OF INFO**
- **CONFIDENTIALITY HIPPA STATEMENT**
- **MEDICATION SHEET**
- **RIGHT TO CHOOSE IS LOCATED IN BILL OF RIGHTS**
- **CLIENT AIDE RELATIONSHIP FORM**
- **HOME ASSESSMENT FOR SAFETY**
- **EMERGENCY PREPARDNESS**
- **CLIENT ORIENTATION INFO**
- **ANTI FRUAD**

CONSENT AND VERIFICATION OF RECIEPT OF INFORMATION. BY SIGNING I ACKOWLEDGE THAT I HAVE RECEIVED VERBAL AND WRITTEN INFO ON THE ABOVE TOPICS.

PATIENT/CAREGIVER SIGNATURE_____ **DATE**_____

WITNESS SIGNATURE_____ **DATE**_____

Medication Profile

Patient Name:_____MR# _____

Pharmacy:_____Pharmacy Phone#. _____

Allergies: _____

Medication	Dosage	Routine	Frequency	Start/DC	N	C

Oxygen _____L/M Cont./PRN N/C/Vent/Mask

Signature:_____Date: _____

HOME SAFETY CHECKLIST

Client Name: _____ Date: _____

Client Address: _____

SAFETY CRITERIA	YES	NO
• Are the steps & sidewalks in good repair and free from debris/material?		
• Are the railings on the steps secured?		
• Is there a functional peephole in the front door?		
• Are working smoke detectors installed?		
• Is there a "ready-to-use" fire extinguisher(s) on the premises?		
• Are throw rugs removed?		
• Are there sturdy handrails or banisters by all steps and stairs?		
• Are electrical cords un-frayed and placed to avoid tripping?		
• Are electric outlets/switches overloaded (e.g., warm to the touch)?		
• Are hazardous products labeled and kept in a secure place?		
• Does anybody smoke in homes where oxygen is in use?		
• Are all animals, on site, controlled?		
• Is the home free from bugs, mice and/or animal waste?		
• Does the client wear an emergency response necklace/bracelet?		
• Are used needles placed in a sharp container?		
• Is oxygen tubing kept off the walking path?		
• Is medical equipment properly stored?		
• Do telephone cords/electronic wires run across walking areas?		
• Is the floor waxed or otherwise slippery?		
• Are there any flammable items near the heat source?		
• Are the necessary appliances working properly?		
• Is there sufficient heat?		
• Is there running hot water?		

• Is the house livable?		

