METROPOLITAN
HOME HEALTH CARE

PATIENT SERVICE AGREEMENT

PATIENT NAME: _____ SS # _____

☐ **CONSENT FOR CARE**:
I authorize METROPOLITAN HEALTH CARE, Inc. to perform necessary treatments to facilitate proper health care in accordance with the orders of my physician. The nature and purpose of all treatments have been explained to me. I understand that I may refuse treatment within the confines of the law and will be informed of the consequences of my actions.

☐ **RELEASE OF INFORMATION**:
I authorize the release of medical and other information needed to determine these benefits to METROPOLITAN HOME HEALTH CARE, Inc. or Medicare / Public Aid, and/or other insurance and its agents. I authorize METROPOLITAN HOME HELATH CARE, Inc to disclose to, furnish a copy of, or permit bearer (agency employee) to view or copy clinical record information in connection with any past or present illness, treatment or prescription pertinent to my care. *I give authorization for a copy of this service agreement to be considered as effective and valid as the original.* If my care is transferred to another agency or facility, I authorize METROPOLITAN HOME HEALTH CARE, Inc. to increase all pertinent information related to my care to the new home health agency or facility.

☐ **FINANCIAL AGREEMENT/ASSIGNMENT OF BENEFITS**:
I request that my Medicare / Public Aid benefits be paid directly to METROPOLITAN HOME HEALTH CARE, Inc. on my behalf for services provided to me by or through METROPOLITAN HOME HEALTH CARE, Inc.. METROPOLITAN HEALTH CARE, Inc. agrees to accept the Medicare / Public Aid benefits as total payment and will not bill the patient for any services provided. To the best of my knowledge, all information given to my admission nurse, by me, regarding my source of payment is correct. *I agree to inform METROPOLITAN HOME HEALTH CARE, Inc. immediately if there are any changes in the above insurance information*. I understand that METROPOLITAN HOME HEALTH CARE, Inc. will forward all necessary information to my source of payment for billing purposes. I have been informed of my agency's charges and policies concerning payment for services, including, to the extent possible, insurance coverage and other methods of payment.
_____ I have received the Medicare explanation of Patient Fees for services and equipment. For transfer of care from another HH agency the other HH agency will no longer receive Medicare payment on my behalf and will no longer provide Medicare covered services to me after the date of the transfer.

☐ **PATIENT'S RIGHTS AND RESPONSIBILITIES**:
I have received a copy of the Patient's Bill of Rights and Responsibilities/Non discrimination form, which I have read. I understand both my responsibilities to my care and the agency's responsibility for my care. I understand that I will be discharged from the agency for verbal, physical and or mental abuse staff.

☐ **ADVANCE DIRECTIVES**:
I have received written and verbal notice of my right to complete an advance directive. I have been given the opportunity to ask questions when information was not clear.

- ☐ I do not choose to have an Advance Directive at this time.
- ☐ I will provide the agency a copy of my medical power of attorney.
- ☐ I will provide the agency a copy of my Living Will.

METROPOLITAN
HOME HEALTH CARE

☐ **PHOTOGRAPHIC RELEASE**:
I hereby give my permission for an agent of METROPOLITAN HOME HEALTH CARE, Inc. to take photographs as a supplement to my medical record. All photographs will remain with the clinical record and be considered confidential.

☐ **BILLING ALERT**:
This is to certify that no other home health agency is currently providing services for my care in order to avoid duplication of service and billing errors with my insurance.

☐ **FREQUENCY OF VISIT VERIFICATION**:
I have been given written verification of the type, frequency and duration of all disciplines that will participate in my plan of care.

☐ **PROVISION OF THERAPY AND MEDICAL SUPPLIES (FOR MEDICARE PATIENTS ONLY)**

- I have been instructed to inform the home health agency if I were receiving medical supplies from another DME supplier prior to this admission.
- I have been informed about the home health benefit under Medicare entitles me to receive therapy services and medical supplies as long as it is appropriate and complies with the criteria of a billable visit.
- I have been alerted to the possibility of payment liability if I were to obtain therapy services and medical supplies from anyone other than this agency.

☐ **TRANSLATOR/INTERPRETER AVAILABILITY**
I have received written and verbal notice of the translator/interpreter availability form to ensure adequate provisions and accessibility for meeting all communication needs.

☐ **HOME SAFETY**:
I have received, read and understand the Basic Home Safety Instructions given to me by my admission nurse.

☐ **HIPAA/PRIVACY ISSUES**
I have received a copy of the Notice of Privacy Practices regarding my health information. I have been made aware that I have the right upon request to review the Complete Policy regarding Privacy issues.

_____	_____
Patient or Guardian's Signature	Relationship if not patient
_____	_____
Reason patient is unable to sign	Date
_____	_____
RN Signature	Date

PATIENT'S BILL OF RIGHTS/RESPONSIBILITIES AND TRANSFER/DISCHARGE CRITERIA

Home care patients have a right to be notified in writing of their rights during the initial evaluation visit before initiation of care and to exercise those rights. The patient's family or guardian may exercise the patient's rights when the patient is incapacitated. Home care providers have an obligation to protect and promote the patient's rights, including the following:

Patients have a Right to Dignity and Respect

Home care patients and their formal caregivers have a right to not be discriminated against based on race, color, religion, national origin, age, sex, sexual preference or handicap. Furthermore, patients and care givers have a right to mutual respect and dignity, including respect for property. Agency staff is prohibited from accepting personal gifts and borrowing money or items from patients.

As a Patient of Metropolitan Home Health Care, Inc. you have the right:

- To be advised of the telephone number and hours of operation of the state's Home Health Agency hotline, that receives complaints or questions about local home care agencies. The hours are 24 hours a day, seven (7) days a week and the telephone number is 800-252-4343. The hotline also receives complaints about advance directives.
- To refuse to participate in investigational, experimental, research, or clinical trials.
- To be informed of rights under state law to make decisions concerning medical care, including the right to accept or refuse treatment and the right to formulate advance directives.
- To be informed of policies and procedures for implementing advance directives, including any limitations if the Agency cannot implement an advance directive based on conscience.
- To receive care without condition on, or discrimination based on, the execution of advance directives.
- To have access upon request to all bills for service the patient has received, regardless of whether the bills are paid out-of-pocket or by another party.
- To be admitted by the Agency only if it has the resources needed to provide the care safely and at the required level of intensity, as determined by a professional assessment. The Agency with less than optimal resources may nevertheless admit the patient if a more appropriate provider is not available. But only after fully informing the patient of the Agency's limitations and the lack of suitable alternative arrangements.
- To effective pain management.
- Be informed of his/her rights.
- Exercise rights at any time.
- Have his/her property and person treated with respect.
- Be free from neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and/or misappropriation of patient property by anyone furnishing services on behalf of the Agency.
- Make complaints to the Agency regarding treatment or care that is (or fails to be) furnished, and the lack of respect for property and/or person by anyone who is furnishing services on behalf of the Agency.
- Voice and report grievances or complaints regarding treatment or care that are (or fail to be) delivered, the lack of respect for property and/or person/ or the violation of any rights to the Agency, and state of local agencies.

- Receive all services in the plan of care.
- Have a confidential patient record and access to or release of patient information and records in accordance with Health Insurance Portability and Accountability Act (HIPPA) law and regulation.
- Be advised of the extent to which payment for services may be expected from Medicare, Medicaid or any other federally funded or federal aid program known to the Agency.
- Be advised of the charges for services that may not be covered by Medicare, Medicaid or any other federally funded or federal aid program known to the Agency.
- Be advised of the charges the individual may have to pay before care is imitated.
- Be advised of any changes in the information provided with respect to payment and charges, if they occur. The patient and representative (if any) are advised of these changes as soon as possible, in advance of the next home visit.
- Receive proper written notice, in advance of a specific service being furnished, if the Agency believes that the service may be non-covered care or in advance of the Agency reducing or terminating on-going care. Agency will also comply with the federal requirements.
- Be advised of the names, addresses and telephone numbers of the following federally funded and state-funded entities that serve the area where the patient resides:
    - Agency on Aging 630-293-5990
    - Center for Independent Living 217-744-7777
    - Protection and Advocacy Agency 800-252-8966
    - Aging and Disability Resource Center 800-322-1051
    - Quality Improvement Organization 800-383-2856
- Be free from any discrimination or reprisal for exercising his/her rights or for voicing grievances to the Agency or an outside entity.
- Be informed of the right to access auxiliary aids and language services and how to access these services.
- Participate in, be informed about and consent or refuse care in advance of and during treatment, where appropriate, with respect to:
    - Completion of all assessments.
    - The care to be furnished based on the comprehensive assessment.
    - Establishing and revising the plan of care.
    - The disciplines that will furnish the care.
    - The frequency of visits.
    - Expected outcomes of care, including patient-identified goals and anticipated risks and benefits.
    - Any factors that could impact treatment effectiveness.
    - Any changes in the care to be furnished.
- To be informed of the patient's rights in a language and manner the individual understands. The Agency must protect and promote the exercise of these rights. The Agency will provide verbal notice of the patient's rights and responsibilities in the individual's primary or preferred language and in a manner the individual understands, free of charge, with the use of a competent interpreter, if necessary, no later than the completion of the second visit from a skilled professional.
- The following information during the initial evaluation visit, in advance of furnishing care to the patient:
    - Written notice of the patient's rights and responsibilities and Agency's transfer and discharge policies. Written notice will be understandable to persons who have limited English proficiency and accessible to individuals with disabilities.

  - Contact information for the Agency Administrator, including the Administrator's name, business address and business phone number in order to receive complaints.
  - An OASIS privacy notice to all patients for whom the OASIS date is collected.
- Receive written notice of the patient's rights and responsibilities and the Agency's discharge policies to a patient-selected representative within 4 business days of the initial evaluation visit.
- If a patient has been adjudged to lack legal capacity to make health care decisions as established by state law by a court of proper jurisdiction, the rights of the patient may be exercised by the person appointed by the state court to act on the patient's behalf.
- If a state court has not adjudged a patient to lack legal capacity to make health care decisions as defined by state law, the patient's representative may exercise the patient's rights.
- If a patient has been adjudged to lack legal capacity to make health care decisions under state law by a court of proper jurisdiction, the patient may exercise his/her rights to the extent allowed by court order.
- To have complaints investigated. The Agency will investigate complaints made by a patient, the patient's representative (if any) and the patient's caregivers and family, including, but not limited to, the following topics:
  - Treatment or care that is (or fails to be) furnished inconsistently or is furnished inappropriately.
  - Mistreatment, neglect or verbal, mental, sexual and physical abuse, including injuries of unknown source and/or misappropriation of patient's property by anyone furnishing services on behalf of the Agency.
  - Document both the existence of the complaint and the resolution of the complaint.
  - Take action to prevent further potential violations, including retaliation, while the complaint is being investigated.
- To know that any Agency staff (whether employed directly or under arrangement) in the course of providing services to patient, who identifies, notices or recognizes incidences or circumstances of mistreatment, neglect, verbal, mental, sexual and/or physical abuse, including injuries of unknown source or misappropriation of patient property, must report these findings immediately to the Agency and other appropriate authorities in accordance with state law.
- To be informed of:
  - Visit schedule and frequency.
  - Patient medication schedule/instructions.
  - Treatments to be administered by Agency staff.
  - Other pertinent instructions related to care.
  - Name of Clinical Manager_____and contact information_____.
  - Have the patient's or legal representative's sign confirming that he/she has received a copy of the notice of rights and responsibilities.

Agency Transfer Criteria

Patients will be transferred from Agency based on Agency Transfer Criteria Policy:

- Transfer is necessary for the patient's welfare because the Agency and the physician who is responsible for the home health plan of care agree the Agency can no longer meet the patient's needs, based on the patient's acuity. The Agency will arrange a safe and appropriate transfer to other care entities when the needs of the patient exceed the Agency's capabilities.
- The patient or payer will no longer pay for the services provided by the Agency.

- The transfer is appropriate because the physician who is responsible for the home health plan of care and the Agency agree that measurable outcomes and goals set forth in the plan of care have been achieved and the Agency and physician responsible for the home health plan of care agree the patient no longer needs the Agency's services.
- Patient refuses services or elects to be transferred.
- Agency ceases operation.
- Patient/family requests transfer.
- Patient has moved out of service area.

Agency Discharge Criteria

Patient will be discharged from Agency based on Agency Discharge Criteria Policy:

- Discharge is necessary for the patient's welfare because the Agency and the physician who is responsible for the home health plan of care agree that the Agency can no longer meet the patient's needs, based on the patient's acuity. The Agency will arrange a safe and appropriate discharge to other care entities when the needs of the patient exceed the Agency's capabilities.
- The patient or payer will no longer pay for the services provided by the Agency.
- The discharge is appropriate because the physician who is responsible for the home health plan of care and the Agency agree that measurable outcomes and goals set forth in the plan of care have been achieved and the Agency and physician responsible for the home health plan of care agree that the patient no longer needs the Agency's services.
- Patient refuses services or elects to be discharged.
- Agency ceases operation.
- Patient/family requests discharge.
- The patient's (or other persons in the patient's home) behavior is disruptive, abusive or uncooperative to the extent that delivery of care to the patient or the ability of the Agency to operate effectively is seriously impaired. The Agency will do the following before it discharges a patient for cause:
    - Advise the patient, representative (if any), the physician(s) issuing orders for the home health plan of care and the patient's primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the Agency (if any) that a discharge for cause if being considered.
    - Make efforts to resolve the problem(s) presented by the patient's behavior, the behavior of other persons in the patient's home or situation.
    - Provide the patient and representative (if any), with contact information for other agencies or providers who may be able to provide care.
    - Document the problem(s) and efforts made to resolve the problem(s) and enter this documentation into its clinical record.
- Patient dies.
- Patient moves out of service area.
- Services can no longer be provided safely and/or effectively in the patient's place of residence (patient's physician will be consulted for alternative follow up care and/or referral).
- Patient refuses to follow physician's prescribed plan of care/treatment (physician will be notified).
- Physician orders discharge of patient from service.
- Patient is no longer homebound.

Patient Responsibility

As a Patient of Metropolitan Home Health Care, Inc. you have the responsibility to:

- Notify the Agency of any perceived risks in you care or unexpected changes in you condition, e.g., hospitalization, changes in the plan of care, symptoms to be reported, etc.
- Notify the Agency if the visit schedule needs to be changed.
- Notify the Agency of the existence of, and any changes made to, advance directives.
- Notify the Agency of any problems or dissatisfactions with the services provided.
- Provide a safe environment for care.
- Follow instructions and express any concerns you have about your ability to follow and comply with proposed plan of course of treatment. The Agency will make every effort to adapt the plan to your specific needs and limitations. If such changes are not recommended, the Agency will inform you of the consequences of care alternatives.
- Provide accurate and complete information about present complaints, past illnesses, hospitalization, medications and other matters related to the patient's health.
- Know that in the event of an emergency that disrupts Agency's services to patient, that Agency will make every effort to visit or telephone patient. However, if patient has a medical emergency and is not able to contact the Agency, the patient should access the nearest emergency medical facility. Ask questions about care or services when you do not understand your care or what you are expected to do.
- Provide feedback about service needs or expectations.
- Follow Agency rules and regulations concerning patient care and conduct.
- Show respect and consideration for Agency's personnel and property.
- Meet financial commitments agreed upon with the Agency promptly.
- Understand and accept consequences for the outcomes if the care and services or treatment plans are not followed

I acknowledge that I have received a copy of the notice of Rights/Responsibilities and Transfer/Discharge Criteria.

_____ _____

Patient Signature/Date Representative Signature/Date

_____

Agency Representative/Date

METROPOLITAN HOME HEALTH CARE

Individual Patient Emergency Preparedness Plan

Identifying Information

Patient Name:_____ SOC Date:_____
Phone Number:_____Physician:_____
Address:_____
City:_____ State:_____ Zip:_____

Relevant Healthcare Information

Primary Dx:_____ Secondary Dx:_____
Daily or more frequently Agency Services: No_____ Yes_____
If yes, describe:_____
Oxygen dependent: Flow Rate_____ Hours of Use:_____ Delivery Device:_____
Life Sustaining Infusion: No_____ Yes_____
If yes, describe:_____
Other IV Therapy: No_____ Yes_____
If yes, describe:_____
Patient/caregiver Independent: No_____ Yes_____
Ventilator Dependent: No_____ Yes_____
Dialysis: No_____ Yes_____
If yes, describe:_____
Tube Feeding: No_____ Yes_____
If yes, describe:_____
Patient/caregiver Independent with Self-Administered Medications: No_____ Yes_____
Functional Disabilities (check all that apply): _____ Walker/Cane _____ Wheelchair _____Bedbound
_____Hearing Impairment _____Visual Impairment _____Mental/Cognitive Impairment

Emergency Plan

Emergency Contact Name:_____ Phone Number:_____
If necessary, patient will evacuate to: Relative / Friend
(Name/Phone Number):_____
Hotel (Name/Phone Number):_____
Shelter (Location):_____
Is patient registered for special needs shelter? No_____ Yes_____
Other (Describe):_____

Priority/Acuity Level:_____

_____

Clinician/Date

*Copy to patient and original on medical record.

METROPOLITAN HOME HEALTH CARE

212 S Milwaukee Ave. Ste G
Wheeling, IL 60090

Tel: (847) 568-1033
Fax: (847) 568-1034
Email: metro@emetrocare.com
http:/www.emetrocare.com

MEDICATION PROFILE

Patient Name: _____
Physician: _____
Allergy: _____
DX: _____

Pharmacy: _____
Address: _____
Phone: _____
HT: _____ WT: _____

Start Date	C/N	Medication	Dose/Route	Frequency	Purpose	C/DC Date

Date Reviewed/ Clinician Signature

METROPOLITAN HOME HEALTH CARE

212 S Milwaukee Ave. Ste G Wheeling, IL 60090

INFLUENZA / PNEUMONIA VACCINE QUESTIONNAIRE

Patient Name: _____ Date: _____

INFLUENZA VACCINE

Are you interested in receiving the Influenza Vaccine?

☐YES ☐NO

_____ Age 65 years and older
_____ Age 50-64 with 1 or more medical condition
_____ Personal preference
_____ Other _____

_____ Recently had a flu shot DATE: _____
_____ Allergic to eggs
_____ Reaction to flu shot in the past
_____ Personal preference

If you answered **YES**, please choose one of the following implementations:

☐Influenza vaccine to be administered by Agency visiting nurse
☐Patient referred to visiting physician **OR** to the primary care physician
☐Patient referred to local health department or other community location where the vaccine is available
☐Arranged for the local health department or other private or community health organization to provide the vaccination in the patient's home

PNEUMONIA VACCINE

Are you interested in receiving the Pneumonia Vaccine?

☐YES ☐ NO

_____ Age 65 years and older
_____ Has chronic health problem (heart disease, lung disease, sickle cell disease, diabetes)
_____ Personal preference

_____ Received pneumonia vaccine in the past
Date received: _____
_____ Personal preference

If you answered **YES**, please choose one of the following implementations:

☐ Pneumonia vaccine to be administered by Agency visiting nurse
☐ Patient referred to visiting physician **OR** to the primary care physician
☐ Patient referred to local health department or other community location where the vaccine is available
☐ Arranged for the local health department or other private or community health organization to provide the vaccination in the patient's home

VACCINE ADMINISTRATION

☐ Influenza ☐ Pneumonia Date: _____

Site: _____ Manufacturer/Lot# _____ Expiry: _____

_____ Nurse Signature

_____ Patient Signature

OUTCOME FOLLOW-UP

☐ Influenza ☐ Pneumonia Date: _____

Any Vaccine related reaction? ☐ YES ☐ NO

Comment: _____

_____

_____ Nurse Signature

_____ Patient Signature

Patient Name: _____

Date: _____

The Norton Pressure Sore Risk-Assessment Scale Scoring System

The **Norton Scoring system**, shown below, and created in England in 1962, has been the first pressure sore risk evaluation scale to be created, back in 1962, and for this it is now criticized in the wake of the results of modern research. Its ease of use, however, makes it still widely used today.

To evaluate the Norton Rating for a certain patient look at the tables below and add up the values beside each parameter which apply to the patient. The total sum is the Norton Rating (NR) for that patient and may vary from 20 (minimum risk) to 5 (maximum risk).

(Indicatively, a Norton Rating below 9 means Very High Risk, 10 to 13 means High Risk, 14 to 17 medium risk and above 18 means low risk)

Physical Condition	Good	4
	Fair	3
	Poor	2
	Very Bad	1
Mental Condition	Alert	4
	Apathetic	3
	Confused	2
	Stuporous	1
Activity	Ambulant	4
	Walks with help	3
	Chairbound	2
	Bedfast	1
Mobility	Full	4
	Slightly Impaired	3
	Very Limited	2
	Immobile	1
Incontinence	None	4
	Occasional	3
	Usually Urinary	2
	Urinary and Fecal	1

Generally, the risk factor is coded this way:

Greater than 18	Low Risk
Between 18 and 14	Medium risk
Between 14 and 10	High Risk
Lesser than 10	Very High Risk

Another rating system getting more and more popularity is the **Braden Scale**, created in the USA, more recent and precise than the Norton scale, which evaluates factors such as sensory perception, skin wetness, nutrition and such.

Nurse Signature: _____ Date: _____

212 S Milwaukee Ave. Ste G Wheeling, IL 60090
(847) 568-1033 | Fax: (847) 568-1034

BENEFICIARY-ELECTED TRANSFER

I understand that my previous Home Health Agency _____ located at _____ will no longer:

- Provide home health services to me after today's date.
- Receive any payment from any health insurance on my behalf.

I also understand that I am now electing transfer to Metropolitan Home Health Care, Inc. to provide home health services effective immediately.

_____ _____

Patient Signature Date

_____ _____

Witness Date

METROPOLITAN
HOME HEALTH CARE

212 S Milwaukee Ave. Ste G Wheeling, IL 60090

HMO NOTICE

IF YOU JOIN A HEALTH MAINTENANCE ORGANIZATION (HMO), YOU MUST NOTIFY OUR OFFICE IMMEDIATELY.

An HMO administrates your Medicare health benefits and designates which home health agency *must* use along with the Physician and Hospital.

If we are not notified of your enrollment in an HMO or that you are currently enrolled, you will be billed for all visits made because Medicare will no longer pay Metropolitan Home Health Care, Inc.

It is your responsibility to call us at 847-568-1033 to notify us of the date you enrollment in the HMO takes place. If you are enrolled in an HMO, it takes 30 days to withdraw.

If you have any questions, do not hesitate to call our office at 847-568-1033.

The above information has been explained to me.

Patient's Signature:_____ Date:_____

Witness:_____ Date:_____

Patient's Name:_____

METROPOLITAN HOME HEALTH CARE

212 S Milwaukee Ave. Ste G Wheeling, IL 60090

Medicare Secondary Payer Screening Form

Please answer the following questions. Thank you for your cooperation.

	Circle One	
1. Is this illness/injury covered by Worker's Compensation? If yes, note employer's name, address, and claim number in section 10.	Yes	No
2. Are you or your spouse actively employed? If yes, enter group health insurance information in section 10.	Yes	No
3. Is this illness covered under the Federal Bank Lung Program? If yes, note where bill should be sent in section 10.	Yes	No
4. Is this illness/injury due to an auto accident?	Yes	No
5. Are you entitled to Medicare solely on the basis of End Stage Renal Disease? If yes, please answer question number 6.	Yes	No
6. Have you completed the End Stage Renal Disease coordination period?	Yes	No
7. Are you entitled to Medicare due to disability? If yes, complete section 8.	Yes	No
8. Are you covered by a group health plan? If yes, enter insurance information in section 10.	Yes	No
9. Are you or your spouse retired? If yes, indicate retirement date. Patient_____Spouse_____	Yes	No

10. Name of Insurance Company_____
    Insured Name_____
    Policy Number_____
    Employer_____

Patient Signature:_____ Date:_____

Medicare Number:_____

METROPOLITAN HOME HEALTH CARE

Patient Advance Directives Statement

I understand that an advance directive includes:

- A living will.
- Durable power of attorney for health are.
- Any other written document executed by the patient, signed and dated that expresses the patient's health care treatment decisions.

I understand that additional information is included in my home health folder.

I understand that the Agency will honor all of my advance directives.

☐ I would like more information regarding advance directives.

☐ I would like to execute one or more advance directives.

☐ I have a living will: Yes_____ No_____
If Yes, copy obtained? Yes_____ No_____
If No, describe patient's wishes:_____
_____
_____
_____

☐ I have a durable power of attorney: Yes_____ No_____
If Yes, Name:_____ Telephone:_____

☐ I have an advance directive: Yes_____ No_____
If Yes, copy obtained? Yes_____ No_____
If No, describe patient's wishes:_____
_____
_____
_____

I have reviewed and understand my Bill of Rights/Responsibilities as described above and have been given written information concerning advance directives and my rights and responsibilities.

_____ _____
Patient Signature Witness Signature

_____ _____
Date Date

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www.emetrocare.com

Notice of Medicare Non-Coverage

Patient name: _____ **Patient number:** _____

The Effective Date Coverage of Your Current Home Health

Services Will End: _____

- Your Medicare provider and/or health plan have determined that Medicare probably will not pay for your current home health services after the effective date indicated above.
- You may have to pay for any services you receive after the above date.

Your Right to Appeal This Decision

- You have the right to an immediate, independent medical review (appeal) of the decision to end Medicare coverage of these services. Your services will continue during the appeal.
- If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
- If you choose to appeal, you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should not continue. You will receive this detailed notice only after you request an appeal.
- If you choose to appeal, and the independent reviewer agrees services should no longer be covered after the effective date indicated above;
    - "Neither Medicare nor your plan will pay for these services after that date.
- If you stop services no later than the effective date indicated above, you will avoid financial liability.

How to Ask For an Immediate Appeal

- You must make your request to your Quality Improvement Organization (also known as a QIO). A QIC is the independent reviewer authorized by Medicare to review the decision to end these services.
- Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above.
- The QIO will notify you of its decision as soon as possible, generally no later than two days after the effective date of this notice if you are in Original Medicare. If you are in a Medicare health plan, the QIO generally will notify you of its decision by the effective date of this notice.
- Call your QIO at: **1-800-647-8089** to appeal, or if you have questions.

See page 2 of this notice for more information.

If You Miss The Deadline to Request An Immediate Appeal, You May Have Other Appeal Rights:

- If you have Original Medicare: Call the QIO listed on page 1.
- If you belong to a Medicare health plan: Call your plan at the number given below.

Plan contact information: _____

_____

Additional Information (Optional):

Please sign below to indicate you received and understood this notice.

I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO.

_____ _____

Signature of Patient or Representative Date