Home Care Agency Name
Home Care Agency Address

Call: 212-718-9005 | **Fax:** 212-718-9006
Location: 101 Bedford Ave, Brooklyn, NY

Welcome Package

John Doe

DOB: 01/15/1950 **Gender:** M **Mobile:** 212-718-9005 **Address:** 101 Bedford Avenue, Brooklyn, NY **Clinician:** Jane Doe, RN

Included Materials

- ☑ Services Consent
- ☑ Statement of Services and Charges
- ☑ Patient Bill of Rights
- ☑ Patient Responsibility
- ☑ HIPAA Consent
- ☑ Notice of Privacy Practices
- ☑ EVV Orientation Document
- ☑ Complaint/Grievance Procedure
- ☑ Palliative Care & Counseling Info
- ☑ Advanced Directives Information
- ☑ Safety Info & Infection Control
- ☑ Emergency & Disaster Preparedness

Acknowledgment of Access

I acknowledge that I received the Home Care Agency Welcome Package with the materials listed above, and that it was provided to me via a link sent by the Home Care Agency by SMS during my Start of Care visit.

PATIENT

John Doe 02/09/2026
Patient Signature

REGISTERED NURSE

Jane Doe, RN 02/09/2026
RN Signature

Services Consent

Statement of Services and Charges — Release of Information / Acknowledgement

- ☑ I **authorize** Home Care Agency staff to provide services, as requested by myself/representative and ordered by my physician. Services provided by the Agency may include Nursing, Medical Social Worker, Home Health Aide, Personal Care Aide, Therapy, Nutrition, Physician Services, Housekeeper and Homemaker.
- ☑ The services provided which Home Care Agency will provide 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 Home Care Agency by physician and other health care providers, facilities.
- ☑ I **give consent** for release of my medical/demographic information to agencies/entities that partner Home Care Agency to provide my services.
- ☑ I **authorize** Home Care Agency and other licensing/regulatory bodies to periodically examine my medical record for the purpose of checking compliance to applicable rules, regulations and standards.
- ☑ I understand that it would be prudent and in my best interests to establish a **Home Health Service Plan of Care** in the event of an emergency. Therefore, I hereby grant Home Care Agency permission to reveal to any governmental agency records regarding my nursing care in such events.
- ☑ I acknowledge receiving verbal and written information concerning my **Rights and Responsibilities** 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.
- ☑ I **agree not to pay personnel directly** for services during the time care is being provided by Home Care Agency, as well as after discharge from the agency. I will not solicit or accept employment of Home Care Agency personnel.

Financial Responsibility

Based on your current health status, your physician's orders and the insurance information we have at the time, we anticipate that these services will be covered by: **Current Payer Source:** ☑ Managed Long-Term Care ☐ Certified Home Health Agency ☐ Private ☐ Other

Service	Frequency	Cost	Responsibility
☐ HHA ☑ PCA	26 hrs x week	$35/hour	$ 0
RN Initial	1 visit	$125/visit	$ 0
RN Visit	Every 6 months/PRN	$100/visit	$ 0

Note: Home Care Agency may be required to obtain prior approval. Services are subject to change. We will notify you of any changes within 30 days.

☑ **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.**

Patient Bill of Rights

Upon admission to Home Care Agency, you are given these rights to exercise during the course of care and treatment. **THE CLIENT HAS THE RIGHT TO:**

1. To be **fully informed** of these rights and knowledgeable of all rights and responsibilities in writing before providing care.
2. All information regarding rights, policies and procedures will be provided in both **writing and orally**.
3. To receive treatment with **utmost dignity and respect** by all agency representatives, regardless of lifestyle, beliefs, race, religion, sex, disability, or age.
4. To have his/her **property and person treated with respect**, consideration, and recognition of client dignity.
5. If the client lacks capacity, rights may be exercised by an individual or **guardian**.
6. To **recommend changes** in policies and services to the agency staff or other entities of the client's choice free from restraint, interference, coercion, discrimination or reprisal.
7. To be **informed of all services** from the Agency that is to be provided, when and how the services will be provided before care is given.
8. To **participate in the planning** of his or care and of any changes in the care to be provided before the change is made.
9. To **know the names**, positions and functions of any agency staff involved in your care and frequency of visits proposed to be provided.
10. To receive and access services **consistently and in a timely manner** from the agency to his/her request for service.
11. To receive all the information that you need to give **informed consent** for any proposed procedure or treatment. This information shall include the possible risks and benefits.
12. To have the information necessary to **refuse care and treatment** after being fully informed and understanding the consequences of such actions.
13. To be informed of client rights under state law to **formulate advance directives**.
14. To **privacy** and be treated with consideration, respect and full recognition of his or her dignity and individuality.
15. To **confidentiality and privacy** of all information contained in the client record and of Protected Health Information.
16. Participate in all decisions about your treatment and **discharge** from the agency.
17. To receive a **statement of the services** by the agency and related charges.
18. Be **advised before care is started** of the extent of which payment for the agency services may be expected from third-party payers.
19. To be informed orally and in writing of any **changes in payment information** as soon as possible, no later than 30 days.
20. To be **referred to another agency** if he/she is dissatisfied with the agency.
21. Be informed of procedures for submitting a **client complaint** about the care and services provided.

Patient Responsibility

The Patient has the responsibility:

1. To provide, to the best of his/her knowledge, **accurate and complete information** about: past and present medical histories, unexpected changes in condition, and whether he/she understands a course of action selected.
2. To **follow the treatment recommended** by the physician handling the case.
3. For his/her actions if he/she **refused treatment** or does not follow the physician's orders.
4. For ensuring that the **financial obligations** of his/her health care are fulfilled as promptly as possible.
5. To **respect the rights** of all staff providing service.
6. To **notify the agency promptly** in advance of an appointment or visit you must cancel.
7. To become **independent in care** to the extent possible, utilizing self, family, and other resources.
8. To provide a copy of all **advance directives** to the Agency as requested.
9. For complying with the **rules and regulations** established by the agency.
10. Assist in maintaining a **safe environment**.

HIPAA Consent

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care services. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care services. You have the right to revoke this consent, in writing, except where we have already taken actions and made disclosures in reliance on your prior consent.

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 it carefully.

Our Legal Duty: We are required by law to maintain the privacy of your health information.

Uses and Disclosures: We may use or disclose your health information for **Treatment**, **Payment**, and **Health Care Operations**.

Your Rights: Right to request restrictions, receive confidential communications, inspect/copy, amend, and receive accounting of disclosures.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with Home Care Agency.

EVV Orientation Document

As part of our commitment to enhancing the quality and efficiency of your care, we are introducing **Electronic Visit Verification (EVV)**. This initiative aligns with the evolving healthcare landscape.

WHAT IS EVV?

EVV is mandated by New York Medicaid to ensure that you receive the approved services timely and efficiently. During each visit, your caregiver will use EVV to report essential information related to the care you receive.

WHAT INFORMATION IS REPORTED?

- Date and duration of the visit
- Type of services provided
- Caregiver's name
- Your name as the recipient
- Location of the visit
- (Privacy and Protection guaranteed)

WHY EVV?

The introduction of EVV is not meant to change your care in any way. Its goals are to ensure timely service delivery, reduce administrative burdens, and prevent fraud.

HOW WILL CAREGIVERS USE EVV?

Caregivers will use our mobile app for quick and secure Electronic Visit Verification (EVV). This user-friendly tool allows them to effortlessly report visit details.

> **Your Role:** Your awareness and cooperation with the EVV process are crucial. By signing on page 1, you acknowledge that you understand the necessity of EVV.

Complaint/Grievance Procedure

You may express complaints or grievances about the care and services provided and have the agency investigate such complaints or grievances. You may voice your complaints or problems in person, via phone, or in writing to:

Home Care Agency
101 Bedford Avenue, Brooklyn, NY
Tel: 212-718-9005 (24/7 After hours)

SPECIFIC COMPLAINTS SHOULD BE ADDRESSED TO:

- **Professional staff:** Director of Patient Services.
- **Paraprofessional staff:** Staffing Coordinator.
- **Payroll/Billing:** Business office (9 AM – 5 PM).
- **HIPAA violations:** HIPAA Privacy Officer (9 AM – 5 PM).

Written complaints will be responded to in writing within 15 business days. If you are dissatisfied with the resolution of your complaint, you may appeal this in writing to the Governing Authority of the agency (30 days).

NEW YORK STATE HEALTH DEPARTMENT
Metropolitan Area Regional Office
90 Church Street, New York, NY 10007
800-628-5972

Palliative Care & Counseling

What is Palliative Care?	Specialized medical care focusing on relief from pain and other symptoms of serious illness. The goal is to improve quality of life for both the patient and family.
When is it Appropriate?	Palliative care is appropriate at any age and at any stage in a serious illness and can be provided along with curative treatment.
Services Available:	Pain management, Emotional/spiritual support, Coordination of care, Family support.
Counseling Services:	Individual/Family counseling, Grief counseling, Support groups.
Access:	Contact Home Care Agency at 212-718-9005.

Advanced Directives

What are Advanced Directives? Advanced directives are legal documents that allow you to convey your decisions about end-of-life care ahead of time.

TYPES OF ADVANCED DIRECTIVES:

Living Will:	Written document stating wishes if unable to speak.	**Health Care Proxy:**	Appoint someone to make decisions.
DNR Order:	Do Not Resuscitate order.	**MOLST:**	Medical Orders for Life-Sustaining Treatment.

YOUR RIGHTS UNDER NEW YORK STATE LAW

- Right to **make decisions** about your medical care.
- Right to **accept or refuse** medical treatment.
- Right to **prepare an advanced directive**.
- You cannot be discriminated against based on whether you have an advanced directive.

HOW TO CREATE ADVANCED DIRECTIVES

You can obtain forms from: Your doctor, Your lawyer, Local hospitals, NYS Dept of Health website, Home Care Agency staff can provide forms.

> **Important Notes:** Advanced directives must be signed by you and witnessed according to state law. You should give copies to your doctor, family members, and health care agent.

Safety Information and Infection Control

Providing safety information to patients — especially elderly individuals receiving home care — is essential to prevent accidents and emergencies in the home.

HOME SAFETY GUIDELINES

Fall Prevention:	Keep walkways clear of clutter. Ensure adequate lighting. Use assistive devices. Wear non-skid socks.
Fire & Electrical:	No smoking with oxygen. Check smoke detectors. Avoid overloading outlets. Keep fire extinguisher handy.
Medical Equipment:	Follow instructions; our staff will teach safe use. Report any malfunction immediately.
Household Safety:	Clear ice in winter. Keep flashlight accessible. Consider daily check-in if living alone.
Emergency Comm.:	Keep telephone within reach. Post emergency numbers near the phone: 9-1-1, doctor, and agency on-call number.

Infection Control and Hygiene

Infection control is critical in home care to protect both the patient and the caregivers.

Hand Hygiene:	Wash hands or use sanitizer when entering the home, before/after care.
Use of Gloves:	Aides wear gloves during tasks involving bodily fluids.
Respiratory Etiquette:	Cover coughs and sneezes. Wear a mask if instructed.
Wound Care:	Keep wounds clean and covered. Report infection signs.
Clean Environment:	Regularly dispose of garbage. Maintain clean surfaces.
Safe Waste Disposal:	Proper disposal of sharps (needles).
Standard Precautions:	Treat all bodily fluids as potentially infectious.
Patient's Role:	Inform us if you develop symptoms of illness or have an infection.

Emergency and Disaster Preparedness

Home Care Agency has an emergency preparedness plan in place to ensure patients are safe.

AGENCY PROCEDURES

- **24/7 Emergency Phone Line:** Call our on-call number if you have an urgent issue.
- **Patient Priority Levels:** We prioritize patients with critical medical needs first.
- **Information Sharing:** Ensure we have your current phone number.

GENERAL EMERGENCY PREPAREDNESS TIPS FOR PATIENTS

Emergency Kit ("Go Bag" and Supplies):

- **Medications:** At least a 3-day supply.
- **Important Documents:** ID, insurance, advance directives.
- **Basic Supplies:** Flashlight, batteries, radio, water, food.

Emergency Scenarios

Plan for Evacuation vs. Shelter-in-Place

Evacuation:	If advised to evacuate, do so promptly. Inform the agency.
Shelter in Place:	Ensure supplies. Stay away from windows.

SPECIFIC EVENTS

Blizzards & Extreme Cold:	Stay indoors. Keep warm. If you lose heat, call 911. Agency will reschedule visits.
Hurricanes & Flooding:	Stay informed. Evacuate if in flood zone. Watch for downed lines.
Utility Outages — Power:	If on life-sustaining equipment, have backup power. Register with utility.
Utility Outages — Water:	Use stored water.

AGENCY AND PATIENT COLLABORATION

Communication:	We will attempt to call patients during emergencies.
During an Emergency:	If travel is impossible, we will inform you if a visit is delayed. If urgent, we will help get emergency services.
Priority Response:	Critical needs patients are prioritized.
Patient Responsibility:	Implement your personal emergency plan and notify the agency.