Caregiver Pro Homecare, Inc.
12201 Liberty Ave, 2FL, Richmond Hill, NY 11419
Phone: (718)-504-8054 | Fax: (866)-220-5663
Email: Info@Caregiverprohomecare.com

COMPLAINTS

As a home care client, you have the right to voice and submit complaints and dissatisfaction about the care and services provided or not provided by **Caregiver Pro Homecare, Inc.**

The procedure to submit your complaints are as follows:

1. Call the agency Phone: **(718)-504-8054**,
2. Ask for the Director of Patient Services or Administrator
3. Explain your concerns

You may submit your complaint in writing:

12201 Liberty Ave, 2FL, Richmond Hill, NY 11419
Fax: (866)-220-5663

The agency will investigate your allegations within 15 days of receipt of complaint. A written response will be provided to all written complaints and to oral complaints, if requested by the individuals making the oral complaint. Also, if dissatisfied with the outcome, you may submit and appeal to the agency's governing authority. All appeals will be reviewed within 30 days of receipt of appeal request.

In New York State, home care clients may also submit complaints to the Department of Health. If you are dissatisfied with the outcome of our complaint resolution, you may also submit the complaint to the New York State Department of Health or any outside representative of the client's choice.

NVS Department of Health
Metropolitan Reglonal Offlce
90 Church Street
New York, NV 10007
212-417-5888
Hotline (available 24/7): 1-800-628-5972

The expression of such complaints by the client or client designee shall be free from interference, coercion, discrimination, or reprisal.

Client Name:

Client Signature:

Date:

CARE GIVER

HOME CARE BILL OF RIGHTS AND CLIENT RESPONSIBILITIES: PAGE 1 OF 2

CLIENT'S NAME:

As a patient of **Caregiver Pro Homecare, Inc.** you have the right to:

1. Be informed of your rights both verbally and in writing at the time of admission and prior to the initiation of care.
2. Receive competent, individualized care and service from **Caregiver Pro Homecare, Inc.** staff regardless of age, race, color, national origin, religion, sex, disease, disability or any other category protected by law or decisions regarding advance directives.
3. Be treated with dignity, courtesy, consideration, respect, and have your property treated with respect.
4. Be informed verbally and in writing of the services available and related charges, as they apply to the primary insurance, other payers, and self-pay coverage before care is initiated. To be informed of any changes in the sources of payment and your financial responsibility as soon as possible but no later than thirty (30) calendar days after **Caregiver Pro Homecare, Inc.** becomes aware of the change.
5. Be informed both orally and in writing, in advance of the plan of care, of any changes in the plan of care, and to be included in the planning of care before treatment begins; be informed of all treatment prescribed, when and how services will be provided, and the names and functions of any person and affiliated program providing care and services, including photo identification of agency staff and participate in the development of the discharge plan.
6. Participate in the planning of your care and be advised in advance of any changes in the plan of care.
7. Refuse care and treatment after being fully informed of and understanding the consequences of such actions and to initiate an advance directive, "living will," durable power of attorney and other directives about your care consistent with applicable law and regulations. Refuse to participate in research or experimental treatment.
8. To appropriate assessment of pain and management of his/her pain.
9. Receive information regarding community resources and to be informed of any financial relationships between **Caregiver Pro Homecare, Inc.** and other providers to which you may be referred to by **Caregiver Pro Homecare, Inc.**
10. Be informed of the procedures for submitting patient complaints, voice complaints, and recommend changes in the policies and services to the Administrator by calling the agency.

    If dissatisfied with the outcome, you have the right to submit the complaint to the New York State Department of Health or any outside representative of the patient's choice. The expression of such complaints by the patient or patient designee shall be free from interference, coercion, discrimination, or reprisal. They can be contacted at:

    NVS Department of Health
    Metropolitan Reglonal Offlce
    90 Church Street, New York, NV 10007
    212-417-5888
    Hotline (available 24/7): 1-800-628-5972

HOME CARE BILL OF RIGHTS AND CLIENT RESPONSIBILITIES: PAGE 2 OF 2

CLIENT'S NAME:

Express complaints about the care and services provided or not provided and complaints concerning lack of respect for property by personnel furnishing services on behalf of **Caregiver Pro Homecare, Inc.** LLC and to expect the agency to investigate such complaints within 15 days of receipt of complaint. Also, if dissatisfied with the outcome, you have the right to submit an appeal to the agency's governing authority which will be reviewed within 30 days of receipt of appeal request.

11. Receive timely notice of impending discharge or transfer to another agency or to a different level of care and to be advised of the consequences and alternatives to such transfers.
12. Privacy, including confidential treatment of records and access to your records on request. Information will not be released without your written consent except for those instances required by law, regulation, or third-party reimbursement.
13. In the situation when the patient lacks capacity to exercise these rights, the rights shall be exercised by and individual, guardian, or entity legally authorized to represent the patient.

As a home care client, you have the responsibility to:

1. Be seen by a doctor on a regular and ongoing basis.
2. Share complete and accurate health information.
3. Be responsible for following the recommended treatment plan.
4. Make it known if you do not understand or cannot follow the treatment plan.
5. Cooperate with agency staff and not discriminate against staff.
6. Notify the agency in advance when you cannot keep a scheduled appointment.
7. Notify the agency if you receive services from another agency.
8. Notify the agency in the event of change in your health status.
9. Be responsible for your actions if you refuse treatment or do not follow the agency's recommendations/directions.
10. Take responsibility for financial obligations of your care.
11. Maintain a home environment that facilitates effective home care.

