Welcome to

Axzons HomeCare

Consumer Admission Packet

Axzons Health System Corporation
70 E Sunrise Hwy, Suite # 500,
Valley Stream, NY 11581
Tel 1-866-429-9667
info@axzonshomecare.com
axzonshomecare.com

Axzons HomeCare

WE CARE FOR THOSE YOU CARE FOR

January 1 2023

Dear Axzons Patient:

Thank you for choosing **Axzons Home Health Care** as your in-homecare provider. We are honored to assist you on your path to recovery and wellness. Our goal is to fulfill your health care needs by partnering with you and providing an exceptional care experience.

At Axzons we have an exciting news to share with you. Axzons has been selected as a LEAD FI for the state of New York by Department of Health NY. Only 68 agencies out of 700-800 agencies across New York have been approved and the rest will be asked to discontinue their services by DOH by December 01 2021.

What it means for you:

Your service with Axzons will stay as it is and there is nothing you need to do to make any changes.

If you are also enrolled or entirely enrolled with another agency doing CDPAP Program then you should make sure to check the other agency has been approved as a Lead FI. If the other agency has not been selected as the Lead FI, you are welcome to enroll with Axzons as CDPAP Provider. This timely change will help you avoid service interruptions later in the year when it will be mandated to switch your agency only to a lead FI Agency.

For assistance with switching to Axzons, please call our care coordinators at 1-844-429-9667 or email us info@axzonshomecare.com

In case you or anyone you know are looking to enroll in a CDPAP program, then Please call your care coordinator at Axzons and they can help you enroll in the CDPAP program.

Axzons team comprises of competent, caring and compassionate healthcare professionals. Each team member is well qualified in their area of expertise and have been vetted by New York State Department of Health in their background and professional history. Our wide-ranging services include: Skilled Nursing, Private Duty Nursing, Physical Therapy, Occupational Therapy, Speech Therapy, Medical Social Work, and Personal Care Assistance. We offer numerous, dedicated clinical programs that include Wound Care, Telehealth Monitoring, Medication Management, Strength Training, and Fall Prevention.

Our patients are the center of our universe. The mission of **Axzons Home Health Care** is to promote, maintain and restore the health, and minimize the effects of illness and disability thus promoting health and well-being of the seniors/elders, and people with disability that we care for.

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Axzons has maintained its role as an industry leader in patient outcomes. We are proud to be the most trusted home health care provider across our service area, in large part due to our steadfast commitment to excellence in care quality and experience.

We are fully committed to exceeding your expectations. If there's anything we can do to make your experience better, please do not hesitate to contact our Customer Care team at 1-866-429-9667

Thank you for allowing us to serve your health care needs.

Contact Information:
Accounts: accounts@axzonshomecare.com
Scheduling: scheduling@axzonshomecare.com.
Nursing: nursing@axzonshomecare.com
Care coordination: 1-866-429-9667 Ext. 701

Healthcare Updates: Please visit regularly https://axzonshomecare.com/blogs for ongoing updates on various new healthcare challanges facing our patient community and how Axzons helps in preventing or treating them.

Sincerely,

Dr. Sandeep Kalra

info@axzonshomecare.com
Axzons Homecare
1-866-429-9667

U. S. ADVANCE DIRECTIVE(S) INFORMATION SHEET

for the STATE of NEW YORK

Federal Law Regarding the Provision of Information on Advance Directive(s)

Federal law requires that hospitals, skilled nursing facilities, hospices, home health agencies and health maintenance organizations (HMOs) which provide service to clients, who are in receipt of benefits from either Medicare or Medicaid, give you information about Advance Directive(s) and explain your legal choices in making decisions about your medical care. These organizations are required to give you the information about Advance Directive(s) that applies to for the state in which they are located.

Defining Advance Directive(s)s

Advance Directive(s)

An Advance Directive(s) is a written set of instructions that outlines your choices for health care and/or states the name of a person who you designate to make such decisions for you should you become incapacitated. Such documentation is recognized under state law, when the individual is incapacitated. State laws vary in their “Advance Directive” requirements. Examples of Advance Directive(s) include, but are not limited to, the following:

1. Living Will

A living will describes your feelings about what types of care you want or don’t want to keep you alive. You can accept or refuse medical treatments e such as resuscitation, dialysis, tube feeding, respirators, organ donation, etc.

2. Durable Power of Attorney for Health Care

A Durable Power of Attorney for Health Care enables you to name a “Patient Advocate” to act on your behalf, should you become incapacitated, by carrying out your wishes. The “Patient Advocate” could be a family member, friend or anyone you trust as long as the/she is least18 years old and is competent.

3. Surrogate Decision Maker Relating to the Provision of Health Care or Health Care Proxy

A Surrogate Decision Maker or Health Care Proxy speaks on your behalf regarding your wishes for life. The role of the Surrogate Decision-Maker/Health Care Proxy is to try to ensure that any decisions he/she makes about your care are consistent with your wishes and adhere to any documented Advance Directive(s) that you have.

4. Do-Not-Resuscitate Orders

A Do-Not Resuscitate" (DNR) order is a request that you not be given cardiopulmonary resuscitation (CPR) if your heart stops or if you stop breathing. If a DNR order is not in place, staff will assist you if your heart stops or you stop breathing. You can use an Advance Directive(s) form or tell your doctor that you don't want to be resuscitated. In this case, a DNR order is put in your medical chart by your doctor. DNR orders are accepted by doctors and hospitals in all states.

5. Advance Instructions for Mental Health Treatment

An advance instruction for mental health treatment is a legal document which advises that tells doctors and health care providers what mental health treatments you would want and what treatments you would not want if you ever become unable to make that decision. .

Requirements to have an Advance Directive(s)

You do not have to have an Advance Directive(s) if you prefer not to have one.

Benefits of Having an Advance Directive(s)

You might want to prepare an Advance Directive(s) if:

1. You do not want to burden your family and friends with the decisions of what types of medical care to give you, should you become incapacitated.
2. You want your physician or other health care provider(s) to fully understand what types of medical care you want, should you become incapacitated.

Number and Types of Advance Directive(s) to Have

You can have any number of Advance Directive(s), to the extent of what is relevant in your state.

Advance Directive Requirements

Advance Directive requirements in **NY** are as follows:

State of NY does not have laws for Advance Directive

How to Create an Advance Directive(s)

Some ways you can obtain an Advance Directive(s) include:
1. writing your wishes on paper;
2. requesting a form from your doctor;
3. contacting your state department on aging;
4. contacting your state's Attorney General's Office
5. contacting your state Department of Health;
6. contacting a lawyer; or,
7. using software specializing in computer documents.

Advance Directive(s) should follow state laws and can be short or long. Regardless of their length, you should ensure that your doctor understands your wishes and it is recommended that your take them to your lawyer for review. It is also a good idea to have your Advance Directive(s) notarized.

Where to Keep Advance Directive(s)

Copies of your completed documents should be given to your surrogate decision maker, family, doctor, lawyer and relevant health care professionals/facilities. It is recommended that you advise them, in advance, to avoid conflict later on and to give them peace of mind. You should also be aware of the U.S. Living Will Registry. It is a nationwide service that stores your Advance Directive(s) electronically and makes them available 24 hours a day to health care providers across the country. Here is a link to their website:

http://liv-will1.uslivingwillregistry.com/individuals.html

When Does an Advance Directive(s) Go to Into Effect?

Advance Directive(s) become effective when you become incapacitated. A living will goes into effect when you are going to die soon and cannot be cured, or when you are in a persistent vegetative state. The powers granted by your health care power of attorney go into effect when your doctor states in writing that you are not able to make or to make known your health care

choices. When you make a health care power of attorney, you can name the doctor or mental health provider you would want to make this decision. An advance instruction for mental health treatment goes into effect when it is given to your doctor or mental health provider. The doctor will follow the instructions you have put in the document, except in certain situations, after the doctor determines that you are not able to make and to make known your choices about mental health treatment. After a doctor determines this, your Health Care Power of Attorney may make treatment decisions for you. An advance instruction for mental health treatment expires after two years.

How to Make Changes to Advance Directive(s)?

As long as you are thinking rationally and are able to relay your wants clearly, you are able to edit or cancel your Advance Directive(s), whenever you wish to. Any and all changes must be made, signed and notarized according to the laws in your state. It is your responsibility to ensure that all people/organizations that received copies of your original documents are advised of the changes.

Should you not have the opportunity to make your desired changes in writing (e.g. you are in hospital), be sure to pass on your new wishes to your doctor, family or other relevant persons and ensure there is complete understanding of your revised instructions.

Validity of Advance Directive(s) from Other States

If you have an Advance Directive(s) from another state, it may not meet all of your state's laws and regulations. You could either have your current one reviewed by a lawyer or make up new one that is valid in your state.

