OASIS
PEDIATRIC THERAPY

Admission & Service Information

OASIS Pediatric Therapy

(With services provided by Front Range Therapists)

Welcome and Philosophy

Thank you for choosing OASIS Pediatric Therapy (with services provided by FRT) as your in-home provider. We extend a warm welcome to you, your family and friends. We consider it a privilege to serve you and we assure you that your medical care, safety and satisfaction are the most important to us. Please don't hesitate to ask us any questions you may have concerning your care and treatment.

OUR MISSION:
OASIS Pediatric Therapy joyfully serves underserved families who have children with delays/disabilities to THRIVE by providing therapies, respite and resources.

OUR VISION:
Empower children with delays, and their families to maximize independence and life satisfaction.

This is in compliance with Title VI of the Civil Rights Act of 1964, with section 504 of the Rehabilitation Act of 1973 and with the Age Discrimination Act of 1975 and does not discriminate on the basis of race, color, religion, sex, national origin, age or disability with regard to admission, access to treatment or employment. We will make every effort to comply with these and similar statutes.

We are committed to protecting your rights and privileges as a healthcare patient. Since many aspects or our services and procedures may be new to you, we have prepared this packet to help you become better acquainted with us, to assist you in understanding the process of homecare, and explain your rights as a patient. As state and federal regulations change, there may be additions or changes to this booklet. Our complete policy and procedure manual regarding your care and treatment is available upon request for your viewing at the agency office, any time during normal business hours.

Our official business hours are Monday-Friday, 8am-4pm. If you have any questions or concerns outside of those hours, please contact the office and the on-call person will be happy to assist you. If no one is available to answer your call immediately, please leave a clear voice mail with your name, phone number, and reason for your call, and the on-call person will respond within an hour. We are available 24 hours a day, 7 days a week at 970-451-1234.

Again, thank you for choosing OASIS Pediatric Therapy (with services provided by FRT).

Lacy Hoyer-Helms, Administrator

HOURS OF OPERATION

- **Office Hours:** Monday through Friday from 8:00 a.m. to 4:00 p.m., except during company holidays or as authorized by the Administrator.
- **After Hours Coverage:** We provide 24-hour on call **no emergent care service,** 7 days per week. Our clinicians do not carry equipment with them to respond to emergency situations. ***In case of a medical emergency, go to the nearest emergency room or call 911.***
- **Weather Conditions:** During inclement weather or natural disasters, our staff may not be able to travel to your home. OASIS Pediatric Therapy (with services provided by FRT) will attempt to contact you by phone to let you know that they are unable to make your visit that day.

YOUR EMERGENCY PREPAREDNESS PLAN

In case of environmental natural disaster or emergency, we have an emergency plan to continue necessary patient services. All patients are assigned an acuity level that is updated as needed. You will be contacted for medical attention according to your acuity level:

- ❑ Level 1 – Same Day as Scheduled (i.e., urgent therapy such as very recent Botox, tendon release, etc.)
- ❑ Level 2 – Within 96 hours

In the event of an emergency, I understand: **(agency staff to make a ✓ and client initial indicated lines)**

___ 1. If possible, I will be contacted by the agency to make arrangements for home visits.

___ 2. In the event that phone service is lost for an extended period of time, I know that local radio and television stations should be utilized as a means of communication for emergency planning.

___ 3. I understand, as the patient, if my Classification Category is II or III; that either I, my family *or* other non-agency persons who assist me may be responsible for my care until I am notified that the emergency no longer exists.

___ 4. If my Classification Category is I, the agency will coordinate my care with the local sheriff's office, emergency operations center or local ambulance services for transportation to an acute care facility.

SERVICES WE PROVIDE

- **Physical, Occupational and Speech Therapy** provided by a licensed therapist or licensed therapy assistant under the direction of the therapist.
- **Skilled Nursing** provided by an RN or LPN with training and experience in providing care in the home.
- **Medical Supplies and Outpatient Therapy may be supplied depending on your payor source.** These needs must be coordinated with OASIS Pediatric Therapy (with services provided by FRT) while you are receiving Medicare covered home health services. If you arrange for these services or supplies on your own while under our plan of care, Medicare will not reimburse you or the other suppliers. The agency will *only* be responsible for those items and services that it has arranged. It is your responsibility to notify the agency of any supplies and therapies needed and/or ordered by your physician while under our agencies care. Please inform our staff member if you are currently receiving therapy and/or ordering supplies from another agency or vendor.

CHARGES

We accept payment for services from Medicare and Medicaid, Worker's Compensation, Private insurance and Private Pay. OASIS Pediatric Therapy (with services provided by FRT) will bill all payer sources for our services on your behalf. Deductible and co-pay information associated with your insurance will be provided to you, both verbally and in writing, based on the information that is provided to OASIS Pediatric Therapists (with services provided by FRT) at the time of admission.

- If services are paid for by Medicare or Medicaid, then the assigned payment is accepted as payment in full. If services are ordered which are not covered by the Medicare, you will be notified before these services are provided or as soon as our staff is aware of this.
- Please notify us if you decide to enroll in a Medicare Advantage plan, a Medicaid HMO or in a private HMO or a Hospice.
- Diabetic supplies and briefs/pads are only provided when used during a scheduled visit by a member of our staff.

Regardless of your payor source, if we cannot meet your needs or your home environment will not support our services, we will not admit you or continue to provide services to you.

RATES:

SN: $200/visit **PT:** $200/visit **OT:** $200/visit **SLP:** $200/visit

MEDICARE PATIENTS

CRITERIA FOR ADMISSION

The following guidelines are required for Medicare to pay for your home health care services:

- You are **homebound.** This means it takes a considerable and taxing effort for you to leave your home and your absences are infrequent and of relatively short duration. You can still be considered homebound to attend a religious service or to receive health care treatment when transported by someone else.
- You have had a **recent** illness, injury or worsening of a condition which requires skilled care on an intermittent basis (*Other than solely for venipuncture/blood draws).*
- You are an **eligible Medicare beneficiary.**
- You are under the **direct care of a doctor** who has ordered the treatment we are providing.
- Care is provided on an **intermittent basis.**
- **Effective April 1, 2011,** Medicare requires a face-to-face encounter with your physician within 90 days before admission to home health services or within 30 days following admission. Failure to meet this requirement will require discharge from home health services on the 31st day following your admission.

If we cannot meet your needs or your home environment will not support our services, we will not admit you or continue to provide services to you.

MEDICARE NON-COVERAGE

In the event that you have been admitted with the understanding that Medicare will pay for your care, and it is determined that Medicare will not pay for your current services, you will be advised of the effective date that services will cease. You will be given the opportunity to assume responsibility for the cost of the services. If you choose to discontinue receiving services, you will be given notice of the date on which your services will cease.

If you chose to appeal then you have the right to an immediate, independent medical review (appeal) while your services continue. Both 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 if you have requested an appeal.

If you choose to appeal, the independent reviewer will ask for your opinion, review 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 the independent reviewer agrees with the determination that services should no longer be covered after the effective date that you were given, then you will need to either stop services no later than that effective date or accept financial liability for the services.

To begin the appeal process, call the office at 970-451-1234 and speak with Agency Administrator Lacy Hoyer-Helms

PROBLEM SOLVING

The services provided for you through OASIS Pediatric Therapy (with services provided by FRT) in collaboration with your doctor. A Plan of Care will be established between your doctor, our licensed care staff, yourself and your family, if you so choose. These services may be provided for you under Medicare or other health insurance. We are able to assist you in coordinating benefits for your home health care. For assistance, please call our office at and ask to speak with a representative in the billing department.

We are committed to assuring that your rights are protected. If you feel that our staff has failed to follow our policies or has in any way denied you your rights or discriminated against you; please follow these steps without fear of discrimination or reprisal:

1. Contact the Clinical Manager or Administrator at the number listed above. We will give priority attention to resolve the problem.
2. If you feel satisfactory action has not been taken, you may contact the Section 504 Coordinator at the following:

The Office for Civil Rights, U.S. Department of Health and Human Services

For information on how to file a complaint of discrimination, or to obtain information of a civil rights nature, please contact us. OCR employees will make every effort to provide prompt service.

Hotlines: 1-800-368-1019 (Voice) 1-800-537-7697 (TDD)
E-Mail: ocrmail@hhs.gov Website: http://www.hhs.gov/ocr

EXPANDED RIGHTS AND RESPONSIBILITIES

1. Be fully informed in advance about services provided by the agency and specifically the service, care to be provided included the disciplines that furnish care and the frequency of visits as well as any modifications to the service care plan.
2. Receive information about services provided under the Medicare Home Health benefit, for Medicare beneficiaries.
3. Participate in the development and periodic revision of the Plan of Care and be advised of any change in the plan of care before it is made.
4. Be informed of the right to refuse in advance or during care or treatment after the consequences of refusing care or treatment are fully presented.
5. Participate in, be informed about and consent to (i) completion of all assessments, (ii) care to be furnished based on the assessment(s), (iii) expected outcomes, including developing patient identified goals, (iv) disciplines that will furnish care and frequencies of visits, (v) anticipated risks and benefits, (v) factors that could affect treatment, (vi) changes in care to be furnished.
6. To personally or have patient representative except in an emergency consent or refuse treatment.
7. Except in an emergency be informed of proposed alternatives to psychotropic medication and the risks and possible complications of a psychotropic medication.
8. Be informed, both verbally and in writing, of care being provided of the charges, including payment for service and care, including payment for service/care expected from third parties and any charges for which the patient will be responsible and i. The extent to which payment for HHA services may be expected from Medicare, Medicaid, or any other federally funded or federal aid program known to the HHA; (ii) The charges for services that may not be covered by Medicare, Medicaid, or any other federally-funded or federal aid program known to the HHA; (iii) The charges the individual may have to pay before care is initiated; and (iv) any changes in the information provided in accordance with 42 CFR 484.50(c)(7) of this section when they occur. The HHA must advise the patient and representative (if any), of these changes as soon as possible, in advance of the next home health visit before the charges become effective.
9. Receive all services in the plan of care.
10. Receive written notice in advance of furnishing any service if the agency believes services may not be covered by the patient's payer, and in advance of the agency reducing or terminating care.
11. Have one's property and person treated with dignity, consideration and respect, consideration and recognition of patient dignity and individuality.
12. Be able to identify visiting staff members through proper photo identification.

13. Be free from mistreatment, neglect or verbal, mental, sexual and physical abuse including injuries of unknown source and misappropriation of patient property, seclusion, restraint, sexual assault, manipulation, coercion, exploitation.
14. Voice grievances/complaints to the agency or other entity regarding treatment or care, lack of respect of property or recommend changes in policy, staff or service/care without restraint, interference, coercion, discrimination or reprisal.
15. Have grievances/complaints regarding treatment or care that is or fails to be furnished or lack of respect of property investigated.
16. Choose a health care provider including an attending physician.
17. Confidentiality and privacy of all information contained in the patient record and of protected health information.
18. Be advised on agency's policies and procedures regarding the disclosure of clinical records.
19. Receive appropriate care without discrimination in accordance with physician orders.
20. Be informed of any financial benefits to the agency when referred to an organization.
21. Be fully informed of one's responsibilities.
22. Receive information about the scope of services that the organization will provide and specific limitations on those services.
23. Be informed of patient rights under state law to formulate advance directives.
24. Be informed of anticipated outcomes of care and of any barriers in outcome achievement
25. Be informed of that OASIS information collected will not be disclosed except for legitimate purposes allowed by the Privacy Act.
26. The right to be advised orally and in writing, before care is initiated, of the extent that payment for the agency services may be expected from Medicare or other sources, and the extent of that payment; furthermore, to receive written notice if the agency believes a service is non-covered.
27. Be informed of organizational ownership and control.
28. Be informed of the names and addresses of federally and state funded entities that serve the area in which the client resides.
29. Be informed of the right to access and how to access auxiliary aids.
30. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
31. To receive treatment that supports and respects the patient's individuality, choices, strengths, and abilities;
32. To receive privacy in treatment and care for personal needs;
33. To review, upon written request, the patient's own medical record according to A.R.S. §§ 12-2293, 12-2294, and 12-2294.01;
34. To receive a referral to another health care institution if the home health agency is not authorized or not able to provide physical health services needed by the patient;

35. To participate or have the patient's representative participate in the development of a care plan or decisions concerning treatment;
36. To participate or refuse to participate in research or experimental treatment; and
37. To receive assistance from a family member, the patient's representative, or other individual in understanding, protecting, or exercising the patient's rights.

If you believe your rights have been violated or have any questions about advance directives you may contact the agency directly:

OASIS Pediatric Therapy (with services provided by FRT)
Lacy Hoyer-Helms, Administrator
3344 11th Ave.
PO Box 200506
Telephone: 970-451-1234

Written Notice of Home Care Consumer Rights

As a consumer of home care and services you are entitled to receive notification of the following rights both orally and in writing. **You have the right to exercise the following rights without retribution or retaliation from agency staff:**

1. Receive written information concerning the agency's policies on advance directives, including a description of applicable state law;

2. Receive information about the care and services to be furnished, the disciplines that will furnish care, the frequency of proposed visits in advance and receive information about any changes in the care and services to be furnished;

3. Receive care and services from the agency without discrimination based upon personal, cultural or ethnic preference, disabilities or whether you have formulated an advance directive;

4. Authorize a representative to exercise your rights as a consumer of home care;

5. Be informed of the full name, licensure status, staff position and employer of all persons supplying, staffing or supervising the care and services you receive;

6. Be informed and participate in planning care and services and receive care and services from staff who are properly trained and competent to perform their duties;

7. Refuse treatment within the confines of the law and be informed of the consequences of such action;

8. Participate in experimental research only upon your voluntary written consent;

9. Have you and your property to be treated with respect and be free from neglect, financial exploitation, verbal, physical and psychological abuse including humiliation, intimidation or punishment;

10. Be free from involuntary confinement, and from physical or chemical restraints;

11. Be ensured of the confidentiality of all of your records, communications, and personal information and to be informed of the agency's policies and procedures regarding disclosure of clinical information and records;

12. Express complaints verbally or in writing about services or care that is or is not furnished, or about the lack of respect for your person or property by anyone who is furnishing services on behalf of the agency.

If you believe your rights have been violated you may contact the agency directly:
Front Range Therapists, Lacy Hoyer-Helms, Administrator
23830 County Rd. 48, LaSalle, CO 80645 Telephone: 970-451-1234

You may also file a complaint with the Health Facilities and Emergency Medical Services Division of the Colorado Department of Public Health and Environment via mail or telephone:
4300 Cherry Creek Drive South
Denver, CO 80246
303-692-2910 or 1-800-842-8826

I attest to verbal and written receipt of the aforementioned notice of rights:

_____ _____
Consumer or Authorized Representative Signature Date

_____ _____
Agency Representative Signature Date

PATIENT / FAMILY RESPONSIBLITIES
As a Home Care Patient, You (or Your Family) Have the Responsibility To:

1. Remain under a doctor's care.

2. The patient or family is responsible for notifying Front Range Therapists of schedule changes or unavailability at the predetermined place of care and visit time.

3. The patient/family notify agency of any changes in condition, or dissatisfaction with services provided.

4. The patient/family will notify the agency of existence of or changes to advance directives.

5. The patient/family is responsible for following the recommendation and advice, prescribed by agency personnel, in conjunction with the physician's plan of treatment, and accept responsibility for the outcomes if you do not follow the care or treatment.

6. The patient/family is to notify the agency of any insurance changes.

7. The patient is responsible for assuring that the financial obligations of his/her care are fulfilled as promptly as possible in accordance with any arrangement made with Front Range Therapists.

8. The patient/family is responsible to establish with the agency a contingency plan if the agency is not able to provide services. The agency will make every effort to visit or telephone patient if agency has an emergency that disrupts service. If the patient has a medical emergency and is unable to contact the agency, the patient should access emergency assistance by calling 911.

9. The patient/family is responsible for being respectful of the safety of all personnel involved in their care while the care provider is in the home, providing a safe environment. The patient/family will identify safety concerns to agency staff.

11. The patient is responsible for providing, to the best of his/her knowledge, information that is accurate and complete with regards to past illness, hospitalizations, medications, pain management, present complaints and all other health related matters that will assist in developing an effective care plan.

12. The patient is responsible for treating agency personnel and agency equipment with respect and consideration.

13. The patient is responsible for maintaining records left in their home in a safe and secure manner, protecting the confidentiality of such information.

You may be discharged from services if you do not fulfill all the patient responsibilities.

Front Range Therapists

AGENCY DISCLOSURE NOTICE

Agency Type: ☐ Home Care Placement ☒Home Health Care ☐ Personal Care or Non-Medical

Each home care agency or home care placement agency is required to provide the consumer information as to the responsibilities of the agency, the home care worker, and the consumer regarding the employment and duties of each.

☒ Agency is the employer of record for all staff providing direct care services and is responsible for all items listed below.

☐ Responsibilities are delineated below:

Consumer	Worker	Agency	
		✓	Employer of the home care worker.
		✓	Supervision of the home care worker.
		✓	Scheduling of the home care worker.
		✓	Assignment of duties to the home care worker.
		✓	Hiring, firing and discipline of the home care worker.
✓Cleaning Supplies		✓	Provision of supplies or materials for use in providing services to the consumer.
		✓	Training and ensuring qualifications that meet the needs of the consumer.
		✓	Liability for the home care worker while in the consumer's home.
Consumer	Worker	Agency	Payment of:
		✓	Wages to the home care worker.
		✓	Employment taxes for the Home Care Worker.
		✓	Social Security taxes for the Home Care Worker.
		✓	Unemployment insurance for the Home Care Worker.
		✓	General liability insurance for the Home Care Worker.
		✓	Worker's Compensation for the Home Care Worker.
		N/A	Bond Insurance (if provided).

The above information and areas of responsibility have been explained and any questions have been answered in regard to responsibilities held by the consumer, the home care worker and the agency.

Consumer or Authorized Representative:_____ Date:_____

Home Care Worker : _____ Discipline: _____ Date:_____

(if not employee or contractor to the agency where the agency holds full responsibility)

Agency Representative: _____ Title: _____ Date:_____

Printed Name of Consumer: _____ Start of Care Date: _____

CDPHE 3/2009

OASIS PEDIATRIC THERAPY (WITH SERVICES BY FRT)

DISCHARGE POLICY

Discharge Planning is initiated for every home care client at the time of the client's admission for home care. The transfer process is based on the client's assessed needs. To facilitate the client's discharge or transfer to another entity. To ensure continuity of care, treatment and services when needed. To assure collaboration with the physician, client, family and other disciplines in planning for discharge from the agency.

DISCHARGE PROCEDURE:

1. Planning for discharge is provided as part of the ongoing assessment of needs and in accordance with expected care outcomes. The client/family will participate in this process beginning with the initial assessment visit.
2. Client's needs for continuing care to meet physical and psychological needs are identified and clients are told in a timely manner of the need to plan for discharge or transfer to another level of care/organization. Clients are informed of the reason for discharge and anticipated needs for services after discharge.
3. Unplanned discharges for reasons listed as discharge criteria
4. The physician will be involved in the discharge plan and specific ongoing care needs will be identified and addressed as part of the plan.
5. The impending discharge will be reviewed with other members of the home care team to assure coordination and continuity with the client and family/caregivers.
6. The Registered Nurse or Therapist shall review the clinical record to assure accuracy and completion. A discharge plan shall be developed that is documented in writing and includes all written/verbal instruction regarding the client's ongoing care needs and available resources provided to the client and family.
7. The Registered Nurse/Therapist shall ensure that the treatment goals and client outcomes have been met or, if unmet needs are present, appropriate referrals are made to agencies/institutions to meet continuing client needs.
8. Medicare beneficiary clients will be given the Notice of Medicare Non-Coverage as indicated and/or appropriate HHCCN to explain Agency decision related to discharge from services. Medicaid beneficiary clients will be provided written notice in accordance with state Medicaid regulations or rules.
9. Refer to the Client Transfer Policy for additional information on the transfer referral process.
10. Upon discharge to self-care, the client will receive verbal/written information regarding community services, medication use, any procedures/treatments to be performed, and follow-up visits for physician care.
11. The agency will document physician will order the patient to be transferred or discharged, as appropriate.
12. A discharge OASIS assessment will be completed for those clients who require OASIS

assessments.

13. A discharge summary will be completed, per agency policy, and maintained in the client record. A copy of the discharge summary is submitted to the physician who will be managing the client's care after discharge.
14. Unplanned discharges, for cause, will be handled and documented including the following:
    a. Agency makes effort to work with client, representative if any to resolve the issue triggering possible discharge. Agency will assure documentation of communication with the client, including trigger for potential for discharge, actions to avoid discharge and any behavioral agreements.
    b. Agency communicates with physician(s) issuing orders for the home health plan of care, and all physicians issuing home health orders, and also physician or health care professional that will be responsible for care management after discharge from the agency.
    c. The client/ responsible party will receive discharge notice verbally and in writing. Notice of discharge will include the date of discharge and reason.
    d. Agency will provide client and/or representative, if any, contact information for other agencies who provide services that the client will need after discharge.
    e. If there are unmet needs and the agency is no longer able to meet those needs, documentation will demonstrate that appropriate notice was given (verbal and written) and referrals made as indicated.

DISCHARGE CRITERIA:

1. Criteria for discharge may include, but are not limited to the following:
    a. Agency and physician ordering home health agree that the client has either met the goals/outcomes or that the client no longer needs home health services.
    b. Client or client's payer has failed to or will no longer pay for services.
    c. Client refuses services, or requests discharge or change to a different agency.
    d. Client has more than 2 cancellation/no shows in a 60-day period with less than 24-hour cancellation notice, services will be discharged.
    e. Client's behavior is not conducive to the safe delivery of care by the agency: disruptive or uncooperative, or if the client environment is unsafe for agency staff to provide care.
    f. Client dies; or
    g. Agency ceases operation.
2. Criteria for transferring a patient to an acute or sub-acute care facility which may result in discharge:
    a. The patient has demonstrated deterioration, appearance of acute symptoms, adverse effects of medical treatment, or other change in status.
    b. There is a threat to patient safety due to unsafe home environment, absence of physician, family, or caregiver involvement.

OASIS PEDIATRIC THERAPY (WITH SERVICES BY FRT)

TRANSFER POLICY

Home care services shall not be arbitrarily terminated. A client may be transferred as determined by the Clinical Manager or designated Registered Nurse/Therapist in response to the client's request and/or identified need that cannot be met by the agency. A transfer from the agency to another agency will be documented as a discharge from the agency.

To assure continuity of care by providing pertinent information to another home health care company or facility when a client chooses another provider.

1. Transfers will occur when the agency and the home health ordering physician agree that the agency can no longer meet the client's needs or cannot met acute clinical needs the client is experiencing.
2. Transfer to another healthcare entity may also occur to facilitate a discharge for reasons including, but not limited to agency and physician ordering home health agree that the client has either met the goals/outcomes or that the client no longer needs home health services.
    a. Client or client's payer has failed to or will no longer pay for services.
    b. Client refuses services, or requests discharge or change to a different agency.
    c. Client's behavior is not conducive to the safe delivery of care by the agency: disruptive, abusive or uncooperative.
    d. Client dies; or
    e. Agency ceases operation.
3. The client/representative, if any, shall be informed by the Registered Nurse/Therapist of the need for transfer whether expected to be short term for an acute need or to facilitate a discharge, or the client will inform the agency of his/her desire to transfer to another service provider.
4. In the event, of the need or desire to change provider of care client/caregiver will be active participants in selecting another provider and communicating the decision to the agency.
5. The agency will transmit/share information with the receiving healthcare entity by secure electronic means, telephone call initiated by the agency, or written information sent with EMS transport or recognized representative. Transfer of information will be in compliance with local, state and federal regulations.
6. The plan for transfer shall be discussed with the physician in advance as the acuity of the patient condition allows and orders to hold services will be obtained.
7. A Transfer Summary will be completed by the Registered Nurse/Therapist. This summary will be based on data collected on the last visit and may include date of transfer, patient identifying and contact information including emergency contact information, physician name and phone number, documentation of services received,

reason for transfer/discharge from agency including diagnosis related to transfer, the client's physical and psychosocial status, current medications, continuing symptom management needs, instruction and referrals provided to the client, summary of care, any existing advance directives, an any relevant changes in caregiver support, and relevant lab results. If indicated as the reason for transfer the summary will include those services, the agency cannot or can no longer provide the client.

8. The Transfer Summary will be sent to the new provider or facility within two (2) days of a planned transfer, if the patient's care will be continued by the receiving entity. In the event that the transfer was unplanned and if the client is still receiving care by the receiving entity when the agency becomes aware of the transfer then the transfer summary/report will be sent within two (2) business days.
9. A copy shall be retained for the client's chart. The documentation will include the name of the facility and person receiving the client and the transfer report/summary.
10. The agency must have a signed Client Authorization for the release of pertinent information on file in order to provide the receiving health care provider with the appropriate client information.
11. If a client transfers to another health facility or home health agency, a copy of the summary shall be sent to the receiving agency.
12. The receiving health care provider shall be responsible for obtaining new physician's orders from a physician licensed to practice in the state in which care is to be provided.
13. If the client is transferred to another home care provider, the agency will complete a discharge oasis and a discharge summary. The discharge summary will be sent to the physician.
14. A client who is transferred to an inpatient facility will have a transfer OASIS assessment completed. If the client is also being discharged from the agency, a discharge summary will be completed

ADVANCE DIRECTIVES

It is your right to decide about the medical care you will receive. You have the right to be informed of treatment options available before giving consent for medical treatment. You also have the right to accept, refuse or discontinue any treatment at any time.

However, there may be times when you may not be able to decide, or make your wishes known.

Advance Directives let you make your wishes for treatment known in advance. A person can decide ahead of time what kinds of treatment they want to keep them alive depending on their clinical condition at that time.

Our agency complies with the Patient Self-Determination Act of 1990 which requires us to:

- Provide you with written information describing your rights to make decisions about your medical care.
- Document advance directives prominently in your medical record and inform all staff.
- Comply with requirements of State law and court decisions with respect to advance directives; and
- Provide care to you regardless of whether or not you have executed an advance directive.

OASIS Pediatric Therapy (with services provided by FRT) also recognizes that when the patient is not legally responsible, the surrogate decision maker has the right to refuse care, treatment and services on the patient's behalf.

The health care staff at OASIS Pediatric Therapy (with services provided by FRT) will request from the patient a copy of his/her Advance Directive to ensure the agency staff understands and follows the patient's wishes.

The patient has the right to revoke or change an advance directive at any time. The patient will need to notify OASIS Pediatric Therapy (with services provided by FRT) of any changes made.

If the agency cannot, for any reason, carry out the patient's advance directive, they will notify the patient/caregiver and, if necessary, assist the patient to find an alternate provider.

If Advance Directive does not identify the patient's wish to withhold resuscitation and there is no physician order to do so, OASIS Pediatric Therapy (with services provided by FRT) staff will initiate CPR in event of Cardiopulmonary Arrest.

Please be aware that what follows is just information, not advice. Every situation is different. For questions about your particular situation, please consult the appropriate qualified professional: your physician, attorney, or estate planner.

MEDICAL DURABLE POWER OF ATTORNEY

- The Medical Durable Power of Attorney (also called the "Power of Attorney for Health Care") is a document you sign to appoint someone to make your health care decisions for you. The person you name is called your agent.
- In most cases, your agent only makes decisions for you when you cannot. This may be temporary, while you recover from an accident or injury, or long term, if you are permanently incapacitated or become chronically or terminally ill.
- Your agent can get copies of your medical records, consult with your doctors and other health care providers, and make all decisions necessary for your care.
- Your agent is supposed to act according to your wishes and values, so it's important to discuss your life values, your goals, and your preferences for treatment. Ideally, the agent is someone who knows you very well. He or she must be able to devote the time and energy to handling your health care needs.
- A Medical Durable Power of Attorney (MDPOA) is not the same as a general Power of Attorney (POA). The MDPOA is only authorized to make health care decisions. A general POA covers legal and financial affairs. The authority of both types of agents ends at your death.
- Only you are required to sign the MDPOA document; however, a notary seal can help support your agent's authority if you are sick or injured in another state.

LIVING WILL

- A living will your doctor what to do about artificial life support measures if you have an injury, disease, or illness that is not curable or reversible and is terminal.**
- Your Living Will does goes into effect after doctors agree you have a terminal condition, **and** you are unconscious or otherwise unable to make your own medical decisions.
- In these circumstances, your Living Will directs your doctors to continue or discontinue, as you direct, life-sustaining procedures, artificial nutrition, and artificial hydration.
- You do not need an attorney or a doctor to complete a Living Will, but you do need two witnesses. The witnesses cannot be your health care providers, an employee of your health care provider, or anyone likely to inherit property from you.
- A notary's signature is a good idea but not required.
- A Living Will is not the same as a regular will ("Last Will and Testament") or a Living Trust, which refer to possessions and property. A Living Will only provides instructions on medical treatment, not the distribution or disposal of your property.

DIRECTIVE

- A CPR (cardiopulmonary resuscitation) directive allows you to direct in advance that no one should give you CPR if your heart or your breathing stop.
- CPR directives are almost always used by people who are severely or terminally ill or elderly. For them, the trauma involved in CPR is likely to do more harm than good, but emergency personnel are required to perform CPR unless a directive tells them not to.
- A CPR directive is not the same as a DNR order. A DNR order is a doctor's order made for severely ill patients in health care facilities, including nursing homes. The DNR does not require the patient's consent, and it expires when the patient leaves the facility.
- The Colorado CPR directive (or "blue form") must be signed by both the individual (or the individual's MDPOA agent or "proxy"—see below) and his/her physician.
- Other forms, such as those particular to a health care facility or created by individuals, are valid and should be signed by a physician to avoid any question about their validity. However, emergency personnel should honor any directive, made by the principal or his or her agent, to refuse CPR.
- The CPR directive form does NOT have to be "original" nor do the signatures have to be "original." Photocopies, scans, and faxes are valid.
- CPR directives must also be immediately visible to emergency personnel. Keep the form in an easy-to-get to place, like the front of the fridge. For more active folks with CPR directives, a wallet card or special CPR directive bracelet or necklace can be obtained.

