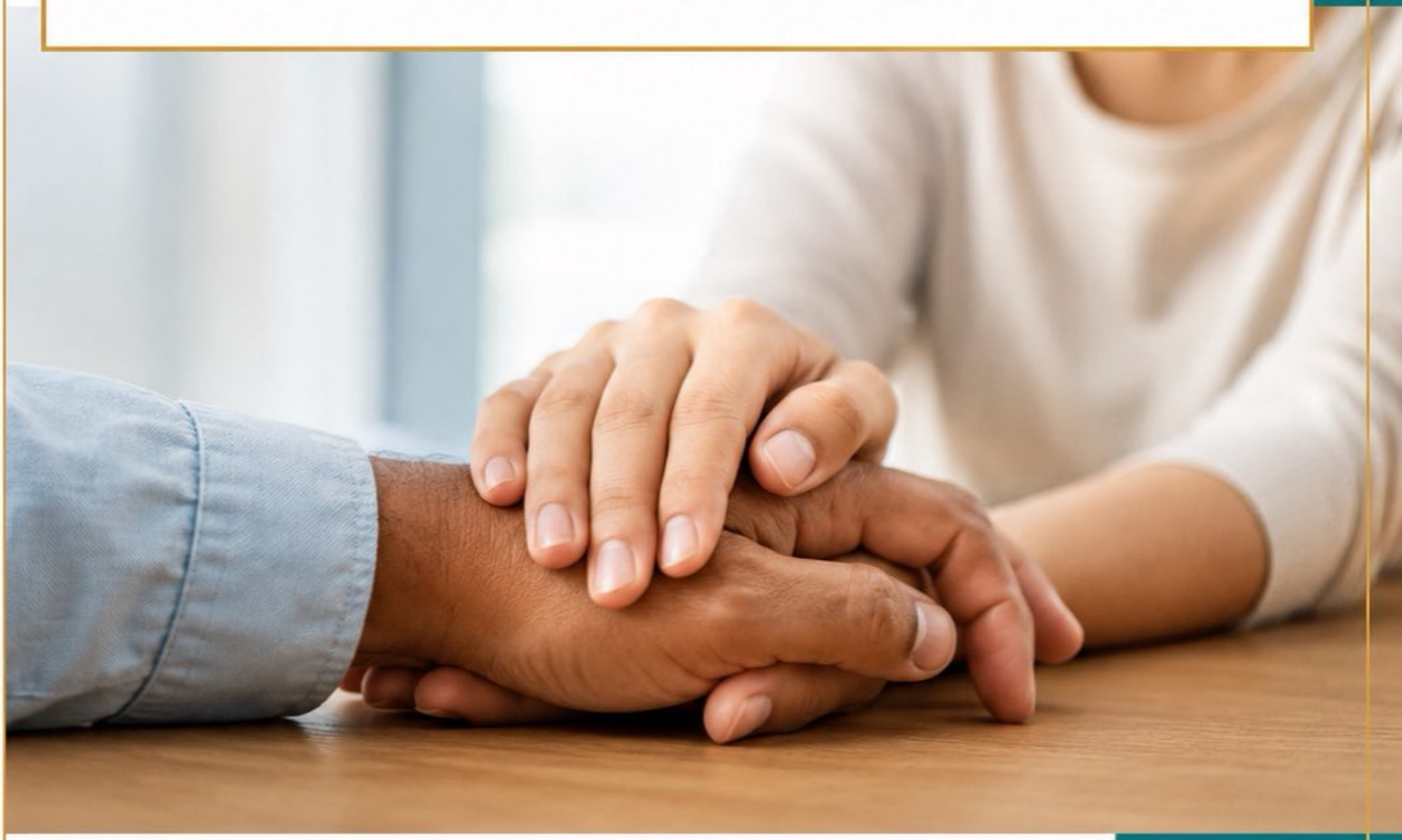
HARMONY HEIGHTS

HOME HEALTH SERVICES LLC

HOME HEALTH ADMISSION & WELCOME BOOK



"COMPASSION. EXCELLENCE. DIGNITY."

8888 Keystone Crossing, Suite 1300
Indianapolis, IN 46240

463-304-5003 (Main) **317-747-0780 (24/7 Emergency)**

Fax: 317-887-6044

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harmonyheights.care@gmail.com

Office Hours:
Monday – Friday
9:00 AM – 5:00 PM

Welcome to Harmony Heights Home Health Services

At Harmony Heights Home Health Services, our mission is to provide compassionate, patient-centered care that promotes healing, independence, and dignity in the comfort of your home. We are dedicated to helping patients remain safe and comfortable while receiving exceptional clinical care and support services.

Our team of skilled professionals works together to meet your medical and personal care needs. We collaborate closely with your physicians, hospitals, caregivers, and other healthcare providers to ensure seamless, high-quality care and positive health outcomes.

Your privacy, safety, and well-being are our highest priorities. We are committed to delivering care with professionalism, respect, and integrity while maintaining the highest standards of clinical excellence.

Our office is open Monday through Friday from 9:00 AM to 5:00 PM. For urgent concerns outside normal business hours, 24/7 on-call support is available by calling **317-747-0780**

We value your feedback and encourage you to contact our office with any questions, concerns, or suggestions regarding your care.

Thank you for choosing Harmony Heights Home Health Services as your trusted healthcare provider. It is our privilege to serve you and your family with compassion, excellence, and dignity.

Sincerely,

Faatin Ector

Faatin Ector
Chief Executive Officer
Harmony Heights Home Health Services LLC

GUIDE TO SAFETY IN THE HOME

People of all ages have accidents, but they're more common and more serious for older people. Please take a few minutes to review the safety guide; you can protect yourself and those around you by taking the right precautions.

FALLS

Falls are the most frequent and most serious accidents in the home. There are several things you can do to prevent falls.

- Remove throw rugs when patient is relying on ambulatory aides such as walkers and canes or has a shuffling gait.
- Use nonskid tape or backing on throw rugs. Tack down the edges of all carpets.
- Be sure there are firmly anchored non-slip treads, good lighting and a solid, easy-to grasp handrail that is rounded or knobbed at the end of stairs.
- Consider painting or taping the top and bottom steps so they'll be easily noticed.
- Make sure there is a clear walkway through every room. Don't use halls or stairways for storage.
- Be sure halls and stairways are well lit.
- Don't walk on a freshly washed or waxed floor until it is dry.
- Wipe up any spills immediately.
- Avoid wearing only socks, smooth-soled shoes, or slippers on uncarpeted floors.
- In the bathroom, be sure mats are nonskid and there are treads in the tub or shower to prevent slips.
- Keep outdoor stairs, porches, and walkways free of wet leaves, snow, and ice.
- Make sure stairs and walkways are in good repair.
- Protect Yourself and Your Family from Fire and Burns
- Don't smoke in bed or when sleepy, or while under sedation, or around oxygen.
- Use portable heaters according to manufacturer's instructions. Turn it off before going to bed.
- Has your home checked if there are signs of wiring problems?
- Check hot water temperature. Experts suggest setting hot water at 120 degrees Fahrenheit or lower.
- Keep pot handles turned away from front of stove. Use potholders when necessary.
- Never leave unattended food cooking on the stove.

BE PREPARED

- Install smoke detectors and check them regularly.
- Keep multipurpose fire extinguisher charged and handy.
- Make a fire escape plan. Check fire exits to be sure they open easily and are free of clutter.
    - If you live in an area where weather conditions change suddenly, make sure you have an evacuation plan or call your city hall regarding the emergency evacuation plan.

INDIANA STATE RESOURCES

- Area Agency on Aging (AAAs)- a network of senior organizations nationwide which serve the elderly population (60+) in local areas. AAAs receive funding from the Older Americans Act to provide/coordinate a variety of programs & services for older adults.
- Center For Independent Living (CIL)- Centers for Independent Living, often referred to as "CILs", are non-residential places of action and coalition designed and operated by people with disabilities.
- Aging & Disability Resource Center (ADRC)- Aging and Disability Resource Centers (ADRCs) serve as single points of entry into the long-term services and support (LTSS) system for older adults, people with disabilities, caregivers, veterans, and families. Some states refer to ADRCs as "access points" or "no wrong door" systems.

