Patient Acknowledgement Checklist

Patient Name: ________________________________

NA (NA) Not applicable Verbal (V) Written (W)	**Subject / Topic** **Written Material and / or Verbal Explanation has been given to patient as appropriate. Written information has been placed in patient folder.**
(W) (V)	Advance Directives / Information Sheet/ Agency Policy / Declaration for Mental Health
(W) (V)	Drug Testing Policy / Method of Testing
(W) (V)	Medicare Homebound Eligibility Criteria / Admission Criteria
(W) (V)	Non-Discriminatory Policy
(W) (V)	Admission Consent / Proposed Plan of Care / Charges if Applicable
(W) (V)	Services Provided / Home Health Aide Policy and Procedures
(W) (V)	Confidentiality / HIPAA / Notice of Privacy Practices
(W) (V)	Patient Rights and Responsibilities / Rights of the Elderly (HR Code 102)
(W) (V)	Abuse, Neglect and Exploitation
(W) (V)	OASIS Statement of Privacy Rights
(W) (V)	Emergency Preparedness Plan / Disaster Readiness Resources and Tips
(W) (V)	Medication Safety, Fall Prevention and Safety in the Home / Sharps and Waste Disposal
(W)(V)	Oxygen, Equipment and Fire Safety (if applicable)
(V)	Weapons and Threatening Situation /Terms for Immediate Discharge
(W) (V)	Infection Control
(W) (V)	Complaint and Grievance Procedures / State Hotline Numbers
(W) (V)	On Call Procedure / Agency Phone Number / Emergency Phone Numbers

I received written and / or verbal education on the topics listed above during admission process. The Medicare Homebound Eligibility Criteria was reviewed and explained to me.

I understand and agree that I meet requirements for homebound status. I further agree to notify Agency if I no longer meet requirements for homebound status.

______________________________________ ______________________________________

Patient/ Representative Date Agency Representative Date

Consent for Service / Release of Records

I, ______________________________, have been informed that Boundless Home Health is licensed to provide home health services according to the Plan of Treatment established by the home health staff and the physician. I accept treatment from Boundless Home Health. I can call the Agency 24 hours a day regarding my health care at (469) 779-6406. This is not an emergency line. Call 911 in an emergency.

It is the policy of the Agency to protect all clinical records against loss, defacement, tampering and use by unauthorized persons. I authorize the agency to release medical information to my physician, the facility of my choice, payer source, or accrediting/regulatory/consulting organizations, as appropriate. I authorize the release of the Plan of Treatment, Transfer Summary or Discharge Summary upon my transfer to another health care facility.

Financial Authorization

I authorize benefits to be made in my behalf.

Bill Medicare 100% - Medicare #: ______________________Effective Date: Part A ______________ Part B ______________

Bill Medicaid 100% - Medicaid #: ______________________Effective Date: ____

Bill Primary Insurance: _____________________ % Insurance Co: ____ Bill Secondary Insurance: ___________________ % Insurance Co: ____ Bill Patient: Co-payment ___________________________Payment of _______________________ ❑ Per Visit ❑ Per Hour

I am responsible to inform the Agency if I change to an HMO, Medicare Advantage/HMO; or if HMO refuses coverage, I am responsible for the home health charges incurred.

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

Discipline	Cost per Visit	Insurance Payment	Patient Payment
SN	$150.00		
PT	$150.00		
OT	$150.00		
SLP	$150.00		
MSW	$150.00		
hha	$150.00		

Frequency / Rights / Hotline / Procedures

I understand that a Registered Nurse will supervise all nursing services. Home Health Aide services will be supervised by a Registered Nurse or a Therapist, as appropriate. A Physical Therapist or Occupational Therapist will supervise therapists for each specific therapy discipline. A Masters Social Worker will supervise all social services. A Clinical Manager will supervise all services. I understand the frequency of services. This frequency may change according to need. Skilled Nursing: ______________________, Home Health Aide: _________________, MSW Evaluation:___________, PT Evaluation:____________, OT Evaluation:____________, SP Evaluation: ____________.

I have received a copy and an explanation of my **Patient Rights, Patient Responsibilities** and **Rights of the Elderly**, if appropriate.

I have received ❑ Patient Information & Emergency / Disaster Preparedness Plan ❑ Responsibilities of Patient and Agency During a Disaster ❑Emergency Preparedness tips and resources ❑Emergency Preparedness was discussed.

I have been informed on what to do in an ❑ emergency/natural disaster. I have been informed verbally and in writing regarding Agency policy on ❑ abuse, neglect and exploitation, ❑ agency drug testing policy and ❑ hazardous waste disposal in the home. I have received: ❑ discharge & transfer policy, ❑ clinical manager contact information for asking questions about services.

❑I do not wish to select a patient representative to be involved in the coordination of care activities.

❑ I have selected _________________________Phone: _________________________ as my patient representative. ❑ Patient representative received a copy of the patient rights, discharge and transfer policy; or ❑ Patient representative was not available; will receive information within 4 business days of today's visit.

❑ I authorize the release of medical records related to services beginning on ____________ to _____________ at

____ (healthcare provider) __________________(city), ____________(state) to Boundless Home Health

You have the right to request that the Agency communicate with you in a certain way.

❑ I authorize Boundless Home Health to release of information to: ❑spouse: _______________

❑ children: ____; ❑ other: _______________.

The release of information will remain in effect until terminated by me in writing.

If you are unable to contact me, you may:

❑ Leave a detailed message on voicemail ❑ Leave a message asking me to return your call

I have received Agency policy and information sheet on **Advance Directives** including Out of Hospital DNR.

❑ I do not have an advance directive.

❑ I have an advance directive for: ❑Living Will/Directive to Physician ❑Out of Hospital DNR ❑Medical Power of Attorney

I am ❑ I am not ❑ providing a copy for my record.

Name of Medical POA: ____ Phone #: _______________

I have been notified of my right to voice a complaint and may direct that complaint to the Texas Health and Human Services Commission, Consumer Rights and Services, PO Box 149030, Austin, TX 78714-9030, at **1-800-458-9858**. The line is open 24 hours/day, 365 days/year. This includes a complaint regarding advance directives. Complaints regarding Utilization Review or HMO services can be made directly to TX Dept. of Insurance at PO Box 149091, Austin, TX 78714, at **1-800-252-3439**.

I may also direct a **complaint** to the Boundless Home Health or designee at (469) 779-6406. The investigation of the complaint will be initiated within 10 calendar days and resolved within 30 calendar days of receipt.

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

I understand the Agency will not be able to provide medications.

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

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

❑ I authorize the use or disclosure of Protected Health Information for future research.

❑ I do not authorize the use or disclosure of Protected Health Information for future research.

❑ I authorize the Agency to send treatment communications concerning alternatives or health related products or services where the Agency receives financial remuneration from a third party in exchange for making communications. I have a right to opt out of receiving such communications at any time.

❑ I do not authorize the Agency to send treatment communications concerning alternatives or health related products or services where the Agency receives financial remuneration from a third party in exchange for making communications.

____

Patient/Authorized Agent Signature (Relationship) Date

____

Agency Representative Signature Date/Time Reason patient is unable to sign

Patient Information & Emergency / Disaster Preparedness Plan

Boundless Home Health **(469) 779-6406**

IN EMERGENCY: CALL 911 OR APPROPRIATE EMERGENCY ACCESS

Patient Name: ______________________ DOB: ____________ Phone: ________________
Physical Address: ______________________ City: ________________ Zip: ________
Your Physician: ______________________ Phone: ________________
Pharmacy: ______________________ Phone: ________________
DME Company: ______________________ Phone: ________________
Do you have transportation to evacuate? [ ] Yes [ ] No Number of others evacuating with you: # ____________
By Whom? ______________________ Relationship: ____________ Phone: ________
Emergency contact: Name: ______________________ Relationship: ____________ Phone: ________
Do you have pets or service animals? [ ] Yes [ ] No Number of pets evacuating with you: _____ Carriers available? [ ] Yes [ ] No
Do you have special needs? [ ] **None** [ ] **Life support equipment: ____________________; [ ] Transportable**
[ ] Battery operated [ ] Electrical Condition of equipment: ______________________
[ ] **Special dietary needs: ______________ [ ] Communication challenges: ______________**
[ ] Language barriers: Primary language: __________ [ ] Intellectual disabilities: ______________
[ ] Mobility issues: [ ] Bedfast [ ] Chairfast [ ] Wheelchair needed [ ] Cane needed [ ] Needs assistance for ambulation/transfers
[ ] Special procedures/medical care needed: ______________________
[ ] Special adaptive equipment: ______________________
Other entities involved in care: ______________________ Phone: __________
______________________ **Phone: __________**
______________________ **Phone: __________**
Registered with 211 [ ] Yes [ ] No [ ] **Assisted with 211/STEAR Registration** [ ] **Assistance with registration declined**

Emergency

If the Patient's condition changes significantly or for medical emergencies such as chest pain, difficulty in breathing, paralysis, bleeding, or injury from falls, please call 911, or your appropriate emergency access for immediate attention. The agency does not operate as an emergency service; therefore, valuable time may be lost by contacting the agency.

Non-Emergency

For a non-emergency, the agency has a nurse "on-call" 24 hours per day, seven days per week. Your call will be forwarded to an answering service/machine during unscheduled business hours. Please leave your name, the name of the Patient, the tele 214-501-6675 and address, and a brief description of the problem. This message will be forwarded to the "on-call" nurse who will return your call within 30 minutes.

Natural Disaster

In the event of a natural or man-made disaster (e.g., to include tornadoes, hurricanes, winter storms, nuclear power plant disaster, floods, chemical toxicity, and fire, etc.) **the agency will prioritize visits according to the following: What category describes your special needs?**

[ ] Class I - Life threatening (or potential) requiring ongoing medical treatment to prevent a life threatening episode. Patient is unable to withstand any interruption in power supply. Patient is unable to evacuate/transport self. No readily available caregiver or caregiver is unable to provide needed care. Appropriate arrangements to transfer to an acute care facility will be made by the agency in collaboration with the local county or city authorities (fire department, police, and sheriff), the Patient/family and the physician.

[ ] Class II - Not immediately life threatening but Patient may suffer adverse effects without service (i.e. new insulin-dependent diabetic unable to self- inject insulin, IV medications, or sterile wound care with large amounts of drainage). Visits may be postponed 24-48 hours with minimal adverse effect. Patient is unable to transfer/transport self or no transportation available from the caregiver. Appropriate arrangements may be made if necessary, to send Patient to a facility that can meet their needs. This will be done in collaboration with the Patient/family, physician, and local or city authorities.

[ ] Class III - Services may be postponed 48-72 hours without adverse effect on the Patient (i.e. new insulin-dependent diabetic able to self inject, cardiovascular and/or respiratory assessments, or sterile wound care to a wound with minimal to no drainage). Transportation is available from family, friends, volunteers or caregivers.

[ ] Class IV - Services may be postponed 72 hours or more without adverse effect on the Patient (i.e. routine catheter changes or postoperative with no open wound). Willing able caregiver is readily available or Patient independent in most ADL's. Transportation is available from family, friends, volunteers or caregivers.

Patient/caregiver has been instructed & provided written information on an individualized Emergency Preparedness Plan. Agency will notify State and local emergency preparedness officials of need for patient evacuation during a disaster due to patient medical condition or home environment.

____
Agency Representative Signature Date

Beneficiary Elected Transfer / Right of Choice Statement

Patient name: ____
Date:_________________________

Discovery efforts:

- HIQH Query /Customer Service indicates Patient under an established home health plan of care

I, ____, choose to transfer to

Boundless Home Health

From:

____
(Initial home health agency).

Effective transfer date ____________________________.

I understand the initial home health agency will no longer receive Medicare Payment on my behalf and will no longer provide Medicare covered services to me after the effective date of transfer.

I request that my records be released to the receiving agency to ensure continuity of care.

____
__ Patient/Beneficiary Signature Date

For Agency Use Only

Coordination of Transfer:

- Phone call to ____ (initial home health agency) for coordination of transfer on____

Contact person:

____

- Beneficiary Elected Transfer/Right of Choice form sent /faxed to Initial agency on ______________________

____