ORIGIN

License # 299993096 Home Health Care

ADMISSION PACKAGE /FORMAS DE ADMISIÓN

CLIENT INFORMATION HANDBOOK

Nurse / Enfermera: _____

Physical Therapist/ Terapista: _____

Occupational Therapist/ Terapista: _____

Physician/doctor: _____

ALLERGIES / ALERGIAS

CONFIDENTIAL

To report concerns/complaints or if you have questions you may contact/Para reporter quejas o preguntas llamar a:

Director of Nursing, Clinical Manager/Director de Enfermería, Gerente Clínico: Norma Meza-Duarte, RN
Administrator/Administrador: Maria Claudia Caraco, RN

441 Apollo Beach Blvd. Apollo Beach, FL 33572

Office: **813-641-0500** Fax: **844-718-0076**

CHAP EST. 1965

www.originhomehealth.com

Hello,

Welcome to Origin Home Health. It is our honor to be able to serve you during your period of recuperation. This home manual includes information about our agency and resources you can use to optimize your recovery. If you have any questions or need further expansion of the contents of this booklet, you can reach us Monday through Friday from 8 am to 5 pm. We also have an on-call service available during non-business hours, which will relay messages to our staff and address all immediate concerns. Thank you for becoming a part of the Origin Family!

AGENCY INFO

Genesis HealthCare, doing business as Origin Home Health, has been serving the community since 2007. Origin is committed to providing quality care that encourages the safe and cost-effective delivery of home health services, maximizing patient autonomy, and coordinating community and agency resources to decrease illness burden and unnecessary duplication of services, promoting positive patient outcomes. Patient care is tailored to meet each patient's individualized needs best. In addition, Origin provides one-on-one combining the benefits of nursing, physical therapy, occupational therapy, and speech therapy, as well as medical-social services through an interdisciplinary approach as ordered by your physician.

Origin's commitment to serving its community has made it a preferred provider for many health plans in Florida.

OUR MISSION STATEMENT

Origin is committed to providing a level of quality care that encourages the safe and cost-effective delivery of home health services, maximizing patient autonomy, and coordination of community and agency resources to decrease illness burden and unnecessary duplication of services thereby promoting positive outcomes.

Our professional staff are on call 24 hours a day, 7 days a week. Personnel respond to the needs of patients in accordance with organizational policy and patient needs to make certain you are provided with outstanding care when you need it. Our professionals administer care from your initial recovery to completion of care. All staff is CPR trained, certified and if needed can initiate CPR unless your advance directive is a DNR.

CONSENT/AGREEMENT/AUTHORIZATION/ ACKNOWLEDGEMENT

Patient Name (Last, First, MI): _____ MR #: _____

SOC Date: _____ Referral Source Date: _____

Consent To Receive Services

I, _____, hereby consent and authorize _____ (Agency Name), its agents, and associates to provide care and treatment to me in my home as prescribed by my physician and per program policy. I understand that I must have an attending physician for the duration of this agreement. I have received an explanation of the services to be provided (including disciplines, proposed frequency of visits and anticipated outcomes). I understand that I and/or my caregiver will participate in developing the Plan of Care. I recognize that I have the right to refuse treatment or terminate services at any time by notifying the agency office. Also, the agency may terminate service by notifying me of termination and reason.

I believe my services to be: _____

Authorization For Payment To Provider

I certify that information given by me in applying for payment under title XVIII or title XIX of the Social Security Act (SSA), or other third party pay, or coverage, is correct. I authorize any holder of medical or other information about me to be released to the SSA or its intermediaries, or other third-party payers any information needed for this or other related claims. I request that payment, as authorized, be made on my behalf to the agency. This authorization and request shall apply to the certification period starting _____, 20 ___ until the order is discontinued by my physician.

Charge For Services

Your initial services from the agency will include the following services, initial frequency of visits and charge per visit, if private insurance or private pay.

Payer for services: _____

Service	Frequency & Duration	Charge Per Visit	Payor Source Liability	Patient Liability
Skilled Nursing		75		0%
Physical Therapy		75	100%	0%
Home Health Aide		75	100%	0%
Occupational Therapy		75	100%	0%
Medical Social Worker		75	100%	0%
Other		75	100%	0%

Liability for Payment

I understand and agree to pay deductibles, co-payments, spend downs and any amount due after payment of benefits on my behalf by any and all third-party payers.

I verify that ☒ **I am** ☐ **I am not** a participating member of an HMO (Health Maintenance Organization). If I enroll in one, I will immediately notify the organization.

I understand that services provided to me by this organization will be billed as follows:

- ☐ Medicare fee for service (Project 100% covered).
- ☐ Medicaid (Project 100% covered after meeting spend down and/or other requirements.)
- ☐ Insurance (Coverage varies with individual policy. The patient's anticipated payment amounts per visit will be provided in writing when the insurance company informs the organization of the patient's financial liability. See organization's separate Visit Rate information. When known at time of Admission: Project _____% of charges to be covered after deductible met. (**Specify amounts** _____).
- ☐ Private Pay (See separate Private Pay Rate Sheet. Patient is responsible for the timely payment of all charges.)

Confidentiality

It is our policy to protect all clinical records against loss, defacement, tampering and use by unauthorized person(s). All patient identifiable information in the clinical record, including OASIS data, remains confidential and is not released to the public. OASIS data will be electronically

transmitted to the state. The patient's written consent is required for the release of medical information to persons not otherwise authorized by law (federal and state) to receive this information. Authorized persons who may review the clinical record include surveyors, physicians, Centers for Medicare, and Medicaid Services (CMS), and external and internal auditing personnel.

Assignment of Benefits

I request that payment of authorized benefits be made on my behalf directly to the organization. In consideration of any services rendered, I hereby assign and transfer, to the agency, any benefits payable to, or for my benefit under, the rules and regulations prescribed by Medicare. I agree to cooperate, aid, and assist the agency in the process of billing Medicare for these services. I certify that no other home health agency is currently providing home healthcare and understand that misrepresentation of this fact shall cause me to be liable financially for care, rendered by the agency. If home health services were provided by another home health agency in the past, I have requested discharge from those services, prior to my start of care date with this agency.

Acknowledgement of Information

I have received a copy of the Patient Handbook from the agency which explains to me the services under the Medicare and Health Benefit including routine intermittent visits. I have also received verbal and written information in the handbook on the following:

- Advanced Directives information regarding this topic and a copy of the agency policy on respecting my rights under the Patient Self Determination Act of 1990 and state law. In addition, I understand that the organization's policy is to respect individual choice and to avoid discrimination based on whether or not you have an Advance Directive or a Do Not Resuscitate (DNR) directive.
- Patients' Rights and Responsibilities. This also includes information about how to use the organization's complaint process and the state's toll-free hotline.
- Statement of Patient Privacy Rights and Privacy Act Statement-Health Care Records for Medicare and Medicaid patients, and/or Notice about Privacy for patients who do not have Medicare and Medicaid.
- Receipt of Notice of Privacy Practices/HIPAA and OASIS Privacy Notice contained in the Patient Handbook.
- Basic Home Safety.
- Emergency Planning for disaster planning and information related to disruption in service in the event of a disaster.

- Infection Control & Hand-Washing Techniques and Disposal of Biomedical waste
- Discharge & Transfer Policy
- Service Outline
- Emergency contact information
- Non-discrimination policies
- Abuse, Neglect, and Exploitation which lists the abuse & state hotline numbers
- Medication information, if appliable

I UNDERSTAND that the agency will notify me, and my representative (if any), in writing and orally, as soon as possible, in advance of the next home health visit, of charges not covered by Medicare or other sources.

I REALIZE that the agency reserves the right to substitute employees at its discretion and to make supervisory visits of staff as deemed needed. Every effort will be made to provide a caregiver; however, the agency cannot guarantee scheduling. The agency staff may not be present in my house, at all times, and I, my caregiver, or legal guardian will assume responsibility for my care when agency staff is not present.

I UNDERSTAND The agency makes an effort to provide uninterrupted services; however, sometimes interruptions are unavoidable due to inclement weather or natural disasters. During the interruption of essential services, I agree to provide or arrange for backup care. If I cannot provide care, I understand that the agency may assist in arranging for transfer to an appropriate emergency facility.

I UNDERSTAND that, in the event of an emergency, during which, the agency cannot meet my needs, the agency can transfer me to another agency that can provide the care I require.

I HAVE BEEN INFORMED of my rights and that I may file complaints, about the agency, with the Home Health Hotline during regular business hours. After hours/ holiday calls will be answered by machine and responded to the next business day.

I UNDERSTAND that the agency does not routinely perform drug testing on its employees. If they choose to do so, it will be at their discretion using urine samples.

I UNDERSTAND that If I choose to hire a current agency employee (or former employee who has rendered services for me in the past 12 months) The agency will charge a fee of 30% of full time (2080) hours at the employee's bill rate. After 12 months, the fee is 15%. After 18 months it is 12% and after 24 months it is 10%.

I UNDERSTAND that the agency is the employer of the home care worker and is responsible for all state and federal regulations regarding employment. The agency conducts a criminal background check on all employees, including fingerprinting, and reference checks. The agency is responsible for payment of wages, withholding of payroll taxes, payment of unemployment insurance, worker's compensation, and time off. The supervisor is responsible for supervision of the employee, assignment of duties, and oversight of care provided. All disciplinary action is handled by the agency.

I HAVE BEEN INFORMED of the agency's policies for resuscitation, medical emergencies, and accessing 911 services (EMS).

RELEASE OF RECORDS I understand the agency policy in regard to confidentiality and release of records prohibits access to my records by persons other than personnel involved in care. I therefore give written consent for release of medical records to health care providers in my treatment care.

I AUTHORIZE the agency to release any medical information requested by representatives of local, state, or federal agencies, accrediting bodies, insurance companies, or other organizations or entities as may be required for payment of claims to the agency which are due.

Advanced Directive

I certify that I have read and received a copy of the Client Rights and Advance Directives information specific for the state and that I am the consumer, or am acting in the consumer's behalf, to accept their terms.

- ☐ I have prepared an advance directive regarding my healthcare and will provide a copy to the agency.
- ☒ I have not prepared an advance directive and do not wish to at this time regarding my health care.
- ☐ I have not prepared an advance directive but wish to make an advance directive at this time.

Permission to Photograph

Photography may be needed to assist in the patient's care. For example, the nurse may need a picture of a wound or rash to assist the physician in the treatment plan. Permission is hereby granted to allow photography for the purpose of medical care.

☒ **I do** OR ☐ **I do NOT** allow photography.

Authorization

☐ **I do** OR☒ **I do NOT** authorize the agency to access to my personal funds in order to pay for services it provides to me. _____ **Client Initials**

☐ **I do** OR☒ **I do NOT** authorize the agency to use my personal vehicle in order to provide services to me. _____ **Client Initials**

This **Admission Agreement** is applicable to admission into this agency, and I authorize the Medicare Benefit and/or services to begin. I have read the information, and listened to what was explained to me, and agree to the terms and conditions as above and understand my right to make my healthcare decisions.

I agree to provide information regarding the physical, emotional, and psycho-social information on an ongoing basis to ensure optimal care and have participated in the development of the plan of care. I understand the reason for the services and agree with the plan of care.

I recognize that I have the right to refuse treatment or terminate services at any time by notifying the agency's office. Also, the agency may terminate service by notifying me of termination and reason without penalty.

Signatures

Patient Or Authorized Agent Signature	Relationship To Patient	Date
Agency Representative Signature	Title	Date

☐ Patient unable to sign due to cognitive impairment/or disease process.

BILL OF RIGHTS

Patient Name: _____

Patient Rights

Patients have certain rights when receiving home health care, including:

1. The right to receive care in a safe and clean environment, that is respectful of their cultural, linguistic, and personal needs.
2. The right to be informed about initiation of care in accordance with state law and regulation.
3. The right to receive care that is appropriate to their condition and that is provided in a timely manner.
4. The right to receive information about their care and treatment in a way they can understand.
5. The right to be involved in decisions about their care and treatment.
6. The right to ask a home health staff member to present a badge.
7. The right to ask a home health staff to wear masks or other PPE.
8. The right to receive care that is provided by qualified and competent staff.
9. The right to receive care that respects their privacy and confidentiality.
10. The right to receive care that is provided in a manner that preserves their dignity and autonomy.
11. The right to receive care that is provided in a manner that promotes their independence.
12. The right to receive care that is provided in a manner that promotes continuity of care.
13. The right to voice complaints, grievances, and appeals about the care and services received without fear of retaliation.
14. The right to receive information about the home health agency's grievance procedure.
15. The right to have their property treated with respect.
16. The right to deny any service.
17. The right to request a discharge at any time, for any reason.

Patient Responsibilities

When receiving home health care, patients have certain responsibilities to ensure that they receive the best possible care and to promote their own health and well-being. These responsibilities may include:

1. Following the care plan: Patients are responsible for following the care plan provided by their healthcare provider and home health agency. This may include taking medications as prescribed, following instructions for wound care, and participating in physical therapy or other therapies.
2. Communicating with the healthcare team: Patients are responsible for communicating with their healthcare team, including home health staff, their doctor, and any other healthcare providers involved in their care. This includes reporting any changes in their condition or any side effects from medications.
3. Taking care of themselves: Patients are responsible for taking care of themselves and managing their condition, as much as possible. This may include following a healthy diet, getting enough exercise, and managing any chronic conditions, such as diabetes or heart disease.
4. Following safety guidelines: Patients are responsible for following safety guidelines provided by their healthcare team, such as keeping walkways clear of tripping hazards and using assistive devices, as needed.
5. Keeping appointments: Patients are responsible for keeping appointments with their healthcare team and any other appointments, such as lab tests or follow-up visits.
6. Following up with care team: Patients should follow up with their care team regularly, to ensure that their care plan is working as intended and to make any necessary adjustments.
7. Participating in patient education: Patients should participate in patient education, to learn how to manage their condition and how to prevent complications.

By following these responsibilities, patients can help to ensure that they receive the best possible care and can promote their own health and well-being. It's important for the patient and their family to be informed about their responsibilities before starting home health care services.

Signature _____ Date _____

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Home Health Care

EMERGENCY DISASTER FORM

Client Name: _____ Date of Birth: _____ Age: _____

Date: _____ MR #: _____

Address: _____

Caregiver Name: _____ Phone #: _____

Primary Language: _____

Pharmacy: _____ Doctor: _____

Emergency Contact: _____

Relationship: _____ Phone #: _____

Mental Status: ☒ Oriented ☐ Disoriented ☐ Dementia ☐ Forgetful ☒ Alert ☐ Alzheimer

CLIENT EMERGENCY CLASSIFICATION:

- ☐ Level I: Life threatening condition requiring ongoing medical treatment or a medical device to sustain life
- ☒ Level II: Greatest need for care that will be seen as soon as possible (Daily insulin injections, IV medications, sterile wound care with large amount of drainage
- ☐ Level III: Services could be postponed 24-48 hours. without adverse effects. (Diabetic who can self-inject, sterile wound care with minimal drainage.)
- ☐ Level IV: Services could be postponed 72-96 hours without adverse effects. (Postoperative with no wound, routine catheter changes, discharge within 10-14 days)

Client Signature: _____

Allergies: _____ Stay Home: [X] Evacuate to: _____

Clinician Print Name & Title: _____

Clinician Signature & Date: _____

Patient Consent Form for Data Collection

This consent form authorizes Origin Home Health Care and its affiliated clinicians to capture audio recordings and collect observational data during home health assessments. The purpose of these recordings and observations is to improve the quality of care, support training initiatives, and assist in product development for enhancing clinician and staff workflows. Your privacy and confidentiality are of utmost importance to us.

The recordings and data collected will be used for the purpose of quality and training of healthcare professionals and the development and improvement of healthcare technology. During the assessment, audio recordings of your interactions with the clinician and observational notes made by the clinician regarding your health status.

All information recorded during this assessment, including audio recordings, will be treated as confidential and handled in a way that ensures the privacy of your health information. No identifiable information will be shared with anyone outside of authorized personnel, and data will be used in compliance with HIPAA regulations. Any identifiable information (such as names, contact details, and health record numbers) will be anonymized before use in training and development to ensure compliance with HIPAA regulations.

Your Rights

● Participation in the recording and data collection is entirely voluntary.

● You have the right to withdraw consent at any time without any impact on your care or treatment.

● You may request to review how your anonymized data is being used.

Authorization

By signing below, you confirm that you understand the purpose of this data collection and consent to the audio recording and data collection under the conditions outlined in this form.

Signed by:
Anderson Jerome
6B8DE83BB9D8423...

ORIGIN
Home Health Care

Medication Discrepancy Tool (MDT)

To be completed by Home Health Clinicians at SOC/ROC.
Information should be based on your assessment of the patient, the problems AND the patient's perception of the discrepancies.

Patient: Physician: Physician ƒax #: OASIS **Date:**

Medication	Causes and Contributing Factors *List all that apply from list below (By Number)*	Resolution *List all that apply from list below (By Number)*

Causes and Contributing Factors:	Resolution:
Discrepancies (Patient Level) 1. Adverse drug reaction or side effect 2. Intolerance 3. Did not fill prescription. 4. Patient feels they do not need prescription. 5. Money/financial barriers. 6. Intentional non-adherence (*"I was told to take this, but I chose not to"*) 7. Non-intentional non-adherence (Knowledge deficit – *"I don't understand how to take this medication"*) 8. Performance deficit *("Maybe someone showed me, but I can't demonstrate to you that I can")* **Discrepancies (System Level)** 9. Prescribed with known allergy/intolerance. 10. Discharge instructions incomplete/ inaccurate/ illegible *(*includes use of "resume all meds" order) 11. Duplication (*Taking multiple drugs with the same action without any rationale*) 12. Incorrect label 13. Incorrect dosage 14. Incorrect quantity 15. Cognitive impairment not recognized. 16. No caregiver/need for assistance not recognized. 17. Sight/dexterity limitations not recognized.	1. Clinician contacted the primary provider and clarified medication regimen. 2. Discussed potential benefits and harm that may result from non-adherence. 3. Provided resources and information to facilitate adherence. 4. Addressed performance/knowledge deficit. 5. Encouraged patient to call their doctor with further questions. 6. Primary provider will address problem at next visit. 7. Encouraged patient to schedule an appointment with primary provider or to discuss problem at next provider visit. 8. Other (*please explain*) _____