TOTAL CARE HOME HEALTH AGENCY

CHECKLIST FOR PATIENT HANDBOOK

1. Welcome and General Information
2. Policy on Acceptance of Patients
3. Patients' rights and Responsibilities
4. Patient Privacy Rule
5. Instructions on Calling 1-800-962-2873 (ABUSE)
6. Instructions on Calling 1-866-966-7226 (MEDICAID FRAUD)
7. Instructions on Calling Complaints
8. Policy on Patient/Client Grievance
9. Designation of Representative
10. Information on Health Care Advance Directives
11. Communication Record/Medication Schedule
12. Medication Assistance Informed Consent
13. Safety Tips and Safety Checks
14. Medication Side Effects Information
15. Information Packet on Emergency Management

ACKNOWLEDGMENT OF RECEIPT

I have received, read and understand the above listed documents.

_____ _____

Patient's Signature Date

_____ _____ _____

Responsible Party's Signature Relationship Date

TOTAL CARE HOME HEALTH AGENCY

AGREEMENT CONSENT FOR SERVICES

This agreement is made between ……..……, (the "patient") and Comfort Care Nursing Registry, LLC

1. The patient wishes to directly engage a person referred to by Comfort Care Nursing Registry, LLC to come into the home and perform all necessary duties of a …….. for the delivery of home healthcare.

2. If within a period of three hundred and sixty five (365) days from the last day of service provided by the Comfort Care Nursing Registry, LLC the patient hires the independent contractor directly, the patient shall pay to the Comfort Care Nursing Registry, LLC a referral fee in the amount of $10,000 as liquidated damages of the independent contractor's gross annual salary.

3. All referral fees owed to Comfort Care Nursing Registry, LLC by the patient are due and payable upon hire.

4. You will be billed weekly for the total hours worked. Because Comfort Care Nursing Registry, LLC's invoices reflect payroll we have already paid, our invoices are due upon receipt.

5. If any fee is not paid within ten (10) days of demand the patient agrees to pay interest on the unpaid balance at a rate of 1 ½ % per month (annual rate of 18%) together with attorney's fees.

6. The patient acknowledges that the person referred is an independent contractor and that they are not employees or agents of Comfort Care Nursing Registry, LLC. The caregiver referred is an independent contractor and the nurse registry is not obligated to monitor, supervise, manage or train a Registered Nurse, Licensed practical Nurse, Certified Nursing assistant, Companion, or homemaker, or home Health Aide referred for contract.

7. Comfort Care Nursing Registry, LLC pre-screens and pre-qualifies all independent contractors and verifies references, past employment history and certification on each independent contractor registered with the Comfort Care Nursing Registry, LLC.

8. **Authorization for release of information:**
I understand that Comfort Care Nursing Registry, LLC will submit accurate billings and insurance claims on my behalf to the authorized person or insurance company. I authorise the insurance company to pay directly to Comfort Care Nursing Registry, LLC all benefits which are due to me for covered services rendered. I authorise the release of all records required to act on this request for payment of authorized benefits made on my behalf. I authorize the records reviewed for any necessary audits within the registry. I authorize release of my medical information to hospitals, physicians who are treating me, or other skilled facilities (nursing home, outpatient therapy, clinics, accrediting bodies, regulatory agencies.)

[X] I understand that I may terminate this agreement by giving at least (4) hours notice to and that notification by telephone is an acceptable format.
[X] I understand that Comfort Care Nursing Registry may terminate this agreement by providing at least 5 days notice or such other minimum notice as required under applicable law. I recognize that notification may be furnished verbally, in person or telephone, and that written confirmation would then follow by mail.
[X] I understand that Comfort Care Nursing Registry may terminate this agreement without prior notice in those circumstances in which the life, safety, or wellbeing of registry personnel is or may be jeopardized by my actions or the actions residing or visiting my home. Termination in these circumstances would be confirmed in writing and sent to me by mail.

_____ _____
Patient Signature or Legally Responsible Party Date

If not patient, list party's legal status: _____

_____ _____
Signature of CCNR Representative Date

TOTAL CARE HOME HEALTH AGENCY

INFORMED CONSENT
ASSISTANCE WITH SELF-ADMINISTERED MEDICATION
BY TRAINED UNLICENSED PERSONNEL

An unlicensed person may, consistent with a dispensed prescription's label or the package directions of an over-the-counter medication, assist a patient whose condition is medically stable with the self- administration of routine, regularly scheduled medications that are intended to be self-administered. Assistance with self-medication by an unlicensed person may occur only upon a documented request by, and the written informed consent of, a patient or the patient's surrogate, guardian or attorney in fact. Self- administered medications include legend and over-the-counter oral dosage forms, topical dosage forms, and topical ophthalmic, otic and nasal dosage forms, including solutions, suspensions, sprays, and inhalers. *"Assistance with self-administered medication"* means that trained unlicensed staff can help a person to self-administer their medications by performing such tasks as:

a)Taking the medication, in its previously dispensed, properly labeled container, from where it is stored and bringing it to the patient.

b)In the presence of the patient. reading the label, opening the container, removing a prescribed amount of medication from the container, and closing the container.

c)Placing an oral dosage in the patient's hand or placing the dosage in another container and helping the patient by lifting the container to his or her mouth.

d)Applying topical medications.

e)Returning the medication container to proper storage.

f)Keeping a record of when a patient receives assistance with self-administration under this section.

Assistance with self-administration does not include:

a)Mixing, compounding, converting, or calculating medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed.

b)The preparation of syringes for injection or the administration of medications by any injectable route.

c)Administration of medications through intermittent positive pressure breathing machines or a nebulizer.

d)Administration of medications by way of a tube inserted in a cavity of the body.

e)Administration of parenteral preparations.

f)Irrigations or debriding agents used in the treatment of a skin condition.

g)Rectal, urethral: or vaginal preparations.

h)Medications. ordered by the Physician P.A. ARNP with prescriptive authority are given "as needed" unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and at the request of competent patient.

i)Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person.

Acknowledgement and Request

I have been informed of this policy and agree to have trained; unlicensed H.H.A. / CN.A. provide me with assistance in self-administering my medications. By signing below I am also requesting that the trained unlicensed personnel assist me with my medication administrator.

_____ _____

Patient or Representative Print Name Signature

_____

Date

TOTAL CARE HOME HEALTH AGENCY

Patient's Authorization to Release Medical Information

I understand that my family members, friends, and co-workers may ask questions about my medical condition over the telephone or in person. I also understand it is a breach of patient confidentiality for my you to discuss my medical information in any way with anyone without my expressed written consent. By signing this form I am designating the parties below with whom I wish Comfort Care Nursing Registry, LLC be able to discuss my medical condition.

I understand this form will be updated every calendar year. If I change my mind regarding the release of information to any of the listed people, it is my responsibility to inform Comfort Care Nursing Registry, LLC in writing of my decision.

In accordance with the above, I _____,

hereby authorize Comfort Care Nursing Registry, LLC to discuss with and release my medical information to the following individuals:

_____ _____

_____ _____

NOTIFY IN CASE OF EMERGENCY_____

_____Telephone ♯ _____

Furthermore, I understand that if there is any information in my medical record I do not want discussed with or released to the above, I must designate it here by stating what information is to be excluded.

_____ _____

_____ _____

Patient Signature_____

Date:_____

TOTAL CARE HOME HEALTH AGENCY

DISASTER CODING FOR PATIENTS

INSTRUCTIONS: Please place a check mark to the most appropriate disaster code. In the event of an emergency, this classification will assist us in managing the patient's care.

Patient's Name	SOC
Patient's Address	Phone Number
Caregiver's Name	Caregiver's Phone Number
Physician	Physician Number

Class I: Highest Need

[ ] Patient is dependent on electrical equipment for which the interruption of services endangers life.
[ ] Patient is maintained on oxygen above 2 L/min
[ ] Patient is insulin-dependent diabetic, either uncontrolled or unable to self-administer insulin injection.
[ ] Patient has other conditions which interruption of home care service may endanger life.

Class II: Moderate Need

[ ] Patient lives alone and/or interruption of service would severely impact patient's ability to meet basic physiologic and safety needs without intervention.

Class III: Lowest Need

[ ] Patient lives with a new caregiver or patient is able to meet basic physiologic needs and safety needs without registry intervention.
[ ] Patient has made specific prior arrangements for evacuation/admission to skilled facility, or shelter including transportation.

****

SPECIAL NEEDS PATIENT INFORMATION LISTING

Does the special needs patients have in the home folder:

A list of specific medications? [ ] Yes [ ] No

List supplies and registered equipment needed to accompany the patient in the event of an evacuation.

_____
_____
_____

In the event of an emergency or disaster does the patient plan to evacuate or remain at home?

[ ] Stay at Home [ ] Evacuate [ ] Hospital [ ] With family/friends [ ] Shelter

Additional information regarding the patient's evacuation plan:

_____
_____
_____

Is a copy of this plan included in the patient clinical record? [ ] Yes [ ] No
Is a copy of this plan included in the patient home record? [ ] Yes [ ] No

Name of CCNR Representative _____

Signature of CCNR Representative_____ Date: _____