Assisted Living Waiver MedCompass Profile Access Request

Member's Name:_____ **Home Phone:** _____

Date of Birth: _____ ☐ **Male** ☐ **Female** **Married:** ☐ Yes ☐ No

9-Digit CIN Number:_____ **SSN (If no CIN)**_____

Address:_____ **City:**_____ **Zip:**_____

County in which the applicant currently resides: _____

Care Coordination Agency (CCA) Name:_____

Where is the applicant currently residing: ☐ Acute Hospital ☐ At Home ☐ Homeless
☐ Residential Care Facility or the Elderly(RCFE) ☐ Skilled Nursing
☐ Other (please specify): _____

Who has the legal authority to make the applicant's health care decisions?
☐ Applicant
☐ Other (Name) _____

Have you spoken with the applicant/participant or legal rep and confirmed were not placed on the ALW Waitlist by another CCA? ☐ Yes ☐ No

Have you spoken with the applicant/participant or legal rep and confirmed are not Enrolled or in the Initial Applicantion or Re-Enrollment process with another CCA? ☐ Yes ☐ No

I (applicant or legal representative) understand that, by signing this form, I am requesting to be added to the waitlist for the Assisted Living Waiver (ALW).

Applicant/Participant or Legal Representative Signature

_____

Date: _____

CCA Staff Signature

_____

Date:

CCA Staff Name/Title

_____

Client Name: _____ **Date of Birth:** _____

PATIENT CONSENT TO RECEIVE SERVICES AND CERTIFICATION

Consent for Admission and Treatment:
I hereby consent and authorize Libertana Home Health of Sherman Oaks (Agency) and associates to provide transition care and/or case management services at my home or alternate place of temporary residence per policy of the Health Care Program:
____ Assisted Living Waiver Program Care Coordination (ALWP)
____ California Care Transitions (CCT)
____ Intensive Case Management Services (ICMS)
I consent to the initial evaluation at which time the Agency will determine if I am eligible for admission to the Health Care Program and Agency services.
A proposed Plan of Care including services to be provided and frequency has been discussed with me. I understand that I have the right to participate in and agree or disagree to the Plan of Care without retribution. I agree to notify the Agency in the event of a change in my condition or other significant events that will affect my eligibility to the Health Care Program.
I understand that I have the right to refuse services at any time by calling the Agency at **Tel. 800-750-1444 or 818-902-5000.**

Payment Request and Assignment of Benefits:
I authorize the Agency to request insurance or other health care payment to the Agency on my behalf and I authorize the release of all records required to act on this request. I authorize payment and hereby assign benefits payable on my behalf directly to the Agency. Agency accepts all Medicare and/or Medi-Cal reimbursement as payment in full for all services provided.

Authorization to Release Information:
I consent to the release of information by any recognized health care institution or agency in which I have been a patient and I authorize the health care professional to disclose any or all of my medical records to the Agency.

Consent to Photograph:
I consent and authorize the Agency to have a picture of me on file while under the care of the Agency as needed. I agree and permit the Agency to use the images as they may deem necessary. I also hold the Agency free and harmless from any and all liability resulting from the photographing and subsequent use.

I attests that I have been given information and/or explained the following:

- Ethics/Grievance Complaint Procedure and the California Department of Public Health Complaint **(CDPH) Hotline: 800-228-1019 or 213-351-8144, Department of Health Care Services Hotline (DHCS): 916-552-9322**
- Patient Rights and Responsibilities
- Notice of Private Practices, Health Insurance Portability and Accountability Act (HIPAA)
- Transfer and Discharge Policy
- Contact Information on Federally-funded and State-funded Entities.

____ I have ____ I have not completed an Advance Health Care Directive.

____ I have a Durable Power of Attorney for Health Care, or ____ Living Will, or ____ Other _____.

A copy must be made available for the agency to honor your wishes. ____ Copy is Provided ____ Copy is Not Provided.

Certification:
I certify that I have read and understand the above agreement, received a copy thereof and agree with the above conditions. I am the patient or a duly authorized representative of the patient legally authorized to execute the above and accept its terms.
I understand that this agreement can be revoked at any time by written notice to the Agency.

_____
Patient or Legal Representative Printed Name / Signature / Relationship / Date

_____
Agency Representative Printed Name / Title / Signature / Date

LIBERTANA HOME HEALTH

Authorization to Release Personal and Health Information

Protected Health Information (PHI), Personally Identifiable Information (PII) – Individually identifiable health and personal information including demographics transmitted or maintained in any form that relates to an individual's physical or mental health or the provision of payment for services.

I,_____hereby authorize Libertana Home Health the disclosure of my PHI / PII as described below:

☐ Demographics (previous and current)
☐ Diversity and Ethnicity
☐ Religious Affiliations
☐ Financial Information
☐ Medical Information
☐ Criminal Background Check
☐ Social Security
☐ Family and Friend Relations
☐ Other or Exclusions:

The following person(s), specified by name, or class of persons may receive disclosure of my PHI / PII:

☐ Family members:

☐ Caregivers:

☐ Spiritual and Religious Advisors

☐ Potential Landlords and Facility Managers

☐ Transportation Services _

☐ Financial Institutions:

☐ Other / Relation:

___ The purpose/use of the information is for the coordination of:

☐ Health Care
☐ Housing
☐ Financial Status
☐ Personal Needs
☐ Other:

I may revoke this authorization by notifying Libertana Home Health of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

Libertana Home Health
5805 Sepulveda Blvd. Suite 605
Sherman Oaks, CA 91411
Tel. 818-902-5000 Fax. 818-902-5008

Client Printed Name / Signature / Date

Witness Printed Name / Signature / Date

Form: ARPHI Jan2018

Client Name: _____ **Date of Birth:** _____

PATIENT CONSENT TO BE PLACED ON THE ASSISTED LIVING WAIVER PROGRAM WAITLIST

Consent for Waitlist Placement:
I hereby consent and authorize Libertana Home Health of Sherman Oaks (Agency) and associates to submit my name, personal and medical information to the State for the purpose of being placed on a waitlist for the Assisted Living Waiver Program (ALWP).
I give both verbal and written consent to proceed with the process for placement on said waitlist.
I agree to notify the Agency in the event of a change in my condition or other significant events relating to my personal and health status.
I understand that the period or length of my waitlist status may depend on the type of my current residency. Example: State prioritizes processing the applicants in the waitlist that are residing in a Skilled Nursing Home, Long Term Care Facility or Acute Hospital. A change in residency from one of this facilities to home while still on the waitlist may cause a delay in the application being processed.

I understand that I have the right to refuse and cancel the waitlist placement at any time by calling the Agency at **Tel. 800-750-1444 or 818-902-5000.**

Payment Request and Assignment of Benefits:
I understand that there will be no cost incurred for me to be placed on the ALWP waitlist.

Authorization to Release Information:
I consent to the release of information by any recognized health care institution or agency in which I have been a patient and I authorize the health care professional to disclose any or all of my medical records to the Agency. In addition, I authorize the Agency to release any information to any health care organizations or professionals who are involved in my care, including all Federal, State, or Accrediting Agencies. I also authorize the release of medical and other related information to social and /or other health care agencies, medical equipment and supply vendors whose services may be required in conjunction with the services provided by the Agency.

Certification:
I certify that I have read and understand the above agreement, received a copy thereof and agree with the above conditions. I am the patient or a duly authorized representative of the patient legally authorized to execute the above and accept its terms.
I understand that this agreement can be revoked at any time by written notice to Libertana Home Health of Sherman Oaks.

_____
Patient or Legal Representative Printed Name / Signature / Relationship Date

_____
Agency Representative Printed Name / Title / Signature Date



LIBERTANA®

LIFE | HEALTH | FREEDOM

PATIENTS RIGHTS AND RESPONSIBILITIES

PATIENTS' RIGHTS

CMS 42 CFR § 484.50

The patient and/or legal/patient-selected representative have the right to:

1. Be provided with an oral and a written notice of the patient's rights in a manner that the individual can understand.

2. Have his or her property and person treated with respect.

3. Be free from verbal, mental, sexual and physical abuse, including injuries of unknown source, neglect and misappropriation of property.

4. Make complaints to the HHA regarding treatment or care that is (or fails to be furnished, and the lack of respect for property and/or person by anyone who is furnishing services on behalf of the HHA). Have documented the existence and resolution of complaints about the care furnished by the HHA that were made by the patient, representative, and family.

5. Participate in, be informed about and consent or refuse care in advance of and during treatment, where appropriate, with respect to:
    a. completion of **all** assessments
    b. the care to be furnished, based on the comprehensive assessment
    c. establishing and revising the plan of care
    d. the disciplines that will furnish the care
    e. the frequency of visits
    f. expected outcomes of care, including patient-identified goals and anticipated risks and benefits
    g. any factors that could impact treatment effectiveness
    h. any changes in the care to be furnished

6. Receive all services outlined in the plan of care and receive clinical and educational information.

7. Have a confidential clinical record. Be advised the patient of the HHA's policies and procedures regarding the disclosure of patient records.

8. Be advised of expectation of payment for services from federal payers or the patient.

9. Receive proper written notice in advance of a specific service being furnished if the HHA believes that the service may be non-covered care or in advance of the HHA reducing or terminating ongoing care.

10. Be advised of the state toll free home health telephone hotline, its contact information and its hours of operation and that its purpose is to receive complaints or questions about local HHAs.

11. Be advised of the names, addresses and telephone numbers of the following federally funded and state-funded entities that serve the area where the patient resides:
    a. Agency on Aging
    b. Center for Independent Living
    c. Protection and Advocacy Agency
    d. Aging and Disability Resource Center
    e. Quality Improvement Organization

12. Be free from any discrimination or reprisal for exercising his or her rights or for voicing grievances to the HHA or an outside entity.

13. Be informed of the right to access auxiliary aids and language and how to access these services.

PATIENTS' RESPONSIBILITIES

The patient and/or legal/patient-selected representative have the right to:

1. Remain under a physician's care while receiving services from the Agency.
2. Provide accurate and complete health information. Report risks and unexpected changes.
3. Provide the Agency with all requested insurance information and appropriate financial records.
4. Follow instructions, rules and regulations. Be an active and compliant participant in your Plan of Care and accept the consequences if you do not.
5. State any concerns about your ability to follow your Plan of Care. Ask questions concerning anything you do not understand.
6. Maintain a safe home environment in which your care may be given. Treat staff with respect and consideration.
7. Follow instructions on the care, use and maintenance of equipment and return rental equipment in good condition.
8. Contact your physician whenever you notice a change in your condition.
9. Notify the Agency if you acquire any infectious disease, except where exempt by law.
10. Notify the Agency whenever you have a problem with our equipment.
11. Meet any financial commitments agreed to with the Agency.
12. Contact Libertana Home Health (Agency) when:
    - You have any concerns about safety.
    - You change doctors.
    - Your doctor changes your orders.
    - You are hospitalized or go to a long-term care facility.
    - You change your address or phone number.
    - You change your insurance carrier or your insurance plan changes.
    - You are unable to keep appointments for deliveries or home visits.

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