Patient/Representative Signature:	Date:
Witness Signature:	Date:

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SERVICES CONSENT/STATEMENT OF SERVICES AND CHARGES
RELEASE OF INFORMATION/ACKNOWLEDGEMENT

Client:

( ) I authorize the staff to provide services, as requested by myself/representative and ordered by my physician. Services provided by **Caregiver Pro Homecare, Inc.** may include nursing, home health aide, personal care aide, social worker, dietician/nutritionist, physical therapist, speech therapist, occupational therapist, audiologist, respiratory therapist, homemaker, and housekeeper.

( ) The services provided by **Caregiver Pro Homecare, Inc.** will have been explained to me and I understand that I may refuse treatment within the confines of the law after being informed of the consequences of my action.

( ) I give my consent and authorization for release of medical information to **Caregiver Pro Homecare, Inc.** by physician and other health care provider facilities.

( ) I authorize **Caregiver Pro Homecare, Inc.** and other licensing/regulatory bodies to periodically examine my medical record for the purpose of checking compliance to the applicable rules, regulations, and standards.

( ) I understand that it would be prudent and in my best interest to establish a Home Health Service Plan of Care in the event of an emergency such as a fire, hurricane, severe snowstorm, or other natural disaster. Therefore, I hereby grant **Caregiver Pro Homecare, Inc.** permission to reveal to any governmental agency, supplemental provider agency, community volunteer service, or any other providers of services, medical records regarding my nursing care, except where otherwise prohibited by law. I further understand this would be done as necessary, upon request, in order to ensure a safe and effective emergency preparedness plan of care.

( ) I acknowledge receiving verbal and written information concerning my **Rights and Responsiblllties** as a home care client and the **NYS Proxy Law/Advance Directives.** In addition the agency has provided a *written procedure for submitting complaints and concerns, and directions regarding contacting the agency after hours, on weekends, and holidays.*

Service	Frequency	Hourly Fee	Weekend/Holiday Fee	Expected Insurance Coverage	Patient's Financial Responsibility
PCA/HHA		N/A	N/A	100%	0%
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* See Agency's Rate/Fee Sheet

( ) I agree that I (or my representative) shall be directly responsible for payment for all home care services provided according to this service agreement. I understand that the invoices are rendered weekly and payable upon receipt. Late payments over 30 days will result in a **1.5%** late fee charge per month.

( ) I agree to pay a sum of **$2500** in damages to reimburse **Caregiver Pro Homecare, Inc.** for the cost of recruiting, hiring, and training, if I directly employ an employee of the company that has provided services within six months of services.

Client/Representative Signature:	Date:

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ASSIGNMENT OF INSURANCE BENEFITS

Client Name:

Address:

Client Representatives:

Relationship:

Assignment of Benefits

I authorize direct payment to **Caregiver Pro Homecare, Inc.** of any insurance benefits otherwise payable to me for home health care services. I also authorize my insurance company(ies) to furnish to an agent of **Caregiver Pro Homecare, Inc.** any and all information pertaining to my insurance benefits and status of claims submitted by **Caregiver Pro Homecare, Inc.** for services rendered. I further authorize **Caregiver Pro Homecare, Inc.** to release my insurance company(ies) any and all information pertaining to me for benefit determination.

Acknowledgment of Financial Responsibility:

While there may be insurance coverage for those services provided by **Caregiver Pro Homecare, Inc.** to me relative to my care needs, I recognize that all services may not be covered, or that reimbursement may be less than 100 percent of charges billed, in accordance with my policy coverage. Therefore, I acknowledge financial responsibility for any balance owing on my account. In addition, I agree to be responsible for the full amount of the charges if no payment has been made by 45 days from the date a claim was submitted to an insurance company or if my physician or I fail to provide within 45 days, the information necessary to submit the claim for service. I agree to transfer immediately to **Caregiver Pro Homecare, Inc.** any payment made directly to me for services provided by **Caregiver Pro Homecare, Inc.** on an assignment basis.

The undersigned certifies that he/she has read the Assignment of Insurance Benefits and Acknowledgement of Financial Responsibility, has received a copy, and is the client or is duly authorized by the client as the client's general agent to execute the above and accept its items.

Beneficiary/Representative Signature:	Date:
Witness:	Date:

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NOTICE OF PRIVACY PRACTICES

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

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the NASW Code of Ethics. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As a social worker licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the NASW Code of Ethics and HIPAA.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information

regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (SO} years is not protected under HIPAA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent} and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent}, court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. We may send you fundraising communications at one time or another. You have the right to opt out of such fund raising communications with each solicitation you receive.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii} disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer.

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- Right of Access to Inspect and Copy. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- Right to Amend. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- Right to an Accounting of Disclosures. You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- Right to Request Restrictions. You have the right to request a restrlction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- Right to Request Confidential Communication. You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- Breach Notification. If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- Right to a Copy of this Notice. You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at or with the New York State Department of Health.

Client Name:

Client Signature:

Date: