SUMMIT
HOME CARE

START OF CARE CHECKLIST

*HIPPA COMPLIANT APP MUST BE USED TO SCAN DOCUMENTS TO CHART (Genius Scan, Adobe Scan, Etc.)
PHOTOS ARE NOT HIPPA COMPLIANT

- ☐ Issued & reviewed Patient Handbook
- ☐ Start of Care Checklist (Scan to chart)
- ☐ Consent (Admission Service Agreement) filled out and signed (Scan to chart-CONSENT TASK)
- ☐ Review & Acknowledgement of Privacy Practices (Scan to chart)
- ☐ Patient Notification of Face-to-Face Requirement (Scan to chart)
- ☐ EP plan sheet completed (Scan to chart)
- ☐ Emergency Plan covered for patient/family
- ☐ Patients' rights explained (Handbook)
- ☐ Plan of care discussed and patient/CG in agreement
- ☐ Advance Directives discussed
- ☐ Communication preferences regarding PHI filled out and signed
- ☐ Med Reconciliation completed **(Look at actual bottles)**
- ☐ Med sheet filled out completely for ALL meds and left in SOC folder
- ☐ Calendar used in SOC folder

CLINICIAN SIGNATURE: _____

PATIENT/POA SIGNATURE: _____

DATE: _____

SCAN TO PATIENT CHART [ ]

SUMMIT
HOME CARE

SCAN TO PATIENT CHART

ADMISSION SERVICE AGREEMENT

Consent for care, Service(s), And Photography: I hereby give permission to Agency to provide care and treatment to me per program policy and as prescribed by my physician. I understand that the plan of care will be developed In consultation with me. My physician must agree with the plan of care unless I am receiving only homemaker assistance. I understand that changes to the plan of care may be indicated. Those changes will be made in consultation with me, and that physician's orders are necessary to make changes. Instructions for my care have been explained to me. I am responsible for ensuring my needs are met when Agency is not present in my home. I agree to notify Agency, my physician and others providing care of any changes or problems. "I understand that I have the right to review assessment information (including OASIS data) and physician orders that the agency may complete to ensure accuracy. I consent to HCD associates taking photographs as indicated, including tracking wound healing and education. Agency has my permission to use said pictures as needed, including sharing this information with my physician. I accept no compensation or other remuneration for the use of such photographs.

Insurance Information and liability for payment
To the best of my knowledge, I am entitled to home care services through any and all of the following third payer sources:

[ ] Medicare #:_____ [ ] Medicaid #:_____ [ ] Passport [ ] Waiver [ ] Senior Options [ ] Private Pay [ ] Other: _____ HIC: _____
I understand that I will be receiving the following service(s):
[ ] SN [ ] PT [ ] PTA [ ] OT [ ] COTA [ ] HHA
The agency has informed me that the anticipated payer source for this care is: _____and that I will be responsible for 100% of anything not covered by insurance.

Assignment of Benefits: I request that payment of the authorized benefits on my behalf be made to the Agency. I understand that I will be responsible for any co- payments, deductibles, or any amounts due after payment of benefits on my behalf by any and all third-party payers. I understand that I must keep the home health agency informed of any changes that occur that may jeopardize my qualifying for these or any other benefits I may be entitled to. Agency accepts assignment from Medicare, Medicaid, PASSPORT, and Senior Options as payment in full.

Receipt and review of client handbook: I certify that I have received and understand the information contained in the Patient Handbook. This handbook contains important information regarding my rights and responsibilities as a client, the Statement of Patient Privacy Rights, Notice about Privacy Act Statement - Health Care Records, the HIPPA

Statement of Patient Privacy Rights, Nondiscrimination Policy, Section 504 Notice of Program Accessibility/ Translation Assistance, Information about Safety and Infection control, Advance Directives, EP Plan, Payment for Home Care Services. Grievance Procedure, the State Complaint Hotline Number, and payment rates for services.

Release of information: I give my permission to Summit Home Care to release to or receive from hospitals, physicians, other agencies including regulatory or accrediting agencies, and / or other persons involved in my care all medical records and information important to my care, including the presence or absence of communicable disease. I authorize agencies to release medical and other related information (unless I indicate otherwise in writing) to above and social/health care agencies, contracted agencies, case management agencies, laboratories, family members, and medical equipment/ supply vendors whose services may be required in conjunction with the services provided.

Advance Directives: I understand it is the policy of Summit Home Care to provide services to all persons without regard to whether they have executed any Advance Directives. I understand that my decision regarding Advance Directives can be changed at any time. I will notify Summit Home Care, my physician(s) and my family should I wish to make changes. I would like to indicate the following at this time:

_____

In the event of an emergency, I request the following Code Status: [ ] Full Code [ ] No Code

[ ] Other:_____

_____ I have not and do not wish to execute Advance Directives at this time.

_____ I have or would like to execute the following Advance Directives [ ] Living Will

[ ] Durable Power of Attorney [ ] Do not Resuscitate Orders

[ ] Refusal of Specific Treatments, Services, and Medications [ ] Other: _____

Certification: I understand the statements contained herein and have received a copy of and an explanation of this agreement, I agree with the conditions. I am the patient or am duly authorized by the patient as the patient's general agent and can execute the above and accept its terms. I understand that this agreement can be revoked in writing at any time. This information has been provided to me prior to the provision of my care

Patient / Representative Signature: _____ Relationship to Patient: _____

Date: _____

Witness Signature: _____Witness Name: _____

Date: _____

SCAN TO PATIENT CHART [ ]

NOTICE OF PRIVACY PRACTICES
SUMMIT HOME CARE

Effective Date: October 7th, 2022

IBIS 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.

As Summit Home Care, we understand the importance of keeping your medical information confidential. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment/or services provided to you as allowed by your health plan and ID enable us to meet our professional and legal obligations to operate this therapy practice properly. We are required by law to maintain the privacy of protected health information, to inform our patients of our privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical/ information. If you have any questions about this Notice, please contact our Compliance Officer.

A. How Summit Home Care May Use or Disclose Your Health Information

Summit Home Care collects health information about you and stores it in an electronic health record. This is your medical record. The medical record is the property of Summit Home Care, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. TREATMENT We use medical information about you lo provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

2. PAYMENT We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them fa obtaining payment for services they have provided lo you.

3. HEALTH CARE OPERATIONS We may use and disclose medical information about you to operate this agency. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services, and law enforcement officials, we will further comply with the requirements set forth below concerning those activities.

4. PUBLIC HEALTH We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to; preventing or controlling

disease, injury, or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions io medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

5. HEALTH OVERSIGHT ACTIVITIES We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

6. JUDICIAL AND ADMINISTRATIVE PROCEEDINGS We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if: (a) reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order; or (b) reasonable efforts have been made by the party seeking your information to secure a qualified protective order which prohibits the parties from using or disclosing your information for any purpose other than the litigation or proceeding and requires the return of your information to your health care provider or the destruction of your information at the end of the litigation or proceeding.

7. LAW ENFORCEMENT We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

8. CORONERS We may, and are often required by Jaw, to disclose your health information to coroners Jn connection with their investigations of deaths.

9. PUBLIC SAFETY We may, and are sometimes required by Jaw, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

10. SPECIALIZED GOVERNMENT FUNCTIONS We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

11. WORKERS' COMPENSATION We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

12. RIGHT TO AMEND OR SUPPLEMENT You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information and will provide you with information about this agency's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subquery disclosure of the disputed information.

13. RIGHT TO AN ACCOUNTING OF DISCLOSURES You have a right to receive an accounting of disclosures of your health information made by this therapy practice, except that this therapy practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 {notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by Jaw, or the disclosures to a health oversight agency or law enforcement official to the extent this agency has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

14. RIGHT TO ELECTRONIC COPY OF THIS NOTICE You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to an electronic copy of this Notice of Privacy Practices.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Compliance Officer.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been offered Summit Home Care's Notice of Privacy Practices:

_____ I have received a copy of the Notice of Privacy Practices

_____ I do not wish to receive a copy of the Notice of Privacy Practices

_____
Patient Name

_____ _____
Signature Date

_____
Printed Name of Person Acknowledging Receipt (if other than the patient) and Relationship to Patient

COMMUNICATION PREFERENCES REGARDING PHI

To assist in your care, it may be necessary to release our Protected Health Information to someone other than yourself. To whom may we talk?

YES NO

Spouse _____

Parent _____

Step-Parent _____

Other Person(s) _____

May we leave a message on:

YES NO Your answering machine/voicemail

Preferred Phone Number _____ circle one: home/work/mobile/other

_____
Patient Name

_____ _____
Signature Date

_____
Printed Name of Person Acknowledging Receipt (if other than the patient) and Relationship to Patient

SCAN TO PATIENT CHART [ ]

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PATIENT NOTIFICATION OF FACE TO FACE HOME CARE REQUIREMENT

PATIENT NAME_____PATIENT ID NUMBER_____

I _____ (Patient Name) have received notification that my insurance provider requires face to face visit with my physician (whom agrees that I need home care services) and that I have had that visit either 90 days prior to the start of home care services or 30 days after home care services have begun.

I understand that I am responsible to meet this requirement in order for my home care services to continue uninterrupted and I understand that if this visit is not conducted, my homecare services may be put on hold and/or I may be discharged from care.

_____ (Initials)

I also understand that my insurance company may not pay for any visits that have occurred during the time period that this requirement is not met.

_____ (Initials)

Patient Signature: _____ Date: _____/_____/_____

Print Name: _____

Clinician Signature: _____ Date: _____/_____/_____

Print Name: _____

SCAN TO PATIENT CHART [ ]

Emergency Guidelines/Instructions

Symptoms to report with call to:

911: i.e., Signs/symptoms of a heart attack, stroke, trouble breathing, fall with injuries, etc.

Physician: i.e., Significant change in weight, painful urination, dizziness, foul smelling urine, etc.

Summit On Call Nurse: i.e.: Medication questions, wound care, catheter issues, home services being provided, etc. Please circle the appropriate answer for the following questions:

Personal Emergency Response System? NO YES Specify: _____

Emergency Evacuation List Received and Reviewed? NO YES Date: _____/_____ /_____

Emergency Phone Numbers and Instructions for your location:
Summit Home Care Office/24 Hour On-Call Line: 1-800-969-6577

EMERGENCY CONTACT PHONE NUMBERS		
	NAME	PHONE
Hospital		
Primary Care Physician:		
Next of Kin/Emergency Contact:		
Fire Department:		
Police Department:		
County Ambulance:		
Primary Summit Clinician's Name:		
Equipment Company- EX: Wheelchair, O2, Walker		
Pharmacy:		
Red Cross:		

DNR ORDER FORM

A printed copy of this order form or other authorized DNR identification must accompany the patient during transports and transfers between facilities.

Patient Name:	Patient Birth Date:
Optional Patient or Authorized Representatives Signature	
Printed name of Physician, APRN or PA*	Date
REQUIRED Signature of Physician, APRN or PA	Phone
REQUIRED for APRN or PA: Name of the supervising physician (PA) or collaborating physician (APRN) for this patient and the physician's NPI, DEA or Ohio medical license number.	

CHECK ONLY ONE BOX BELOW

☐ **DNR Comfort Care — Arrest:** Providers will treat patient as any other without a DNR order until the point of cardiac or respiratory arrest at which point all interventions will cease and the DNR Comfort Care protocol will be implemented.

☐ **DNR Comfort Care:** The following DNR protocol is effective immediately.

DNR PROTOCOL

Providers Will:

- Conduct an initial assessment
- Perform Basic Medical Care
- Clear airway of obstruction or suction
- If necessary for comfort or to relieve distress, may administer oxygen, CPAP or BiPAP
- If necessary, may obtain IV access for hydration or pain medication to relieve discomfort, but not to prolong death
- If possible, may contact other appropriate health care providers (hospice, home health, physician, APRN or PA)

Providers Will Not:

- Perform CPR
- Administer resuscitation medications with the intent of restarting the heart or breathing
- Insert an airway adjunct
- De-fibrillate, cardiovert or initiate pacing
- Initiate continuous cardiac monitoring

Physicians, emergency medical services personnel, and persons acting under the direction of or with the authorization of a physician, APRN or PA who participate in the withholding or withdrawal of CPR from the person possessing the DNR identification are provided **immunities under section 2133.22 of the Revised Code.** This DNR order is effective until revoked and may not be altered. Any medical orders, instructions or information other than those required elements of the form itself, that are written on this order form are not transportable and are not provided protections or immunities.

* A DNR may be issued by an Advanced Practice Registered Nurse (APRN) or Physician Assistant (PA) when authorized by section 2133.211 of the Ohio Revised Code.

HEA 1930 Revised 09/01/2019

MEDICATION PROFILE

Patient Name_____ Physician Name_____ Phone_____

Allergies_____ Weight_____ Height_____

Pharmacy_____ Phone_____ Fax_____

*Form to be completed without medical terminology i.e. Instead of BID use Twice a Day

Date Started	Date Disc	Code	Medication	Dose/Route	Freq.	Purpose	Admin By	Potential Side Effects*

Medications Administration Key: A= HHA Personnel P= Patient C=Caregiver F=Family

DRUG REGIMEN REVIEW	DATE >	1	2	3	4
A. The patient reports experiencing 1 or more significant side effect to current drug regimen		☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
B. Does the patient and/or caregiver demonstrate a knowledge deficit related to current medication use?		☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
C. Does the patient demonstrate noncompliance with medication use, as prescribed by physician?		☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
D. Does patient and/or caregiver have any questions related to current medications including purpose, dosage, or administration?		☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
E. Have potential adverse effects, significant drug interactions, duplicate/ineffective drug therapy and potential contraindications been identified?		☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

F. Describe Problem and Action for any "Yes" responses:	
Date:	
Date:	
Date:	
Date:	
Date:	
G. Medications Reconciled (per agency policy)	
1.Signature/Date/Time	*2.Signature/Date/Time*
3.Signature/Date/Time	*4.Signature/Date/Time*

**POTENTIAL SIDE EFECTS LIST

Medication Listed Above	Potential Side Effects
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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PATIENT: MONTH: YEAR:

*Dates subject to change due to patient preference or doctors' orders

PHYSICAL THERAPY:

NURSING:

OCCUPATIONAL THERAPY:

SOCIAL SERVICE:

SPEECH THERAPY:

HHA:

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PATIENT: MONTH: YEAR:

*Dates subject to change due to patient preference or doctors' orders

PHYSICAL THERAPY:

NURSING:

OCCUPATIONAL THERAPY:

SOCIAL SERVICE:

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HHA:

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VITAL SIGN & WEIGHT FLOW SHEET

Date	Blood Pressure	Temp.	Pulse	Respiration	Weight	Blood Sugar	Comments	Initials

Admission Date: _____ Admission Height/Length: _____ Admission Weight: _____

_____

Last Name First Initial

Attending Physician_____ Record #_____

SUMMIT
HOME CARE

SCAN TO PATIENT CHART

NOTICE OF MEDICARE NON-COVERAGE

Patient Name: _____ Patient Number: _____

The Effective Date Coverage of your Current_____

Services will end: _____

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

Your Right to Appeal This Decision

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

How To Ask for An Immediate Appeal

- You must make your request to your Quality Improvement Organization (also known as a QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end these services.
- Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above.

SEE PAGE 2 OF THIS NOTICE FOR MORE INFORMATION

- The QIO will notify you of its decision as soon as possible, generally no later than two days after the effective date of this notice if you are in Original Medicare. If you are in a Medicare health plan, the QIO generally will notify you of its decision by the effective date of this notice.
- Call your QIO at: (216) 447-9604 or (800) 589-7337 to appeal, or if you have questions.

If You Miss the Deadline to Request an Immediate Appeal, You May Have Other Appeal Rights:

- If you have Original Medicare: Call the QIO number listed above.
- If you belong to a Medicare health plan: Call your plan at the number given below.
  For: Anthem Sr Advantage or Medicare Preferred in Ohio, Kentucky & Indiana.
  Please call toll free: 1-855-408-8557 or for local calls: 1-813-280-8256
  For: Aetna Medicare Phone 1-866-269-3692

Additional Information (Optional):

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

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

_____ _____

Signature of Patient or Representative Date

SCAN TO PATIENT CHART [ ]