MEDICAL PROXY FOR DECISION MAKING

- No one is given automatic authority in decision making for another adult, and health care providers cannot make decisions for patients except in an emergency.
- If you have not appointed an agent, and if you are unable to make or express your decisions for yourself, a "proxy" is needed.
- Your spouse or partner, parent, adult child, grandchild, brother or sister, close friend, or other "interested party" may be chosen as your proxy by the group.
- Like your agent, your proxy should act according to your wishes and values, so the proxy should be the one who knows your medical treatment wishes the best.
- Proxies selected in this way cannot refuse artificial nutrition and hydration for you.
- If the group can't agree on who the proxy should be, then guardianship needs to be pursued through the courts

PRIVACY

HIPAA NOTICE OF PRIVACY PRACTICES

In compliance with HIPAA – The Health Insurance Portability and Accountability act of 1996

If you are a client of OASIS Pediatric Therapy (with services provided by FRT), this notice describes how your medical information may be used and disclosed and how you can get access to this information. Please review this notice carefully.

I. USES AND DISCLOSURES

OASIS Pediatric Therapy (with services provided by FRT) will not disclose your health information without your authorization, except as described in this notice.

Plan of Care/Treatment. OASIS Pediatric Therapy (with services provided by FRT) will use your health information for the plan of care/treatment; for example, information obtained by a nurse/therapist will be recorded in our record and used to determine the course of treatment. Your nurse and other personal assistance staff will communicate with one another personally and through the case record to coordinate care provided.

Payment. OASIS Pediatric Therapy (with services provided by FRT) will use your health information for payment for services rendered. For example, the agency may be required by your health insurer to provide information regarding your health care status so that the insurer will reimburse you or OASIS Pediatric Therapy (with services provided by FRT). The agency may also need to obtain prior approval from your insurer and may need to explain to the insurer your need for personal assistance services and the services that will be provided to you.

Health Care Operations. OASIS Pediatric Therapy (with services provided by FRT) will use your health information for personal assistance services operations. For example, agency nurses, field staff, supervisors and support staff may use information in your case record to assess the care and outcomes of your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of services we provide. Regulatory and accrediting organizations may review your case record to ensure compliance with their requirements.

Notification. In an emergency, OASIS Pediatric Therapy (with services provided by FRT) may use or disclose health information to notify or assist in notifying a family member, personal representative or another person responsible for your care, of your location and general condition.

Public Health. As required by federal and state law, OASIS Pediatric Therapy (with services provided by FRT) may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Law Enforcement. As required by federal and state law the agency will notify authorities of alleged abuse/neglect, and risk or threat of harm to self or others. We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Charges against the Agency. In the event you should file suit against OASIS Pediatric Therapy (with services provided by FRT), the agency may disclose health information necessary to defend such action.

Duty to Warn. When a client communicates to OASIS Pediatric Therapy (with services provided by FRT) a serious threat of physical violence against himself, herself or a reasonably identifiable victim or victims, the agency will notify either the threatened person(s) and/or law enforcement.

The Agency may also contact you about appointment reminders, treatment alternatives or for public relations activities.

In any other situation, OASIS Pediatric Therapy (with services provided by FRT) will request your written authorization before using or disclosing any identifiable health information about you. If you choose to sign such authorization to disclose information, you can revoke that authorization to stop any future uses and disclosures.

II. INDIVIDUAL RIGHTS

You have the following rights with respect to your protected health information:

1. You may request in writing that OASIS Pediatric Therapy (with services provided by FRT) not use or disclose your information for treatment, payment or administration purposes or to persons involved in your care except when specifically authorized by you when required by law, or in emergency situation. The agency will consider your request; however, OASIS Pediatric Therapy (with services provided by FRT) is not legally required to accept it. You have the right to request that your health information be communicated to you in a confidential manner such as sending mail to an address other than your home.
2. Within the limits of the statutes and regulation, you have the right to inspect and copy your protected health information. If you request copies, OASIS Pediatric Therapy (with services provided by FRT) will charge you a reasonable amount, as allowed by statute.

3. If you believe that information in your record is incorrect or if important information is missing, you have the right to submit a request to OASIS Pediatric Therapy (with services provided by FRT) to amend your protected health information by correcting the existing information or adding the missing information.
4. You have the right to receive an accounting of disclosures of your protected health information made by the agency for certain reasons, including reason related to public purposes authorized by law and certain research. The request for an accounting must be made in writing to Privacy Officer. The request should specify the time period for the accounting starting on or after April 14, 2003. Accounting request may not be made for periods of time in excess of six (6) years. The agency would provide the first accounting you request during any 12-month period without charge. Subsequent accounting request may be subject to a reasonable cost-based fee.
5. If this notice was sent to you electronically, you may obtain a paper copy of the notice upon request to the agency.

III. OASIS PEDIATRIC THERAPY (WITH SERVICES PROVIDED BY FRT) DUTIES

1. OASIS Pediatric Therapy (with services provided by FRT) is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices with respect to protected health information.
2. The agency is required to abide by the terms of this Notice of its duties and privacy practices. The agency is required to abide by the terms of this Notice as may be amended from time to time.
3. OASIS Pediatric Therapy (with services provided by FRT) reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all protected health information that it maintains. Prior to making any significant changes in our policies, OASIS Pediatric Therapy (with services provided by FRT) will change its Notice and provide you with a copy. You can also request a copy of our Notice at any time. These requests should be made in writing. For more information about our privacy practices, please contact the office at 970-451-1234.

IV. COMPLAINTS

If you are concerned that OASIS Pediatric Therapy (with services provided by FRT) has violated your privacy rights, or you disagree with a decision the agency made about access to your records, you may contact the office at 970-451-1234. You may also send a written complain to the Federal Department of Health and Human Services. OASIS Pediatric Therapy (with services provided by FRT) office staff can provide you with the appropriate address upon request. Under no circumstances will you be retaliated against for filing a complaint.

V. CONTACT INFORMATION

OASIS Pediatric Therapy (with services provided by FRT) is required by law to protect the privacy of your information, provide this Notice about our information practices, and follow the information practices that are described in the Notice. If you have any questions or complaints, please contact: **Lacy Hoyer-Helms**

OASIS PEDIATRIC THERAPY (WITH SERVICES BY FRT)

PRIVACY ACT STATEMENT - HEALTH CARE RECORDS

THIS STATEMENT GIVES YOU ADVICE REQUIRED BY LAW (THE PRIVACY ACT OF 1974).
THIS STATEMENT IS NOT A CONSENT FORM.
IT WILL NOT BE USED TO RELEASE OR TO USE YOUR HEALTH CARE INFORMATION.

I. Authority for collection if your information, including your Social Security Number, and whether or not you are required to provide information for this assessment Sections 1102(a), 1154, 1861(o), 1861(z), 1863, 1864, 1865, 1871, 1891(b) of the Social Security Act. Medicare and Medicaid participating home health agencies must do a compete assessment that accurately reflects your current health and includes information that can be used to show your progress toward your health goals. The home health agency must use the "Outcome and Assessment Information Set" (OASIS) when evaluating your health. To do this, the agency must get information from every patient. This information is used by the Centers for Medicare and Medicaid Services to be sure that the home health agency meets quality standards and gives appropriate health are to its patients. You have the right to refuse to provide information for the assessment to the home health agency. If your information is included in an assessment, it is protected under the federal Privacy Act of 1974 and the "Home Health Agency Outcome and Assessment Information Set" (HHA OASIS) System of Records.

II. Principal purposes for which your information is intended to be used.
The information collected will be entered into the Home Health Agency Outcome and Assessment Information Set (HHA OASIS) System No. 09-70-9002. Your health care information in the HHA OASIS System of Records will be used for the following purposes:

- Support litigation involving the Centers for Medicare and Medicaid Services.
- Support regulatory, reimbursement, and policy functions performed within the Centers for Medicare and Medicaid Services or by a contractor or consultant.
- Study the effectiveness and quality of care provided by those home health agencies.
- Survey and certification of Medicare and Medicaid home health agencies.
- Provide for development, validation, and refinement of a Medicare prospective payment system.
- Enable regulators to provide home health agencies with data for their internal quality improvement activities.
- Support research, evaluation, or epidemiological projects related to the prevention of disease or disability, or the restoration or maintenance of health, and for health care payment related projects.

- Support constituent requests made to a Congressional representative.

III. Routine Uses

These "routine uses" specify the circumstances when the Centers for Medicare and Medicaid Services may release your information from the HHA OASIS System of Records without your consent. Each prospective recipient must agree in writing to ensure the continuing confidentiality and security of your information.
Disclosures of the information may be to:

1. The federal Department of Justice for litigation involving the Centers for Medicare and Medicaid Services.
2. Contractors or consultants working for the Centers for Medicare and Medicaid Services to assist in the performance of a service related to this system of records and who need to access these records to perform the activity.
3. An agency of a state government for purposes of determining, evaluating, and/or assessing cost, effectiveness, and/or quality of health care services provided in the State; for developing and operating Medicaid reimbursement systems; or for the administration of Federal/State home health agency programs within the State.
4. Another Federal or State agency to contribute to the accuracy of the Centers for Medicare and Medicaid Service's health insurance operations (payment, treatment, and coverage) and/or to support State agencies in the evaluations and monitoring of care provided by HHA's.
5. Peer Review Organizations, to perform Title XI or Title SVIII functions relating to assessing and improving home health agency quality of care.
6. An individual or organization for a research, evaluation, or epidemiological project related to the prevention of disease or disability, the restoration or maintenance of health, or payment related projects.
7. A congressional office in response to a constituent inquiry made at the written request of the constituent about whom the record is maintained.

IV. Effect on you, if you do not provide information

The home health agency needs the information contained in the Outcome and Assessment Information Set in order to give you quality care. It is important that the information be correct. Incorrect information could result in payment errors. Incorrect information also could make it hard to be sure that the agency is giving you quality services. If you choose not to provide information, there is no federal requirement for the home health agency to refuse you services.
NOTE: This statement may be included in the admission packet for all new home health agency admissions. Home health agencies my request you or your representative to sign this statement to document that this statement was given to you. **Your signature is NOT required.** If you or your representative signs the statement, the signature merely indicates that you received this statement. You or your representative must be supplied with a copy of his statement.

CONTACT INFORMATION

If you want to ask the Centers for Medicare and Medicaid Services to see, review, copy, or correct your personal health information which that Federal agency maintains in its HHA OASIS System of Records:

Call 1-800-MEDICARE (1-800-633-4227), toll-free, for assistance in contacting the HHA OASIS System Manager. TTY for the hearing and speech impaired: 1-877-486-2048

CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. A written consent is obtained from all patients that OASIS Pediatric Therapy (with services provided by FRT) admits for services in the event the agency requires additional information from sources not covered by HIPAA. The consent will be obtained prior to using or disclosing protected health information to carry out treatment, payment or health care operations.
2. The patient will be provided the opportunity to review the agency's Notice of Privacy Practices prior to signing the consent.
3. If the consent cannot be obtained prior to treatment due to communication barriers or emergency situations, it will be obtained as soon as possible. Reasons why it is not signed must be documented.
4. The signed consent gives permission to OASIS Pediatric Therapy (with services provided by FRT) and its business associates to use and disclose patient's protected health information only for the purposes of treatment, payment and health care operations.
5. The signed consent is effective indefinitely or until/unless it is revoked in writing by the patient
6. Signed consent forms will be documented and retained for six (6) years after its effective date.
7. OASIS Pediatric Therapy (with services provided by FRT) is allowed and required to disclose protected health information without a signed consent for purposes of law enforcement, judicial proceedings, and public health activities, as detailed in the Notice of Privacy Practices.
8. Privacy regulations with respect to protected health information continues after the patient is deceased.
9. OASIS Pediatric Therapy (with services provided by FRT) will treat a patient's personal representative as the individual for the purposes of the privacy regulation.

CONSENT IS NOT REQUIRED IN THE SPECIFIC SITUATIONS DESCRIBED BELOW

1. Consent is not required if OASIS Pediatric Therapy (with services provided by FRT) received the health information in the course of providing health care to an individual who is an inmate of a correctional institution.
2. Consent is not required in an emergency treatment situation if the provider attempts to obtain consent as soon as it is reasonably possible after the delivery of emergency treatment.
3. Consent is not required if the provider is required by law to treat the individual and the provider attempts to obtain consent but is unable to do so.

We reserve the right to change this Notice and to make the revised /new Notice effective for all health information already received. A copy of any revised Notice will be provided you.

PERSONAL AND HOME SAFETY

I. FIRE

1. At least one smoke detector is recommended on every level of the home.
2. Develop a plan for evacuating your home.
    a. Plan pathways out of your home for fires in various locations in your home.
    b. Assign family members who require assistance to a responsible family member who can assist.
3. Always make sure exits to your home are not blocked with furniture, boxes or similar items.
4. Have a key near all deadbolt locked doors and make sure all family members know its location.
5. Do not leave cooking unattended.
6. Do not leave heaters, stoves, fireplaces unattended during use.
7. Have chimneys inspected annually for creosote buildup or other fire dangers.
8. Don't smoke in bed or when using oxygen.
9. Don't place furniture or supplies near heat sources.
10. Don't wear loose, long clothing near fires or stoves.
11. Baking soda can be used to extinguish small kitchen fires.

II. ELECTRICAL

1. Avoid overload on outlets.
    a. Check label on cords and appliances for rating.
    b. Avoid use of multiple adapters on plug inserts.
2. Replace frayed cords or dispose of appliances with frayed cords.
3. Never run electrical cords beneath rugs or furniture.
4. Cover outlets with safety caps.
5. Never use a knife or fork to retrieve toast while the toaster is plugged in.

III. TELEPHONE

1. Keep telephone instruments accessible for use and within easy reach of all household members.
2. Provide emergency numbers near or on the phone where all family members can see them.

IV. RUGS

1. Secure all loose rugs, runners and mats with two-sided tape, tacks, or nails.
2. Tack down all carpet edges.
3. Replace torn, worn or frayed carpeting.

V. MEDICATIONS

1. Keep all medications out of the reach of children and confused adults.
2. Do not take medications that are prescribed for someone else.
3. Separate medications for individual family members into distinct areas.
4. Know the name of each of your medicines; why you take them; how to take them;

potential side effect; and what foods or other things to avoid while taking them.
5. Report medication allergies or side effects to your healthcare provider.
6. Do NOT use alcohol when you are taking medications.
7. Do not stop or change medications without your doctor's approval, even if you are feeling better. If you miss a dose, do not double the next dose later. Take medications exactly as instructed.
8. Use a chart of container system to help you remember when to take your medications. Your home care nurse can assist you with this.
9. Discard outdated medications.
10. Take medications according to your doctor's prescription and instructions only.

VI. BATHROOMS

1. Nonskid mats, strips or textured surfaces should be used in all tubs and showers.
2. Water temperature should be checked with the hands/arms before entering shower or tub.
3. Grab bars should be installed for persons needing assistance with transfers to the toilet, bath, or shower.
4. Night lights should be used in bathrooms and passageways from bedrooms to bathrooms.

VII. STAIRS

1. Handrails should be in place and utilized at all times.
2. Stairways should be well lit and free from clutter.
3. Beware of slippery surfaces or footwear when climbing steps.

VIII. STORAGE/CLOSET/CUPBOARDS

1. Heavier goods and items should be stored on lowest levels of the space.
2. Use only a sturdy step stool when needed. A rail or bar on the stool is needed for balance.
3. Frequently used items should be stored at eye level.
4. Clean up spills promptly.
5. Keep paint, gasoline, solvents, etc. stored in tightly sealed containers.

IX. GENERAL SAFETY

1. Use all equipment as per instructions.
2. Lock wheelchair wheels prior to transfer.
3. Keep side rails up on beds at all times.
4. Consult a Health Care Professional before implementing an exercise program.
5. Keep entries and pathways clear and well-lighted.
6. Do not open the door to strangers.

X. WEATHER

1. If local authorities issue a **flood** watch, lock your doors and windows. Put important items on upper floors of your house; fill a clean bathtub with water in case local water is unsafe or unavailable.
2. Do not touch electrical equipment if you are wet or standing in water. Never walk

in moving water.

3. During **hot** weather, never leave anyone in a closed, parked vehicle.
4. Drink plenty of water, avoid alcohol and caffeine and don't overeat at any meal or snack.
5. If possible, stay indoors in a well air conditioned or ventilated area.
6. Use water or sponge off frequently when in a warm area.
7. If you feel dizzy, or have nausea, headaches or muscle cramps, cool off and drink fluids. Get medical assistance if these symptoms do not go away.
8. If there is an **earthquake**, protect yourself from falls, falling objects and crumbling buildings. It is best to stay where you are. If inside, get under a sturdy table and protect your head. If you are in a wheelchair, move to a doorway, lock the wheels and cover your head with your arms. If you are in a bed, stay there, pull covers up, and cover your head. If you are outside, stay there and stay away from buildings. When in a car, stop, park away from dangerous items and stay there until the quaking stops.
9. For **tornado** safety, go to shelter immediately. Stay away from windows, doors and outside walls. Access a basement, storm cellar or interior room on the lowest level of your building. Do not attempt to out-drive a tornado, if there is no shelter nearby; lie flat in the nearest ditch, ravine or culvert with your hands shielding your head.

EVACUATION TO A SHELTER

IF INDICATED BRING:

- ❑ A two-week supply of medications/supplies.
- ❑ Non-perishable special dietary foods and a manual can opener.
- ❑ Air mattress, cot, lightweight folding chair, sleeping bag, blankets, pillow.
- ❑ Extra clothing, personal hygiene items, glasses.
- ❑ Important papers and valid ID with your name and current address.
- ❑ Your OASIS Pediatric Therapy (with services provided by FRT) family portal login or folder.
- ❑ Assistive devices such as wheelchair, walker, cane and portable oxygen.
- ❑ If you are electrically dependent and have to go **you must bring your electrical device** (such as oxygen concentrator) with you. Special Needs Shelters have electric power from a generator.
- ❑ **NOTE:** In most cases, pets are not allowed in shelters. IF you do take your pet take food, medications and a bowel for water. Remember to leave food and water for your pets if you need to leave them behind.

INFECTION CONTROL AT HOME

Cleanliness and good hygiene help prevent infection. Improper disposal of contaminated materials such as bandages, dressings or surgical gloves, can spread infection and harm the environment.

WAYS TO HELP CONTROL INFECTION:

1. **Hand washing** – Wash your hands after giving any care to the patient (even if you are wearing gloves), before handling or eating foods, after using the bathroom, changing a diaper, handling soiled linens, touching pets, coughing, sneezing or blowing your nose. Hand washing needs to be done frequently. There are two methods that may be used for cleaning your hands:
   a. Soap and water procedure: Rub your hands together under warm running water with soap for at least 20 seconds. Clean all surfaces and any dirt from under your nails. Use a clean towel or a paper towel to dry hands off. Liquid soap is recommended. Use the same towel to turn off the water faucets.
   b. Waterless antiseptic hand cleanser: If hands are not visibly dirty, contaminated or soiled with blood or other body fluids, an alcohol-based hand sanitizer may be used. Place a dime size amount of sanitizer in the palm of one hand and then rub hands together vigorously, covering all surfaces. If all the washing dries out your skin, you can apply a light amount of lotion after washing.

Hand washing is the number 1 prevention in controlling the spread of infection.

2. **Disposable Items** – Place in a waterproof plastic bag, securely fasten and dispose of in the trash. Sharp items are never to be disposed of in this manner.
   a. One time use items including: tissues, dressings, urinary catheters, disposable diapers, tubing, gloves, etc. can be disposed of in household trash.
3. **Non-Disposable Items** – Proper cleaning of these items are important.
   a. Soiled laundry should be washed separately in hot soapy water. Handle these items as little as possible to avoid spreading infection. Household liquid bleach should be added if viral contamination is present. A mixture of 1 part bleach to 10 parts water solution is recommended to wash viral contaminated laundry.
   b. Equipment used by the patient should be cleaned immediately after use. Small items (except electrical equipment including thermometers) should be washed in hot soapy water, rinsed and dried with clean towel. You should follow manufacturer's recommendations for electrical equipment. Equipment can also be wiped down with germicidal or disinfectant household cleaner or diluted bleach.
   c. Thermometers can be wiped with alcohol before and after each use.
   d. Liquids can be discarded in the toilet and the container cleaned with hot soapy water, rinsed and allowed to air dry.
4. **Sharp Objects** – *Items which are sharp including: needles, syringes, lancets, scissors, knives, staples, glass tubes or bottles, IV catheters, razor blades, disposable razors, etc.* Place used "sharps" directly into a clean, hard plastic or metal container with a lid that can be secured tightly. When the container is ¾ full, secure the lid and cover with tape. Dispose of the contaminated container at the appropriate sites that have been designated for your local area. **Never recap a used needle.**
5. **Spills in the Home** – Blood/body fluid spills are wiped up using paper towels. **Always wear gloves.** Use diluted household bleach to wipe the area once the spill has been cleaned up. Double bag used paper towels and dispose of in the trash.

ON CALL GUIDELINES

OASIS Pediatric Therapy (with services provided by FRT) has a nurse on call 24 hours a day. You can reach the nurse by calling **970-451-1234** anytime**,** if it is after normal business hours; ask to have the RN paged to your home telephone number. The RN will then return your call, answer any questions you may have, or come see you if necessary.

We do not carry medication with us and cannot give anything unless ordered by the physician. If you have a question, please contact our office during regular business hours, if possible, so we can determine if a visit needs to be made and communicate with your physician, if necessary.

In case of a serious medical emergency, the patient should be taken to the hospital emergency room and contact the agency as soon as possible. OASIS Pediatric Therapy (with services provided by FRT) does not operate as an emergency service.

We recommend you call 911 or go to the nearest emergency room under these circumstances:

- Excessive difficulty breathing
- Severe and unrelieved chest pain
- Loss of consciousness
- Excessive bleeding
- Fall or injury resulting in acute, unrelieved pain, inability to walk, or disfigurement at sight of injury that may indicate a broken bone.

Routine supplies or equipment cannot be delivered after regular office hours. Please call the office during regular office hours before all current supplies that OASIS Pediatric Therapy (with services provided by FRT) has agreed to supply you in the home, have been used.

After you have been discharged from homecare with our agency please contact your physician to report any of the above problems.

OASIS PEDIATRIC THERAPY (with services provided by FRT)

CONSENT AND ADMISSION

PATIENT: _____

CONSENT AND RELEASE OF INFORMATION:
I consent to the provision of services and do authorize the staff of OASIS Pediatric Therapy (with services provided by FRT) to provide in home services ordered by physician as noted in my Plan of Care which I participated in developing. I authorize release of information regarding my treatment including inpatient stays, testing and results and payment information to be released from my physician and/or any treatment facility to OASIS Pediatric Therapy (with services provided by FRT) under HIPAA guidelines. I understand and agree that OASIS Pediatric Therapy (with services provided by FRT) may share my protected health information for purposes of treatment, payment and operations.

FINANCIAL RESPONSIBILITY: (AGENCY STAFF TO MARK BOX AND PATIENT TO INITIAL)

☐ ____ I understand that charges for my services are:

SERVICE	FREQUENCY	SERVICE	FREQUENCY	SERVICE	FREQUENCY
_____	_____	_____	_____	_____	_____

I also understand the following: (Agency to note which payor applies. Client to initial understanding)

☐ ____ All my care will be paid for by ___ Medicaid ___Medicare. I certify that I understand it is my responsibility to inform OASIS Pediatric Therapy (with services provided by FRT) if I choose to participate in an HMO or if my Medicaid status changes. I authorize release of all records required to act on this request. I request that payment of benefits be made on my behalf.

☐ ____ OASIS Pediatric Therapy (with services provided by FRT) will bill my insurance. I understand that I am responsible for any portion of my bill that my insurance does not pay. I understand my current co-pay is and my deductible is _____ _____ . I request that payment of benefits be made on my behalf to OASIS Pediatric Therapy (with services provided by FRT). I understand that if payments are made directly to me from a third party, it is my responsibility to pay all invoices from OASIS Pediatric Therapy (with services provided by FRT).

☐ ____ I am responsible for paying my bill within 30 days of the invoice/statement date. I understand that I may be charged 18% interest for any portion of my bill unpaid for more than 60 days.

CONSENT AND ADMISSION AGREEMENT

INFORMATION RECEIVED:

_____ I have received the following and had the opportunity to have my questions answered regarding: Written Consumer Rights & Responsibilities; Agency Disclosure Notice; Charges for all Services; Advance Directives state information and agency policy; Notice of Privacy Rights; OASIS Privacy Information; Emergency Preparedness Training; Access to My Records; Basic Home and Medication Safety; Emergency planning related to a disruption in service; Infection Control; names and addresses of federally and state funded entities in the area and the name of my Clinical Manager.

ADVANCE DIRECTIVES:

☐ _____ Client has not made any advance directive and has no Medical Power of Attorney

☐ _____ Client has made advance directives, location _____

☐ _____ Client has Medical Power of Attorney, _____ ph # _____ location _____

☐ _____ Client has Do Not Resuscitate order, location

_____ I understand that if I make any new or different decisions, I will notify OASIS Pediatric Therapy (with services provided by FRT) and I agree to provide a copy of all my Advance Directives and Medical Power of Attorney authorizations.

CONSENT TO PHOTOGRAPH:

_____ I consent to have photograph(s) taken of me for identification purpose

_____ I consent to have photograph(s) taken of parts of my body to provide supporting documentation of my medical condition. I understand any photograph taken will be placed in my medical record.

_____ I understand that any photograph of me may be shared with my physician, payor source or state or federal surveyors under my HIPAA releases as stated in my admission booklet.

CONSENT AND ADMISSION AGREEMENT

_____ I understand that I am not to do any still photographs, audio or video recording during the time while OASIS therapists are with my child.

COORDINATION OF CARE:

_____ I understand OASIS Pediatric Therapy (with services provided by FRT) must coordinate with all companies providing healthcare services in my home and I agree to share this information with OASIS Pediatric Therapy (with services provided by FRT).

_____ I refuse to share this information, and do not wish OASIS Pediatric Therapy (with services provided by FRT) to coordinate with other providers.

CHOSEN REPRESENTATIVE:

Telephone # _____ Address _____

The scope of participation of my Representative

_____

AGREED UPON DAYS AND TIMES: _____

_____ I understand that my staff scheduled to see me may arrive up to 30 minutes before or after my scheduled visit time.

_____ OASIS Pediatric Therapy (with services provided by FRT) staff have discussed with me, and I understand expected outcomes of care , risk and benefits of my care plan and factors that could impact the effectiveness of my treatment/services/care. I have been provided the opportunity to develop the goals of my care.

_____ I understand that OASIS Pediatric Therapy (with services provided by FRT) is the employer, or contractor, or all staff that provide my care. I agree not to hire any staff from OASIS Pediatric Therapy (with services provided by FRT) while they are working on my case without express permission of OASIS Pediatric Therapy (with services provided by FRT).

CONSENT AND ADMISSION AGREEMENT

I have read and understand all 4 pages of this consent.

Signature Client/Legally Responsible Party Responsible Party/ Relation	Date	Printed Name of Legally

Signature OASIS Pediatric Therapy (with services provided by FRT)	Date

As the chosen representative I was present during the admission visit and understand my role. I have received a copy the Patient Rights and Responsibilities, including the agency Discharge and Transfer policies.

Signature Chosen Representative Representative	Date	Printed Name of Chose

Signature OASIS Pediatric Therapy (with services provided by FRT)	Date

IMPORTANT PHONE NUMBERS:

OASIS Pediatric Therapy (with services provided by FRT): **970-451-1234**

The Clinical Manager: Kristin Ceriani, PT, DPT who can be reached at the agency number

Your PHYSICIAN: _____

Your PHARMACY: _____

Your OXYGEN COMPANY: _____

Your EQUIPMENT COMPANY: _____

Area Agency on Aging:
☐ WELD County: 315 N 11th Avenue, Bldg C Greeley, Colorado 80632 (970) 400-6950
☐ LARIMER County: 1501 Blue Spruce, Fort Collins, CO 80524 970-498-7750
☐ DENVER AREA: 1001 17th Street, Suite 700, Denver, CO 80202 (303) 480-6700

Center for Independent Living:
☐ WELD County: 1331 8th Avenue Greeley, CO 80631 (970) 352-8682
☐ LARIMER County: 1017 Robertson St, Fort Collins, CO 80524 (970) 482-2700
☐ DENVER AREA: 201 S Cherokee Denver, CO 80223 (303) 733-9324

Protection and Advocacy Agency:
ALL COLORADO Child Protection Hotline 1-844-CO-4-KIDS (1-844-264-5437)
☐ WELD County APS: 315 N. 11th Avenue, Bldg C Greeley, CO 80632 (970) 346 -7676
☐ LARIMER County APS: 2555 Midpoint Dr, Ste F, Fort Collins,CO 80525 (970)498-7770
☐ DENVER Area APS: 1200 Federal Blvd, Denver, Colorado 80204 (720) 944-4347

Aging and Disability Resource Center:
☐ WELD County: 315 N 11th Avenue, Bldg C Greeley, Colorado 80632 (970) 400-6952
☐ LARIMER County: 1017 Robertson St, Fort Collins, CO 80524 (970) 482-2700
☐ DENVER AREA: 1001 17th Street, Suite 700, Denver, CO 80202 (303) 480-6700

Quality Improvement Organization- ALL COUNTIES
KEPPRO: 888-317-0891
5700 Lombardo Center Dr., Suite 100 Seven Hills, OH 44131

COLORADO
Department of Health Care Policy & Financing

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

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

Child's Name: _____

DOB: _____

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, bill 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**

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 healthcare 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 OTHER situation, 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