Area Served	AAA/ ADRC	CIL	County Served
Area 1: Lake, Porter, Newton, Jasper, Starke, Pulaski	Northwest Indiana Community Action Corporation 5240 Fountain Drive Crown Point, IN 46307 219.794.1829 OR 800.826.7871 TTY:	accessibility, 9105 E 56th Street, Suite 308, Indianapolis, IN 46216 317-926-1660 www.abilityindiana.org	Boone, Hamilton, Hancock, Hendricks, Johnson, Shelby, Marion, Morgan, Carroll,

	888.814.7597 FAX: 219.794.1860 www.nwi-ca.com		Clinton, Montgomery, Tippecanoe
Area 8: Boone, Hamilton, Hancock, Hendricks, Marion, Morgan, Johnson, Shelby	CICOA Aging and in Home Solutions 8440 Woodfield Crossing Boulevard, Suite 175 Indianapolis, IN 46240-2476 317.254.5465 OR 800.432.2422 TDD: 317.254.5497 FAX: 317.254.5494 www.cicoa.org	SIILC, 114 W. Main Street, Vevay, IN 47043 812-427-3333 www.siilc.org	Dearborn, Jefferson, Jennings, Ohio, Ripley, Switzerland, Clark

- Protective Services Agency- An agency focused on protecting those who may be at risk of abuse or neglect.
  - Elder Abuse Hotline (800) 992-6978
  - Child Abuse Hotline: (800) 800 5556

- Quality Improvement Organization (QIO)- part of a national Healthcare quality improvement initiative directed by the Centers for Medicare & Medicaid Services (CMS). A QIO is a private company of health quality experts, clinicians, and consumers, contracted with CMS to improve the care delivered to people with Medicare. Every US state is assigned to a QIO.
  - Livanta Region 5:
    - Livanta LLC
    - Ready and Willing 2 Help Healthcare LLC

- BFCC-QIO Program
- 10820 Guilford Road, Suite 202, Annapolis Junction MD 20701-1105
- Phone: (888) 524-9900
- TTY: (888) 985-8775

- State Emergency Management Office—Provides oversight for the state's emergency management planning/preparation and activation of the plan for an emergency/disaster situation.
  Indiana Emergency Management Office (317) 232-2222
  https://www.in.gov/dhs/index.htm

- Ombudsman- An independent, impartial, free advocate for individuals receiving home care & other services. Ombudsman investigates complaints that haven't been solved by the Agency.
  Office of the Long-Term Care Ombudsman
  402 W. Washington St., Room W451
  Post Office Box 7083, MS 27
  Indianapolis, IN 46207-7083
  Phone: 800-622-4484 or 317-232-7134 Email:
  LongTermCareOmbudsman@fssa.IN.gov
  https://www.in.gov/ombudsman/
  Serving: Boone, Hamilton, Hancock, Hendricks, Johnson, Marion, Morgan, and Shelby Counties. Phone: 317-631-9424.
  Stacey Writt, LTC Ombudsman: Email: Stacey.Writt@lsi.net
  John Heinz, LTC Ombudsman: Email: John.Heinz@lsi.net
  Indiana Legal Services
  1200 S. Madison Ave, Suite #300 Indianapolis,
  IN. 46225.

- Alzheimer's Association- National organization focusing on services/programs for those diagnosed with Alzheimer's & Related dementias- 800-272-3900.

- Medicare/Medicaid Fraud Reporting- Call 800-MEDICARE (800-633-4227)

- Emergency Preparedness Resources
  - CDC Emergency Preparedness for People with Disabilities:
    https://www.cdc.gov/ncbddd/disabilityandhealth/emergencypreparedness.html.
  - FEMA Emergency Planning Guides:
    https://www.fema.gov/emergency-managers/national-preparedness/plan.

- Disability Preparedness DHS- https://www.hhs.gov/civil-rights/for-individuals/specialtopics/emergency-preparedness/resources-persons-disabilities/index.html.
- The Red Cross- http://www.redcross.org.
- Ready.gov- http://www.ready.gov/.
- Ready.gov Disability Information - https://www.ready.gov/disability.

Skilled Nursing Care

Skilled nursing services are provided by specially trained registered nurses and licensed practical nurses that begin all cases with an assessment to obtain information to establish a plan of care. The services are prescribed by a doctor on an intermittent basis and include such things as dressing changes, teaching and administration of medications, intravenous therapy, catheter care, diabetic care, wound care, and teaching the family how to care for the patient in the home.

Rehabilitation Services

Rehabilitation services include physical therapy, occupational therapy, and speech therapy. They are provided on an intermittent basis in the home as needed for patients who have functional limitations or sensory deficits.

Home Health Services

Home health aides work under the supervision of a registered nurse or therapist. Services primarily consist of assistance with personal care. A home health aide may give a bath, give oral care, foot care, shampoo, shave, skin care, and change linens. Under Medicare, a home health aide may stay in the home for a limited time or for a visit only and is authorized to provide personal care only.

Social Services

The social services staff provides social casework services to patients as needed to augment other services of the agency. Services include the evaluation of social functioning, particularly as it relates to medical problems, and initiation and follow-up of referrals to other community resources as applicable.

PCA

Personal Care services include the provision of services such as assist with personal care, light housekeeping, meal preparation.

Homemaker

Homemaker services include assistance with instrumental activities of daily living and may include housekeeping tasks, meal preparation. Durable medical equipment, such as walkers, wheelchairs, and hospital beds are covered separately. We can provide assistance in arranging for a certified supplier.

LIMITATIONS ON CARE/SERVICE:

Harmony Heights Home Health Services LLC will only provide services that have been advertised by the Agency.
We will also provide certified professionals for skills requiring certification. If the skill of the patient is higher than the skills of the professional or if Harmony Heights Home Health Services LLC determines that its staff may be in an unsafe situation the patient will not receive care.

AGENCY TRANSFER & DISCHARGE POLICY

The patient and representative (if any), have a right to be informed of Harmony Heights Home Health Services LLC's policies for transfer and discharge.
Harmony Heights Home Health Services LLC may only transfer or discharge the patient from the Agency if:

- The transfer or discharge is necessary for the patient's welfare because the Agency and the physician who is responsible for the home health plan of care agree that the Agency can no longer meet the patient's needs, based on the patient's acuity. The Agency must arrange a safe and appropriate transfer to other care entities when the needs of the patient exceed the Agency's capabilities.
- The patient or payer will no longer pay for the services provided by the Agency.
- The transfer or discharge is appropriate because the physician who is responsible for the home health plan of care and the Agency agree that the measurable outcomes and goals set forth in the plan of care have been achieved, and the Agency and the physician who is responsible for the home health plan of care agree that the patient no longer needs the Agency's services.
- The patient refuses services or elects to be transferred or discharged.
- The Agency determines, under a policy set by the Agency for the purpose of addressing 'discharge for cause' that meets the DISCHARGE FOR CAUSE REQUIREMENTS below, that the patient's (or other persons in the patient's home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the Agency to operate effectively is seriously impaired.

DISCHARGE FOR REQUIREMENTS: The Agency must do the following before it discharges a patient for cause:
Advise the patient, representative (if any), the physician(s) issuing orders for the home health plan of care, and the patient's primary care practitioner or other healthcare professional who will be responsible for providing care and services to the patient after discharge from the Agency (if any) that a discharge for cause is considered.

Make efforts to resolve the problem(s) presented by the patient's behavior, the behavior of other people in the patient's home, or situation.

Provide the patient and representative (if any), with contact information for other agencies or providers who may be able to provide care; and

Document the problem(s) and efforts made to resolve the problem(s) and enter this documentation into its clinical records.

- The patient dies; or Harmony Heights Home Health Services LLC ceases operating.

VACCINE INFORMATION STATEMENT

Influenza (Flu) Vaccine (Inactivated or Recombinant): *What you need to know*

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1 Why get vaccinated?

Influenza ("flu") is a contagious disease that spreads around the United States every year, usually between October and May.

Flu is caused by influenza viruses, and is spread mainly by coughing, sneezing, and close contact.

Anyone can get flu. Flu strikes suddenly and can last several days. Symptoms vary by age, but can include:

- fever/chills
- sore throat
- muscle aches
- fatigue
- cough
- headache
- runny or stuffy nose

Flu can also lead to pneumonia and blood infections, and cause diarrhea and seizures in children. If you have a medical condition, such as heart or lung disease, flu can make it worse.

Flu is more dangerous for some people. Infants and young children, people 65 years of age and older, pregnant women, and people with certain health conditions or a weakened immune system are at greatest risk.

Each year thousands of people in the United States die from flu, and many more are hospitalized.

Flu vaccine can:

- keep you from getting flu,
- make flu less severe if you do get it, and
- keep you from spreading flu to your family and other people.