Community Based Care Request for Services Form – Confidential

<table>
<tr><td colspan="6">KeyPRO/DMAS now require any Medicaid Provider submitting Service Authorization using their National Provider Identifier (NPI) or Atypical Provider Identifier (API) to provide their 9-dieit zip code. If you do not know your 9-digit zip code, then please visit: http://zip4.usps.com/zip4/welcome.jsp. Please see Instructions per service type.</td></tr>
<tr><td colspan="3">Fax: I-S77-OKBYFAX (877-652-9329)</td><td colspan="3">Phone: 1-888-827-2884</td></tr>
<tr><td>1. □ New Request</td><td>□ Change SRVAUTH#</td><td colspan="2">□ Cancel SRVAUTH#</td><td colspan="2">□ Transfer</td></tr>
<tr><td>2. Date of Request</td><td colspan="5">3. Review Type: (Please Check One)</td></tr>
<tr><td>(mm/dd/yyyy)</td><td colspan="5">□ Waiver Enrollment</td></tr>
<tr><td rowspan="2">/ /</td><td colspan="5">□ Waiver Enrollment-Retrospective Review (Date Notified of Eligibility) / /</td></tr>
<tr><td colspan="5">□ Service Request-If a Retrospective Review (Date Notified of Eligibility) / /</td></tr>
<tr><td>4. Member Medicaid ID Number:</td><td>5. Member Last Name:</td><td>6. Member First Name:</td><td>7. □ Date of Birth</td><td colspan="2">8. Gender</td></tr>
<tr><td>ID Number (12 digits)</td><td rowspan="2"></td><td rowspan="2"></td><td>(mm/dd/yyyy)</td><td colspan="2">□ Male</td></tr>
<tr><td></td><td>/ /</td><td colspan="2">□ Female</td></tr>
<tr><td colspan="2">9.</td><td colspan="4">10, Primary Diagnosis Code/Description;</td></tr>
<tr><td colspan="2">a. Service Provider Name:</td><td colspan="4">a.</td></tr>
<tr><td colspan="2">b. NPI/API Provider ID Number:</td><td colspan="4">b.</td></tr>
<tr><td colspan="2">c. 9-digit zip code: (required)</td><td colspan="4">c.</td></tr>
<tr><td colspan="2">11.</td><td colspan="4">12. SRVAUTH Service Type:</td></tr>
<tr><td colspan="2" rowspan="2">a. NPI/API Submitting Provider/Case Manager for DD Waiver / Transition Coordinator (for EDCD Waiver only). Name and Provider ID Number:</td><td colspan="2">□ 0900-EDCD Waiver</td><td colspan="2">□ 0090-EPSDT Private Duly Nursing</td></tr>
<tr><td colspan="2">□ 0902-DD Waiver</td><td colspan="2">□ 0091-EPSDT Personal/Attendant Core</td></tr>
<tr><td colspan="2" rowspan="2">b. 9-digit zip code: (required)</td><td colspan="2">□ 0909-MlfP</td><td colspan="2">□ 0098-GPSDT Private Duty Nursing In School-MCO</td></tr>
<tr><td colspan="2">□ 0969 Technology Waiver</td><td colspan="2"></td></tr>
<tr><td colspan="6">13. Justification/Need for Waiver Service Requested:</td></tr>
</table>

14. Additional Comments (See instructions pertaining to each procedure code).

Community Based Care Request for Services Form Confidential

Member Last Name:		**Member First Name:**				**Member Medicaid ID Number:**		
15. Procedure Code (National Code):	**16. Narrative Description;**	**17, Modifiers (If Applicable)**	**18. Units/Hours Requested**	**19. Frequency**	**20. Actual Cost per Unit (if applicable)**	**21. Total Dollar Requested (If applicable)**	**22. Dates of Service**	
							From (mm/dd/yyyy)	**Thru (mm/dd/yyyy)**
							/ /	/ /
							/ /	/ /
							/ /	/ /
							/ /	/ /
							/ /	/ /
23. Contact Person:		**24. Contact Phone Number:**				**25. Contact Fax Number:**		

The information contained in this facsimile is legally privileged mid confidential information Intended only for the use of the entity named above. 1 f the render of this message is not the intended member, or the employee or agent responsible for delivering this communication In error, please notify KeyPRO by telephone or FAX at the appropriate number listed above and destroy the misdirected document. Thank you.

Community Based Care Request for Services Form Confidential

KeyPRO/DMAS now require any Medicaid Provider submitting Service Authorization using their National! Provider Identifier (NPI) or Atypical Provider Identifier (API) to provide their 9-digit zip code, If you do not know your 9-dicit zip code, then please visit: http://zip4.usps.com/zip4/welcome.jsp. Please see Instructions per service type.			
Fax; 1-877-OKBYFAX (877-652-9329)		**Phone: 1-888-827-2884**	
1. □ Now Request	**□ Change SRV AUTH#**	**□ Cancel SRV AUTH#**	**□ Transfer**
2. Date of Request	**3. Review Type: (Please Check One)**		
(mm/dd/yyyy)	**□ Waiver Enrollment**		
/ /	**□ Waiver Enrollment-Retrospective Review (Date Notified of Eligibility) / /**		
	□ Service Request-If a Retrospective Review (Date Notified of Eligibility) / /		

