Convenient Home Care LLC

ADMISSION PACKET

2023

CLIENT ASSESSMENT

CLIENT ASSESSMENT

CLIENT NAME			**SOC Date:**
MARITAL STATUS	❑ S ❑ M ❑ W ❑ D	**LANGUAGE**	
LIVES WITH:	❑ Alone ❑ Spouse ❑ Relative ❑ Friend ❑ Other Responsible Person		
PRIMARY CAREGIVER	❑ Self ❑ Spouse ❑ Relative ❑ Friend ❑ Other Responsible Person If other than self: Name _____ Contact Phone_____		
CLIENT/CAREGIVER SUPPORT		❑ GOOD ❑ FAIR ❑ POOR	
CLIENT ABLE TO RECEIVE INSTRUCTIONS		❑ YES ❑ NO	
CAREGIVER LIMITED BY:	❑ EMPLOYMENT ❑ PHYSICAL LIMITATIONS ❑ AGE ❑ LACK OF KNOWLEDGE ❑ OTHER RESPONSIBILITIES		
COMMENTS			

iADLs

ACTIVITY	LEVEL OF FUNCTION	ACTIVITY	LEVEL OF FUNCTION
KITCHEN WORK		MEAL PREP (FULL)	
HOUSEKEEPING		MEAL PREP (LIGHT)	
TRANSPORTATION		LAUNDRY	
AMBULATION		SHOPPING	
PHONE USE		BILL PAYING	
TRANSPORTATION			

KEY: 1 = INDEPENDENT A = ASSISTANCE NEEDED U = UNABLE

COMMENTS:

ADL			
ACTIVITY	**LEVEL OF FUNCTION**	**ACTIVITY**	**LEVEL OF FUNCTION**
BATHING ASSIST		GROOMING	
DRESSING			
TOILETING			

BARRIERS:

SAFETY HAZARDS:

OTHER ISSUES:

HOME SITUATION APPROPRIATE FOR SERVICES: ❑ YES ❑ NO if no explain:

BEHAVIORAL: ❑ ORIENTED ❑ DISORIENTATED ❑ AGITATED ❑ ANXIOUS

PSA ASSESSOR SIGNATURE/TITLE: _____

DATE: _____

CLIENT SIGNATURE: _____

DATE_____

CLIENT NAME:_____

CLIENT Non-Medical ASSESSMENT (3 page)

Consumer Name:		**Phone:**
Address:		
Physician Name:		**Phone:**
Contact Name:		**Phone:**
ASSESSMENT		
General Topics	**Subject Matter**	**Action(S) Indicated**
General Information		
Current Situation HX		
Recent Hospitalizations		
Height & Weight	Weight Status: ____ Increase ____ Static ____ Decrease Recent WT Changes:	
Medications		
Need for Palliative Care	❑ YES ❑ No	
Dental Care		
Vision		
Hearing		
Mental Health Status		
LIVING HABITS		
Smoking Habits	Consumer Smokes: ❑ Yes ❑ No Issue/Problem: ❑ Yes ❑ No	
Alcohol Consumption	Consumer Drinks: ❑ Yes ❑ No Issue/Problem: ❑ Yes ❑ No	
Current Diet		Page 1 of 3
Allergies Food & Other		
Eating Habits Appetite	❑ Good ❑ Fair ❑ Poor	