2 Inactivated and recombinant flu vaccines

A dose of flu vaccine is recommended every flu season. Children 6 months through 8 years of age may need two doses during the same flu season. Everyone else needs only one dose each flu season.

Some inactivated flu vaccines contain a very small amount of a mercury-based preservative called thimerosal. Studies have not shown thimerosal in vaccines to be harmful, but flu vaccines that do not contain thimerosal are available.

There is no live flu virus in flu shots. **They cannot cause** the flu.

There are many flu viruses, and they are always changing. Each year a new flu vaccine is made to protect against three or four viruses that are likely to cause disease in the upcoming flu season. But even when the vaccine doesn't exactly match these viruses, it may still provide some protection.

Flu vaccine cannot prevent:

- flu that is caused by a virus not covered by the vaccine, or
- illnesses that look like flu but are not.

It takes about 2 weeks for protection to develop after vaccination, and protection lasts through the flu season.

3 Some people should not get this vaccine

Tell the person who is giving you the vaccine:

- **If you have any severe, life-threatening allergies.** If you ever had a life-threatening allergic reaction after a dose of flu vaccine, or have a severe allergy to any part of this vaccine, you may be advised not to get vaccinated. Most, but not all, types of flu vaccine contain a small amount of egg protein.
- **If you ever had Guillain-Barré Syndrome (also called GBS).** Some people with a history of GBS should not get this vaccine. This should be discussed with your doctor.
- **If you are not feeling well.** It is usually okay to get flu vaccine when you have a mild illness, but you might be asked to come back when you feel better.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

VACCINE INFORMATION STATEMENT

Pneumococcal Conjugate Vaccine (PCV13)

What You Need to Know

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1 Why get vaccinated?

Vaccination can protect both children and adults from pneumococcal disease.

Pneumococcal disease is caused by bacteria that can spread from person to person through close contact. It can cause ear infections, and it can also lead to more serious infections of the:

- Lungs (pneumonia),
- Blood (bacteremia), and
- Covering of the brain and spinal cord (meningitis).

Pneumococcal pneumonia is most common among adults. Pneumococcal meningitis can cause deafness and brain damage, and it kills about 1 child in 10 who get it.

Anyone can get pneumococcal disease, but children under 2 years of age and adults 65 years and older, people with certain medical conditions, and cigarette smokers are at the highest risk.

Before there was a vaccine, the United States saw:

- more than 700 cases of meningitis,
- about 13,000 blood infections,
- about 5 million ear infections, and
- about 200 deaths

in children under 5 each year from pneumococcal disease. Since vaccine became available, severe pneumococcal disease in these children has fallen by 88%.

About 18,000 older adults die of pneumococcal disease each year in the United States.

Treatment of pneumococcal infections with penicillin and other drugs is not as effective as it used to be, because some strains of the disease have become resistant to these drugs. This makes prevention of the disease, through vaccination, even more important.

2 PCV13 vaccine

Pneumococcal conjugate vaccine (called PCV13) protects against 13 types of pneumococcal bacteria.

PCV13 is routinely given to children at 2, 4, 6, and 12–15 months of age. It is also recommended for children and adults 2 to 64 years of age with certain health conditions, and for all adults 65 years of age and older. Your doctor can give you details.

3 Some people should not get this vaccine

Anyone who has ever had a life-threatening allergic reaction to a dose of this vaccine, to an earlier pneumococcal vaccine called PCV7, or to any vaccine containing diphtheria toxoid (for example, DTaP), should not get PCV13.

Anyone with a severe allergy to any component of PCV13 should not get the vaccine. *Tell your doctor if the person being vaccinated has any severe allergies.*

If the person scheduled for vaccination is not feeling well, your healthcare provider might decide to reschedule the shot on another day.

4 Risks of a vaccine reaction

With any medicine, including vaccines, there is a chance of reactions. These are usually mild and go away on their own, but serious reactions are also possible.

Problems reported following PCV13 varied by age and dose in the series. The most common problems reported among children were:

- About half became drowsy after the shot, had a temporary loss of appetite, or had redness or tenderness where the shot was given
- About 1 out of 3 had swelling where the shot was given
- About 1 out of 3 had a mild fever, and about 1 in 20 had a fever over 102.2°F.
- Up to about 8 out of 10 became fussy or irritable.

Adults have reported pain, redness, and swelling where the shot was given; also mild fever, fatigue, headacke, chills, or muscle pain.

Young children who get PCV13 along with inactivated flu vaccine at the same time may be at increased risk for seizures caused by fever. Ask your doctor for more information.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

ADVANCE DIRECTIVES - YOUR RIGHT TO DECIDE

Under federal law, you have the right to complete an "advance directive' which outlines one's desire in advance on what type of treatment you want or do not want under special, serious medical conditions (conditions that would prevent you from telling your doctor how you want to be treated)

There are various kinds of Advance Directives, including, but not limited to those listed below.

- ***Living Will*** • ***Healthcare Surrogate/Proxy*** • ***Durable Power of Attorney for Healthcare***

If you have executed any of these documents, please advise your Admission clinician and they will make a copy of the document for our records.

If you do not currently have an advanced directive in place, we encourage you to consult an attorney or the State Department of Aging for additional information and forms. If you create an Advance Directive, please advise us immediately.

The agency has adopted policies regarding the implementation of your advance directive. It includes the incorporation of the document into your clinical record, communication of the directive to caregivers, and the assurance that the provision of your care is in no way conditional upon an advance directive or the refusal of medical or surgical treatments.

The agency will in no way place conditions on the provision of care, or in any way discriminate against patients, based on their right to refuse medical treatment or the creation of an Advance Directive.

Our objective is to assure that the patient's rights are respected and that any such decisions or documents will not place conditions on the provision of care.

Our Agency Advance Directive (AD) Procedures:

1. The existence of an AD will be asked about upon admission to our agency.
2. Patients who are cognitively impaired shall have AD information provided to family or a surrogate.
3. If an AD has been executed, the medical record will indicate such and efforts will be made to obtain a copy for placement in the medical record.
4. At the time an AD takes effect, care will continue in compliance with said instructions to the extent permitted by law. The agency will obtain Physician orders as needed based on the content of your AD.
5. Care shall continue according to a physician's plan of care and the patient's wishes unless the patient's refusal of treatments negates the only service being provided, at which time, after patient and physician notification, care would cease, or patient would be referred to appropriate agency.
6. Patients are informed in writing in the Admission Packet of their right to register complaints concerning AD requirements through the toll-free home care hotline in the Patient Rights.

Extraordinary Life-Prolonging Measures: The agency's goal is to meet the needs of our patients, to help them achieve the highest level of health and function possible and to respect their rights. We are committed to use all means at our disposal to sustain life when appropriate but recognize the right of refusal of extraordinary life-prolonging measures if the physician certifies that the patient suffers either from a terminal illness or such a magnitude of health problems that an acceptable quality of life can no longer be sustained. When appropriate, discussions regarding these issues may be initiated by the agency's professional staff or by the patient/family/responsible party.

HOME HEALTH AGENCY OUTCOME AND ASSESSMENT INFORMATION SET (OASIS)
STATEMENT OF PATIENT PRIVACY RIGHTS

As a home health patient, you have the privacy rights listed below:

- You have the right to know why we need to ask you questions.
  - We are required by law to collect health information to make sure you get quality Healthcare, and payment for Medicare and Medicaid patients is correct.
- You have the right to have your personal Healthcare information kept confidential. You may be asked to tell us information about yourself so that we will know which home health services will be best for you. We keep anything we learn confidential. This means, only those who are legally authorized to know, or who have a medical need to know, will see your personal health information.
- You have the right to refuse to answer questions.
  - We may need your help in collecting your health information. If you choose not to answer, we will fill in the information as best we can. You do not have to answer every question to get services.
- You have the right to look at your personal health information.
  - We know how important it is that the information we collect about you is correct. If you think we made a mistake, ask us to correct it. If you are not satisfied with our response, you can ask the Centers for Medicare & Medicaid Services, the federal Medicare and Medicaid agency, to correct your information.
- You can ask the Centers for Medicare & Medicaid Services to see, review, copy, or correct your personal health information which the Federal agency maintains in its HHA OASIS System of Records. See the back of this Notice for CONTACT INFORMATION. If you want a more detailed description of your privacy rights, see the PRIVACY ACT STATEMENT - HEALTHCARE RECORDS.

This is a Medicare & Medicaid Approved

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

NOTICE ABOUT PRIVACY

For Patients Who DO NOT Have Medicare or Medicaid Coverage

- As a home health patient, there are a few things that you need to know about our collection of your personal Healthcare information.
  - Federal and State governments oversee home Healthcare to be sure that we provide quality home Healthcare services, and that you, in particular, get quality home Healthcare services.
  - We need to ask you questions because we are required by law to collect health information to make sure that you get quality Healthcare services.
  - We will make your information anonymous. That way, the Centers for Medicare & Medicaid Services, the federal agency that oversees this home health agency, cannot know that the information is about you.
- We keep anything we learn confidential.

This is a Medicare & Medicaid Approved Notice.

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRIVACY ACT STATEMENT -- HEALTHCARE RECORDS

THIS STATEMENT GIVES YOU ADVICE REQUIRED BY LAW (THE PRIVACY ACT OF 1974).
THIS STATEMENT IS NOT A CONSENT FORM.
IT WILL NOT BE USED TO RELEASE OR TO USE YOUR HEALTHCARE INFORMATION.

I. Authority for collecting your information, including your Social Security Number, and whether or not you are required to provide information for this assessment. Sections 1102(a), 1154, 1861(o), 1861(z), 1863, 1864, 1865, 1866, 1871, 1891(b) of the Social Security Act.

Medicare and Medicaid participating in home health agencies must do a complete assessment that accurately reflects your current health and includes information that can be used to show your progress toward your health goals. The home health agency must use the "Outcome and Assessment Information Set" (OASIS) when evaluating your health. To do this, the agency must get information from every patient. This information is used by the Centers for Medicare and Medicaid Services to be sure that the home health agency meets quality standards and gives appropriate Healthcare to its patients. You have the right to refuse to provide information for the assessment to the home health agency. If your information is included in an assessment, it is protected under the federal Privacy Act of 1974 and the "Home Health Agency Outcome and Assessment Information Set" (HHA OASIS) System of Records.

II. Principal purposes for which your information is intended to be used.

The information collected will be entered into the Home Health Agency Outcome and Assessment Information Set (HHA OASIS) Your Healthcare information in the OASIS System of Records will be used for the following purposes:

- Support litigation involving the Centers for Medicare and Medicaid Services.
- Support regulatory, reimbursement, and policy functions performed within the Centers for Medicare and Medicaid Services or by a contractor or consultant.
- Study the effectiveness and quality of care provided by those home health agencies.
- Survey and certification of Medicare and Medicaid home health agencies.
- Provide for development, validation, and refinement of a Medicare prospective payment system.
- Enable regulators to provide home health agencies with data for their internal quality improvement activities.
- Support research, evaluation, or epidemiological projects related to the prevention of disease or disability, or the restoration or maintenance of health, and for healthcare payment related projects; and
- Support constituent requests made to a Congressional representative.

HARMONY HEIGHTS
HOME HEALTH SERVICES

III. ROUTINE USES

These routine uses specify the circumstances when the Centers for Medicare & Medicaid Services may release your information from the HHA OASIS System of Records without your consent. Prospectivities recipient must agree in writing to ensure the continuing confidentiality and security of your information. Disclosures of the information may be to:

1. The Federal Department of Justice for litigation involving the Centers for Medicare & Medicaid Services.
2. Contractors or consultants working for the Centers for Medicare & Medicaid Services to assist in the performance of a service related to this system of records and who need to access these records to perform the activity.
3. An agency of a state government for purposes of determining, evaluating, and/or assessing cost, effectiveness, and/or quality of healthcare services provided in the State; for developing and operating Medicaid reimbursement systems; or for the administration of Federal/State home health programs within the State.
4. Another Federal or State agency to contribute to the accuracy of the Centers for Medicare & Medicaid Services' health insurance operations (payment, treatment, and coverage) and/or to support State agencies in the evaluations and monitoring of care provided by HHAs.
5. Quality Improvement Organizations, to perform Title XI or Title XVIII functions relating to assessing and improving home health agency quality of care.
6. An individual or organization for research, evaluation, or epidemiological project related to the prevention of disease or disability, the restoration or maintenance of health, or payment related projects.
   A congressional office in response to a constituent inquiry made at the written request of the constituent about whom the record is maintained.

IV. EFFECT ON YOU, IF YOU DO NOT PROVIDE INFORMATION

The home health agency needs the information contained in the Outcome and Assessment Information Set in order to give you quality care. It is important that the information be correct. Incorrect information could result in payment errors. Incorrect information also could make it hard to be sure that the agency is giving you quality services. If you choose not to provide information, there is no federal requirement for the home health agency to refuse your services.

NOTE: This statement may be included in the admission packet for all new home health agency admissions. Home health agencies may request you or your representative to sign this statement to document that this statement was given to you. Your signature is NOT required. If you or your representative signs the statement, the signature merely indicates that you received this statement. You or your representative must be supplied with a copy of this statement.

CONTACT INFORMATION

If you want to ask the Centers for Medicare & Medicaid Services to see, review, copy or correct your personal health information that the Federal agency maintains in its HHA OASIS System of Records:

Call 1-800-MEDICARE, toll free, for assistance in contacting the HHA OASIS System Manager.

TTY for the hearing and speech impaired: 1-877-486-2048

Pain Management Information

Pain afflicts millions of Americans. It is a condition that affects quality of life and economic security not only of the person with pain, but also their family. Chronic pain can overwhelm a person and cause them to become isolated and fearful.

The following information is offered to assist the person in pain.

- Learn all you can about what is causing your pain. Understand there may not be a current cure.
- Take an active role in your recovery. Follow the doctor's advice.
- Learn to set priorities. Setting priorities can help you find a starting point to lead you back to your normal lifestyle.
- Set goals with manageable steps and celebrate your successes.
- Your emotions are affected by your physical well-being. By acknowledging your feelings, you can reduce stress and decrease the pain you feel.
- Pain increases in times of stress. Relaxation exercises can be beneficial in reclaiming control of your body.
- Exercise. Unused muscles feel more pain than toned, flexible muscles. Check with your doctor to identify an exercise routine that will help you build strength and decrease your pain.
- Focus on your abilities. Pain does not need to be the center of your life.

Helpful Pain Relief Methods

Some of the following methods may require a physician's order and a referral for service. Please consult your physician.

- Massage & Therapeutic Touch can help patients to relax, release muscle tension, and enjoy a sense of comfort.
- Heat & Cold Therapy can be effective pain relievers. Cold packs can help reduce tissue swelling and muscle spasm and improve range of motion. Moist hot packs, heating pads can increase blood flow, reduce muscle spasm, and provide relaxation.
- TENS - transcutaneous electrical nerve stimulation uses a mild electrical current on the surface of the skin to block pain signals to the brain.
- Relaxation & distraction techniques help people in pain redirect their attention. Options include breathing exercises, guided imagery, biofeedback, hypnosis, progressive muscle relaxation. (Some of management centers.) Listening to music, reading, and getting involved in hobbies will help you focus on things you enjoy which can reduce pain.
- Acupuncture involves inserting tiny needles into specific sites on the body.
- Exercise can improve range of motion. It also has the added benefit of building strength, conditioning the heart, and improving metabolism. Exercise may also help the body produce natural painkillers called endorphins.
- Sleep can impact your ability to cope with pain. Make sure your bed supplies enough support. You can place a sheet of plywood between your mattress and springs. Limit extended periods in bed which can aggravate back, leg, neck, shoulder, and hip pain. Try placing a pillow between your legs while lying on your side. Stay on a routine bedtime and out-of-bed schedule.

Patients Rights & Responsibilities

These Rights and Responsibilities will be followed by all employees of Harmony Height Home Health Services LLC that provided care/services to you in your residence. Our Agency protects and promotes the exercise of rights at any time. You have the right to exercise these rights at any time without fear of reprisal or discrimination in care/services.

As a patient of our Agency, you have the right to:

1. Be informed of your Patient Rights.
2. Exercise these rights at any time.
3. Have your property and person treated with respect.
4. Be free from neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and/or misappropriation of patient property by anyone furnishing services on behalf of our Agency.
5. Voice and report grievances/complaints regarding treatment or care that are (or fail to be) delivered, the lack of respect for property and/or person, or the violation of any rights to the Agency, accrediting body, and state or local agencies.
6. Participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to:
    a. Completion of all assessments.
    b. The care to be furnished, based on the comprehensive assessment.
    c. Establishing and revising the plan of care.
    d. The disciplines that will furnish the care.
    e. The frequency of visits.
    f. Expected outcomes of care, including patient-identified goals, and anticipated risks/benefits.
    g. Any factors that could impact treatment effectiveness.
    h. Any changes in the care to be furnished.
    i. The mode of care delivery including the use of telecommunications when applicable
7. Receive all services outlined in the plan of care.
8. Choose a health care provider, including an attending physician or allowed practitioner.
9. Receive appropriate care without discrimination in accordance with physician or allowed practitioners orders.
10. Be informed of any financial benefits referred to Harmony Height Home Health Services LLC

Patients Rights & Responsibilities

11. Have a confidential clinical record. Access to or release of patient information and clinical records is available with a written request of the agency.

12. Be advised of:

    a. The extent to which payment for Agency services may be expected from Medicare, Medicaid, or any other federally-funded or federal aid program known to the Agency,

    b. The charges for services that may not be covered by Medicare, Medicaid, or any other federally-funded or federal aid program known to the Agency.

    c. The charges the individual may have to pay before care is initiated.

    d. Any changes in the information provided when they occur, including payments & fees. The Agency must advise the patient and representative (if any), of these changes as soon as possible, in advance of the next home health visit and in accordance with the patient notice requirements at 42 CFR §411.408(d)(2) and 42 CFR §411.408(f).

    e. That the Agency must comply with the covered/non-covered patient services notification requirements.

13. Have a confidential patient record and access to or release of patient information and records in accordance with Health Insurance Portability and Accountability Act (HIPAA) law and regulation (45 CFR parts 160 and 164).

14. Receive proper written notice, in advance of a specific service being furnished, if the Agency believes that the service may be non-covered care; or in advance of the Agency reducing or terminating on-going care. The Agency must also comply with the requirements of notifying patients regarding termination of services.

15. Be advised of the names, addresses, and telephone numbers of the following Federally-funded and state-funded entities that serve the area where the patient resides (as listed in your SOC document STATE RESOURCES):

    a. Area Agency on Aging (AAA)
    b. Center for Independent Living (CIL)
    c. Protection and Advocacy Agency
    d. Aging and Disability Resource Center (ADRC)
    e. Quality Improvement Organization (QIO)

16. Be free from any discrimination or reprisal for exercising your rights or for voicing grievances to the Agency or an outside entity.

17. Be informed of the right to access auxiliary aids and language services, and how to access these services.

18. Be advised of our Agency's transfer and discharge policies.

19. Be able to identify visiting personnel members through agency-generated photo identification.

20. Be informed of any financial benefits when referred to our HHA

21. Be informed how to contact (contact information and hours of operation) the state toll-free hotline, and if the Agency is accredited, the accreditation body hotline, and that its purpose is to voice grievances or receive complaints/questions about local agencies and to receive complaints concerning the implementation of Advance Directive requirements.

Indiana Hotline: (800) 246-8909

You may also write to:
Indiana State Department of Health
Health Care Facility Complaint Program
2 North Meridian Street, 4B
Indianapolis, IN 46204

To Fax Complaints: (317) 233-7494

To Email Complaint Forms: complaints@isdh.in.gov

22. Our Agency will honor any court decisions concerning competency and the role of the appointed representative.

23. To be informed in writing of policies and procedures for implementing advance directives and have health care providers comply with advance directives in accordance with state laws.

Harmony Heights Home Health Services LLC
8888 Keystone Crossing, Suite 1300
Indianapolis, IN 46240

Patient/Representative Signature: _____

Date: _____

Patients of Harmony Heights Home Health Services LLC have the responsibility to:

1. Notify Harmony Heights Home Health Services LLC of changes in their condition or care situation (hospitalization, symptoms, etc.).
2. Follow the plan of care.
3. Notify Harmony Heights Home Health Services LLC if the visit schedule needs to be changed.
4. Keep appointments and notify Harmony Heights Home Health Services LLC if unable to do so.
5. Inform Harmony Heights Home Health Services LLC of the existence of, and any changes to, advance directives.
6. Advise Harmony Heights Home Health Services LLC of any problems or dissatisfaction with the service.
7. Provide a safe environment for care to be provided.
8. Carry out mutually agreed responsibilities.

A reasonable attempt has been made and documented that the patient and family understand these rights and responsibilities which have been reviewed with the patient prior to or at the start of care visit and periodically thereafter.

Harmony Heights Home Health Services LLC

NOTICE OF HIPAA PRIVACY PRACTICES FOR PHI – PAGE 1 OF 3

[45 CFR 164.520] OCR HIPAA Privacy December 2002
THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION
IT IS PROTECTED & MAY BE USED AND DISCLOSED

We are required by law to support the privacy of your health information; to provide you this detailed Notice of our legal duties and privacy practices, and to abide by the terms of the Notice that are currently in effect.

You have the right to: Advise our Agency to limit what information is utilized or shared:

- Ask our Agency not to use or share certain health information for treatment, payment, or operations.
- Our Agency is not required to agree to your request and may say "no" if it would affect your care.
- If you pay for a service or Healthcare item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurance. Our Agency will say "yes" unless a law requires us to share that information.

Choose someone to act on your behalf:

- If you have designated an individual medical power of attorney or have a legal guardian, that individual may exercise your rights and make choices about your health information.
- Our Agency will make sure the person has this authority and can act for you before we take any action.

Obtain a list of those with whom we've shared information:

- You can ask for a list (accounting) of the times the Agency has shared your health information for six (6) years prior to the date you ask, who the Agency shared it with, and for what purpose.
- Our Agency will include all the disclosures except for those about treatment, payment, and Healthcare operations, and certain other disclosures (such as any you asked us to make). Our Agency will provide one accounting a year at no charge but will charge a reasonable fee if you ask for another within 12 months.

Request confidential communications:

- You can ask our Agency to contact you in a specific way (i.e., at home/work phone) or send mail to a specific address.
- Our Agency will comply with all reasonable requests.
- Get an electronic or paper copy of your medical record;
- You can ask to see or receive an electronic or paper copy of your medical record and other health information the Agency has about you. Ask our Agency how to do this.
- The Agency will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record:

- You can ask our Agency to correct health information about you that you think is incorrect or incomplete. Ask our Agency how to do this.
- Our Agency may say "no" to your request, but we will explain why in writing within 60 days.

Get a copy of this private notice:

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. Our Agency will provide you with a copy of a paper promptly.

For certain health information, you can tell us your choices about what we share: If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care.
- Share information in a disaster relief situation.

- *Include your information in a hospital directory.*

  If you are not able to tell us your preference, we may share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

USES AND DISCLOSURES:

For Treatment: Our Agency will use and disclose your health information by providing you with treatment/services and coordinating your care and may disclose information to other providers involved in your care. Your health information may be used by doctors involved in your care and by nurses and health aids as well as by therapists, pharmacists, suppliers of medical equipment, or other people involved in your care.

For Payment/Billing: For Services. Our Agency may use and disclose your health information for billing and payment purposes. We may disclose your health information to your representative, or to an insurance company or another third-party payer. We may contact your health plan to confirm your coverage or to request prior approval for services that will be provided to you.

For Healthcare Operations: Our Agency may use and disclose your health information as necessary for operating our Agency, such as management, personnel evaluation, education, and training, and monitoring our quality of care. We may disclose your health information to another entity with which you have or had a relationship if that entity requests your information for certain of its Healthcare operations or Healthcare fraud and abuse detection or compliance activities.

To Do Research: Our Agency can use or share your information for health research.

To Comply with the law: Our Agency will share information about you whether state or federal laws require it, including with the US Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

To Respond to organ and tissue donation requests: Our Agency can share health information about you with organ procurement organizations.

To Work with a medical examiner or funeral director: Our Agency can share health information with a coroner, medical examiner, or funeral director when an individual dies.

To Address workers' compensation, law enforcement, and other government requests:

Our Agency can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, etc.

To Respond to lawsuits and legal actions: Our Agency can share health information about you in response to a court or administrative order, or in response to a subpoena.

We will never share your information for the following purposes unless you give written permission:

- Marketing purposes.
- Sales of your information
- Most sharing of psychotherapy notes
- We may contact you for fundraising efforts, but you can tell us not to contact you again.

We are allowed to use or share your health information in other ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

To help with public health and safety issues:

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety.

SPECIFIC USES/DISCLOSURES OF YOUR HEALTH INFORMATION

Individuals Involved in Your Care or Payment: For your care. Unless you object, our Agency may disclose health information about you to a family member, close personal friend, or other person you identify, including clergy, who is involved in your care.

Emergencies: Our Agency may use or disclose your health information as necessary in emergency treatment situations.

As Required by Law: We may use or disclose your health information when required by law to do so.

Business Associates: Our Agency may disclose your protected health information to a contractor or business associate that needs the information to perform services for our Agency. Our business associates are committed to preserving the confidentiality of this information.

RESPONSIBILITIES OF OUR AGENCY:

- Our Agency is required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

You have the right to express concerns/complaints, without fear of retaliation, to our Agency or to the US Department of Health & Human Services, regarding any act that you consider a violation of these privacy rights.

If you feel your privacy rights have been violated, please direct concerns to our agency at: **Harmony Heights Home Health Services LLC** 8888 Keystone Crossing, Suite 1300, Indianapolis, IN 46240

Our agency will never retaliate against you for filing a complaint.

Or you can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 877-696-6775, or www.hhs.gov/ocr/privacy/hipaa/complaints/.

For more information: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html. Our Agency can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available on request and be posted in our office.

AGENCY GRIEVANCE POLICY / PROCESS

Harmony Heights Home Health Services LLC

We strive to provide the highest quality health care services for our patients. To ensure that our services meet your needs, we encourage you to make us aware of any complaints or concerns. Complaints should be addressed to the Administrator who will promptly review the problem. If at any time you feel that a situation was not resolved to your satisfaction by this process, you may contact the office at the number listed below.

We appreciate your candid comments as this helps us in the process of continually working to improve our services to our many valued patients. If you have information about unethical behavior, criminal activities, or other concerns regarding your services, please call the Director at your office. Your confidentiality will be protected. The following are examples of issues that should be brought to our attention immediately:

- Potential criminal violations
- Bribes and kickbacks
- Breach of confidentiality of company information or patient records
- Privacy of employee and patient records
- On-the-job substance abuse
- Violation of patients' rights
- Health and safety issues
- Conflicts of interest
- Antitrust laws
- Harassment or discrimination
- Billing and documentation/ insurance fraud
- Theft and fraud
- Insider trading

GRIEVANCE PROCESS

Our Agency is committed to providing excellence in patient care. We will give full consideration to your issues and make an effort to resolve any issues to your satisfaction.

We will provide you with every opportunity to voice grievances without discrimination, fear of reprisal, or any discrimination from our Agency or its employees.

If you have any concerns at all, please tell us, either verbally or in writing, the Administrator or Clinical Manager or any staff member with whom you are comfortable. They will ensure the concern is presented to the Administrator or Clinical Manager. If you call after business hours, the Administrator/Clinical Manager will be in contact with you the next business day.

The Administrator or Clinical Manager will contact you within 10 days and will help to resolve the complaint/concern to your satisfaction. They will look at all aspects surrounding the grievance, investigation, and resolution. You will be notified of the Administrator's decision within thirty (30) days. If you are dissatisfied with the outcome of the complaint investigation, you may request that the Administrator submit an appeal with the Agency's Governing Body.

You may also file a complaint with the Indiana Complaint Hotline at (800) 246-8909

You may file a grievance/concern with our Agency at any time without fear of reprisal.

PLEASE CONTACT OUR AGENCY AT:

AGENCY NAME:
Harmony Heights Home Health Services LLC

AGENCY ADDRESS:
8888 Keystone Crossing
Suite 1300
Indianapolis, IN 46240

AGENCY ADMINISTRATOR:
Derricka Smith, RN

AGENCY TELEPHONE:
317-548-8446

EMERGENCY PREPAREDNESS INFORMATION

Harmony Heights Home Health Services LLC

To attempt to keep all our patients informed and educated, Harmony Heights Home Health Services LLC wants to give you the best advice and preparedness tips possible. We have assigned you a priority code based on your own unique situation at home.

DISASTER EMERGENCY PRIORITY CLASS

- **Class I – HIGHEST** – Patients with life threatening conditions that require ongoing medical treatment or a medical device to sustain life.
- **Class II** – Patients with a great need for care but not life threatening. Visits could be postponed without adverse effects. Capable caregiver is present to provide care until emergency is over.
- **Class III** – Visits could be postponed 24 or more hours without adverse effects. Patient is stable & has access to informal resources.
- **Class IV – LOWEST** – Service could be postponed for 72 or more hours without adverse effect.

You have been assigned as priority code: _____

During an emergency situation, patients can expect that we will do everything within our means to continue servicing your emergent needs. Some of the situations that may cause us to close an office and put the emergency plan in effect are:

- Severe winter storms/weather conditions (hurricane, tornado, winter storms, etc.)
- National Emergency status called for by the Governor

In the event that we have notification of the emergency situation, you can expect a phone call from our office explaining when we anticipate your next visit to be done and by whom. If you are a priority 2, 3 or 4 patient, we are likely to postpone your scheduled visit to another day in the same week. If you are a priority 1 patient we will make every effort to provide your visit.

We advocate that all persons create at least a 3 day supply of clean drinking water, nonperishable food, a flashlight/extra batteries, extra blanket, medication, portable radio, and critical documents. If you have a pet, please research local shelters that accept pets. To keep pets comfortable, have their favorite toy/blanket, pet carrier, leash, and food.

When an emergency condition occurs our office begins a specialized procedure to assure your care. The Administrator will begin notifying their staff and the phone tree continues until all employees are contacted so that everyone knows what to do and when to do it. Please refrain from calling the office unless you have a true emergency situation.

OUR AGENCY DESIGNATES THE FOLLOWING EMERGENCY BACKUP COMMUNICATION METHODS:

TELEVISION STATION NAME: FOX 59

RADIO STATION NAME: 106.7 FM

Emergency Preparedness Kits

Prepare different kits for different places and situations
(Carry on You, Grab-and-Go, Bedside, Home)

A "carry-on-you" kit is for essential items, such as medications, contact names and phone numbers, health information etc., to keep with you at all times.

"Grab-and-go kits" are easy-to-carry kits you can grab if you have to leave in a hurry. They have the things you cannot do without but are not so big or heavy that you cannot manage them.

A "home kit" is your large kit with water, food, first aid supplies, clothing, bedding, tools, emergency supplies, and disability-specific items. It includes all the things you would most likely need if you had to be self-sufficient for days either at home or in an evacuation shelter.

A "bedside kit" has items needed if you are trapped in or near your bed and unable to get to other parts of your home.

Keep important items in a consistent, convenient, and secured place, so you can quickly and easily get to them. (Items such as teeth, hearing aids, prostheses, canes, crutches, walkers, wheelchairs, respirators, communication devices, artificial larynx, sanitary aids, batteries, eyeglasses, contact lens with cleaning solutions, etc.)

Emergency Supplies Kits (Carry on You, Grab-and-Go, Bedside, Home)

- Emergency health information
- Cell phone
- Standard telephone (does not need to be plugged into an electric outlet)
- Essential medications
- Other medications
- Flashlights and extra batteries. (People with limited reach or hand movement should consider low cost battery-operated touch lamps.)
- Extra batteries for oxygen, breathing devices, hearing aids, cell phone, radios, pagers, PDAs.
- Copies of prescriptions
- Emergency food
- Assorted sizes of re-closeable plastic bags for storing, food, waste, etc.
- Sturdy work gloves to protect your hands from sharp objects you may try to lift or touch by mistake while walking or wheeling over glass and rubble
- Lightweight flashlight (on key ring, etc.)
- Small battery-operated radio and extra batteries
- Signaling device you can use to draw attention to you if you need emergency assistance (whistle, horn, beeper, bell(s), screecher)
- A container that can be attached to the bed or nightstand (with cord or Velcro) to hold hearing aids, eyeglasses, cell phones, etc., oxygen tank attached to the wall, wheelchair locked and close to bed. This allows quick access to essential items during an emergency.

Harmony Heights Home Health Services LLC helps prevent them from falling, flying, or rolling away during an earthquake or other jarring, jolting event.

A patch kit or can of "sealant" to repair flat tires and/or an extra supply of inner tubes for non-puncture-proof wheelchair/scooter tires Keep needed equipment close to you so you can get to it quickly. If available, keep a lightweight manual wheelchair for backup.

Source: http://www.ready.gov/

Patient Financial Authorization

Name (*Last, First*): _____

_____ Address: _____

_____ State: _____ Zip Code: _____ City: _____

Phone: _____

Payer Information

Primary insurance to be billed for your services is:

☐ **MEDICARE** (expected amount payer will not pay _____)

☐ **MEDICAID** (expected amount payer will not pay _____) ☐

INSURANCE (expected amount payer will not pay _____)

Insurance company will pay _____% of our charges and your portion is _____% or $_____ per hour/per visit/per day. There is an out of pocket expense of $_____ and a deductible of $_____. The insurance company will pay (____ of visits).

You will be notified of any changes to the charges as soon as the Agency becomes aware of them but at least no later than 30 days from the date we learned of the change.

Service Order

I hereby authorize the Agency to provide the following initial services with identified frequencies:

Service	Frequency*	Charge	Service	Frequency*	Charge
RN		$ _____ /hr	Physical Therapy		$ _____ /hr
LPN		$ _____ /hr	Occupational Therapy		$ _____ /hr
Aide		$ _____ /hr	Speech Therapy		$ _____ /hr
MSW		$ _____ /hr	Other:		$ _____ /hr

The billing rate for the above service checked is $_____ per hour, per day, per visit

The billing rate for the above service checked is $_____ per hour, per day, per visit

The billing rate for the above service checked is $_____ per hour, per day, per visit

Or _____% of the agreed insurance arrangement as determined by your policy. My signature on this document indicates permission for Harmony Heights Home Health Services LLC to bill my insurance carrier for my homecare services as provided by my policy. I agree to pay any co-pay or non-covered amount over and above what my insurance covers.

*Pending MD/Insurance approval

Terms of service: The signature below acknowledges my acceptance of the following:

Consent to the services outlined above.

Full financial responsibility for service(s) is rendered to the above named person.

Assignment of Payment of any benefits payable to/for me, be made payable to Harmony Height Home Health Services LLC.

Have right to request that all visits be invoiced to your insurance company.

That I have not been coerced or forced to sign this document.

Patient/Representative Signature _____ _____

Signature/Title of clinician _____ _____

Printed Name of clinician _____ _____

Patient Consent & Authorization Form

RELEASE OF INFORMATION: I do hereby authorize Harmony Heights Home Health Services LLC to release information contained in my medical record and any other medical information about me in their possession in the following instances:

- To health care providers who, with my consent, are involved in my care and in the transfer of my care and or in the co-ordination of my care.
- To my insurance company/third party payer for the purpose of obtaining payment for care provide.
- To peer review, utilization review or other organizations responsible for monitoring the quality or appropriateness of patient care.

This authorization does not permit the disclosure of release of information that may arise out of communications with a psychotherapist, social worker or sexual assault counselor, HTLV-III (HIV or AIDS) test results, records from an alcohol or drug abuse treatment facility or records pertaining to sexually transmitted diseases. Release of any such information shall require an additional specific consent for disclosure. I understand that this authorization shall pertain to and remain in effect for the time I receive care from the Agency. I also understand that no further consent for release of information shall be required in the above circumstances unless I notify the Agency otherwise in writing.

CONSENT TO TREAT: I hereby authorize this Agency and its agents full consent for the provision of care and treatment under the plan of care of the primary physician and to abide by the Agency's specific policies and procedures relating to home health care which have been reviewed with me and which include provisions for termination of home health care services at my request, my physician's request and/or the Agency's request. I acknowledge that no guarantees have been made with respect to the outcome of this service or of any treatments or procedures.

PHOTO CONSENT: I hereby give the agency and its staff, consent to photograph me and any parts of my body, in relation to my care/services while under the care of the agency.

I acknowledge that the Agency does not routinely perform drug testing on employees but may do so at their discretion.

ELECTRONIC RECORDS & E-SIGNATURE CONSENT: I consent to the use of electronic medical records and e-signature(s) for documents related to my care. I understand that electronic records and signatures have the same legal effect as paper records and handwritten signatures.

PATIENT ACKNOWLEDGMENT

By signing below, I acknowledge that I have read, understand, and agree to the information above.

Patient Printed Name: ___ Date: _

Patient Signature / Authorized Representative: _

Relationship (if not patient): ___

PATIENT EMERGENCY CONTACT

Name: _ Relationship: _

Home Phone: Phone:

Insurance Information Form

Harmony Heights Home Health Services LLC

PATIENT INFORMATION

Patient Name: _____ Date of Birth (DOB): _____

Medical Record #: _____

MEDICARE INFORMATION

Please provide your Medicare card to our office so we may make a copy for your medical records.

☐ I have Medicare Part A ☐ I have Medicare Part B

MEDICARE PART A (HOSPITAL INSURANCE)

Medicare Number:	
Effective Date:	
Entitled To:	☐ Self ☐ Spouse ☐ Other _____ *(If other, please specify relationship)*
Name of Insured:	
Is Patient the Insured?	☐ Yes ☐ No
Insurance Company If Self Employed:	
Group #:	

MEDICARE PART B (MEDICAL INSURANCE)

Medicare Number:	
Effective Date:	
Entitled To:	☐ Self ☐ Spouse ☐ Other _____ *(If other, please specify relationship)*
Name of Insured:	
Is Patient the Insured?	☐ Yes ☐ No
Insurance Company If Self Employed:	
Group #:	

IMPORTANT: Please notify our office immediately of any changes to your insurance information.

Additional Insurance Information

Harmony Heights Home Health Services LLC

PRIVATE INSURANCE

Please list any additional insurance you have. Provide copies of all insurance cards to our office so we may keep a copy for your medical records.

PRIVATE INSURANCE #1

Carrier's Name:		Insurance Agency Name:	
Customer Service Phone #:		Subscriber's Name:	
Subscriber ID / Member #:			
Group #:		Policy #:	
Plan Name:		Effective Date:	

PRIVATE INSURANCE #2

Carrier's Name:		Insurance Agency Name:	
Customer Service Phone #:		Subscriber's Name:	
Subscriber ID / Member #:			
Group #:		Policy #:	
Plan Name:		Effective Date:	

☐ Check this box if patient has NO insurance of any kind: **FREE CARE**

MEDICARE CARD

Please provide a copy of your Medicare card (front and back) to our office. This helps us bill accurately for your services.

IMPORTANT: Please notify our office immediately of any changes to your insurance information including cancellations, new insurance, or change of address.

NON-DISCRIMINATION & LANGUAGE ASSISTANCE NOTICE

Harmony Heights Home Health Services LLC

OUR COMMITMENT TO EQUAL ACCESS

Harmony Heights Home Health Services LLC complies with applicable Federal civil rights laws and does not discriminate in the admission or provision of services, or in employment, on the basis of race, color, national origin, age, disability, or sex.

FREE SERVICES FOR INDIVIDUALS WITH DISABILITIES

Harmony Heights Home Health Services LLC provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print documents, accessible electronic formats, other formats)
- Accessible electronic formats
- Audio formats

FREE LANGUAGE ASSISTANCE SERVICES

Harmony Heights Home Health Services LLC provides free language assistance services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

IF YOU NEED THESE SERVICES, CONTACT:
Derricka Smith, RN, Administrator
Phone: 317-548-8446
Email: harmonyheights.care@gmail.com

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 317-548-8446 (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 317-548-8446 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 317-548-8446 (TTY: 711).

HOW TO FILE A CIVIL RIGHTS GRIEVANCE

If you believe that Harmony Heights Home Health Services LLC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance.

You can file a grievance in person, by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

CONTACT OUR CIVIL RIGHTS COORDINATOR:

Civil Rights Coordinator: Derricka Smith, RN, Administrator

Mailing Address: 8888 Keystone Crossing, Suite 1300
Indianapolis, IN 46240

Phone: 317-548-8446

Email: harmonyheights.care@gmail.com

YOU CAN ALSO FILE A CIVIL RIGHTS COMPLAINT WITH THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

If you believe you have been discriminated against on the basis of race, color, national origin, age, disability, or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW., Room 509F, HHH Building
Washington, DC 20201
1-800-368-1019, 800-537-7697 (TDD)

NOTE: Grievance forms are available upon request at our office.

SECTION 504
NOTICE OF PROGRAM ACCESSIBILITY

The regulation implementing Section 504 requires that an agency "*...adopt and implement procedures to ensure that interested persons, including persons with impaired vision or hearing, can obtain information as to the existence and location of services, activities, and facilities that are accessible to and usable by disabled persons.*" **(45 C.F.R. §84.22(f))**

Harmony Heights Home Health Services LLC and all of its programs and activities are accessible to and useable by disabled persons, including persons who are deaf, hard of hearing, or blind, or who have other sensory impairments.

Harmony Height Home Health Services LLC

Access features include:

- Parking designated specifically for disabled persons.
- Level access into first floor level with elevator access to all other floors.
- Fully accessible offices, meeting rooms, bathrooms, public waiting areas.
- A full range of assistive and communication aids is provided to persons who are deaf, hard of hearing, or blind, or with other sensory impairments. There is no additional charge for such aids.

Some of these aids may include:

- Qualified sign language interpreters for persons who are deaf or hard of hearing.
- Readers and taped material for the blind and large print materials for the visually impaired.
- Flash cards, alphabet boards and other communication boards.
- Assistive devices for persons with impaired manual skills.

If you require any of the aids listed above, please advise your nurse or other Agency staff member, or call our Agency office.

HARMONY HEIGHTS
HOME HEALTH SERVICES

Start Date	Stop Date	Class	N = New C = Changed O = Ongoing	Medication and dosage	Route	Freq	Instructed Yes/No	Pill count if appl	Purpose

Clinician Signature: _____ _____

PATIENT DESIGNATED REPRESENTATIVE INFORMATION

Patient Name: _____ **PT ID#:** _____

MY DESIGNATED REPRESENTATIVE

Name: _____ Relationship: _____

Phone: _____ Email: _____

Address: _____

DEFINITION: PATIENT REPRESENTATIVE – the patient's legal representative, such as a guardian, who makes health care decisions on the patient's behalf or ***a patient-selected representative*** who participates in making decisions related to the patient's care or well-being, including but not limited to, a family member or an advocate for the patient. The patient will determine the role of the representatives, to the extent possible.

PATIENT DETERMINATION OF EXTENT OF REPRESENTATIVE INVOLVEMENT:

The patient will determine the role/extent to which they wish their representative to be involved.

I designate that my named representative shall have the following involvement with my care:

- ☐ Notice of all information provided to the patient
- ☐ Notice of partial information provided to the patient
  (If checked, specify what information to provide as specified by the patient):
  _____
- ☐ Notice of patient change in condition/plan of care
- ☐ No involvement
- ☐ Other –as determined by the patient
  (If checked, specify what information): _____

Patient Signature: _____ Date: _____

Staff Signature: _____ Date: _____

This form is a permanent part of the clinical record and shall be shared with staff involved in the patient's care.

REVIEW OF ADMISSION DOCUMENTS

Patient Name: _____ **PT ID#:** _____

Address: _____

Our Agency is pleased to have the opportunity to care for you. As part of your plan of care, we are giving you a **Patient Information Folder** that includes important information about our services.

Please review the contents of this folder with your clinician and sign below.

I have received my Patient Information Folder which has been reviewed with me and includes:

- ☐ Welcome Letter
- ☐ Advance Directive Information
- ☐ OASIS Privacy Notice
- ☐ HIPAA Notice of Privacy Rights
- ☐ Patient Consent Form
- ☐ Patient Authorization Form
- ☐ Agency Complaint/Grievance Process
- ☐ Disaster Planning/Emergency Plan Information
- ☐ Section 504 Notice of Program Accessibility
- ☐ Home Safety Guidelines
- ☐ Pain Management Information
- ☐ Community Resources
- ☐ Abuse & State Hotline Information
- ☐ Insurance Information Form
- ☐ Med Work Sheet/Lock Box Agreement
- ☐ Non-Discrimination Statement/LEP
- ☐ Patient Rights & Responsibilities
- ☐ Discharge Policy

Patient Signature: _____ Date: _____

Representative Name (if applicable): _____ Relationship: _____

Representative Signature (if applicable): _____ Date: _____

EMERGENCY PREPAREDNESS & HEALTH CARE PROXY INFORMATION

Patient Name: _____ **PT ID#:** _____

1. POWER OF ATTORNEY (POA) STATUS

☐ None in place ☐ Executed POA Name: _____

2. PLAN FOR EVACUATION DURING AN EMERGENCY / DISASTER SITUATION

☐ With family ☐ To a shelter ☐ Stay in Home ☐ Other: _____

3. DOES PATIENT REQUIRE EVACUATION ASSISTANCE FROM EMERGENCY MANAGEMENT PERSONNEL?

☐ No ☐ Yes

4. HEALTH CARE PROXY INFORMATION

☐ Health Care Proxy in place ☐ No Health Care Proxy in place ☐ If Health Care Proxy is in place:

Health Care Proxy / Agent Name: _____ Phone: _____

5. ADDITIONAL EMERGENCY CONTACT (OPTIONAL)

Name: _____ Relationship: _____

Phone: _____ Email: _____

6. AGENCY REPRESENTATIVE ACKNOWLEDGMENT

I have reviewed the above information with the patient and/or their representative. I have provided education regarding emergency preparedness and the importance of having a health care proxy in place.

Agency Representative Signature: _____ Date: _____

INFECTION MONITORING & PREVENTION

Our Agency is committed to providing a safe environment for our patients and staff. Infection prevention is an important part of your care.

PATIENT & CAREGIVER EDUCATION

Our Agency will provide training to patients and caregivers regarding infection prevention control issues and practices. Education will include, but not be limited to:

INFLUENZA PREVENTION & SIGNS AND SYMPTOMS – Annual flu vaccination is recommended. Symptoms may include fever, chills, cough, sore throat, body aches, fatigue, and headache.

PNEUMOCOCCAL PREVENTION & SIGNS AND SYMPTOMS – Vaccination is recommended for adults as advised by your healthcare provider. Symptoms may include fever, cough, shortness of breath, chest pain, and fatigue.

SHINGLES PREVENTION & SIGNS AND SYMPTOMS – Vaccination is recommended for adults 50 years and older. Symptoms may include a painful rash, burning, tingling, itching, or localized pain.

COVID-19 PREVENTION & SIGNS AND SYMPTOMS – Vaccination and boosters are recommended as advised by your healthcare provider. Symptoms may include fever, cough, shortness of breath, fatigue, sore throat, headache, and loss of taste or smell.

HANDWASHING – Wash hands often with soap and water for at least 20 seconds, especially before eating, after using the restroom, and after coughing or sneezing.

RESPIRATORY HYGIENE – Cover your mouth and nose with a tissue or elbow when coughing or sneezing. Dispose of tissues properly and wash hands immediately.

INFECTION MONITORING PLAN

The infection control plan will be monitored by the Clinical Manager and evaluated annually as part of the Agency QA Program. Infection control data will be collected, as identified in the following procedure, analyzed, and trended.

Information obtained will be reviewed at Agency quarterly QA meetings and utilized to improve patient care and our Agency's performance in the implementation of its infection/exposure control plan.

In order to protect our patients and employees we have established a symptom tracking log. We ask that our patients monitor their health during times of personal illness and during times of outbreaks. Employees will monitor their symptoms likewise.

FOR QUESTIONS REGARDING INFECTION PREVENTION OR SYMPTOMS, PLEASE CONTACT:

Clinical Manager: Derek Smith
Agency Phone: 317-548-8446
Email: harmonyheights.care@gmail.com

SYMPTOM MONITORING LOG

Patients are encouraged to monitor their health daily. Please record any symptoms or concerns.

Date	Temperature >100.1°F (37.83°C) Y / N	New Onset or Worsening Cough Y / N	New Onset or Worsening Shortness of Breath Y / N	Nausea and/or Vomiting Y / N	Notes or Comments

FINAL ACKNOWLEDGMENT

Your health, safety, and satisfaction are our top priorities. Please read the following statements carefully. By signing below, you acknowledge that you have received, read, and understand the information in your **Harmony Heights Home Health Services, LLC** admission packet.

BY SIGNING BELOW, I ACKNOWLEDGE THAT:

- I have received a copy of Harmony Heights Home Health Services, LLC's admission packet.
- I have had the opportunity to ask questions, and all of my questions have been answered to my satisfaction.
- I understand the services provided, my rights and responsibilities, and the agency policies.
- I understand how to contact the agency with any questions or concerns.
- I agree to participate in my care and to communicate openly with my care team.
- I understand that this acknowledgment will be kept as part of my patient record.

IMPORTANT NOTE

This acknowledgment is not a contract. Services will not begin until all required documents have been completed and accepted by **Harmony Heights Home Health Services, LLC.**

Patient Name (Printed): _____ **Date:** _____

Patient Signature: _____ **Date:** _____
(Or Legal Representative if applicable)

Relationship to Patient (if applicable): _____

Staff Member Name (Printed): _____ **Date:** _____

Staff Member Signature: _____ **Date:** _____

HARMONY HEIGHTS
HOME HEALTH SERVICES

THANK YOU
FOR CHOOSING
HARMONY HEIGHTS
HOME HEALTH SERVICES, LLC.

We are honored to be a part of your healthcare journey and look forward to providing compassionate, high-quality care.

HARMONY HEIGHTS HOME HEALTH SERVICES, LLC
317-548-8446 ♥ harmonyheights.care@gmail.com ♥ Indianapolis, Indiana