4. Member Medicaid ID [Number:	5. Member Last Name:	6. Member First Name:	7. □ Ditto of Birth	8. Gender
ID Number (12 digits)			(mm/dd/yyyy)	□ Male
			/ /	□ Female
9.		10, Primary Diagnosis Code/Description:		
n. Service Provider Name:		a.		
b. NPI/API Provider ID Number:		b.		
c. 9-digit zip code: (required)		c.		
11.		12. SRV AUTH Service Type:		
a. NPI/API Submitting Provider/Case Manager for DD Waiver / Transition Coordinator (for EDCD Waiver only). Name and Provider BD Number:		□ Q900-EDCD Waiver	□ 0090-KPSDT Private Duty Nursing	
		□ 0902-DD Waiver	□ G091-EPSDT Personal/Attendant Care	
b. 9-digit zip code: (required)		□ 0909-MFP	□ 0098-EPSDT Private Duty Nursing in School-MCO	
		□ 0960-Technology Waiver		
13. Justification/Need for Waiver Service Requested:				
14. Additional Comments (See instructions pertaining to each procedure code):				

Community Based Care Request for Services Form Confidential

Member Last Name;		Member First Name:				Member Medicaid ID Number:		
15. Procedure Code (National Code):	16. Narrative Description:	17, Modifiers (If Applicable)	18. Units/Hours Requested	19. Frequency	20. Actual Cost per Unit (if applicable)	21. Total Dollar Requested (If applicable)	22. Dates of Service	
							From (mm/dd/yyyy)	Thru (mm/dd/yyyy)
							/ /	/ /
							/ /	/ /
							/ /	/ /
							/ /	/ /
							/ /	/ /
23. Contact Person:		24. Contact Phone Number:				25. Contact Fax Number:		

Medicaid LTC Communication Form	Patient Name: Medicaid ID#: SSN:

Provider Name: **Address:**

Provider NPI#: **Provider Rep.:** **Title:**

Telephone: **Fax:** **Date: / /**

Patient Information: DMAS-96 □ attached □ unavailable

Patient/Enrollee admitted to this facility/service on / / (date), from □ Home □ Hospital □ Other Facility

□ Patient Pay determination requested □ Patient Funds Account balance $ as of / / (date).

□ Patient/Enrollee discharged / / (date), to: □ Home □ Hospital □ Other Facility □ Deceased

□ Change in income, deductions, health insurance or other:

* Enrollee Residential Address:

Medicaid Per Diem Rate: $ *Enrollee FIPS: (Waiver Enrollees Only)

CBC Provider Hourly Rate: $ Hours received in the month of Discharge:

LDSS: FIPS Code: Eligibility Worker:

Telephone: Fax: Date: / /

Eligibility Information:

□ Eligible, full Medicaid services beginning / / (date) □ Eligible, QMB Medicaid only

□ Eligible Medicare premium payment only

□ Ineligible for Medicaid □ Ineligible for Medicaid payment of LTC services from / / to / / □ Medicare Part A insurance Other health insurance: LTC insurance:

□ Change in deductions, health insurance or other:

ASPIRATION IN LIFE HOME HEALTHCARE LLC

CLIENTS BILL OF RIGHTS

1. Be informed and participate in the development of your plan of care.
2. Voice grievances about your care and not to be subjected to discrimination or reprisal for doing so.
3. Confidentiality of your records.
4. Be informed of your liability for payment of services.
5. Be informed of the process for acceptance and continuance of services and eligibility determination.
6. Accept or refuse service.
7. Be informed of the organizations on call services.
8. Be informed of supervisory accessibility and availability.
9. Be advised of the organization's procedures for discharge.
10. Be informed of the right to consent to service and to what degree services shall be rendered.
11. Be informed of the name, business telephone number and business address of the person supervising services.
12. Be informed of the complaint procedures, as well as the right to submit complaints and have them investigated by the provider within a reasonable period.
13. Receive a written notice from the Virginia Department of Health. Office of Licensure and Certification Section when/if licensing regulations are being violated by the provider. All inquiries should be forwarded to the following address:

Office of licensure and certification

VDOH

9960 Maryland Dr., Suite 401

Henrico, Virginia 23233

Complaint Hot Line 1-800-955-1819

If any additional information is needed regarding the services provided, or if there are other questions or complaints, call ASPIRATION IN LIFE HOME HEALTHCARE LL Cat 410-300-0684. In addition, the complaint hot Line is available for any unresolved concerns 1-800-955-1819.