Axzons Health System Corporation
70E Sunrise Highway, Valley Stream, NY 11581
www.axzonscdpap.com

Axzons HomeCare

CONSUMER CONTRACT

Agreement for the Provision of Fiscal Intermediary Services for the Consumer Directed Personal Assistance Program (CDPAP)

Please review this agreement carefully, as it sets forth the understanding between you ("Consumer") and ***Axzons Health System Corporation*** ("FI" or the "Agency") regarding the services you have requested, and we will provide for you. If you have any questions, concerns or issues about the content of this Agreement please contact us for clarification before signing it.

THIS AGREEMENT ("Agreement") is made and entered into as of January 1 2023 ("Effective Date") by and between ***Axzons Health Systems Corp.*** ("FI" or the "Agency") and

(Axzons Office use only)

_____
MRN

Consumer Information:

_____ - Select - _____
Name of Consumer M/F DOB Social Security Number

_____
Insurance Name Insurance ID # Medicaid ID #

_____ - State - _____
Street Address City State Zip Code

_____
Home Phone Cell Email Address

_____
Emergency Contact Name 1 Relationship

_____
Email Address Phone No. Alternate No.

_____
Emergency Contact Name 2 Relationship

_____
Email Address Phone No. Alternate No.

_____
Client Diagnosis Code Client Primary Diagnosis Client Diagnosis Code Client Secondary Diagnosis

_____ - Select - _____ Required
Type of Service Needed Level of Service Needed Nursing Assessment

Authorization Number	From Date	To Date	Code	Modifier

Primary Care Physician information:

PCP First Name	PCP Last Name	NPI	Phone No.	Fax No.

Street Address	City	- State -	Zip Code

("Consumer"). Consumer and FI are referred to hereinafter individually as "Party" and collectively as the "Parties". WHEREAS, Consumer wishes to engage FI to provide fiscal intermediary services in relation to consumer directed personal assistance program benefits for Members of such plans; WHEREAS, FI is a fiscal intermediary designated to provide wage and benefit processing for consumer directed personal assistants on behalf of an employing consumer and other responsibilities specified in this Agreement in accordance with 18 N.Y.C.R.R. Section 505.28 CDPAP program; and WHEREAS, Consumer and FI desire to enter into this Agreement.

NOW THEREFORE, the Parties agree as follows:

Definitions:
"consumer" means a medical assistance recipient who a social services district or Managed Care Organization has determined eligible to participate in the consumer directed personal assistance program. "consumer directed personal assistance" means the provision of some or total assistance with personal care services, home health aide services and skilled nursing tasks by a consumer directed personal assistant under the instruction, supervision and direction of a consumer or the consumer's designated representative.

"consumer directed personal assistant" ("CDPA") means an adult who provides consumer directed personal assistance to a consumer under the consumer's instruction, supervision and direction or under the instruction, supervision and direction of the consumer's designated representative.

A consumer's spouse, parent or designated representative may not be the consumer directed personal assistant for that consumer; however, a consumer directed personal assistant may include any other adult relative of the consumer who does not reside with the consumer or any other adult relative who resides with the consumer because the amount of care the consumer requires makes such relative's presence necessary.

"continuous consumer directed personal assistance" means the provision of uninterrupted care, by more than one consumer directed personal assistant, for more than 16 hours per day for a consumer who, because of the consumer's medical condition and disabilities, requires total assistance with toileting, walking, transferring or feeding at times that cannot be predicted.

"designated representative" means an adult to whom a self-directing consumer has delegated authority to instruct, supervise and direct the consumer directed personal assistant and to perform the consumer's responsibilities specified in subdivision (g) of Section 505.28 of Title 18 of the New York Codes, Rules and Regulations ("NYCRR") and who is willing and able to perform these responsibilities. With respect to a non-

self-directing consumer, a "designated representative" means the consumer's parent, legal guardian or a responsible adult surrogate who is willing and able to perform such responsibilities on the consumer's behalf. The designated representative may not be the consumer directed personal assistant or a fiscal intermediary employee, representative or affiliated person.

"Fiscal Intermediary" ("FI") means an entity that has a contract with MCO (Managed Long-Term Care) to provide wage and benefit processing for consumer directed personal assistants and other fiscal intermediary responsibilities specified in subdivision (i) of Section 505.28 of Title 18 of the NYCRR.

"home health aide services" means services within the scope of practice of a home health aide pursuant to Article 36 of the Public Health Law including simple health care tasks, personal hygiene services, housekeeping tasks essential to the consumer's health and other related supportive services. Such services may include, but are not necessarily limited to, the following: preparation of meals in accordance with modified diets or complex modified diets; administration of medications; provision of special skin care; use of medical equipment, supplies and devices; change of dressing to stable surface wounds; performance of simple measurements and tests to routinely monitor the consumer's medical condition; performance of a maintenance exercise program; and care of an ostomy after the ostomy has achieved its normal function.

"MCO" (Managed Long Term Care)

"NYSDOH" means the New York State Department of Health.

"personal care services" means the nutritional and environmental support functions, personal care functions, or both such functions, that are specified in Section 505.14(a)(6) of Part 505 of Title 18 of the NYCRR except that, for individuals whose needs are limited to nutritional and environmental support functions, personal care services shall not exceed eight hours per week.

"self-directing consumer" means a consumer who can make choices regarding the consumer's activities of daily living and the type, quality and management of his or her consumer directed personal assistance; understands the impact of these choices; and assumes responsibility for the results of these choices.

"skilled nursing tasks" means those skilled nursing tasks that are within the scope of practice of a registered professional nurse or a licensed practical nurse and that a consumer directed personal assistant may perform pursuant to Section 6908 of the Education Law.

"some assistance" means that a specific personal care service, home health aide service or skilled nursing task is performed or completed by the consumer with help from another individual.

"stable medical condition" means a condition that is not expected to exhibit sudden deterioration or improvement and does not require frequent medical or nursing evaluation or judgment to determine changes in the consumer's plan of care.

"total assistance" means that a specific personal care service, home health aide service or skilled nursing task is performed or completed for the consumer.

"*live-in 24-hour" consumer directed personal assistance* means the provision of care by one consumer directed personal assistant for a consumer who, because of the consumer's medical condition, needs assistance during a calendar day with toileting, walking, transferring, turning and positioning, feeding, home health aide services, or skilled nursing tasks and whose need for assistance is sufficiently infrequent that a live-in 24-hour consumer directed personal assistant would be likely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide's eight hour period of sleep

RIGHTS & RESPONSIBILITIES OF THE FI/Agency and the CONSUMER

As a Consumer of Axzons Health System Corporation (FI) the above-named Consumer has rights and responsibilities including, but not limited to, those outlined below:

Consumer's Rights

The Consumer has the right to:

1. PRIVACY AND SECURITY - to respect your property, personal privacy and security during homecare visits. You have a right to contact with visitors and others and to communicate privately with these persons;
2. CONFIDENTIALITY - to confidentiality of written, verbal and electronic information including your medical records, information about your health, social and financial circumstances or about what takes place in your home;
3. HEALTH INFORMATION - to access, request changes to and receive an accounting of disclosures regarding your own health information as permitted by law.
4. RELEASE OF INFORMATION - to request us to release information written about you only as required by law or your written authorization. Our Notice of Privacy Practices describes your rights in detail.
5. INSURANCE INFORMATION - to be informed of the extent to which payment may be expected from Medicaid or any other payer known to us before any care is delivered e.g.: the hours of service.
6. KNOW CHARGES NOT COVERED - to be informed verbally and in writing at the time of admission, the approximate maximum dollar amount, if any, of care or services to be borne by the patient.
7. HAVE ACCESS TO ALL BILLS - to have access, upon request to all bills for services that you have received, for out-of-pocket expenses.
8. RECEIVE EMERGENCY INSTRUCTIONS - to be told what to do in case of an emergency.
9. be fully informed of your rights and the Agency's requirements governing Consumer responsibilities; and the services available from the Agency;
10. be treated with courtesy, consideration, respect, and full recognition of your human dignity and individuality, including privacy during treatment and care for personal needs;
11. receive service and be dealt with without regard to race, color, age, sex, sexual orientation, creed, religion, disability and familial/cultural factors;
12. approve or refuse the release of the personal or medical records to any individual/entity other than the Agency except when Consumer records are transferred to another service provider or a health facility or as otherwise authorized by law;
13. make suggestions or complaints or present grievances to the Agency, government agencies or other entities or individuals without fear of the threat of retaliation.
14. receive a prompt response, through an established complaint or grievance procedure, to any complaints, suggestions or grievances they may have;
15. receive written information for Consumer and PA handbooks & Supervisor assigned and the Agency's phone number;
16. be informed, within a reasonable amount of time, of the Agency's plans to terminate the service and/or their intention to transfer their care to another agency;
17. have their family or designated legal representative exercise the Consumer's rights when the legal representative is legally authorized to do so.

Consumer or Designated Representative's Responsibilities:

The Consumer has a responsibility to:

1. Manage the services of the Personal Assistant employed and carry out the defined responsibilities in the Consumer Agreement
2. Notify the Agency Service Coordinator of any changes in status, including, but not limited to, the Consumer's address. Telephone number and hospitalization.
3. Notify the Service Coordinator of any changes of each Personal Assistant (s) name, address, phone number, employment status, and hours worked.
4. notify the Agency, in advance, of any changes to the PA's work schedule; and arrange and schedule back-up Personal Assistant coverage for vacations, holidays, absence due to illness and personal time.
5. Develop an emergency backup system in the event substitute employees are needed to replace permanent employees.
6. Process in a timely manner the required paperwork such as time sheets, health assessment, vacation and time off requests, and other required employment documentation
7. Attesting to the accuracy of each consumer directed personal assistant's time sheets;
8. Transmitting the consumer directed personal assistant's time sheets to the Agency according to its procedures;
9. Schedule visits with a registered nurse once every six (6) months for the required nursing assessment
10. Sign a contractual agreement with the Program to fulfill these responsibilities
11. Consumer or the designated representative should know the Consumer's medical history and have details on any medications being taken; and accept the consequences of their own decisions;
12. Report unexpected changes in their condition, such as having suffered a mild stroke;
13. Report any potential risks that might exist to the Personal Assistant (PA) such as the possibility that a Consumer/family member might have a contagious illness or condition;
14. Advise the Agency of any changes being made to Consumer's health care professionals. e.g. physician, physiotherapist, occupational therapist, dietician, registered nurse, etc.
15. Be responsible for payment for charges that are not covered by other parties such as Medicare & Medicaid or any private pay services;
16. Notify the Agency of any changes in insurance coverage for the CDPAP services;
17. Assume financial responsibility for all materials, supplies and equipment required for their care, which are not covered by other parties;
18. Provide a safe environment for care and services to be delivered by the PA and provide a smoke free environment
19. Give reasonable notice, when possible, if service is going to be cancelled

Fiscal Intermediary (FI/Agency) Responsibilities

The fiscal intermediary shall have the following responsibilities:

1. Process each CDPA's wages and benefits including establishing the amount of each assistant's wages and benefits; process all income tax and other required wage withholdings; and comply with workers' compensation, disability and unemployment insurance requirements.
2. Ensure that the health status of each consumer directed personal assistant is assessed pursuant to 10 NYCRR § 766.11(c) and (d) or any successor regulation.
3. Maintain records for each CDPA which shall include, at a minimum, time records, the CDPA health assessments required pursuant to 10 NYCRR § 766.11(c) and (d) or any successor regulation, and the information needed for payroll processing and benefit administration.

4. Maintain records for each consumer, including copies of the authorizations, reauthorizations, and the contracts between the consumer and the FI.
5. Obtain a signed agreement with consumer outlining consumer's responsibilities as contained in 18 NYCRR § 505.28. Use best efforts to notify the MCO (Managed Long Term Care) if the FI becomes aware that the consumer has been admitted to a higher level of care such as an inpatient hospital or skilled nursing facility. Monitor enrollment in MCO on the 1st and 15th of each month; provided, however, that such monitoring on the part of the FI shall not relieve the MCO of the MCO's responsibility to notify the FI in the event of a consumer's disenrollment in the MCO or in the event of a determination that the consumer is no longer authorized to participate in the CDPAP program.
6. Monitor the ability of the consumer, or the ability of the consumer's designated representative, if applicable, to fulfill the consumer's responsibilities under the consumer directed personal assistance program and notify the MCO promptly if the FI becomes aware of any circumstances that may affect the ability of the consumer, or that of the consumer's designated representative, if applicable, to fulfill such responsibilities.
7. Comply with applicable NYSDOH regulations regarding the responsibilities of providers enrolled in the medical assistance program.
8. Enter into an Agreement with the consumer that stipulates that the consumer and, as applicable, the consumer's designated representative shall be solely responsible to:
    a. Manage the plan of care authorized by the MCO, including recruiting and hiring a sufficient number of CDPAs to provide authorized services as set forth in the plan of care authorized by the MCO; training, supervising and scheduling each CDPA; terminating the CDPA's employment with the consumer; and assuring that each CDPA completely and safely performs the personal care services, home health aide services and skilled nursing tasks included on the consumer's MCO approved plan of care;
    b. Notify the MCO within 5 business days of any changes in the consumer's medical condition or social circumstances including but not limited to, any hospitalization of the consumer or change in the consumer's address or telephone number;
    c. Timely notify the FI of any changes in the employment status of each CDPA;
    d. Attest to the accuracy of each time record for each CDPA;
    e. Transmit the CDPA's time records to the FI according to the FI's policies and procedures;
    f. Timely distribute each CDPA's paycheck, if needed;
    g. Arrange and schedule substitute coverage when a CDPA is temporarily unavailable for any reason;
    h. Acknowledge and agree that: (1) any person who receives, directly or indirectly, an overpayment from the Medicaid program is obligated to report and return the overpayment, within sixty days of the identification of the overpayment. Failure to do so may expose the person to liability under the False Claims Act, including whistleblower actions, treble damage and penalties; and (2) that the Office of the Medicaid Inspector General or MCO may suspend payments to the FI and CDPA, if applicable, pending an investigation of a credible allegation of fraud against the FI or CDPA, as applicable, unless the state determines there is good cause not to suspend such payments;
    i. Comply with applicable labor laws and provide equal employment opportunities to CDPAs in accordance with applicable laws.
    j. Notify the FI and/or MCO of any disclosure of information that the MCO has taken reasonable measures to maintain as confidential and which derives independent economic value from not being generally known or readily ascertainable by the public (Proprietary information). Proprietary information includes the compensation arrangements between the MCO and the FI and the amount the FI pays the CDPA and any other information relating to the MCO's business that is not public information.

FI does not assume responsibility at any time of any weapons or hazardous materials owned, stored or used by the Consumer or its family at the residence where the service is being provided by the Personal Assistant (PA). Axzons also will not be responsible for any aggressive or menacing pets of the consumer. Consumer will be the sole responsible party for any type of injury or threat be it mental, physical or any type of other harm to the Personal Assistant (PA) working for the consumer.

This Consumer Contract including the *Rights and Responsibilities* form has been reviewed with, and a copy given to, the named Consumer/Consumer's representative.

IN WITNESS WHEREOF, the undersigned with the intent and authority to legally bind the respective Party, have caused this Agreement to be duly executed and effective as of the Effective Date.

_____ _____

Consumer/Consumer's Representative Signature **Date**

_____ _____

Agency Authorized Signature & Position **Date**

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number

Patient Address

- State -

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Axzons Health System Corp 70 E Sunrise Hwy, Ste 500, Valley Stream, NY 11581

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

☐ Medical Record from (insert date) _____ to (insert date) _____

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test result, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other:

Include: *(Indicate by Initialing)*

☐ **Alcohol/Drug Treatment**
☐ **Mental Health Information**
☐ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider)

to discuss my health information with my attorney, or a governmental agency, listed here:

_____
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☐ Other:	
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____
Signature of patient or representative authorized by law.

*** Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

Instructions for the Use of the HIPAA compliant Authorization Form to Release Health Information Needed for Litigation

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as "at the conclusion of my court case" or provide a specific date amount of time, such as "3 years from this date".

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.

Axzons Health System Corporation

NOTICE OF PRIVACY PRACTICES

Effective Date: July 15, 2017

THIS NOTICE DESCRIBES HOW MEDICAL/HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Axzons Health System Corporation.(the "Agency") is required by law to maintain the privacy of your health information and notify you in the event there is a breach of your unsecured health information. We are also required by law to provide you with this Notice of Privacy Practices ("Notice") detailing our legal duties and privacy practices with respect to your health information and to abide by the terms of the Notice that are currently in effect.

The term "health information" means information about you created or received by us, including demographic information, that may reasonably identify you and that relates to your physical or mental health condition, the provision of health care to you, or payment for the provision of your health care.

I. USES AND DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

The following lists various ways in which we may use or disclose your health information for purposes of treatment, payment and health care operations.

For Treatment. We may use and disclose your health information to provide you with medical treatment and related services and coordinate your care. Your health information may be used by doctors involved in your care and by nurses and home health aides as well as by physical therapists, pharmacists, suppliers of medical equipment or other persons involved in your care. For example, we may contact your physician to discuss your plan of care.

For Payment. We may use and disclose your health information for billing and payment purposes. We may disclose your health information to your representative, or to an insurance or managed care company, Medicare, Medicaid or another third party payor. For example, we may contact Medicare or your health plan to confirm your coverage or to request prior approval for services that will be provided to you.

For Health Care Operations. We may use and disclose your health information as necessary for health care operations, such as management, personnel evaluation, education and training and to monitor our quality of care. We may disclose your health information to another entity with which you have or had a relationship if that entity requests your information for certain of its health care operations or health care fraud and abuse detection or compliance activities. For example, patients' health information may be combined and analyzed for purposes such as evaluating and improving quality of care and planning for services.

