DELUXE HOME HEALTH CARE AGENCY

# CLIENT ADMISSION PACKET

4893 S. Himalaya Ct
Aurora, CO 80015
Phone: 303-564-8086
Fax: 720-612-7661
Email: info@deluxehomehealth.com

# DELUXE HOME HEALTH CARE AGENCY

**Welcome!**

We at Deluxe Home Health Care Agency look forward to getting to know you and your family. Our desire is to help you achieve optimal health! Our pledge to you is to give you the very best care possible and help you maintain a good quality of life. We do this by assigning you one of our professional personal care providers.

Our intake specialist has come to your home and determined how our services will best meet your needs. Our staff is caring and will treat you like royalty around the clock. We are certified and trained in personal care, we are CPR/First Aid Certified, licensed, bonded and insured. Each of our employees has their own backup and supervisor ready to be of service to you.

Deluxe Home Health Care Agency respects your right to privacy and further requires our personal care providers maintain confidentiality of information. Therefore access to records is restricted to those employees who are directly involved with your care.

We truly appreciate the trust you have given us in helping you care for yourself or a loved one. If you feel our services might benefit a friend or a family member, you can simply call 303-564-8086 we would love to hear from you.

Thank you,

Patricia I. Ezeaku
Administrator
Deluxe Home Health Care Agency

4893 S. Himalaya Ct, Aurora CO 80015 Phone: 303-564-8086 Fax: 720-612-7661 E-mail: info@deluxehomehealth.com

# DELUXE HOME HEALTH CARE AGENCY

## NOTICE OF PRIVACY PRACTICE

**To our Clients**
THIS NOTICE DESCRIBES HOW YOUR INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

This notice applies to all of the records of your care generated by this Agency. Our policies on protecting your health information extend to all professional authorized personal that have a need to know to provide care to you. The policies apply to all areas of the Agency including all Agency staff, front desk, billing and administration. It also applies to any entity or individual with whom we contract services, such as referral providers.

**Your Protected Information**
As our client, we create paper and electronic medical records and documents concerning you and your health, as well as the care and services we provide to you. We need this record to provide continuity of care and to comply with certain legal requirements. We are required by law to:
Make sure that your protected information is kept private, provide you with this Notice of Client Privacy Rights, and make sure the law and your legal rights are in effect.

**How we may use and disclose your personal health information**

- ❖ **Treatment.** We use information previously compiled about you to provide you with current or future care and services.
- ❖ **Payment.** We may use and disclose information about you concerning services and procedures so they may be billed and collected from you, your insurance company or third party reimbursement entity such as Workers Compensation or Medicaid.
- ❖ **Operational Use.** We may use and disclose your information in order to operate the Agency efficiently and make sure our clients receive quality of care.
- ❖ **Appointment and Recall Reminders.** We may use and disclose your information to contact you to remind you regarding scheduled visit appointments for care that you are to receive.
- ❖ **Required by law.** We will disclose information about you when required to do so by federal, state or local law.
- ❖ **To avert serious threat to health or safety.** We may use and disclose your information to persons who need to know when necessary to prevent a serious threat to either your health or the health and safety of others.
- ❖ **Victims of Abuse, Neglect or Domestic Violence.** We may disclose your health information to law enforcement, social services, or other government agencies authorized to receive the report if we have reason to believe that you are a victim of abuse, or domestic violence.

**You have the right to:**

- **Inspect and copy of your client information.** You may ask to review and get a copy of your client records that the Agency keeps for as long as the Agency keeps it. If you request to review your information, the Agency will determine whether to allow you to review some or all of the information you asked for. The Agency may charge a fee for any copies that you ask for. Please make this request in writing to the Agency's Administrator.
- **Amend your client information,** if you feel it is wrong or not complete. You may request that we amend the health information the Agency keeps. If the Agency accepts your request to amend your information, the change will become a permanent document in your client record. Please make this request in writing to the Agency's Administrator.
- **Request a limit to the health information we disclose.** You may ask the Agency not to use or disclose your information. Your request must describe the specific limits you are requesting. The Agency may deny your request. Please make this request in writing to the Agency's Administrator.
- **Receive a paper copy of this Notice from us.** You may request a copy of this Notice at any time.
- **Complaints.** If you believe that your privacy rights have been violated you may file a complaint with the Agency or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing and all complaints will be investigated.

## ADDITIONAL RIGHTS

**You also have the right to be informed of:**

1. Agency ownership and control, any beneficial relationships with referral source and its liability insurance;

2. How much your care will cost, what portion will be paid by Medicaid or other sources and how billing is handled; and of

3. Any changes in payment information, before the changes are made, or within a minimum of thirty (30) days after Deluxe Home Health Care becomes aware of them.

**You have the right to:**

- Be free from the imposition of another's belief or value system
  - 
- Receive a paper copy of Deluxe Home Health Care Notice of Privacy Practices
- Lodge complaints about Deluxe Home Health Care privacy practices
- Request restrictions on the uses and disclosures of your health information
- Request to receive your confidential communication

- Access your protected health information for inspection and/or copying
- Amend your health care information
- Request an accounting of disclosures of your health information
- Privacy and to have your client/medical records and other information treated confidentially;
- Be referred to another agency if you are not satisfied with care or if this agency cannot meet your needs.

**You are responsible to:**

1. Give truthful and accurate information
2. Notify Deluxe Home Health Care of changes in significant information such as your condition or advance directives
3. Notify Deluxe Home Health Care in advance if you cannot keep appointments
4. Follow through with the care plan and referrals agreed upon
5. Voice disagreements, dissatisfactions and grievances to the appropriate persons
6. Inform Deluxe Home Health Care if you have a Living Will, Durable Medical Power of Attorney or Do Not Resuscitate wishes

# DELUXE HOME HEALTH CARE AGENCY

## WRITTEN NOTICE OF HOME CARE CONSUMER RIGHTS

As a consumer of home care and services you are entitled to receive notification of the following rights both orally and in writing. **You have the right to exercise the following rights without retribution or retaliation from agency staff:**

1. Receive written information concerning agency's policies on advance directives, including a description of applicable state law;
2. Receive information about the care and services to be furnished, the disciplines that will furnish care, the frequency of proposed visits in advance and receive information about any changes in the care and services to be furnished;
3. Receive care and services from agency without discrimination based upon personal, cultural or ethnic preference, disabilities or whether you have formulated an advance directive;
4. Authorize a representative to exercise your rights as a consumer of home care;
5. Be informed of the full name, licensure status, staff position and employer of all persons supplying, staffing or supervising the care and services you receive;
6. Be informed and participate in planning care and services and receive care and services from staff who are properly trained and competent to perform their duties;
7. Refuse treatment within the confines of the law and be informed of the consequences of such action;
8. Participate in experimental research only upon your voluntary written consent;
9. Have you and your property to be treated with respect and be free from neglect, financial exploitation, verbal, physical and psychological abuse including humiliation, intimidation or punishment;
10. Be free from involuntary confinement, and from physical or chemical restraints;
11. Be ensured of the confidentiality of all of your records, communications, and personal information and to be informed of agency's policies and procedures regarding disclosure of clinical information and records;
12. Express complaints verbally or in writing about services or care that is or is not furnished, or about the lack of respect for your person or property by anyone who is furnishing services on behalf of agency.

**If you believe your rights have been violated you may contact agency directly:**
**Deluxe Home Health Care Agency**
**4893 Himalaya Ct. Aurora, CO 80015**
**Patricia Ezeaku 303-564-8086**

**You may also file a complaint with the Health Facilities and Emergency Medical Services Division of the Colorado Department of Public Health and Environment via mail or telephone:**

**4300 Cherry Creek Drive South**
**Denver, CO 80246**
**303-692-2910 or 1-800-842-8826**

I attest to verbal and written receipt of the aforementioned notice of rights:

______________________________________ __________________

Client/Representative Signature Date

______________________________________ __________________

Deluxe Home Health Care Agency Staff Signature Date

# DELUXE HOME HEALTH CARE AGENCY

## RECEIPT OF NOTICE OF PRIVACY PRACTICE

Client Name: ________________________________

Date of Admission: ___________________________

My signature on this form acknowledges that I have received a copy of ***Deluxe Home Health Care Agency's*** Notice of Privacy Practice. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by ***Deluxe Home Health Care Agency*** in Home and of my rights with respect to my health information.

I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my heath information.

______________________________ ______________________________
Client Signature Date

______________________________ ______________________________
Signature of Client's Representative Date
If Client is Unable to sign.

1- Was the client provided with a copy of the Agency's Notice of Privacy Practices?
Yes ______ No _____
2- Briefly describe efforts made to obtain the client's acknowledgment of Receipt of the Notice and explain why the patient was not able or willing to sign this form:
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

_________________________________________ ____________________
Deluxe Home Health Care Agency Staff Signature Date

4893 S. Himalaya Ct, Aurora CO 80015 Phone: 303-564-8086 Fax: 720-612-7661 E-mail: info@deluxehomehealth.com

# DELUXE HOME HEALTH CARE AGENCY

## AGENCY DISCLOSURE NOTICE

Agency Type: ☐ Home Care Placement ☐ Home Health Care ☐ Personal Care or Medical

Each home care agency or home care placement agency is required to provide the consumer information as to the responsibilities of Deluxe Home Health Care Agency, the home care worker, and the consumer regarding the employment and duties of each.

- ☐ Agency is the employer of record for all staff providing direct care services and is responsible for all items listed below.
- ☐ Responsibilities are delineated below:

| Consumer | Worker | Agency | |
|---|---|---|---|
| | | ✓ | Employer of the home care worker. |
| | | ✓ | Supervision of the home care worker. |
| | | ✓ | Scheduling of the home care worker. |
| | | ✓ | Assignment of duties to the home care worker. |
| | | ✓ | Hiring, firing and discipline of the home care worker. |
| ✓ | | | Provision of supplies or materials for use in providing services to the consumer. |
| | | ✓ | Training and ensuring qualifications that meet the needs of the consumer. |
| | | ✓ | Liability for the home care worker while in the consumer's home. |
| **Consumer** | **Worker** | **Agency** | **Payment of:** |
| | | ✓ | Wages to the home care worker. |
| | | ✓ | Employment taxes for the Home Care Worker. |
| | | ✓ | Social Security taxes for the Home Care Worker. |
| | | ✓ | Unemployment insurance for the Home Care Worker. |
| | | ✓ | General liability insurance for the Home Care Worker. |
| | | ✓ | Worker's Compensation for the Home Care Worker. |
| | | ✓ | Bond Insurance (if provided). |

The above information and areas of responsibility have been explained and any questions have been answered in regard to responsibilities held by the consumer, the home care worker and Deluxe Home Health Care Agency.

Printed Name of Client: ______________________________ Start of Care Date: __________

________________________________________ ____________________
Client/Representative Signature Date

________________________________________ ____________________
Deluxe Home Health Care Agency Staff Signature Date

# DELUXE HOME HEALTH CARE AGENCY

## CLIENT INFORMATION

**Date: ________________**

**Client Information**

Client Name: ______________________________

Client SS#:_________________________ Client DOB________________ Sex_______

Street Address: _______________________________

City: _________________ State: ________ Zip: _______________

Telephone Number: ___________________________ E-mail ________________________

Medicaid#:____________________________ Medicare#:_____________________________

Other Insurance Information: __________________________________

**Emergency Contact/Responsible Party**

Name: ______________________________________

Street Address: _______________________________

City: __________________ State: _________ Zip: _______________

Telephone Number: ___________________________ E-mail ________________________

Relationship to Client: ______________________________

**Physician Information**

Physician Name: ______________________________

Street Address: _______________________________

City: ____________________ State: _________ Zip: ______________

Telephone Number: ___________________________ E-mail ________________________

Diagnosis/Special Needs or Condition: ______________________________________________

________________________________________________________________________________

____________________________________________________________________________

**Case Manager Information**

Case Manager Name: __________________________

Street Address: _______________________________

City: ____________________ State: _________ Zip: ______________

Telephone Number: ___________________________ E-mail ________________________

# DELUXE HOME HEALTH CARE AGENCY

## MEDICAL HISTORY FORM

Client Name: ____________________________ Client Number: ________________

PRESENT HEALTH CONCERNS OR FUNCTIONAL LIMITATIONS:

________________________________________________________________________________

________________________________________________________________________________

__________________________________________

MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs:

_____________________________________________ Dose: ______________ Time _______

_____________________________________________ Dose: ______________ Time _______

_____________________________________________ Dose: ______________ Time _______

_____________________________________________ Dose: ______________ Time _______

_____________________________________________ Dose: ______________ Time _______

_____________________________________________ Dose: ______________ Time _______

_____________________________________________ Dose: ______________ Time _______

ALLERGIES or REACTIONS TO MEDICINES/FOODS/OTHER AGENTS:

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________

PERSONAL MEDICAL HISTORY:

Please indicate whether you have had any of the following medical problems (with approximate date of illness or diagnosis).

____Congenital Heart disease:

*Specify type*___________________

____Myocardial Infarction (Heart Attack)

____Hypertension (High blood pressure)

____Diabetes

____High cholesterol

____Stroke

____Coagulation (bleeding/clotting)

____Cancer

*Specify Type*________________

___Thyroid problem

*Specify type*__________________

____Depression/suicide attempt

____Alcoholism

____ Have you ever had a blood transfusion

Other health problems or concerns

_____________________________________

_____________________________________

_____________________________________

Special Diet: ___________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

# DELUXE HOME HEALTH CARE AGENCY

## CLIENT PERSONAL INFORMATION

Source/Agency Name: Deluxe Home Health Care Agency, LLC.
Phone: **303-564-8086** Fax**: 720-612-7661**

| | | |
|---|---|---|
| Client Name: | Referral Date: | Requested SOC Date: |
| | Referral Source: | Phone: |
| Address: | Responsible Party:<br>Emergency Contact:<br>_____Relative _____Significant Other _____Caregiver<br>Name:<br>Address:<br>Phone: | |
| Phone: | D/C from: ___Hospital ___ SNF/Rehab Facility | |
| DOB: Sex: ____Male ____Female | Date Adm: D/C | |
| Marital Status: ____S ____M ____D ____SEP ____W | Cross Streets/ Directions: | |
| Medicare #: | | |
| Medicaid #: | Other Insurance: Phone: | |
| DIAGNOSIS: Date:<br>(List Primary Diagnosis first)<br>1)<br>2)<br>3)<br>4) | Surgery: Date/s:<br>Allergies:<br>Last Seen by MD:<br>Brief Medical History: | |
| HME/Supplies | Special Diet: | |
| HOME CARE PLAN:<br>DISCIPLINE: ___PCP ___RPP<br>SPECIAL NEEDS? ___Yes ___No MI BI<br>BEHAVIOR NEEDS? ___Yes ___No<br>Medications:<br>Treatments:<br>Other Agencies Involved In Care: | | |
| Physician Name:<br>Address:<br>Phone Number: | Case Manager Name:<br>Address:<br>Phone Number: | |
| Staff Signature/Title: | Date: | |

# DELUXE HOME HEALTH CARE AGENCY

## CLIENT CONTRACT

Clients will be accepted for home care with the expectation that Deluxe Home Health Care Agency(DHHCA) can provide the services needed by the client, that the client will work towards achieving his/her highest possible level of independence, and that the client's condition can be managed safely in the home care setting. No person receiving services will be discriminated against on the basis of age, sex, religion, ethnic origin, sexual orientation, political belief, physical diagnosis, or disability.

As a client seeking care from DHHCA, I do hereby agree to the following:

1. To work toward achieving my highest possible level of independence.
2. To facilitate the exchange of my medical and other background information among the members of my health care team (physician, therapists, social worker, psychiatrist, nurses, agency staff, etc.) as necessary to provide me with the best possible services.
3. To notify Deluxe Home Health Care staff immediately of significant changes in my condition, health insurance, orders from my physician, hospitalizations, etc.
4. To assume responsibility for maintaining my personal hygiene and the care of equipment and supplies used on my behalf.
5. To provide adequate and appropriate cleaning and laundry supplies.
6. To provide coins for laundry machines and to pay agency staff in advance for expenditures for groceries, medications or other purchases made on my behalf.
7. To maintain safe conditions in my home which promote my personal well being of and that of agency staff. These conditions include but are not limited to proper sanitation, the absence of sexual harassment, verbal or physical abuse, the risk of violence, and the abuse or misuse of drugs or alcohol.
8. To give Deluxe Home Health Care staff the same respect and concern I expect to receive.
9. To be present for planned visits or to notify Deluxe Home Health Care twenty-four hours in advance of changes to my schedule that negatively impact arrangements for my care, e.g. physician appointments, trips, etc.
10. To notify agency one week in advance (or as soon as known) when termination of services is planned.
11. To notify Deluxe Home Health Care within 20 minutes of staff absences for planned visits.

# DELUXE HOME HEALTH CARE AGENCY

## CLIENT CONTRACT (Cont'd)

12. To call the office during business hours with non-emergent requests for information or issues.

13. To direct all questions, suggestions, complaints, dissatisfaction with services and other concerns to appropriate agency staff.

14. To participate to the fullest extent of my ability in planning and carrying out my care.

15. I understand that: Preliminary and periodic evaluation visits will be conducted by agency staff to gather information necessary to provide initial and ongoing services. These evaluations of my needs determine the services I receive and visit frequency, length and duration.

**16.** Plans of Care will be developed with the participation of the client by the Director or Consumer Services or designee.

**17.** Only services stipulated by the Plan of Care will be provided by the agency staff.

**18.** Deluxe Home Health Care will not duplicate services of, nor provide services for roommates who are live-in aides. These services include but are not limited to unskilled housekeeping and personal care services.

**19.** In the event that my regularly scheduled Personal Care Provider or Homemaker is unable to provide care, Deluxe Home Health Care will provide another Personal Care Provider or Homemaker upon my approval.

**20.** If I am not at home when my Personal Care Provider or Homemaker arrives, the Personal Care Provider or Homemaker will wait 20 minutes. If I do not arrive during that time, I must make my own arrangements for the care I would have received during that visit. **Personal Care Providers or Homemakers are not allowed in my home when my family or I am not present.**

**21.** All staff hired by the agency is carefully screened, oriented and trained, and are covered by Deluxe Home Health Care liability insurance. Individuals who are hired directly by clients may not have the reference checks, competency evaluation, insurance and other credentials.

**22.** The Staff will leave my home and services may be terminated immediately if there is the potential for violence, the presence of weapons, verbal or physical abuse, sexual harassment and the abuse or misuse of drugs or alcohol.

____________________________________ __________________
Client/Representative Signature Date

____________________________________ __________________
Deluxe Home Health Care Agency Staff Signature Date

# DELUXE HOME HEALTH CARE AGENCY

## ADMISSION AGREEMENT

I hereby consent to care and services in my home according to agency policy and the plan of service developed with my participation by the staff of Deluxe Home Health Care Agency . I authorize and request that staff take such actions as necessary and desirable in the exercise of sound professional judgment.

**I have been informed in language I understand, and have been given copies of:**

- My rights and responsibilities
- Charges for services not covered by Third party payers.
- Information about Advance Directives
- Agency privacy practices
- Disclosure Notice
- Emergency phone numbers, procedures hours and the staff who will visit me
- Agency grievance procedures
- Eligibility requirements for Medicaid and other payers

**Privacy of Clinical Records**

Information from my records will be released only upon my written authorization, which I may stop at any time. I authorize the staff of Deluxe Home Health Care Agency to release information in my records to the referring agency, my physician, and persons or agencies that will perform related services, and to Medicare, Medicaid, private insurance, or other payer I have indicated above.

I understand that my records will be kept locked at all times except when used by authorized agency personnel, that my records may be reviewed for quality assurance, certification or accreditation purposes, and that I have the right to have access to my records according to agency policy.

My signature on this form acknowledges that I have received a copy of Deluxe Home Health Care Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by Agency and of my rights with respect to my health information.

I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information.

**ASSIGNMENT OF BENEFITS & FINANCIAL RESPONSIBIL**ITY: I authorize Deluxe Home Health Care Agency to bill for services on my behalf and that benefit payments be made directly to Deluxe Home Health Care Agency . I also acknowledge that I am ultimately responsible to pay for services I receive. **If these services are not covered by my insurer I will be provided a detailed listing of the services and what my financial liability will be prior to receiving those services.**

**My signature on this form indicates I have read and understand the above information pertaining to my privacy and financial rights and obligations.**

______________________________________ __________________

Client/Representative Signature Date

______________________________________ __________________

Deluxe Home Health Care Agency Staff Signature Date

4893 S. Himalaya Ct, Aurora CO 80015 Phone: 303-564-8086 Fax: 720-612-7661 E-mail: info@deluxehomehealth.com

# DELUXE HOME HEALTH CARE AGENCY

## ADVANCE DIRECTIVES

As a Consumer, and under Colorado State Law, you may to consent to (accept) or refuse any medical care and treatment, unless care is ordered by a court. If and when you are unable to make your own decisions, Colorado law allows your guardian or your agent "appointed" or "named" under a medical durable power of attorney to make your health care decisions. In the absence of an advance medical directive or guardian, Colorado law allows a person close to you to be a substitute decision maker (proxy). In the absence of advance directives, Colorado law requires the physician or the physician's designee to make reasonable efforts to contact those close to the patient for the purpose of seeking a substitute decision maker (proxy). If you have an advance directive from another state, it may still be valid in Colorado. However, it is recommended you prepare a new advance directive under Colorado law.

Deluxe Home Health Care Agency policy states that we inform you of your rights as a consumer regarding advance directives. Deluxe Home Health Care Agency will not refuse service if no advance directives are in place. Deluxe Home Health Care Agency regrets we are unable to provide advice to you about how to complete the forms. All advance directives you have established will be honored by Deluxe Home Health Care Agency.

Colorado State Law allows you to request the following advance directives:

- Medical Durable Power of Attorney
- Living Wills
- Cardio Pulmonary Resuscitation (CPR Directive)
- Do Not Resuscitate Order (DNR Directive)
- Substitute Decision Makers (Proxies)
- Guardians

I have developed: (Consumer will initial all that apply):

_____ No Advance Directives _____ Living Will
_____ Medical Durable Power of Attorney _____ Do Not Resuscitate Orders
_____ Substitute Decision Makers (Proxies) _____ Guardians

Notes: ______________________________________________________________________

__________________________________________________________________________

__________________________________________
Consumer's/Authorized Representative Printed Name

__________________________________________ ____________
Consumer's/Authorized Representative Signature Date

____________________________________________ ____________
Deluxe Home Health Care Agency Signature Date

4893 S. Himalaya Ct, Aurora CO 80015 Phone: 303-564-8086 Fax: 720-612-7661 E-mail: info@deluxehomehealth.com

# DELUXE HOME HEALTH CARE AGENCY

## COMPLAINT OR GRIEVANCE PROCEDURE

You have the right to voice grievances or to complain about the treatment or care that is (or fails to be) given to you or about lack of respect by anyone furnishing Services to you. You also may complain about Deluxe Home Health Care Agency practices regarding advance directives and privacy. There will be no reprisal or discrimination as a result of your complaint. Please use the following procedure:

1. You may report problems to the staff assigned to your case during visits to your home or at the office, during regular working hours **(303) 564-8086.**

2. If the problem lies with the staff assigned to your case or if the complaint is not resolved within 5 working days, you may speak to the supervisor. **Benjamin Ezeaku (303)564-8086**.

   The supervisor will investigate the problem with you and the involved staff and if necessary, take appropriate corrective action within 10 working days of your complaint. The supervisor will inform you within 5 working days of the outcome of the investigation.

3. If you continue to be dissatisfied, please speak to the Executive Director **Patricia Ezeaku (832)704-0393.**

4. The State of Colorado operates a toll free complaint hotline, (**303)692-2800 or 1-800-842-8826** which is available 24 hours a day. Complaints made to this number can be kept anonymous.

The investigation and resolution of your complaint will be brought to the attention of Deluxe Home Health Care Agency Performance Improvement program and Governing Body. You will be notified by Deluxe Home Health Care Agency Executive Director of the outcomes of the investigation and the final resolution within 15 working days.

____________________________________ ____________________
Client/Representative Signature Date

____________________________________ ____________________
Deluxe Home Health Care Agency Staff Signature Date

# DELUXE HOME HEALTH CARE AGENCY

## RELEASE OF LIABILITY

I understand that money given to **DELUXE HOME HEALTH CARE AGENCY** employee(s) to make small purchases (i.e. food, and other home supplies), needs receipt documentation.

I understand that it is my responsibility to secure valuables in the home and that **DELUXE HOME HEALTH CARE AGENCY** encourages me to keep these things put away.

I understand that if money or valuables are stolen from my home, I will report this behavior to **DELUXE HOME HEALTH CARE AGENCY** and contact the appropriate authorities to file an official report against the person(s) involved. I also understand that if I do not want to prosecute the individual, **DELUXE HOME HEALTH CARE AGENCY** will prosecute.

**DELUXE HOME HEALTH CARE AGENCY** will inform me of the criminal background checks run through the Colorado Bureau of Investigation on their employees if requested.

I understand that when care providers enter my home, **DELUXE HOME HEALTH CARE AGENCY** has taken every precaution to protect my interests and provide me with personal care services. In addition, **DELUXE HOME HEALTH CARE AGENCY** will take the necessary steps to insure the safety and security of all our consumers.

I understand that I will not hold **DELUXE HOME HEALTH CARE AGENCY** liable for any actions of individual employees and that **DELUXE HOME HEALTH CARE AGENCY** has done and will do whatever is necessary to ensure the security and safety of services offered to all our consumers.

____________________________________ _________________
Client/Representative Signature Date

_____________________________________ _________________
Deluxe Home Health Care Agency Staff Signature Date

# DELUXE HOME HEALTH CARE AGENCY

## WORK SCHEDULE NOTICE

**TO:** ALL CONSUMERS
**FROM:** DELUXE HOME HEALTH CARE AGENCY
**DATE:** REVIEWED 10/14/2015
**RE:** WORK SCHEDULES

Deluxe Home Health Care Agency staff is given a schedule of time to arrive and to depart consumer homes. they are also given the duties that they are to perform. you, as the consumer, are informed to call the office if our staff does not follow schedule or does not complete tasks. you are given a copy of your care plan, which details days, times and tasks to be completed.

**THEFT, BORROWING, OR LENDING OF MONEY, ARRIVING LATE, DEPARTING EARLY, CHANGING TIMES AND/OR MOVING IN OF AN EMPLOYEE (OTHER THAN FAMILY MEMBERS),** is not acceptable behavior for Deluxe Home Health Care Agency employees. in the event that any of these things occur during the Deluxe Home Health Care Agency staff visit, it is your responsibility to call Deluxe Home Health Care Agency immediately. this needs to be done the day of the incident. if incidents are not reported within 48 hours of it taking place, the full responsibility will be yours.

Deluxe Home Health Care Agency staff has been informed of appropriate work ethics. the ones listed above are grounds for immediate termination and/or the police being called. deluxe home health care agency feels that if the consumer and staff would work together, we could eliminate inappropriate work behaviors.

by signing this, you agree to follow our policy on inappropriate work behaviors.

if you have any questions or concerns, please contact Patricia Ezeaku at 303-564-8086. Thank you.

_________________________________________ ____________________
Client/Representative Signature Date

_________________________________________ ____________________
Deluxe Home Health Care Agency Staff Signature Date

# DELUXE HOME HEALTH CARE AGENCY

## BACKGROUND CHECK NOTICE

### ATTENTION ALL CONSUMERS

Criminal background checks are run on **ALL** Personal Care Providers prior to employment and assignment to consumer's homes.

If you have any concerns about the results of a criminal background check, please contact this office.


DELUXE HOME HEALTH CARE AGENCY
4893 SOUTH HIMALAYA CT
AURORA, CO 80015
PHONE: 303-564-8086
FAX: 720-612-7661
E-MAIL: INFO@DELUXEHOMEHEALTH.COM

# DELUXE HOME HEALTH CARE AGENCY

## PAYMENT FOR SERVICES

☐ **INSURANCE**

_____ I understand that my insurance will cover _____% of my personal care services billing, and request that payment for said services provided to me are to be made payable to DELUXE HOME HEALTH CARE AGENCY **and/or**

☐ **PRIVATE PAY**

_____ I will be billed by DELUXE HOME HEALTH CARE AGENCY and am expected to remit payment by the day immediately following the month billed.

_____ I request that payment for personal care services provided to me are to be made to DELUXE HOME HEALTH CARE AGENCY on my behalf.

DELUXE HOME HEALTH CARE AGENCY attempts to be flexible in meeting the needs of consumers as it relates to reimbursement of services provided. We offer the following options:

_______ per hour for _______ hours per week

I have been given the opportunity to discuss my Individualized Service Plan and my rights as a consumer whose privacy will be observed during the course of my contract with DELUXE HOME HEALTH CARE AGENCY. My signature below acknowledges, also, that I have received a copy of the Agency's Notice of Privacy Practices. I understand that this document offers an explanation of the ways in which my health information may be used or disclosed by DELUXE HOME HEALTH CARE AGENCY, and of my rights in regard to my health history.

_________________________________________
Client/Authorized Representative Printed Name

_________________________________________ ____________
Client/Authorized Representative Signature Date

_________________________________________
Deluxe Home Health Care Agency Staff Printed Name

_________________________________________ ____________
Deluxe Home Health Care Agency Staff Signature Date

# DELUXE HOME HEALTH CARE AGENCY

## ADMISSION FORM

Client Name (Please Print)______________________________________________________
(Last, First, MI)

Client Record #: ____________________________________________

I have received and understood the following information:

___ Bill of Rights and Responsibilities

___ Written Notice of Home Care Consumer Rights

___ Advance Directives

___ Consumer Grievance Procedure

___ Privacy Rights

___ Safety/Disaster Plan/ Emergency Procedures

___ Disclosure Notice Signed Independently of this form

___ **Release of Information and Medical Records**. I consent to the release of information by: _________________________________ (*Physician, Licensed Health Care Professional, Facility which has provided care*); and allow the disclosure of medical records kept by the above-named to DELUXE HOME HEALTH CARE AGENCY. I consent to the release of information by DELUXE HOME HEALTH CARE AGENCY or its representative to representatives of other health providers involved in my health care, to third party payers and to regulatory, fiscal or accreditation persons in order to assure continuity of treatment, proper reimbursement of services, and communication of information to my physician and referral source.

___ **Consent for Services**. I voluntarily consent to receive care and services from DELUXE HOME HEALTH CARE AGENCY consistent with a plan of care authorized by my physician or case manager as appropriate. I understand that if I am in such a condition as to need services not provided by DELUXE HOME HEALTH CARE AGENCY, such services must be arranged by me, my authorized representative, and my physician or case manager. DELUXE HOME HEALTH CARE AGENCY shall assist in locating such services, but shall in no way be responsible for failure to provide the same and is hereby released from any and all liability arising from the fact that I am not provided with such additional care. In the event a health care worker sustains exposure to my blood, I understand that the blood will be tested for infectious diseases such as Hepatitis and HIV and that the exposed employee will be informed of the results of the test.

_____________________________________ ____________________
Client/Representative Signature Date

______________________________________ ____________________
Deluxe Home Health Care Agency Staff Signature Date

# DELUXE HOME HEALTH CARE AGENCY

## CHANGE OF CLIENT INFORMATION

**Date:** ________________

**Client Information**

Client Name: ______________________________

Client SS#:_________________________ Client DOB________________ Sex:_______

Street Address: _______________________________

City: _________________________ State: ________ Zip: ______________

Telephone Number: ___________________________ E-mail ________________________

Medicaid#: ______________________________ Medicare#:______________________________

Other Insurance Information: __________________________________

**Emergency Contact/Responsible Party**

Name: ______________________________________

Street Address: _______________________________

City: _____________________ State: _________ Zip: _______________

Telephone Number: ___________________________ E-mail ________________________

Relationship to Client: ______________________________

**Physician Information**

Physician Name: ______________________________

Street Address: _______________________________

City: ______________________ State: _________ Zip: ______________

Telephone Number: ___________________________ E-mail ________________________

Diagnosis/Special Needs or Condition: ______________________________________________

________________________________________________________________________________

____________________________________________________________________________

**Case Manager Information**

Case Manager Name: __________________________

Street Address: _______________________________

City: ____________________ State: _________ Zip: ______________

Telephone Number: ___________________________ E-mail ________________________

Information being changed: _______________________________________________________

Form Completed by: _____________________________________________________________

# DELUXE HOME HEALTH CARE AGENCY

## CHANGE OF MEDICAL HISTORY

**Client Name:** ____________________________ **Client Number:** ________________

**PRESENT HEALTH CONCERNS OR FUNCTIONAL LIMITATIONS:** _______________
________________________________________________________________________________
____________________________________________________________________________

**MEDICATIONS:** Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs:

____________________________________________ Dose: ______________ Time _______
____________________________________________ Dose: ______________ Time _______
____________________________________________ Dose: ______________ Time _______
____________________________________________ Dose: ______________ Time _______
____________________________________________ Dose: ______________ Time _______
____________________________________________ Dose: ______________ Time _______
____________________________________________ Dose: ______________ Time _______

**ALLERGIES or REACTIONS TO MEDICINES/FOODS/OTHER AGENTS:**

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________

**PERSONAL MEDICAL HISTORY:**
Please indicate whether you have had any of the following medical problems (with approximate date of illness or diagnosis). Hardly

____Congenital Heart disease:
*Specify type*__________________
____Myocardial Infarction (Heart Attack)
____Hypertension (High blood pressure)
____Diabetes
____High cholesterol
____Stroke
____Coagulation (bleeding/clotting)
____Cancer
Specify Type________________
____Thyroid problem
*Specify type*__________________

____Depression/suicide attempt
____Alcoholism
____ Have you ever had a blood transfusion
Other health problems or concerns
_____________________________________
_____________________________________
_____________________________________
_____________________________________
________________________

Special Diet _____________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

# DELUXE HOME HEALTH CARE AGENCY

## CONFLICT LOG

Client Name: ________________________________________________
Client Representative Name: ___________________________________
Staff Member Name: _________________________________________
Date Incident happened: ______________________________________

Conflict (please describe in detail):

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Resolution (lists all actions taken and staff members involved): ___________________________

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

________________________________________ ____________________
Client/Representative Signature Date

________________________________________ ____________________
Deluxe Home Health Care Agency Staff Signature Date

# DELUXE HOME HEALTH CARE AGENCY

| CLIENT RECORD CONTENTS | PRESENT |
|---|---|
| Welcome Letter | |
| Notice of Privacy Practice | |
| Additional Rights | |
| Written Notice of Consumer Rights | |
| Receipt of Notice of Privacy Practice | |
| Agency Disclosure Notice | |
| Client Information | |
| Medical History | |
| Client Contract (2pgs) | |
| Admission Agreement | |
| Advance Directives | |
| Complaint or Grievance Procedure | |
| Release of Liability | |
| Work Schedule Notice | |
| Background Check Notice | |
| Financial Agreement | |
| Admission Form | |
| Change of Personal Information | |
| Change of Medical Information | |
| Conflict Log Form | |

**I have been informed in language I understand, and have been given copies of all the documents listed above:**

_______________________________________ _____________________

Client/Representative Signature Date

________________________________________ _____________________

Deluxe Home Health Care Agency Staff Signature Date

4893 S. Himalaya Ct, Aurora CO 80015 Phone: 303-564-8086 Fax: 720-612-7661 E-mail: info@deluxehomehealth.com