_____ _____

Client Signature Date

ASPIRATION IN LIFE HOME HEALTHCARE LLC

QUESTIONAIRE REGARDING ADVANCE DIRECTIVES

Client Name: _____

1. Do you have a formal surrogate, and is it stated in writing that this person shall be given the right to make decisions concerning your health care if you are not competentto do so?

   _____No_____Yes

   If yes, who will make the decision?

   Name:_____

   Address: _____

   Phone Number: _____

2. Note: The facility/provider will resuscitate or use life-sustaining mechanisms if there is not a formal written agreement in the medical record.

3. Do you want to be resuscitated?

   _____No_____Yes

4. Do you want other life sustaining mechanisms used?

   _____No_____Yes

   (If no, written agreement must be provided for the record)

5. If you would like to pursue further, please contact your attorney.

_____ _____

Client Signature Date

VIRGINIA ADVANCE DIRECTIVE FOR HEALTH CARE

I,_____willingly and voluntarily make known

Printed Name of individual Making This Advance Directive for Health Care (Declarant)

my wishes in the event that I am incapable of making an informed decision about my health care, as follows:

(YOU MAY INCLUDE ANY OR ALL OF THE PROVISIONS IN SECTIONS I, II AND III BELOW.)

SECTION I: APPOINTMENT AND POWERS OF MY AGENT

(CROSS THROUGH THIS SECTION I IF YOU DO NOT WANT TO APPOINT AN AGENT TO MAKE HEALTH CARE DECISIONS FOR YOU.)

A. Appointment of My Agent

I hereby appoint_____

Name of Primary Agent **E-mail Address**

Home Address **Telephone Number**

as my agent to make health care decisions on my behalf as authorized in this document.

If the primary agent named above is not reasonably available or is unable or unwilling to act as my agent, then I appoint as successor agent to serve in that capacity:

Name of Successor Agent **E-mail Address**

Home Address **Telephone Number**

I grant to my agent full authority to make health care decisions on my behalf as described below. My agent shall have this authority whenever and for as long as I have been determined to be incapable of making an informed decision.

In making health care decisions on my behalf, I want my agent to follow my desires and preferences as stated in this document or as otherwise known to him or hen If my agent cannot determine what health care choice I would have made on my own behalf, then I want my agent to make a choice for me based upon what he or she believes to be in my best interests.

B. Powers of My Agent

(IF YOU APPOINTED AN AGENT ABOVE, YOU MAY GIVE HIM/HER THE POWERS SUGGESTED BELOW. YOU MAY CROSS THROUGH ANY POWERS LISTED BELOW THAT YOU DO NOT WANT TO GIVE YOUR AGENT AND ADD ANY ADDITIONAL POWERS YOU DO WANT TO GIVE YOUR AGENT.)

The powers of my agent shall include the following:

1. To consent to or refuse or withdraw consent to any type of health care, including, but not limited to, artificial respiration (breathing machine), artificially administered nutrition (tube feeding) and hydration (IV fluids), and cardiopulmonary resuscitation (CPR). This authorization specifically includes the power to consent to dosages of pain-relieving medication in excess of recommended dosages in an amount sufficient to relieve pain. This applies even if this medication carries the risk of addiction or of inadvertently hastening my death.
2. To request, receive and review any oral or written information regarding my physical or mental health, including but not limited to medical and hospital records, and to consent to the disclosure of this information as necessary to carry out my directions as stated in this advance directive.
3. To employ and discharge my health care providers.
4. To authorize my admission, transfer, or discharge to or from a hospital, hospice, nursing home, assisted living facility or other medical care facility.

5. To authorize my admission to a health care facility for treatment of mental illness as permitted by law. (If 1 have other instructions for my agent regarding treatment for mental illness, they are stated in a supplemental document.)
6. To continue to serve as my agent if I object to the agent's authority after I have been determined to be incapable of making an informed decision.
7. To authorize my participation in any health care study approved by an institutional review board or research review committee according to applicable federal or state law if the study offers the prospect of direct therapeutic benefit to me.
8. To authorize my participation in any health care study approved by an institutional review board or research review committee according to applicable federal or state law that aims to increase scientific understanding of any condition that I may have or otherwise to promote human well-being, even though it offers no prospect of direct benefit to me.
9. To make decisions regarding visitation during any time that I am admitted to any health care facility, consistent with the following directions:

   _____

10. To take any lawful actions that may be necessary to carry out these decisions, including the granting of releases of liability to medical providers.

ADDITIONAL POWERS OR LIMITATIONS, IF ANY:

_____

_____

_____

SECTION II: MY HEALTH CARE INSTRUCTIONS

[YOU MAY USE ANY OR ALL OF PARTS 1, 2 OR 3 IN THIS SECTION TO DIRECT YOUR HEALTH CARE EVEN IF YOU DO NOT HAVE AN AGENT. IF YOU CHOOSE NOT TO PROVIDE WRITTEN INSTRUCTIONS, DECISIONS WILL BE BASED ON YOUR VALUES AND WISHES, IF KNOWN, AND OTHERWISE ON YOUR BEST INTERESTS. IF YOU ARE AN EYE, ORGAN OR TISSUE DONOR, YOUR INSTRUCTIONS WILL BE APPLIED SO AS TO ENSURE THE MEDICAL SUITABILITY OF YOUR ORGANS. EYES AND TISSUE FOR DONATION.]

1. I provide the following instructions in the event my attending physician determines that my death is imminent (very close) and medical treatment will not help me recover:

   [CHECK ONLY 1 BOX IN THIS PART 1.]

   □ I do not want any treatments to prolong my life. This includes tube feeding, IV fluids, cardiopulmonary resuscitation (CPR), ventilator / respirator (breathing machine), kidney dialysis or antibiotics. I understand that I still will receive treatment to relieve pain and make me comfortable. (OR)

   □ I want all treatments to prolong my life as long as possible within the limits of generally accepted health care standards. I understand that I will receive treatment to relieve pain and make me comfortable. (OR)

   □ *[YOU MAY WRITE HERE YOUR OWN INSTRUCTIONS ABOUT YOUR CARE WHEN YOU ARE DYING, INCLUDING SPECIFIC INSTRUCTIONS ABOUT TREATMENTS THAT YOU DO WANT. IF MEDICALLY APPROPRIATE. OR DONT WANT. IT IS IMPORTANT THAT YOUR INSTR UCTIONS HERE DO NOT CONFLICT WITH OTHER INSTRUCTIONS YOU HAVE GIVEN IN THIS ADVANCE DIRECTIVE.]:*

   _____

   _____

   _____

2. I provide the following instructions if my condition makes me unaware of myself or my surroundings or unable to interact with others, and it is reasonably certain that I will never recover this awareness or ability even with medical treatment:

[CHECK ONLY 1 BOX IN THIS PART 1.)

□ I do not want any treatments to prolong my life. This includes tube feeding, IV fluids, cardiopulmonary resuscitation (CPR), ventilator/respirator (breathing machine), kidney dialysis or antibiotics. I understand that I still will receive treatment to relieve pain and make me comfortable. (OR)

□ I want all treatments to prolong my life as long as possible within the limits of generally accepted health care standards. I understand that I will receive treatment to relieve pain and make me comfortable. (OR)

□ I want to try treatments for a period of time in the hope of some improvement of my condition. I suggest _____as the period of time after which such treatment should be stopped if my condition has not improved. The exact time period is at the discretion of my agent or surrogate in consultation with my physician. I understand that I still will receive treatment to relieve pain and make me comfortable. (OR)

[YOU MAY WRITE HERE YOUR INSTRUCTIONS ABOUT YOUR CARE WHEN YOU ARE UNABLE TO INTERACT WITH OTHERS AND ARE NOT EXPECTED TO RECOVER THIS ABILITY. THIS INCLUDES SPECIFIC INSTRUCTIONSABOUT TREATMENTS YOU DO WANT, IF MEDICALLY APPROPRIATE, OR DONT WANT. IT IS IMPORTANT THAT YOUR INSTR UCTIONS HERE DO NOT CONFLICT WITH OTHER INSTRUCTIONS YOU HAVE GIVEN IN THIS ADVANCE DIRECTIVE.]