II. SPECIFIC USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

The following lists various ways in which we may use or disclose your health information.

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose health information about you to a family member, close personal friend or other person you identify, including clergy, who is involved in your care.

Emergencies. We may use or disclose your health information as necessary in emergency treatment situations.

As Required By Law. We may use or disclose your health information when required by law to do so.

Business Associates. We may disclose your health information to a business associate who needs the information to perform services for the Agency. Our business associates are committed to preserving the confidentiality of this information.

Public Health Activities. We may use or disclose your health information for public health activities. These activities may include, for example, reporting to a public health authority for the purpose of preventing or controlling disease, injury or disability; reporting child abuse or neglect or reporting births and deaths.

Reporting Victims of Abuse, Neglect or Domestic Violence. If we believe that you have been a victim of abuse, neglect or domestic violence, we may use and disclose your health information to notify a government authority, if authorized by law or if you agree to the report.

Health Oversight Activities. We may disclose your health information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections and licensure actions or for activities involving government oversight of the health care system.

To Avert a Serious Threat to Health or Safety. When necessary to prevent a serious threat to your health or safety or the health or safety of the public or another person, we may use or disclose health information, limiting disclosures to someone able to help lessen or prevent the threatened harm.

Judicial and Administrative Proceedings. We may disclose your health information in response to a court or administrative order. We also may disclose information in response to a subpoena, discovery request, or other lawful process if such disclosure is permitted by law.

Law Enforcement. We may disclose your health information for certain law enforcement purposes, including, for example, to comply with reporting requirements, to comply with a court order, warrant, or similar legal process, or to answer certain requests for information concerning crimes.

Research. We may use or disclose your health information for research purposes if the privacy aspects of the research have been reviewed and approved, if the researcher is collecting information in preparing a research proposal, if the research occurs after your death, or if you authorize the use or disclosure.

Coroners, Medical Examiners, Funeral Directors, Organ Procurement Organizations. We may release your health information to a coroner, medical examiner, funeral director or, if you are an organ donor, to an organization involved in the donation of organs and tissue.

Disaster Relief. We may disclose health information about you to a disaster relief organization.

Military, Veterans and other Specific Government Functions. If you are a member of the armed forces, we may use and disclose your health information as required by military command authorities. We may disclose health information for national security purposes or as needed to protect the President of the United States or certain other officials or to conduct certain special investigations.

Workers' Compensation. We may use or disclose your health information to comply with laws relating to workers' compensation or similar programs.

Inmates/Law Enforcement Custody. If you are under the custody of a law enforcement official or a correctional institution, we may disclose your health information to the institution or official for certain purposes including the health and safety of you and others.

Fundraising Activities. We may use certain limited information to contact you in an effort to raise funds for the Agency and its operations. You have the right to opt out of receiving these communications and will be provided with an opportunity to do so.

Appointment Reminders. We may use or disclose health information to remind you about appointments.

Treatment Alternatives and Health-Related Benefits and Services. We may use or disclose your health information to inform you about treatment alternatives and health-related benefits and services that may be of interest to you.

III. USES AND DISCLOSURES WITH YOUR AUTHORIZATION

Except as described in this Notice, we will use and disclose your health information only with your written authorization. Your written authorization will specify particular uses or disclosures that you choose to allow. You may revoke an authorization in writing at any time. If you revoke an authorization, we will no longer use or disclose your health information for the purposes covered by that authorization, except where we have already relied on the authorization.

Marketing. A signed authorization is required for the use or disclosure of your health information for a purpose that encourages you to purchase or use a product or service except for certain limited circumstances such as when the marketing communication is face-to-face or when marketing includes the distribution of a promotional gift of nominal value provided by the Agency. An authorization is not required to describe a health-related product or service provided by use; to make communications to you regarding your treatment; or to direct or recommend alternative treatments, therapies, providers or settings of care for you. An authorization is also not required for the coordination or management of your treatment or consultations between the Agency and other health care providers related to your treatment.

Sale of Protected Health Information. A signed authorization is required for the use or disclosure of your health information in the event that the Agency directly or indirectly receives remuneration for such use or disclosure, except under certain circumstances as allowed by federal or State law. For example, authorization is not needed if the purpose of the use or disclosure is for your treatment, public health activities, or providing you with a copy of your protected health information

IV. YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Listed below are your rights regarding your health information. Each of these rights is subject to certain requirements, limitations and exceptions. Exercise of these rights may require submitting a written request to the Agency. At your request, the Agency will supply you with the appropriate form to complete. You have the right to:

Request Restrictions. You have the right to request restrictions on our use or disclosure of your health information for treatment, payment, or health care operations. You also have the right to request restrictions on the health information we disclose about you to a family member, friend or other person who is involved in your care or the payment for your care.

We are not required to agree to your requested restriction unless it involves the disclosure of health information to a health plan for purposes of carrying out payment or health care operations that pertains solely to a health care item or service for which the Agency has been paid out of pocket in full. If we do agree to accept your requested restriction, we will comply with your request except as necessary to provide you with emergency treatment.

Access to Personal Health Information. You have the right to inspect and obtain a copy of your health information for as long as the health information is maintained by the Agency. If we maintain your health information electronically in a designated record set, then you have the right to request an electronic copy of such health information. To inspect and copy your health information, you must submit your request in writing to the Agency. In most cases we may charge a reasonable fee for our costs in copying and mailing your requested information.

We may deny your request to inspect or receive copies in certain limited circumstances. If we deny your request, we will provide you with a written explanation of the reason for the denial. In some cases, you

may have the right to request review of this denial. This review would be performed by a licensed health care professional designated by the Agency who did not participate in the decision to deny.

Request Amendment. You have the right to request amendment of your health information maintained by the Agency for as long as the information is kept by or for the Agency. Your request must be made in writing and must state the reason for the requested amendment.

We may deny your request for amendment if the information (a) was not created by the Agency, unless the originator of the information is no longer available to act on your request; (b) is not part of the health information maintained by or for the Agency; (c) is not part of the information to which you have a right of access; or (d) is already accurate and complete, as determined by the Agency.

If we deny your request for amendment, we will give you a written denial including the reasons for the denial and the right to submit a written statement disagreeing with the denial.

Request an Accounting of Disclosures. You have the right to request an "accounting" of certain disclosures of your health information. This is a listing of disclosures made by the Agency or by others on our behalf, but does not include disclosures for treatment, payment and health care operations, disclosures made pursuant to your authorization, and certain other exceptions.

To request an accounting of disclosures, you must submit a request in writing, stating a time period that is within six years from the date of your request. The first accounting provided within a 12-month period will be free. We may charge you a reasonable, cost-based fee for each future request for an accounting within a single twelve-month period. However, you will be given the opportunity to withdraw or modify your request for an accounting of disclosures in order to avoid or reduce the fee.

An accounting of disclosures from an electronic health record related to treatment, payment or health care operations will be made only for the three (3) year period preceding the request.

Request a Paper Copy of This Notice. You have the right to obtain a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time. In addition, you may obtain a copy of this Notice at our website, www.axzons.com, by clicking on 'Privacy Policy.'

Request Confidential Communications. You have the right to request that we communicate with you concerning your health matters in a certain manner. We will accommodate your reasonable requests.

V. SPECIAL RULES REGARDING DISCLOSURE OF PSYCHIATRIC, SUBSTANCE ABUSE AND HIV-RELATED INFORMATION

For disclosures concerning health information relating to care for psychiatric conditions, substance abuse or HIV-related testing and treatment, special restrictions may apply. Except as provided below and as specifically permitted or required under state or federal law, health information relating to care for psychiatric conditions, substance abuse or HIV-related testing and treatment may not be disclosed without your special authorization.

- Psychiatric information. If needed for your diagnosis or treatment in a mental health program, psychiatric information may be disclosed. Certain limited information may be disclosed for payment purposes. Otherwise, we will only disclose such information pursuant to an authorization, court order or as otherwise required by law. For example, all communications between you and a psychologist, psychiatrist, social worker and certain therapists and counselors will be privileged and confidential in accordance with Connecticut and Federal law.
- HIV-related information. We may disclose HIV-related information as permitted or required by Connecticut law. For example, your HIV-related information, if any, may be disclosed without your authorization for treatment purposes, certain health oversight activities, pursuant to a court order, or in the event of certain exposures to HIV by personnel of the Agency.

- Substance abuse treatment. If you are treated in a specialized substance abuse program, your special authorization will be needed for most disclosures, not including emergencies.

VI. FOR FURTHER INFORMATION OR TO FILE A COMPLAINT

If you have any questions about this Notice or would like further information concerning your privacy rights, please contact: Compliance Officer, .

If you believe that your privacy rights have been violated, you may file a complaint in writing with the Agency or with the Office of Civil Rights in the U.S. Department of Health and Human Services. We will not retaliate against you if you file a complaint.

To file a complaint with the Agency, contact:

Axzons Health System Corporation
70 E Sunrise Hwy, Suite # 500
Valley Stream, NY 11581

Compliance Officer - 1-866-429-9667

VII. CHANGES TO THIS NOTICE

We reserve the right to change this Notice and to make the revised or new Notice provisions effective for all health information already received and maintained by the Agency as well as for all health information we receive in the future. We will provide a copy of the revised Notice at your next home visit and upon request.

Axzons Health System Corporation	Axzons HomeCare

CONFIDENTIALITY & NON DISCLOSURE AGREEMENT

It is the responsibility of all Agency employees to preserve and protect confidential Agency, client and employee medical, personal and business information and, thus, shall not disclose such information except as authorized by law, client or individual.

Confidential Client Information includes, but is not limited to any identifiable information about a client's and/or his/her family including, but not limited to:

- medical history;
- mental, or physical condition;
- treatments and medications;
- test results;
- Conversations;
- financial information; and,
- household possessions.

Confidential Employee information includes, but is not limited to:

- contact information i.e. telephone number(s); address, email address;
- names of spouse and/or other relatives;
- Social Security Number;
- performance appraisal information;
- health status and treatments; and,
- other information obtained from their personnel files which would be an invasion of privacy e.g;
  - Date of Birth;
  - Place of Birth
  - Traditional password identifiers
  - Bank account numbers
  - Income tax records
  - Driver's license numbers
  - Credit card numbers
  - Passport numbers

<u>Confidential Business Information</u>

Confidential business information includes, but is not limited to:

- client lists;
- Security data and credentials such as passwords,
- any information that, if released, could be harmful to the Agency; and,
- any financial information including accounts receivable, accounts payable and payroll.

I acknowledge that:

1. I understand that it is my legal and ethical responsibility to protect the security, privacy, and confidentiality of all client records, Agency information and other confidential information relating to the Agency, including business, employment and medical information pertaining to clients, their families and employees.
2. I will only discuss confidential information during the performance of my duties and only for job related purposes and shall take caution to ensure such conversations are not within hearing range of anyone who is not entitled to have this information
3. I shall respect and maintain the confidentiality of all discussions, conversations, and any other information generated while providing service to clients in connection with individual client service, risk management and/or peer review activities.
4. I shall not disclose the content of any discussions, deliberations, client records, peer reviews or risk management information, except to persons authorized to receive such information, while conducting Agency business.
5. I shall only access or distribute client care information when executing my job duties or when required to do so by law.
6. I will only access records on a “need-to-know” basis in the performance of my duties.
7. I will not share my Login or User ID and password for accessing electronic records with anybody. If I believe someone else has used my Login or User ID and/or password, I will immediately notify the Supervisor.
8. I will only use mobile computing devices, with Agency approval, AND providing they are encrypted with an approved data encryption solution before using them for any Agency-related business. I understand that I may be personally responsible for any breach of confidentiality resulting from unauthorized access due to hacking or other means to Agency information stored on my unencrypted device
9. I understand that the Agency will undertake measures to determine if client and employee records have been accessed without authorization.
10. I understand that state and federal laws/regulations governing a client’s right to privacy, the illegal or unauthorized access or disclosure of client’s confidential information may result in disciplinary action up to and including immediate termination from my employment and possible civil fines and criminal sanctions.
11. I understand that I am obligated to maintain these confidentialities after my employment with this Agency ceases.

I hereby acknowledge that I have read and understand the above mentioned information and that my signature below indicates my agreement to comply with these terms.

First and Last Name	Designation

Signature	Date

Axzons Health System Corporation	Axzons HomeCare

ASSESSMENT: NURSING, HOME HEALTH CERTIFICATION AND PLAN OF CARE

Provider's Name, Address and Telephone Number
Axzons Health System Corporation
70 E Sunrise Hwy, Ste 500
Valley Stream, NY 11581
Telephone/Fax: 1-866-429-9667

MRN

- Select -

Name of Client and/ or Responsible Person | M/F | DOB | Social Security #

Insurance Name | Insurance ID # | Medicaid #

- State -

Street Address | City | State | Zip Code

Home Phone | Cell Phone | Email Address

Emergency Contact Name 1 | Relationship

Email Address | Phone No. | Alternate No.

Emergency Contact Name 2 | Relationship

Email Address | Phone No. | Alternate No.

Client Diagnosis Code | Client Primary Diagnosis | Client Diagnosis Code | Client Secondary Diagnosis

- Select - Required

Type of Service Needed | Level of Service Needed | Nursing Assessment

Authorization Number | From Date | To Date | Code | Modifier

PCP First Name | PCP Last Name | NPI | Phone No. | Fax No.

- State -

Street Address | City | State | Zip Code

NURSING ASSESSMENT		
General Topics	**Subject Matter**	**Action(S) Indicated**
Medical Information		
Height & Weight	Height: _____ ft _____ in Weight: _____ Lbs Weight Status: ◯ Increase ◯ Static ◯ Decrease Reason for Any Weight Change: _____	
Vital Signs	Blood Pressure: _____ / _____ mmHg Pulse: _____ bpm Respirations: _____ bpm Temperature: _____ ^{0}F ◯ Yes ◯ No Pain. If Yes, Level of pain (0-10) 0 Location & Description: _____	
History of Present Illness		
Past History		
Family and Personal History		
General Appearence		
Skin		

NURSING ASSESSMENT		
General Topics	**Subject Matter**	**Action(S) Indicated**
HEENT(Head, Eye, ENT)		
Neck		
Chest and Lungs		
Cardiovascular		
Abdomen		
Genitourinary		
Rectal		
Neurological/ Psychiatry		

NURSING ASSESSMENT

Medications

Medication	Dose	Frequency	Route/Changes

1OD: One Tablet Once a day **1BD:** One Tablet Twice a day
1TDS: One Tablet Thrice a day **1QID:** One Tablet Four times a day.

NURSING ASSESSMENT		
General Topics	**Subject Matter**	**Action(S) Indicated**
Medication Allergies Food and Other		
Prognosis	◯ Poor ◯ Guarded ◯ Fair ◯ Good ◯ Excellent	
Safety Measures		
Dental Care	Does client have dental problems? ◯ Yes ◯ No Is Client Under Care Of Dentist? ◯ Yes ◯ No **Dental State:** ☐ No Dentures ☐ Full Upper ☐ Full Lower ☐ Partial Denture ☐ Dentures Damaged ☐ Not Wearing Dentures ☐ No Teeth Can Client Chew Food Effectively? ◯ Yes ◯ No Dentist's Name: _____ Dentist's Phone Number: _____ Dentist visit: ◯ Current ◯ No If not when in next appointment (Date): _____	
Vision	☐ Unimpaired ☐ Adequate For Personal Safety ☐ Distinguishes Only Light Or Dark ☐ Blind - Safe In Familiar Locale ☐ Blind - Requires Assistance Wears Glasses: ◯ Yes ◯ No Ophthalmologist's Name: _____ Ophthalmologist's Phone Number: _____ Opthalmologist visit: ◯ Current ◯ No If not when in next appointment (Date): _____	
Hearing	☐ Unimpaired ☐ Mild Impairment ☐ Moderate Impairment But Not a Threat to Safety ☐ Impaired – Safety threat exists. ☐ Totally Deaf Uses Hearing Aid(s): ◯ Yes ◯ Right Ear ◯ Left Ear ◯ No ENT's Name: _____ ENT's Phone Number: _____ ENT visit: ◯ Current ◯ No If not when in next appointment (Date): _____	

Mental Health

Attitude
- ☐ Cooperative
- ☐ Indifferent
- ☐ Resistive
- ☐ Demanding
- ☐ Suspicious
- ☐ Hostile

Appearance
- ○ Well Groomed
- ○ Adequate
- ○ Disheveled
- ○ Inappropriately Dressed
- ○ Not Dressed

Self-Direction
- ○ Independent
- ○ Needs Motivation
- ○ Dependent
- ○ Needs Direction

Behavior
- ☐ Normal
- ☐ Wandering
- ☐ Sun downing
- ☐ Restless
- ☐ Hostile
- ☐ Withdrawn
- ☐ Self Destructive
- ☐ Safety Hazard
- ☐ Aggressive
- ☐ Verbal
- ☐ Physical

Influence
- ☐ Appropriate
- ☐ Inappropriate
- ☐ Anxious
- ☐ Blunted
- ☐ Euphoric
- ☐ Depressed
- ☐ Angry
- ☐ Mood Swings

Thought Content
- ○ Normal
- ○ Delusions
- ○ Obsessions
- ○ Phobias
- ○ Persecutory
- ○ Guilt
- ○ Can't Assess

