Dear Parent(s)/Guardian:

OASIS Corporation provides home health and outpatient Physical, Occupational and Speech therapy services under physician's orders. We want to thank you for choosing OASIS to provide services for your child and are looking forward to a great relationship!

These documents have been provided to help you maintain a file of your Rights and Responsibilities Notice, Disclosure Notice, as well as communication from your therapist(s). It has copies of all the paperwork that needs to be signed in order to begin services as well as good information regarding safety, infection control and emergency. preparedness.

If you have questions, complaints, or concerns about the services you are receiving or would like to look into adding a service, please do not hesitate to contact us at (970)451-1234 or via email at office@oasispediatrictherapy.com. We are more than happy to assist you and your requests.

Sincerely,

Lacy Hoyer-Helms
President

Kristin Ceriani
CEO

OASIS RELEASE

Patient's Name:_________________________________**DOB:**_______________ **SOC:**________________

Consent for Treatment

I consent and authorize OASIS Pediatric Therapy with services provided by Front Range Therapists, LLC and Liberty Homecare, LLC ("the Agency"), its agents and associates to provide care and treatment to my child in my home, as prescribed by my physician and per agency policy. I understand that I am required to have an attending physician at all times, that it is my responsibility to ensure that my physician remains active in my treatment unless otherwise discussed with the Agency or my physician, and that my therapy plan of treatment may change depending on my physician's orders. I have received an explanation of the services that will be provided to me, including disciplines and proposed frequencies of treatment/visits, and understand that I have the right to participate in developing my plan of care. The initial service plan is as follows:

PT:_________________________ **OT**:_________________________ **ST**:_______________________

Authorization for Release of Information

I hereby consent and authorize the Agency to release and receive healthcare documents and information for the purposes of treatment, payment and health care operations. The exchange of information may occur between, but is not limited to, physicians, third party payors, other health providers, and regulator and/or accrediting reviewers.

Statement to Permit Payment for Outpatient Services

I hereby request that payment of authorized medical therapy services be made on my behalf to the Agency.

I understand the Agency will bill ___ Medicaid ___ Insurance Co. _______________ Patient for the following services being provided to me by the Agency. I understand that I may be responsible for the following amount __________ .

Acknowledgements

I have received verbal and written information on the following and have had that information explained to me:

1. Patient Bill of Rights, including receipt of the Agency complaint process and the state toll free hotline number.
2. Agency contact information, including emergency and after hours contact numbers.
3. Notice of Agency Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by the Agency and my rights with respect to my health information (see Authorization for Release of Information paragraph above).
    a. I acknowledge that I have been provided with the opportunity to discuss concerns regarding the privacy of my health information.
4. Agency Disclosure Notice
5. Emergency Preparedness, Infection Control and Safety Education Information Sheets
6. OASIS statement of Privacy Rights (for clients 18 years of age or older)

Cancellation Policy: 24 hour cancellation notice is required or it is considered a no-show. If there are more than 2 cancellation/no shows in a 60 day period, services will be discharged. We will provide you with a list of other providers in the area.

Advance Directives: I have received written information and been instructed on Advance Directives.

I certify that I have read and agree with the information written in this document and have been provided a copy for my records.

____

Parent/Guardian Signature **Date**

____

Witness Signature **Date**

OASIS
PEDIATRIC THERAPY

PATIENT BILL OF RIGHTS

Clients of OASIS have the right to:

- Receive considerate and respectful care in the home at all times, and have property treated with respect.
- Participate in the development of the plan of care, and receive an explanation of any services proposed, changes in service, and alternative services that may be available.
- Receive complete written information on the plan of care, including the names of the therapists and the supervisor responsible for the services and the agency phone number.
- Refuse treatment or other services without fear of reprisal or discrimination.
- Be fully informed of the consequences of all aspects of care, unless medically contraindicated, including the possible results of refusal of medical treatment, counseling or other services.
- Privacy and confidentiality about one's health, social and financial circumstances and about what takes place in the client's home.
- Know that all communications and records will be treated confidentially and that no information will be given out without a written release from the client or authorized family..
- Expect that all home care personnel, within the limits set by the plan of care, will respond in good faith to the client's requests for assistance in the home.
- Receive information on the agency's policies and procedures upon request, including information on charges, qualifications and supervision of personnel, hours of operation, and discontinuation of service; request a change of caregiver.
- Participate in the plan for discontinuation of service with the right to appeal.
- Have access to all bills for service regardless of whether they are paid for out-of-pocket or through other sources of payment.
- Receive a clear explanation of which services and equipment provided by the agency are covered by third-party reimbursement and which services and equipment will be paid for by the client and of the charges which will be incurred.
- Receive a clear explanation of the process to voice grievances about care, treatment, or discontinuation of service without fear of discrimination or reprisal for doing so.
- Appeal agency decisions regarding care, following grievance procedures.
- Know the agency maintains liability insurance coverage; and be given in writing the name and telephone number of a contact person for 24 hour access to the agency.
- Be given written information concerning the agency's policy on advance directives upon request.
- Choose their provider of services and be informed of the right to be included in that decision.
- Call the State Department of Health HOTLINE at 1-800-842-8826 to report any issues or perceived issues with my care, and to discuss other matters of public health.

Clients of OASIS have the responsibility to:

- Notify the agency of changes in their condition or care situation (hospitalization, symptoms, medication, etc.).
- Follow the plan of care provided to them by OASIS.
- Notify the agency as soon as practicable if the visit schedule needs to be changed.
- Keep appointments and notify the agency if unable to do so.
- Inform the agency of the existence of, and any changes to, advance directives.
- Advise the agency of any problems or dissatisfaction with the service.
- Provide a safe environment for care to be provided.
- Carry out mutually agreed responsibilities.

Patient/Responsible Party Signature **Date**

Witness Signature **Date**

INFORMATION RECEIPT AND EMERGENCY CONTACT INFORMATION

PATIENT NAME: ______________________________

I have received the notice of the following documents: Consent for Treatment, Home Care Rights and Responsibilities, Privacy Notice, and the Agency Disclosure Notice. An agency representative has reviewed each of these with me and I understand them.

Emergency Contact Information:

In the event of an emergency or unforeseen circumstance, please list all emergency contacts:

Parents/Guardians Names	Home Phone	Mobile Phone

Names and phone numbers for any other qualified caregivers:

Qualified Caregivers Names	Home Phone	Mobile Phone

If a non-life threatening emergency or an unforeseen circumstance occurs in which the patient caregiver is not able to care for the patient while an OASIS provider is present, the OASIS provider will first attempt the emergency contacts listed above and if no one is available, will then dial 911. If a life-threatening emergency occurs, the provider will first call 911 and then attempt the emergency contacts.

I have reviewed and agreed with the above statements. I understand that OASIS shall not be liable for any such emergencies, and agree that OASIS, and understand the procedures outlined above and acknowledge them to be adequate given the circumstances.

____

Parent/Guardian Signature **Date**

____

Witness Signature **Date**

SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Colorado Medical Orders for Scope of Treatment (MOST)

- **FIRST follow these orders, THEN contact Physician, Advanced Practice Nurse (APN), or Physician Assistant (PA) for further orders if indicated.**
- These Medical Orders are based on the person's medical condition & wishes.
- If Section A or B is not completed, full treatment for that section is implied.
- May only be completed by, or on behalf of, a person 18 years of age or older.
- **Everyone shall be treated with dignity and respect.**

Legal Last Name		
Legal First Name/Middle Name		
Date of Birth		Sex
Hair Color	Eye Color	Race/Ethnicity

In preparing these orders, please inquire whether patient has executed a living will or other advance directive. If yes and available, review for consistency with these orders and update as needed. *(See additional instructions on page 2.)*

A — Check one box only

CARDIOPULMONARY RESUSCITATION (CPR)

Person has no pulse and is not breathing.

☐ **Yes CPR:** Attempt Resuscitation ☐ **No CPR:** Do Not Attempt Resuscitation

NOTE: *Selecting 'Yes CPR' requires choosing "Full Treatment" in Section B.*
When not in cardiopulmonary arrest, follow orders in Section B.

B — Check one box only

MEDICAL INTERVENTIONS

Person has pulse and/or is breathing.

☐ **Full Treatment–primary goal to prolong life by all medically effective means:**
In addition to treatment described in Selective Treatment and Comfort-focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. Transfer to hospital if indicated. Includes intensive care.

☐ **Selective Treatment–goal to treat medical conditions while avoiding burdensome measures:**
In addition to treatment described in Comfort-focused Treatment below, use IV antibiotics and IV fluids as indicated. **Do not intubate.** May use noninvasive positive airway pressure. Transfer to hospital if indicated. **Avoid intensive care.**

☐ **Comfort-focused Treatment–primary goal to maximize comfort:**
Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. **Do not transfer to hospital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location.**

Additional Orders: ______________________________

C — Check one box only

ARTIFICIALLY ADMINISTERED NUTRITION

Always offer food & water by mouth if feasible.

Any surrogate legal decision maker (Medical Durable Power of Attorney [MDPOA], Proxy-by-Statute, guardian, or other) must follow directions in the patient's living will, if any. Not completing this section ***does not*** imply any one of the choices—further discussion is required. ***NOTE:*** *Special rules for Proxy-by-Statute apply; see reverse side ("Completing the MOST form") for details.*

☐ Artificial nutrition by tube long term/permanent if indicated.
☐ Artificial nutrition by tube short term/temporary only. (May state term & goal in "Additional Orders")
☐ No artificial nutrition by tube.

Additional Orders: ______________________________

D

DISCUSSED WITH (check all that apply):

☐ Patient
☐ Agent under Medical Durable Power of Attorney
☐ Proxy-by-Statute (per C.R.S. 15-18.5-103(6))
☐ Legal guardian
☐ Other:______________________________

SIGNATURES OF PROVIDER AND PATIENT, AGENT, GUARDIAN, OR PROXY-BY-STATUTE AND DATE (*MANDATORY*)

Significant thought has been given to these instructions. Preferences have been discussed and expressed to a healthcare professional. This document reflects those treatment preferences, which may also be documented in a Medical Durable Power OA, CPR Directive, living will, or other advance directive (attached if available). To the extent that previously completed advance directives do not conflict with these *Medical Orders for Scope of Treatment*, they shall remain in full force and effect.

If signed by surrogate legal decision maker, preferences expressed must reflect patient's wishes as best understood by surrogate.

Patient/Legal Decision Maker Signature *(Mandatory)*	***Name*** *(Print)*	***Relationship/ Decision maker status*** *(Write "self" if patient)*	***Date Signed*** *(Mandatory; Revokes all previous MOST forms)*

Physician / APN / PA Signature *(Mandatory)*	***Print Physician / APN / PA Name, Address, and Phone Number***	***Date Signed*** *(Mandatory)*
Colorado License #:		

HIPAA PERMITS DISCLOSURE OF THIS INFORMATION TO OTHER HEALTHCARE PROFESSIONALS AS NECESSARY

Authority for this form and process is granted by C.R.S. 15-18.7: Directives Concerning Medical Orders for Scope of Treatment, enacted 2010.

ADDITIONAL INFORMATION: *Please provide contact information below, in case follow up or more information needed.*

Patient Legal Last Name	***Patient Legal First Name***	***Patient Middle Name (if any)***	***Patient Date of Birth***
Primary Contact Person for the Patient	*Relationship and/or MDPOA, Proxy, Guardian*	*Phone Number/email/Other contact information*	
Healthcare Professional Preparing Form	*Preparer Title*	*Phone Number/Email*	*Date Prepared*
Patient Primary Diagnosis	*Hospice Program (if applicable) /Address*	*Hospice Phone Number*	

DIRECTIONS FOR HEALTH CARE PROFESSIONALS

For more information, please go to: https://www.civhc.org/programs-and-services/most-program/

Completing the MOST form:

- MOST form master may be downloaded from https://www.civhc.org/programs-and-services/most-program/ and photocopied onto **Astrobrights® "Vulcan Green"** or **"Terra Green"** 60lb paper. This special paper is strongly encouraged but not required.
- The form must be signed by a physician, advanced practice nurse, or physician assistant to be valid as medical orders. Physician assistants must include physician name and contact information. In the absence of a provider signature, however, the patient selections should be considered as valid, documented patient preferences for treatment.
- Verbal orders are acceptable with follow-up signature by physician, advanced practice nurse, or physician assistant in accordance with facility policy, but not to exceed 30 days.
- **Completion of the MOST form is *not* mandatory.** "A healthcare facility shall not require a person to have executed a MOST form as a condition of being admitted to, or receiving medical treatment from, the healthcare facility" per C.R.S. 15-18.7-108.
- Patient preferences and medical indications shall guide the healthcare professional in completing the MOST form.
- Patients with capacity should participate in the discussion and sign these orders; a healthcare agent, Proxy-by-Statute, or guardian may complete these orders on behalf of an incapacitated patient, *making selections according to patient preferences, if known.*
- "Proxy-by-Statute" is a decision maker selected through a proxy process, per C.R.S. 15-18.5-103(6). Such a decision maker may not decline artificial nutrition or hydration (ANH) for an incapacitated patient without an attending physician and a second physician trained in neurology certifying that "the provision of ANH is merely prolonging the act of dying and is unlikely to result in the restoration of the patient to independent neurological functioning."
- **Photocopy, fax, and electronic images of signed MOST forms are legal and valid.**

Following the Medical Orders:

- Per C.R.S. 15-18.7-104: **Emergency medical personnel, a healthcare provider, or healthcare facility *shall* comply with an adult's properly executed MOST form that has been executed in this state or another state and is apparent and immediately available.** The fact that the signing physician, advanced practice nurse, or physician assistant does not have admitting privileges in the facility where the adult is receiving care does not remove the duty to comply with these orders. Providers who comply with the orders are immune from civil and criminal prosecution in connection with any outcome of complying with the orders.
- If a healthcare provider considers these orders *medically* inappropriate, she or he should discuss concerns with the patient or surrogate legal decision maker and revise orders only after obtaining the patient or surrogate consent.
- If Section A or B is not completed, full treatment is implied for that section.
- **Comfort care is never optional.** Among other comfort measures, oral fluids and nutrition must be offered if tolerated.
- When "Comfort-focused Treatment" is checked in Section B, hospice or palliative care referral is strongly recommended.
- If a healthcare provider or facility cannot comply with these orders due to policy or ethical/religious objections, the provider or facility must arrange to transfer the patient to another provider or facility and provide appropriate care until transfer.

Reviewing the Medical Orders:

- These medical orders should be reviewed
  - regularly by the person's attending physician or facility staff with the patient and/or patient's legal decision maker;
  - on admission to or discharge from any facility or on transfer between care settings or levels;
  - at any substantial change in the person's health status or treatment preferences; and
  - when legal decision maker or contact information changes.
- If substantive changes are made, please complete a new form and void the replaced one.
- **To void the form, draw a line across Sections A through C and write "VOID" in large letters. Sign and date.**

REVIEW OF THIS COLORADO MOST FORM

Review Date	Reviewer	Location of Review	Review Outcome
			☐ No Change ☐ New Form Completed
			☐ No Change ☐ New Form Completed
			☐ No Change ☐ New Form Completed
			☐ No Change ☐ New Form Completed

EQUIPMENT USE POLICY – LIABILITY WAIVER

Introduction

From time to time OASIS allows OASIS clients to use OASIS owned equipment ("loaned equipment") at home without the supervision of a therapist or home health worker. This is necessary if there will be a delay of the client's acquisition of the equipment from a durable medical vendor or if the equipment is being used on a trial basis. Examples include wheelchairs, walkers, oxygen tanks, therapeutic devices, etc.

Return of Equipment

The loaned equipment remains the property of OASIS and must be returned no later than when replacement equipment is acquired by the client or 3 months. The loaned equipment must be returned in its original condition, normal wear and tear excepted. If the loaned equipment is damaged, the client will notify OASIS promptly and will pay for any repairs or replacement.

No Warranties

While being used unsupervised by OASIS, client disclaims all warranties, whether express, implied or statutory, as to any aspect of the loaned equipment, its operation including without limitation, warranties fitness for a particular purpose, design condition, capacity, performance.

Acknowledgement of Danger

While using the loaned equipment unsupervised by OASIS, the client acknowledges it may be dangerous and that usual risks, hazards and dangers of personal injury, death and disability or property damage and loss necessary increase when using the loaned equipment.

Release

The client hereby elects to and does assume all risks of injury, including all payments for medical treatment or ambulance services, that may result due to the use of the loaned equipment, whether those risks are known or unknown. The client affirmatively states that they have medical insurance coverage or are otherwise financially capable of paying all costs of medical treatment or ambulance services that might occur due to use of the loaned equipment. The client further knowingly releases and forever discharges OASIS, its employees, agents, successors, and assigns from all liabilities, claims, bills, demands, suits or losses with respect to the use of the loaned equipment and from all liabilities, claims, bills demands, suits, or losses that the client has or may have in the future that are based in any way with the use of the loaned equipment.

Acknowledge and Agreed:

____

Parent/Guardian Signature **Date**

____

Witness Signature **Date**

OASIS PEDIATRIC THERAPY

SURPRISE/BALANCE BILLING DISCLOSURE FORM

Surprise Billing – Know Your Rights

Beginning January 1, 2020, Colorado state law protects you* from "surprise billing," also known as "balance billing." These protections apply when:

- You receive covered emergency services, other than ambulance services, from an out-of-network provider in Colorado, and/or
- You unintentionally receive covered services from an out-of-network provider at an in-network facility in Colorado

What is surprise/balance billing, and when does it happen?

If you are seen by a health care provider or use services in a facility or agency that is not in your health insurance plan's provider network, sometimes referred to as "out-of-network," you may receive a bill for additional costs associated with that care. Out-of-network health care providers often bill you for the difference between what your insurer decides is the eligible charge and what the out-of-network provider bills as the total charge. This is called "surprise" or "balance" billing.

When you CANNOT be balance-billed:

Emergency Services

If you are receiving emergency services, the most you can be billed for is your plan's in-network cost-sharing amounts, which are copayments, deductibles, and/or coinsurance. You cannot be balance-billed for any other amount. This includes both the emergency facility where you receive emergency services and any providers that see you for emergency care.

Nonemergency Services at an In-Network or Out-of-Network Health Care Provider

The health care provider must tell you if you are at an out-of-network location or at an in-network location that is using out-of-network providers. They must also tell you what types of services that you will be using may be provided by any out-of-network provider.

You have the right to request that in-network providers perform all covered medical services. However, you may have to receive medical services from an out-of-network provider if an in-network provider is not available. In this case, the most you can be billed for covered services is your in-network cost-sharing amount, which are copayments, deductibles, and/or coinsurance. These providers cannot balance bill you for additional costs.

Additional Protections

- Your insurer will pay out-of-network providers and facilities directly.
- Your insurer must count any amount you pay for emergency services or certain out-of-network services (described above) toward your in-network deductible and out-of-pocket limit.
- Your provider, facility, hospital, or agency must refund any amount you overpay within sixty days of being notified.
- No one, including a provider, hospital, or insurer can ask you to limit or give up these rights.

If you receive services from an out-of-network provider or facility or agency, you may still be balance billed, or you may be responsible for the entire bill. If you intentionally receive nonemergency services from an out-of-network provider or facility, you may also be balance billed.

If you want to file a complaint against your health care provider, you can submit an online complaint by visiting this website: https://www.colorado.gov/pacific/dora/DPO_File_Complaint

If you think you have received a bill for amounts other than your copayments, deductible, and/or coinsurance, please contact the billing department, or the Colorado Division of Insurance at 303-894-7490 or 1-800-930-3745.

*This law does NOT apply to ALL Colorado health plans. It only applies if you have a "CO-DOI" on your health insurance ID card.

Please contact your health insurance plan at the number on your health insurance ID card or the Colorado Division of Insurance with questions.

Parent/Guardian Signature **Date**

Witness Signature **Date**

INFECTION CONTROL INFORMATION

The client/client's family plays an important role in infection control.

We ask that you assist our care providers to minimize risk of spreading germs by doing the following:

- Please wash hands with soap and water and dry with a paper towel before and after caring for your child
- Have soap/water and paper towels available for your homecare provider. They are not allowed to use cloth towels to dry their hands
- Notify your provider if your child/children are ill
- Cover coughs/sneezes
- If client or family member has Hepatitis, Staph, TB, MRSA or E.coli infections, notify your homecare provider immediately
- Clean equipment with 10% bleach solution: Add 9 parts water to 1 part household bleach. Once missed, the solution needs to be discarded within 24 hours.
- Bathrooms should be cleaned with a 10% bleach solution
- Dispose of syringes/needles per your Supply Vendor instructions
- If you have further questions/concerns, please contact our office at (970)451-1234

OASIS
PEDIATRIC THERAPY

PARENT/GUARDIAN ACKNOWLEDGEMENT AND WRITTEN CONSENT FOR TELEMEDICINE SERVIES:

By signing below, I give consent and acknowledge that my child can receive telemedicine for services provided by OASIS Pediatric Therapy. I understand that I have the right to refuse telemedicine services at any time. All therapy sessions will remain confidential and I understand that I may not post videos/pictures/audio of any therapy session in order to protect my child and the clinician.

______ **I give consent for telemedicine services.**

______ **I have equipment necessary for telemedicine services.**

______ **I understand that I may not post video/audio/pictures of sessions on the internet or social media at ANY TIME (this is to protect the child and the clinician).**

____

Parent/Guardian Signature **Date**

SAFETY EDUCATION

In the event of an emergency that interrupts our services to you, the Agency will make every effort to call and/or visit you (if necessary). However, if you have a medical emergency and are not able to contact us, you should access the nearest emergency medical facility. The Agency shall not be liable for any interruption in service to you outside of the Agency's control.

Emergency Contact Numbers:

In an EMERGENCY, CALL 911

RESCUE SQUAD: 911 **POLICE: 911** **FIRE DEPARTMENT: 911**

Emergency Contact Persons:

Names of emergency contact persons (your physicians, etc. who can respond in less than 48 hours):

Parents/Guardians Names	Home Phone	Mobile Phone

OASIS Office Phone:

NON-EMERGENCY; leave a message and someone will call you between 8am-4pm Monday – Friday

(970)451-1234

Local Resources for Civil Preparedness:

Red Cross Mile High Region Headquarters

Phone: (303)722-7474

Email: questions@denver-redcross.org

CO Dept. of Public Health & Environment

Emergency Reporting Line: 1-877-518-5608

Transport Options: Car ______ Ambulance: **911**

Evacuation Routes: Wait for instructions from local and/or County Officials

Other Community Resources: Rocky Mountain Poison and Drug Center at 1-800-222-1222

If possible, you should keep a 2 week supply of medications/supplies/available at all times.

Obtain medications from: ____________________

Obtain supplies from: ____________________

If you have OXYGEN, keep enough back-up oxygen for at least 24 hours.

Obtain from:

If you think your child is having a MEDICATION REACTION:

- If child is having trouble breathing, call 911 immediately
- If child is having mild symptoms, call your doctor/healthcare provider: ____________________
- When child is stabilized, notify your pharmacist: ____________________

EMERGENCY PREPAREDNESS INSTRUCTIONS

(In Case of Emergency)

There may be occasional weather and other emergencies that may delay or stop home-based services to your child/family. This packet gives information on what to expect and suggestions on course of action if one of these emergencies occurs. Please note that OASIS shall not be held liable for any stoppage in home-based services based upon such emergencies or force majeure.

If one of these emergencies should happen in your neighborhood/community, please notify our office at (970)451-1234 and we will alert your therapist(s).

SEVERE WEATHER/TORNADOES

- STAY CALM
- Have emergency equipment and medical supplies readily available
- Close all drapes/curtains
- Move away from windows
- CLOSE exit doors
- Go to inside room of building with no windows, if available.
- Do not enter damaged portions of the building until instructed
- Monitor weather bulletins/radio announcements
- Do not exit building until instructed

SNOW EMERGENCY (snow emergency or winter storms)

- Keep a one (1) to two (2) week supply of heating fuel, food, and water on hand in case of isolation at home
- Keep your car properly services, with snow tires and filled with gas
- Keep emergency supplies in the car including:
  Container of sand, shovel, windshield scraper, tow chain or rope, flares, blanket, flashlight
- Dress appropriately – wear several layers of loose, lightweight, warm clothing, mittens and winter headgear to cover head and face
- Carry a cellular phone (if available)
- Drive with all possible cautions. If caught in a blizzard, seek refuge immediately. Keep car radio on for weather information
- If your car breaks down – turn on flashers or hang a cloth from the radio aerial; stay in your car. If your car is stuck in snow or traffic jam and the car is running, crack the windows to prevent carbon monoxide poisoning and keep exhaust pipe free of snow. If engine is not running, you do not need to crack the windows.

WILDFIRE EMERGENCY (see also CO Bureau of Land Management Website)

- Stay tuned to local emergency broadcast in your area; prepare for possible evacuation
- Have at least 1 week worth of diapers/medications/medical supplies available in case of long-term evacuation

  Before the Fire Approaches Your House

  - **EVACUATE**: Evacuate all family members and pets who are not essential to house preparation. Anyone with medical or physical limitations, the young and the elderly should be evacuated immediately.
  - Wear protective clothing

- Remove combustibles. Clear items that will burn from around the house, including wood piles, lawn furniture, barbecue grills, tarp coverings, etc. Move them outside of your defensible space.
- Close/Protect openings. Close outside attic, eaves and basement vents, windows, doors, pet doors, etc. Remove flammable drapes and curtains. Close all shutters, blinds or heavy non-combustible window coverings to reduce radiant heat.
- Close Inside Doors/Open Damper. Close interior doors inside the house to prevent draft. Open the damper on your fireplace but close the fireplace screen.
- Shut off any natural gas, propane or fuel oil supplies at the source.
- Water. Connect garden hoses. Fill any pools, hot tubs, garbage cans, tubs or other large containers with water.
- Pumps. If you have gas-powered pumps for water, make sure they are fueled and ready.
- Ladder. Place the ladder against the house in clear view.
- Car. Back your car into the driveway and roll up the windows.
- Garage Doors. Disconnect any automatic garage door openers so that doors can still be opened by hand if the power goes out. Close all garage doors.
- Valuables. Place valuable papers, mementos and anything "you can't live without" inside the car, ready for quick departure. Any pets still with you should also be put in the car.

Preparing to Leave

- Lights. Turn on outside lights and leave a light on in every room to make the house more visible in heavy smoke.
- Leave doors and windows closed but unlocked. It may be necessary for firefighters to gain quick entry into your home to fight fire. The entire area will be isolated and patrolled by sheriff's deputies/police.

FLOODS (flood warnings, alerts, or an actual flood)

Precautions before the Flood:

- Make sure emergency supplies and equipment are readily available
- Do no touch any electrical equipment unless it is dry

Precautions if Evacuation is ordered:

- Travel only routes designated
- Do not try to cross a stream or other water areas unless you are sure it is safe
- Monitor local radio broadcast
- Watch for fallen trees, live wires, etc.
- Watch for washed out roads, earth slides, broken water lines, etc.
- Watch for areas where rivers, lakes, or streams may flood suddenly

After the Flood

- Do not enter the building until an all-clear has been given
- Do not use any open flame devices until the building has been inspected for possible gas leaks
- Do not turn on any electrical equipment that may have gotten wet
- Shovel out mud while it is still moist

Flash Floods

- Remember, flash floods can happen without warning
- When a flash flood warning is issued, take immediate action
- Follow all instructions issued without delay

CLIENT COMPLAINTS POLICY

Purpose

To assure that clients of OASIS (the "Agency") and their families have the opportunity to voice complaints and concerns about the quality of care they receive, the Agency's response to their advance directives and other issues without fear of reprisal.

Affected Areas: All Staff

Definition: "*Complaint" is any expression of dissatisfaction by the client or family.*

Policy

The client/family has the right to voice grievances about any concerns they may have. Regulations require that they be informed on admission specifically of their right to voice grievances or complain about the treatment or care given, failure to provide services as promised, lack of respect by anyone furnishing services and agency practices regarding advance directives and privacy practices.

Procedure

1. On admission, the admitting professional shall explain the Agency's complaint policy verbally and give a written notice of its complaint procedure to the client and family. The client also is given the complaint hotline phone number and hours of operation of the state.
2. The client can make a complaint to any member of OASIS staff.
3. If the complaint is not resolved at the staff level, the complaint is forwarded to the President and/or CEO.
4. The President and/or CEO shall investigate the complaint, take appropriate corrective action and report the findings of the investigation to the client within 10 working days.
5. If still not satisfied with the resolution of the complaint, the client may choose to make a complaint with the Governing Body.
6. If still dissatisfied, the client can use the State hotline.
7. A log shall be kept of all complaints received.
8. Complaints are reported to the Governing Body, trended, and analyzed as follows:
   Source of complaints; Nature of complaints; Action taken; Whether the complaint is resolved.
9. Results shall be reviewed by the Professional Advisory Committee and Governing Body.
10. Substantiated findings shall be incorporated into the quality assurance program to evaluate and implement systemic changes as needed.
11. Separate records detailing activities related to complaints, their investigation and resolution shall be maintained for at least two (2) years period and made available for audit and inspection purposes.
12. OASIS does not discriminate or retaliate against a consumer for expressing a complaint or multiple complaints.
13. Each family receives a copy of the OASIS Complaint Policy, which is attached. All OASIS patients receive an Admission Packet which provides information on how a family can register a concern or complaint.
14. When doing an initial evaluation visit, please be sure the family has received the Admission Packet and has sent the signed consents back to the office.
15. If the family has any questions regarding information in the Admission Packet, please have them contact the office at (970)451-1234.

For questions or to file a complaint, please contact:

Lacy Helms
MA CCC-SLP, President
(970)451-1234

Kristin Ceriani
PT, DPT, CEO
(970)451-1234

You can also send an email to oasiskidsco@gmail.com or mail to OASIS Corporation at the below address.

OASIS Pediatric Therapy
Attention: Kristin Ceriani
RE: Complaint Processing
3344 11th Ave
PO Box 200506
Evans, CO 80620-9998

Colorado Medicaid
Change of Provider Form

This form must accompany the new Prior Authorization Request (PAR) Form when a client has a current and active PAR with another provider.

Client Information

Client Name:	Medicaid ID#:
Date of Birth:	Current PAR Number (if known):

Previous Provider Information

Name:	Last Day of Services:

New Provider Information

Name:	Provider ID#:
Client Start Date of Service:	Provider Signature:

This notice is to inform you that I, ______________________________
(Client's name)

have changed providers effective: ______________________
(Date)

I am changing from provider: ______________________________
(Provider's name)

to provider: ______________________________
(New provider's name)

The following services/equipment will be affected by this change:

______________________ ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________

______________________________ ______________________
Client's Signature or (Guardian if client cannot sign) (Date)

Client's address: ______________________________
(Address line 1)

____
(Address line 2)

____
(City, State and Zip Code)

Revision date: March 2015