COMMUNICATION		
Language/ Communication	Primary Language: Speaks/Understands English: ❑ Yes ❑ No Can make needs known: ❑ Yes ❑ No	
Speech		
Understanding	❑ Unimpaired ❑ Understands Simple Phrases Only ❑Understands Key Words Only ❑ Understanding Unknown ❑ Not Responsive	
ACTIVITIES OF DAILY LIVING		
Mobility		
Ambulation		
Transfers		
Bathing	❑ Independent in Bathtub or Shower ❑ Independent with Mechanical Aids ❑ Requires Minor Assistance or Supervision: ❑ Getting In/Out of Tub/Shower ❑ Turning Taps On/Off ❑ Washing Back ❑ Requires Continued Assistance ❑ Resists Assistance	
Dressing	❑ Independent ❑ Supervision or Needs some occasional assist ❑ Periodic or Daily Assist Needed: Difficulty with:	
Grooming & Hygiene	❑ Independent ❑ Reminder, Motivation&/or Direction ❑ Assistance with Some Things ❑ Requires Total Assistance ❑ Resists Assistance	
Eating	❑ Independent ❑ Independent with Special Provision for Disability ❑ Intermittent Assist With: ❑ Cutting Up/Pureeing Food ❑ Must Be Fed ❑Resists Feeding	
Bladder Control	❑ Totally Continent ❑ Needs Routine Toileting or Reminder ❑ Incontinent occasionally ❑ Incontinent daily	
Bowel Control	❑ Total Control ❑ Needs Routine Toileting or Reminder ❑ No Bowel Control Due to Identifiable Factors ❑ Loses Bowel Control occasionally ❑ Loses Bowel Control daily	
Toileting	❑ Raised Toilet Seat or Commode ❑ Difficulty with Buttons, Zippers ❑ Needs Help with Aids (E.g. Catheter, Condom Drainage, etc.) ❑ Other:	
Exercise/ Movement	❑ Exercises Regularly: ❑ Daily ❑ Weekly ❑ Other: ❑ Type/Time/Distance: ❑ Recent Changes to Routine: ❑ Exercise Alone ❑ Exercises with Attendant ❑ At Home ❑ At Facility	
INSTRUMENTAL ACTIVITIES OF DAILY LIVING		
Food Prep	❑ Independent ❑ Able if Ingredients Supplied ❑ Can Make/Buy Meals Diet is Inadequate ❑ Physically/Mentally Unable to Prepare Food ❑Chooses Not to Prepare Food	
Housekeeping	❑Independent ❑ Generally Independent but Needs Help with Heavier Tasks ❑ Can Perform Only Light Tasks Adequately ❑ Performs Light Tasks but Not Adequately ❑ Needs Regular Help and/or Supervision ❑ No Opportunity to Do Housework/Chooses Not to Do Housework	NAME: Page 2 of 3
Shopping	❑ Independent ❑ Independent for Small Items Only ❑ Can Shop if Accompanied ❑ Physically/Mentally Unable to Shop ❑ No Opportunity to Shop/Chooses Not to Shop	
Transportation	❑ Uses Private Vehicle ❑ Uses Taxi/Bus ❑ Independent ❑ Must be Accompanied ❑ Must be Driven ❑ Physically or Mentally Unable to Travel ❑ Needs Ambulance for Transporting	
Telephone	❑ Independent ❑ Can Dial Well Known Numbers ❑ Answers Telephone Only ❑ Physically or Mentally Unable ❑ No Opportunity to Use Telephone/Chooses Not to	
ATTENDANT PROFILE		

Attendant	❑ Independent ❑ Needs Attendant: Frequency of Need: ❑ Intermittent ❑ 24 hours ❑ Daytime ❑ Night ❑ Attendant Needs Met by: ❑ Spouse ❑ Friend ❑ Family ❑ Other:	
SOCIAL PROFILE		
Housing	❑ House ❑ Apartment ❑ Condo ❑ Mobile Home ❑ Facility ❑ Other:	
Living Companions	❑ Alone ❑ With Spouse/Partner ❑ With Adult Child ❑ With Child(ren) ❑ With Other Adult Male ❑ With Other Adult Female ❑ Principal Helper:	
Religion & Culture	Ethnicity: Religion: Actively Practicing: ❑ Yes ❑No	
FINANCIAL PROFILE		
Financial Benefits	❑ Social Security ❑ State Income Supplement ❑ Veterans/Disability Pension ❑ Company Pension ❑ Other	
Financial Management	❑ Self ❑ Spouse ❑ Family ❑ Friend ❑ Trustee ❑ Power of Attorney ❑ Other	
ADDITIONAL INFORMATION		
	CONSUMER NAME:	Page 3 of 3

_____

Assessor Name/Title (Print)

_____

Assessor Signature Date

_____

Client or Client's Representative's Signature Date

PLAN OF SERVICE

Client name: _____ DOB: _____ ❑ Male ❑ Female MR #: _____
SOC Date: _____

Client address: _____Phone: _____
Lives with: _____ Relationship to Client: _____

