Home Health Admission Agreement

Ohio Living
Home Health & Hospice

Consent for Care/ Service
I request home health care services from Ohio Living Home Health & Hospice (the "Organization") and consent to such care and treatment. The services to be provided have been explained to me. I consent to allow the Organization's staff to provide the services to me in my place of residence. I understand that the treatment plan may change and that these changes will be discussed with me. I understand that I or my family/caregiver will receive instructions about my care and that my care will become my responsibility in the absence of the home health staff in my place of residence. I understand that I must have an attending physician at all times for the duration of this agreement, unless the Organization determines otherwise.

Consent to Use and Disclosure Protected Health Information
I consent and authorize the Organization to release and receive my medical and other personally identifiable information, including if applicable, permission to take wound photographs for the purposes of documenting my medical condition, with the intent of coordinating, providing and billing for home care services. Information may be shared verbally, electronically or in hard copy and may be exchanged in person, by mail, e-mail and/or by facsimile. The exchange of information may include, but is not limited to:

1) Physicians, hospitals, adult day care, long term care facilities and other providers involved in my care;
2) Agencies, companies, or businesses such as, but not limited to, durable medical equipment, infusion therapy or respiratory care providers, for the purpose of planning, authorizing and providing my home care and/or health care needs;
3) Selected community resources that may assist to meet my home health care needs;
4) Persons and/or entities, including governmental, commercial or individual payers, responsible for all or part of the payment to the Organization for services rendered, and/or
5) Surveyors from state or federal agencies or accreditation organizations.

Third Party Payers
I certify that the information given by me in applying for payment under Title XIX of the Social Security Act or from any third party payer is correct. I authorize any holder of medical or other relevant information about me to release such records as may be required to act on this request. I request that payment of authorized benefits be made on my behalf to the Organization.

Patient Rights and Responsibilities
I have access to a copy and explanation of the Organization's:

- ***Patient Rights and Patient Responsibilities***. This includes information about how to use the Organization's complaint process and Corporate Compliance Hotline.
- ***Statement of Patient Privacy Rights and Privacy Act Statement-Health Care Records*** (Medicare and Medicaid patients), and/or
- ***Notice About Privacy*** (patients who do not have Medicare and Medicaid).
- ***Notice of Privacy Practices.***

Consolidated Billing- Supplies (Medicare Home Health Patients Only)
I understand that I will be informed which supplies are covered by Medicare while I am under a physician's home health plan of care. I understand that when the Organization provides these types of supplies I have no financial liability, but if I choose to obtain them or not to use the Organization's vendor and/or brands, I will be responsible for the payment of that bill. I also understand when I am no longer an active patient under a Medicare home health plan of care that I am responsible for obtaining supplies and arranging for payment under Medicare Part B, if allowable.

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Patient Name _____MBI # _____
Photo ID type _____ID# _____

Advance Directive for Health Care
I have received an explanation and written information regarding advance directives. I understand that it is the policy of the Organization to respect individual choice and to avoid discrimination based on whether or not I have an advance directive.

I have the following advance directives: Where is this located

- ☐ DNR _____
- ☐ Living Will _____
- ☐ Durable Health Care _____
- ☐ Other: _____ _____

Safety, Emergency and Infection Control:
I have received information about basic home safety, emergency/disaster planning related to a disruption in service and infection control practices as appropriate to my care in the home. I understand staff may instruct me on these areas as needed.

Liability for Payment:
I understand that all services provided to me by the Organization will be billed. I agree it is my obligation to pay deductibles, co-payments, coinsurance, or spend-downs and any other amounts not covered by Medicare, Medicaid, or my primary insurance. I will be responsible for any balance not paid by my insurance company. I will also be responsible for billing other companies for reimbursement directly to me. Refunds will be processed within 60 days.

Choose PAYER		**Projected Payment due from client**
Traditional Medicare		$0
Medicaid		$0
Other Insurance		Coverage varies with individual policy. There may be deductible $_____, co-pay $_____ per visit; and coinsurance _____ %.

Proposed Initial Visit Plan	Frequency	# weeks		Frequency	# weeks
Nursing			Home Health Aide		
Physical Therapy			Speech Therapy		
Occupational Therapy			Social Worker		

THIS ADMISSION AGREEMENT IS APPLICABLE TO THIS ADMISSION TO THE ORGANIZATION. I UNDERSTAND WHAT I HAVE READ AND WHAT WAS EXPLAINED TO ME AND AGREE TO THE TERMS AND CONDITIONS AS STATED ABOVE.

Additionally, I understand that I, as either the patient or patient representative, may terminate this agreement at any time for any reason. I further understand that Ohio Living Home Health & Hospice is required to follow its discharge and transfer notification policies and procedures, as written in the Home Health Handbook in the event that this agreement is terminated prior to the end of the services as ordered by my physician.

Signatures

_____
Patient or Authorized Representative Relationship Date

_____
Home Health Representative Date