Perceptions
- ☐ Normal
- ☐ Hallucinations
- ☐ Auditory
- ☐ Visual
- ☐ Other

Cognition
- ○ Normal
- ○ Impairment
- ○ Mild
- ○ Moderate
- ○ Severe

Insight
- ○ Good
- ○ Partial
- ○ None

Judgment
- ○ Good
- ○ Adequate
- ○ Poor

LIVING HABITS

Smoking Habits

Client Smokes
- ○ Yes
- ○ No

Degree of Problem
- ○ No Problem
- ○ Some Problem
- ○ Major Problem

Alcohol Consumption

Client Drinks
- Yes ○
- No ○

Degree of Problem
- ○ No Problem
- ○ Some Problem
- ○ Major Problem

Current Diet

- ☐ Regular
- ☐ Diabetic
- ☐ Low Fat
- ☐ Low Salt
- ☐ Vegetarian
- ☐ Other_____

Takes Supplement (E.g. Ensure)

_____

Nutritional Requirement:

_____

Eating Habits

- ○ Good
- ○ Fair
- ○ Poor

Comments:

_____

COMMUNCATION		
Language Spoken	☐ English ☐ French ☐ Chinese ☐ Japanese ☐ Italian ☐ Spanish ☐ Russian ☐ East Indian ☐ Other: _____	
Speech	○ Unimpaired ○ Simple Phrases - Understandable ○ Simple Phrases - Partially Understandable ○ Isolated Words - Understandable ○ Speech Not Understandable Or Does Not Make Sense ○ Does Not Speak If Client Cannot Speak, Indicate Method of Communicating: _____ **Method is:** ○ Effective ○ Partially Effective ○ Moderately Effective ○ Not Effective	
Understanding	○ Unimpaired ○ Understands Simple Phrases ○ Understands Key Words Only ○ Understanding Unknown ○ Not Responsive	
ACTIVITIES OF DAILY LIVING		
Mobility Aids	☐ Uses Cane ☐ Uses Walker ☐ Uses Crutches ☐ Uses Wheelchair: ☐ Manual ☐ Electric ☐ Uses Grab Bars ☐ Other Prosthesis Or Aid: _____	
Ambulation	○ Independent In Normal Environments ○ Independent Only In Specific Environment ○ Requires Supervision ○ Requires Occasional Or Minor Assistance ○ Requires significant or Continued Assistance	
Transferring	○ Independent ○ Needs Assistance: Needs Supervision transferring to: ☐ Bed ☐ Chair ☐ Toilet Needs Intermittent Assistance transferring to: ☐ Bed ☐ Chair ☐ Toilet Needs Continued Assistance transferring to: ☐ Bed ☐ Chair ☐ Toilet ○ Completely Dependent for All Movements	

Bathing	☐ Independent in Bathtub or Shower ☐ Independent with Mechanical Aids (E.g. bath seat) ☐ Requires Minor Assistance or Supervision: ☐ Getting in and Out of Tub/Shower ☐ Turning Taps On and Off ☐ Washing Back ☐ Requires Continued Assistance ☐ Resists Assistance ☐ Other: _____
Dressing	☐ Independent ☐ Supervision or Needs some help ☐ Selecting Appropriate Clothing ☐ Coordinating Colours ☐ Periodic or Daily Help Needed: ☐ Putting on Clothing ☐ Doing up Buttons, Laces, Zippers ☐ Pulling on Trousers, Socks, Shoes ☐ Determining Condition or Cleanliness of Clothing
Grooming & Hygiene	☐ Independent ☐ Requires Reminder, Motivation&/or Direction ☐ Requires Assistance with Some Things ☐ Putting Toothpaste of Toothbrush ☐ Using Electric Razor ☐ Requires Total Assistance ☐ Resists Assistance
Eating	○ Independent ○ Independent with Special Provision for Disability ○ Requires Intermittent Help With: ☐ Cutting Up/Pureeing Food ○ Must Be Fed ○ Resists Feeding
Bladder Control	○ Totally Continent ○ Needs Routine Toileting or Reminder ○ Incontinent Due to Identifiable Factors ○ Incontinent Once Per Day ○ Incontinent More than Once per Day
Bowel Control	○ Has Total Control ○ Needs Routine Toileting or Reminder ○ No Bowel Control Due to Identifiable Factors ○ Loses Bowel Control Once Per Day ○ Loses Bowel Control More than Once per Day
Toileting	☐ Requires Raised Toilet Seat or Commode ☐ Has Difficulty With Buttons, Zippers ☐ Needs Help with Aids (E.g. Catheter, Condom Drainage, etc.) ☐ Other:

Exercising	☐ Exercises Regularly: ○ Daily ○ Alternate Days ○ Twice a Week ○ Weekly ○ Other _____ ☐ Time and/or Distance _____ ☐ Recent Changes to Exercise Regime _____ ☐ Exercise Alone ☐ Exercises With Attendant ☐ Other	
INSTRUMENTAL ACTIVITIES OF DAILY LI VING		
Preparing Food	○ Independent ○ Adequate if Ingredients Supplied ○ Can Make or Buy Meals But Diet is Inadequate ○ Physically or Mentally Unable to Prepare Food ○ No Opportunity to Prepare Food or Chooses Not to Prepare Food	
Housekeeping	○ Independent ○ Generally Independent But Needs Help With Heavier Tasks ○ Can Perform Only Light Tasks Adequately ○ Performs Light Tasks But Not Adequately ○ Needs Regular Help and/or Supervision ○ No Opportunity to Do Housework or Chooses Not to Do Housework	
Shopping	○ Independent ○ Independent But For Small Items Only ○ Can Shop if Accompanied ○ Physically or Mentally Unable to Shop ○ No Opportunity to Shop or Chooses Not to Shop	
Transportation	○ Uses Private Vehicle ○ Uses Taxi or Bus ○ Independent ○ Must be Accompanied ○ Must be Driven ○ Physically or Mentally Unable to Travel ○ Needs Ambulance for Transporting	
Telephone	○ Independent ○ Can Dial Well Known Numbers ○ Answers Telephone Only ○ Physically or Mentally Unable to Use Telephone ○ No Opportunity to Use Telephone or Chooses Not to Use Telephone	
Medication/ Treatments	○ Completely Responsible for Self ○ Requires Reminder or Assistance ○ Responsible if Medications Prepared in Blistopax ○ Physically or Mentally Unable to Take Medications and Conduct Treatments ○ Resists Taking Medication or Conducting Treatments	

ATTENDANT PROFILE		
Attendant	☐ Independent ☐ Needs an Attendant ☐ Frequency of Attendant Assistance ◯ Intermittent ◯ Constantly ◯ During Day ◯ During Night ☐ Attendant Needs Met by: ◯ Spouse ◯ Friend ◯ Family ◯ Other _____	
SOCIAL PROFILE		
Housing	◯ House ◯ Apartment ◯ Condominium ◯ Mobile Home ◯ Room ◯ Facility ◯ Other _____ ◯ Self Owned ◯ Rental ◯ Urban ◯ Rural	
Living Companions	◯ Lives Alone ◯ Lives with Spouse or Spousal Equivalent ◯ Lives With Adult Children ◯ Lives With Child(ren) ◯ Lives with Other Adult Male ◯ Lives with Other Adult Female ◯ Principal Helper: _____	
Religion & Culture	☐ Ethnicity: _____ ☐ Religion: _____	
Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)		

Goals/ Rehabilitation Potential/ Discharge Plans		
VACCINATION STATUS		
COVID 19	Is all vaccinations done? ◯ Yes ◯ No	
Flu	Is all vaccinations done? ◯ Yes ◯ No	
Pneumococcal	Is all vaccinations done? ◯ Yes ◯ No	

Nurse's Signature and Date of Verbal SOC Where Applicable

Date of HHA Received Signed POT

- State -

Physician's Name and Address

I certify/recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized services on this plan of care and will periodically review the plan.

Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

Note for the Physician:

Axzons Health System Corporation	Axzons HomeCare

PLAN OF CARE/SERVICE PLAN

MRN

Name of Client and/ or Responsible Person | - Select - M/F | DOB

Street Address | City | - State - State | Zip Code

Home Phone | Cell Phone | Email Address

Emergency Contact Name 1 | Relationship

Phone Number | Alternate Number

Emergency Contact Name 2 | Relationship

Phone Number | Alternate Number

- Select - Type of Service Needed | Level of Service Needed | Required Nursing Assessment

Axzons Health System Corporation	Axzons HomeCare

Client's Functional Limitations:

☐ Hearing ☐ Speech ☐ Vision ☐ Mobility ☐ Swallowing

☐ Breathing ☐ Cognition ☐ Performing Activities of Daily Living

Height: _____ ft _____ in Weight: _____ Lbs

Special diet and /or Nutritional Needs Yes: ◯ No: ◯

Allergy(ies) Yes: ◯ No: ◯

Services Requested	√	Frequency (per visit, per request, daily, weekly, etc.)	Services Requested	√	Frequency (per visit, per request, daily, weekly, etc.)
PERSONAL CARE					
Brush Teeth / Clean Dentures	☐		Clean Hearing Aid(s)	☐	
Clean Nasal Cannula	☐		Shave (Electric)	☐	
Routine Skin Care	☐		Dressing/Undressing	☐	
Bath		☐ Bed ☐ Sponge ☐ Tub ☐ Shower	Toileting		☐ Toilet ☐ Bedside Commode ☐ Bedpan ☐ Urinal ☐ Toilet Hygiene
Hair Care		☐ Wash ☐ Shampoo			
Nail Care (Filing, DO NOT CUT)	☐		Incontinent Care		☐ Changing Diapers ☐ Skin Care
Foot Care	☐				

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Services Requested	√	Frequency (per visit, per request, daily, weekly, etc.)	Services Requested	√	Frequency (per visit, per request, daily, weekly, etc.)
NUTRITION					
Meal Preparation	☐ Breakfast ☐ Lunch ☐ Dinner ☐ Food For Next Day		Feeding	☐ Reinforce Diet ☐ Serving ☐ Clean Up	
Fluids	◯ Yes ◯ No ☐ Encourage ☐ Restrict		Other	☐	
ACTIVITIES/ASSISTIVE DEVICES					
Ambulation	☐ Walking ☐ Walker ☐ Rollator ☐ Cane ☐ Wheelchair		Take Client for Walk	☐	
			Weight Bearing Restriction	◯ Yes ◯ No	
			Transferring	☐	
			Turning/Positioning	☐	
			Complete Bedrest	☐	
Bedrest with Bathroom Previleges	◯ Yes ◯ No		Supervision/Assistance with Exercise and Therapy	☐	
Up As Tolerated	◯ Yes ◯ No		Other	☐	
RELATED DUTIES					
Medication Reminding	☐		Grocery Shopping	☐	
Pick Up Mall	☐		Trash Management	☐	
Other	☐		Other	☐	
FRIENDLY REASSURANCE / PHONE CHECK / HOME VISIT					
Friendly Home Visit Check	☐		Telephone Check/Monitor	☐	
Other	☐		Other	☐	

Axzons Health System Corporation	Axzons HomeCare

Services Requested	√	Frequency (per visit, per request, daily, weekly, etc.)	Services Requested	√	Frequency (per visit, per request, daily, weekly, etc.)
HOMEMAKING TASKS					
Make Bed	☐		Light Housekeeping		
Change Linen	☐			☐ Vaccum / Sweep Floors	
Laundry	☐			☐ Dust Furniture	
Other	☐			☐ Clean Oven / Microwave	
Other	☐			☐ Wet Mop Floors	
				☐ Clean Kitchen Surfaces	
				☐ Clean Bathroom Sink	
				☐ Clean Bathtub / Shower	
				☐ Clean Toilet	

Notes/Comments:

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Plan of Care			
Medications			
Medication	**Dose**	**Frequency**	**Route/Changes**
1OD: One Tablet Once a day **1TDS:** One Tablet Thrice a day		**1BD:** One Tablet Twice a day **1QID:** One Tablet Four times a day.	

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The following information has been provided to and/or discussed with the Client:

☐ Roles and Responsibilities ☐ Code of Ethics ☐ Costs & Billing

☐ Confidentiality of Client Information ☐ Contact Information ☐ Client Consent

☐ Other: _____ ☐ Other: _____

Patient/HHA/PCA Acknowledgement:

I acknowledge that in case of any adverse change including but not limited to hospitalization, in the condition of patient. I will report to the agency supervisor as soon as feasible at **1-866-429-9667.** In case the supervisor is not immediately available, I will leave a detailed vaoice message and or email at nursing@axzonshomecare.com

Documentation & Information:

I acknowledge that the information and documentation as noted above, has been discussed with me and I will be provided with a copy.

Client Consent:

I consent to have the Non-Medical Home Services as requested and recorded in this Service Plan. I understand that my service requests/needs will be reviewed by the Supervisor at least every _____ months, or as required, and that the service(s) may be changed according to the patient needs as prescribed by the Patient's Physician.

_____

Client/Client's Representative's Signature Date

_____

Agency Supervisor/Designee's Signature Date

_____

Name of Individual Preparing Service Plan Title of Agency Represent

_____

Service Start Date Day(s) of Service(s) in a Week

12 00 AM 12 00 PM _____ _____

Service Start Time Service End Time Authorized Number of hours

Verbal Consent Received from Client Service End Time ○ Yes ○ No

Patient Emergency Preparedness Plan Guidelines

Emergency Contact Information:

Name1 _____ Name2 _____

Relation _____ Relation _____

Phone _____ Phone _____

Address | Address

Police: _____

Fire: _____

EMS: _____

Local Red Cross: _____

Local Emergency Management Office: _____

Pharmacy: _____

Medical equipment provider Name: _____ and Ph: _____

Medical supplies provider Name: _____ and Ph: _____

Neighbor: _____

Relatives: _____

Radio or TV stations: Know which station will have emergency broadcast announcements and set a TV or radio to that station.

Smoke Alarm and Escape Routes Locations:

Smoke Alarms How many: _____ Location: _____

Carbon monoxide Alarms How many: _____ Location: _____

Escape Routes How many: _____ Location: _____

Person to Call in case of separation Name: _____ Ph: _____

Make a ready list and update regularly:

Medications
Medical information
Allergies and sensitivities
Copies of health insurance cards
Food and Water store for 3 days for each person (1 Gallon per day per person) Yes ◯ No ◉
Emergency Survival Kit Yes ◯ No ◉
Is the patient using oxygen Yes ◯ No ◉
Ventilator/Light support equipment Yes ◯ No ◉
(If Yes Register with local utility company and with local emergency offices)

Recommended items to have on hand:

A seven-day supply of essential medications
Cell phone
Standard telephone (that does not need to be plugged into an electric outlet) Flashlights and extra batteries.
Emergency food
Assorted sizes of re-closeable plastic bags for storing, food, waste, etc.

- Small battery-operated radio and extra batteries
- Assemble a first aid kit (Appendix A)

Evacuation Plans:

Know where the shelter is located that can meet your special needs
Plan for alternate locations
Plan for transportation to a shelter or other location.
"Have a "grab bag" prepared (Appendix B)
Arrange for assistance if you are unable to evacuate by yourself

Shelter–in-Place:

Maintain a supply of non-perishable foods for seven days
Maintain a supply of bottled water; one gallon per person
Be prepared to close, lock and board/seal windows and doors if necessary
Have an emergency supply kit prepared (Appendix C)

Pets:

Have a care plan for your pet
Locate a shelter for your pet (hotel, local animal shelter etc.) Emergency shelters will not accept animals.
Extra food and/or medications, leashes, carriers, bowls, ID tags etc.

Special Needs Considerations

Speech or communication Issues:

If you use a laptop computer for communication, consider getting a power converter that plugs into the cigarette lighter

Hearing Issues:

Have a pre-printed copy of key phrase messages handy, such as "I use American Sign Language (ASL),""I do not write or read English well, "If you make announcements, I will need to have them written simply or signed"
Consider getting a weather radio, with a visual/text display that warns of weather emergencies

Vision Issues:

Mark your disaster supplies with fluorescent tape, large print, or Braille
Have high-powered flashlights with wide beams and extra batteries
Place security lights in each room to light paths of travel.

Assistive Device Users:

Label equipment with simple instruction cards on how to operate it (for example, how to "free wheel" or "disengage the gears" of your power wheelchair) Attach the cards to your equipment.
If you use a cane, keep extras in strategic, consistent and secured locations to help you maneuver around obstacles and hazards.
Keep a spare cane in your emergency kit.
Know what your options are if you are not able to evacuate with your assistive device.

Axzons HomeCare

FAX

TO:	Dr.	FROM:	Axzons Home Health Care
FAX:		FAX:	1-866-429-9667
PHONE:		PHONE:	1-866-429-9667
SUBJECT:	Home health plan of care and certification	DATE:	

COMMENTS:

Dear Dr. _____.

Attached is the Home Health certification and plan of care for

_____, DOB: _____

_____ _____ - State - _____ _____

Please sign and return the same to Axzons at
FAX: 1-866-429-9667 or Email: nursing@axzonshomecare.com

Warm Regards

Rosemarie Gurion RN
Director Patient Services
Axzons Home Health Care
1-866-429-9667 Ext. 701

For any questions and suggestions, please visit www.axzonshomecare.com.

Axzons is the Lead CDPAP Agency of New York

Axzons HomeCare

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB No. 0938-0357

HOME HEALTH CERTIFICATION AND PLAN OF CARE

1. Patient's HI Claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
		From: To:		

6. Patient's Name and Address

- State -

7. Provider's Name, Address and Telephone Number

Axzons Health System Corp
70 E Sunrise Highway, Ste 500
Valley Stream, NY 11581
1-866-429-9667 www.axzonshomecare.com

8. Date of Birth

9. Sex - Select -

10. Medications: Dose/Frequency/Route (N)ew (C)hanged

11. ICD 1	Principal Diagnosis	Date
12. ICD 2	Other Pertinent Diagnoses	Date
13. ICD 3	Surgical Procedure	Date

14. DME and Supplies

MLTC for Diapers and PPE, Agency for PPE

15. Safety Measures

16. Nutritional Req.

17. Allergies

18.A. Functional Limitations

1 ☐ Amputation
2 ☐ Bowel/Bladder (Incontinance)
3 ☐ Contracture
4 ☐ Hearing
5 ☐ Paralysis
6 ☐ Endurance
7 ☐ Ambulation
8 ☐ Speech
9 ☐ Legally Blind
10 ☐ Dyspnea With Minimal Exertion
11 ☐ Other (Specify)

18.B. Activities Permitted

1 ☐ Complete Bedrest
2 ☐ Bedrest BRP
3 ☐ Up As Tolerated
4 ☐ Transfer Bed/Chair
5 ☐ Exercises Prescribed
6 ☐ Partial Weight Bearing
7 ☐ Independent At Home
8 ☐ Crutches
9 ☐ Cane
10 ☐ Wheelchair
11 ☐ Walker
12 ☐ No Restrictions
13 ☐ Other (Specify)

19. Mental Status: 1 ☐ Oriented 2 ☐ Comatose 3 ☐ Forgetful 4 ☐ Depressed 5 ☐ Disoriented 6 ☐ Lethargic 7 ☐ Agitated 8 Other

20. Prognosis: 1 ◯ Poor 2 ◯ Guarded 3 ◯ Fair 4 ◯ Good 5 ◯ Excellent

21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)

22. Goals/Rehabilitation Potential/Discharge Plans

23. Nurse's Signature and Date of Verbal SOC Where Applicable:

25. Date of HHA Received Signed POT

24. Physician's Name and Address

- State -

26. I certify/recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized services on this plan of care and will periodically review the plan.

27. Attending Physician's Signature Date Signed

28. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

Privacy Act Statement

Sections 1812, 1814, 1815, 1816, 1861 and 1862 of the Social Security Act authorize collection of this information. The primary use of this information is to process and pay Medicare benefits to or on behalf of eligible individuals. Disclosure of this information may be made to: Peer Review Organizations and Quality Review Organizations in connection with their review of claims, or in connection with studies or other review activities, conducted pursuant to Part B of Title XI of the Social Security Act; State Licensing Boards for review of unethical practices or nonprofessional conduct; A congressional office from the record of an individual in response to an inquiry from the congressional office at the request of that individual.

Where the individual's identification number is his/her Social Security Number (SSN), collection of this information is authorized by Executive Order 9397. Furnishing the information on this form, including the SSN, is voluntary, but failure to do so may result in disapproval of the request for payment of Medicare benefits.

Paper Work Burden Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0357. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Mailstop N2-14-26, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

ORIENTATION LETTER

Dear _____,

Welcome to Axzons.

This is an **introductory orientation** to familiarize you with Axzons, The only Home Health Care Agency in NY managed by healthcare professionals. Axzons services the areas of Suffolk, Nassau, Queens and Westchester besides most of the upstate NY. Axzons is the Lead FI in the State of New York.

This is an **admission package**. Please **sign the admission package** sent to you electronically or by mail and return to us.

You are required to **fill in the daily flow sheet** (timesheet) in the Axzons PA Handbook. Please make sure to fax (1-866-429-9667) or send an image by text (516-738-6860) or email the timesheet to accounts@axzonshomecare.com at the end of shift every Sunday or on Monday. Completion of this sheet is essential for agency to know about the care performed.
PAs also check in and check out electronically from their phones every time upon start of the visit to the client and at the end of the visit to the client.
In case of any **change in patient's condition** or upon admission to a higher level of care such as an inpatient hospital or skilled nursing facility, PAs are required to inform the Agency as soon as possible by calling at 1-866-429-9667 Ext 701 or by emailing nursing@axzonshomecare.com.
Please always inform the agency in case of any schedule change requirements.

For afterhours care issues, please call at 1-866-429-9667 and someone will get back to you in a short time. The messages are sent over to the relevant team members on call during weekends and will respond promptly upon receiving.
We are also at Facebook, Twitter, Instagram, YouTube and linked in.
Please do visit us at the above social media sites and website at www.axzonshomecare.com to interact with other patients and caregivers and just about everyone.

Contact Information:
Accounts: For any accounting issues please direct all your queries to accounts@axzonshomecare.com
Scheduling: 1-866-429-9667 Ext. 707 or email scheduling@axzonshomecare.com.
Nursing: 1-866-429-9667 Ext 701 or email nursing@axzonshomecare.com
Care coordination: 1-866-429-9667 and ask for your care coordinator

Healthcare Updates: Please visit regularly https://axzonshomecare.com/blogs for ongoing updates on various new healthcare challanges facing our patient community and how Axzons helps in preventing or treating them.

Handbook for PA: Please read the instructions in the PA Handbook at this link.
https://axzonshomecarecom.sharepoint.com/:b:/g/EQHbaVHOiZ1Kp2Pnt4uz538BQgZI3RTwvp4eIGv8vYxIJQ?e=lRjSwR

Expires 12/31/2023

Consumer Welcome Handbook: Please read the instructions in the Consumer Handbook at this link. **https://axzonshomecarecom.sharepoint.com/:b:/g/EfcOVGkB6IlOn_VxYvTQ144BSBy7Y3AAMZzr5kxe8yA5-g?e=k925I0**

PA Timesheets for Printing: Please print the time sheets from this link, in case you have run out or are still in the mail to you. **https://axzonshomecarecom.sharepoint.com/:b:/g/EfLcUwHFHo1Khwh7h0vYhjwBvylyk96Sk-fjDYFAeqFpVQ?e=IC7hqE**

Regards
Nursing Department
Axzons Home Health Care

Expires 12/31/2023

Axzons HomeCare

FULL SERVICE HOME CARE

Are you looking for home healthcare professionals who are compassionate with the knowledge to care and be there for you?

.....then you have found the best professional team!

CONTACT US

1(866) 429-9667
1(866)4AXZONS
www.axzonshomecare.com
info@axzonshomecare.com

Axzons Home Health Care locations are open
Monday to Friday 8:00 am to 8:00 pm

Axzons In-Home Healthcare

866-4AXZONS

Axzons In-Home Healthcare

866-4AXZONS

At AXZONS HOME HEALTH CARE we believe in putting you first. We will work closely with you and those important to you to provide professional in-home care.

NEW YORK STATE LICENSED HOME CARE COMPANY

NASSAU SUFFOLK QUEENS WESTCHESTER
BROOKLYN BRONX CONNECTICUT MASSACHUSSETS
PENNSYLVANIA

AVAILABLE 24X7

#axzonscare

www.axzonshomecare.com

Expires 12/31/2023

Axzons Health System Corporation

Axzons HomeCare

FAX: _____

DISCHARGE/TRANSFER:

Patient's Physician NOTIFICATION TO _____

_____
MRN

_____ - Select - _____
Name of Client and/ or Responsible Person M/F DOB Social Security Number

_____
Insurance Name Insurance ID # Medicaid #

_____ - State - _____
Street Address City State Zip Code

_____
Home Phone Cell Phone Email Address

_____
Emergency Contact Name 1 Relationship

_____
Email Address Phone No. Alternate No.

_____
Emergency Contact Name 2 Relationship

_____
Email Address Phone No. Alternate No.

_____
Client Diagnosis Code Client Primary Diagnosis Client Diagnosis Code Client Secondary Diagnosis

_____ - Select - _____ Required
Type of Service Needed Level of Service Needed Nursing Assessment

_____
Authorization Number From Date To Date Code Modifier

_____
PCP First Name PCP Last Name NPI Phone No. Fax No.

_____ - State - _____
Street Address City State Zip Code

Please be advised that effective _____,Patient will get discharged from the services being provided by Axzons Health System Corp.

The Patient has been discharged to:

- ☐ Hospital
- ☐ Self/Family/Friends
- ☐ Nursing Home
- ☐ CHHA (Certified Home Health Agency)
- ☐ LTHHCP (Long Term Home)
- ☐ LHCSA (Another Agency)
- ☐ Hospice
- ☐ Adult Care Facility
- ☐ MLTC/MCOs
- ☐ Death
- ☐ Transferred to: _____
  Name of Facility/Agency/Other
- ☐ Other (Specify): _____

Summary of care provided:

Summary of patient progress:

Patient status and the description of any remaining needs for patient care and supportive services upon discharge:

Patient or family's ability to self-manage in relation to any remaining problems, and recommendations and referral for any follow-up care If applicable:

You may request an informal meeting to discuss this plan with the Agency Management Team within 10 days of the date of this notification. You also have the right to seek legal counsel.

_____ _____

Signature of Agency Representative Date

_____

Title of Agency Representative