3. I provide the following other instructions concerning my health care:

(YOU MAY WRITE HERE STATEMENTS AND INSTRUCTIONS ABOUT TREATMENTS THAT YOU DO WANT, IF MEDICALLY APPROPRIATE, OR ABOUT TREATMENTS YOU DO NOT WANT UNDER SPECIFIC CIRCUMSTANCES OR ANY CIRCUMSTANCES. IT IS IMPORTANT YOUR INSTRUCTIONS HERE DO NOT CONFUCT WITH OTHER INSTRUCTIONS YOU HAVE G/VEN IN THIS ADVANCE DIRECTIVE.)

SECTION III: ANATOMICAL GIFTS

(YOU MAY USE THIS DOCUMENT TO RECORD YOUR DECISION TO DONATE YOUR ORGANS, EYES AND TISSUES OR YOUR WHOLE BODY AFTER YOUR DEATH. IF YOU DO NOT MAKE THIS DECISION HERE OR IN ANY OTHER DOCUMENT, YOUR AGENT CAN MAKE THE DECISION FOR YOU UNLESS YOU SPECIFICALLY PROHIBIT HIM/HER FROM DOING SO, WHICH YOU MAY DO IN THIS OR SOME OTHER DOCUMENT. CHECK ONE OF THE BOXES BELOW IF YOU WISH TO USE THIS SECTION TO MAKE YOUR DONATION DECISION.)

□ I donate my organs, eyes, and tissues for use in transplantation, therapy, research, and education. I direct that all necessary measures be taken to ensure the medical suitability of my organs, eyes, or tissues for donation. I understand that I may register my directions at the Department of Motor Vehicles or directly on the donor registry, www.DonateLifeVirginia.org. and that I may use the donor registry to amend or revoke my directions, OR

□ I donate my whole body for research and education.

[Write here any specific instructions you wish to give about anatomical gifts.]

_____

_____

_____

_____

AFFIRMATION AND RIGHT TO REVOKE: By signing below, I indicate that I understand this document and that I am willingly and voluntarily executing it. I also understand that I may revoke all or any part of it at any time as provided by law.

Date **Signature of Declarant**

The declarant signed the foregoing advance directive in my presence, [TWO ADULT WITNESSES NEEDED]

Witness Signature **Witness Printed**

Witness Signature **Witness Printed**

This form satisfies the requirements of Virginia's Health Care Decisions Act. If you have legal questions about this form or would like to develop a different form to meet your particular needs, you should talk with an attorney. It is your responsibility to provide a copy of your advance medical

Directive to your treating physician. You also should provide copies to your agent, close relatives and/or friends. This form is provided by the "Virginia Hospital & Healthcare Association as a service to its members and the public. (July 2011, unvw.vhha.com)

HIPPA Privacy Authorization Form

** Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

* 1. Authorization* *

I authorize_____(healthcare provider) to use and disclose the protected health information described

Below to_____(individual seeking information.)

2. Effective Period

This authorization for release of information covers the period of healthcare

from:

A. □_____to _____

** OR**

B. □ All past, present, and future periods.

3. Extent of Authorization

A. □ I authorize the release of my complete health record (including records to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

B. □ I authorize the release of my complete health record with the exception of the following information:

□ Mental Health Records

□ Communicable Diseases (Including HIV and AIDS

□ Alcohol/Drug Abuse Treatment

□ Other (Please Specify):

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
5. This authorization shall be in force and effect until_____(date or event), at which time this authorization expires.
6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient or personal representative

Printed name of patient of personal representative and his or her relationship to patient

Date

RIGHTS & RESPONSIBILITIES

Client Name: _____

As a client of ASPIRATION IN LIFE HOME HEALTHCARE LLC, the above-named client has rights and responsibilities including, but not limited to, those outlined below:

Client Rights

The Rights and Responsibilities form shall include, but not be limited to, the client's right to be:

1. treated with courtesy, consideration and respect and is assured the right of privacy.
2. assured confidential treatment of his medical and financial records as provided by law.
3. free from mental and physical abuse, neglect, and property exploitation.
4. assured the right to participate in the planning of the client's home care, including the right to refuse services.
5. served by individuals who are properly trained and competent to perform theirduties.
6. assured the right to voice grievances and complaints related to organizational services without fear of reprisal.
7. advised, before care is initiated, of the extent to which payment for the home care organization services may be expected from federal or state programs, and the extent to which payment may be required from the client.
8. advised orally and in writing of any changes in fees for services that are the client's responsibility. The home care organization shall advise the client of these changes as soon as possible, but no later than 30 calendar days from the date the home care organization became aware of the change: and
9. provided with advance directive information prior to start of services and given at least five days written notice when the organization determines to terminate services.
10. Before care is initiated, the home care organization shall inform the client, orally and in writing, of:
    a. The nature and frequency of services to be delivered and the purpose of the service.
    b. Any anticipated effects of treatment, as applicable:
    c. A schedule of fees and charges for services.
    d. The method of billing and payment for services, including the:
        I. Services to be billed to third party payers.
        II. Extent to which payment may be expected from third party payers known to the home care organization; and
        III. Charges for services that will not be covered by third party payers.

e. The charges that the individual may have to pay.
f. The requirements of notice for cancellation or reduction in services by the organization and the client; and
g. The refund policies of the agency.

Client Responsibilities:

Clients are responsible for:

1. providing complete information about matters relating to their health and abilities when it could influence the care they are being given.
2. reporting any potential risks that might exist to the Home Care Worker such as the possibility that a client/family member might have a contagious illness or condition.
3. reporting unexpected changes in their condition, such as having suffered a mild stroke.
4. requesting information about anything that they do not understand.
5. contacting the office with any concerns or problems regarding services.
6. following service plans and/or expressing any concerns they have about the Service Plan.
7. accepting the consequences if the Service Plan is not followed.
8. following the terms and conditions of the Service Agreement.
9. notifying the Agency, in advance, of any changes to the work schedule.
10. notifying the Agency of any advanced directives they sign. e.g., a Do Not Resuscitate order.
11. being considerate of property/equipment belonging to the Agency and/or Home Care Worker.
12. notifying Agency of any changes being made to their contact information such as address or phone number.
13. advising Agency of any changes being made to their Health Care ASPIRATION IN LIFE HOME HEALTHCARE LLCs, e.g., Physician, Physiotherapist, Occupational Therapist, Dietician, Director of Nursing, etc.
14. advising the Agency if they are not satisfied with the cane or services being delivered.
15. paying bills according to agreed upon rates and timeframes.
16. assume financial responsibility for all materials, supplies and equipment required for their care.
17. providing a safe environment for care and services to be delivered.
18. abiding by Agency's cancellation policy.
19. keeping all weapons in the home away from the work area during visits made by the Home Care Workers.
20. securing aggressive or menacing pets before the Home Care Worker enters the home.
21. providing a smoke free environment when Home Care Worker is present.
22. reviewing and signing Provider Aide Record.
23. treating Home Care Workers in a courteous and respectful manner, and,
24. ensuring that Home Care Workers are free from any actions that could be deemed to be

abusive such as intimidation, physical/ sexual/ verbal/ mental/ emotional/material/ financial abuse, etc.

Agency Responsibilities

ASPIRATION IN LIFE HOME HEALTHCARE LLC shall be responsible for:

1. providing competent employees.
2. ensuring home care service delivery standards are met.
3. ensuring federal, state, county & municipal legalities are researched and applied.
4. adhering to labor regulations.
5. conducting needs assessments and service plans with client's/family's input.
6. maintaining the client's/family's confidentiality, privacy, and dignity.
7. being alert for and reporting signs of elder abuse.
8. issuing client an Advanced Medical Directive Form for client's review

This Rights and Responsibilities form has been reviewed with, and a copy given to, the named client/client's representative.

Signature of Client/Client's Representative

_____

Signature of Agency's Representative & Position

_____

Date

ASPIRATION IN LIFE HOME HEALTHCARE LLC

DISCHARGE SUMMARY

Client:

Address:

Date of Birth:

Date HHA Services Began:

Date HHA Services Terminated:

Date notified of termination:

Last date HHA in home:

Reason for termination:

Summary of Services provided:

_____ _____

Service Supervisor Date

_____ _____

Administrator Date