Emergency contact: _____
(name, relationship, phone number)
Evacuation plan: _____
Disaster Class level: ❑ I ❑ II ❑ III ❑ IV

Identified Problems:

Allergies: _____Diet (specify): _____

Assistive devices:

Psychosocial: ❑ Alert ❑ Oriented ❑ Confused ❑ Forgetful ❑ Wanders

Functional limitations:

Discipline/s to provide care:	❑ Personal Care Worker	❑ Homemaker	❑ Companion	❑ Other

Duration of services: _____Frequency of visits: _____

Special requests from Client or family:

Supervisor name and number:

Frequency of supervisory visits:

_____

Goals for care:

Staff completing POC: _____ Date: _____
Signature/Title

Care plan reviewed with Client/family: _____Date: _____
Client Signature

Reviewed with Staff at SOC: _____Date: _____
Staff Signature/Title

Reviewed with Staff at Reassessment: _____Date: _____
Staff Signature/Title

CLIENT NAME:

Personal Care Tasks								Nutrition tasks							
Days to be performed	**M**	**T**	**W**	**Th**	**F**	**Sa**	**Su**	**Days to be performed**	**M**	**T**	**W**	**Th**	**F**	**Sa**	**Su**
1. Total bed bath								29. Prepare meal ❑ B ❑ L ❑ D							
2. Assist bed bath								30. Total feed							
3. Assist shower								31. Assist with feeding							
4. Assist tub								32. Snacks:							
5. Sponge bath								**Mobility tasks**	**M**	**T**	**W**	**Th**	**F**	**Sa**	**Su**
6. Shampoo								33. Bedrest; Turn q hr.							
7. Conditioner								34. Assist to transfer							
8. Comb/brush hair								35. Assist to ambulate							
9. Brush teeth								36. Wheelchair							
10. Clean dentures								37. Walker							
11. Apply lotion to skin								38. Cane							
12. Dress								39. Crutches							
13. Shave: ❑ safety razor ❑ electric								40. ❑ Exercise ❑ Range of motion							
14. Nail care: ❑ clean ❑ file								**Precautions**	**M**	**T**	**W**	**Th**	**F**	**Sa**	**Su**
15. Medications ❑ remind ❑ assist with self-administered meds								41. Infection control: Hand washing; Standard Precautions							
16. Apply:								42. Choking							
17. Remove:								43. Bleeding							
Toilet/Elimination tasks	**M**	**T**	**W**	**Th**	**F**	**Sa**	**Su**	44. Oxygen safety							
18. Urinal								45. Fall prevention							
19. Bedpan								**Support Service task**	**M**	**T**	**W**	**Th**	**F**	**Sa**	**Su**
20. Commode								46. Clean Client areas							
21. Toilet								47. Change bed linens							
22. Incontinence brief								48. Make Client bed							
23. Incontinence care								49. Client laundry							
24. Empty urinary bag								50. Shopping for:							
25, ❑ Empty ostomy bag ❑ Rinse ostomy bag								51. Errands to:							
Special Instructions	**M**	**T**	**W**	**Th**	**F**	**Sa**	**Su**	52. Transportation to:							
26. Vitals signs ❑ Temp ❑ Pulse ❑ Resp. ❑ B/P								53. Other							
27. Weigh															
28. Other:															

Report the following changes to the Supervisor (list):

The Client or legal representative participated in development of the care plan. ❑Yes ❑ No
Explain why if no:

The care plan was discussed with the discipline(s) that will be providing care. ❑ Yes ❑ No Explain why if no:

ADMISSION DOCUMENTS LIST:

- **Assessment (1 or 3 page)**
- **Plan of Service**

- Welcome Letter
- Guide to Safety at Home
- Community Resources
- Home Care Services
- Client Rights & Responsibilities
- HIPAA Privacy Practices
- Agency Grievance/Complaint Policy/Process
- Emergency Preparedness Info Sheet
- Client Financial Authorization/Client Service Order ***(in duplicate, one for client file)***
- Client Consent Form ***(in duplicate, one for client file)***
- 3rd Party Payer Info Sheet
- Non-Discrimination/LEP
- Review of Admissions Documents Form ***(in duplicate, one for client file)***

Convenient Home Care LLC

Welcome Letter

We would like to thank you for choosing our Agency to service your homecare needs. The owners of our Agency are experienced in the home services industry. We are dedicated to working diligently to find better solutions for your unique homecare situations.

The Agency's mission is to provide quality, reliable services to you. Our staff delivers the highest standards in home services. Our administrative and office staffs coordinate all these services to provide seamless, effortless service for you. There is always someone for you to call when you have changes or need questions answered.

At Convenient Home Care LLC, we collaborate with you and your family members to provide the services you need when you need them.

Our Agency maintains a client record of the services we provide. Your record is secured, and its privacy protected at all times. You may request a copy of your record by sending your request to us in writing. By signing your admission documents, you are authorizing our Agency to collect and maintain that record by either paper charts or electronic client record.

You can contact us Monday to Friday during business hours, 9 AM-5 PM, at our office phone. After normal business hours, should you need assistance you can call us through our answering service by calling our regular phone number which is forwarded to on call after hours. Either our on-call Supervisor or on call scheduler will return your call.

Although we fully expect you to be extremely pleased with our services, if ever you should have a complaint, please feel free to call our office directly at: (701) 781-0208 and the ND State Complaint Line as listed in your Client Rights.

We evaluate our Agency on an annual basis, reviewing all aspects of our services.

Although the record is the property of Convenient Home Care LLC, should you ever need access to your record, you may obtain copies by submitting a written request to the office that provides your services.

We look forward to providing you with excellent home care service and thank you for choosing Convenient Home Care LLC.

Best Regards,
Ibrahim Ahmed,
Agency Manager

Guide to Safety in the Home

People of all ages have accidents. Please take a few minutes to review the safety guide; you can protect yourself and those around you by taking some 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 client 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. Avoid using halls/stairways for storage.
- Be sure halls/stairways are well lit.
- Don't walk on a freshly washed or waxed floor until it is dry.
- Wipe up any spills immediately to avoid slips.
- 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.
- 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.
  Smoking includes e-cigarettes and vaping.
- Use portable heaters according to manufacturer's instructions. Turn off before going to bed.
- Have your home checked if there are signs of any 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.

COMMUNITY RESOURCES

1. AGING SERVICES INFORMATION

Call toll-free 1-855-462-5465, 711 (TTY), or **email** carechoice@nd.gov.
Website: https://www.nd.gov/dhs/services/adultsaging/

2. Senior Legal Helpline

The Helpline provides FREE legal information, advice and referral services for senior citizens (60 years or older) in most areas of civil law.

- Age 60+ call toll-free 1-866-621-9886

Monday - Thursday between 8 a.m. - 5 p.m. CST.
Friday between 8 a.m. - 2 p.m. CST.

3. Protective Services Program

The Executive Office of Elder Affairs is required by law to administer a statewide system for receiving and investigating reports of elder abuse, and for providing needed protective services to abused elders when warranted.

Be advised of the State Abuse hotline:
ND Elder Abuse Hotline: 1-855-462-5465

Homecare Services

AGENCY NAME: Convenient Home Care LLC

AGENCY ADDRESS: 819 30th Avenue S, Suite 200E, Moorhead MN 56560

AGENCY PHONE: (701) 781-0208

Personal Care Services

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

Companion Services

Companion services include transportation, meal preparation, shopping, light housekeeping, companionship and household management.

Homemaker Services

Homemaker services includes assistance with instrumental activities of daily living and may include housekeeping tasks, meal preparation.

If you have any questions, or need further information, please call our office.

Client's Rights and Responsibilities

These Rights and Responsibilities will be followed by all employees of Convenient Home Care LLC that provided services to you in your place of residence. You receive a copy of these rights upon admission to our Agency, and at re-assessments. You have the right to exercise these rights at any time without fear of reprisal or discrimination in care/services.

You have the right to:

1. Receive considerate and respectful service in the home at all times, be treated with dignity and have property treated with respect.
2. Receive access to service without regard to race, creed, gender, age, handicap, veteran status, sexual preference or lifestyle.
3. Be informed of organizational ownership and control (upon request).
4. Participate in the development of and make informed decisions regarding the plan of service, and receive an explanation, in advance, of any services proposed and the frequencies suggested in a way that is understandable to you.
5. These Rights are provided to our clients in advance of providing pre-planned services. Our clients have the right to exercise his/her rights at any time. Either you or your designated representative is authorized to exercise your rights.
6. Be informed in advance about service to be furnished and of any changes in the service to be furnished including advance notice if changes to the plan of service are occurring.
7. Receive and access services consistently and in a timely manner in accordance with our Agency's stated operational policy with regular supervisory visits.
8. Refuse service without fear of reprisal or discrimination.
9. Privacy and confidentiality about one's health and circumstances and about what takes place in the home.
10. Know that all communications and records will be treated confidentially, and that no information will be given out without a written release from the client or family.
11. Receive information on Convenient Home Care LLC's policies including information on charges, names and professional qualifications and supervision of personnel, hours of operation, and discontinuation of service; request a change of caregiver.
12. Participate in the plan for discontinuation of service with the right to appeal and to be notified in advance of transfers, when and why care will be discontinued.
13. Receive education, instructions and requirements for continuing service when the services of Convenient Home Care LLC are discontinued. Clients shall participate in the selection of options for alternative levels of service or referral to other organizations as indicated.
14. Be referred to another provider organization if our Agency is unable to meet the client's needs or if the client is not satisfied with the service they are receiving.
15. Have access to all bills for service.
16. Be free from any mental, physical abuse, neglect or exploitation of any kind by agency staff.
17. Be advised of Agency's policies and procedures for accessing or disclosure of the record.
18. Be advised of the Agency's notice for cancellation or reduction in services and the refund policies of the Agency.
19. Receive a clear explanation of the process to voice grievances about service or discontinuation of service without fear of discrimination or reprisal for doing so by calling the Agency at (701) 781-0208.
20. Appeal agency decisions regarding service, following grievance procedures. Expect to have an investigation done following a complaint regarding service. Be assured that Convenient Home Care LLC shall document the existence of the complaint and the resolution or findings of the complaint.
21. Know the Agency maintains liability insurance coverage; and be given in writing the name and telephone number of an Agency contact person.

22. Be informed that our Agency complies with Subpart 1 of 42 CFR 489 and receive a copy of Convenient Home Care LLC's policy regarding Advance Directives, including the individual's right under applicable state law and how such rights are implemented by our Agency that I can call (800) 472-2622 for any issues regarding Advance Directives implementation.
23. Be fully informed about billing policies, payment procedures and any changes in the information provided on admission as they occur within 30 days from the date that Convenient Home Care LLC is made aware of the change.
24. Access to an interpreter if needed.
25. Our clients always have the right to express or voice complaints/grievances regarding service without fear of reprisal or discrimination.
26. The Complaint Hotline and the reasons for calling the hotline are for asking questions or voicing concerns/complaints about Convenient Home Care LLC.

    The ND Complaint Hotline: (701)-328-2310
    Toll Free: (800)-472-2622
    ND Relay TTY: (800)-366-6888

    You can also write to:
    ND Department of Human Services
    600 East Boulevard Avenue, Dept 325
    Bismarck N.D. 58505-0250

    Phone: (701) 328-2310
    Toll Free: (800) 472-2622
    ND Relay TTY: (800)-366-6888
    Fax: (701) 328-2359
    Email: dhseo@nd.gov

    Be advised of the State Abuse hotlines:
    ND Elder Abuse Hotline: 1-855-462-5465
    ND Child Abuse Hotline: 1-833-958-3500

Clients of Convenient Home Care LLC have the responsibility to:

- Notify our Agency of changes in their situation (hospitalization, symptoms, etc.).
- Follow the plan of service.
- Notify our Agency if the visit schedule needs to be changed.
- Keep appointments and notify our Agency if unable to do so.
- Advise our Agency of any problems or dissatisfaction with the service.
- Provide a safe environment for services to be provided.
- Carry out mutually agreed responsibilities.

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

Convenient Home Care LLC
819 30th Avenue S, Suite 200E, Moorhead MN 56560
(701) 781-0208

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 IS PROTECTED & MAY BE USED AND DISCLOSED

We are required by law to maintain 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 health care 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 insurer. 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 ensure 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 health care 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 (ie. 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 privacy 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 paper copy 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.

NOTICE OF HIPAA PRIVACY PRACTICES FOR PHI page 2 of 3

- 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 in 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 aides as well as by therapists, pharmacists, suppliers of medical equipment, or other persons 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 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 Health Care 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 to monitor 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 health care operations or health care 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 if 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
- Sale 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

NOTICE OF HIPAA PRIVACY PRACTICES FOR PHI page 3 of 3

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 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:

Convenient Home Care LLC
Ibrahim Ahmed
819 30th Avenue S, Suite 200E, Moorhead MN 56560
(701) 781-0208

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 upon request and be posted in our office.

Client Grievance Policy

Convenient Home Care LLC

We strive to provide the highest quality services for our clients. That is why your concerns are our concerns.

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 Agency Manager who will promptly review the problem. Following that review, the Agency Manager will make written or verbal contact with you to assure you that the problem has or is being addressed. It is in our agency policy to address the complaint within 30 days. If at any time you feel that a situation was not resolved to your satisfaction by this process, you may contact the office at (701) 781-0208.

We appreciate your candid comments as this helps us in the process of continually working to improve our services to our many and valued clients.

If you have information about unethical behavior, criminal activities, or other concerns regarding your services, please call the Agency Manager at the office. Your confidentiality will be protected.

The following are examples of issues that should be brought to our attention immediately

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

Agency Grievance Process/Reporting Abuse

Convenient Home Care LLC

Our Agency is committed to providing excellence in client service.
We will give full consideration to your issues and make an effort to resolve any issues to your satisfaction.
We will provide you 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 Agency Manager or Supervisor or any staff member you are comfortable with. They will ensure the concern is presented to the Agency Manager. If you call after business hours, the Agency Manager will be in contact with you the next business day.

The Agency 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 Agency Manager's decision within thirty (30) days.
If you are dissatisfied with the outcome of the complaint investigation, you may request that the Agency Manager submit an appeal with the Agency's Governing Body.

You may also file a complaint with: The ND Complaint Hotline: (701)-328-2310
Toll Free: (800)-472-2622
ND Relay TTY: (800)-366-6888

You can also write to:
ND Department of Human Services
600 East Boulevard Avenue, Dept 325
Bismarck N.D. 58505-0250

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

Please contact us at:

AGENCY: Convenient Home Care LLC
AGENCY MANAGER: Ibrahim Ahmed
AGENCY TELEPHONE: (701) 781-0208

REPORTING ABUSE

Are you aware of any instances of abuse, neglect or mistreatment of a client or misappropriation of a client's 'property? If so, you are encouraged to report these conditions to the Agency Manager of this agency and contact:

ND Elder Abuse Hotline: 1-855-462-5465
ND Child Abuse Hotline: 1-833-958-3500

Convenient Home Care LLC

Emergency Preparedness Info Sheet

To attempt to keep all our Consumers informed and educated Convenient Home Care LLC wants to give you the best direction possible to be prepared. When your service began, we assigned you a priority code based on your own unique situation at home.

As your safety is of great importance to us, if you relocate during an emergency situation, please let the agency know your location: (701) 781-0208

DISASTER EMERGENCY PRIORITY CLASS

- Class I – **HIGHEST**-Clients in serious situations that require ongoing care to remain safe in the residence.
- Class II – Clients with the greatest need for care. Services could be postponed for 24-48 hours without adverse effects.
- Class III – Services could be postponed 72-96 hours without adverse effects.
- Class IV – **LOWEST**-Service could be postponed for 5 days without adverse effects.

You have been assigned as priority code: _____

During an emergency situation, Convenient Home Care LLC clients 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
- Severe weather conditions (hurricane, tornado etc)
- National Emergency status called for by the Governor
- Terrorist attack
- Pandemic threat such as Avian Influenza

In the event that we have some 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 client, we are likely to postpone your scheduled visit to another day in the same week. If you are a priority 1 client, we will make every effort to provide a visit.

We advocate that all persons create a 3-day supply of clean drinking water, canned/nonperishable food, and a flashlight with extra batteries, extra blanket, medication, and portable radio. Please take some time now to be sure these are in place BEFORE an emergency event should occur.

When an emergency condition occurs, our office begins a specialized procedure to assure your care. The Agency Manager 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 as our offices are likely to be very busy during the time of an emergency. We will be calling you to keep you informed.

(701) 781-0208

Patient Financial Authorization

Name *(Last, First)*:_____

Address: **City** **State** **Zip**

Phone: _____

Payer Information

Primary insurance to be billed for your services is:

o **MEDICARE** (expected amount payer will not pay_____)

o **INSURANCE/Medicaid** (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 changes to the charges as soon as the Agency becomes aware 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.			$/hr.
LPN		$/hr.			$/hr.
Aide		$/hr.			$/hr.
		$/hr.	Other:		$

The billing rate for _____ service identified above is $_____ per hour, per day, per visit.
The billing rate for _____ service identified above is $_____ per hour, per day, per visit.
The billing rate for _____ service identified above 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 Convenient Home Care LLC to bill my insurance carrier for my services as provided by my policy. I agree to pay any co-pay/non-covered amount.

:

Terms of service: The signature below acknowledges my acceptance of the following:
Consent & Full financial responsibility for service(s) rendered to the above-named person.
Assignment of Payment of any benefits payable to/for me, be made payable to Convenient Home Care LLC. That I have not
been coerced or forced to sign this document.
Either side may terminate this agreement with Termination Notice of _____ days.

Client/Representative Signature_____ Date_____

Signature/Title of Agency Staff_____ Date_____

Printed Name of Agency Staff_____

Convenient Home Care LLC
819 30th Avenue S, Suite 200E, Moorhead MN 56560
(701) 781-0208

Convenient Home Care LLC

CLIENT COPY

Patient Financial Authorization

Name *(Last, First)*:_____

Address: City State Zip

Phone: _____

Payer Information

Primary insurance to be billed for your services is:

o **MEDICARE** (expected amount payer will not pay_____)

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been coerced or forced to sign this document.
Either side may terminate this agreement with Termination Notice of _____ days.

Client/Representative Signature_____ ******* CLIENT COPY NO SIGNATURE NEEDED***

Signature/Title of Agency Staff_____ Date_____

Printed Name of Agency Staff_____

Convenient Home Care LLC
819 30th Avenue S, Suite 200E, Moorhead MN 56560
(701) 781-0208

CLIENT CONSENT FORM

CONSENT TO RELEASE INFORMATION: I do hereby authorize Convenient Home Care LLC to release information contained in my medical record and any other medical information about me in their possession in the following instances:

- ❑ To service/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 service provide (if applies).
- ❑ To peer review, utilization review or other organizations responsible for monitoring the quality or appropriateness of Client 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 services under the Service Plan and to abide by the Agency's specific policies and procedures relating to home care which have been reviewed with me and which include provisions for termination of home care services at my 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 in relation to my care/services while under the care of the agency.

ELECTRONIC RECORDS/SIGNATURES CONSENT: if our agency utilizes an electronic medical record system, I give my consent to the use of electronic medical records & e-signature use.

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

I consent to the proposed Service Plan and authorize care be provided by the Agency under supervision of agency staff. I understand that I have the right to refuse treatment or terminate care at any time by providing the agency notification.

Convenient Home Care LLC
819 30th Avenue S, Suite 200E, Moorhead MN 56560
(701) 781-0208

Clients Printed Name _____Date:_____

Client Signature /Authorized Representative_____

Client Emergency Contact: _____ Relationship: _____
Home Phone: _____ Cell Phone: _____

CLIENT CONSENT FORM *(CLIENT COPY)*

CONSENT TO RELEASE INFORMATION: I do hereby authorize Convenient Home Care LLC to release information contained in my medical record and any other medical information about me in their possession in the following instances:

- ❑ To service/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 service provide (if applies).
- ❑ To peer review, utilization review or other organizations responsible for monitoring the quality or appropriateness of Client 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.

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Convenient Home Care LLC
819 30th Avenue S, Suite 200E, Moorhead MN 56560
(701) 781-0208

Clients Printed Name **** no signature required Date:_____

Client Signature /Authorized Representative_____
Client Emergency Contact: _____ Relationship: _____
Home Phone: _____ Cell Phone: _____

PAYER INFORMATION FORM

Convenient Home Care LLC

CLIENT NAME: _____

DOB:_____ Medica Record # _____

3rd Party Payer

Carrier's Name	Name	Customer Service PH#	Subscriber's Name
	Plan Name	Policy #	

3rd Party Payer

Carrier's Name	Name	Customer Service PH#	Subscriber's Name
	Plan Name	Policy #	

3rd Party Payer

Carrier's Name	Name	Customer Service PH#	Subscriber's Name
	Plan Name	Policy #	

NON-DISCRIMINATION/LEP STATEMENT 6.2016

Convenient Home Care LLC complies with applicable Federal civil rights laws and does not discriminate in hiring or admissions, on the basis of race, color, national origin, age, disability, or sex. Our Agency does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Convenient Home Care LLC:

- Provides free aids and services to patients with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters.
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).

- Provides free language services to patients whose primary language is not English (LEP) such as:
  - Qualified interpreters.
  - Information written in other languages.

If you need these services, contact Ibrahim Ahmed.

If you believe that Convenient Home Care 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 with:

Agency Name: Convenient Home Care LLC
Agency Civil Rights Coordinator: Ibrahim Ahmed
Agency Address: 819 30th Avenue S, Suite 200E, Moorhead MN 56560
Agency Phone: (701) 781-0208

You can file a grievance in person or by mail or fax. If you need help filing a grievance, Ibrahim Ahmed is available to help you.

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
1-800-368-1019, 800-537-7697 (TDD)

Review of Admission Documents

CLIENT:

ADDRESS:

Convenient Home Care LLC is pleased to have the opportunity to provide service for you. As part of your plan of service, we are giving you a Client Information Folder that includes important information about our services. Please review the contents of this folder with the Admitting Staff and sign below. We recommend that you keep your Client Information Folder handy and refer to it if you have questions about your service. We recognize your rights as a client and asks that you assume certain responsibilities. I have received my Client Information Folder which has been reviewed with me and includes:

- Welcome Letter
- Agency Complaint/Grievance Process
- Abuse and State Hotlines
- HIPAA Notice of Privacy Rights
- Client Consent Form
- Client Authorization Form
- Home Safety Guidelines
- Disaster/Emergency Plan Information
- Community Resources
- Non-Discrimination/LEP Statement
- 3rd Party Payer Info Sheet
- Client Rights & Responsibilities

I have read and understand all of the written information as outlined above, as well as the verbal review offered by the Agency Staff. I agree to the terms presented in this material. I also agree to contact Convenient Home Care LLC if I have questions about my service.

_____

Signature of Client /Client's Legally Authorized Representative Date

_____

Signature/Title of Agency Representative Date

Convenient Home Care LLC
819 30th Avenue S, Suite 200E, Moorhead MN 56560
(701) 781-0208

Review of Admission Documents
(CLIENT COPY)

CLIENT:
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Convenient Home Care LLC is pleased to have the opportunity to provide service for you. As part of your plan of service, we are giving you a Client Information Folder that includes important information about our services. Please review the contents of this folder with the Admitting Staff and sign below. We recommend that you keep your Client Information Folder handy and refer to it if you have questions about your service. We recognize your rights as a client and asks that you assume certain responsibilities. I have received my Client Information Folder which has been reviewed with me and includes:

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I have read and understand all of the written information as outlined above, as well as the verbal review offered by the Agency Staff. I agree to the terms presented in this material. I also agree to contact Convenient Home Care LLC if I have questions about my service.

******* CLIENT COPY NO SIGNATURE REQUIRED***_____

Signature of Client /Client's Legally Authorized Representative Date

_____

Signature/Title of Agency Representative Date

Convenient Home Care LLC
819 30th Avenue S, Suite 200E, Moorhead MN 56560
(701) 781-0208

Visit Calendar

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday